

An Insider View on Specialty Units

By Gail & Co.

Last year, after an almost uncountable number of admissions to general adult psychiatric units, we found ourselves again confronted with another ultimatum to seek admission to a private psychiatric hospital having a unit specializing in the treatment of MPD. Two prior refusals on our part had resulted in the eventual discontinuation of therapy with each of the two recommending therapists. At that time we could not handle outpatient therapy. When confronted with this we accepted the reality that to eventually reach a stage where outpatient therapy would be effective for us, we needed the intensive therapy and care provided on a specialty unit. It is only today that we can see the damage done to ourselves, those around us, and our family in general—damage created by existing in a constant state of crisis.

When our therapist and all of us began wading through the vast quantities of pamphlets and brochures provided by the various facilities, we carefully examined what our needs were at that point in time. There are many such specialty units and it's important to be aware of each particular ones' philosophy and modes of treatment, the patient community size and environment, and what type of treatment regimen each offers to the prospective client. We had to make an educated guess as to which facility would be the most effective for us. For all of us that included details such as whether or not the unit was a locked one (some are, but many aren't); that their beliefs in forms of child abuse were consistent with that which we had experienced, particularly ritual abuse; (Some units do not accept and thus do not work on issues related to ritual abuse); were their modes of therapy consistent with that which we needed (restraint therapy, videotaped amyntal interviews, etc.); that they offer intensive individual and group therapies; the cost for hospitalization and therapy (this is something generally not stated up front and in most instances can be

determined by a phone call to the unit coordinator); whether or not they operated on any type of progressive level system, and whether or not each alter within our system would be accepted out on the unit. (This is essential for us.)

The specialty unit which we decided upon was one which had a large patient community and had a warm, comfortable environment which allowed for a smooth transition into unfamiliar surroundings. Within a short period of time we had developed a support system on the unit. It was comforting to be with other multiples, many of whom had similar difficulties. The days were comprised of hours and hours of individual and group therapies, topic groups, art therapy, movement groups, and other activities specifically designed for the treatment of MPD and Dissociative Disorders. Each of us inside learned that it was safe to let go and through doing this, however scary it may have been, alters who otherwise would not have been able to work in outpatient therapy worked through major issues. We emerged with a new awareness and understanding of each other.

We would not be where we are today if we had chosen not to embark on this route. We still have difficulties today, but the lengthy period of time on a specialty unit helped us to progress rapidly and reach our current level of functioning. Now, after years of attempting outpatient therapy unsuccessfully, we are continuing our rapid progression toward integration on an outpatient basis successfully.

Inpatient treatment was a last resort for us, and we certainly do not believe it is a necessity for all multiples to achieve either integration or a general cooperative system among alters. In our instance it was necessary due to the large number of alters in our system, the fact that at the time we were living in a remote area of the country that lacked expertise in treating MPD, amongst us there existed many violent and self-

destructive alters who were constantly creating difficulties, and there were constant hospitalizations on general psychiatric units with no improvement. There was no other alternative at that time. All of our surrounding family, friends, our therapist, and especially all of us benefitted from this experience. We cannot remove all of the scars from our arms, legs, hands etc., nor can we change how the many years of existing as we did has affected our family. But now we can go on with the knowledge that our future can be as magnificent as we make it.

All of us would like to give many thanks to *Many Voices* and all of its inspirational contributors, the psychiatric community of Cincinnati where we were initially diagnosed with MPD, the psychiatric community of Pacific Northwest who convinced us to take these steps towards healing, and to the dedicated staff of the particular MPD/DD unit where we took these important steps. You all have been so helpful!

MV

You're Award-Winners!

All folks who contributed to the book *MPD: From the Inside Out* should have received a plaque for their very own wall from the ISSMP&D for your accomplishments. Instead, the editors got the plaques (Barry Cohen, Esther Giller, and myself) from the ISSMP&D at the Rush/Presbyterian MPD Conference in Chicago, November 1991. But *you* are the real winners... without you, there would be no book! There are 8,000 in print now and the response from clients and therapists is terrific. There's even a wonderful, positive review by Dr. Kluft in *DISSOCIATION*, the professional journal of the field. So give yourselves a pat on the back, or come to Cincinnati and I'll do it for you! THANKS and Congratulations!

—LW

Healing

(a positive experience in a special facility)

By S.B. Haven

No bleeding hearts required here
for there are already too many ruptured souls.
Hundreds of people yet very few bodies
all searching for themselves amidst deep dark holes.

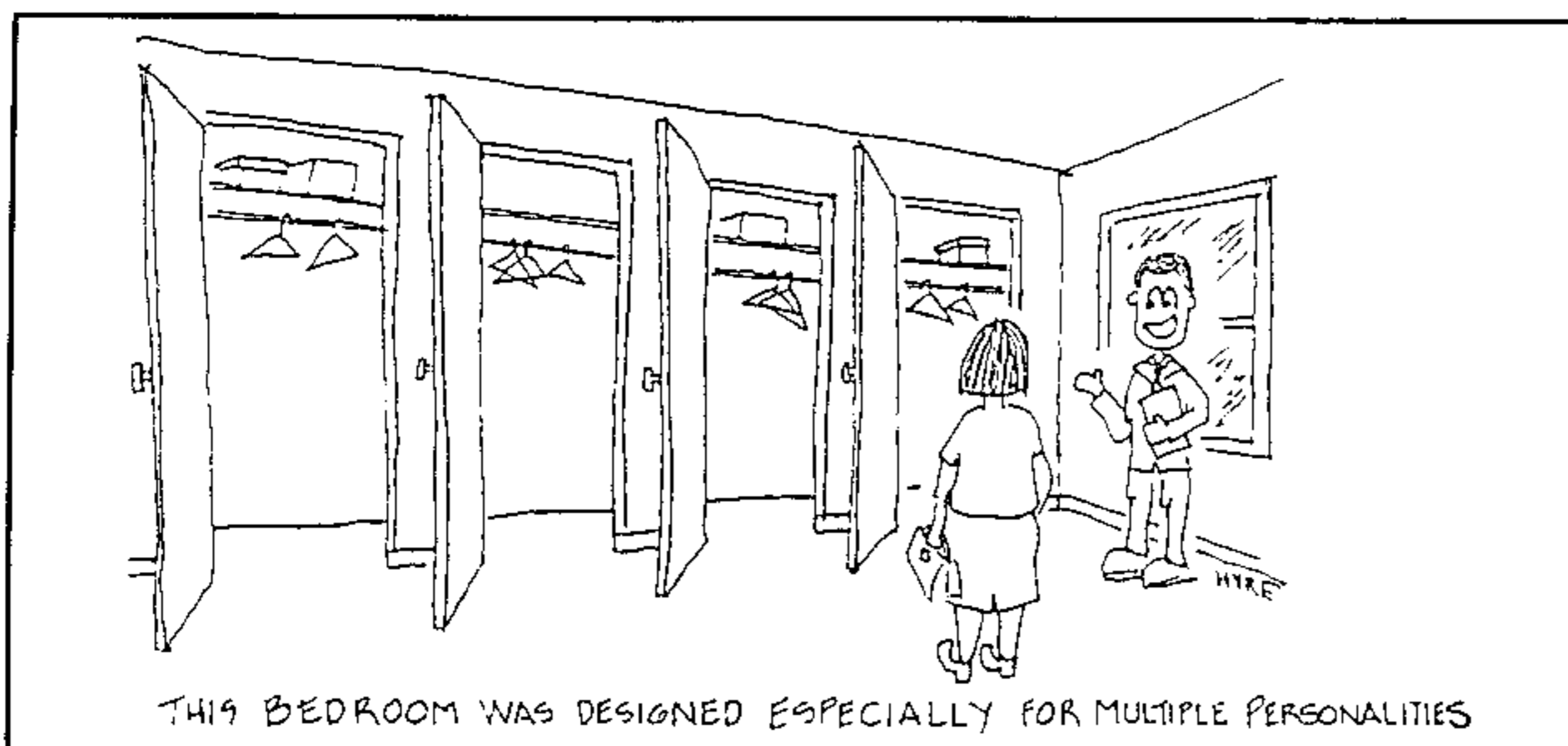
There are children here
though all were born grown up.
For most, as their innocence was stolen,
they learned how to cut.

Their faces are filled with expression,
there's not a single empty stare,
for their minds are webs of impressions,
thousands of forms of fear.

One wonders in watching them how the genius in each survives.
Yet in looking closer one will find that it's the genius that's kept them
alive.

One can hardly help but admire in them the courage and the dare,
for each of them has walked through hell,
and yet they know compassion, and that keeps them here.

No bleeding hearts are wanted, nor a single crying towel.
Just room to grow and the right to each individual's power.



THIS BEDROOM WAS DESIGNED ESPECIALLY FOR MULTIPLE PERSONALITIES

This issue is made possible in part by
a contribution from:

**The National Center for
the Treatment of
Dissociative Disorders**

1290 S. Potomac
Aurora, CO 80012

(303) 751-8373 or
1-800-441-6921

Walter C. Young, M.D.;
Clinical Director

The National Center is not affiliated with nor
does it have input to or control over the contents
of this publication

One of the things my inner child and myself learned when we were in the hospital was that we did find someone who cares about us and that we could take the frown off our faces and smile. We also learned that if there's a way for us to keep getting better we would take that, even if it means that we might have to end up back in the hospital some day. We may not like going to the hospital, but we would go because being in treatment helps teach us how to live each time we go. It also gives us a chance to get in touch with more of our inner family that we didn't even know we had. The times we end up in the hospital in treatment, we have always gotten something out of it.

By Baby and Me

Resources

A seminar for survivors of extreme child abuse will be held March 14, 1992 near Fair Oaks, CA, sponsored by Survivors Reaching Out and Fair Oaks Hospital. For more information, call 916/361-3238 or 916/967-8277. To be on the mailing list for future seminars, send a safe address to Mary Clawson, Survivors Reaching Out, 106 McRoberts, Mather A.F.B., CA 95655.

The state of Nebraska will be considering a bill introduced by Senator Carol McBride Pirsch to change the statute of limitations for survivors with repressed memories. Therapists and survivors willing to testify before the

legislative committee can call Bruce Boyer, her legislative assistant, at 402/471-2718. In the Omaha region, Patricia Hudson, PhD, heads the lobbying effort. Her assistant, Liz Kofoed, can be reached at 206/330-1144. You may write to Senator Pirsch at State Capital Room 1124, Lincoln, NE 68509.

Katie Ciurej (who told us about the Nebraska legislation) and her sister Barbara are in the process of establishing the Gerald Ciurej Memorial Fund for Adult Survivors of Incest and Child Abuse. It is founded in memory of their brother, who committed suicide two years after remembering sexual abuse by their mother. They hope to raise funds to pay for

therapy of adult survivors, to educate therapists about sexual abuse, and to educate the public. If interested in helping make the effort nationwide, please call Katie at 206/271-7537 or write to 15252 Pine Drive, Renton WA 98058-8102.

Poetry, prose, artwork and first-person accounts by survivors and friends are sought for an anthology about ritual/satanic abuse. You do not need to identify yourself. Send material by Sept. 1, 1992 to Fighting Words Press, PO Box 4, Northampton, MA 01061-0004.

An exciting catalog with lots of goodies is available from Ther-A-Play Products. Send for one! PO Box 761, Glen Ellen, CA 95442, or call 707/938-3074.

Therapists' Page

While planning this issue, I knew professional input was extremely important. So I sent a set of questions to several eminent physicians who head specialty units or facilities for Dissociative Disorders. To *your* benefit (and my great relief and appreciation) the following comments were received—a wealth of ideas to ponder if you are considering your first hospital stay. Or, if you've had unfortunate experiences already, these comments may help you figure out what went wrong, and what could be done to improve the outcome next time.

Let me stress that this is *not* a comprehensive review of how professionals view hospitalization for DD clients. Many fine doctors and facilities are not represented here. MANY VOICES does not recommend programs or psychiatrists. The selection process belongs to you and your therapist. However, we have listed addresses and phone numbers for the programs directed by this small panel, if you want more detailed information.

The experts responded to one or more of the following questions:

- 1 Some MPD/DD clients seem to benefit from time spent in hospitals. Others don't. Are there patient-characteristics that explain this? Is there anything a client can do to get the most out of a hospital stay?
- 2 What does your hospital do when an MPD/DD patient's insurance money runs out before treatment goals are achieved?
- 3 What supports might help numerous clients who can't receive inpatient service?
- 4 Other than for crisis/safety reasons . . . should a functioning MPD/DD client be hospitalized and why?
- 5 What questions should a client or therapist ask when choosing a hospital for treatment of MPD/DD? —LW

Richard P. Kluft, MD FAPA
 Director, Dissociative Disorders
 Program
 The Institute of Pennsylvania
 Hospital
 111 North Forty-ninth St.
 Philadelphia PA 19139
 215/471-2484
 Professor of Psychiatry, Temple
 University
 School of Medicine
 Editor-in-chief, DISSOCIATION
 Fellow, ISSMP&D

Q.1:

Our experience is that the MPD/DD patients who benefit most from their stay in the hospital are those that either arrive with or develop a good therapeutic alliance early in their stay, either arrive with or readily develop realistic treatment goals, and focus their energy on the goals of the admission rather than becoming avoidant, distracted, or preoccupied with issues of entitlement. They realize that their hospital stay is only a phase of their ongoing treatment, a place in which some work is to be done that will make it possible to continue rather than replace their outpatient work. The patients who do best appreciate that the hospital, like all else in life, is imperfect, and dedicate themselves to the task at hand rather than finding fault, an ever-available focus for resistance. We have noted that patients whose referring therapists have good boundaries do much better than those whose therapists do not. The latter group

often has difficulty making a transition into an environment in which they feel less special. The patient who wants to get the best out of a hospital stay should encourage a dialog between the outpatient therapist and the hospital, so that mutual expectations are clarified, and unrealistic expectations are addressed. With the outpatient therapist's help, she/he should think through across all alters how important it is to use the time wisely, and how disappointed they will be if they misuse their scant hospital time. Also, preparatory outpatient therapy should address likely situations and work them through as much as possible; ie, that the alters will not have much time to get to know the hospital therapist before they must plunge into the work that must be done; that they may never feel as safe as they would like to feel in the hospital environment, but must do what they are there to do regardless; that they will be exposed to other people's pain as well as their own, and that may be upsetting; etc.

Q.2:

It is precisely because insurance benefits are limited that every day in the hospital must be used well and realistic goals agreed upon. Pursuing overly ambitious goals when resources are limited puts the patient in a very vulnerable position — she/he may wind up leaving the hospital feeling worse than when she/he was admitted.

Q.3:

In our experience, the best alternative to hospital care is the meticulous management of outpatient care, with an emphasis on scrupulous pacing. We have found professionally led MPD/DD groups of benefit, but have been troubled by what we have seen of peer support groups.

Q.4:

The functioning MPD/DD patient should not be hospitalized unless there is ample reason to suggest that therapeutic work that needs to be done would disrupt that functioning and require the temporary security, structure, and additional therapeutic modalities available in a hospital setting. In that case a well-thought-out elective admission is preferable to allowing the patient to decompensate on an outpatient basis, compromise her/his life circumstances, and require an emergency admission.

Q.5:

We appreciate that many MPD/DD patients have unique concerns and anxieties, and that many want extensive reassurances. However, a given program may be structured in a way that makes it impossible to address these apprehensions in a way that reassures or satisfies the potential patient's misgivings. We consider the most important questions to be : 1) What therapies will I receive? 2) What are the qualifications of the individual therapist to whom I may be

(cont'd on page 5)

(Dr. Kluff, cont'd)

assigned, and how many times a week will I be seen by her/him? 3) Have the program and my therapist come to an

understanding of whether the tentative goals of the admission are reasonable given the resources available? 4) What will happen if

what is found during my hospital stay requires a reassessment of my diagnosis, the goals of the admission, etc.

Moshe Torem, MD
Chairman of Akron General
Medical Center
Dept. of Psychiatry &
Behavioral Sciences
400 Wabash Ave.
Akron, OH 44307
216/384-6525
Professor & Chairman of
Psychiatry,
Northeastern Ohio Universities
College of Medicine
President-elect/ISSMP&D

Q. 1:

There seem to be two types of patients. One says "Fix me, cure me." This patient wants to be the passive recipient of a magic cure from the hospital and/or therapist.

The other type of patient takes an active role. She says "What can I learn in this [hospital] program that will help me get better?"

At Akron General, we believe in the partnership of patient and therapist. The doctor/therapist is a mentor or coach, and the patient takes the responsibility to get well. We make decisions together; the patient has input even in areas such as medication.

Some patients don't want to work at their healing. I've met patients who don't believe in journaling, medication or hypnosis. They want to fight. I tell them, "I don't want to fight with you. If you don't believe in any of this — why are you here?"

A patient who is narcissistically invested in separateness will find hospitalization a waste of time. A system that doesn't want to integrate, won't integrate.

Success is more likely if the patient believes that the specific therapist can help him or her, and that the hospital program or philosophy makes sense or "feels right". It is vital for the client to have faith in the choice of facility. . . not to feel pushed into a program by an agency or family member. The patient who believes

"I have no choice" has fewer chances to get better.

Other important ingredients for healing are adequate resources of intelligence, and a body free of street drugs and alcohol. This type of client has the mental "hardware" to do the work.

Qualities of the successful therapist are similar: a belief in one's ability to help these patients; an innate ability to be a healer. The therapist needs an optimistic view of life and good personal mental health. And he or she must believe in the method of therapy being used, and the capacity of this particular patient to improve. Any doubts about the usefulness of therapy may be communicated to the patient with negative results.

Ideally, the patient, therapist and hospital program work together in a cooperative harmony. The closer one comes to this ideal, the greater the likelihood of success.

Q2:

There are two types of hospitalizations, elective and emergency. In an emergency hospitalization, the patient enters for safety reasons. It may be voluntary or involuntary, but typically the patient is served by the closest primary hospital or emergency room. In an emergency, the patient is billed for each day in the hospital, and is released when he or she is ready psychologically. If long term care is necessary, the patient is transferred to a different facility.

In an elective admission, we work out the resources in advance. The client decides, going in, what tasks can be accomplished within the available resources. If the treatment isn't working as expected, we discuss this with the client before the resources run out, and explain that either the goals will be met for discharge at the expected time, or an extended stay will be billed to the client. Our philosophy is joint responsibility, all the way.

It's interesting, but I've found that most patients, faced with the prospect of absorbing additional cost, will find the inner strength to pull together and get the work done on schedule.

Q.3:

A social support system is very important, so whatever can be done to build and maintain social support is a good idea.

Safety is a priority. If the people around you now are not safe, make changes. Find a safe house or something like it. Stay one day or one week. If you can't find a safe house nearby, go to a farm or move to a different city and do simple work for room and board.

If you suffer flashbacks, learn some centering techniques to create a focus that anchors you in the present day. Concentrate on something that reminds you of who you are *now*, whether it is a wedding ring, or an audio tape made by a friend you trust. Find an anchor in the present that works for you, and teach yourself to transform the flashback (which feels like it is happening all over, right now) into a memory (which you know is in the past.) A good therapist may be able to help you learn this in an outpatient setting.

Q.4:

There are several reasons why a DD/MPD client may benefit from an elective (voluntary, non-emergency) hospital stay in a program or unit that specializes in dissociative disorders. At Akron General, we offer an acute-care setting, with relatively short-term goals (3 months or less.) Such goals may include:

1. Learning specific coping skills for special problems. For example, a person may want to enter a hospital to learn techniques to control flashbacks.

2. Special procedures, such as sodium amytal interviews, narcoanalysis and narcosynthesis.

(cont'd on page 6)

(Dr. Torem, cont'd)

3. Medication adjustment, which is sometimes done best in a hospital.

4. Working through deep traumas in a safe place.

5. Diagnostic sleep lab, and other methods for refining and confirming a diagnosis.

Q.5:

The more you know about a

facility, the better you can judge whether it is right for you, so ask lots of questions. Ask about the philosophy of the program itself and its director. What strategies and techniques are used for treatment, such as restraints or medication? What adjunctive therapies are available, such as art therapy or group therapy? Is the unit open or closed? If you want

to sign yourself out, what is the procedure? What if there is a disagreement between patient and staff? What is the breakdown of hospital and therapist component of fees? Don't be afraid to ask direct questions, and don't accept vague answers. Choosing a hospital is an important decision. Make it carefully and wisely.

Walter C. Young, MD
Director, The National Center
for the Treatment of
Dissociative Disorders
1290 S. Potomac
Aurora, CO 80012
1/800/441-6921 or
303/751-8373
Fellow and Past-president,
ISSMP&D

Q.1:

In my opinion, the selection of a hospital for a client is exceedingly important when hospitalization is necessary. Therapists who are not physicians should have some identified psychiatrist available for the use of medication or for hospitalization in emergencies. If one suspects that hospitalization may be necessary at some point, begin to look at programs early-on, in preparation.

In most instances, hospitalization should be voluntary; only in instances where there is clear danger to self, others or such disorganization that the patient can't function adequately in their own behalf should hospitalization be enforced.

As soon as a person is able to take care of themselves, or is not likely to be dangerous in the immediate future — which is Colorado law — enforced hospitalization should be discontinued; however, there are times when patients will enter an altered state in order to sabotage treatment and try to be released from the hospital.

In these instances, I make all efforts to find out whether the system as a whole, or the primary personality, is in agreement with this decision prior to automatically releasing a patient. This may

require a period of discussion with other members of the system, or the primary personality. Sometimes, this is a maneuver by the patient to avoid issues in the treatment.

Very often, there is a difference in the expectations of the patient and the hospital. A program needs to be able to tailor itself to a patient's needs, and also to recognize needs that the patient may have, but not know themselves. For example, some patients want to work memories before they have the skills available to deal with the hyperarousal that may occur during the time that memory is emerging.

In these instances, in addition to the memory work, there may also be a necessity to learn some basic skills to contain excessive reactions and emotional states between sessions.

Q.2:

The most difficult problem to solve concerns patients who don't have the financial resources to afford hospitalization. Unfortunately, I am at a loss for a good answer. Patients who are indigent or don't have insurance often have access to mental health centers and state-run facilities. In these instances, if it's possible to develop an alliance with some member of that facility or mental health center, it may be possible to receive at least some treatment.

It may be necessary for the patient to postpone the harder part of the memory work while they place themselves in a position to be able to afford better-quality care. This may involve obtaining some vocational training or finding a job with better benefits. On the

downside, this may result in some delay; however, getting ready for treatment is an important part of the package and may need to precede jumping into the heaviest part of the work.

It's hard to say which external resources are best for an individual, but a good support system is very important. Close friends and family that survivors can turn to in moments of crisis are very helpful in calming a person. Certain activities which are soothing and relaxing to the patient are a valuable mechanism for quieting a system when it's agitated. Some of these activities may be: journaling, art work, music, hobbies, etc. The person should make a list of 10-20 activities before a crisis set in. This provides easy reference when in a crisis situation, and the person cannot think clearly what to do.

The last item on the list should be calling the therapist. Too frequent calls may result in a therapist becoming excessively fatigued or unresponsive in periods of true emergencies. The more self-sufficient one can become, the better.

Q.3:

Everyone should be aware that hospitalization fosters a sense of dependency and regressions.

The mere giving up of one's day-to-day responsibilities leads one to the sense that a therapist expects a patient cannot handle themselves on an outpatient basis; and secondly, simply being in the hospital with another group of patients who may also be quite dysfunctional tends to foster more dependent and "regressive" behaviors.

(cont'd on page 7)

(Dr. Young, cont'd)

Part of this is expected because of the intensity of treatment, but part of it is an artifact of hospitalization itself. This is not a reflection of DD, however, since regression and dependency tends to occur in most patients who are hospitalized for whatever reasons.

For this reason, if outpatient therapy can be maintained, this is obviously more desirable since existing support systems and significant others are more readily available. In my opinion many dissociative conditions may require at least three sessions of outpatient psychotherapy each week.

There are certain advantages to hospitalization. More intensive work can often be done in a safer and controlled setting. Also, patients may feel less "unusual" when they can work with other dissociative patients and see that they're not alone in the world.

Q.5:

Choosing a hospital is very difficult. The ideal situation is to find a program close to home which has good clinical experience. However, in many instances there is not a facility nearby which is familiar with the treatment of dissociative disorders. Frequently, patients with DD find that general psychiatric units without experience with DD are apt to mishandle or become frightened of issues surrounding dissociation and trauma. Their training does not allow them to respond appropriately toward the emergence of memory and traumatic material.

Robert Benjamin, MD PC
 Assoc. Medical Director
 Northwestern Institute of
 Psychiatry
 450 Bethlehem Pike
 Fort Washington, PA 19034
 (215) 641-5300
 Member, ISSMP&D

Q1:

Besides choosing a facility that has the required expertise (see Q. 5,) the next step for a good result is for the client to bring the right

Such hospitals are more likely to see behavioral escalation and some of the disorganization as requiring "limit setting", "control", or anti-psychotic medication, and miss the boat altogether on the fact that this reflects an emotional state that requires other treatment interventions to deal with trauma, or the containment of excessive emotional responses so that the patient can work on their own issues. In an emergency situation the closest psychiatric facility may be all that's available. For longer-standing periods of treatment, however, I would recommend a dissociative unit.

Across the country, there are lots of new units attempting to establish themselves in this field. In my opinion, they are developing so quickly, that it's difficult to evaluate how effective their staff are.

Some of the questions a patient seeking information regarding the various programs might want to ask are:

How long has the program been in operation? What is the overall philosophy of the program? Who are the Clinical Directors? Who are the major clinical leaders? What is their experience with dissociative conditions? What is the training level the therapists who run the program day-to-day? How do they handle switching on the unit?

(I believe that appropriate behavior, not which alters present themselves, is what's most important. Excessive rigidity and rules which cannot be flexed in a treatment-planning conference are too much for me.)

Do the program leaders make

attitude towards the work that lies ahead. This often means being willing to at least try out new ideas and methods to see if they might prove helpful. But beware of One Size Fits All treatment plans! Everyone is an individual with their own path to health.

Q.2:

We try to help the client have a realistic view of their resources prior to coming to the hospital so that they don't have nasty surprises later on, although sometimes unavoidable circumstances do

sense when you talk to them? Do they seem to have an understanding of the function of dissociation as a defense mechanism? Are women's issues addressed?

Is the unit part of a general psychiatric ward where there is a mixture of patients, often called a "track", or does the unit have its own separate space where patients with DD live and function among themselves?

(Since patients often feel unaccepted in a mixed setting, a general psychiatric unit is often overwhelmed or upset by dissociative patients if they take an inordinate amount of time for staff.)

What is the ratio of treating personnel to the patient population? (i.e., how many nursing staff and professionals are available per patient for a unit?)

Many of the new programs coming into existence are understaffed and not always able to respond to patients in an agitated state. A ratio of three patients per clinical staff member is minimally desired, but many programs may not be able to obtain this. In our program, we are closer to two-and-a-half patients per staff person. We consider ours an acute psychiatric unit requiring a lot of attention. Units which are understaffed tend to have staff members who burnout and turn over rapidly; the program does not function smoothly.

If there's an issue of ritual abuse involved, make sure the staff is willing to listen and work with patients reporting ritual abuse.

We advise prospective clients that if their insurance is poor, they should either plan for a brief stay with limited goals, or postpone non-emergency in-hospital work for a time when the DDU has less of a waiting list so that the hospital is not being asked to turn away paying patients to take charity cases.

Q.3:

We provide a Day Program for MPD patients, led by experienced therapists. This option is often

(cont'd on page 8)

(Dr. Benjamin, cont'd)

more cost-effective than full hospitalization and helps to preserve independent functioning. Outpatient groups are also available.

Q.4:

The essential element in determining whether or not to hospitalize and how long to stay, once admitted, is the balancing act between the need to function effectively in the world versus the need to progress in treatment. Sometimes the only way for an MPD client to get "unstuck" from an impasse in treatment is to enter a hospital, but if the result of the hospitalization is that they cease to function, what has been gained? On the other hand, a successful hospital stay may assist functioning. Therapists and clients must be alert to the risks of encouraging excessive regression, counterbalanced by the possibility of therapeutic breakthroughs that

can also be engineered by a judicious hospitalization at a reputable treatment center.

Q.5:

Hospitals have had a bad reputation for most MPD clients. Even if one is fortunate enough to have an excellent therapist, unless the hospital staff and power structure is attuned to the therapist's treatment plan, much good work can be undermined. It is preferable to seek a facility with expertise in working with DD clients, or a dedicated DD program in which all the clients are working on similar issues. Ideally, such specialty units can provide "extended consultation" to the outpatient therapist, which should be the primary part of treatment. Unfortunately, with the recent upsurge in interest in our field by hospitals who are looking for a new angle to fill their beds during a time of economic cutbacks, promises may be made

that cannot be fulfilled. Many of these newer programs have campaigned aggressively for patients to come there without having demonstrated any special competence to help DD clients, or worse, are employing questionable, even harmful methods.

In choosing a hospital, patients and their therapists can be guided by the experience level of the facility, and the level of expertise of *all* treatment staff. This gets confusing, because many good treatment units have migrated from one facility to another, looking for a more accommodating home. "Length of experience" needs to take that into account. But just because a program has a Big Name on the roster doesn't mean that the client will necessarily benefit; they might as easily be assigned to a trainee while the Great Therapist is on a speaking tour! The client needs to know who will *really* be taking care of them.

Colin A. Ross, MD
 Director, Dissociative Disorders Unit
 Charter Hospital of Dallas
 6800 Preston Rd.
 Plano, TX 75024
 (214) 618-3939
 Fellow, ISSMP&D

Q.1:

To get the most out of a hospital stay it is important to work hard, participate in the program, and achieve a balance between recovering traumatic memories and maintaining adult functioning.

Our focus is on shorter term admissions, structure, stabilization, and as early a return to outpatient therapy as possible. The treatment plan includes a map of the personality system and specific goals. The insurance status of the patient is taken into account and an effort is made to preserve insurance coverage for ongoing outpatient therapy.

Q.4:

The reasons for admission may include suicide risk, disorganization of the personality system,

impasses in therapy, and the need to do specific memory work in a safe contained environment, lack of specialty inpatient treatment in the patient's home area, and inability to maintain a satisfactory level of function. It is best to be an outpatient as much as possible. Most patients can benefit from hospitalization and use it to prepare for and return to productive outpatient therapy.

Q.5:

I recommend choosing a specialty in-patient program with staff who are committed to continuing education, teaching, and professional growth within the dissociative disorders field.

Q.1:

Patients who are well informed are more able to effectively collaborate in working with the crucial issues in their treatment. These issues include the nature of post-traumatic and dissociative symptoms, and the process of therapy.

We believe it is important for patients to develop a sense of control over their symptoms (e.g. flashbacks, self-destructive behavior) *prior* to engaging in a great deal of exploration and abreaction. Hence, many patients who are admitted in crisis work on stabilization and finding alternative ways of coping and functioning.

We emphasize developing and maintaining the patient's collaborative relationships within the hospital and the community. Friends and significant others are encouraged to be involved in the treatment process. Most of our patients live in New England, which enables us to provide individualized support and consultation to the outpatient therapist.

James Chu, MD
 Director, Post-Traumatic Stress Program
 McClean Hospital
 115 Mill St. Belmont, MA
 02178
 Fellow, ISSMP&D
 (617) 855-2350 (info)
 1-800-955-9005 (admissions)

An Option We Need

By Laura, age 9, from the top level where Almost Vivian stays

A few of us sometimes get dangerous (suicidal). Then the ones of us who want to live get very scared and want to go to a hospital so we can be safe. But others of us won't let this happen, because they are afraid that we would get stuck in the hospital for a few days. They need for us to be able to leave the very next day so we can go to work.

Almost Vivian worked very hard to get a job to make sure that she can pay the rent and buy us food and take care of the car and pay for the things that we need to live. Even when she can't do a lot of work because too many of us are upset, she always shows up and goes through the motions. Work is the only thing that gives structure to our life. It is the only thing that holds us together when everything else is falling apart. We are very afraid to miss work.

None of the ones who are dangerous would ever do anything at work. It is outside of work that we are worried about.

I wish there was a hospital where we could go just for a few hours or overnight in an emergency — if we are getting too dangerous for comfort. But most hospitals don't understand that we could be dangerous for a few hours or a night and then be OK to go to work the next morning. They are afraid to let you go so soon.

All the shelters near us are for specific groups, like battered

women or crime victims. We don't fit their criteria, so they won't take people like me.

Our therapist agreed with us, that we didn't need to be in the hospital for a long time, and that it would be good if there were a place we could go when we were dangerous and leave when we felt better. But she didn't know of a place like that either.

The ones who wanted to live got more worried and made a lot of phone calls. At last, Almost Vivian found a place for us. She called a doctor whom we had seen many years ago who is associated with a hospital. At the time we had seen him, we hadn't know we were MPD. We told him our diagnosis, and explained what we needed. We are so fortunate that he was receptive. We arranged with him and our therapist that we can go to the emergency room of that hospital if we get dangerous. He let the emergency room staff know about us, so if we go there in an emergency, there won't be a lot of explaining to do. The day after we made that arrangement, we went to the emergency room just to look at it, and to see how to get there and what entrance to go into — so in case we had to go there when someone was very upset, we wouldn't have to walk around figuring out how to get in. Since we made that arrangement a few days ago, the ones who want to live are much calmer. We may never have to use the plan, but

just having it feels like we finally found a bottom to the hole that we were falling into.

The best thing would be if there were some place that you could go — not exactly a hospital, but something like it, with nurses that would make sure that you were safe — who understood MPD and that there could be people in you who were trying to live at the same time that there were people in you who were trying to die — and who understood that if it was very important for you to go to work, letting you go out to work would help you stay on the living side more than keeping you in the hospital would

Maybe you could even go out to work and then come back there after work if the dangerous ones were still around. It would be good if it could be like the walk-in clinics for people who are physically sick — the kind where you don't need an appointment — because you can't know ahead of time when things will get dangerous

If there were such a place, you could keep on functioning as best you could in the world without isolating yourself in a hospital and going through the hard time of being discharged from the hospital and trying to re-start your life after the interruption. Getting out of the hospital and starting your life over is sometimes the hardest part of being in the hospital

MV



Outpatient Preferred

When I saw you wanted input about hospitals, I knew I wanted to write, but it might not be what you want to hear. I would fight with all of my strength to keep us out of any hospital. Years ago when Sue was 15, I thought a hospital would be the answer, a safe place for us to be, but I was so wrong. It turned out to be a nightmare. They doped us, restrained us, locked us up, electro-shocked us, to name only a few. And we were not the crazy ones. It totally destroyed any trust in hospitals as a safe place. Even though it may be different today with people who know about all of us, I would never let myself trust anyone there. Some of the little ones are so frightened at the mention of the word "hospital", any benefit would be far overshadowed by mistrust and fear.

Sue started seeing this shrink about a year and a half ago and I didn't trust her either. After what all those others did I wanted no part of "therapy". But this lady is different. She talks to me and writes to me and tells me I'm important. No one has ever treated me the way she does. I think she really cares about me and all the others too. We talked about hospitals and she promised *never* to hospitalize us. That was hard to believe at first cause I'd heard that before and then had it done "for my own good". But I believe her now. She says if we go slow enough we won't be overwhelmed or unable to function. Sue and Susan go to work every day (or at least Susan does during the really hard times). NO hospitals and very slow — that's how it has to be for us. It won't work any other way. I guess it's taken me a long time to even begin to trust the therapist, but she's very patient and understanding. And she lets us go as slow as we need to, to still be OK.

By Diana



When we first started therapy there were many things we said we would never do. One of them was "We'd never go to a hospital." We came to realize that this fear was holding us back from working as hard in therapy as we could, so we had to let that "never" go. We still don't want to go, but if we have to go to save the body's life, we will. The hospital is like our final safety net.

When too many of us talk at once for a long time, Mary Kay tells us we are taking the first step to the hospital. When she says that, we try to get organized and talk one at a time. We don't know how many steps there are to the hospital, but we don't want to find out!

By Julie and the concerned Kids



Most of our experiences with hospitals have been very negative. I feel the only times MPD people should go is when the body is in danger from an alter who is suicidal or wants to mutilate the body, then only for a short time stay.

Hospitals can be confusing and trigger the alters within, especially when you don't want the other patients to know about the MPD. The vulnerability and exposure can make the situation worse. Then there are the doctors the patient may be dealing with, who may not believe in MPD at all, or may try to change a treatment plan for the after-care.

Being cut off from your regular support system might also trigger feelings of abandonment and precipitate a secondary crisis, if the client is cut off from his/her regular doctor and therapist.

I know that every time we are hospitalized we come out very angry about what the hospital stay involved us in... doctors who say that you aren't sick, or re-diagnose us. We have many angry alters and it's usually the anger that we get in trouble with.

I think that if someone with MPD needs a hospital they should look for one with a doctor who can support and believe in the client, that has a safe and calm atmosphere, and a safe room — a quiet seclusion room that the patient can go to to work through or vent emotions. If venting anger is needed then there should be a way that is safe and nonthreatening to other inpatients.

We have been out of the hospital for one full year now. There have been plenty of times that the fatigue from fighting the daily battles sends us looking for a resting place. Instead of going to the hospital we have been learning new survival skills to make our home our safe resting place. Our treatment team have all worked together to help us through the roughest times in 1991. Our faith in God and so many people who are willing to help has made this possible. It's hard work, but less frustrating than a hospital for us.

By Martie in Stacy

MV



Did you see anybody in there? Martha is missing.

STACY

Hospitals — Learning How to Heal

I was recently hospitalized for the fourth time, and it was the most beneficial in terms of me being in control of my behaviors and not being victimized by others, inside or out.

Unlike previous admissions, this time I paid attention to the warning signs: the memories pressing on my mind, the need for increased activity and structure to maintain control, the disturbed sleep, the increased need for medication, that sense of warped time. Of course I didn't want to go because there were so many things that needed to be done. So I created a win-win-situation. I listed all of the things to do before allowing myself to be hospitalized, and then completed each item. If I went in, fine, these things were done. If I didn't go in, fine, these things were still done. I made lists of clothing and items to have with me in the hospital. I shopped and cleaned the house. My husband and I agreed that the most logical route to admission was after a therapy session. It happened just that way. This time in the hospital I discussed my fears of losing control and becoming violent and going into seclusion. The psychiatrist gave me the control by allowing me to ask for an effective tranquilizer if I felt my anger escalating beyond control.

During this time I also had an encounter with a psychologist who was unfamiliar with my situation. During our conversation he carelessly used some techniques which evoked threatening feelings. I was able to successfully defend myself and not feel victimized and succumb to his grossly uneducated treatment.

My advice to anyone being hospitalized.

1. Tell the staff about your feeling out of control before you do something which will only recreate abusive feelings.

2. Don't be afraid to express yourself regarding certain requirements if you feel they are threatening. But do so in an assertive and not aggressive manner.

3. Gather as much support as you can. Being in the hospital cuts off many sources of support and coping behaviors. Find the staff members you can talk to.

4. Get comfort items from home. Write or do some comfort activity to structure the "down time" while in the hospital.

5. Feel good within yourself and thank your people for whatever they did (or didn't do) to help.

By Karen W.



In my case, hospitalization saved my life three times. But my visits have been brief, no longer than six weeks, and now only for a few days of safe abreactive work which has been very effective. The information uncovered has been hard to deal with afterward, but I am moving forward. I don't know if it works for everyone. Many years ago, my brother was hospitalized, given many psychoactive drugs and many electric shock treatments. That episode, too, was an intervention, because had it not happened, he may have killed one or all of the family members. I do not condone what they did to him because he was a victim, but perhaps it saved his life, too. It definitely saved ours.

One final point about hospitalizations. I have been an isolationist in this conscious life except for very brief periods of time. We trusted no one and did not expect anything. In the hospitals, we have found people like us that we could care about, bond with, and be happy and real with. It has given us hope that eventually we will be able to have friends on the outside. Those experiences we will never "forget"

By Deborah H.



We have been admitted into the hospital Intensive Care Unit many times the past year.

As much as our therapist likes us to work outside the hospital,

there are times that we need protection from ourselves. Unfortunately if one of us is suicidal and can't be controlled, we all have to go in. I am the lsh for the system, however I also am the outside helper. The core personality (Laurie) hasn't been able to accept her diagnosis very well, so I'm out 75% of the time. At the same time, I'm trying to keep control over what's going on inside. We have been hospitalized before because I had gotten very little sleep. When that happens I get weaker, and the angry and violent personalities get stronger.

We are very lucky in that the staff in the hospital we go to are very good with us. Margo, our nurse, always puts us in a room in which we can't crawl into the ceiling. (Some of the younger ones, especially Christopher, feel safe when they are high.) She also puts paper on the walls so the younger ones can come out and color. Sometimes we have to go into the "time out" room, where the violent ones can come out and smash at a mattress instead of the wall.

Being a survivor of a Satanic Cult we have a personality who believes it is the child of Satan. He likes to play with fire and cut the body. Sometimes we have to be put in restraints, but this is only if Mark comes out and refuses to go back in. (He is very aggressive and very strong.)

The rest of the time in the hospital is spent in therapy. The little ones like to draw a lot and sometimes draw pictures of the abuse, or sometimes they can tell their stories with clay; however, we also do this with our therapist outside the hospital.

Being a second year University student(s) we like to stay out of the hospital as much as possible. It's just good to know that it is a place where we can go and know that we will be safe.

By Tracy (the helper)

Rough Times

I've been inpatient in several hospitals from "know-nothing-abusive" to know-nothing-neutral to know-all-abusive. I'm shaking as I write.

In one hospital I was drugged and raped repeatedly by a male nurse. My psychiatrist tried exorcism while I was tied down. I can't finish the court case because of lack of funds.

In others I have been labeled, ignored, humiliated, drugged, threatened in the name of "professionalism." I had to agree to change what I was saying about what was happening with me, because I was told that if I didn't stop lying, I would be put in an institution by court order.

But worse yet has been the extra confusion, heightened terror, severe regression in therapy and confounded health problems caused by treatment in "expert" inpatient dissociative units. In one such unit, I was told that I was a very complex case they weren't sure what to do exactly but would do their best for me. The doctor said I would require at least seven months inpatient care. I stayed only two weeks — I was too afraid to do the work.

In another inpatient dissociative disorders unit, I was diagnosed as borderline, depressed, with a thyroid condition (which later re-tested in my hometown, proved false) and given 5 or 6 meds, at least 4 very addictive. Also there after a memory seizure/abreaction in which I didn't hurt myself or others (as told to me by the staff) I was put in five-point restraint and the only reason offered over and over again was "to help you." When I left that place I was extremely depressed and suicidal, more confused, scared to death about everything, non-trusting to even my own therapist (who I wished could have helped me), and our relationship ended a few months later. My inner system's sense of safety disappeared.

It has been a year since my stay there and I've started connecting

some in therapy, but overall I regressed tremendously.

Recently, I've been in treatment for the last seven months in a hospital where they've never claimed to be "experts" but where I've received excellent inpatient and partial-hospitalization care. The majority of staff have been willing to learn about MPD. It has all been very healing to me. There has been a lot of communication and care, and a willingness on both sides to learn. It has been good for me to be in some therapy with non-MPDs, as the sense of isolation and being "weird" is less present. And the unit has been willing to make minor changes that also enabled me to get extra help for things that are different in a patient population where MPD is the minority.

Ideas that may help others include

1. Avoid out-of-state inpatient hospitalization if at all possible. In-state has many advantages for you and your therapist.

2. Regardless of location, tour the facility with your therapist and ask questions.

3. If the unit is so tight that your therapist can't talk to any past a nurse in the unit, don't go. Tight, closed hospital systems are similar in control to cultish groups, and are therefore destructive.

4. If checking out a treatment unit on the phone, be on a conference call with your therapist and preferably a third party, so more than one person hears the information. This is to avoid misunderstandings and being told "I didn't say that. You were dissociated."

5. Give the unit and the hospital a list of your needs and have them tell you and your therapist specifically what they can or can't do.

6. If possible, stay outpatient rather than inpatient. Also check for partial-hospitalization programs if more intensive care is needed.

7. If an out-of-state hospital

won't consult with your therapist, don't go. If in-state, make sure your therapist is your primary therapist in the hospital.

8. Most of all, don't compare yourself to other MPD's. They have their therapy and you have yours. Trust your instincts and insight.

By C.A.S.



I spent 16 months in a long-term hospital. I learned to make belts and baskets but I did not learn how to talk to my others. I had been diagnosed as MPD before I went there. I think this was a total negative experience. Along with making me believe that I could not live outside the hospital by myself, it also tore my family apart. I had just left my husband of 20 years and my daughter, age 13, lived with my sister. There was no family therapy done at all because the hospital was in another state. I felt that I would always be in the hospital and there was no hope for me.

After being discharged from this hospital I returned to my home. I had no belongings, so was forced to start all over again, and to get to know my daughter all over again. She was scared of me and believed she could not leave me alone. It has taken almost two years to convince her that I am okay. I have MPD but I can and do survive in the outside world.

I am not saying that I have not been in the hospital since. I have, but only to work on some difficult problem, and only for a short amount of time. I am not afraid of the hospital now because my therapist has helped me learn that the hospital is to help, and is not a punishment.

I believe that people with MPD may need the hospital, but only for short periods of time. It is too easy for us to believe that we are unable to handle our problems, and boundaries are always troublesome. Most of all, we need

(cont'd on page 13)

(Rough Times, cont'd)

to know that we can ask to go to the hospital when we need help and we will not be locked away forever. When we are ready to leave, we can leave.

By Elizabeth Alexander



For the most part, all of us try to live a normal working and social life in spite of our disorder. Still, for some of us, things can get out of hand and a short hospitalization is necessary to help pull things together. When I realized I could not keep my contract with my therapist on a suicidal issue, I began to look into the world of hospitals as an alternative. Here is what I found:

Many MPD therapists do not have admitting privileges and are not, really, aware of what kind of experience a facility actually has in treating MPDs. This is not meant as a put down, but my therapist and I found that the psychiatrists we spoke to, prior to admittance, all claimed to have a vast amount of knowledge in this area. This simply was not the case, and valuable insurance money was wasted looking for a program that actually did know what MPD was.

The first hospital I entered had one Ph.D. who had seen a person with MPD for a few weeks in private practice. The staff made it very clear that they felt I was a fake since I wasn't acting bizarre all the time. The chief psychiatrist, who hardly spoke English, saw me for ten minutes, charged me for a full hour and stated that, in his opinion, I wanted to make a career out of living in mental hospitals.

The second hospital I contacted, as my suicidal parts were getting stronger, not only assured me that they had a good program for people with MPD, but went on to explain about how many groups their patients attended on a daily basis. When I got there, I was a mess. I hadn't slept in three days and the voices were louder than they had ever been before. I needed to be stabilized...badly! It took them three days before I even saw a therapist, who spent ten

minutes with me, prescribed 150 mg. of Mellaril for sleep and bid me goodbye. My bed was moved five times, and the best part of this was that they (the staff) didn't tell me where it was...Easter Egg Hunt! During the seven days that I was there, my case was transferred to four different therapists. I checked out on my own, but I was so rattled and knew that I needed help that I couldn't find my way home. It took me two hours to drive from my home to this hospital, and it took two whole days to find my way home again!

The moral of this story is to carefully select the hospital that you enter and *know* that they have long-standing experience in the treatment of MPD. I finally found an excellent program that not only put me through hours of testing, but taught me some coping skills to get through rough times. They worked closely with my therapist to give him added skills for work with me.

So if you are hanging in there by your fingernails and are considering going to a hospital, please examine the programs carefully. The outcome and your own personal health is well worth it.

By Wendy



I have been at this one place several times. I have repeatedly told them I will not "map" my alters because they just change identities because they are scared. It is counter-productive. You'd think they'd drop it. No, every time I go in they ask me who's there and why I don't want to integrate. Very annoying and not helpful.

They had one doctor who treated people who were in Satanic Cults. I am quite sure my alters and I were not involved in this type of abuse. But everytime I go in they try and talk me into "remembering" I was in a Satanic Cult. I keep telling them that wasn't my abuse. They just say "You don't know that for sure. They're right. I don't know it for

sure...but let me remember stuff on my own! Don't go talking me into stuff that probably didn't happen. I feel this is a very dangerous practice.

Also, the staff tells me all people with MPD are different, and that's OK with them. Yet when they work with me, they talk about the other patients and ask if I'm like that. Gee, ever hear about *confidentiality*? If they're telling me about other patients, do they think I'd be stupid enough to tell them something they can pass along to others?

And *please* stop telling me to access or get in touch with my other parts. I try to talk to my alters so we can help each other out, but we are not reachable on demand at this point in time.

I think the staff here got stuck in one doctor's methods and they need to loosen up and be open to new approaches. Be flexible. Don't expect everyone to use hypnosis (my alters laugh at it and refuse to come out) or to journal (I get beaten if I write), or to map (they change identities and function out of fear), or to access parts on command (Wish I could. They'll come out when they're ready.)

Helpful hints I have for professionals:

1. Start where the patient is at.
2. Be patient and non-judgemental. (I had one nurse ridicule me in front of group for not having a spiritual side. She kept trying to get me to say I believed in God, or at least a Higher Power. It was very humiliating for me.)
3. Even if the person with MPD can't do/say what's going on, spend time with them. That way they'll know you are there and may eventually feel safe enough to talk to you. It would be helpful if the staff regularly scheduled one-on-one time to talk or play a game. It's very important to help establish trust by showing some sort of interest.
4. Don't talk about the other patients. It's ok to say "Sometimes people with MPD have trouble trusting." But don't say "We had an MPD who was in restraints for 17

(cont'd on page 14)

(Rough Times, cont'd)

days because she was that scared to trust us." People with MPD are often repeat patients. I can usually figure out who they're talking about. I would not like to be talked about. It makes me feel used.

5. Don't lecture me (or anyone else) about the dangers of bulimia or compulsive overeating when you yourself are 50-100 pounds overweight. It is hard to take seriously.

6. Don't talk me into abuse. Think about what you say. I don't know exactly what happened. I am highly suggestible. I want to please you so you will like me. If you want me to be a Satanic Cult survivor I will become one. Don't

give me a new problem.

And for patients: if you don't like something, tell your doctor. Tell him/her again. Bring it up with a staff person. Go to administration. Go to outside agencies and file complaints.

Crummy staff stays because nobody complains effectively (or at all), and because hospitals are short-staffed. They have a hard time getting and keeping people. If we patients act more like educated consumers, hospitals may take that into account and spend a little extra money to get decent staff.

I hope this helps.

By Mary

Recovering

By Rita M.

Q: I'm in the mental health field, and learned I have MPD. I want to stay functional, but now I'm noticing changes inside. What can I do?

A: Many clients feel as though, once in therapy, their alters begin to get more active. It's my belief that prior to therapy which directly addresses the MPD, the system has a balance to it. Memories that are supposed to be repressed are repressed. The system functions fairly well. Once therapy starts opening up the system and memories are retrieved, the system is forever changed. Alters lose their balance within the system. It's fairly typical to see alters 'coming out and/or acting out' once the memory-retrieval begins. This is one reason to *take it slowly!!* The idea is to do the work and stay functional while you're doing it. You may also simply be more aware of your alters.

I think one of the hardest occupations to have if you are MPD and in the process of therapy is to be a therapist or counselor. I do not recommend that you share your condition with your colleagues, and especially not with

your supervisor! There are many disturbed people in the helping professions, and you may face very serious discrimination, abuse, and be the subject of much misunderstanding if you reveal your situation to others. If you do decide to share to someone you trust implicitly, be sure they will keep the information confidential.

I realize this places you in a position of being isolated. It is common for MPD's to feel isolated and alone. Meeting other MPD clients is often quite helpful. I am a strong advocate for group therapy for DD/MPD clients. However, there are also some drawbacks to contact with other MPD's. One is that clients often 'compare' their stuff with other MPD clients' stuff. No two MPD clients are the same, although they may be quite similar. Another issue is enmeshment. MPD clients generally do not have good boundaries, (it's a consequence of the abuse) and can get quite enmeshed with other MPD clients. I have observed this a few times and it was a real mess. Also there is the risk of having your own issues stirred up by other people

with MPD, and a risk of being manipulated by them. On the positive side, there is a tremendous opportunity for fellowship and sharing... to realize you're not alone in this.

I think reading about MPD can be helpful, but one can also become compulsive about finding "answers" in journals and books, which could become a way of avoiding doing the work. Dr. Kluff has studied clients who immersed themselves in MPD literature and conferences, vs clients who did not... and found that among those who did, some tended to have a longer therapy, especially when they themselves were therapists. Primarily, he found that such individuals often became overwhelmed by information, or had memories triggered before they were ready to handle them. In particular, being a therapist added extra stress, of listening to the content of clients while having to deal with their own issues. Having to stay functional necessitated a slower pace in therapy, thus causing an elongation of the healing process. I can certainly

(cont'd on page 15)

Conferences

Our conference listing was squeezed out by hospital information this time. We may try again in April. Early '92 events include the following:

Southeastern Regional Conf. on MPD

Atlanta, GA, Feb 21-23. Call Ridgeview Inst. 404/434-4567.

2nd Annual Southwest Regional Conf. on MPD

Albuquerque, NM, April 9-11. Call U of NM Dept. of Cont. Ed., 505/277-2931.

5th Annual Western Regional Conf. on MPD

Costa Mesa, CA April 10-12. Call St. Joseph Hosp. 310/499-1055.

7th Regional Conf. on Trauma, Dissociation, and MPD

Akron, OH April 23-25. Call Akron Gen'l Med. Cntr. 216/384-6525.

Int'l Conf. on MPD & Dissociated States. (ISSMP&D)

May 21-23, The Free University, Amsterdam, The Netherlands. Write to Postgraduate Medical Education, Tafelbergweg 25, 1105 BC, Amsterdam, The Netherlands or call 011-31(0)20-566-4801.

(Recovering, cont'd)

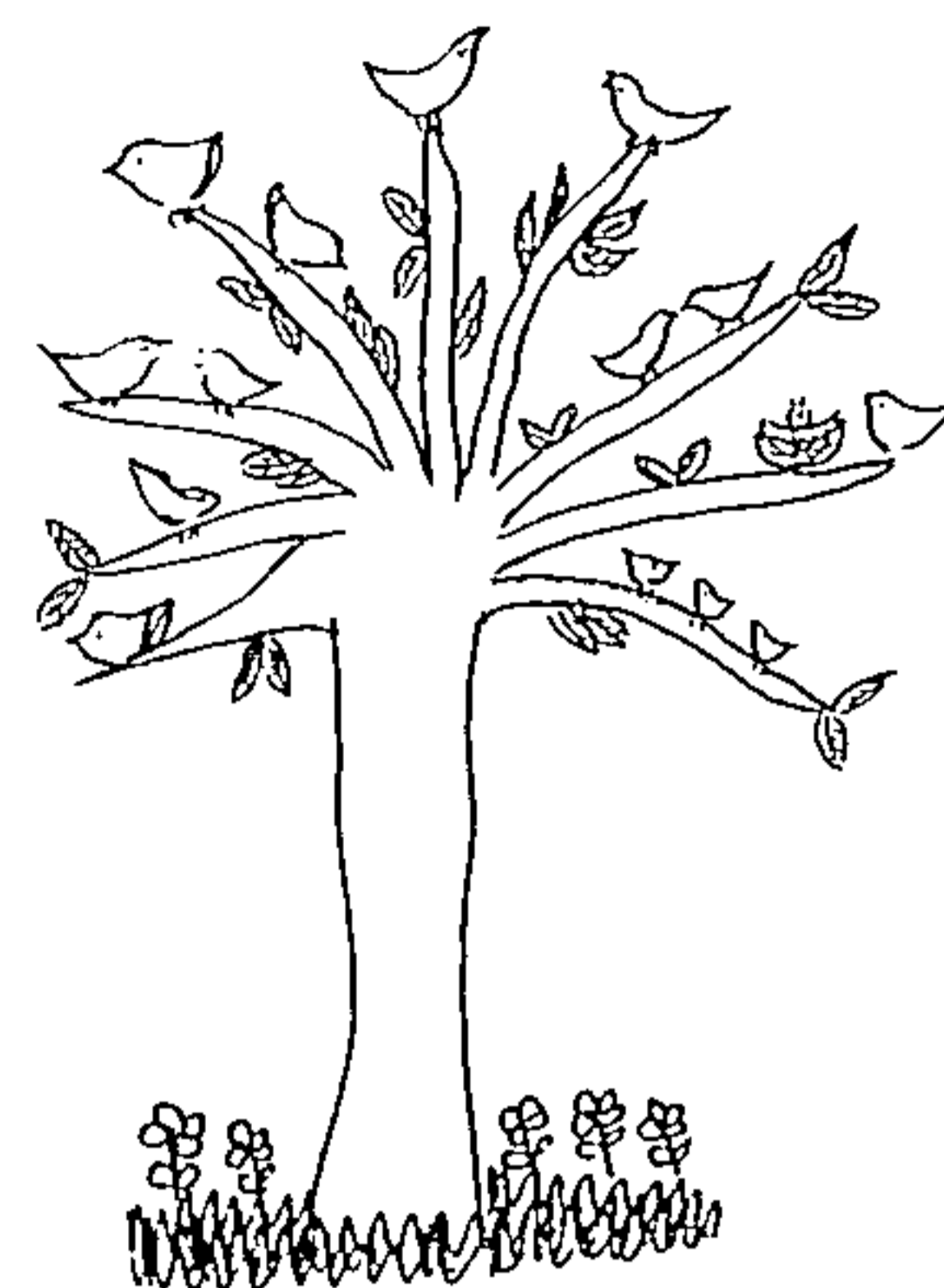
relate to this, and did go through at least one period of time when I simply could not work at all and other periods when working was quite difficult.

About hospitalization: in general I'm not in favor of it. I think too many people see the hospital as a place where they will be "taken care of". This may be a conscious or unconscious thought. I think hospitalization should be utilized only when one simply cannot guarantee the safety of the body. There are few inpatient programs that understand dissociative disorders, and you're quite likely to be misdiagnosed, overmedicated, and possibly

retraumatized by the staff (however well-meaning they may be) as you are to get help. This is not to say that one should never be hospitalized. If one has to go, then there should be a plan. In other words, use the hospitalization to your advantage. My problem with hospitalization is that everyone has to go home sometime. Your problems will still be there when you get out. I've seen too many people use the hospital to avoid taking responsibility for working toward recovery. The programs that deal specifically with Dissociative Disorders are preferred.

MV

Rita M. is a Licensed Independent Social Worker and Certified Alcoholism Counselor (LISW.CAC), and is also a recovering MPD client. She functions at a very high level (after much therapy) and is "integrated". MANY VOICES is pleased to have her help us provide the special viewpoint of a recovering, knowledgeable, MPD client/therapist. Readers may send questions to Rita, C/O MANY VOICES. We'll use as many as possible. —LW



Amy made the Flowers
She's four

This is our happy tree
from Katie
and AMY

Books

Daybreak Meditations for Women Survivors of Sexual Abuse

1991 by Maureen Brady Published by HarperCollins, NYC. 380 pgs. \$8.95. Paperback.

This small, inch-thick book is one of the Hazeldon Meditation Series. It is structured like the books for Al-Anon and other 12-step programs, in that there is a daily affirmation, followed by a one-page discussion its meaning. The various topics are indexed in the back, so you can look for a subject that is particularly pressing, or just turn to the page-for-the-day, as you choose.

I found this book to be quite comforting. It is refreshingly light on the 12-step jargon, which if one is not engaged in 12-step programs, can be annoying to read. (The index lists only four dates directly targeted to the Higher Power.)

Even better, the affirmations and the expanded discussions seem sensible, clear, and practical. They touch on areas many of us experience, but may not think about . . . such as wanting to be invisible (May 1), or dealing with voices in one's head (Oct.9), just to pick two at random. These affirmations are targeted to the abuse survivor, and so speak more clearly than the average self-help book, to me.

The final plus: it's small enough to tuck into a purse or briefcase, or even a coat pocket. What more could you want?

Give Me Wings An Incest Survivor's Journal of Recovery

1990 by Sandra J. Hocking, Millie Vincent & Co. Published by Morning Star Ltd., PO Box 5305, Cottonwood, CA 96022. 48 pgs. \$6.00. Paperback

This is a small, self-published

book of poetry by a survivor who has chosen to reveal her name and her truth, "and let the chips fall where they may," as Ms. Hocking says in the introduction.

The poetry quality is uneven, as in most books of this type. But all of the pieces are very poignant examples of the stages of therapy, the agonizing realizations of inside-others viewing the outside world, coming to new conclusions about relationships, feelings, and so much more. One of my favorites is called "Growth" . . . "In the beginning I told everybody everything . . . I flaunted the Survivors books publicly, defiantly . . . A badge of courage stained red with Victim's blood . . . Today I turn the books face down on the counter . . . And if you ask me I may just tell you 'It's none of your business.'" Very believable. — LW.

Coming Up!

Thank you for sharing your art, prose, poetry and humor! We love to hear from you!

April 1992

Finding an effective therapist
Innovative ways to budget for therapy and other essentials (food/shelter stuffed animals) ART Draw your strong wise self DEADLINE for submissions February 1 1992

June 1992

People parts fragments ego states What is your concept of self? How do you deal with differences between your outside (physical) self and internal (psychic) structures (different genders, animal alters, etc) ART Exotic alters and their purpose DEADLINE for submissions April 1 1992

August 1992

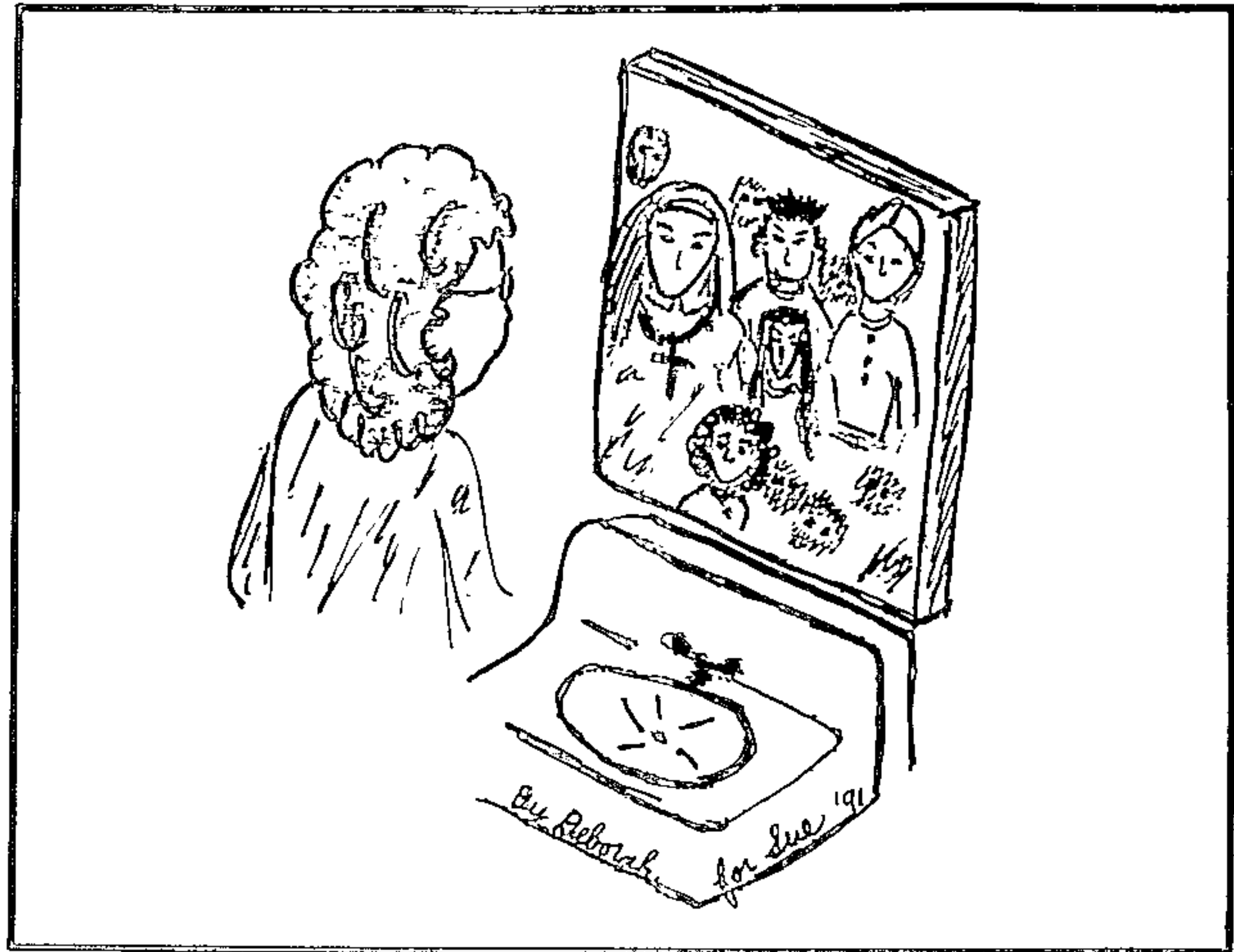
Memories are they all real? Does it matter? Retrieving and processing memories safely ART Draw memory containment or pacing images that reduce overloading your system DEADLINE for submissions June 1 1992

October 1992

Employment and dissociative disorders Keeping a job or getting one while in therapy Strategies to improve selves control ART New Fall Styles in defensive barriers for the workplace DEADLINE for submissions August 1 1992

December 1992

How to build a safe support system, with peers or "normals" or both. Info list of support groups/resources ART Draw your connections with society, as they are or will become, with healing DEADLINE for submissions October 1, 1992



Share with us!

Prose, poetry, and art are accepted on upcoming issue themes (and even on NON themes, if it's really great.) DO send humor, cartoons, good ideas, and whatever is useful to you. Please limit prose to about 4 typed double-spaced pages. Line drawings (black on white) are best. We can't possibly print everything. Some pieces will be condensed, but we'll print as much as we can. Please enclose a self-addressed, stamped envelope for return of your originals and a note giving us permission to publish and/or edit or excerpt your work.

Subscriptions for a year (six issues) of *MANY VOICES* are \$30 in the U.S., \$36 elsewhere. Please enclose the form below (or a copy) with your check, and mail to *MANY VOICES*, P.O. Box 2639, Cincinnati, OH 45201-2639.

MANY VOICES

Name _____

Address _____

City/State/ZIP _____

Please check one:

I am a client Professional/therapist Relative/friend

Subscription type: New Renewal Gift

Please start subscription with Feb '89 Feb '90 Feb '91 Feb '92 _____

Other _____

1 year: \$30 in U.S. Elsewhere, \$36 in U.S. currency

Make check payable and send with this form to *MANY VOICES*

P.O. Box 2639 Cincinnati, OH 45201 2639