
THE CUTTING EDGE

A Newsletter for Women Living With Self-Inflicted Violence

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This issue concludes twelve years of publication of **The Cutting Edge**, and I thank everyone who has made this possible, especially those contributors who have dared to write their stories so that I, and all the readers, can learn from their experience.

My heartfelt gratitude goes to all of you who have supported this newsletter with your recent donations. I remain amazed by the network of people who receive and support **The Cutting Edge** as it travels throughout North America and to Africa, Asia, Australia and New Zealand, Europe and the United Kingdom. My best to all of you, and thank you for allowing me to keep this work alive.

SIV: WHO ARE THE EXPERTS?

The focus of this editorial is the issue of expertise regarding the concept of Self-Inflicted Violence (SIV). I have long been fascinated by the disparity between what is said *about* women living with SIV compared to what is said *by* women living with SIV. The “why” of SIV depends on who is speaking and their background, experience, and bias; beliefs about self-injury are determined by the philosophy and knowledge of the believer. Oftentimes, the “expertise” of the person holding the opinion is based on formal credentialing, and is deemed more valuable than lived experience. This popular mentality is unfortunate, however, and is often used to invalidate the intuitive knowledge held by each person who lives with SIV herself or himself. Public opinion is often formulated by quotations from “professionals” or “experts,” these often being researchers. How often have you heard: “Research indicates, proves, demonstrates that ____?” This research and expertise is meant to be accepted as truth and proof, yet should not be so simply accepted.

I have spent over a decade searching for and analyzing a variety of research that deals with SIV. Most of the time I have felt battered by the discouraging and disparaging opinions of “experts” about people living with SIV. Most often we have been defined by our labels and discussed in the context of pathology with little attention paid to the context in which we live and to the experiences that have formed our ability to make choices.

Most of the research that I have found that discusses SIV does so in the context of the label of Borderline Personality Disorder (BPD). Much of this discussion has centered on the contextualization of SIV as a problem with impulse control, and the self-injury as a highly troublesome symptom of the “disorder.” It is

still not unusual to read descriptions of SIV being an “attention-seeking” behavior, and the patient described as highly problematic and manipulative. Most of the recommended treatments center on medications and interventions that are meant to change the behavior of the person. Little regard is ever given to the concept of healing. Therefore, this type of research leads to a very pessimistic and rather hopeless perspective for those working with people who self-injure as well as people living with SIV themselves if they believe what is written about them.

Even in research regarding the medicating of “self-mutilating” patients, the authors often disagree about the type of medications they recommend. It is common to see suggestions for “polypharmacy,” which is the use of multiple combinations of drugs until they seem to get the desired result. This “result” is often determined by the researcher/physician’s perception of their patient’s behavior rather than a report of improvement from the patient herself. Of particular interest to me has been the degree to which psychotropic drug manufacturers are involved in the research via funding the actual design and implementation of the work, as well as controlling the interpretation of results. Yet the general public is kept unaware of the amount of funding businesses provide to control what is later determined to be medical knowledge. The pharmaceutical companies also have lobbyists at the federal level and donate heavily to organizations such as NAMI (the National Association for the Mentally Ill, a group that represents the mentally ill, but actually consists of many family members of people with psychiatric labels; the group promotes the biomedical model of mental illness).

Similar trends apply to reports that discuss varieties of new therapies, such as behavioral therapies and techniques like EMDR (a technique based on rapid eye movements to desensitize stress reactions), as well as powerful and invasive psychiatric practices such as electroshock and brain surgery. This is truly a time when consumer awareness needs to be heightened, and the medical establishment exposed for the business side of its practices. Too often these are hidden and the illusion of altruism is promoted. Mental health professionals are finding themselves having to work very hard to determine what is truly helpful for their clients, rather than practicing by what is being currently promoted. Many of the best clinicians have to do considerable research of the research itself in order to form their own opinions. It is my belief that the best clinicians consider their clients as experts on their own lives and healing paths, and work in service as supports and guides for them along the way.

An alarming statement from a monthly publication of the World Health Organization was reported in the February 1st, 2002 issue of *Psychiatric News*. The director of Essential Drugs and Medicines Policy for the World Health Organization said, in regard to American research policies and practices, that “the reliability of clinical trials is seriously threatened in three major ways: conflicts of interest on the part of investigators, inappropriate involvement of research sponsors in the design and management of trials, and publication bias in disseminating results.” The piece went on to discuss an assortment of very serious concerns that should alarm the international community to take American research conclusions with a grain of salt. It is common sense to recognize that a business will only pay millions of dollars for research if there is a great deal to be gained from doing so. An example of this is the title from a recent article published in *Psychiatric News*: “Drug Makers Find Sept. 11 A Marketing Opportunity.”

Many clinicians who work with clients who self-injure are not aware of the way research is currently being conducted. Yet there is increasing skepticism, and a growing concern about research practices and how those outcomes dictate treatment choices and reimbursement. Not all mental health care workers accept the literature so readily. For example, let me tell you about a “game” I play with a dear friend who is a physician. We go through her professional journals, videos, tapes, and pamphlets that come from a variety of sources, including pharmaceutical companies as well as professional organizations. I don’t show her the information. Instead I tell her the title of the article or video, and name the “illness” being addressed as well as the company that has paid for the research (described by the words “unrestricted grant by (name of company)”). She then names the drug made by that company and I go to the conclusion section of the information and, not surprisingly, we both discover that “x” company’s drug works more effectively than other companies drugs for the treatment of the disorder being discussed. As a result, we have discovered that a plethora of drugs and a few therapies work for treatment of SIV, but each depends on who wrote and funded the article! This would be amusing if it weren’t so horrifying. A naive person might presume the information to be accurate and unbiased.

So what does formal research say about people living with SIV? If you ask psychiatrists you will hear that it is caused by mental illness; if you ask addictionologists, you will hear that it is caused by an addictive disorder; if you ask prison guards, you will hear that it is the behavior of manipulative inmates. If you ask trauma specialists, some will say that SIV is a repercussion of abuse (or other trauma) survival, often linked with childhood sexual abuse or other severe forms of abuse. Depending on the clinician, they may or may not view SIV as pathological and needing to be stopped before continuing with therapy, or they may view SIV as a “negative” coping strategy that helps manage the sequelae of trauma. Some will believe that people who self-injure need to be hospitalized for “their own good;” others may promote written contracts to encourage or demand their clients to stop self-injuring. The most helpful will work on developing a trustworthy relationship with their clients and, in the process of healing the multiple repercussions of trauma, work on the SIV if and when the client wants.

What if you ask people living with SIV and their allies about self-injury? You’ll hear something very different and vastly more reasonable and hopeful. You will hear that self-injury serves an assortment of purposes in the life of someone who is coping with intense pain and struggle, and who has learned that self-injury at least temporarily mediates times of great stress and emotion, often preventing the profound despair that can lead to suicide. SIV helps to manage dissociation that is so common in survivors of childhood abuses. It gives a voice to the inner pain that cannot find an outlet any other way. It can serve to communicate and express and de-stress. For whatever reason people self-injure, there is a personal purpose to the behavior and, therefore, great potential for healing. And we do heal, if we choose to and if we have support for the journey. Healing is the development of a respectful relationship with oneself, often facilitated by the development of a relationship with another person who already respects us and recognizes our strengths and integrity before we do. Specifically regarding SIV, there are many ways to heal from it. Some people want to address it as a highly troublesome area, and may invest a great deal of effort and energy in learning how to avoid self-injury. Others may not see it as needing such an intense focus, and may want to focus their therapeutic work on other aspects of their lives. The healing of trauma however, will gradually lead to the healing of SIV, either way. Successfully stopping SIV may be considered a positive outcome of therapy, but what if the person remains imprisoned by her history? Is not cutting enough? Traditional research would say yes – success is the elimination of the behavior regardless of how you got there. I think it is more than reasonable to say that we can expect more than that as an outcome. We can expect movement towards healing and not a simple reduction of symptoms. Whether we believe this or not is determined by what we believe the reasons for SIV are. Which brings us back to the issue of looking at research.

As I see it, research is meant to address issues of concern by identifying the issue, the context in which it exists, and the various factors which impact how things might change, possibly figuring out a way to identify a particular “intervention” that causes a measurable change. It is much easier to construct research that measures the elimination of behavior rather than research that would evaluate the growth of potential, ability to make proactive choices, and a sense of integrity. Yet this is the direction human mental health research must be directed if we are to begin to understand what constitutes healing. As difficult as this type of research is to do, it will ultimately bring us much more useful knowledge, perhaps even some glimmers of wisdom about human potential. Perhaps much more difficult than figuring out how to actually do this form of research is finding a source of funding to pay for it. Certainly the current major funders are not interested, for what would the pharmaceutical industry have to gain from this type of research? Yet there is much to be gained from efforts in this direction.

What brought about all this thinking about the impact of research on people who live with SIV? Imagine my surprise, a little over 3 years ago, when I was asked to join a federal research project. The job has provided me with an opportunity to involve myself in a five year long project assessing new and sometimes innovative ways of providing services for women who have received multiple labels and who have histories of experiencing violence. We are attempting to measure the impact of various services women receive to learn if, when addressing many of the woman’s needs and provided in an integrated fashion, they really help her. The hopeful part is that such services must at least partially address the violence that she has experienced in her life. Unfortunately, we are mostly measuring standardized interventions. We are barely scratching the surface when it comes to analyzing the quality of relationships that impact a woman’s life.

But there has been a beginning attempt to do so, and it will hopefully provide us with at least a sense of what women find helpful for themselves as they struggle with profound problems. Hopefully we will gain much-needed information to further our knowledge about what helps women heal, and provide impetus for future research of the sort that addresses all the issues that face many of the most marginalized persons in our society. Certainly I think that bold steps have been taken in that direction, as evidenced by my involvement with the project. However the research turns out, at least it has welcomed this cynic to express her thoughts and roll up her sleeves with everyone else!

I want to share with you that I've just spent almost three weeks locked in a filthy little box for cutting myself. Twelve of those days were spent naked while being viewed, by anyone who entered the office, via closed circuit TV. It was awful. I wished for death many times.

I've written the first "poem" I've composed in months in this letter. It's how I feel at present:

*I can't help myself, the demons of
My past do my presence of mind
Freak, that's what you are – a freak
I am fooled into believing that one
Small, shallow cut will suffice and I
Foolishly set that goal for myself,
Thinking that I can stop after one
Little harmless cut – a scratch really
But, of course, that doesn't happen
The razor comes alive in my hand
Develops a life of its own
Becomes my enemy once again
To become an object of ridicule
A societal outcast – yes, a freak
To seek help only makes things worse
Who feels "better" stripped and locked
Up in a filthy cell?
Yes, doctor, I'm okay now, I have no
Thoughts of harming myself – yes,
Tell them whatever they want to hear
Anything to get out of this hole
Wondering endlessly what I might have
Done to deserve such a blemish
Upon my life – why should I even
Try any more anyhow? What's the point?*

... A lot has happened to me since I wrote that. To make it brief, I am currently housed in an inpatient psychiatric unit with the institution. The guards violated my right to confidentiality by ripping the pages out of my journal and art therapy book, passed them around amongst themselves, then punished me by sentencing me to thirty days in solitary confinement – because they didn't like what I had said. However, mental health won't back me up – even though art therapy and journaling is/was my course of therapy. Now, I'm being threatened with discharge and face going to confinement.

I'm not ashamed to say that I'm afraid to go to confinement – because of the hostility displayed towards me by various guards. Confinement has always been a notorious place to be beaten up and otherwise abused, without any cameras or witnesses anywhere. I was severely brutalized down there seven years ago and I wear a brace on my leg as a result, and will for the rest of my life.

I am fighting the desire to slash my entire body open, from head to foot. Deep gashes. Not any superficial stuff. So that's what's going on at present.

CeCe (BCI)

Abused One

a tortured soul,
the razor is my only
calm, release, my only
peace. The overwhelming
pain. am I insane?
maybe they are right
I am evil and to blame
I feel there's no help or peace
for me. I guess I
don't deserve it.
But maybe I do.
I "hurt" everyone I touch
"God why was she born so black and blue?"

Sandra

Goodbye

You took away the pain inside.
Causing new pain that made me hide.
I don't need you any more.
Please don't knock on someone else's door.
Goodbye old friend, goodbye.
I really don't want to die.
I hurt myself as you stood by.
You helped me through the toughest times.
As the hurt inside took over you helped me find relief.
That only caused a new kind of grief.
Though the relief inflicted was of great pain as well.
I've lived through my own kind of hell.
Oh I live in such shame, will life ever be the same?
I just can't go on this way.
Now it's time, time to say goodbye to all the pain.
I'll say goodbye to all the tears and all the bloodshed that we've shared.
Thank you for pulling me through these times of despair.
When no one else seemed to care.
Goodbye one last time I'll say now, it's time for you to go.
I've reached deep inside my heart.
I have found a brand new start.
I have the strength to say I really want you to go away.
Oh Lord I pray you never come back this way.

Paula

I am a 38 year-old veterinarian and survivor of incest that I've been able to trace back four generations on my father's side of the family. When I was growing up there was domestic violence, alcoholism, drug abuse, and incest going on... all behind the public illusion of a white, middle-class, professional, Christian family. As I was the youngest of five children and the one to have to endure the obscene dysfunctionality the longest from day to day, I developed Dissociative Identity Disorder (DID) at a very young age. It is a severe mental illness that I believe my father also suffers from (my abuser). It is also what literally saved my life in the long run.

My SIV became conscious to me when I was a young teenager. I had eating disorders and often banged my head against walls when I was alone. I had episodes of severe depression that was not diagnosed or understood throughout high school being an outwardly appearing perfect young woman. I didn't begin cutting myself until my mid-twenties when my life seemed to be spiraling out of control. Though I still managed to be the best in my profession and work as an emergency veterinarian in Buffalo, NY. One day, after driving home from work, I dissociated and tried to literally euthanise myself. This was in 1992 and it was the first of four serious suicide attempts over the next nine years. I was hospitalized nearly thirty times during that period of time for SIV, depression, and losing time (DID). I was fortunate to have a wonderful psychiatrist who was everything and more for those nine years... we were a team together.

I always went to the same hospital, Strong Memorial Hospital in Rochester, NY. Sometimes I would be there only in the emergency room for a night, once I was there for eleven weeks. I nearly killed myself three times.

*What is important to acknowledge is that, over the nine years, I saw a transition taking place and even a transition in how the hospital and staff treated me as I learned the **skills** needed to stay alive and safe to make it through the healing process completely. Every one was important, from my therapist to my primary physician, the nurses, activities therapists, art therapists, the maintenance and cleaning staff, to the long list of supportive friends I developed over time. I learned how to ask for the things I needed to feel safe -- like only women with me when I was on 24 hour one-to-one watches, to asking to not be watched as I went to the bathroom or showered. Gradually, I learned all the symptoms and **triggers** of the symptoms, which allowed me to get myself to a safe place **before** something happened. But it was extremely HARD! It took years of SIV before I got the hang of it. Therapy was the heart of my healing process. I was completely disabled for many years, but it allowed me to have therapy 2-3 times a week if needed. Sometimes all I could try to look forward to was my next breath. I did need medications for depression, mood stabilization, and help with sleeping, but the number of medications has dramatically decreased over time. I resisted antipsychotics as they seemed to only render me unfunctional and I wanted to hear my voices after I began to gain an understanding of my illness. The staff at the hospital truly seemed to be going through this with me as I reflect back... they kept hoping for me like an extended family.*

*I am writing to you tonight because I want to let you and other SIV sufferers know that it is possible to completely heal from SIV and a traumatic past. I feel I can **thrive** now as a human being for the first time in my life! I feel afraid to die for the first time in my life in a healthy way... I want to see my future now!*

*The scars and burns my body wears are always constant reminders to me of how strong a person I am inside. I do not feel shame any more to wear clothes that disclose my past... they (the scars) are a part of who I am and what I've accomplished in life. I found myself agreeing with Dr. Gilbert (interviewed in the Summer 2000 issue), as one who has come full circle, on almost every thought that she expressed. It takes a **profoundly observant** and **compassionate** person to realize all that she stated in your interview. As a veterinarian, my skills in observation and searching for answers have led me to my own recovery. SIV survivors need to first of all be compassionate to themselves. I was once advised to try to completely avoid or remove myself from everyone in my life that could not be 100% supportive. It was the best advice I ever received.*

Dr. Beth C. Stoutz, D.V.M.

Resource Review

Pharmaceutical Industry Agenda Setting in Mental Health Policies. Richard Gosden, PhD and Sharon Beder, PhD. *Ethical Human Sciences and Services: An International Journal of Critical Inquiry*, Vol. 3, No. 3 (Fall/Winter), 2001: pp. 147-159.

This article powerfully and effectively describes the multifaceted ways pharmaceutical companies manipulate to determine public health policies that ultimately provide for their financial gain. The authors inform the reader of the multitude of ways that this is done, including the use of front groups as advocates, public relations campaigns, and funding of research. An in-depth discussion of these processes is given by focusing on the recent pharmaceutical industry campaign to set the agenda for policy regarding schizophrenia. This fascinating and enraging expose` describes how the drug manufacturer used multiple methods to promote its drug, including the development of an anti-stigma campaign which promoted the elimination of discrimination by focusing on the need of schizophrenic persons to be medicated, and underhandedly promoting the belief that unmedicated persons with schizophrenia are prone to violence. As many people have to be coerced to keep taking antipsychotic drugs, the campaign also advocated for forced treatment on many fronts, bringing in the new phrase of "assisted treatment" to downplay the coercive nature. Of interest was the fact that as patents for the old drugs were expiring, the new drugs were being promoted as solutions, and it is only then that the harm caused by the old drugs started appearing in the psychiatric literature. The authors stated:

The use of sophisticated public relations techniques for setting political agendas has become a standard practice in most advanced democracies. The consequences are slowly becoming apparent. The system of representative democracy is being reshaped into a new kind of "managed corporatocracy" in which public opinion and government policy are custom-made products that can be shaped, packaged and sold by skilled public relations experts.

I think this article is necessary reading for anyone who still believes that medical research and treatment are based on attitudes of concern for patients or scientific inquiry. Certainly we must be critical and not believe all that we are told by the pharmaceutical industry, whether via television commercials or professional literature. If you are in doubt, please read this piece.

Skin Picking as a Form of Self-Injurious Behavior. Fugen Neziroglu, PhD, ABPP; and Marla Mancebo, MA. *Psychiatric Annals*, Vol. 31, No. 9 (September), 2001: pp. 549-555.

I am reviewing this article to provide readers with insight into what some clinicians are doing with psychiatric research and issues of SIV. These authors take one particular form of SIV, which they call skin picking, and look at it from a variety of diagnostic angles." It is apparent that the authors relate skin picking behavior to obsessive-compulsive disorder when one observes that this article appears in the journal subsection titled "Neuropsychiatric Aspects of Obsessive-Compulsive Spectrum Disorder. The authors also mention other diagnoses they think might be related, such as borderline personality disorder, body dysmorphic disorder, and delusional disorder-somatic type (formerly titled monosymptomatic hypochondriasis). They then attempt to correlate skin picking with mood disorders, substance use, and genetic disorders. Basically, they are striving to make the issue of skin picking a separate, yet major, psychiatric issue.

The authors discuss possible neurobiological influences, making various suppositions but not validating anything. It is in the discussion of psychological influences that the authors seem to grasp the idea that skin

picking may be a form of coping mechanism to deal with emotions and/or dissociation. At this point they mention the possibility of childhood abuse as a factor, but limit the discussion to family modeling of abuse. There is no further mention of any possible precipitating trauma as a factor in this form of SIV. Trauma-focused therapy is not mentioned in the discussion of possible treatment options, but medications, behavioral therapies, and stress management techniques are.

This article is a good example of dissecting a patient into an assortment of diagnoses and problem areas and never looking at the patient as a whole person who has a history and unique set of personal strengths as well as struggles. The process described here of studying one particular behavior shows the perception of SIV to be as a separate and isolated problem that may or may not be related to other diagnoses. It seems that the authors are pushing its identification as a unique category of its own. That would provide for yet another label for patients to be given, and some prestige for the authors. This article provides a good example of how this process begins.

A Critique of Medical Coercive Psychiatry, and an Invitation to Dialogue. Ron Leifer, MD. *Ethical Human Sciences and Services: An International Journal of Critical Inquiry*, Vol. 3, No. 3 (Fall/Winter), 2001: pp. 161-173.

Written by a physician, this article is unique in that it is calling all of us to open ourselves up to the idea of dialogue on the issues of mental illness, coercive psychiatry, social control, and personal responsibility. In his introduction, the author discusses his main criticisms of the medical model of psychiatry, and identifies several major areas of concern, including research methods and practices, as well as the use of coercion to serve as a method of social control.

The body of Ron Leifer's article outlines 10 points of criticism of medical coercive psychiatry, and he presents information on each point. His first, "Who Controls the Discourse?" discusses the degree of silencing and repression that critics of psychiatry have and still face in this country. He mentions the degree to which academic and professional journals and institutions go to prevent open dialogue on the issues of biopsychiatry and forced "treatment," and points out that such silencing violates the basic principles of the scientific method itself. He says:

Critical discourse and debate, while anathema to those whose personal careers and ideological agendas are sustained by the medical model, might allow the emergence of new paradigms for understanding human behavior and new strategies for addressing vexing modern problems such as our endemic domestic violence, stress, anxiety, and depression.

His further points are all very worthy of discourse, if such could happen. He explores the use of the medical model of psychiatry to function as an instrument for social control, where coercive practices are meant to be interpreted as benevolent interventions. He discusses the relationships between coercive-medical psychiatry and the drug companies and the insurance industry. He identifies how psychotherapy is discouraged via the use of the medical model, and therefore access to therapy has become highly limited, as it is often excluded from insurance reimbursement. Dr. Leifer goes on to explore the further impact of biopsychiatry on the concept of personal responsibility, and the diminishment of focus on real social issues. He says: "To regard anger, aggression, and violence as symptoms of brain disease distracts us from a criticism of the social conditions and values of our anomic, consumer society in which desires run rampant and violence is recreational." He explores this through the example of the diagnosing of so many children with ADHD, which places emphasis on a supposed brain defect rather than current school culture.

In the midst of his criticisms, Ron Leifer takes a moment to "pay homage" to mental health practitioners who act as helpers, utilizing the qualities of warmth, wisdom, respect, and kindness in their work with people who are suffering. Regarding medical-coercive psychiatry, he writes "If our thoughts, feelings, and actions are no more than neurochemical eruptions, then we have lost our humanity... We have lost the

capacity to heal ourselves.” I agree that this is the pessimistic belief system of traditional psychiatry. I also agree with Dr. Leifer that respect and kindness can go a long way in helping people heal their wounds. A dialogue on this is much overdue.

The Cutting Edge, published quarterly, is a forum for women living with Self-Inflicted Violence and our allies. I am interested in your opinions and experiences, and in publishing the work of women who have lived with or are currently living with SIV. Please consider contributing to *The Cutting Edge* in whatever way you can. Poetry, prose, art and opinion statements are welcome. Artwork is limited to that which can be reproduced by photocopying. Please include a written statement with your work giving me permission to publish. Please let me know if and/or how you wish to be identified. All communication is kept strictly confidential, as is the mailing list. Your work is needed, appreciated, and celebrated. **The address for *The Cutting Edge* is P.O. Box 20819, Cleveland, Ohio 44120 USA. I can also be reached via e-mail at rutamaz@eohio.net.**

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Ruta Mazelis, Publisher

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