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the Cutting Edge

A Newsletter for People Living with Self-Inflicted Violence

Welcome to this, the 67th issue of *The Cutting Edge*. My deepest thanks to all of you who shared your experiences, beliefs, and wisdom about living with SIV while incarcerated. The paper on this topic is now complete, and I hope that it will promote understanding and healing. It will be available from the web sites of The National Center for Trauma-Informed Care (http://mentalhealth.samhsa.gov/nctic) and the Sidran Institute (www.Healingselfinjury.org). If you do not have Internet access, please feel free to write or call us at the Sidran Institute and we will send you a copy of the paper. I was so touched by the willingness of people to share their struggles and hopes. I feel honored to include one of the pieces I received in this issue. I hope that it touches your heart and inspires you when you read about Stephanie's healing journey.

I am currently working on papers to encourage understanding of SIV in young people and would appreciate your thoughts and opinions on what it is like to be young and living with SIV. I'd be grateful to learn about how SIV serves you, how it hurts you, what is helpful to and what has been hurtful to you in how people respond to you, how you feel about life with self-injury, and anything else you might want to tell. Thank you in advance for taking the time to teach others.

—Ruta Mazelis, Editor

Self-Inflicted Violence— An Addiction/Not an Addiction: Does It Matter?

The idea for this editorial came to me as I struggled to write a review of *Secret Scars: Uncovering and Understanding the Addiction of Self-Injury* (see p. 7). The perspective that Self-Inflicted Violence (SIV) is a simple, biologically based addiction has been gaining acceptance, and while I understand why this is so, I believe it is important to consider the repercussions of labeling people who live with SIV as addicts to their own self-destruction.

SIV can certainly appear addictive. It is a behavior that brings relief when experiencing distress, can be habitual (its effect will continue to work over time), and can appear to increase in intensity over time (especially if it is not understood, the person does not have support to begin healing, and traumatic events continue to occur or are re-experienced by the survivor). SIV can feel out of control, is often kept secret, and often gets people "in trouble" with family and friends.

Why does SIV feel like an addiction to some people? Because it is a means of coping and that is the primary fulfillment of most addictions—they provide temporary comfort, changing feelings and experience. There are different ways to think about what addiction is. For some people the concept of addiction is limited to substances that are physically and psychologically mood-altering, such as methamphetamines, heroin, alcohol, nicotine, caffeine, or prescription drugs such as Oxycodone. (There are people who become physically addicted to narcotics but not psychologically dependent on them. These people use the narcotics as measures to alleviate severe physical pain. Are they addicts?) It has also become popular to consider many other behaviors—such as gambling, eating, shopping, and surfing the Internet—as addictions. This perspective has now been applied to SIV as well.

There are some mental health professionals who argue that SIV is a chemical addiction in its own right. It is this promotion of the idea that SIV is a simplistic chemical addiction that concerns me the most. In *Secret Scars*, the author gives the impression that people who scratch their forearms end up in a drug-induced haze as a result. The chemicals that are being portrayed as the culprits in this scenario are the endogenous opioids known as endorphins. These are chemicals found normally in the brain at different times and are believed to act as natural narcotics. The current thinking is that SIV causes these chemicals to be released and that they therefore provide the self-injurer with a "high."

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At first glance this seems to make some sense, as SIV tends to bring feelings of relief and calm. But it doesn't hold up under deeper scrutiny. First of all, the majority of wounds resulting from SIV, if any, are medically very minor, and there would be no reason for the opioids to be released in a quantity large enough to give someone a "high." If minimal injuries did this, many of us would feel "high" after getting paper cuts and bruises, but we don't. What makes sense is that the endogenous opioids are already present in the body as part of a post traumatic stress reaction, in response to trauma or the triggering of past trauma, *before someone self-injures.* Intense emotions, flashbacks, or dissociation all bring on physiological reactions that include biochemical ones—those that are responsible for the fight, flight, or freeze responses that we see in survivors of trauma. Some of the chemicals released at times of stress include the opioids, and I believe it is they that provide the analgesia, the numbness, for the wounds of SIV, as many people who self-injure feel no pain at the time. The opioids are present before the SIV, not as a result of it. The SIV serves as an action that interrupts the stress response by signaling that the experience of crisis is over and the body can then regain balance, thus leading to calming and relief.

The suggestion that SIV is an opiate addiction led some psychiatrists to prescribe the opiate antagonist drug Naltrexone to people living with SIV. Antagonist means that the drug blocks the effects of the opiates. What happened? SIV and other coping strategies didn't seem to help, and people taking the drug simply felt numb as a result, as if they were living zombies. They said that they didn't feel much different than when overwhelmed with doses of antipsychotic drugs, which are also very numbing. Of course, no one wanted to continue living this way, and they stopped taking the drug. It is rarely prescribed any more, although it was originally touted as a medication breakthrough for treatment of self-injury. It is another example of how the emphasis on eliminating SIV at any cost, without understanding the purpose it serves in the life of the person living with it, leads to unacceptable interventions. The greatest danger occurs when these forms of treatment are forced on people as mandatory solutions when they are, in effect, retraumatizing and add to the person's stressors. Perspectives that focus only on biology or on eliminating SIV at all costs ignore the understanding of why these behaviors occur in the first place, and people, when perceived from this perspective, are not guided to understand the functions of their behaviors, nor the aspects of their lives that are still impacting them and causing pain, confusion, and anxiety.

Does it matter if SIV is seen as an addiction? What truly matters is what we believe about addiction as a whole. Some see addiction as a moral weakness, some as a biological illness, others as a coping strategy following traumatic experiences. Of course, I believe that the first two perspectives are hurtful to people and that the latter is accurate and hopeful. I share the perspective of John N. Briere, author of *Child Abuse Trauma: Theory and Treatment of the Lasting Effects,* who wrote:

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Resource Review

Secret Scars: Uncovering and Understanding the Addiction of Self-Injury. V. J. Turner. Copyright 2002 by Hazelden Foundation. Published by Hazelden, Center City, MN 55012-0176.

I began reading this book with hope and curiosity. While not in agreement that SIV is a simple addiction, I was eager to hear what the author had to say, knowing that she would be writing about her experiences as someone who has self-injured. My interest grew as the author strongly identified the history of trauma that exists in the lives of people who live with SIV and discussed the high prevalence of childhood abuse as an important aspect of that trauma.

Ms. Turner's acknowledgment of the painful histories of people who self-injure is the strength of this book. The text soon deteriorates into a discussion of SIV being an addiction to brain chemicals. Of additional concern, the author unfortunately promotes the idea that SIV is primarily a problem for women and girls when she states that few men or boys self-injure and that those who do are dramatically more self-destructive. While these beliefs were once prevalent, along with a host of other misperceptions, it is now clear that men and boys live with SIV, and that their reasons for self-injury parallel those of women and girls.

My hopes deteriorated as I kept reading. When mentioning how often the diagnosis of Borderline Personality Disorder is given to people who self-injure, the author avoids mentioning the controversy about this diagnosis and how it brings mistreatment to most who receive it. Yet the author decided to create controversy by questioning the validity of Dissociative Identity Disorder (formerly known as Multiple Personality Disorder). The creation of alternate personalities is a way of responding to severe childhood trauma and many who are multiple live with SIV. When the author states that many people have been misdiagnosed with it, and that it is extremely rare, I knew that I would be greatly disappointed by this book. Instead of furthering the reader's understanding of trauma and its repercussions, Ms. Turner's writing begins to sound like a misguided text on psychopathology. Beyond this discussion of psychiatric diagnoses, the author then presents a different opinion, that of SIV being a chemical addiction. The author dramatically argues that self-injury is no different than substance abuse and that addictions are simplistically biologically driven. This simplistic, and unproven, perspective ignores the reality that many behaviors that appear as addictions serve the purpose of helping people manage the repercussions of prior trauma. By portraying self-injury as only a negative addictive behavior without any discussion of how it serves people, such as providing an alternative to suicide by providing temporary management of extremely painful emotions, the author does people living with SIV a great disservice.

In the section on "where to go for help" Ms. Turner divides resources into different categories, such as medical help, psychological/psychiatric help, and 12-step programs. Each of these has subcategories but rarely is trauma care even mentioned. The author is supportive of coercion and unwanted/unrequested interventions. Most unfortunately, nowhere in the book does she inform the reader about the potential harms of different psychiatric interventions, or point out the risks of revictimization that come from engaging with the mental health system. Her dramatic demand that SIV be stopped immediately, and that there is no movement toward recovery until one stops self-injuring, are dangerous and unenlightened opinions. It feels as if she has not recognized the impact of her own history on her own life, and has not yet developed a compassionate understanding of herself, much less her clients. The saddest I felt in reading this book came when Ms. Turner mentioned, in a list of how her self-injury had harmed her, that she lived with the fear that the SIV might get worse and she might die and then "God wouldn't be too happy with [her] and [she] might have to do some time in purgatory or hell." I would rather believe that she had survived her hell, and that SIV had helped her to get through some of it for a while.

In the section on healing the author never mentions trauma work, outside of stating that one must not address trauma for a year after beginning recovery. These sorts of dictates concerned me greatly. There is no mention of the importance of empowering clients, helping them to understand how SIV served them. There is little mention of peer support outside of suggesting that people living with SIV attend open AA (Alcoholics Anonymous) or other 12-step meetings. People who care about those who live with SIV were directed to obtain professional care for them without any suggestion that the person living with SIV needs to direct what, if any, care they wish to receive. What confused me is that the author must have come across much more healing and optimistic information as she quotes the work of people such as Robin Connors, Ph.D. (author of *Self-Injury: Psychotherapy with People Who Engage in Self-Inflicted Violence*) who promote trauma-informed and client-directed care while refuting the need for force or coercion. I am curious as to why this way of promoting healing from SIV was not mentioned, much less highlighted.

More than anything else I learned not to naively believe that someone who has lived with SIV in the past will promote compassionate and understanding ways of responding to others who live with SIV. My naivete has been eliminated, now I can only hope that Ms. Turner will consider looking at this topic from a kinder, less psychopathological perspective. I really don't want to believe that those of us who lived with SIV are simply addicts out of control or at risk of needing to do time in hell.

To Bear My Soul

To bear my soul,
is to cry, to tell a tale
of hopeless love;
to relive a life that
seems a dream.
Little food, rare parent-teacher conferences,
Dingy hand-me-downs, drug deals, abandonment
and death.
Life began the 24th of February in the year 1979.
My cherished parents took me home, loved me,
Cherished me.
A story book,
perfect family.
A third birthday,
a pony
came from Illinois,
and a life-long dream was born.
July 21st, 1984, a gift,
for me, arrived from my
mother's swollen belly.
A sister,
Jessica Lee.
May 5th, 1986,
another present,
from my mother's enlarged abdomen,
a baby brother, Justin Reed,
labeled for my grandfather.
On my eighth birthday,
a black and white,
sweaty POA, a gift I hated,
but soon stole my heart.
Caprice, Jessica, and Justin became my life
when we were abandoned for drugs.
A deadbolt lock appeared on our
Parents bedroom door.
Strangers came and went.
Secrets created and lives demolished.
An uncle, Barry,
plagued with muscular dystrophy,
a confidant, a companion, a best friend,
I found gone, forever,
taken from me by pneumonia.
A seed was planted from where
a depression would grow with death
attached.
Bodies mishandled,
innocence assassinated
by one of their drug comrades
What could a ten-year-old child
ever do to deserve a distinctive
detail destroyed by a sick demented man,
we called uncle?
A quest for love began.
A boyfriend and
yet another.
Caprice's life no longer part of mine.
My companions,
dogs and horses,
Chase and Kit,
Jessica and Justin,
Grandma and Grandpa
Kept me breathing my
Heart beating.
When denied a love, a question unanswered,
two shots. One bullet
meant. A man dead, and
a woman bleeding.
A mistake,
his life wasn't meant.
Only mine.
The life I knew,
gone, changed forever.
A day never ends, when his life isn't
Missed.
Two lives directly, permanently
destroyed, many more changed.
My love for him could never be put into words.
All I wanted was the love that had been given to
loan sharking, gambling, marijuana, and a
powerful, destructive drug they called crank.
I sit here alone, in myself.
The bodies fall on the radio,
the rage builds,
restraint used for no more scars,
disfigurements,
or death designed for me.
But they did the best they could.

Stephanie Sara Timothy

. . . the various behaviors described [such as SIV and substance abuse] . . . relate less to acting out, impulse control problems, or addictions than they do to the overwhelming dysphoric tension experienced by many abuse survivors. In the face of extreme abuse-related distress, often restimulated by revictimization and/or perceived abandonment or rejection, the survivor may engage in any number of external activities that anesthetize, soothe, interrupt, or forestall painful affect.

Some might call those "external activities" addictions, I call them coping strategies, but ultimately what is important is the understanding that these are a means of providing temporary comfort for intense reactions to trauma.

We know from the Adverse Childhood Experiences study (www.acestudy.org) that people who become addicted to drugs, including nicotine and alcohol, tend to have had more adverse childhood experiences than those who don't. They have greater physical and emotional health problems, even decades after their childhoods. Many people who receive psychiatric labels, and not only those labels that are obviously understood to be repercussions of trauma—such as Post Traumatic Stress Disorder and Dissociative Identity Disorder—have histories of childhood trauma. It is becoming more apparent in the literature what some have been espousing for quite some time: that people who are labeled with disorders such as schizophrenia, bipolar disorder, eating disorders, anxiety, depression, and various personality disorders have histories of some form of trauma. If you listen to people who have recovered from these disorders you will hear that one of the most important aspects of their healing was understanding the relationship between their histories and their struggles and having that connection acknowledged. If we ignore this relationship and focus solely on what we perceive to be biological origins (rather than biological adaptations) then we miss wonderful opportunities for facilitating healing for ourselves as well as others, including our communities as a whole.

Not long ago, Oprah Winfrey devoted a program to people who had had bariatric surgery after living with obesity. The surgery drastically changed the amount and types of food they could eat, and the participants lost a great deal of weight. That weight loss wasn't the focus of the show, however. Rather, it was the fact that when food no longer became an option, they turned to alcohol, relationships, and other behaviors to provide what food no longer could. They turned to other addictions as ways to cope with unaddressed historical events and pain.

In the same regard, it is not unusual for people who are recovering from substance abuse who had not self-injured while using drugs to turn to SIV when clean and sober. This is especially true for those people who have intense and prolonged histories of childhood trauma. People can spend their lives changing addictions, switching from obvious problematic ones such as drug abuse, to more hidden and/or socially acceptable ones, such as workaholism or hyper-religiosity, but they remain in pain regardless. Healing is much more than the absence of addiction.

How do most people heal from their addictions? The single most successful means of healing from substance abuse is participation in 12-step programs such as Alcoholics Anonymous. Some people choose to believe in the tenets of 12-step programs, yet others, who do not, still benefit greatly from being in a community of people who share similar struggles and hopes for recovery. The experience of this sort of "peer support" is known to be helpful to many people, addressing various problems. This newsletter is a good example. It was founded on the belief that providing people who live with SIV a space and opportunity to express themselves and connect with each other in some way is useful. It certainly seems to have been, as *The Cutting Edge* has been in existence for nearly 17 years.

To "work the steps" of any 12-step program requires participants to admit powerlessness over their addiction and to acknowledge that the addiction has made their lives unmanageable. When considering SIV an addiction, this can be problematic for many people, especially those who see the useful aspects of SIV in their lives and not just the negative ones. Also, while we might feel that SIV is out of control in our lives, most of the time we have choices we can make regarding SIV. Many people do not stop self-injuring based on a commitment to abstinence or based on acknowledging their powerlessness. Most slowly stop turning to SIV as they begin to understand both the SIV and their histories. Many are able to reduce the harmfulness of their SIV as they continue to develop healing alternatives. When I ask people why they stopped cutting, burning, punching themselves, or living with any form of SIV, they say that they simply did not need it any longer, they had acknowledged how it served them and made changes in their lives to help them heal from the wounds of the past. This is very different from feeling that you are a victim of a biological illness that has left you helpless. Helplessness often triggers trauma reactions, while empowerment heals.

It has been quite a while since I worked as a chemical dependency counselor in various settings. I remember giving lectures on the "disease concept" of addiction and promoting the idea that addictions are simplistic biological illnesses, just as mental illnesses are being portrayed today. A few years later the very research that I had been quoting was debunked, and I was surprised. Those were the days when I just begin-

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Contributions

My name is Stephanie Sara Timothy. I'm 27 years old. I've been incarcerated since July 19, 1998. At 19 years old I killed my boyfriend in a suicide attempt. I'm the oldest child of three. My parents have been married 29 years. I now have a 22-year sentence.

I first found myself thinking "I'm depressed" after my Uncle Barry's death. I was 13 years old when I found him dead in his wheelchair. He was one of the greatest men I have ever known. I felt an intense feeling of guilt for his death. I found comfort only in my horse, Caprice, and dog, Chase. I began to cry a lot—soon to follow was fascination with death. It began with my wishing for death, wanting nothing more than to not wake up in the morning. By the age of 15 I was using drugs, engaging in casual sex, ditching classes, and sneaking out at night. Yet, I was also active in the sport of cutting. At this time I didn't know of any act of self-harm with that name. I rode a "cutting" horse, attended cuttings with my grandfather. It was something I was good at and enjoyed immensely. Unfortunately it didn't have the power to keep me in a positive mindset at home.

When I was 16 I took matters into my own hands and attempted suicide. I took every medication that was in the house. All this did was make me incredibly sick. When my mother found me in the living room throwing up, she didn't notice the pills or see it as a suicide attempt. She had been up for days on meth. She didn't know better. This only quelled my hunger for death temporarily. To bury my mental anguish I eventually gave up drugs for physical pain. It started with a steak knife, but soon graduated to a razor I found in my father's tool cabinet. I took to carrying it around with me; I found comfort in this. Back then the cuts weren't deep, more or less just beyond scratches, nor were they frequent. At one point I had even gone a year without cutting.

On July 18, 1998, I once again found myself dancing with death. My last suicide attempt killed my boyfriend. Immediately after shooting him I shot myself in the head. The bullet ricocheted off my head, fracturing my skull. We were found by friends. Later I was charged with first-degree murder. During my time in county jail I was so drugged up that I didn't feel like taking care of myself, let alone hurting myself. I took a plea bargain and walked into the Colorado Department of Corrections with a 48-year sentence. This was a tough pill to swallow so more antidepressants were prescribed. This clouded all thought processes, creating a zombie.

I don't remember the first time I resorted to cutting again, but I do remember the pain was unbearable. The wounds weren't too bad and they were well hidden. But after a visit with my family I had to be stripped out, and my secret became a burden for the staff at CWCF. Mental Health was notified.

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ning to learn to think critically about research and the business aspects of medicine and the social sciences.

When I worked with a director who understood that the young people we were hoping to help had histories of trauma, we considered the substance abuse as "medicating" the repercussion of the trauma. Later, after a management change, the staff was instructed to consider substance abuse a disease without a context, and any attempt to help people understand the impact of trauma was negated. Even people who had survived severe trauma, such as rape, were confronted on using the trauma as an "excuse to use," and therefore the trauma was not to be addressed, nor was there any exploration of how substance abuse dulled the repercussions of the trauma. This shift in philosophy greatly impacted how well people did during treatment and afterwards. It was a very frustrating time, to see understanding and opportunities for healing begin to evaporate, and that trend continued for quite a few years. Now people living with SIV are treated in much the same way—they receive demands that they stop the behavior regardless of how it serves them and with little or no understanding of the roots of their struggles. And yet we do know that there is a better way.

So, what difference does it make if we see SIV as an addiction or not? Certainly it is up to the people living with SIV to decide what it means to them, how it serves them and how it doesn't. I don't believe that opinions of mental health professionals or addictionologists can or should override the ultimate expert—the person living with SIV who is experiencing both gains and losses from the behavior. So I ask that you consider what serves you and your healing regardless of what you are told about your life with SIV. Please be gentle with and honor yourself in the process.

At times the need to bleed would subside for months on end, at other times it lasted weeks. July 2004 through November 2004 the cutting became more intense, then diminished for a short time. In March 2005 the urge to cut attacked me like a wolf does his prey. The cuts became deeper, more frequent. By June I was cutting at least once a day. Not once have I had to be taken to medical for stitches. Some could have used sutures, but my desire to keep them hidden overruled that. At times I would talk to my "therapist" about it, desperate to make the desire diminish. But DOC has done little to help me in my recovery. Because I do not do enough damage they don't care much. Mental Health keeps me on my meds. They'll ask about the desire to cut, but when it comes down to it nothing is done. This is a common behavior in the facility, but most "cutters" use cutting in a different manner than I do. This makes it difficult because population "classifies" me with this group. These "cutters" cut deep, requiring immediate medical attention. I use my cutting as a way to typically hide my anguish, sadness, and guilt. If I use violence against myself I can typically hide all the negative feelings, appearing quite happy and content to those who don't know me. This decreases the questions and prying, providing a completely false sense of security and comfort.

Many people are surprised that I indulge in such behaviors. Some say, "You're too pretty to be doing that to yourself." Honestly, this helps in no way. I feel so ugly inside and disfigurement makes the outside match the feelings within. For some reason people have a difficult time understanding this. I also use disfigurement as a punishment. I will do this to myself to remember the act that I messed up, creating a reminder not to do it again. At times I feel so incredibly stupid that I don't deserve to be happy or pretty, so I'll cut.

The most help I have received has been provided by those with no psychological training, the other people who are housed here with me. The ones I have allowed close enough to get to know the real me. The people who do not acknowledge my problem help me more than anyone else. I'm not quite sure why. When people help me by giving me bandages, it helps. It may seem backwards but perhaps I'm backwards. When people aren't afraid of me or the fact that I may cut this helps me to feel "normal," which helps the desire decrease.

Being in prison is in no way helpful to the sickness that thrives on hatred, loneliness, and guilt. In Colorado they don't try to cure a person. They don't provide the necessary equipment for a person to want to heal themselves. They will give you Elavil, Effexor, or some other antidepressant and send you on your way. I'm not saying it is impossible to better yourself here, they just don't seem to care if you do or don't. From my observation it is those who do nothing for themselves who are paroled. The ones who actually work on bettering themselves are stuck with denials and setbacks, leaving me, among others, with hopelessness as well as a "why should I?" attitude. It's sad and depressing, but a trap that can be avoided. Personally, I've two-stepped a little too close to this trap. Luckily I have found that somehow things could always be worse. I'm fortunate, I'm appreciated, loved, and I know this. I have found true love, my family, and hope for the future. This all I found myself, within myself, for myself, my family, and those I love.

It is crazy how those who can make you want to stop hurting yourself can also make the desire so intense. Learning to live and deal with this has been one of the hardest things I've ever done. I don't want to be looked at as the girl who can't cope. That is not the way it is. I am the girl who has learned to cope in a manner which frightens others. What many fail to realize is that usually what scares a person is what they don't understand.

One thing that has most recently made me feel the desire to harm myself is the departure of my best friend and roommate. When she left I made a verbal contract with her, more like a deal, that I won't cut unless she uses. <u>That</u> has kept me from cutting.

What it all comes down to is yes, I am a felon, a murderer, a cutter. I have been diagnosed with Dependent Personality Disorder, Post Traumatic Stress Disorder, and Dysthymia. But I am a sister, an aunt, a daughter, a granddaughter, friend, and lover. I am Stephanie Sara Timothy, a young woman who has survived herself.

Stephanie Sara Timothy