
THE CUTTING EDGE

**A Newsletter for Women Living With
Self-Inflicted Violence**

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Welcome to the beginning of the thirteenth year of **The Cutting Edge**. It feels incredible to recognize that this newsletter has been in publication for over a dozen years. As always, I remain continuously grateful to those of you who have made this possible through your support and contributions.

This issue serves as an opportunity to reflect on the past twelve years of **The Cutting Edge**. In pulling my thoughts together, it is my hope that sharing what I have learned over the years will be of use to those of you who struggle with self-injury or care about those who do.

DEMYSTIFYING SELF-INFLICTED VIOLENCE:

LESSONS LEARNED FROM THE PAST DOZEN YEARS

So often I think about all that I wish could be changed to better support people living with Self-Inflicted Violence (SIV). I have a habit of looking at what needs to be done and often forget to stop for a moment, take a breath, and reflect on the changes that have occurred, the progress that has been made. This editorial serves as that look backwards, at how things have changed for those who live with self-injury, and what has been learned in the process. My reflections span both what I have witnessed occurring in the mainstream mental health community, and what I have learned from the profound privilege of dialoguing with people who live with self-injury.

A diversity of terms has evolved over the past 20 years to describe what was initially labeled as “self-mutilation.” In the late 1980s SIV was barely mentioned anywhere except for psychiatric literature writings about Borderline Personality Disorder (BPD), the only diagnosis that psychiatry specifically mentions self-mutilation as part of. This label, most often applied to women, became the hallmark label of self-injurers, especially those that were deemed to be “treatment resistant,” “manipulative,” or otherwise frustrating to clinicians. The self-mutilation was described as being a simple attention-seeking behavior with manipulative intentions. The person cutting herself was perceived to do so in an attempt to get the attention of the professionals she came in contact with. What was not discussed very readily, however, was the type of attention that woman would receive.

Psychiatry's traditional response to people living with SIV has been to focus on stopping the behavior regardless of the reasons it exists, and regardless of what the impact of such "treatment" might be. Treatment that makes SIV "go away" is acceptable and lauded. Therefore, it remains standard that people living with SIV are shamed, controlled, forcibly restrained, secluded, drugged, and committed to institutions. While these forms of "intervention" rarely have a lasting impact on stopping self-injury, they have a profoundly wounding impact on the person being coerced by them.

Progress in the psychiatric community has been agonizingly slow. Awareness of the impact of trauma on mental health diagnosis and treatment has remained limited, although the diagnosis of Post Traumatic Stress Disorder has gained attention since the terrorist attacks of Sept. 11, 2001. However, this focus, and the mentality of understanding traumatic stress in general, has remained very narrow. As well, the focus of treatment has emphasized the use of psychiatric drugs. This is, of course, not surprising as the majority of the research on psychiatric disorders has been funded by the pharmaceutical industry itself. Fewer people are able to access psychotherapists, especially those knowledgeable in trauma dynamics. The attention has remained on the management of symptoms as if there were little possibility of actual mental/emotional/physical/spiritual healing. The advent of managed care has led to fewer resources for most people, and it is not unusual to find most mental health coverage limited to the provision of psychotropic drugs. One benefit is that at least it is no longer as easy to institutionalize people against their will. However, the general public seems to be gaining insight into the business of medicine, and many people are beginning to question the disease mentality touted by the drug industry. Perhaps the pharmaceutical industry's television commercials will eventually backfire as people no longer choose to believe in marketing strategies to provide health care advice.

Regarding SIV, psychiatry remains judgmental rather than understanding, although there are pockets of physicians who are doing excellent work with those who self-injure. They remain, however, quite difficult to find. Slowly there has been increased awareness of the need to separate SIV from suicidal intentions, even in those persons who experience both the desire to die as well as self-injure. There are some clinicians who now understand the implications of labeling someone with BPD, and refrain from sentencing them to the stigma that comes with it. This is progress, yet BPD remains the most common diagnostic label applied to people who live with SIV

While the impact of psychiatry remains generally destructive rather than helpful to those who live with SIV, there has been an increasing improvement in the way other mental health professionals approach clients who self-injure. Over the past years I have noticed a growing acceptance of the concept that SIV is a form of coping method that people utilize to manage very difficult emotions or otherwise intense stressors. Of particular grace are the therapists who have continued to work from the knowledge that life experiences can cause profound harm, and who work with people from a base of dignity and compassion, understanding the importance of walking alongside those they aim to help, rather than acting upon them.

There has been more exposure of the topic of self-injury, both in the professional literature as well as the mainstream media. Some of it has been useful, some sensationalized, some serving as a barely disguised advertisement for a hospital program. I think that, after the initial outpouring of interest, people have begun to accept the presence of those who live with SIV, and have begun the process of understanding its roots. Perhaps, very slowly, the intense reactivity to self-injury is beginning to abate.

I remember the very first workshop I organized on the topic of SIV, held in 1988. I distinctly recall the nervousness of the participants, the fear we all shared of exposing ourselves to each other just by showing up, as if attendance somehow implicated a person as someone living with SIV. We released a lot of collective shame, confusion, and loneliness that day. The understanding and respect we showed for each other remain in my bones. I am reminded of them every time I receive a letter from someone saying "I didn't know that I wasn't alone with this."

In that very first workshop I remember the fear of one woman who was very concerned about being seen, even though she lived several states away from the workshop site. She was a mental health professional, concerned about being exposed for living with SIV. She was sure that she would lose her job, and the professional respect she had earned, if her SIV were to become known. Certainly her fears were realistic.

Unfortunately not much has changed in the mental health community to allow for the wisdom of those who have lived experience, as well as professional training, to draw from in their work. This lost opportunity to learn openly from those who have journeyed to healing is poignantly sad.

I have been tremendously moved by the privilege of listening to the voices of those who live with SIV. These voices are diverse. They are the voices of the young and old, women and men, people of many races and cultures. Some are wealthy, others poor. Some are physicians, academics, engineers. Others are institutionalized in prisons and psychiatric hospitals. Most remain very private about their lives with SIV, others are open about their scars. All want relief from their personal pain and struggle. All deserve the right to decide how they choose to live.

How does SIV provide relief? Many people living with SIV say that the self-injury helps them maintain psychic integrity, however briefly, that helps them survive intense discomfort that might otherwise lead them to consider suicide. All of the people I have communicated with regarding SIV have a history of some form of trauma in their lives. This trauma is significant enough for them to struggle greatly with painful emotions and/or dissociation (the feeling of mental fogginess and disconnectedness from the world around oneself). Most often the trauma is a history of abuse, especially brutal childhood violence, often sexual as well as physical, and profound neglect. Yet we remain in a culture of silence regarding abuse. We'd rather believe people are smitten by mysterious brain diseases rather than the reality that they react to trauma in a wide variety of ways, and with a creative assortment of coping methods.

So why do people cut their arms, burn their stomachs, punch their faces? Because they hurt. Hurt more than the cut, the burn, or the punch. It is all relative. And when those who wish to be helpful understand this, and attend to the deeper pain, to the much more tragic wounds, then great possibilities for healing become available. Demands to stop SIV, contracts to punish those who do not, restraints, drugs, and seclusion rooms to make sure "it cannot happen" remove choices, narrow vision, compound the pain.

Many, many people are in pain. The voices of the teachers who have taught me about self-injury come from throughout the United States and Canada, from Africa and Europe, India and Asia, Australia and New Zealand, and the United Kingdom. From all of these places I have heard that women have felt alone and misunderstood. I have learned that they found hope and compassion through connection with others by learning that, they too, share similar experiences. Most of us have been victimized, some brutalized, by the systems of "care" that judge, shame, punish, and sometimes destroy us. Some women living with SIV have found others who are willing to serve as enlightened witnesses and guides for healing. Some have shared their stories of healing, and they can teach us all a great deal about perseverance, resilience, and the power of hope.

This is what I have learned: that if you acknowledge the greater pain, whatever its source, you can hope for change and healing. If you care for someone who is living with SIV and you acknowledge the deeper wounds, you can then gain the privilege of bearing witness to the pain and serve as an anchor and a salve to the wounded soul. You can participate in a partnership for healing rather than serve as a mechanism for revictimization. It is that simple. This is a path of compassion for self and others, with a vision of hope that promotes incomprehensible healing and maximizes human potential.

What I have learned from the past twelve years of listening to people whose lives have included SIV is to bring you a message of inspiration and hope. Inspiration from witnessing the strength and creativity of the human spirit as it manages to survive great brutality and profound despair. Hope from the awareness that people strive for healing, first surviving, but then actually pursuing a greater vision and a grand experience of life. People who are "self-injuring" are not. They are surviving their painful moments. People whose wounds have begun to heal have the experience of moments of life without despair, with a vision for the future. Women whose scars are fading and receding have uncovered, through great effort and the willingness to hope, a life that truly validates the belief that there is so very much worth surviving for. I celebrate you all.

I see
My body
 marred
by the indentations
 made
by my own teeth
I bite down
viciously
longing for
pain
to tell me
I am
 still
 alive.

The Biter

Seeing that I've had fall and winter as a vacation from nosy inappropriate remarks about my appearance, I sit here bracing myself for the return of this particular ramification of life with or after SIV. Most people associate late winter/early spring with frantically dieting to "get in shape for summer." However, I have come to use this part of the earth's life-cycle to expand my repertoire of responses to unsolicited inquiries from those who I have come to term the "unS.I.V.-ilized," or those not living with SIV.

Here are a few of my favourites (credit to my best friend for some of them):

- Homicide prevention: I do this to myself so I don't have to kill people that can't mind their own business.
- My plastic surgeon was on LSD.
- I don't know what it is, but the last person that asked me that question died from it.
- It's an allergic reaction to _____ (fill in the blank by choosing the appropriate answer: ignorance/stupidity/bad parenting/misogyny/the education system/modern medicine/psychiatry)
- It takes a lot more than 10 orifices to filter out all the bullshit I have to deal with on a daily basis.
- Sure I'll tell you what happened to me, but you have to tell ME what happened to YOU first.

Loruh Glehn Golden

The Porn Scene

You have done exactly
what they wanted you to do
for years

But now
you are no longer nice
you snap back
hold the door closed
beg to be allowed
to have control
over your own body

Find sympathy
with the abused kids inside
and comfort them

When you are denied
the control
on some level
you know
you deserve

You slash at the body
they've hurt for so long
slash back

Damaged goods
surely they will not want you
for their porn flicks
if you are damaged

But no
the show goes on

They only accentuate
your recent wounds
with fresh blood

And sputter
"Good job!
You're helping us out."

It seems
there is no way
to win control

Dead girl would be
a star feature
in their snuff films

They might regret
not being able
to drag out
the murder

If you did a neat and tidy job
of doing yourself in
(which rarely happens)

Is there no way out?

But wait

Somebody says
"It's over now
That was almost 30 years ago."

Perhaps we're already out

But why
doesn't it feel like it
yet?

I am a survivor of child pornography and prostitution. Sometimes I feel like I'm the only one. But I can't be. There's so much evidence of the abuse and it is expanding exponentially with the Internet.

There was no better training ground for self-injury than the snuff film industry. They skillfully combined rape and torture to link the pleasure and the pain centers in your body so that sometimes when we've cut we feel sexual stimulation. It's a horrifying experience to find your body's responses all mixed-up like that but it helps to understand where these urges come from.

For years I identified as a "Ritual Abuse" survivor. I have come to describe myself differently as I have recognized that "Ritual Abuse" is simply live-show pornography (like theater is to film). I feel fortunate to have enough memories now to recognize that, as a child and young woman, I was in the control of the vast and powerful multi-billion dollar sex industry and this is where my urges to self-injure come from. ("Mental Illness" my ass!)

As we are remembering, feeling, and healing we experience the urge to self-injure less and less. We actually had three months free of self-injury over one of the most difficult times of the year. When we hurt again, it was a victory, in and of itself, in that a big person in us was able to help a small person in us to stop scratching and then comfort her. We really rejoice when we can help each other inside.

Natasha

*The latest issue of **The Cutting Edge** began with an article regarding “I don’t need to subscribe any more... I am not longer a cutter.”*

I, too, am no longer a cutter or a cigarette burner. Hurrah! I have been free of this self-inflicted violence for well over six months, which amazes me every single day. Yes, I still think about it during stressful moments, but I have no desire to actually follow through on those thoughts.

As a medical librarian in a psychiatric hospital, I am now “on the other side of the fence” so to speak. As I look at the inpatients, where more than once I was one, I can honestly say, “I don’t belong there any more.” As I see some with bandages on their wrists and arms, where more than once I had them, I can honestly say, “I won’t do that any more.”

Some of my scars are visible, though fading with time. I am not ashamed of them because they represent an earlier stage in my life – in my growth, when I felt I could not express my despair and pain in any other way. There are people who are close to me who understand those pale lines and why they are there. There are other people who never will understand and that is their loss, because they cannot allow themselves to see some of the results that are caused by evil.

Paula Agranat Hurwitz

Skin Secrets

my skin tells the story
of the pain that i feel
each scar holds an emotion
that i didn’t reveal

i beg the world
say “look at me”
they do, then i hide,
i want no one to see

how will i overcome,
what i feel within?
i no longer want to be afraid
don’t want to keep it all in

yet i can’t tell a soul
for they won’t understand
my life is controlled
by the blade in my hand

but i keep the pain deep inside
never to reveal
the secrets
that only my skin can tell.

Tiffany, 20, Self-Injurer for 6 years

It doesn't work anymore. No thrill. No stupor. No dissociation. Lost my two best friends in the same week. Now all that is left to do is feel. Feel bad. Feel sick. Feel stupid, like a big failure. I can barely bring a blade to my arms any more. I don't even care that the marks I make won't be "etched in stone." And I'm left without a vice. No more "escape valve." Loss. Yet another loss. I can't keep cutting, but I'm terrified to stop. No "results," just humiliation. Don't care if I make the more severe kind any more.

I sit here with bloody arms, no relief, and all the same feelings I started off with, only worse. It is hard to have faith that not cutting will get easier, and the need will diminish, even when I feel horrible, hate myself, and regret things I've done and long for things I can't have and/or haven't had. I feel like the worst asshole in the world. My best friend and I fight constantly and self-injury (the other best friend) has decided to leave after 20 years. 20 out of 26.

I feel pathetic and dare not get my hopes up too high as I know I'll only be let down again. But I've stopped everything else from caffeine to bulimia and anorexia, drugs, alcohol, cigarettes – you name it. That leads me to believe that on some level, the possibility of never having to cut again is not out of reach.

And the biggest obstacles are fear and self-hatred, and how to channel the two, or how to at least learn to give myself a break until I can learn to accept myself.

It just isn't fun any more. No more relief. No more charge at the sight of deep, "fresh" wounds. Just shame and lots of bad feelings, compounded by the "coming down" off of the adrenal charge brought by the blade. And I'm left alone. No blade. No best friend. No company of others. It hurts to lose it all, but it is certainly not the first time. I cut because I lost my hopes and dreams to chronic illness. I cut to punish myself for hurting the ones I love. I cut to express anger too big to fit inside the confines of my body.

It too is coming to pass. Dissociation has turned into humiliation. "High" has become a neutral comedown of self-hatred worse than that which prompted me to resort to self-injury in the first place.

I need to learn to speak with my words, not lashes, blood, scars, and sutures. If I learn to open my mouth rather than my skin, maybe I'll see some transformation. I'm tired of this. Eleven years of cutting. Before that, I was pulling out my eyebrows and eyelashes at age six.

I want out. I want thrills that will last. I want to create good memories to replace the sea of bad ones. I want to do something that will matter in a week or year or a decade. I want to create works of art, not make an art of destroying everything I create for myself. I want something that doesn't hurt.

Loruh Glehn Golden

RESOURCE REVIEW

Sexual Abuse and the Problem of Embodiment. Leslie Young, M.A. *The Journal of Child Abuse and Neglect*, Vol. 16, 1992, pp. 89-100.

Now, ten years after its publication, this article remains viable and vibrant in how it addresses abuse and its sequelae. Rather than the more current style, which links abuse with so-called "illnesses," the author here directly links the events of a traumatic childhood with the development of intense struggles later on in life. She describes the link between childhood sexual abuse and the development of dissociative disorders,

including multiple personality disorder (now renamed as Dissociative Identity Disorder), eating disorders, somatic disturbances, suicidality, and self-injury. She explores the power of abuse by delineating the impact it has on a person's relationship with her physical body. The author states: "a child experiencing severe sexual abuse, seemingly faced with physical and psychological annihilation, may abandon the body, make it 'outside me,' pretend it doesn't exist or turn on it in anger and confusion." Within this context, it is only logical and understandable that the body/mind relationship in an abuse survivor becomes a complex and conflictual one. While the intensity of this disconnection may appear great, this perspective does bring with it a real hope for the possibility of healing. The author particularly mentions the healing potential of the creative art therapies as being fruitful for the possibility of reparation. It is unfortunate that these therapies are rarely available, and often not affordable for many persons.

My hope is that Ms. Young has further developed her thinking regarding her discussion of "self-mutilation." Her perspective in this article is limited and incomplete. She does not correlate the existence of dissociation with SIV, and therefore presumes that self-injury serves to perpetuate an abusive cycle by producing physical pain. This is most often not true. Ultimately the purpose of self-injury is the reconnection of the mind with the body, and that is accurately portrayed. Given that this article is one of the first I read that placed SIV in the context of trauma and its repercussions, there is much of value here. It is my hope that the author has continued to expand her ideas and broadened her work.

Healing Trauma: Guided Imagery for Post Traumatic Stress (PTSD). Belleruth Naparstek, music written by Steven Mark Kohn. Copyright 1999 by Belleruth Naparstek. Produced by Image Paths, Inc. 891 Moe Drive, Suite C, Akron, OH 44310. 1-800-800-8661; <http://www.healthjourneys.com>. Cassette \$12.95, CD \$17.95.

I am often asked for helpful resources for persons living with SIV, and I can gladly recommend this tape as a potentially useful tool for healing. Belleruth Naparstek is a social worker who has long worked with the ideas of intuition and guided imagery. She brings her rich experience to her work in making this tape for people experiencing the effects of stress. More than providing simple relaxation, the imagery contained within the tapes leads to a deeper personal journey of gentle discovery of one's losses and sorrows and helps facilitate a way of giving them not only recognition, but soothing as well. It can be used often without seeming repetitive or boring.

Belleruth Naparstek provides tapes that focus on a variety of areas, from issues of physical health to imagery for dealing with anxiety, depression, and other common struggles experienced by those who also live with self-injury. These may well be worth investigating as well.

Rights, Research and Liberation. Sherry Mead, MSW. *The Rights Tenet*, Winter/Spring 2002, pp. 3 and 15. Available from the National Association for Rights Protection and Advocacy, P.O. Box 1712, Port Washington, NY 11050-1712; <http://www.narpa.org>.

In this time of television commercials touting drugs for sleep, depression, and "social anxiety disorder," we often hear the words "research says..." It is imperative that we view research with a critical eye, assessing it for its worth rather than blindly presuming its correctness. Traditional psychiatric research is done in a vacuum, analyzing symptoms with little regard to context. In this refreshing piece, Sherry Mead challenges us to consider that "At a time in mental health when we are talking about 'paradigm shifts,' we forget that our methods and practices of research must also shift." This brief article is an example of research that is run by consumers, is qualitative in nature, and pays attention to the culture and context in which people live. Much of it revolves around the telling of personal stories as "stories are a relational, dynamic phenomenon that can allow people to challenge their self-images and contribute to the ways in which their listeners/researchers/readers must challenge their own stories and the cultures within which their stories are constructed."

I believe that this type of research would be beneficial for all persons interested in the topic of SIV. What a powerful action, and intense learning experience for everyone, it would be if we gathered together to share and learn from our own stories. The powerful conversations that would be had would be much more informative than clinical drug trials meant to manage people deemed "objects." It is imperative that we make the time and energy available to have the opportunity to speak our own story, and to listen to those of others. We can then challenge our assumptions about ourselves, each other, and the society in which we live. The richness of information to be obtained there is not to be underestimated. I believe that we would learn that there is much more hope and healing to be gained for all of us than traditional research would allow.

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 6196 Vo Ash Dr. SW, Carrollton, OH 44615 USA. I can also be reached via e-mail at rutamaz@eohio.net.**

The future of **The Cutting Edge** is entirely dependent upon your contributions and donations. I am very grateful for the donations I have received. No one is turned away from receiving this publication because of an inability to pay. If you wish to receive the newsletter, please make a donation of \$10 - \$30 per year. I request that professionals and others with financial resources make donations of at least \$20 - \$30 per year. Also, back issues are available. I request a donation of \$10 - \$20 for the compilation of the first two years of publication as well as the following yearly compilations. In order to avoid high bank fees for processing checks from outside the U.S., I respectfully request that international donors send money orders in U.S. dollars. Once again, thank you!

Ruta Mazelis, Publisher

This issue of **The Cutting Edge** was written in May, 2002 in Cleveland, Ohio. All rights are reserved by Ruta Mazelis, Publisher. Rights of individual contributors are retained by the contributor. The mailing address for all correspondence is: The Cutting Edge, P.O. Box 20819, Cleveland, Ohio 44120 USA. Neither the publisher nor laywoman contributors are engaged in the practice of medicine. Women living with Self-Inflicted Violence may wish to consult competent professionals for help with all treatment