

# ● MANY VOICES

WORDS OF HOPE FOR PEOPLE RECOVERING FROM TRAUMA & DISSOCIATION

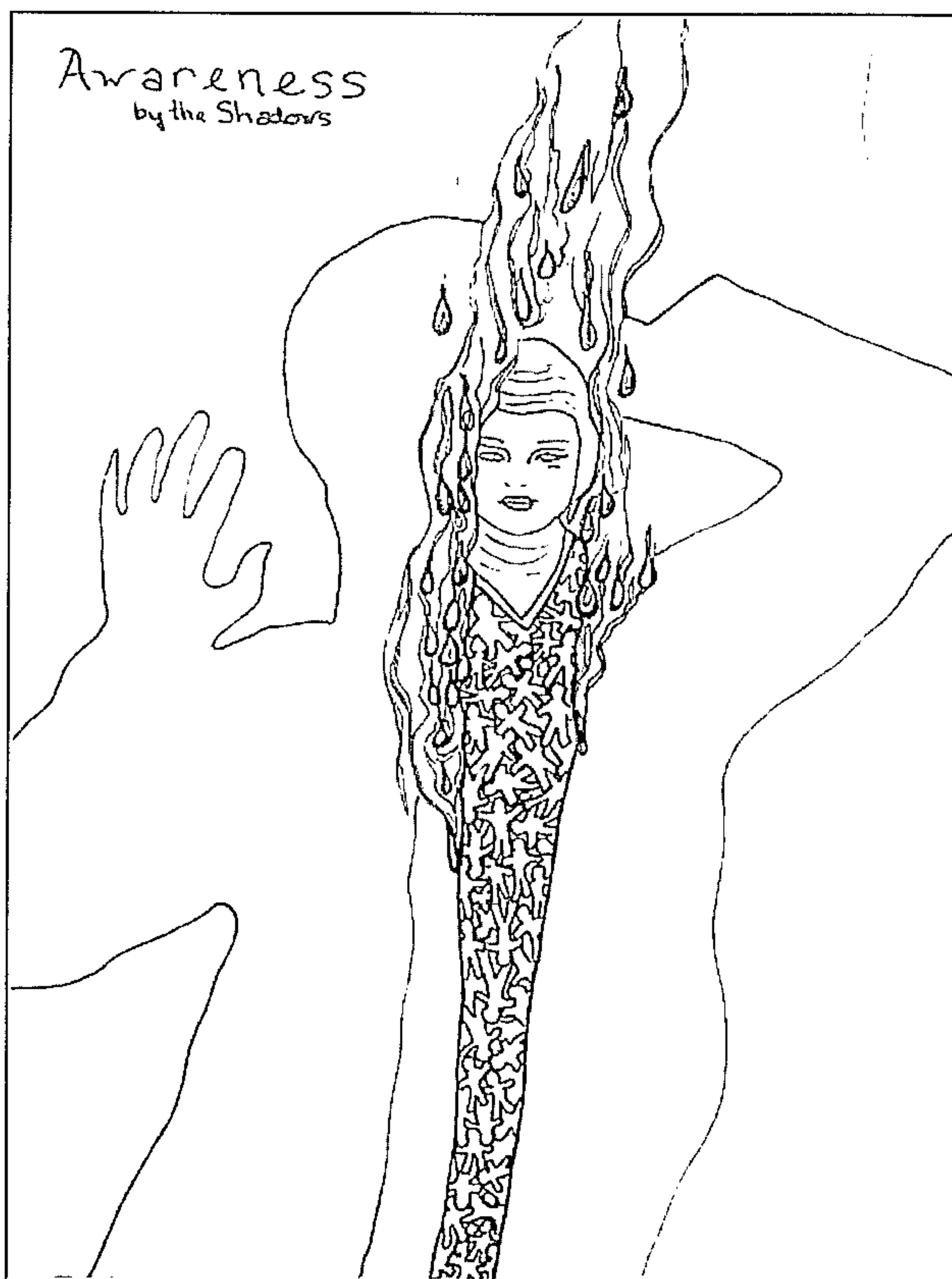
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Inside:

## Hospitals & Doctors: What Traumatized People Need to Know About Good Medical Care



### *Call to the Children*

They hide in the shadows within:

The sanest  
and only choice they thought  
they could make  
in a maddened world.

Some live so deep,  
in what has become a trap  
spun by the shadows of these, my  
children.

In a dance like a spider.  
Their fragility much like the web.  
Some are known,  
some are hidden far, far away  
where you've taught me they need to be  
right now,  
until we're all ready.  
You make it OK  
You give gentleness when i see  
it will never be the way i wish it could be  
and show me what can be  
can make my life OK  
And the children—when you call  
to the children, they do hear  
They hear, most of them scattering,  
fragmenting  
even more.  
until they find the special courage  
they draw from you.  
The words you speak can pass through  
the wall,  
and make it OK for awhile  
When you call to the children,  
they try to believe you're no threat—  
"Allie-Allie-In-come-free..."  
But they still know it's more serious than  
just a game.  
They emerge with borrowed trust,  
from places  
no child should have to be,  
and find the soft safety you so easily give  
just by being.  
A very special being,  
with a very special way to be.

*By Diane H.*

**MV**

# The Mandated Trend Toward Brief Therapy:

## A Cost-Effective (but potentially lethal) Treatment for Major Depression

By C.E.

**W**ithin the darkest, most unmapped recesses of the mind sometimes lie cells bent upon destruction. They become problematic at the slightest provocation—genetic predisposition, hormonal imbalance, chemical insult, scarring from ancient trauma? The actual cause usually remains speculative. The result, however, is familiar—a thing called depression—which puts the whole ship in danger.

So, a declaration of war must be made—usually by people indoctrinated to bow in worship to psychotropic drugs. They equate the prescription pad and pen with having great power and mastery over these microscopic enemies in the brain. Espousing the latest technical and scientific prowess, they say,

"Here. Take two of these a day. I'll see you in a month."

But the body remains uncooperative.

"Didn't help? Well, then four must be the answer. Those side-effects are temporary. You'll feel better in no time. I'll see you in a month."

Is it those cells resisting out of spite, or is it the will of the totality which is fighting the sure-cure claimed by the pharmaceutical ads?

No matter. The head continues to swell with poison as evidenced by its owner's awareness that days are becoming increasingly ink-black and suffocating. But there is no time to listen to details, so the doctor's reply is,

"Perhaps these new blue ones instead of the green. Or, maybe the blue ones *with* the green *and* a white one thrown in to balance things out...I'll see you in a month."

Each new trial of medication reinforces the sense of failure and loss of control. Each new prescription handed across the shiny mahogany desk diminishes trust in the all-knowing psychiatrist who now resorts to hiding behind a vocabulary peppered with words like serotonin,

therapeutic level, synapse, reuptake inhibitors—utter gibberish to one who has lost the ability to think analytically and secretly just craves simple validation and nurturing.

Realizing the responsibility of commanding the ship's course, the head signals for help, but the drugs fail to chart a safe passage through life's rough waters. The ship isolates itself far from shore—a shore populated by people who laugh, love, make plans for next summer vacation, and, mostly remain blind to another's invisible inner misery.

More and more often, the ship cocoons in dark places. More and more often, tears well up from some deep, unknown place within. Animal-like sobs erupt and the throat and chest bear elephantine weight that is unrelenting and merciless...until that day comes when the pain pushes all logic aside.

"If a few pills each day were supposed to bring relief, then perhaps a small handful?"

But the small handful doesn't help except to provide the courage to take a large handful.

And the ship silently waits for the seas to calm and for a welcome sliding into glassy waters, which comes sooner than expected. The resulting stillness in the head is broken only by a tiny nagging thought that swims through the gathering mist and whispers a warning that

this has gone too far,  
that a hand should reach for a phone,  
that others will be hurt by the  
choosing of this particular voyage.

But the fog thickens, and the phone is forgotten.

The wise doctor had no choice, of course.

The number of approved visits allotted for doing things the old way, for becoming allies with this fellow soul

in a search for the pain's cause and cure, were exhausted.

Compassion and caring had crashed headlong into fiscal responsibility, resulting the mandated treatment dictating the outcome (or was it the other way around?)

And the solution successfully erased the pain,

and the ship,  
permanently.

MV

### *Crystal and Crosse*

The battle royal rages  
Within the perimeters of your soul  
Devouring what is innocent  
While you collect crystal and crosses  
to account for your losses.

Believing in a superior intelligence  
You never become lost  
Within the swirling mists of shadowland  
When confusion crowds  
The corners of your mind.  
You simply change direction.

Your philosophies roll from your tongue  
With the ease of raindrops from the heavens,  
But your reality is more complex.  
Tear-eyed behind your smile,  
You pretend to enjoy  
The hell which you have created  
While the flames lick at your heart.

Your soul echoes silently  
While your throat strangles your cries  
of hallelujah and amen  
And your integrity slips into oblivion  
While you continue to collect crystal  
and crosses.

When will you understand  
That all roads do not lead to your  
fantasy?  
When will you understand yourself?

*By Beverly*

MV



## Dinner Crowd

Grey, brown speckled and black soldiers  
Advance across my lawn,  
spreading out from  
Lush, tall grasses,  
a shadow spawned army  
Undercover, using the riotously colored  
leaves  
Of fall as camouflage.  
They stand out, sickly sentinels  
Of summer's death.  
On guard, the inner secret service  
watches, comes on alert.  
Danger, Danger!  
Toadstools have invaded.  
The Mind shivers.

Hands reddened by water too hot to feel  
I stare out the window,  
dissociating in the pursuit  
of the perfectly clean home and hearth.  
The Hands wash and rise, immersed in  
rainbow froth;  
The Body sways absently  
from foot to foot  
To share the weight, (but not the  
shame.)

The Mind functions to connect images  
of both past and present.

Shadow voices of my  
imagination fill the void in my head:  
Old women, old men, friends of my  
youth,  
these images shout, fight for my  
attention,  
yapping on and on in irritating  
commentary.

"Stupid Woman," they say, "wasting  
her time."

"We'll be broke pretty soon.

She should be Losing  
Weight. She's going to kill us all!"

A younger voice says, "But I like  
treatment.

He treats us like real people!"

The Hands, used to this nonsense  
continue to move plates from dishpan  
to the sink, scientifically. The Body  
tingles the hands in response to *that*  
memory.

The Eyes regain their focus and  
zoom in on lawn.

Toadstools, like secrets, are poison on  
the inside.

I sigh and return my gaze to the  
dishwater

The ringing in my ears a wall  
Imposing a silence of its own.

By Rene

MV



## Are You An Angel?

MV would really appreciate support from institutions, so we can continue to expand our outreach to trauma survivors. If you'd like information on our support categories, or other ways to help (that are beneficial to you as well) please write, call (513) 751-8020 or e-mail: LynnWatMV@aol.com. Thank you very much!

## Creative Solutions

One problem that I am dealing with is that my father, who was my perpetrator, keeps sending me flowers! He only knows that I have been hospitalized for depression and a suicide attempt recently. Since that time I have received flowers four different weeks. This only confirms that my otherwise-repressed memories are true! To me this indicates that he is guilty, but I still have parts who love the flowers and do not believe that Daddy could have done that. But having the flowers around bothers other parts of me. In therapy we listened to the voices, and here's what we decided to do: First, I contacted the local florist with instructions to notify me of flowers but to send them to the hospital for

someone else to enjoy. Next, I contacted the florist my father uses, with instructions to only use the local florist that I suggested. I bought some flowers for the part that liked the flowers. Then we dropped the flowers out of a second story window (the teens wanted to do that). Then we took a baseball bat to the flowers. One part wanted to put the flowers on graves because she wanted them to be dead and put with dead people. So today I feel powerful! I don't have to let him continue to haunt me. I am not ready for confrontation or even speaking to him. It just feels so good to be able to destroy something of his! I love this newsletter—it helps me a lot. Thanks.

By JoAnn and the pack

MV

## The Good Days

for ellie's friends



# My Brush with Managed Care

By Laura

**S**teven was different from any of the seven therapists I'd had before. He could connect not only with the camouflage surface me whom I presented to the world, but with those underneath who were closely following everything and needed just a hint of recognition to come out. He was the only one who had ever made contact with those of us who need therapy most—paralyzed babies on the Bottom Level, traumatized little girls on the Middle Level, angry big girls who curse and hit on the Top Level. Before Steven, I had always used therapy as a band-aid to keep me functioning until the next crisis. Now I felt I actually had a chance to get better.

But there was one problem I couldn't talk about with him. Money. I had two sessions a week, each for two hours. His fee was \$150 an hour, which came to \$600 a week, or an average of \$2,500 monthly. The babies and little girls who came to the sessions had no idea that he was a therapist or that we paid him. If they had, they would never have come out. To protect them, AlmostLaura, who is twenty-one and manages things for us, established a routine without ever discussing it with him. At the end of each month, she tallied the number of sessions and mailed him a check. About ten days later, he mailed her a receipt. To us, the out-of-session Steven whom AlmostLaura paid was totally separate from the in-person Steven whom the little ones saw.

I had long ago reached the insurance maximum for therapy, and since the early eighties had been working a second job on weekends to cover expenses. I had never had bills this high, though, and now even my seven-day regimen wasn't enough. So AlmostLaura began using the inheritance money I had gotten from my father, money she had been saving for our retirement (my body is fifty-five years old). Nervously, she watched it disappear, and in the fall of 1995, calculated that there was enough left to keep seeing Steven the way we were—two double sessions a week—for one more year. Then we would have nothing. She panicked. What if we got laid off? What if our car broke? What if we weren't better and still needed him? Her anxiety filtered down, and the message got through to the little ones that soon they would lose Steven.

Eighteen-year-old Lisa came to the rescue with a plan. We would see him for the year, and then, if we weren't better, we would kill ourselves. She even did research into the least painful method and assembled the necessary materials. Lisa's decision calmed AlmostLaura and freed the little ones to

keep coming out in the sessions. Someone told Steven about the plan, and he said it meant that we—he and I—would have to work very hard for the next year. He also said he was in this for the long haul, but he didn't explain what he meant, and I was afraid to ask.

Neither Steven nor I mentioned money after that, and things went well until the summer of 1996. Then I started to have problems with him. Most of them concerned my obsession with having his undivided attention during a session. If his mind wandered for even one minute, or if his beeper went off, I felt he had abandoned me. Each of these upsets took weeks to resolve. During that same time, in my outside life, I was being tossed about by a wave of corporate downsizing. I managed to survive, but was transferred to another department where I was extremely unhappy.

The combined stress of work, Steven, and the fast-approaching financial doomsday overwhelmed AlmostLaura. She finally collapsed, and we lost our entire infrastructure. No one sent Steven a check for three months, even though the year wasn't over and we still had some money left. Steven didn't realize how totally disintegrated I had become, or that AlmostLaura was gone. He wondered why I hadn't paid him, and thought he would give AlmostLaura a gentle reminder by mailing her a blank receipt.

That receipt precipitated an explosion that forced the money issue into the open and wiped away most of the trust he and I had worked so patiently to build. At first he said if I had no money he would still see me, but it would have to be less often. Then he reversed himself, saying it wouldn't have to be less often, and payment was voluntary. I began to feel better and told him I could pay \$50 an hour instead of \$150. When he said \$50 was acceptable but he wanted it in cash, I realized that his definition of *voluntary* wasn't the same as mine. We haggled for several months. I told him I needed canceled checks for income tax receipts. He said it was such a small amount that it wouldn't make a difference in my taxes. He also said that whatever amount I paid would have to be consistent—if I missed any payments because of things like emergency car repair bills, I'd have to make them up. Furthermore, he wanted me to keep a running balance of the difference between his regular fee and what I paid him. Throughout those difficult months, I alternated between being an adult who conducted business negotiations with him, and a devastated child whom he tried to

help through the agony which those negotiations caused.

In December of 1996, just when my bank account was nearing zero, AlmostLaura came back to save us. She decided to try U.S. Behavioral Health, the managed care plan I had through my job. They covered up to twenty sessions per year, at a cost to me of \$20 each. Twenty sessions was hardly enough to establish a bond and do any long-term healing work, but I felt it might get me through this current crisis.

I called the 800 number and reached a Care Manager, someone whom the booklet described as having a "clinical background." When I asked for names of providers in my area who had experience with dissociative disorders, she said she had no way of knowing what their experience was, but it didn't matter—all their therapists were board certified. I told her it did matter, because psychological G.P.'s hadn't helped me in the past. I tried again a few days later and got a different Care Manager, who said that while she couldn't check the therapists' experience, she could check the clients' diagnoses. "I don't want to upset you," she said, "but the most severe form of dissociative disorder is multiple personality, so I'm looking for therapists who had clients with that diagnosis." Relieved, I said nonchalantly, "I'm not upset."

Although I live in a city of several million and asked her to check the suburbs also, she came up with only two names—one male, the other female. I preferred a woman, and tried her first. A secretary answered, told me the doctor wasn't working at that clinic anymore, and gave me her private practice number. I dialed it several times just to listen to her tape and let her voice filter down. The message came back from inside that she seemed OK, so I left my number. When she called back, she told me she was no longer associated with U.S. Behavioral Health. I liked the way she sounded, though, and inquired about her fee. It was \$150.

I tried the man. He answered the phone himself, so I couldn't keep dialing until I got the go-ahead from inside. I told him I had gotten his name from U.S. Behavioral Health and wanted to confirm that he had experience with MPD before I saw him. "Why don't you make an appointment and we can talk about it," he said. I would have preferred a yes or no answer, but made the appointment anyway. I informed my Care Manager, who gave me an authorization number and said the doctor would receive the paperwork in the mail, but it might not arrive before I saw him.



The day came. Everyone was nervously peeking out from inside as I walked down the street, glancing back and forth from the address in my hand to the numbers on the buildings until I found a match. It was an elegant pre-war apartment house with professional offices on the ground floor. From the street, I could see into the open window of a waiting room, and hoped it wasn't his. I usually switched a lot before sessions, and wouldn't feel safe waiting where everyone walking down the busy street could see me. I rang the bell, and an answering buzzer let me into the lobby. Another admitted me to the waiting room. The buzzers disturbed me more than the open window had. If my rings interrupted someone else's session, my session would probably be interrupted with rings, too. I needed a therapist who gave me his undivided attention.

The waiting room *was* the one I had seen from the street. I was surprised to see a receptionist—a short woman of about sixty-five, with dyed blonde hair teased into a sixties bouffant that doubled the height of her head. Her L-shaped desk and surrounding filing cabinets took up half the waiting room. That half was crammed with piles of paper, Christmas decorations, shopping bags, knickknacks, plastic figurines, and plants with bits of colored ribbon on them.

"May I help you?" she inquired nasally, looking over the tops of her glasses. I said I had an appointment. She motioned for me to sit on a small sofa in the uncluttered half of the room—the half I had seen from the street. Then she shuffled through some drawers and assembled a clipboard with a blank index card, on which she asked me to write my name, address, phone number, birth date, and social security number. When I finished in less than a minute, she said, "My, you're fast!"

She asked whether I was from Value Behavior. "No," I said, "I'm from U.S. Behavioral Health."

"The doctor doesn't have U.S. Behavioral Health," she informed me. "He has Value Behavior." I told her that when I spoke with him, he hadn't indicated that there was a problem. She said he probably didn't know, and asked me to call U.S. Behavioral Health to verify it. I gave her the authorization number, and suggested she call them herself if she had any questions.

After this exchange, she turned toward a door that led to an inner hallway and bellowed, "Doctor, your patient is here." A voice boomed back, "All right, I'm coming!" I waited ten minutes, watching her type on an electric typewriter and blow her white-out corrections dry. Then I asked her how much longer it would be. She shouted, "Doctor, your patient is still waiting." Again the booming, "All right, I'm coming!"

A few minutes later, a huge, gray-haired

man emerged from the hallway. His suit jacket barely closed over his belly and I stared at the straining button, wondering whether it would pop. He walked up to me and said, "I'm Dr. Bell\*. You can go in now." I started down the hall, and he took a few steps after me when I heard the receptionist say, "Doctor, she has U.S. Behavioral Health, but you don't have that." He turned back and said, "I don't? What do I have?" "You have Value Behavior." "Don't I have U.S. Behavioral Health?" "No, you have Value Behavior."

At the end of the hall, I paused before a partially open office door. AlmostLaura was calm on top, but the inside ones were edgy. They didn't want AlmostLaura to take them into that office, even if they could hide behind her the whole time. The continuing discussion of managed care companies drifted down the hall, and mingled inside me with images of the knickknacks, the grotesque head that was half hair, the open window, and the doctor who deserted me a second after he said hello. AlmostLaura knew this would never work, and said she was getting us all out of there. Everyone was glad and stayed safely inside her while she walked back down the hall, passed within inches of the doctor's back as he leaned over the receptionist's desk, and opened the door leading to the lobby. When he heard the click, he turned and shouted, "Wait a minute. Where are you going?" But I had already closed the door, and we were all safe in the lobby. A minute later, we were even safer in the street.

Two hours after I got home, the doctor called and asked, "Why did you leave? Were you upset because I didn't have U.S. Behavioral Health?" "No," I said, "I was upset because you didn't make eye contact with me." "I made eye contact with you," he replied. "You're the one who didn't make eye contact with me."

My Care Manager said she was sorry about the doctor's "unacceptable behavior," and would talk to him. She asked whether I wanted to try the woman. I told her I had liked the woman, but she wasn't with U.S. Behavioral Health any more. The Care Manager checked her computer and insisted that she was, but then said that even if she wasn't we might be able to make a special arrangement. I said I would like that. Two days later, the Care Manager said it was "unacceptable" that the doctor hadn't returned her calls, and she would try to find me someone else.

Several more days passed, and she gave me the name of a social worker whom she knew was good. I did my voicemail check, and inside liked what they heard, so I made an appointment. The Care Manager said she was setting me up with ten sessions, after which she would review the case and authorize another ten if she felt it was indicated. I told her I didn't want a stranger knowing personal things about me, and

she assured me that they only asked about my symptoms. I wanted to tell her that I preferred keeping my symptoms private, too, but didn't. When I asked whether she thought twenty sessions a year was sufficient for MPD, she said U.S. Behavioral Health made exceptions if the patient was suicidal.

I liked the social worker, but not the environment. Her waiting room was the hall outside her third-floor apartment, and her office was her living room. The walls were hung with children's finger paintings, and there were tricycles stowed behind the armchairs. The room had three doors—one leading to the kitchen, one to the rest of the apartment, and one to the outside hall. Although they were all closed, I didn't feel I was alone with her.

She was easy to talk to, though, and I told her briefly of my money problems, my feeling that Steven had abandoned me, and our ongoing efforts to work it out. I asked about her experience. She told me she had worked with only one MPD client, whom she hadn't known had MPD when she began with him, but that half her clients were "survivors." I mentioned my concern about the lack of confidentiality, and she said we would fill out the forms together—she wouldn't write anything I was uncomfortable with. "But," she added, "there's a tradeoff. If I don't give enough detail, they won't authorize further sessions."

The forty-five minutes were up, and I left without making another appointment. The next day, I mailed her the \$20 co-payment, along with a personal essay I had written about MPD, and information about *Many Voices* and the local MPD study group, all of which she had expressed an interest in. I included a letter explaining that while I liked her very much, some of us were uneasy with the physical setting, but even so, I might like to see her again. I eagerly awaited her answer—so I could see from her reaction whether it was safe to tell her what kind of environment the little ones needed to feel secure.

That was in January of 1997. When I hadn't heard from her by March, I knew I'd never feel secure, and wrote a formal business note asking for a receipt for the \$20. She sent it two days later, along with a letter apologizing for the delay. She said she had been very touched by my essay, and took so long to answer because she didn't want to sever the connection with me.

By that time, Steven and I had made a tenuous reconciliation, so I didn't go back to my Care Manager. Steven had again said that payment was voluntary, and again I believed he meant it the way the dictionary defined it. I was paying him \$50 an hour by check, and of my own accord was keeping a running balance of what I

*Continued on Page 6*

\*Not his real name



*Managed Care, Cont'd.*

owed him—I had planned to do that even before he mentioned it.

It is now February, 1998. I am still seeing Steven for two double sessions, still paying \$50 (\$200 a week), and have not missed any payments. In the past year, we have gone through several more painful revisions of the definition of *voluntary*. A year ago, I had assumed he meant it literally—that it was up to me whether I paid, and how much. A year ago, he had meant that he trusted me to be "fair." I try to believe him when he assures me that now his definition and mine are the same.

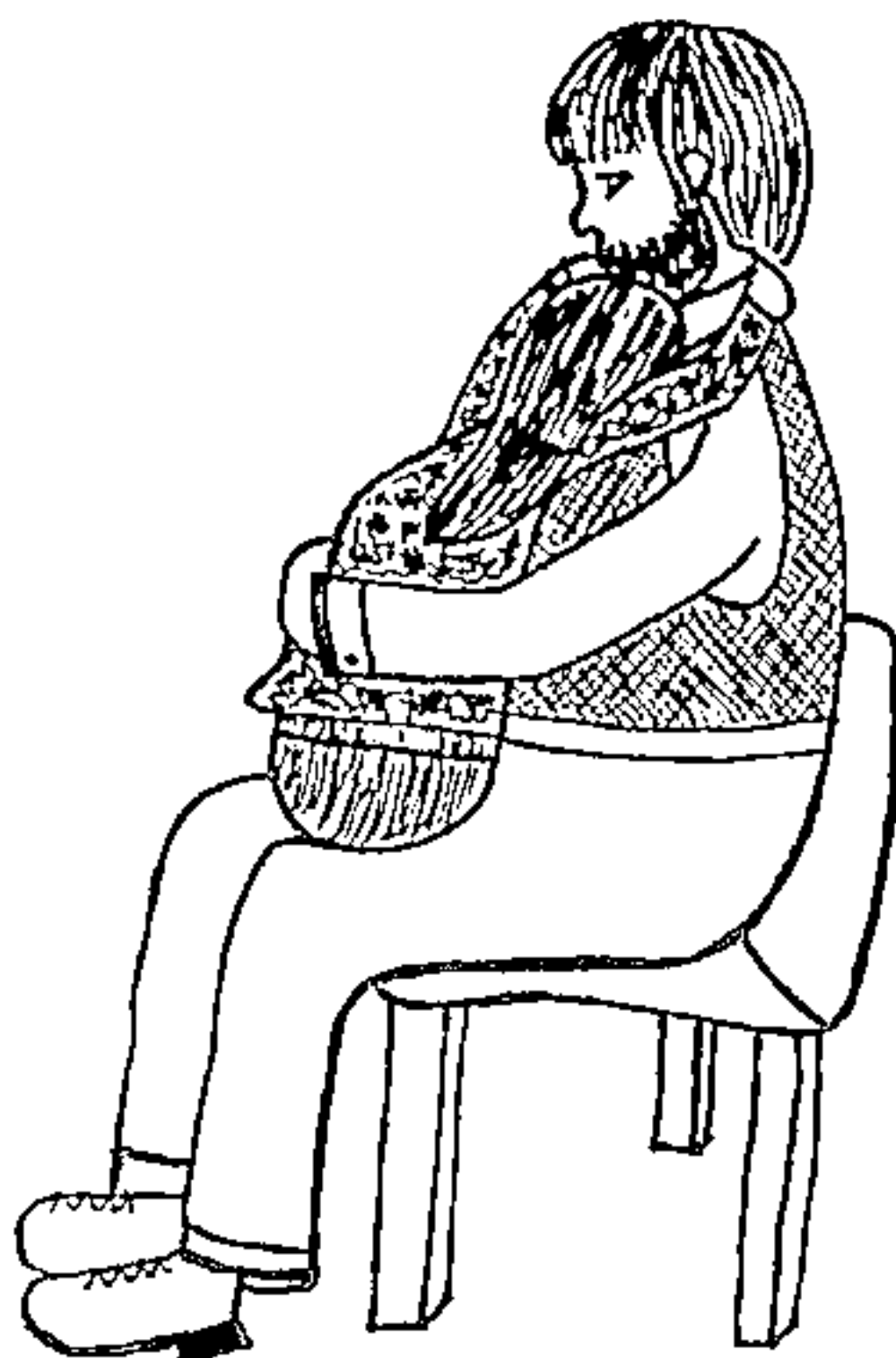
Although we have both worked hard to repair our relationship, we are still doing damage control. The babies and little girls sometimes return for a short while, but someone else pushes them back quickly, so we're not doing the therapy we need to do. He says he made some mistakes, that I've seen the worst of him, that there's really a lot of good and I just have to let go and trust. I'm trying, because I know he's right.

MV

**Bubble Gum Machine**

Who slips out  
Who pushes through  
Who pushes aside  
Who squeezes past  
Who makes a surprise entrance  
Who follows another  
Who gets picked first  
Who really cares  
All bubble gum is sweet  
Even the sourballs

By Marilyn G.



© 1998 Beverly  
& the Girls

**Coping with Body Memories**

By Beverly and the Girls

Once I had a flood of body memories when I was in a safe place with a very safe, healing person.

I work with Osteopathic doctors. I have fibromyalgia, a muscle disorder treated with Osteopathic muscle technique. This treatment philosophy believes that the body stores a muscular/energy block for each trauma we experience. This belief is also held by my therapists, who use bioenergetics therapy. I was working with Dr. Y. at the time of this experience. He is very caring and healing...the most compassionate doctor I've ever worked with. He can work on my muscles to actually open up these "emotional cysts."

When I was 12 years old, my 6-year-old sister and I had spent the night with a friend when a snowstorm hit and our heater quit working. We spent the night with Sharon, who was 20, and her older sister Wanda, who was in the process of leaving an abusive husband. After we went to bed, Sharon's sister shot herself. We didn't know what the noise was, and went to investigate. I found her. Then I had to tell Sharon, and she fell apart. I ended up having to deal with the situation and get an adult to help us. I've left out a lot of details, but have spent years dealing with this trauma. It took years, but we finally found out that I got suicidal every March 6th, the day this happened. It is amazing how the mind works! We finally put together the trauma and March 6th through medical records. So now I work to keep myself safe and deal with the trauma each March.

My therapist always asked me what happened after we left Sharon's house, and the next day. I always had blankness. I didn't remember anything. I asked my mother and she doesn't even remember that this trauma happened! No one ever talked to us after the trauma, just said "lay down and go to sleep." My abusive father has died, and we were disowned 25 years ago, so we didn't ask him.

Last year I worked with my therapists on this. Then on March 6th I had an appointment with Dr. Y. As he started doing cranial work, the girls were screaming inside. Dr. Y. could feel them and said to breathe deep and let it go. My left leg and hand started jerking. I started crying. I asked for the medical student to leave, and shut the door. Then we felt such a flood of emotion—such terror engulfed our whole being. It was as if we were back in that room with Wanda and the gun on the floor next to her. I started shaking all over. I could feel the terror in my stomach surging up, and choking off my air to breathe. I shook, and cried; it seemed to go on forever.

Then Dr. Y. held us on his lap. And there was Mary (an alter) 12 years old, crying and shaking all over, being held by a loving daddy telling her she was safe now, and that was a terrible thing that she experienced. No little girl should have to go through that. It was such an incredible experience, hard to put into words. Feeling Mary sitting on Dr. Y's lap, her arms around his neck and legs dangling on the side, crying and being held, told we are safe now. Then, as he always tells us, "you are acceptable, you are accepted, you are lovable, you are loved. You are a person of great value and worth, just for who you are; not for what you do, just for being. You are special."

I have had other experiences of body memories, ones that have been terrifying, spent alone. I know how fortunate I was to have been able to go through that with someone like Dr. Y. He has since moved away, and I miss him so terribly. Many of the girls are still very attached to him. I know this article will come out after March 6th, and I am nervous, not having Dr. Y. to help us this year. But I do have my two therapists, who are very caring, healing persons that I am fortunate to have in my life.

MV

## Hospitals for Mental Health

(Forgive me, friends, but I have omitted the names of particular hospitals in the following reports, even when favorably mentioned, because I have no way to verify treatment styles, issues, etc. If you are looking for a hospital program, my suggestion is to contact every hospital that is remotely possible for you and evaluate them on the basis of your own individual situation. Each case is different, hospitals and staffs have different strengths and weaknesses, the factors change from month to month, and determining which place might be most suitable for a particular person is beyond the scope of MV. —Lynn W.)

**No insurance, no way to pay for the hospital care.** Hospitalized in a private psychiatric hospital; the doctor assigned to me said, "You don't have any insurance or the money to pay the bill. You're discharged." This doctor handed me fifteen (15) prescriptions with instructions that I failed to hear, for my mind was reeling in pain, voices, chanting, screaming; the noise was deafening.

A nurse escorted me to the door. It was March with winter trappings on the ground. I sat on the stoop of this building in shock. I am a nurse, and this was not the act of a hospital. This trauma was foreign to me; hospitals had been a way of life for me, nurturing and protective. Unbelievable that this could happen—and to me—this violent act of expulsion, dumping me on the street because I could not pay my bill. I had been a patient of theirs for thirteen years. I vowed I would survive this ordeal and return to these steps and this stoop. I would overcome my rage for this treatment that happened to me.

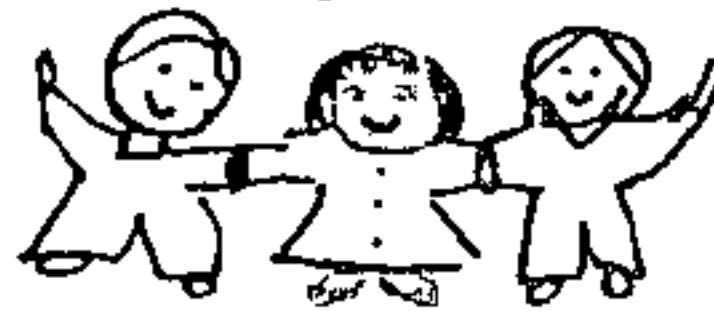
Here I was psychiatrically compromised. I couldn't remember. I was confused. Where was I to go? What was I to do? I was overwhelmed with pain and rage. I had no one and no where to go. I was too sick to rant and rave...and then I knew where I must go. I turned from this building that ejected me. I hitched from the large city to the hospital where I'd worked. My car was still in the parking lot. I found my way, dazed, confused, but able to discern the yellow line to the place where healing began and recovery became a reality.

Like the Velveteen Rabbit who cries, "What is real?" I am real. I cry, for I have ended my multiple personality defense. I am what I am, due to the feeling and knowledge of safety and therapeutic love. In my mind, I run in the halls of this Mental Health Center, daring to be free.

I did go back to the building of the past, to those steps and stoop. As I

retraced my footsteps, tears ran down my face. I survived. I have won. For I am now in a better place. And I can finally see my future.

By C.E.R.



I was recently hospitalized for some short-term memory work, and it was very beneficial to all of us. The kids inside were feeling threatened by our main alter and really wanted to talk with a woman therapist about some graphic memories of past abuse. We were in the hospital for thirteen days and saw her about eight times. It was enough to help the kids, and a restraint to alters who don't always believe them and want to hurt them physically to shut them up.

There were body memories in the hospital, but the therapist helped by ordering the invisible abuser to "Go away! We don't want you here!" The kids keep repeating this and though it seems so simple, it works.

We also have some physical problems: diabetes, and heart and gyn stuff, and went for some invasive procedures in November and December 1997. We believe that these experiences started the abuse memories up again. We tried as hard as possible to keep kids 'way inside, but twice it didn't work and they (the kids) were quite shaken up. I hope you can print this and encourage people to work on short-term stays in the hospital. My mental health coverage is quite limited, so the doctors had to negotiate this long a stay. It's a good place, even though there have been staff cuts and extra program cuts. The MPD/DID program is still excellent.

By Denise for Kitty



"Paula," my 41-year-old host, was diagnosed with DD in 1994. "Tracy," a

13-year-old alter, attempted suicide in April 1995 (feeling lost, overwhelmed, out of control). My current therapist suggested a day program, but we didn't feel safe at home. So we went instead to a 20-day inpatient program.

The staff was excellent, available to talk to, supportive, always willing to listen.

We saw a medical doctor for a check-up: had EKG, blood work-up; saw a psychologist, on an individual basis; art therapy; music; relaxation; role-playing; group therapy.

We picked a "safe place," then filled out a card identifying triggers that is placed on the door of our room.

We had a fairly structured day, with time for homework in the evening.

The Sexual Trauma Unit ate separately from adolescents in the cafeteria.

The staff looked through your suitcase for sharp objects, etc. They were locked up. You could sign out to use a razor for shaving, etc.

We had psychological testing—ink blots, etc.

There was some free time on weekends. Family could visit, and eat in the cafeteria. We could use the pay phone in free time. We received cards and mail.

Though it was a 20-day program, Tracy did the work in 10 days. Insurance was screaming.

I wished Tracy would have stayed longer, to get stronger in recovery. After she got home among doubting people and family, she regressed and made another suicide attempt in May, 1997.

Still in therapy currently, one day at a time. *Many Voices* has helped us a lot, to not feel so alone or that we are crazy. Short-term therapy may help some, but we feel we need ongoing therapy.

By the Comrades



# Therapist's Page

By Christine A. Courtois, Ph.D., and Joan A. Turkus, M.D.

Christine A. Courtois, Ph.D., a psychologist in private practice in Washington, DC, is Clinical Director of THE CENTER: Posttraumatic Disorders Program at The Psychiatric Institute of Washington. Dr. Courtois has authored *Healing the Incest Wound: Adult Survivors in Therapy* (1988) and *Adult Survivors of Sexual Abuse: A Workshop Model* (1993), and is currently preparing a book on guidelines for treatment of posttraumatic conditions with attention to delayed memory issues.

Joan A. Turkus, M.D., a general and forensic psychiatrist in private practice in McLean, Virginia, is Medical Director of THE CENTER: Posttraumatic Disorders Program at The Psychiatric Institute of Washington. Dr. Turkus has authored or co-authored several articles and book chapters on post-traumatic and dissociative disorders and is editor of the forthcoming book, *Dissociative Identity Disorder: Stage-Oriented Treatment*.

## Hospitalization As Part of the Recovery Process: When and How to Use It (and What to Expect!)

The symptomatology of the posttraumatic/dissociative disorder spectrum of adult survivors of childhood trauma is often variable and can be intense and destabilizing. Survivors, despite intelligence, resilience, and even professional competence, may have contended with numerous difficulties related to their past trauma including symptoms that waxed and waned over many years. These symptoms may have been chronic and acute for years or they may have emerged in delayed form as a consequence of a specific trigger or cue or some other circumstance. The most common triggers to the emergence of symptoms and/or memories are developmental milestones (e.g., the birth of a child, a child who reaches the age at which the survivor was abused), major changes in a relationships (often involving loss), revictimization, anniversaries, medical diagnoses or other types of personal crises, or something reminiscent of aspects of the original trauma (a movie scene, a media account).

Posttraumatic symptomatology varies in seriousness and intensity. At its most acute, it often includes but is not limited to, debilitating depression, anxiety and panic, suicidal ideation/behavior, self-mutilation, revictimization, flashbacks and other reexperiencing phenomena, sleep disturbance, numbing and distancing reactions, self-alienation, physiologic hyperarousal, and dissociative experiences ranging from "spacing out" to internal ego states to discrete dissociative identities with amnesia. It

may further include relational and sexual difficulties and associated substance abuse, eating disorders, and medical conditions. Despite these serious issues, symptoms, and their associated diagnoses, many adult survivors are able to function fairly well in the context of outpatient treatment alone; however, they may periodically need more by way of support and safety, making hospitalization the option of choice. Many will be hospitalized on general psychiatric units because specialized services are not readily available to them. This is generally not the optimal circumstance because posttraumatic conditions often go unrecognized and unaddressed or the symptoms are misdiagnosed in such a setting. (As an aside, it is unfortunately still the case that mental health professionals remain undertrained in how to recognize and treat posttraumatic conditions.) Other survivors will have the opportunity to be hospitalized on a specialty unit, one specifically designed to offer services tailored to their diagnosis and symptoms. At the present time, there are approximately 10-15 such units across the country (excluding VA services), all too few for the need.

In this brief article, we review the advantages of specialized hospital programs for posttraumatic conditions and discuss when and how to use such programs and what to expect. We begin by reviewing some of the changes that have occurred in these programs in recent years as the result of two different factors: 1) changes in the larger medical/mental health system, particularly managed care; 2) developments in the field of traumatology along with increased

experience and knowledge in treating complex posttraumatic conditions.

## A Snapshot of Today's Specialty Program

The most obvious change in specialty inpatient programs is the length of stay. Like other medical and mental health treatments and due mainly to the influence of managed care, the average length of stay has dropped dramatically from a high of 6-8 weeks to 10-15 days. At the present time, it is also much more difficult to be hospitalized than previously. Often, admissions must be pre-certified by the insurance carrier and only the most acute situations qualify. These include danger to self and others in the form of a serious suicide attempt, actual violence or threats of violence towards others, and critical decompensation and/or inability to function. This is an unfortunate circumstance because it often means that the survivor entering the hospital is in a more acute state of impairment than if admission had been achieved earlier and that he or she may, therefore, need more time to stabilize before being able to engage in treatment.

Most programs have coped with the shortened length of stay by developing a continuum of care that includes different levels of intensity, from the inpatient setting to a partial hospitalization program to intensive and structured outpatient services. All are designed to function adjunctively and collaboratively with the survivor's outpatient provider. Patients should anticipate that their inpatient stay will be as brief as possible and that they may move through different levels of treatment as they stabilize symptoms and increase their capacity to function.



They will also be encouraged to identify their treatment goals and to engage in the treatment process as quickly as possible.

Specialty programs have been developed with the purpose of attending to victimization/traumatization as an important issue that has had a contributory role in the individual's life and mental health difficulties. Many posttraumatic reactions and symptoms are viewed as normal responses to abnormal circumstances that, over time, have become problematic. A philosophical approach of "What happened to you?" versus "What's wrong with you?"<sup>1</sup> is operative. These programs offer specialized understanding of traumatization and the range of posttraumatic responses including co-morbidity with other psychiatric conditions. They are focused first and foremost on safety and personal stabilization, recognizing that no therapeutic work gets done if the individual is not safe. They seek to actively engage the survivor in the therapeutic work and, through the treatment, to offer and restore the individual's hope. They also focus intensively on education and skill-building directed towards self-management of symptoms since many individuals traumatized as children missed out on learning basic life skills. Most, if not all, of the existing programs have a multidisciplinary staff that offers a wide array of therapeutic activities in a highly structured treatment environment. Most programs now offer programming on week-ends as well as during the week, another development influenced by the demands and constraints of managed care.

The evolving standard of care for trauma treatment (for both posttraumatic and/or dissociative conditions) is that it is organized and progressive. In addition to a pre-treatment assessment, trauma treatment generally has three stages and is sequenced. Each stage has unique treatment goals (or healing tasks) and therapeutic strategies to achieve them, but the progression is not lock step and must be tailored to the needs of the individual. The model plans for regression and relapse.

Patients often need to go back to earlier healing tasks and re-work them, sometimes many times over, before they are resolved. Healing tasks build on each other in hierarchical fashion and the resolution of one issue often opens the way to the emergence of others. The initial stage is devoted to safety, education, self-management, stabilization, and the development of a treatment alliance. It is measured in skill rather than in time and is usually the most lengthy phase of the treatment. Most hospital work is encompassed within this phase. The second stage involves facing and resolving issues related to the victimization/traumatization. It is often the most painful part of the process and may involve additional supports and structure, including hospitalization. This work is done with great attention to pacing so that the patient is not retraumatized in the process and so he or she retains the capacity to function (or return to functioning) as the work progresses. The third phase involves a more direct focus on self and relational development, post trauma resolution. This is often a time of great growth and expanded freedom and opportunity.

#### **When and How to Use A Specialty Program**

Hospitalization is best used as a voluntary or elective option, put in place when safety and functioning are severely compromised. Patients who are likely to benefit the most are those who are willing to work collaboratively with the treatment team and those who develop realistic goals and a solid focus for their treatment. In the current atmosphere, it is helpful for the survivor to understand that an inpatient stay is only one part (and possibly a very small part) of the ongoing treatment. The hospital is where more intensified work is conducted in a highly structured, safety-conscious environment with a range of therapeutic modalities conducted by a multidisciplinary team of professionals; nevertheless, the bulk of the work is still going to be conducted on an outpatient basis. Since length of stay and insurance benefits are limited, it is helpful for the survivor to stay as focused as possible

and to try not to resist, avoid, or distract from the main treatment issues. It is also helpful if the patient is open to new perspectives and to new skills and problem solving mechanisms. Healing is hard work and requires effort and perseverance but it also involves learning to pace the work, modulate and tolerate strong emotion, and "make haste slowly" (and always with safety in mind).

The symptoms leading to hospitalization are often precipitated by psychosocial stressors. Most programs offer social work and case management services to assist with locating resources and addressing and decreasing the impact of external stressors; however, as with other issues, these will be more fully addressed and resolved on an outpatient basis. Since hospitalization is a time of stress, it is also a time to mobilize one's personal support network. Supportive others can be invaluable to the healing process. Most programs coordinate closely with the survivor's outpatient therapist in order to work collaboratively on the same treatment goals (at whatever point on the treatment continuum) and to insure smooth discharge and transition from one level of care to the next.

Discharge planning begins virtually at the time of admission. It is organized primarily around the maintenance of safety and the development of a concrete plan for return to a less restrictive environment. It often begins with a "step down" to a partial hospitalization level care where the same philosophy of treatment holds and intensive educational and skill-building efforts are continued in the context of strong interpersonal support. Often, patients remain in a partial hospitalization program over a more extended period of time (depending on their resources and insurance benefits) and decrease their involvement as they strengthen their skills. The continuum of care offers many options not previously available to support the survivor in healing work as he or she reengages with outside life and with outpatient treatment.

<sup>1</sup> Phrase attributed to Dr. Sandra Bloom, The Sanctuary, Friends Hospital, Philadelphia.

## Partner's Page:

# MAKING LOVE TO A MULTIPLE

By Richard

**M**y wife and I made love last night, and it was *wonderful!*

I was working on this article when she knocked on the door of our computer/guest room and asked, "How'd you like to do it instead of just reading about it? I don't know if I can or not, but I'd like to try." That got a laugh from both of us and instant acceptance from me.

We undressed together (lights on this time) and enjoyed some moderate foreplay and kissing. An oral-sex orgasm for her, an orgasm inside her for me, then we rested together still joined for a few minutes to revel in the afterglow. After thanks and compliments all around, we gently and reluctantly parted and cleaned up. A glass of orange juice apiece (sex is thirsty work on a summer night in Virginia), some firm massage to relax her tight thigh muscles, and cuddled until we fell asleep.

Just average, satisfying Sunday night sex.

What made it wonderful (besides that my wife and I are a good team in bed), is that it doesn't happen often when you love a multiple.

Sex probably causes more problems in our relationships than any single subject, yet it seems almost taboo to discuss. In our support group, whenever sex comes up, a deep silence falls, as if everyone stops breathing and hopes he or she won't have to speak first.

That's strange, because what we deal with are often sexual problems. Our partners have been sexually violated, literally at their physical and psychological cores, and many of the conflicts show up first in sex.

The sexual history of my wife and I seems typical of what most support people face with their partners.

Part of what first brought my wife and I together was her radiant sexuality. She's the best sex partner I've ever had. She was spontaneous and creative, thrilling and exhausting.

She could set boundaries and still accommodate my needs. She equally enjoyed a long, lyrical afternoon of sex, or a romp that swept through like a thunderstorm.

But, as her memories began to surface, sex became more and more difficult. She would go passive-aggressive and just lay there, totally unresponsive. Or she would say something like, "You wanna screw? Okay, here I am; do whatever. I don't care."

Or I'd get the sudden switch. We would be enjoying foreplay, and suddenly she would panic or get angry — "Stop! Why do you have to do that?"

Mixed messages were the worst. She would act sexy and seductive, and when I would respond she would suddenly block and act coy. When I backed off, she would act like, "Oh, you stopped. What did you stop for?" And we would get into the approach-avoidance minuet that ended with no one getting laid and each of us blaming the other.

I've know now that I was seeing uncontrolled switching as sexy teenagers and frightened children fought for control of the body. Or she was leaving her body, behavior that helped her survive ritual abuse and incest.

But that is 20/20 hindsight, compressing years of emotion into a paragraph. At the time, I was frustrated and angry that our sex-life was difficult, and I suspected that she had used sex just to hook me into a relationship.

What saved us? It helped that we both enjoy sex and wanted to do what it takes to make love. We talked about it. We both went into therapy to find out what was wrong and how to deal with it.

She was willing to do her best to meet my sexual needs and be present when we made love. I loved her enough to not leave her, and to put my needs second and accept "No" even when it didn't make sense.

And my wife learned that she *could* state her sexual needs and she *could* say "No." For a sexual abuse survivor, this is a life-changing, liberating breakthrough. They grow up believing they have no control over when, where, or how they'll have sex.

And that's probably the single hardest thing for a support person, to give your partner total control and let him or her dictate when and how often you will have sex.

We both had to work hard during the long periods when sex was nearly impossible for my wife.

For one thing, I refused to let romance die. "You have to recognize that physical contact is the important thing, even just a hug," said Dan, a guy in our group. "You have to start with that and go from there."

So we pushed the boundaries of my wife's reluctance as far as possible. We still kissed and hugged even when she was jumpy in my arms, and held hands when we walked together. I patted her hip when I walked by, and massaged her shoulders for as long as she could stand it.

And gradually the envelope expanded until my wife became comfortable enough to return to sex.

Nevertheless, it can be a long dry spell between rolls in the hay. "How do you deal with that?" is a show-stopper in our group. After a few moments of glancing around, someone mumbles that running helps, and someone else says he throws himself into work. One guy adds it's less of a problem as he ages.

Those are all good ways to handle sexual frustration, but everyone is waiting for someone else to say...

...Well, guys, I masturbate. A lot. And I suspect many other partners, male and female, use self-sex to keep their sexual energy at a manageable level.

I once asked my wife if my masturbation bothers her. "I don't mind at all," she said. I'm glad you



know how to take care of yourself. I don't have to worry that you're building up like some sexual time-bomb. I know that when you ask for sex it's because you really want me, not because you're desperate. And I know that when we initiate sex that it's because we really want you, not because we feel guilty."

Of course, I don't enjoy going without sex any more than the next guy. So my wife and I have worked out rules for getting laid when self-sex and fantasies that fade after orgasm become too lonely.

I make a request. I hold my wife close and tell her I would like to make love sometime soon. Then I wait while her team decides when they can comply and who will do it.

Sometimes it takes a few days, but I've learned to be patient and trust her gatekeepers. I also brace myself to cope if our plans get derailed. My wife, says, "If we plan to make love and can't, you express your disappointment, then immediately express your love and let us know you won't leave us because of that."

Other couple have similar agreements.

"We have a defined time to be close, when we won't be interrupted by the kids," said John in our group. "You have to brace yourself for some pushing away before intimate contact. That's hard to accept, but you just have to be patient."

Besides agreeing on how to make it safe for her to have sex, my wife and I have set some ground-rules.

Our cardinal rule is *no sex with child alters*, even though the child wears the body of a busty 33-year-old woman. That's tougher than it sounds. Some of her kids were created for sex; they can be secretive and very seductive. But if I suspect a child is out, I must stop instantly, no matter how near my orgasm is, and check.

They've put me into double-binds. I won't have sex with child alters, but sometimes one becomes angry, or feels rejected, or is afraid she'll be punished for not doing her job. (And I suspect her team has deliberately tested me once or twice.)

That's hard to deal with on the spur-of-the-moment between the

sheets, and my only solution is to get tough. I first gently explain that it's wrong for men to have sex with children, and ask the child to go back to her safe place. If she refuses or pushes foreplay, I'll tell the gatekeepers to take her back inside. If that doesn't work, my trump card is to go sleep in the guest room and leave her team to cope with the turmoil.

Another important lesson is to treat each sexual alter as an individual. I try to learn each one's voice, sexual desires, and name. If I'm in doubt about who's present, I ask. An alter is just as offended as any woman if I slip and call her by the wrong name during sex.

Another ground-rule is mutual pleasure. That's a given in any healthy sexual relationship, but it's *vital* to a survivor of sexual abuse. My wife says, "You always make sure we're satisfied, whether you go first or last. That lets us know we're not being neglected or used."

My wife had the first word on sex in this article, so it's fitting for her to have the last word as well...

"Probably the most important thing you've done is to allow us to risk loving you in a sexual way," she said. "You know everything about us, about what happened, and about what we've done, and you still love us. And you show that you love us in bed."

MV

## Voices

The thunderous voice of my anger was no longer muffled by my guilt! I heard it rumbling darkly ...released at last, its voice so powerful...so strong! Love stood beside me... giving me the courage to listen... to not run away! And my anger completed its journey... bubbling to the surface of me Its power gone... Its disguise stripped away Its true voice revealed...now only as the tiny squeak of a mouse... And now I no longer need to examine it challenge it, organize it, identify it, classify it, justify it... It just flows peacefully away... out of the heart of me! I released my bitterness, my unforgiveness.. I lay it on the shore and watched as a wave caught it, carrying it out to sea...

And I knew that at last I was free!

By Marguerite/Greta 1997

MV



## Preparing for Medical Treatment

Dear Friends,

We got a lot of material on this important subject. I'll print some here, and some in future issues. Thanks for your help!—LW

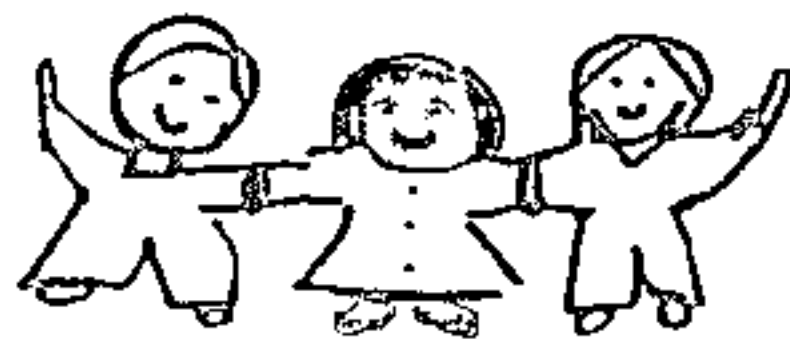
In June of 1997 I had surgery to correct a previously undiagnosed genetic defect that had been causing me serious chronic illness. This was the second surgery in my life, and the first in the years since I have learned that I am a "we."

My doctor, my therapist, and I were not sure how I/we would do emotionally, because my alters have many memories of trauma inflicted by satanic doctors, and because we had very short notice to prepare ourselves for surgery.

However, I found that the effort of more than eight years of therapy has paid off. That's not to say that getting all of us through the surgery in reasonable shape wasn't a struggle, because it was. Yet it was not a nightmare, either. All those little baby steps toward getting alters feeling safer added up to a lot more than I realized until I had to put their trust in me to that kind of test.

It was also extremely helpful that I have put a lot of effort in recent years into finding doctors I/we feel totally safe with. Our primary care physician has worked with many abuse victims, and since becoming my doctor she has done extensive research into medical issues related to MPD/DID. This is important, because our different alters have different medical issues that come out when they do. It can be confusing, but we have decided to address each such condition as a condition of the whole body, and our health has begun to improve since we made that decision. I believe that we multiples are particularly vivid examples of how interwoven mental and physical health issues truly are.

*By Julie of Julie et al*



Even the phrase "invasive medical procedures" churns up my insides! ("Insides" is a pun: my physical inner parts, and my psychic inner parts or alters!) There have been many experiences in the medical field in which the practitioners unknowingly made it to the goal line of triggering flashbacks. In several situations I allowed this. The belief system underlying my behavior was classical: I take whatever the authority gives, without question, as I have no rights; I believe my feelings don't matter; I don't deserve help from another, but if something is to be done regarding me, then it should be abusive and painful. In uprooting the ragweed of lies, I was able to find ways to arm myself so as not to be dissociated nor in trauma before, during,

and after these invasions. I honestly don't know if these suggestions are basic knowledge, but I'm writing in case they're not...in case sharing my experiences could in any way be helpful to another.

After moving to a new area, I called one of the agencies to suggest doctors, with certain specifications on my list. These mostly concerned the doctor's or dentist's general acceptance of the reality of childhood sexual and other abuse, understanding it might remain hidden in the depths of dark caves within until one is ready for the hard work to heal as an adult. I also said that I have a dissociative disorder, and so required the doctor to be aware of this and to be comfortable in working with me/us. I don't recall if it was the advisory agency's protocol, or if I said that I would ask to speak to the doctor on the phone prior to making any appointment. The person handling the doctor hunt called back with the definite words each receptive medical professional used. I have a wonderful, caring and gentle dentist, gastroenterologist, and general practitioner, as a result.

At the first appointment, I requested of the nurse that I speak to the doctor before the examination, definitely before any undressing.

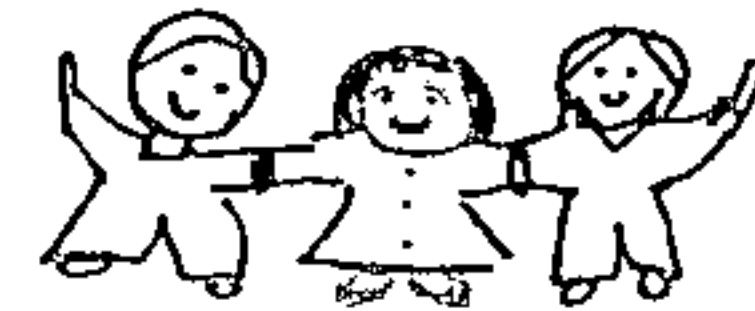
The doctor is informed that I am co-conscious, but in case an alter does take over, how to say my name (core name) to "bring me back" if that would ever be needed. As I say to the person giving a mammogram or any testing, I say to the doctor what I think is most important: "I need to ask you to take it slowly and to request things (more than you might politely do for some other patient). If anything sounds like an order and makes you seem like you have authoritative power over me, whatever is done is experienced by me as abusive. I in turn will continue to remind myself that you do not want to hurt me, that it is safe. If I ask you to stop, I need you to do that immediately, until I get my bearings aligned again. My last abuser was a doctor, so I have an extra strong need to know that you will do these things so I feel to be an adult in control."

You don't need to hear of the many previous horror stories, nor all of the very helpful, out-of-their-way kindnesses each of these people have shown. I'll just give one example. When undergoing a colonoscopy, the doctor asked if I wanted very mild sedation, so I could be in control. He and the nurse both promised they would both be in the room together the whole time of the procedure, and then afterwards just the nurse, as she worked with cleaning instruments and talked with me. I was

crying hard, so soon she led me to a small private room and asked if I wanted my driver, a friend, to come in. I said I needed some time alone and would be ok. The doctor came in later and asked if I remember, or otherwise would want to know, what I called out a few times. Then he asked if I wanted to know the results then or another time away from the experience I had just had. It was all up to me!

I suppose not everyone would have the good fortune I have had. Since I was "up front" and named expectations right from the start, I didn't come on as the "victim-type," so that a doctor would believe s/he could use knowledge of my past to try something abusive.

*By Marj*



Aside from all kinds of abuse, I grew up with a disability which required hospitalizations every year along with numerous medical procedures. When I reached 29 surgeries, I stopped counting. That was about 12-15 years ago. I never attempted to count the various medical procedures. I rate them only by their degree of invasiveness. All this experience does not eliminate anxiety or problems when your background is full of abuse issues.

### My recommendations:

#### 1. Trust your doctor

Especially if you had bad experience(s) with doctors, select a doctor you feel you can trust. Ask everyone you trust (i.e., therapists, other doctors, friends, etc.) for recommendations.

#### 2. Know what the procedure is, what it entails, and why it has to be done.

You have the right to ask questions and know as much as possible about the procedure. Possible questions: why does the procedure need to be done; what is the procedure; what are the expected results; how is the procedure done; what kind of medication is used (this is very important if you have/had a drug addiction problem, past medication problem, allergies, etc.); will you be conscious, semi-conscious, or unconscious; how many people will be in the room, who are they, and why do they need to be there; how exposed will your body be at all stages of the procedure; if the doctor is not doing the procedure, who is, and can you meet him/her in advance; can you see the procedure room in advance. Get as much information as you need to cope as far in advance as possible.



3. Do mock run-throughs of the procedure. Use visualization to run-through the procedure as many times as you need. Stay as conscious as possible, remembering that this is a necessary, beneficial procedure and not abuse. If you have a trusted person (therapist, friend, etc.) who is willing to help you, discuss the procedure and your concerns and fears. This helps find the trigger points/problem areas.

4. Discuss abuse issues or potential problems with your doctor and/or technician.

Discuss the issues/problems that have the potential of interfering with the procedure or the ability to complete the procedure. This does not mean giving details of abuse. Tell only as much as you are comfortable with, and what the doctor or technician is capable of understanding. (Most people, even doctors and technicians, cannot deal with the details of abuse severe enough to cause dissociation of any kind.) The professional doesn't need to understand the problems so much as he needs to respect that problems exist for you, and do what's possible to ease the way.

5. Request a sedative be given prior to the procedure.

After doing some run-throughs, identifying and working on the problems, if the anxiety isn't subsiding to a workable level, a sedative may be an alternative. It does not have to be strong enough to knock you out, just enough to calm you down and make the process easier for all.

6. Have the doctor or technician talk to you during the procedure.

It can aid your comfort level by knowing what is happening. You have the right to say you are uncomfortable and need to pause. A pause can be used in some procedures, but not in others. Take some deep, slow breaths, visualize a calm place, then proceed.

7. Take a trusted person with you.

Have him/her stay with you as long as possible. Just knowing someone is waiting can help.

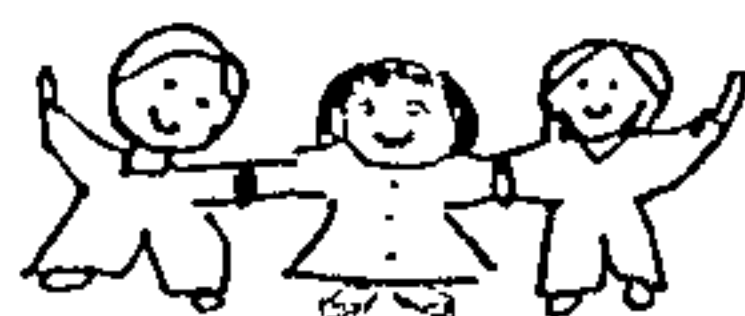
8. Remember, this is not abuse. It is a necessary procedure.

It is a necessary procedure for your present-day health.

No invasive procedure is comfortable for any person. Abuse issues make them even less comfortable. Control over your body and what happens to it can ease the way and leave you your dignity.

I hope these recommendations help and can make things a little easier. For any facing procedures or surgeries, good luck for a speedy recovery.

By Cheryl



One can never prepare too much for invasive medical procedures. In years past, my annual visit to the Gynecologist was never my favorite thing to do, but I really didn't mind either (all things considered). It was an annoying but necessary part of being female. However, that was "before". Now it is "after"...after others within have made their presence and opinions known to my conscious mind. Things are different now. Things need to be planned for and prepared for in advance, in order to maintain control and limit stress-induced reactions or switches.

When my most recent annual Gyn appointment was approaching, my therapist helped me (and others inside) prepare for it. We reminded those who were concerned, that this is *different*. Doctors *help* us, they don't hurt us...at least not in the same way that abuse hurt us in the past. (A footnote here: Our body is unable to have children, and we are on hormonal treatments. Because of this, our annual exam is a little more difficult than the average...we need to endure a type of biopsy each year, to ensure that we are not developing a pre-cancerous condition within our uterus due to the hormone replacement therapy. This biopsy *hurts*.) We knew what to expect, though, and my internal system discussed it at length, in therapy and out. We were prepared...apprehensive, yes...but confident in our ability now to help each other through this difficult but necessary experience.

After all our preparation, things did not turn out as planned this year. But nevertheless, we found that we can survive even when things do not go as planned. Which means *we are making progress!*

This past summer, our body turned 40 years old. We were not aware that this meant anything to our Gyn. However, apparently it did, as he begins a particular kind of screening when his patients turn the magic age of 40. Our appointment was progressing as expected (the internal world was stressed, but controlled), when *without warning* our Gyn proceeded to give us a rectal exam...no explanation, no nothing. (I thought only men had to endure this!) I was stunned and speechless, and the internal world flew into chaos. Whether it was from fear or shock, I don't know, but I simply froze. I think it is a miracle that we did not lose it right there, but somehow I managed to stay in control. When I left the doctor's office though, I left in shock and confusion.

For days and days I replayed the whole thing in my mind. I felt victimized and angry...angry at the doctor for his callous lack of communication, and angry at myself for my inability or unwillingness to control this situation. It has been my job in the past to *always* be in control, to protect everyone at all costs. I felt like a failure, like somehow I had failed to protect us. I felt raped. I talked to my therapist about what happened, and my feelings, and he has

helped us work through it. As awful as this experience was for me and the others within, we have been able to make it a learning experience. What happened in my doctor's office that day was not really rape, but it has given me more compassion for the little ones. I know now, personally, how it feels to feel powerless, victimized, stunned, speechless, frozen. This extremely emotionally-painful experience has bridged another gap between us. I am better able to empathize with them now when they share the hurts from their past. It has also helped us to realize that we truly *can* depend on each other in the worst of circumstances. We did not switch, we did not *lose it*, or "go crazy" on the table. Although frozen in time, we still helped each other get through it. We are finding out that we are not our worst enemies, as some have thought in the past.

After several weeks, I was able to put my thoughts down on paper, and I wrote my doctor a letter. I told him how disappointed I was in his lack of sensitivity. I informed (or reminded) him that I do not relinquish all rights to my body when I walk through his office door. He should have first of all explained the health benefits of doing such a procedure, and then more importantly, asked my permission to do it. I told him that next time I would be prepared, but that he should consider his other patients as well, who innocently schedule an appointment after turning this magic age of 40. I was polite, but direct, in expressing my disapproval. Writing the letter was both frightening and freeing. I was fortunate to receive a response from my doctor several weeks later. He validated my concerns, and apologized for his lack of communication and sensitivity (which, by the way, has helped me to gain back a measure of trust in him). But whether he had responded or not, I felt better having written him to stand up for myself. This is not something we have been in the habit of doing.

One can never prepare too much for invasive medical procedures. Try to *expect the unexpected*. Attempt to keep the internal lines of communication open to avoid unanticipated switches. Know that *you* are in control now. It is *your* choice to see the doctor and take care of your body. Ask questions, and don't be afraid to voice your concerns. We are not powerless victims anymore, subject to the whims of those who surround us. Although we might have child alters within, we are no longer children on the outside. We deserve to be informed and involved in all areas of our own care.

In some ways, on some days, I still feel like I failed by not speaking up at the time...but I (we) have learned much from our experience, even if it was after the fact. And we have been drawn closer together. That (almost) makes it worth it in the end.

By Elly in Ellie's Family

## Letters

Anyone (including non-subscribers) can submit a letter for possible inclusion in this column, on any subject that is pertinent to our readership. Please send answers to writers, too! Your replies can be anonymous, or address enclosed, as you choose. Sometimes we open replies before remailing to be sure the material is OK. Occasionally we print a reply in this column. Keep writing! -LW

*I have some comments on "Internet Support."* Although I've had limited experience with it, I have not found it helpful. I found that many survivors, due to overwhelming defensiveness, are quick to jump to the conclusion that a "real survivor" is a "fake" if that survivor hasn't somehow said or done all the right things. Sometimes compassion for different stages in healing, and for different abilities on the part of dissociative survivors to communicate, is limited. For example, I read recently, posts by a woman (I assume) who felt herself to be a wolf—guardian of inner children—and shared that she sometimes imagines she is killing the predators in her mind as a way of making the inner children feel safe. What followed was barrage of angry and distressed messages about how much these comments had upset other dissociative survivors (i.e., was this a trick? why would she share something so gruesome? didn't she know feral animals trigger survivors? why, if these were child alters really wanting to share, did she use sophisticated concepts? was she violent?) As far as I read, she apologized to no avail. Nothing about her posts—or her capacity for anger at the abuse she'd suffered (and I read carefully) surprised me. But then, I don't generally feel I *must know* whether or not a person is a "real survivor" at once. I listen a lot, and take a good long while to get comfortable. I think that dissociative survivors who do want to go on-line need to better learn to *trust their own judgments over time*. This "attack and grill" procedure I've observed repeatedly can really feel invasive and hurtful in itself. I understand the intense fears, the worries about strange folks and fakes, but I think that those sorts of concerns can really only be addressed over time. My advice to women: if you don't feel safe—don't respond. Someone who is fake isn't likely to stay around if they don't get a response. Someone who is a "real survivor" is also not likely to take a lot

of abuse—she may just walk away—and then you've lost someone who could have added a lot of value.

*Respectfully, Gwen*

**I am in the prison system** for a crime I committed years ago. I have been integrated for six years this coming August. I have been checked twice through hypnosis to see if I had decompensated, and each time I came through with flying colors. I need the opportunity to prove to the Judge that I am all right now, but approval seems impossible to get. He doesn't believe in integration. I am at my wits end, especially since I have recently gotten engaged and my future lives in Scotland. I naturally want to join her there, even though she comes to the hospital to visit me. At Christmas she stayed for two weeks, but we could only have visits in my building. She is coming again in June and I am trying to convince the Judge to let me have a day pass with her.

Do MV readers have a suggestion for me? Perhaps one of your readers is a lawyer who could suggest a way to circumvent these troubles.

*Sincerely, William R.*

**Even though I am almost able** to cope with DID, I have found that the surrounding troubles present themselves in ways I find debilitating. I consider DID one of the lesser evils in my life, compared to depression, panic disorder, and having to live with the aftermath of PTSD and AADD. I have searched for numerous jobs, some of which seem to be very positive until a drug test is completed. But once the employer learns about the medications I am on, and what they are for, I am never called back for the final interview. Voc Rehab and Goodwill, being totally unfamiliar with DID, try to help me, but really don't help. A particular problem is finding a therapist who understands that some part of the "wolfpack" (as we call ourselves collectively) may not be aware of appointments, or why we were

supposed to come. I/we, the wolfpack as a whole, do not know how to convince this "unknown one" of us that it is necessary to keep such appointments. For some reason, the "unknown one" is not ready or willing to meet with certain people. Maybe someone can explain how we can address this situation. I begin therapy with a new therapist on March 3, in the hopes I can find better understanding. All suggestions are appreciated.

*D for the Wolfpack*

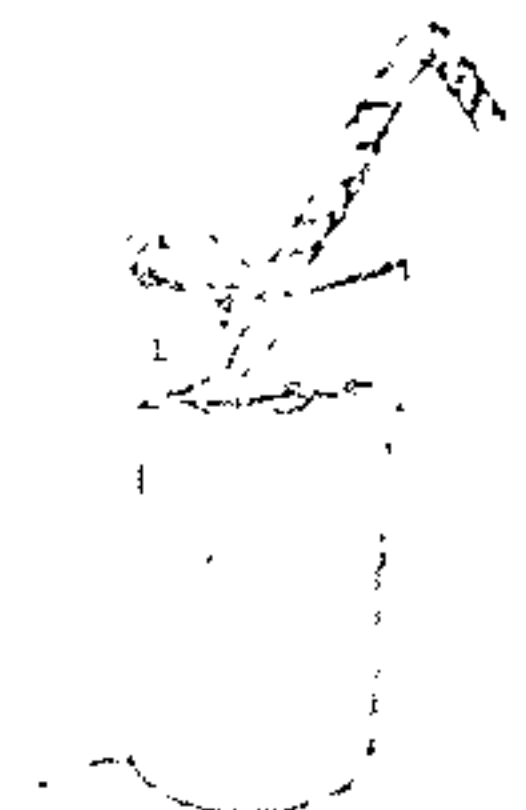
**Does anyone else feel invisible,** or want to remove vocal cords just to save yourself from arguments and mother/daughter money fights? If you struggle with this, or have solutions, please write.

*Thanks, Stacy*

## Chocolate Milk

"Choc'late milk!"  
yell the kids.  
Michael cries.  
He can't talk.  
I know what's  
on his mind.  
He wants his  
too—always.  
Children help  
pour the milk  
A spoon puts  
Nestle's Quik  
in the cup  
Stir it up.  
Straw goes in  
Slurp, slurp, smooth  
Tastes so good  
Hits the spot  
DELICIOUS!

*By Sally B.*





## New Service!

Do you have questions about Vocational Rehab, Public Services or Consumer Credit? Wonder no more...

### JUST ASK EDITH!

"Edith" is a long-time MV subscriber, social worker, and genuine success story herself. She wants to help others research the ins and outs of bureaucracy, help solve credit problems, etc. Send your questions to MV, and we'll forward them to Edith. She will reply directly to you...and sometimes, if the subject seems useful to the general subscriber, we will print Q's and A's. No guarantees, of course. But two heads are better than one...especially when one head belongs to EDITH! (& Let us know how this works for you. -LW)

### Also coming soon:

A semi-regular column on the Americans with Disabilities Act & how it affects people with severe dissociation. Send Questions! -LW



Art  
by  
Living  
Earth

## Books

### Flesh Wounds A Novel

By Mick Cochrane. ©1997. Published by Doubleday, New York. (212)782-9787. 274 pages. \$21.95 (US). Paperback.

This is a first novel about a family derailed by incest. A granddaughter complains, her grandfather Hal is arrested, and the long-buried secret of his abuse of his own daughters emerges. No simplistic answers here, and no great revelations. Perhaps the real tragedy of this story is that it is so sadly reminiscent of the non-fiction lives of many of our readers.

### Unspeakable Truths and Happy Endings: Human Cruelty and the New Trauma Therapy

By Rebecca Coffey. © 1998. Published by The Sidran Press, 2328 W Joppa Rd. Suite 15, Lutherville, MD. (410) 825-8888. 226 pages. \$19.95. Paperback.

**Unspeakable Truths** is a book for survivors of all types of trauma, not only childhood abuse. Subjects include victims of street crime, police officers,

Holocaust survivors and more. Some of the passages are very graphic, so be forewarned. The book is divided into four sections: The first details the frustration of survivors who are often not heard or understood; next, the struggle to understand trauma, followed by the struggle to overcome it. And finally, "happy endings"...the words of trauma survivors who have managed somehow to not only overcome their own horrors, but have found a measure of growth from the process. There is also some discussion of how to choose a responsible and helpful therapist, to avoid memory distortion, and to learn to accept the ambiguities that are part of recovery. Coffey, a mental-health writer, attempts to present both sides of the "memory wars"...claiming to be "avidly pro-survivor while remaining enthusiastically pro-skeptic." Each reader must decide personally how well she manages to carry out this dual point of view. —Lynn W.

### REVIEWERS WANTED!

If you have a book you'd like to review that we haven't written about yet, *please* write it up and send it in. All it takes is a paragraph or two, and the ordering details, price etc. Thanks! - LW

MV



## COMING SOON!

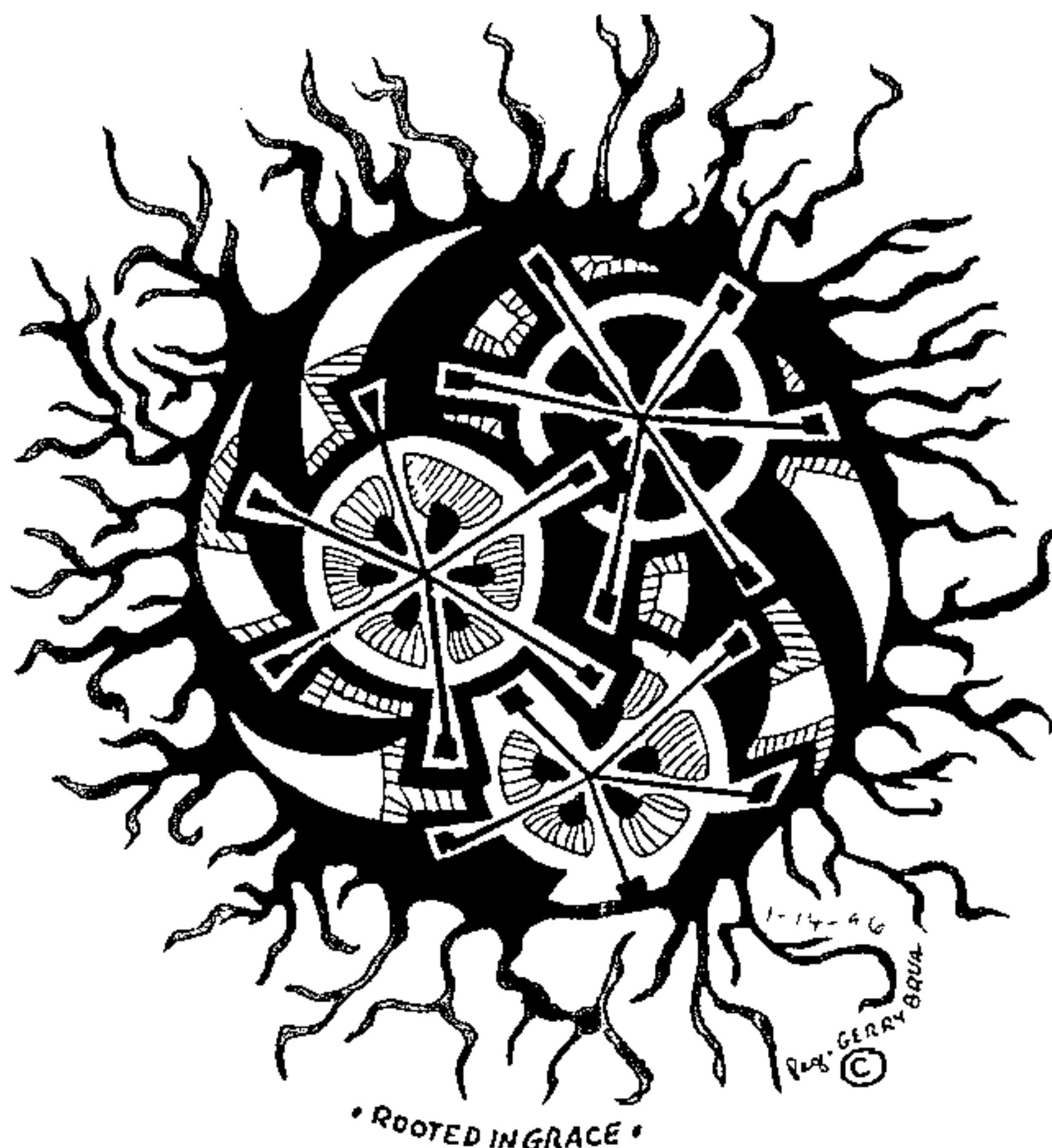
We want to thank every one who sent us such helpful information for this issue. And please, keep sending artwork, cartoons, poems, and good ideas for feeling better...as well as topic themes. This is YOUR newsletter, and your input is vital! Let us know what you think! —LW

### June 1998

Ritual and Sadistic Abuse. Realities and distortions. Is validation possible? Legal issues and risks for survivors & therapists. ART: Serenity.  
DEADLINE: April 1, 1998.

### August 1998

Exploring mind, consciousness and personality. Strengthening the healthy core. Structure of alters and internal systems. Measurable physical differences among alters? ART: What you see when you "look inside."  
DEADLINE: June 1, 1998.



### October 1998

Creative expression: how writing, art, music or other activities help you heal.  
ART: Healing your spirit.  
DEADLINE: August 1, 1998.

### December 1998

Learning to negotiate: with your therapist, your alters, your family, your boss. Being assertive, not offensive. What works? ART: Celebration of togetherness. DEADLINE: Oct. 1, 1998.

## 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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