

MANY VOICES

WORDS OF HOPE FOR PEOPLE RECOVERING FROM TRAUMA & DISSOCIATION

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Coping with Multiple Problems... Looking toward a healthy Future Self!



Fillings

She is a woman who fills things.
Her days, hours,
mind, files,
mouth and stomach.
For it began with hunger,
the natty crown of emptiness.

There was a time,
she was young,
when the Lake Michigan winds
blew through her fourth grade legs,
ankles scabbed by the swinging motion
from the soles of her shoes.
An ill-fitting coat, out-of-date,
torn behind the shoulder.
She got most E's for excellence,
but when another letter crowded her
report card
she fretted and punished herself,
holding her hands out in the wind
until they were cracked and ached.

There were always grits for breakfast.
There was powdered milk,
day-old rye,
stones turned soft by margarine.
Coffee, tea
sometimes canned fruit.
She knew, even then, that people know
when they're sinking
glued to misery
abandoned.

She now puzzles over strange behaviors:
recurring insecurities
about the loyalties of people,
the intense observations
of her bank account,
the way she cleans her plate
never leaving anything.
The end of a meal felt so good,
like putting away her winter wardrobe.
The repetition of her life is so troubling.
She sees herself in the mirror
Her glass-like face is a jar
with nothing in it
but the bent images
collected from across the room.

By Carolyn Ann F.

Graduating from Therapy

By Sandra

I came upon this statement by a Survivor: "I knew I was finished with my issues when someone mentioned incest, and I felt bored." I am not at the point of boredom about Recovery, but I am approaching it. My therapist said a month ago that he believed I had recovered almost all the memories and that I was about two-thirds of the way through therapy.

Here is how I know I am close to finishing the enormous job I set for myself:

Family of Origin work is coming along pretty well. My last major merger was due to the fact that my mother accepted that my dad, who is deceased, had molested and raped me. For four months I had delayed telling her because I was afraid she would deny, then reject me. Most of my siblings believe me, though one sister, daddy's favorite, says that I am lying. I predicted she would have trouble accepting it. Very important is that I no longer feel that I have to pressure my brothers and sisters into facing their own past. Nor do I bring up mine as often.

I am seriously taking steps to accept full responsibility for financial decisions made by all my alters. When my System began breaking down five or six years ago, I could not keep my teaching job. My inappropriate alters had not yet been told to stay home and wait for the

weekend when we could listen to them. I would feel enraged or terrified or panicked for no discernible reason. Several years I did not teach at all. In the space of one calendar year, I took, then quit ten different low-paying jobs. One alter would take a job and another would quit it in disgust a few weeks or a month later. I moved around seven or eight times and left bills unpaid, though I desperately did not want to live that way. I suppose that I could just say I was mentally ill, sort of, and then let myself off the hook. But I am now prioritizing my past bills, and I believe that accepting each responsibility will be rewarded a hundredfold.

I am developing friendships for the first time in my life. I would never let myself trust others, and I often sabotaged my friendships at work. I am reaching out now naturally since my trust level is higher and my boundaries are better. There is a consistency in my relationships which I have never known before, and I find that gratifying.

I have passed through the last stage of grief — acceptance. For several weeks last month my life felt like a barren desert, though there was no pain involved, just a feeling of disenchantment. I had felt a gradual loss of the "specialness" feelings, both the good and the bad specialness. I had accepted my daddy as

tyrant-perpetrator, and my mother as an enabler. I became very pessimistic in the face of reality, and then I chose to be optimistic. I had to believe that although for over four decades I was a Multiple, my life still had and has meaning and worth.

I no longer choose books on MPD exclusively. My therapist generously allowed me to read all his professional books on MPD, and I found a dozen more in libraries or bookstores. More are being published monthly. I am choosing books again about 12-Step, which was my beginning into Recovery five years ago. I got stuck on Step 4. My major problems now are not about how to keep little Ragenia from raging out at my students, or how to keep critical-parent Jane off my case, but are much less dramatic. I am focusing now on passive-aggressive tendencies, a lingering need to please, and some problems with binge eating. In other words, I am more normal.

Sometimes I still cry briefly, but Baby Blue is part of me now. When I hear country music Yolanda wants to dance and display herself. Much of my time is still spent journaling, and much of my money still goes for therapy. Occasionally I confuse my husband with my perpetrator. But life is so much better...so much better. Not exactly what I thought it would be, just better.

MV



MANY VOICES UPDATE

As you know, June is the month when I ask everyone for their suggestions for next year's topics...So, here I go again: Please, please, send me your thoughts on what matters to YOU in understanding dissociation or recovering from a dissociative disorder! I'm also interested in knowing whatever you like/dislike about MV's format, subject matter, art etc. Obviously, we can't accommodate everybody's preference, but I want MV to improve each year (like the rest of us) and to do that, I need your help.

Also, I want to give all of you the opportunity to renew your subscriptions NOW, before the price increase which will take effect August 1, 1994!

As long-term subscribers know, MV has not raised prices from the date of its first promotional material in 1988 - when six pages were promised to subscribers. By our first issue (Feb. '89) we doubled that page count, and have increased it over the years to 16 pages or more. Starting in '92 we provided subscribers with the FREE Resource Guide, *MANY VOICES/MULTIPLE CHOICES*...all without changing the price. We've absorbed all production and postage cost increases since 1989.

But we've reached the limit. Postage and paper are rising again. (I have a wonderful printer who has offered to give us free color from time to time, but he can't give free paper.) My business advisors say "Do it or else," so I'm doing it, albeit reluctantly.

Therefore, beginning on August 1, the price for each issue will rise \$1, making a year's subscription \$36 in the US, and \$6 each for back issues. Foreign subscriptions will be adjusted in similar fashion, with some extra postage cost being added to subscriptions in Europe and the Pacific Rim.

But if you order (or renew) NOW, before August 1, 1994, you can still get the same wonderful *MANY VOICES* at the old price of \$30 per year, or \$5 per back issue.

Don't Delay! Orders received after the deadline will be charged the new price, even if the checks are dated earlier...so keep mailing time in mind when ordering.

And finally -- please keep the extraordinary flow of prose, poetry, cartoons and artwork coming! Sometimes we get a bit overwhelmed with the selection, but it's the great variety received that helps MV give balanced, positive support for your healing process. We value every manuscript and piece of art that comes to us, and thank you so much for sharing!

Sincerely,

Lynn W.
Editor

MV

MANY VOICES wishes to thank the following generous contributors for their help in supporting our work:

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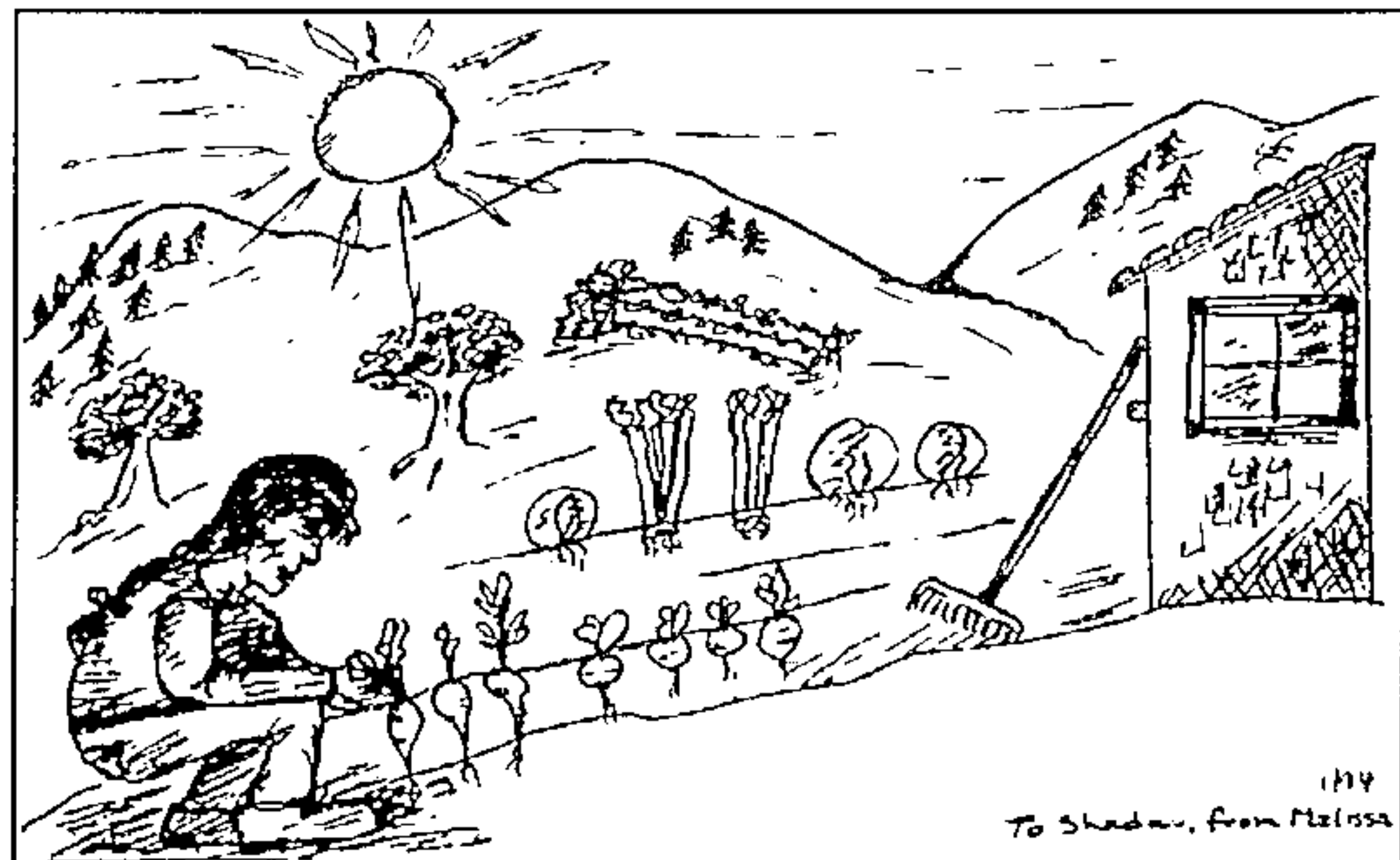
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Therapist's Page

By Joann Ondrovik PhD, and David Hamilton, JD/PhD

Joann Ondrovik PhD is the Director/Psychologist of Allied Counseling center, and a partner in Allied Behavioral Consultants. Her private practice spans 25 years, with extensive forensic experience. She has co-authored numerous forensic articles. She is a member of ISSMP&D (forensic committee), charter member of the Texas SSTD, APA, and several forensic/expert witness organizations.

David Hamilton JD/PhD, is the owner of Allied Legal Services and a partner in Allied Behavioral Consultants. He has been in the private practice of law for 10 years, was a prosecutor for 6 years, has 7 years experience as a law enforcement officer, and is a supervisee of therapists. Dr. Hamilton is a member of the APS, the ISSMP&D, and is the Secretary of the Texas SSTD. He has co-authored several articles addressing dissociative disorders and forensic issues.

Clinical Memories and the Courtroom.

A witness with Dissociative Disorder (DD) presents an intriguing and interesting challenge to the legal system. Testimony is memory under oath. Witnesses are asked to relate their memory or perception of events which may have transpired years prior to trial. Lawyers attempt to discredit memory through cross-examination. While several techniques are utilized to attack the credibility (believability) of witnesses, some of the more frequent approaches are to demonstrate that the witness was not in a position to observe, or that the perception of the witness is faulty or otherwise clouded by secondary gain/motive. In some instances, attempts are made to establish that a witness is actually manufacturing evidence, i.e., lying. All eye-witness testimony involves recollection of past events, and cross-examination is a challenge of the stated memory of those events.

The courtroom challenge of memory produces a difficult environment for a DD patient. This article examines the differences between clinical memory and forensic testimony, including the implications of False Memory Syndrome (FMS).

Memory is stored and retrieved in a variety of ways. Some memory is historically accurate, down to the detail. Other "memories" are confabulations, manufactured by the mind in response to an internal need or an external stimulus. Yet another category of memories are those which are abstract or symbolic. Abstract memories may not be historically or factually accurate, but rather contain a

meaning or a symbol which has relevance to the individual. The friction between memory and testimony arises from the variants in human memory storage and retrieval as it interacts with the clinical and forensic environments.

The law focuses on historical fact. Verdicts are based upon facts perceived to be the truth as established by testimony. Testimony which appears to lack historical accuracy, or which contains factual inaccuracies is discounted in the legal system. This area is known as witness credibility and is grounded in the concept of believability. In order to be successful in the courtroom, one must either (1) produce witnesses who are believable, or (2) discredit the opposing witnesses to the extent that they are not believable.

In a clinical setting, therapy addresses memory in a system of hierarchies, which prioritize affect and symbolic impact above verifiability. This leaves historical accuracy and confabulation at a lower priority and thus establishes the dichotomy between legal testimony and clinical memories. This lower priority generally reflects training in non-judgmental counseling skills of mental health professionals.

An example of the impact of the memory dichotomy between clinical and forensic settings may be seen with a DD patient who determines to sue her abusers over events which transpired twenty years in the past.

Initially, the DD patient is faced with a statute of limitations problem. The statute of limitations is a rule of law which establishes an artificial time limitation for the filing of lawsuits. The time for filing, established by the limitation period, must be met or the

case is barred. The discovery rule is an exception in some jurisdictions. Under this rule, the statute of limitations is tolled until the injury which gives rise to the cause of action is discovered. In DD, this means that an individual who has dissociated from traumatic memories then "discovers" these memories in therapy may be entitled to an extension of time in which to bring the cause of action. There are many variations and exceptions to these broad concepts; therefore, the local jurisdiction must be examined for the applicable laws.

Assuming that the memories of the twenty-year-old abuse were recovered during the course of clinical treatment, the focus has not been on proving whether or not dissociation and repression of memories actually takes place. In all likelihood, the clinical focus has been on the impact of the abuse on the DD patient's memory and identity. Because most mental health professionals consider themselves to be therapists, and not investigators, clinical memories are usually processed in a non-judgmental supportive environment called therapy. This usually means many of the recalled facts and data have not been factually challenged and probably little or no efforts have been made to corroborate the information presented.

Such a protocol may be clinically sufficient; however, once litigation is initiated, the clinical focus must necessarily switch. Unfortunately, few DD patients, who become plaintiffs, are made aware of the distinction between clinical memory and forensic testimony. The difficulty may be that mental health professionals are not versed in law and lawyers are usually not versed in mental health issues.

Whatever the reason, the DD patient is usually uninformed of the change in perspective from clinical memory to forensic testimony.

The absence of communication addressing the clinical/forensic differences produces high risks of another victimization of the DD patient in the process of testimony, depositions, and cross-examination.

A deposition can be an extremely difficult experience. Depositions take place prior to trial as part of a process called discovery. The parties, through their attorneys, actually subpoena or notice individuals to meet at a specific time and place in order to give testimony under oath. No judge is present and the testimony is recorded by a court reporter and often video-taped. In these depositions, the attorney is not limited to asking questions which are relevant or admissible at trial. In most jurisdictions the guidelines are vague and flexible statements, which permit the lawyer to ask questions in any or all areas which may "lead to admissible evidence." Therefore, in a deposition, the deponent (person giving the testimony) has little or no protection because of the broad scope of the deposition process and the absence of a judge to rule on objections.

Into this deposition environment comes the DD patient who has recovered memories of abuse that occurred over twenty years in the past. The historical accuracy of these memories has never been challenged in the clinical environment, and confabulation was never an issue. For this individual, the deposition experience can be brutal. With hostile attacks on the diagnosis of DD, historical accuracy is the focus of the cross-examination. Switching into alter states in response to the stress of the questioning has been reported, and in some instances, cross-examination questions have solicited switching among alters.

One other aspect of deposition testimony is worthy of mention. A court reporter is usually present and transcribes the questions and answers, presenting copies of the transcriptions to all attorneys involved. Later, during the trial of the case, this deposition testimony can actually be introduced

before the jury, or it can be used as a cross-examination technique to point out differences in testimony given during deposition and testimony at trial. This technique is called prior inconsistent statement. If additional memories or details are recovered after deposition and before trial, these details are subject to impeachment by demonstrating to the jury the differences between deposition statements and trial testimony.

As expert witnesses, therapists who treat DD patients are also subject to depositions, production of records, and courtroom testimony. Presently, areas addressed in expert testimony are lack of corroborative data, the scientific credibility of the diagnosis of dissociation, and the false memory syndrome. Therapists are critically examined on the data forming the basis for opinions and conclusions. The questioning involves allegations that the therapist has no other data or information exclusive of the self-report of the patient. The conclusion that the attorney seeks is that the believability of the therapist is conditioned on first believing the DD patient, an individual who stands to receive considerable money as a result of the lawsuit. This secondary gain or motive is used to discredit the DD patient as well as the therapist whose testimony is based on the patient self-report alone.

Basing an expert forensic opinion entirely upon the uncorroborated self-report of a patient is an uncomfortable position in the courtroom. However, the frequency with which this scenario is played and replayed throughout courts is astounding. An intriguing question is why this pattern is so frequent in light of the negative consequences of such behavior.

The *clinical* training of most therapists teaches them to deal non-judgmentally, with the patient's reality. This usually translates into dealing with the information that the client brings into the session, and helping the client process or understand that data. This is a safe position only so long as the facts remain clinical. Once there is a forensic focus on the facts of a case, including therapy procedures, then memory, as we have seen, acquires

different meaning.

A second difficulty is the virtual absence of corroborative data for events that happened twenty years in the past. However, the absence of corroboration does not explain the absence of effort to corroborate. Even should the memory process remain clinical, there are therapeutic benefits to seeking information which tends to validate the memories of a DD patient. In fact, clinical benefits can be derived from occasional considerations of historical accuracy as well as challenging the patient on the memories recalled. Medical, school, family, and legal records are all potential sources of corroboration which should be explored.

This process should begin as soon as the therapist and patient agree that memory work is appropriate. An initial step in the treatment protocol is to obtain an informed consent from the patient which explains factual, symbolic and manufactured memory. Such a document not only provides a protective covering for the therapist from a legal point of view; it also lays a very basic foundation to permit the patient and therapist to discuss memory concepts from the outset of the therapeutic relationship.

If a portion of the treatment of a DD patient is to assist in refocusing on childhood trauma so that the trauma maybe processed and understood, then assignments which encourage reading old newspapers, family albums, family Bibles, diaries, searching for medical records, searching for school records, returning to the abusive environment with camera and tape recorder or video camera in hand, can all be therapeutically beneficial. Certainly, such a protocol is not a therapeutic or treatment requirement, and like all therapeutic decisions, these matters should be discussed openly and honestly in clinical sessions, and incorporated into the treatment plan only if a decision is made that these techniques are in fact appropriate.

The False Memory Foundation(FMF) advocates for FMS, suggest that DD patients are highly suggestible and are manipulated in therapy sessions by

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Therapists' Page, Cont'd.

mental health professionals using questionable technique. The FMF suggests that no scientific support exists for the concept of dissociation or repressed memories. This argument ignores the fact that there are four diagnostic categories for Dissociative Disorders in DSM-III-R, and no diagnostic categories for FMS.

Considerable published research has demonstrated that DD patients are highly suggestible/hypnotizable and FMF takes full advantage of this research by advocating that therapists, using inappropriate therapy techniques, lead or suggest memories of childhood abuse to patients. According to FMF, these so-called memories have no historical, factual basis and are artifacts planted in the DD patient who receives the secondary gain of attention and focus from the therapist. In the face of these allegations, a treatment approach that simply ignores the historical and factual component of memories is opening the door to forensic allegations of FMS.

The appeal of FMS to the lay public, jurors and judges, should not be underestimated. Individuals who have not experienced trauma or suffering in their backgrounds assume that trauma would be a stimulus to recall memory, rather than to repress. These lay persons verbalize that if they were traumatized in a certain way, then they would probably remember the circumstances and injury because of the trauma surrounding the pain.

In a typical case involving dissociation, the jury, uneducated in mental health, is asked to believe that an individual who is 30 or 40 years old, and who has functioned for years, perhaps even maintaining a relationship with the abuser, has now "remembered" chronic childhood abuse. The recovery of these memories is usually associated with entry into therapy and a diagnosis of DD. Next, the jury is saturated with the self-report concept and the lack of independent third party corroboration. This saturation is accompanied with the scientific journals which document the suggestibility of DD patients. If hypnosis or amyltal treatments were

used to facilitate memory work, these procedures are magnified in light of the suggestibility factor.

Considering the factors above set out, and remembering the discussions in this article, the closing argument of an attorney representing the alleged abuser against a DD plaintiff might sound like the following:

"Ladies and gentlemen of the jury, in order to find for the plaintiff you must believe many different things, and your belief must be by a preponderance of the evidence. Initially you must believe that the human mind is capable of dissociating or splitting. That it can repress memories of horrible traumatic events to the point of amnesia. Certainly, the defendants have established that there is a tremendous controversy in the medical field presently, and that the diagnosis of dissociation has been popularized by the media and perhaps is over-diagnosed by that small, small percentage of mental health professionals who believe in the diagnosis.

Next you must believe the plaintiff. The plaintiff is an individual who claims that for five years in childhood, she was sexually, physically, and emotionally tortured by the defendants and yet remembered none of that until one-and-a-half years ago when she entered therapy. It is important for you, as the finders of fact in this case, to remember that it was only after entering therapy that the plaintiff began to recover memories of satanic ritual cult abuse. None of these memories have been corroborated independently by evidence or testimony. The therapist in this case candidly admits her professional opinion is based solely upon the uncorroborated self-report from the plaintiff. And what's in this for the therapist? ...More fees and more money. This plaintiff came into the therapy session, began telling stories of abuse, and there is absolutely no other evidence to support these claims. The therapist cannot tell us whether or not the memories are true or confabulated. Therefore, this case is reduced to a very, very simple

question: can you believe the plaintiff? In reaching your decision on the credibility of the plaintiff, you are entitled to rely upon your own childhood and professional experiences.

We have brought to you several experts who have testified concerning False Memory Syndrome (FMS). The bottom line of this entire lawsuit is that many people who are highly suggestible can be influenced in memory, and in fact adopt false facts as a part of their memory. I suggest to you that is exactly what has happened in this case."

The difficulties outlined in this article are meant to educate and inform both patient and therapist alike. Any DD patient who is considering the courtroom as a remedy should pause to give serious consideration to the details set out in this article as well as the following:

1. The impact on patient/therapist relationship: The therapist will be required to breach the confidential relationship and give public testimony. The rules of evidence and the adversarial nature of the forensic environment will not permit the therapist to be as absolute or supportive as in session. This may undermine the therapeutic relationship.

2. The risk of therapeutic impasse: Litigation may consume years of time. The treatment focus turns from healing toward the lawsuit. Traumas cannot be appreciated, processed and absorbed, but must remain painful emotional scars because of the forensic need to be "consistent". Perhaps an alter with important litigation facts may not integrate because of a fear of blending these forensically necessary memories and losing them.

3. The emotional toll of litigation: Considerable emotional strength is required to confront abusers and their attorneys in court. The trial itself is a draining experience, and the conflict, both internal and external, may be overwhelming.

4. The important absence of Third-party independent corroboration: Without corroboration, a DD patient must convince the fact finders that her memory is accurate

even though she suffers from a disorder which is characterized by disturbances of identity and memory. This dilemma is magnified if there have been no efforts to obtain corroboration.

5. The distinction between forensic testimony and clinical memory: Unchallenged clinical assertions will be critically and repeatedly challenged. Historical verifiability will be the focus.

This article is offered for educational purposes only and is not intended to provide legal or psychological advice. Organizations which may be helpful in this area are:

National organization for victim's assistance
Forensic Committee, ISSMP&D
Local victim advocates
Referrals from Bar Associations
Shelters and Women's Groups.

MV

Expect Setbacks

I am a 39 year-old woman with DD and have been in therapy for 4-1/2 years. The last year has been pretty stable: no major crises, no intrusive abreaactions. I work (as a nurse), am a mom to a thirteen-year-old girl, and continue to advance in therapy — working on integrations of some of my more than 100 parts, learning/teaching all my parts about us/our life. In short, I've felt pretty good and pretty healthy for a long time (at least a year!)

A couple of weeks ago, by chance, a man with the exact same name as my principal abuser (deceased) came to my floor as a patient. I, and every part of me, fell apart. I became severely frightened, depressed, suicidal and had new memories surface. I did not know I would ever feel so sick again. I felt very hopeless against my past...as if I would never truly escape.

I think everyone should know that you can have major setbacks (the kind you fear you won't survive) and by holding on, being determined not to give up (die) it will end. Mine lasted two weeks and two days. I saw my therapist extra, but I did not need to go to the hospital and I did not hurt myself. I believe that if another setback should happen to me, I will remember that the bad time can be outlived and that I didn't lose any of the gains I have made with myself over the years...*things got put on hold, but I'm still here to continue from where I left off.*

I know I'll be stronger the next time. My hope in writing is that others reading this might remember it if a "setback" comes to them. *It doesn't last.* Do what you need to, to survive, and rejoice in your ability to wait it out.

Hoping for Spring,

Chris and All of Me United (determined to survive)

MV

Concern About Health Care Reform

Dear MV,

I attended one of the Presidential Task Force's town meetings on Health Reform. I was very disappointed that representatives from local/regional mental health organizations were not present to testify.

Although I hadn't planned to testify orally because I submitted my views in writing, my name was called and I ended up speaking. I could hardly represent more than myself, but I received compliments for my comments afterward.

(Janice enclosed a card titled "No More BAND-AIDS" that was passed out at the meeting she attended. It lists several important points for a genuinely fair health care plan. Among them: Universal Coverage, Comprehensive Long Term Care, Choice Among Providers and Treatment, Prevents Unfair Discrimination Against People with Disabilities, Coverage for Mental Health Services. You may wish to keep these points in mind when you write to your representatives.

Page 18 of this issue has another important letter about health care. And please see the International Journal of Eating Disorders, Vol. 14, No. 4 for an outstanding article on the subject. Managed Care and Mental Health: The Silencing of a Profession by Susan C. Wooley, Ph.D. is must-reading for professionals and clients who are concerned about what's happening with health insurance. - LW)

I urge mental health professionals and consumers to attend task force meetings in their areas and/or contact their local Congressional representative and State Senators. Voice your views and concerns, especially about quality long-term care availability. I have been in treatment for several years now, and I know of no other DID's (MPDs) who were able to whiz through their recovery quickly enough to suit insurance payers.

By Janice D.

Rhyme, or I got rhythm, too

Hi, my name is Paula
and I have the MPD
I want to shout and holler
on this we all agree.
I am an alcoholic
I like to overeat
I work from dawn to dusk
and I never oversleep
I spend too much money
on things that are so cheap
I also go to therapy
almost every week.
Instead of just surviving,
we are alive and thriving.
We work together
and we get along real swell.
We go to many meetings
For these we can't delete
GOD has given us new meaning
We think He's real sweet.
We'd never change places with
anyone
'Cuz we think we're pretty NEAT!

By Paula S.

Tears

By Antonia Margaret Melamed

Tears .
 Of Pain?
 Of Joy?
 Tears, the water flow of the soul.
 Oh, the pain of the body!
 Every muscle screaming.
 Darts of pain up the legs, back, arms.
 Throbbing pain, agony,
 Nothing but pain
 Grabbing the attention
 "Listen to us,
 Listen to us!" the pain cries.
 "Never mind the soul
 We are where it's at..."
Or is it?
 Oh the cavernous hole in the mouth,
 Impossible to suck, difficult to eat.
 Grasping for food.
 Craving love, understanding.
 A birthmark without grace.
 The stigmata of putrid blackness.
 "All you are is a huge gaping hole.
 You have no soul.
 You are total nothingness,
 That's what you are!"
Or are you?
 Oh, the cries of the heart!
 The terror of nothingness,
 Abandonment, No One There!
 "Oh, where is my soul", I cry
 "Where oh where are you?"
 "Is anybody there?"
 Bleak despair, haunting desperation.
 That's all there is.
 Total darkness, isolation,
 Nothingness is all that is.
 There is no more!
Or is There?
 Attack! Attack!
 Violation of every kind.
 No escape.
 Physical abuse
 Psychological abuse
 Sexual abuse
 Unrelenting danger at every turn.
 Watch out or you'll be killed.
 Double binds, isolation,
 No protection, no boundaries.
 Fear fear everywhere.
 That's where it's at, total fear.
 "Don't listen to your soul, listen to us!"

"Live in fear,
 That's where it's at"
Or is it?
 A tree grounded in the earth, reaching to
 the sky
 A sunrise
 A listening voice.
 Quietly, patiently, ever so patiently.
 Listening to the pain, the horror, the
 isolation,
 and the terror.
 Listening, listening, being there.
 "No Toni, the pain, the isolation, the fear...
 Is NOT where it's at!"
 "Toni," he says,
 "Every moment is a new moment.
 All that pain and terror is in the past.
 All the horror is unreal now,
 A phantom of the past.
 Now is NOW...
 You are compassion
 Thereness
 Joy
 Love Laughing."
 "Listen to your heart,
 Your true self.
 Listen to the light in the darkness.
 See it. Feel it. Taste it.
 The thereness in the nothingness,
 The light,
 The joy of the true light,
 The love."
 At first only glimpses
 But always the listening ear,
 The hug.
 Then rays of light.
 Slowly the terror and despair rise.
 The fog lifts.
 I begin to grow.
 I begin to feel the interconnectedness of all
 things.
 That isolation is a trick of the mind.
 That attack is now an illusion.
 Sometimes I feel connected
 body, mind, soul, spirit.
 Forgiveness comes into my life.
 Not forgiveness for what I've done —
 Which is nothing.
 But forgiveness for what I think I've done.
 Forgiveness for the belief I've done
 something
 terrible to be a feeling thinking being,

A sexual woman,
 A loving person.
 Later I learn forgiveness is only needed
 in a world of the senses.
 In the realms of the spirit, all are blameless,
 (Even the abusers —
 their true souls, not their acts!)

But I don't know that yet.
 I feel forgiveness for myself,
 In my bone...
 In my core being...
 I am healing.
 I learn to watch the mind,
 To meditate,
 To focus on the positive.
 To balance the energies,
 To move my body.
 To sing, to write, to share,
 To be intimate,
 To care and to dare.
 I learn to "Let it go."
 To let the pain, horror, isolation, and fear
 pass right through me.
 To let it go, to let it be.
 I put away judging mind,
 self-judging most particularly.
 I watch judging mind with the utmost
 compassion...
 I try to be in the NOW,
 Watching the process,
 Moment to moment,
 With a wide open heart.
 Becoming just awareness itself.
 I learn I am compassion.
 That is my true nature, love.
 As I am compassionate towards myself,
 so do I show love towards all.
 I learn to sense realms unseen by the
 senses.
 I listen to the silence.
 In the silence speaks the voice of the Tao.
 In darkness is the light.
 In silence all is revealed.
 In stillness, I and the Tao are ONE.
 I feel the tears of joy,
 The light of compassion,
 The love of the soul.
 I have come home.
 I am in my true nature.

Letters

Dear MV,

I am now sixty-four years old. It should be a time in my life that we should be enjoying our retirement, but for the past five years we have been dealing with MPD.

I first knew we were in trouble at the age of twenty-seven after my third child was born. We were hospitalized for three months. They did not know what was wrong so we were given a diagnosis of "Lupus" and we remained physically ill for more than a year. At that time I felt very frightened because of the many mood swings. The doctors considered that to be quite normal; after all, I had just given birth. My other two previous births at twenty-three and twenty-four were also very strained, but we were able to handle those better.

I tried to put all the ill feelings behind and tried to appear normal to the outside world. By this time I had three children in school, had a full-time job, did all my own cleaning, cooking, baking, made all kinds of crafts and volunteered for everything. I was a workaholic and was completely out of control.

I was so depressed I couldn't sleep without pills or booze. When I expressed what I was feeling to my family, I was told that going to see a therapist was out of the question because of all the shame involved. When I started making my many suicide attempts it was then out of their hands. They sent me to many mental hospitals for various lengths of time. All I ever got from them were labels. You name it, I had it. I was also abusing my body by not eating and by taking laxatives.

Ironically, during one stay at a hospital, I had a flashback at a group therapy session. I remembered being raped at the age of four. I got so out of control with the pain and fear I was experiencing I could not stop screaming. The doctor (?) told me that was inappropriate behavior and shot me up with Valium.

After fourteen months I was discharged. Diagnosis: Neurotic. I also

put on one hundred pounds during that stay.

I found my therapist when I went to see her for an eating disorder. It took her about three months to inform me that I was MPD.

To reassure myself, I went to an excellent psychiatrist and she verified my diagnosis.

My question is: are there any senior citizens dealing with this or am I the only one?

Although my therapist is very reasonable in her price, I feel guilty that I am taking money away from my husband. He has many medical problems and mine seem so insignificant compared to his. Should I continue in therapy or will it all just go away? Will I ever know who I am?

Please give me any information that you may have.

By Elizabeth, writing for All.

Dear MV,

I feel very alone and tense. I am in a Master's Program for Rehabilitation Services Administration. The "chronically mentally ill" (CMI) is a population that comes up frequently in discussion. Usually it's characterized as being unable to make decisions, not really wholly rehab-able.

I just want to *scream* "Hey, I'm 'CMI' and I'm here with you all and keeping up better than other people in the class."

But I don't. I'm too afraid to risk it. I don't have any back up. I am really frustrated because I know my silence...or even worse, when we pay lip service to the error of judging the "CMI population"...I am continuing to perpetuate the stereotype and make it harder for myself and others with "CMI".

Do other people with a dissociative disorder find they also unwillingly go along, just to keep from being discovered? Especially in psychology and social work? I'd like to know.

By Barb

Letter Reply

I would like to respond to some of the letters we've read in MV.

First, in response to Marilyn and her letter concerning feelings and words (MV Vol 5 No.2, April '93). You cannot name what you have no name for. Our therapist is constantly asking us "And how do you feel about that?" and we are unable to answer, because the only feelings we have names for are fear, anger, and sadness. Anything in-between is unnamed for us. We feel it, but we don't know what it is. How do you tell another person what it *feels* like when you have no reference for it? This is frustrating to us, not only because we are unable to communicate what we are feeling and experiencing, but also because we are unable to explain it clearly enough for our therapist to name it for us.

On the subject of co-consciousness and "mapping" the system: There have always been some of us who were aware of some of the others. A very few of us were (and are) aware of all of the others, and some of us who only knew that they had terrible memories but didn't know why. For those in the last category, the label "multiple personality" came as quite a shock. And even now, years later, they still have no contact with any of the others. They are aware of them, but cannot hear them, talk to them, or get to know them. Big Me worried about that. One day she asked our therapist about "mapping the system", and why they weren't co-conscious yet, and what we needed to do to achieve that goal. He told her something that calmed her down enough that she is now getting to hear some of us (sort of). He said "You became co-conscious as soon as you became aware of the existence of the others. *That* is co-consciousness." And now that she (& the others) have relaxed and are no longer striving for their idea of co-consciousness, we have indeed begun to be able to start drawing out our system, and the more we draw, the more information we seem to get. to my suggestion is: try to relax and not worry about it so much. If you are unable to contact alters, then they will contact *you* when they are ready (or when they feel you are ready).

Some questions of my own: How does one handle the frustration of knowing where an item is, only to go get it and discover it has been moved to God Knows Where? And how does one work out a daily or weekly schedule for those (of us) who are artistically or musically talented to draw or practice?

By Heather Rose

Healing from Multiple Problems

We are a multiple personality, a recovering alcoholic, and have an eating disorder.

We could not have done therapy without being in a 12-Step program for several years, or learned anything from a 12-Step program without the help of therapy. Many of the concepts of Over-eaters Anonymous (OA) were not clear when we were in complete denial that we even had a problem, though our weight was 267 pounds. We were introduced to OA when we were in the state mental hospital. Then we used the first step of OA, admitting that we had the problem and were helpless, to do a first step in therapy and really come to grips with the fact that we were mentally ill. Even being in the State Mental Hospital did not prove to all of us that we had a mental disorder!

We found dropping the weight and stopping drinking far easier than therapy, though, as hard as they were. Our life had been lived in such complete denial of what our childhood had been and how we were actually feeling, that the acts of eating and drinking were much more identifiable.

After several years of attending OA meetings we have stopped. We do not and cannot believe in a "Lord" so saying the Lord's Prayer at the end of the meetings made us feel increasingly unhappy. And the generally Christian bent of most of the members made us feel like an outcast. But we found the OA literature very helpful and we still read that.

So we think that it is best to deal with other disorders at the same time as therapy — except maybe for alcohol which should come first in some cases. Therapy is different while dealing with other disorders in that the emphasis is somewhat shared, but for us, they worked together very well.

By Panthea, for all of us



I want to tell you about drinking and me. My counselor says "You are an alcoholic." That used to make me so mad I could scream, but it doesn't really matter whether she calls me an alcoholic or any other thing. The most important thing is that I don't drink anymore.

Drinking gives me lots of excuses. It makes me think I can do whatever I want. I can't just do whatever I want, because lots of us live in here. I've got to think about being responsible and not just think about myself. That's hard. Lots of people inside and outside get real upset if I talk about wanting to drink. My counselor says it's ok to talk about it, so we do. She told me that thinking about it and talking about it are a lot different from doing it. Doing it gets you in trouble. Sometimes drinking is all I can think about — but I'm not doing it. I haven't gotten drunk for about a year. I always want my counselor to be proud of me so I am trying very hard to never drink. People can call me an alcoholic. I don't care. All I know is I just don't drink anymore and that's important to me.

By Angel



Our alcohol problems are mostly over. We abstain only because there may be a few left internally that have a desire. We recently found ourselves drinking again, then gave our problem to God. The desire for drink and drugs left us. We had been addicted to pain killers for medical reasons. Now we only think about them when in torment-pain, not when we just want to get high and forget. To us, God is good. He isn't just a Higher Power, He is God and He can heal. That's how we cope day by day.

We have serious eating problems: don't eat, eat junk, eat too much, sometimes vomit, or purge naturally by allowing our irritable bowel syndrome to take over. We aggravate

it a lot by using foods we know will cause us to purge. We feel fat and ugly and know we are 60 pounds overweight. We have no teeth, so sometimes eating and chewing is a problem. We have adapted but the desire to lose weight is strong. We have been doing better at eating normal meals and not using purge foods to lose the weight. We simply eat less and have stopped eating so much candy.

Our other addiction is smoking. The internal kids hate it. Each time we try to quit we get very suicidal, hence we have decided not to try to quit for awhile. We know in good time God will help us out of this crazy addiction.

Healing from DD is God's work. Our Christian counselor helps us understand about cult abuse and faith walks in life. He explains that God isn't happy when we hurt the body; He is sad, not angry, because God doesn't get angry with us. He helps us understand that we are loved and can be forgiven by anyone, even ourselves. And that it isn't our fault that we were abused. We see our MPD/DD as a journey. If we integrate, fine. If we don't, fine. It's in God's hands.

By Terry in S.J.



In my life I have practiced nearly every addiction you can name: compulsive overeating, alcohol, drugs, codependency. Once I saw the whole picture of my addictions and cross-addiction patterns, I could see one reason why those around me didn't seem to notice how much trouble I was in. I had so many crutches, I couldn't possibly fall! My having a high-functioning "front office" of alters, in this instance, worked against me.

I have attended many 12-Step programs. I began seven years ago with AA (Marilyn, Julia, Mac, Tams); then to ACOA (baby, toddler, and young child alters, especially Jennie);

then OA (Jackie, Jessie); and finally NA (Angel). Different alters come forward in each venue to deal with different issues. It often surprised me when an alter identified her/himself as practicing a particular addiction. But after listening to their stories I'd think, *of course*. This also explains the old cliché of alcoholics and addicts seeming to become "different people" when they're using. In my case, and probably many others, it certainly is true!

When I began my 12-Step recovery, I did not know I was MPD. But dealing with the steps caused me to have to face that I had deeper problems than I'd realized. This led me to self-examination, which led to some alters emerging spontaneously. (Thank you, Lyndy, Julia, and Carrie.) This led me to find a therapist who would believe I was experiencing multiple personalities and help me sort it all out.

I try to alternate which meetings I attend so that everyone who wants help and fellowship gets it. But to me, the 12-Step experience is really one unified concept, and the addiction-jumping just another split, in an attempt to stop the pain, suppress the memories, and provide an illusion of comfort, safety, and power.

As my inner people come forward and tell their stories, as they learn new coping tools, the impulse to act out through addictive behavior, even under stress, lessens. I am grateful to all my inner people for their efforts to protect me, because it worked. I am alive to tell about it, and to heal. I have learned to honor the ways I survived. I have also learned that I do not have to choose to survive by those means any longer. Together, my inner people and I are working on a total healing, using new tools of truth, trust, connection to feelings, patience, and faith. I feel a warmth and love for all my inner people now, even the ones who seem contrary or dangerous. And I know I must be doing something right, because my quality of life, health, and happiness have greatly improved.

By Leah et al



I am glad to have this opportunity to discuss my coping behaviors in the context of healing, because my process is contradicted so often by what I encounter in the survivor community that I often feel isolated, disbelieved, and judged. Maybe some other MV subscribers will validate my truth with their truth.

My survival strategies, from dissociation to addiction, have served as very effective coping mechanisms because they have empowered me in contexts in which there was no other source of power. I have consistently, naturally and deliberately discarded each strategy as it was no longer needed, as I discovered and developed more effective alternatives, or as I decided the negative factors outweighed the benefits.

My mother scalded my arm when I was a child and I immediately dissociated from my arm to avoid being overwhelmed by the pain. But I also continued to dissociate during healing to cope with the confirming, although decreasing pain. This enabled me to function relatively normally while my arm healed. Once it was healed sufficiently, I terminated the dissociation.

"Addictions and compulsions" (including writing) are some of my coping mechanisms, and I resent the terminology which judges and distorts.

I discovered cigarettes when I was 13. Smoking increased my sense of reality, identity, and human connection because: 1) the physical act and soothing pleasure "grounded" me; 2) being "the one who smokes" was an identity more powerful (and chosen) than my family's imposed identity of "scapegoat"; 3) smoking disconnected me from my nonsmoking abusive family and connected me with personally-chosen peers who smoked, shared, and cared about me. After leaving home, I developed a stronger sense of identity, social acceptance, and empowerment. When I no longer needed the mechanism of smoking and discovered, as well, that others controlled my behavior because it was an addiction, I lost the desire to smoke and stopped abruptly without experiencing withdrawal. I have not smoked for 20 years.

I went through a similar process with alcohol. I felt nurtured, comforted, and pleased by the act of drinking, and alcohol enabled co-conscious communication by relaxing the "visible" outside personalities (decreasing their will) so that "hidden" inside personalities could come out and express themselves — their memories, needs, desires, feelings. This was safe to do because I only drank at home alone and I have many strong, smart, self-protective personalities. (There was some hurtful but not harmful re-enactment as memories surfaced and were initially misunderstood or denied.) As our co-conscious sharing continued, we healed the hurts, developed self-esteem, and found ways to empower ourselves (including writing this article), our drinking decreased — from 6 to 4 to 2 to no beers. We no longer drink and have no desire to drink.

Many survivors believe that overcoming addictions is prerequisite to their sexual/ritual abuse recovery work, and I respect their right to their belief and their process. I expect the same respect for my process. My coping mechanisms serve as effective supports, and I have discovered through experience that premature removal of a support causes a destructive level of panic, increased compulsivity, shame and guilt, and delays my recovery.

Recently I made an ethical decision to stop using dairy products (a strongly-nurturing support) when I saw horrible abuse of cows during a TV program. My decision to refuse to continue to participate in this abuse as a consumer did not stop my normal desire for the nurturing quality of ice cream. However, in reaction I have begun to eat non-dairy ice cream and potato chips compulsively. I accept the turmoil caused by my premature rejection of a support because my ethics demands it in this instance. I will use this alternative support until I can nurture myself effectively enough so I no longer need them.

I choose to continue my use of coping behaviors that are for my health until they are no longer needed

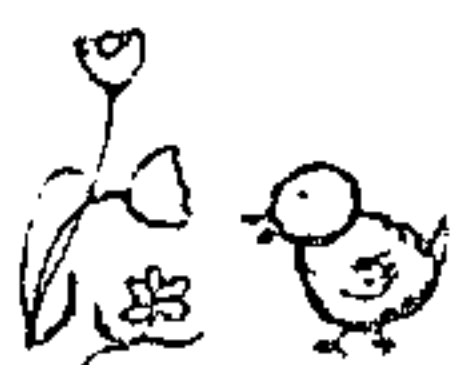
Continued on Page 12

Multiple Problems, Cont'd.

or wanted — coping behaviors that are like bandages covering wounds, and crutches standing me upright.

If I remove a bandage too soon, a wound may bleed excessively or become infected. Some healing is necessary first. If I remove crutches before I can support myself and walk on my own, I will fall down, perhaps reinjure my broken legs, certainly cling to the crutches far longer than if I had waited until I was ready in the first place. And only I know when I am ready. For despite rigorous professional training, I do not believe others can ever know my person, soul, and process as well as I know it myself.

By Sarah



We are a compulsive addict; you name it, we become addicted to it — food, clothes, money, books, tapes — each month a new addiction. This month's has been not-eating and tobacco. We spent every cent that we could on tobacco, taught ourselves to roll cigarettes so that we could know that we would never be without them. We feel we have to have lots of tobacco in the house to feel safe. We have an overabundance of tobacco, but we still feel we need to go buy more so that we will never need to worry about some idiot in here deciding to try and quit again.

Our case manager is putting a limit on how much we can spend on tobacco this month. We aren't very happy about that, so we are phasing into another addiction that is very expensive: art supplies. We are going to have to choose between food and addictions: do we buy the stuff we want, or do we eat? We really don't like to eat, so that might not be a hard choice, but the need to develop healthy eating patterns is an issue in therapy. Starvation diets are not the way to lose weight — we all know this. The normal feeling of hunger is just not normally there, to tell us to eat. This has been a problem from when we were just kids. Starved as an infant, you sort of lose your ability to feel

hunger.

We have many addictions like drinking and drugs, that we are clean and sober of. We have an obsessive-compulsive disorder that can be treated with medications, but we have decided not to use them. We want to use therapy to learn our way out of these compulsive addictions, not mask them with a pretty pill that teaches you nothing.

Addictions are a compelling force that nags in your mind, that tells you "you must, you must, you must have, do, say, these things."

We never know what compulsion will come next. Will we start craving to drink again? Or the drugs...pain killers are a strong desire to contend with, and in some ways are easy to get legally. The bottle is the easiest to get. We live really close to a liquor store. It's a chore to walk by every time we have to, but we do it most of the time.

Our best defense against drinking and drugging is in choosing our friends. Our last time out was influenced by them. We got rid of those friends and have been dry since.

Healing from the dissociative disorder? Well, that is another story. Having DD is a hassle that I can live with. My alters are a good-enough bunch. Not much on hurting the body or junk like that. They mostly try to get along with each other because we all realize that this boat will sink if we don't try to communicate and get along. The ones who aren't ready just stay in the cubbyholes and wait until they find something they want to do. Those of us who are already firmly established in a form of co-consciousness encourage them if we can get to them. That's the hard part: getting to them. It will take time, therapy, and perseverance on all our parts to get to the place where we will end.

We have so many groups of co-consciousness that we really have no idea how many we are. Too many to count. My name is Tonya and I am host — I think — but then, maybe I am not host and someone else is. Someone else claims to be host, but I honestly doubt that. She isn't reliable, will hurt the body, and doesn't try to

control her segment co-consciousness. She lets them screw up and put us into the hospital. We don't share names between co-conscious groups. That is a protective device from early childhood. Each group conscious also works differently from the others: another protective device. This way we can walk the streets and look as normal as possible. MPD/DD is a screwy world to live in, but you have to admit most of us with it are very creative people who can figure out how to rise up and battle daily life. We just do it differently from non-DD people.

By Tonya



As far as we know, we do not have any alters who know how to eat normally. I am anorexic, although I am working at keeping the body healthy by giving the body nutrition, and enough calories to keep the body and brain functioning. We have at least a couple of purging bulimics, and one non-purging bulimic who had the body up above 300 pounds when she was host for a few years. The eating disorders have been our system's major coping mechanism to do just about everything. They have functioned to divert therapists' attention away from our dissociation and multiplicity, and our attention away from knowledge, memories, anxiety, loneliness...you name it. They have also protected us from impulses toward what we have feared would be worse damage to the body. We went through an outpatient residential program for bulimia, and have been hospitalized three times for anorexia, all before our MPD diagnosis. We have never been hospitalized for multiplicity. In fact, we are much more stable/less crisis-prone since the secret of our existence is out in therapy.

We know that the major purpose of our eating disorders is diversion and the maintenance of secrets. However, they have also served as our entry into treatment, as our testing ground for learning how to trust therapy and therapists. The eating disorders and

their treatment were the catalyst for our dissociative defenses to destabilize enough for us and our therapists to discover, step by step, over the course of years: that we use dissociation, that there were probably memory gaps, that we have a dissociative disorder, that we lose time, and that we have MPD (DID). We're not sure that we could have come out (to ourselves, or our therapists) any differently, or any quicker.

We had some excellent treatment for eating disorders. It kept us alive. We even got better, but we never got well. If we had just had an eating disorder, we would have. But we kept cycling back in, because it was the only way we

knew to say "it's not right yet, there's more, keep looking," while remaining in hiding.

We needed that eating disorder treatment that we got, and we needed it first. But when we reached the point that we were no longer benefiting from it, we needed to move on to direct treatment of the multiplicity. Our current therapist, who we found at a point when we knew we needed treatment for both eating disorders and dissociation, is our city's primary expert in dissociative disorders — the one the other therapists go to for supervision. She is the one who has had the courage to say she will not allow therapy to be preempted by the crisis

jumping which has been the hallmark of our use of eating disorders, to divert attention. She has shown us how to do the memory work that we need to do, and steadfastly brings us back to that focus. We still use the eating disorder symptoms, but now we call them what they are. They are no longer so extensive as to be life-threatening, and we know they will go away as we gain even more courage from her. She has offered us hope and means for cure, and sometimes we believe her. She is the most terrifying person in the world, but we trust her.

By Crystal (AFS)

MV



Our future seems so uncertain and unknown. There is so much change. Sometimes everything around me seems so fresh, brand new and exciting. It's like I'm seeing and experiencing everything for the first time. It's so amazing! Other times it seems very scary and I wonder what will happen to me and the parts. I worry that they will go away and leave me, or that we will suddenly blend together into one and each of us will lose our individual specialness and uniqueness. I like my parts and would miss them if they were no longer around.

Recently I've been getting glimpses of myself in the future. This is a big change, as before I saw only emptiness when I tried to look ahead. Now I see a future that is new, interesting, and exciting as well as a little scary.

Whatever my future is, I plan to see it happen. I never thought I'd say this, but *I think I want to live.*

By Clue

MV

Recovering

By Rita M.

(This is an answer for Paul, Deana, Anne, for Rachel etc. - whose letter appeared in MV's April issue. Several subscribers responded to this letter, and we forwarded those replies. The following is Rita's comment. -- Ed.)

Q: It has always been the habit of my personalities to come out only when we are alone with ourselves, or just "around the corner" from people who might detect it. Must one "come out" in the therapist's presence to get better?

A: Dear P,D,A, for Rachel:

I think this is a common misconception that everyone holds about Dissociative Identity Disorder (DID). DID (formerly known as MPD) is a disorder of subtlety and hiddenness. I think that is why most clinicians never suspect it, or miss the clues that clients give in session. Only a small percentage of people who dissociate are flagrant in displaying their alter states. The rest are what I call "garden variety" dissociatives...people who are in pain, depressed, etc., whose symptoms of depression, anxiety, relationship problems, etc., mask the dissociative processes. They are most often misdiagnosed and thus, often do not receive the appropriate treatment.

Now as for your concerns: I have several clients whose alters rarely "came out" in session. While coming out may be helpful, I do not believe it is necessary for treatment to be successful. Only last week, in a session

with one very internal DID client, we remarked to each other how much *integration* had gone on, without me ever really dealing directly with her different ego states. (Note: I call alters "ego states", not out of disrespect, but I do feel it is more representative of what alters really are — a dissociated aspect of self.)

I have worked with this particular client for over seven years, through a lot of turmoil, traumatic reenactment, depression, etc. None of her alters ever spoke to me, and only one (the little girl) ever made an appearance. However, she would tell me about what the others were saying to her or to each other, and I would talk to them *through her* because I knew they were always listening.

I think that the less dramatic and chaotic process is healthier, because it avoids the tremendous secondary gain (attention) and distraction from the therapeutic work. Switching to convince someone else is not necessary, in my mind. TV demonstrations of switching seem like exploitation to me. I try always to be very respectful of my patient's process. I also attempt to model and give guidance, as much as possible, about "normal" behavior and interaction in

relationships — to decrease dissociative process, cognitive distortions, projections, etc. If I allow the client to repeat dysfunctional patterns of interaction and dissociation in the session, I am *not* helping that person, or teaching them anything useful about being a healthy human being.

I would encourage you to talk to your therapist about your perceptions, just to check it out and find out if this is really the way he/she is thinking. Then I would talk to him/her about your letter and how you feel about being dissociative and "presenting" in the session. Open, honest discussion is always more helpful than making assumptions and ending up with misunderstandings.

You do not have to be like other dissociative clients. I have said often, and will repeat again, there are similarities between DID patients, but everyone is unique. My goal as a therapist is to treat each patient with this in mind, and be respectful of our clients' differences, while understanding their similarities.

Good luck.

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

Resources

A two-day symposium, **False Memory Syndrome: A Panel Discussion of Clinical, Ethical, and Legal Considerations**, will be held July 21 & 22 near Chicago. Sponsored by Associates in Counselling & Psychotherapy Inc. and the Midwest Center for Traumatic Disorders, the discussion will feature competent spokespeople on both sides of the issue, including Dr. Pamela Freyd, founder of the FMSF, and Beth Vargo, president of Believe the Children. Cost \$150. Call 708/887-1224 for more information.

Global Alliance, quarterly newsletter for topics related to sexual abuse pregnancy. Write to CSAPI, PO Box 82, Milton, VT 05468-0082 for information.

Healing Our Memories (HOME) is a peer support resource program for adult survivors of childhood abuse. Write or call: PO Box 1604, San Anselmo, CA 94979 (415) 457-5615.

CANADA: Crisis Services for those sexually assaulted and/or sexually abused as children available at Lanark County Interval House Sexual Assault Program. 1-800-267-7946. Box 107, Carleton Place ONT K7C 3P3 Canada.

Partner Communication

We wanted to share something that has helped our relationship with our partner. After therapy visits we rarely feel like talking. Lots of stuff is happening inside. Often times we don't remember what happened during the session. This is hard for our partner and hard on our relationship. We were frustrated, feeling as if we wanted him to know where we were at, but not sure how much we wanted to tell or were able to recall. He was worried and scared, not knowing what to expect. Out of this concern came the enclosed format. We chose some of the scales and items on the scales, and negotiated with our partner what was important to him. Couples could determine the scales important for their relationship. We complete the form at the close of our therapy session by an internal consensus of our states. It could also be filled out by several alters with several color pens. By completing it with our therapist, she can help us remember what issues have come up and decide what ones to share with our partner. Sharing this information helps keep our relationship more connected. We hope it can help others.

Sincerely,

L+

Date: _____						
SUICIDALITY						
Love Life	Things OK	Thoughts	Plans	Hate Life		

SELF HARM						
No Way	Not A Priority	Thoughts	Plans	Will Do It		

QUIETNESS						
Let's Party	Some Time To Think	Side by Side Play	Somewhat Unavailable	Withdrawn		

THERAPY						
Relationship Building	Feelings Management	Situational Stress	Informational/ Heavy Duty	Neediness	Alter Visiting	Memories/ Core Work

HOSPITALIZATION						
Not A Concern	Discussed As Possibility		Recommended	Indicated Immediately		

ANXIETY						
Not At All	Low/Slightly	Moderate/ Uncomfortable	Going Crazy High	Going Crazy Don't leave me	Afraid to be alone	

Specific Topics or Topics to Discuss _____						

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A Kinder, Gentler Way to Control Eating

By Laura

For the past 12 years, we have had an all-consuming food problem. It takes different forms at different times. Sometimes it is bingeing, sometimes taking only supplements and no food (60-70 pills a day), sometimes not putting anything artificial into ourselves (no supplements), and sometimes being compulsive about healthful eating. We spend about 95% of our energy on food — buying it, wrapping and storing it, cooking it, eating it, packing it to carry with us wherever we go, thinking about it, reading about it, being physically sick from it.

Over the years, we had tried to control this by imposing strict rules on ourselves. They involved restrictions such as forbidden foods, portion sizes, and times of day to eat. We would be able to keep the rules for a few days, after which we would lose control again.

Then, about a month ago, we remembered someone at an MPD meeting saying that if you're stuck, ask inside. We did, and were surprised to get an answer. It was from someone very young who needed to be held. We thought that if we imagined that Sarah (our therapist) was holding us, we wouldn't need to eat so much. Sarah wrote us a note that we kept in our wallet. It said that any time we needed to eat, we should know that she was holding us, and then we wouldn't have to eat. We felt slightly less driven about food after that, but not much. So we tried to let inside make their needs known some more, and found that they needed someone to hold them *while* they were eating, not *instead* of eating. Sarah wrote a new note, and that worked a little better, but it was still not enough. We realized that something else was going on, although we didn't know what it was.

We tried asking again, but this time didn't get an answer that could be translated into human language. We just got remote vibrations from tortured, disembodied essences that were buried deep in the ground. We

couldn't reach them, but at least they knew that now we realized they were there.

Recently, we read an article that said in order to properly digest food, you should chew each mouthful 50-100 times, until it becomes liquid. We had never paid attention to chewing before. We had always swallowed after one or two quick chews, and then rushed to put more food in. We tried chewing, and something amazing happened. Someone *tasted* the food. This was a totally new experience for us. We never realized before that we hadn't been tasting when we ate.

We began to see that the process of eating consisted of lots of individual activities, and that each one of us knew about only *one* of those activities — holding and controlling the spoon, or tasting, or chewing, or feeling the food in your mouth touch the inside of your cheeks, or swallowing, or feeling full in your belly. None of us separately had ever experienced the whole of what it felt like to eat, so none of us had ever gotten complete satisfaction from eating. That is why we were so driven to eat all the time. We are now trying to get to know everyone in us who is connected with eating, and to find out what each one needs in order to feel satisfied. Ideally, they could all feel satisfied *at the same time* (sort of like eating-integration).

One day, when we brought some food to a session and ate it with Sarah, someone came who was very young and pre-verbal. Sarah asked whether we wanted her to feed us, and we heard someone else answer an emphatic NO. (We never want any outside person, even Sarah, to have control over putting something into us.) What we did want was for Sarah to attach us with her eyes, the way you attach a baby's eyes when you give her a bottle. While we ate, Sarah did attach us — with constant, kind eyes. We knew that she wouldn't disappear or do anything bad to us. Because we felt safe, the one who tastes started to come, but she couldn't stay very long,

because the sensation of tasting triggered someone else. We started going down, down, underneath death, and we heard whimpering sounds, and soft, desperate moans. The sounds were coming from our mouth, but we were hearing them from outside, just as Sarah was hearing them from outside. We didn't know what was happening, but we knew that it had something to do with the disembodied essences buried underground.

Since then, we have come to realize that different ones of us have different problems with eating. Those most easy for us to deal with are the ones who just need to be held and attached to Sarah through her eyes. But there are others for whom food represents terror, and to whom bad things happen between the time you put food in your mouth and the time you swallow it. (Sometimes you never even get to swallow it.) They can't let themselves taste or have any sensations, because disaster will come, and they have to eat very quickly before it does.

We don't think we would have known about the terrorized ones if the ones who needed to attach to Sarah's eyes hadn't come to eat with her in a session. The terrorized ones never come when we eat alone, because there is no outside person to create a threat. And they never come when we eat with outside people (friends) in a restaurant, because outside people are *so much* of a threat that the food guard comes. The food guard makes sure that none of the ones who are vulnerable come (like the one who tastes). She makes sure that only someone who eats a lot and swallows quickly will be there. But Sarah is a different kind of outside person. She is not a threat. Because she is safe, when we ate in the session, the food guard let the one who tastes come. But as soon as she started to taste, the terrorized ones took over because an outside person was there — even though the outside person was Sarah. That was the first time that we found

out about them. Although it was upsetting, we're glad that it happened, because they needed someone to know they are there.

One of the problems we have is eating in restaurants, even with friends (outside people). Because the food guard won't let anyone come who feels the food, we keep eating quickly and ordering more in an attempt to get satisfaction from it. Then, when we leave the restaurant and are by ourself, we stop in stores on the way home, buy cookies and cake, and desperately eat them while we walk. As soon as we finish what is in hand, we go into another store to get some more. By the time we get home, we are so physically sick from having overeaten in the restaurant and on the way home that it sometimes takes us several days to recover.

If we eat in a restaurant by ourself, we have the same problem, but to a lesser degree. The only place that we feel safe enough to eat slowly, and to chew, taste, and get other sensations, is at home, with the door locked, the radio and the phone turned off, and our eyes closed (against distractions). Even then, it is a struggle to stay present and not switch. We have to concentrate very hard to let the one who tastes come and stay. Often she comes for a minute, and then someone else comes and she disappears. By the time we get her back, we have already eaten 3/4 of

what is on the plate, and she wasn't there to taste it. We are practicing concentrating when we eat so that only the ones involved with eating are here, and no one else switches them out.

Another problem we have is that we don't have any immediate memory of having just eaten. When the eating ends, there is nothingness. No fragrance or sensation of the food lingers in our senses. Whoever tasted it or felt it has gone, and hasn't shared it with the rest of us. We have no sensory memory to sustain us, and that is why sometimes, just seconds after we have finished eating, we need to eat again.

Still another problem is that we don't get accurate physical signals telling us when we are *actually* full, so we keep eating until we *feel* full, but by then we have overeaten, and are very uncomfortable. Some of this may be because our digestion is very poor, and very slow. And some of it may be that someone inside us doesn't let any sensations come into our belly, so we don't always feel the way we should after having eaten a lot.

Getting to know all the ones inside who are involved with food is a difficult process. But we can see that when we do get to know them, it will be better than our former way of trying to control food by imposing strict rules without having any inside understanding.

MV

Resources

The Washington State Hot Line for survivors is no longer in operation. Please cross out this number in your copy of MVMC #2 (page 24).

Extremely useful information for the facially-disfigured is available from Let's Face It, Box 711, Concord, MA 01742-0004. Some of these resources may also be useful to those whose dissociative states resulted from medical treatment, operations etc. when young. Thanks to Jessica T. for this resource!

Answers Within, for Survivors of Trauma is a tape prepared by Mirabye A Boone, MSW, DCH to help clients relax and support their therapeutic experience. Side One: Understanding How Trauma Affects You; Side Two: Experiencing Your Safe Place. \$12.95 plus \$3 shipping to Answers Within, PO Box 3004, Vancouver WA 98668. Washington residents, add 7.6% sales tax.

Editor of proposed book on women and "mental illness" seeks essays, poetry, short stories and artwork re: psychiatry, psychiatric drugs, voluntary/involuntary hospitalization, psychiatric diagnosis. Send by Sept. 1 to Alexandra Laris, PO Box 91106, Santa Barbara, CA 93190-1106.

Canadian MP newsletter seeks submissions. Write to Multiple Creations, 1238 - 1st St., Brandon, MB R7A 2Y6, Canada, for info.

5th Annual Texas Conference on Trauma & Dissociation, Sept. 23-24, 1994, Dallas. Call (903)595-6600 for information.

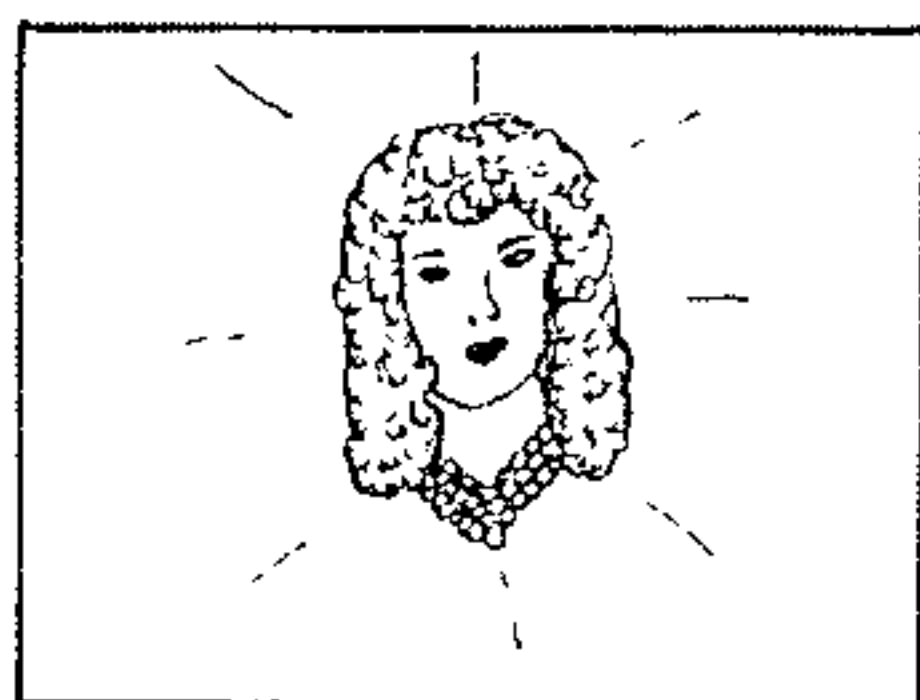
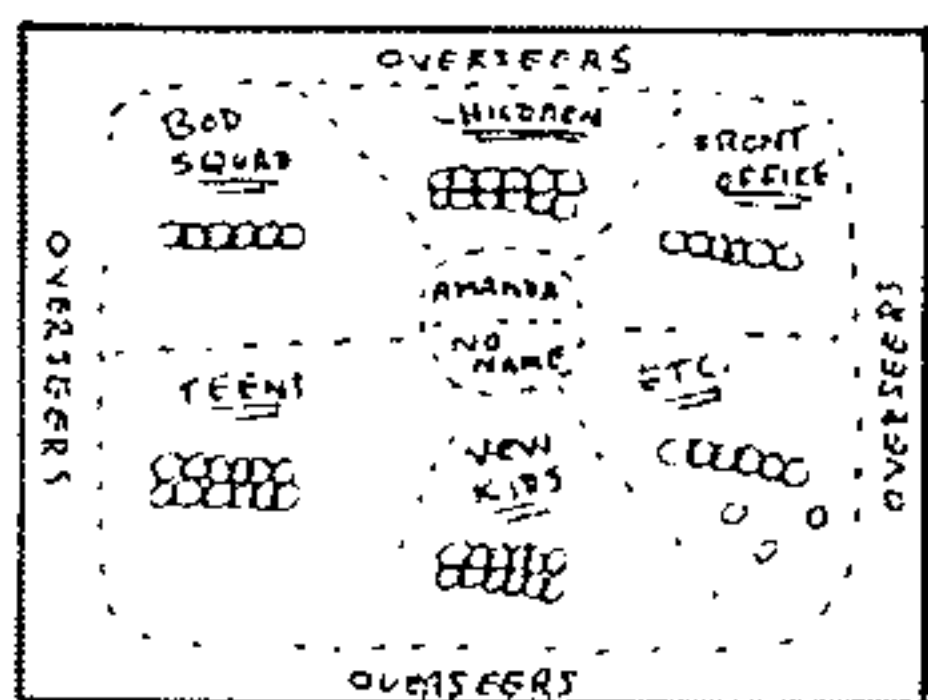
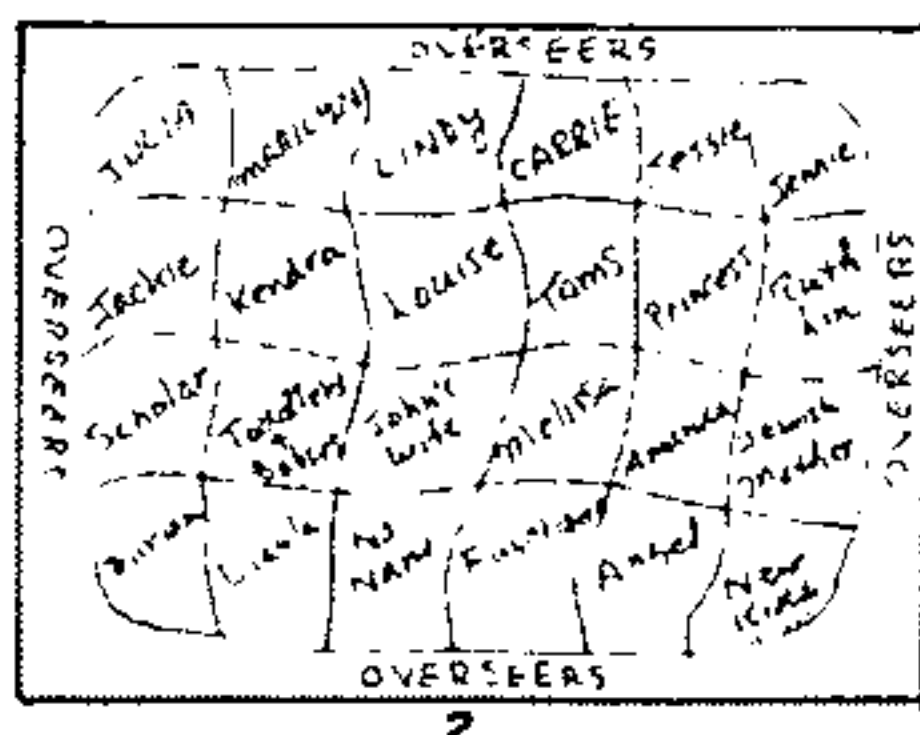
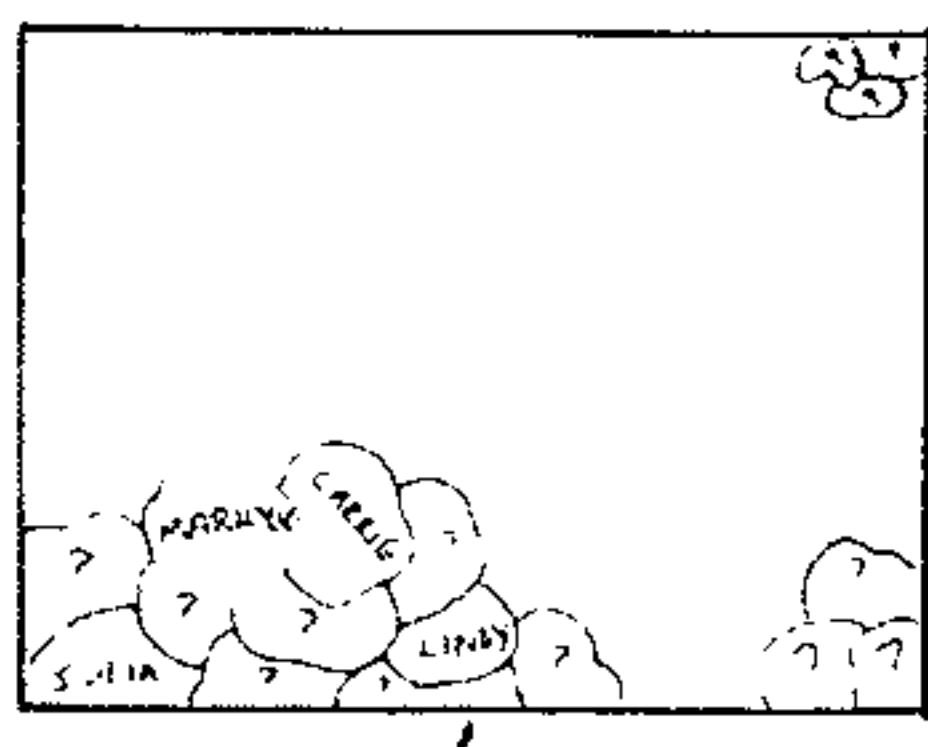
Editor of book on abuse survivors' response to pregnancy and birth wants to hear from dissociative people about their experiences. Also seeks writer of "Some of Us, for Us" in The Compleat Mother magazine, Spring '94. Please write to Alice Van Galen, PO Box 65180, Toronto, ONT M4K 3Z2 Canada.

Our Newsletter, for inner children/alters. Write to Ayla, PO Box 1521, Herndon VA 22070.

The Company of Women is a merchandise catalog that helps support the Rockland Family Shelter in Spring Valley, New York, aiding survivors of rape & domestic violence. Neat books, clothing, etc. 1-800-937-1193.

Subscriber Pat S. sent a clipping from the Wireless catalog: Shirt says THIS IS NO ORDINARY PERSON YOU'RE DEALING WITH. T-shirt, \$17, Sweatshirt, \$27. 1-800-669-9999.

Many Leaves One Tree, newsletter for dissociative disorders. Write to PO Box 36302, Towson MD 21286 for info.



MY THERAPY

by
Lash

\$ Crisis — Health Care

Below, MV prints portions of a letter written by a subscriber to Rep. Dan Rostenkowski, stressing the need for national health care reform. Many of us will identify with Ann's frustration. If so, write to your congressperson. Better to do something besides sit and stew. I'm omitting last names and hospital names for reasons of confidentiality. — LW

My name is Ann ___ and I am now a patron of your congressional district. I am 34 years old. I graduated from my high school class with a ranking of 97.8%. I completed 3 years towards a psychology degree and spent 30 years living with the hard-working middle class. I have driven to (city) to support better funding of education, and I have walked picket lines with my children advocating a better working relationship between parents, teachers and administrators. I am a recently divorced mother of three young boys. This is my first letter to you.

I earnestly read the December "Washington Report". I was impressed by the fact that it did not mention any new reform that would address my own health care coverage problems. Please allow me to explain.

In April of 1990, ten years into my marriage, I suffered a severe depression. My husband had become physically abusive and for the first time in my life I was hospitalized. Although I acted out my suicidal wishes three times within six weeks while hospitalized, I was told I would be released during the eighth week. The business office of (the hospital) and my former psychiatrist determined during the seventh week that our insurance policy only covered \$10,000 towards emotional disorders, or basically, the first three days. They concluded that the "care" needed to be terminated. We still owe, to this date, \$11,400 on these bills.

My husband chose to stop paying for an insurance policy that could not cover me. He placed me on Medicaid. He quit-deeded the extra income properties over to his parents along with other marital assets while I was hospitalized. I was introduced to the University hospital where I was diagnosed with MPD and I did begin

receiving legitimate help from a highly competent psychiatrist who continues to treat me. The initial emotional disorder was caused by severe childhood abuse.

I was released from the University hospital in February, 1991. I began my first non-family, paying, part-time job as a cashier in May 1991. We began marital therapy which continued for 18 months, although I stayed within a separate flat of our 18-room Victorian house. My husband again became abusive and in June 1992 I began divorce proceedings. I received and have maintained custody.

A month before the divorce began I was still working part-time, but had finally begun to receive Medicare and Social Security Disability monies. Public Aid determined that a family of four could only maintain an income of \$524. When I received the \$320 disability income along with \$200 child support income, I felt forced to quit my job to maintain full health care coverage. I knew that even if I could handle full-time work, through the Public Aid "Spend-down" policy, I would only be entitled to keep \$4 of my monthly earnings.

In September 1992, I began to educate myself as a court reporter. I received a grant from the college and monies from the Department of Occupational Rehabilitation for transportation. We also started receiving food stamps. In response to my continuing survival, my husband quit making payments on our home and moved to a house his family purchased for him. The bank began foreclosure proceedings and I volunteered my car for repossession.

The court pushed up child support to \$650 and enabled me to begin the work needed to sell the house. I rented, then sold the house, and the boys and I moved. We moved into a less expensive apartment near public transportation and school where I was receiving an "A" average. In April 1993, through a combination of too much stress, I was again overwhelmed to the point of needing to be hospitalized for the last time,

supported by Public Aid. I wasn't allowed to keep the monies I had won through the court through the forced sale of our home or child support and be fully insured. I lost the nerve necessary to continue. I adjusted and the University hospital temporarily agreed to write-off some therapy costs not covered by Medicare for the boys and me if I could maintain.

In September 1993, the DOOR program again began supporting my educational needs, although this time through a supportive disabled vocational service. I am learning the necessary computer skills to gain employment in order to support a family. I have also earned the credit needed to be working part-time at their facility as a data-entry clerk.

I am yet "covered" by Medicare, although Medicare doesn't cover the first \$700 of any hospitalization, regular physician check-ups, dental, pharmacy, or 20% of any normal medically "covered" costs. If I continue to work for six weeks, my disability benefits will be stopped. If I continue to work for one year, I will no longer receive maintenance through the court. If I continue to work for three years, I will no longer be eligible for Social Security's Medicare benefits. If I lose Medicare and become again insured by a regular insurance group (through a job) I will have run full circle.

Regular insurance does not cover much if anything toward emotional disabilities. Regular insurance does not pay for pre-existing conditions or for child social work. Regular insurance wouldn't allow my father to take out a \$5,000 life insurance policy in order to bury me.

Please, Mr. Rostenkowski, hear me, we are not the millions of Americans, "who live with the fear that their life savings will be swallowed up by medical bills, if they become seriously ill."

We are the millions of Americans who are being swallowed up.

Sincerely,
Ann G.

Multiple's Mobile

Parts of me
 still separated
 fragments
 floating
 agitated
 turning through
 my field of vision
 each requesting
 a decision
 old emotions
 new to me
 rage pain grief
 desire

 I see
 overwhelming
 deep, deep feeling
 each one

 asking
 me for healing.

By Sandi



This is a drawing of my healthier future life. I feel that Unity is a good thing for us. Right now my alters are not getting along. There's a lot of confusion and chaos in our lives. I would be happy if we could all have a fun day in the park, like the picture shows. This picture was done with the help of all my alters. I hope this means that we're one step closer to that day in the park. I thank them for their help in this project.

By Deb & Friends

Books

Nobody Nowhere, The Extraordinary Autobiography of an Autistic.

by Donna Williams. Random House (Times Books) © 1992. \$21 Hardback.

This is the profoundly moving life story of a young woman who was not only autistic, but also very likely a multiple. Driven deeper inside her own world by cruel abuse, Donna is almost totally unable to communicate with "their world," the world of people.

With the help of her two inner "characters," Billy, an aggressive and scholarly boy, and later gregarious, charming Carol, Donna struggles to overcome isolation, confusion and personal poverty. At great emotional expense, she completes college and becomes a successful writer, and considers herself a high-functioning autistic.

Never seeing herself as victim, Donna Williams opens for us the almost unknown world of autism. Her story challenges me personally, for she not only struggles with one, but with *two* major debilitating handicaps. Though never diagnosed with a dissociative disorder, Donna relates a dream in which her characters Billy and Carol are represented by two kittens that someone wants to destroy.

She protects and feeds them, whispering to the man that "there are really seven." *Um-hum*, I said to myself as I read this *She's not finished with her story!*

I expect to see more of Donna's books as her remarkable recovery continues.

By Sandra Price

Promise Not to Tell

By Carolyn Polese. Published by Beech Tree Books, an imprint of William Morrow & Co., New York. ©1985 by Carolyn Polese. \$3.95. 53 pages, paperback.

This small children's book (age 10-up) won the Christopher Medal for its gentle but clear description of an unwanted sexual encounter between a child and adult. It realistically portrays the feelings involved, and helps show children how they might find adults to trust with their traumatic experience. In this story, the perpetrator is not a family member, and the abusive act is not fully carried out. The mother, though initially distracted, finally listens and empathizes with her young daughter. A useful book for parents to discuss with children, to open up the subject of protecting oneself from unwanted sexual acts.

The Path to Wholeness A Personal Approach to Spiritual Healing and Empowerment for Individuals Recovering from Sexual and Spiritual Abuse

By Carol Tuttle © 1993. Published by Covenant Communications, 920 East State Rd., Suite F, American Fork, UT 84003. 240 pages. \$9.95. Paperback.

Carol Tuttle was raised in a family of active Latter Day Saints (Mormons). Her story of the perfectionist "outside life" and the seriously-troubled "inside life" is all too familiar. But the book she prepared concentrates more on the process of healing than on the abuse she suffered. She describes her recovery, (in which she continues to practice her childhood religion) via support groups, therapy, and spiritual guidance. There is also a helpful, candid chapter written by her husband, and brief stories of some other LDS women who were abused as children. Because of its focus, this book may best serve a particular religious audience...but the basic principles of healthy therapy are not neglected or countered by the spiritual content.

By LW

Thank You!

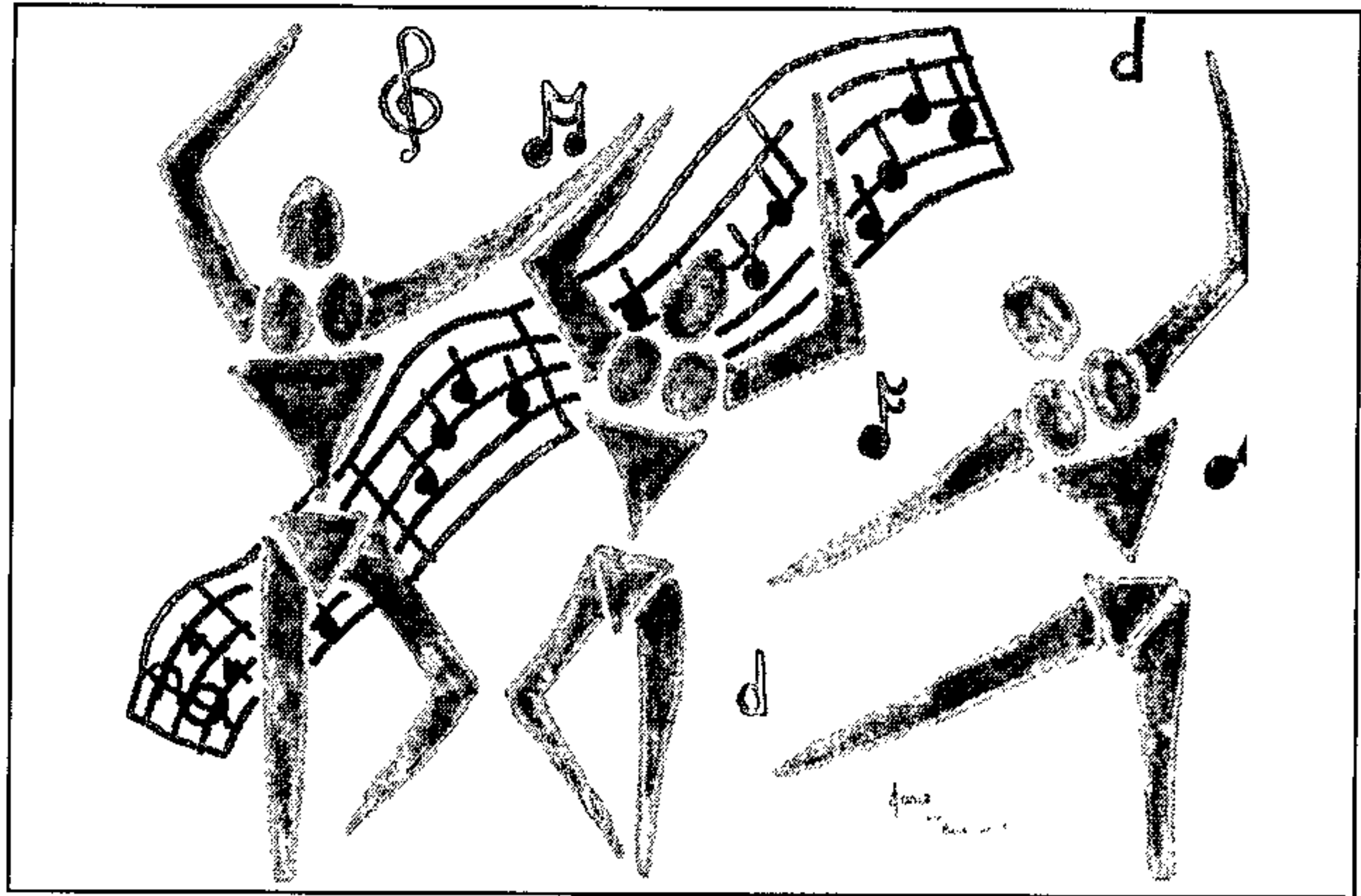
For all your wonderful Artwork, Prose and Poetry!

As usual, you folks outdid yourselves, and made my job as editor a pleasure, not a duty.

Keep up the good work!
And if you have some humorous material or cartoons, please send. We can always use a smile!

Have a great summer!

— Lynn W.



August 1994

Funniest (or strangest) things that have happened in therapy for dissociation. Light-reading suggestions & kids' books. ART: cartoons and drawings of unusual occurrences in therapy.
DEADLINE: June 1, 1994.

October 1994

Creating your own healthy circle. Developing social skills. Groups for therapy &/or support. Meeting peers (How To, risks, rules for safety etc.) Penpal pros & cons. ART: Socializing with outsiders.
DEADLINE: August 1, 1994.

December 1994

Double-topic issue: Dealing with the health-care system (insurance, medical doctors/dentists, social service agencies). ALSO: Reducing dissociation in stressful situations. ART: A gift you'd like to give yourself, a friend, or the world.
DEADLINE: October 1, 1994.

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.

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