May 2005

RAINBOW'S END

Volume 6 **Issue 2**

Support & Information Newsletter of FIRST PERSON PLURAL

the survivor-led association for survivors of trauma and abuse who experience dissociative distress, and for their family, friends and professional allies

Registered Charity No: 1109464

CONTENTS

The above is a black & white copy of one of the masks created by a member attending the April Open Members Meeting for the First Person Plural Display Project *see p12 for further details*

First Person Plural, PO Box 2537, WOLVERHAMPTON, WV4 4ZL

http://www.firstpersonplural.org.uk

email: fpp@firstpersonplural.org.uk

Editorial Statement

While every effort will be made to keep contributions complete and unedited we reserve the right to make amendments when necessary. Decisions about the inclusion and amendment of contributions are made by the editor and are final. Contributions do not necessarily reflect the views and opinions of First Person Plural, members of the executive committee or the editor. Inclusion of any reference to an individual or organisational resource is not a recommendation. The contents of this newsletter are for information and support purposes only. The newsletter is not a substitute for individual therapy or professional supervision. It is an addition to, not a replacement for, other networks of support.

Contributions can be sent in at anytime

articles; stories; resources; book reviews; tips; poetry; artwork; personal experiences

To be considered for the next issue we need to receive them

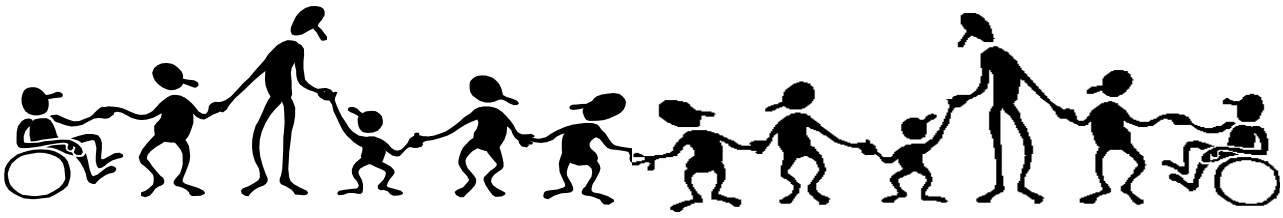
by 20th August, 2005

Originals will only be returned if a suitable stamped addressed envelope is enclosed

IMPORTANT:- When sending material for publication please clearly mark "FOR PUBLICATION" and say what name or pseudonym you wish to use.

ATTENTION

Material in this newsletter may trigger painful memories and feelings.
Read with caution and appropriate support if necessary



B o o k R e v i e w by KL

"Got Parts – an insider's guide to managing life successfully with dissociative identity disorder" by ATW – Loving Healing Press, 2005

I found the format of this book made it difficult to read and therefore review, but this could be just me. I like text that flows and found the very brief paragraphs – some no more than a sentence long – broke my concentration too frequently. In the end I decided it was probably a book to dip into rather than read cover to cover. Dipping is made easy by a detailed contents list and comprehensive index. The book is a self-help guide written by someone who has DID. It contains some useful tips, hints and advice for managing life with DID. I particularly liked the chapter on self care which emphasises the importance of taking care of body, mind and spirit holistically – from basic hygiene and nutrition to developing a support network and finding time to enjoy yourself. The author is a great advocate of self-responsibility which gelled well with my own values as someone with DID. It contained too many 'need tos', 'musts' , 'essentials' and 'shoulds' for my liking but if you can interpret these as suggestions which may or may not work for you 'Got Parts' is a good ideas resource.

Kathryn interviews Angie Davis

Angie Davis is a Community Psychiatric Nurse working in a Community Mental Health Team in Port Talbot, South Wales. In 2003 she was awarded a Nuffield Travelling and Visiting Fellowship to study the treatment and care provided at Dr Colin Ross's Trauma Institute at Timberlawn in Dallas, Texas. **Angie will be speaking about her visit at First Person Plural's AGM & Members Open Meeting on 18th June.**

KL: Why did you choose to visit Dr Colin Ross's Trauma Institute?

AD: While working as a Nurse Therapist I had developed an interest in psycho-social approaches to working with people diagnosed with severe mental health problems. The idea to visit the Institute was born from my frustrations about the lack of recognition and treatment options within British psychiatry for people who had Dissociative Identity Disorder (DID), also known as Multiple Personality Disorder.

KL: Is Multiple Personality Disorder a valid diagnosis in Britain?

AD**:** Yes. There are two main diagnostic classification systems available to psychiatrists across the world. British psychiatry uses both. One is the Diagnostic & Statistical Manual produced by the American Psychiatric Association. Multiple Personality Disorder first appeared in this in 1980 and has since been renamed as Dissociative Identity Disorder (DID) in the current edition (DSM iv). DSMiv categorises DID as a Dissociative Disorder. The other system is the International Classification of Diseases produced by the World Health Organisation. The current edition of this (ICD10) lists Multiple Personality Disorder within it's Dissociative (conversion) Disorders category. There are differences in how the two classification systems categorise the range of disorders with dissociative features but both systems include the most complex of these i.e. Multiple Personality Disorder (or Dissociative Identity Disorder) as a valid diagnosis.

KL: What is the framework for treating DID/MPD patients at Colin Ross's Institute?

AD**:** The treatment framework at the Institute is developed from Dr Ross's "*Trauma Model".* This model addresses unresolved issues connected to a history of childhood abuse. Trauma is seen as an obstacle to normal human development. In early childhood abuse (2 to 7 years old) normal cognitive development especially emotional integrity is impaired. In practical terms this means an 'inability to soothe ones feeling with ones thoughts'. This translates into an internal locus of control (it is my fault bad things happened to me), the need for external validation and behavioural expression of internal conflict.

The Trauma Model is directed towards Borderline Personality Disorder (BPD). It makes a clinical assumption that DID / MPD lies within the far end of the spectrum of BPD. Consequently, while my initial intention was to learn specific skills in the treatment of DID / MPD much of what I learnt at Timberlawn is applicable in contexts far wider than this.

KL: What are the principles of *The Trauma Model?*

AD**:** There are three core principles – locus of control shift; attachment to perpetrator; and grief.

The Trauma Model states that borderline patients with a trauma history see themselves as the perpetrators of their abuse. They have a cognitive distortion around deserving to be mistreated, while at the same time acknowledging fellow patients on the programme as being undeserving of their mistreatment. Ross offers an explanation of this distortion seeing it as being linked to the egocentric child. The child being abused thinks 'the world revolves around me', 'it must be something I am not doing right'. Therefore 'it is my fault'. This perspective solves the problem of 'why' and at the same time offer's hope. If I can get 'it right' then 'it' will stop. Unfortunately this perspective is often inadvertently reinforced with negative criticism by the abuser. The challenge of therapy is to shift the locus of control to where it belongs with the perpetrator.

As mammals we are absolutely dependent on adult caretakers for our survival. The fundamental development task of the human infant is to attach. It is developmental suicide not to attach. In an abusive family, the child pulls away, recoils from the mistreatment and shuts down emotionally but this jeopardises attachment and to ensure survival the young child must attach at all costs. *The Trauma Model* assumes that there is a built in over ride of the withdrawal reflex by the attachment system to allow attachment to the perpetrator. The conflict between the attachment and recoil reflex results in a disconnection from the negative emotions connected to the abuse. This disconnection is the deepest conflict, the deepest source of pain, and the fundamental driver of the symptoms. The fundamental splitting of the psyche is necessary to solve the problem of attachment to the perpetrator. The challenge in therapy is to work towards addressing ambivalent emotions in the 'adult, grounded, present'.

Unresolved grief is said to be at the core of the avoidant strategies of DID / BPD. Avoiding the grief of the childhood and parents you never actually had. The fundamental problem being not what actually happened but the omission of what should have happened. The locus of control is one of the main grief-avoidance strategies, when the locus of control is shifted, and you really get it, in your head and gut, that you didn't deserve or cause the abuse, then you understand that as an innocent child like all other children you deserve to be loved, protected and treated decently. This is where the real grief work begins.

KL: How does the Institute approach these challenges in therapy?

AD: The therapeutic approach is based on a core assumption that the personality and maladaptive behaviour problems of the traumatised individual are part of an avoidant strategy to avoid feeling or remembering painful feelings.

The Institute has developed "The Spectrum of Emotions" which it introduces to inpatient and outpatient individuals as part of a psycho-educational approach. The spectrum looks at how a person might experience emotions if normal development wasn't marred by childhood abuse. Through the spectrum of emotions a survivor can acknowledge and learn how to deal with numbness, extremes of emotions and ambivalence.

An eclectic therapeutic approach is used including:- Cognitive Behavioural Group Therapy, Dialectical Behavioural Group Therapy, Anger management, Individual Therapy and Art Therapy. Through these mediums the patient is encouraged to revisit memories with feelings without using avoiding strategies. This is accomplished using dialectical and graded exposure principle coupled with a dilution of conflicting emotions. It is impossible to feel depressed if you are angry. The patient would have identified combat statements, images and /or memories similar to the techniques used in cognitive behavioural approaches. This skill would be established in advance of a focused piece of revisiting. When the emotions have reached the limit of tolerability the prepared combat statements, images, memories are used, to remain grounded in the present and not being drawn into a 'flashback' of chaotic abusive type material.

KL: Could you give an example of how this technique works?

AD: Art therapy is perhaps the easiest medium to use as an example. The patient is invited to draw a picture which is representative of a trauma. During the course of this task the patient is likely to experience a whole range of emotions. If the emotions become too intense / overwhelming to tolerate there is a pre-agreement that the patient will turn the paper over and start drawing a soothing or contrasting image. This is done before the patient is out of control and engaged in previous avoidant behaviour such as extreme anger, fear, the need to escape, self-harming or disengaged numbness. A contrasting image of anger to dilute sadness was used most often. The technique has a double affect it teaches dilution and tolerance of both emotional experiences and ambivalence.

KL: Does the Institute use any additional techniques to work with people who have DID?

AD: At the Institute the basics of the treatment model remain the same across the BPD spectrum including for those people at the far end of spectrum i.e. those who have DID, However, when working with people with DID specific techniques designed to engage with alters or different personality states are also needed.

The aim of DID therapy is to integrate or partially integrate a fragmented personality. In effect, this aim is the same as that for BPD therapy i.e. to reduce maladaptive behaviour by resolving inner conflict.

KL: What do you think have been the benefits of your visit to Timberlawn?

AD: I am already beginning to apply the new skills I have learnt. This together with the internet facilitated supervision and support from staff at the Institute which are now available provides the opportunity to offer additional hope and treatment options to patients with BPD / DID in the Port Talbot area of South Wales.

Local media interest in my visit plus the opportunities for presenting about my experience to a wide range of audiences means that interest in *The Trauma Model* is growing both locally and nationally. Our local Psychiatrists Education Group described the approach as 'exciting and pioneering'. This interest and enthusiasm I am hopeful will ultimately improve the way in which some people with trauma-related mental health problems including BPD and DID are treated within the NHS.

April 16th Members Open Meeting

Fifteen members and guests attended the Members Open Meeting in Coventry. The day was most enjoyable, relaxed and safe. It included opportunities to try a range of arts and crafts which attracted several inner little ones, as well as adults. There were poetry readings and a journal writing workshop. The highlight of the day was the workshops provided by Small Harps for Coventry. Even the unmusical could enjoy the beautiful melodic sounds and experience of harp playing. By the end of each workshop recognizable strains of 'What shall we do with the drunken sailor" floated out of the workshop room.

Telling friends by Angela and the others

How do you tell friends? This question was asked in an article several issues ago (Volume 5, Issue 2). I think this is a very difficult question. I believe (after a few failures) that it depends on the sort of person that they are and if they are, first of all, willing to listen. That's all – listen.

Most of our friends know Angela "has a problem" and that's as far as it goes; no questions, no mentioning 'the problem' and that's fine. What we can't cope with is the people who say they want to help, they want you to talk to them but they do anything but listen. What we can't understand is why some people will not accept the fact that having MPD or dissociative disorder is bloody hard work.

It is not 'the time of the month' or the weather that makes us feel crappy.

Anyway, back to the question. What we have found helpful is that, if we belong to a group of people (in our case, at work, or in the Writer's case, the book club) we need just one person to know perhaps even not all the details but, if we are having a hard time, we can tell that person and then we feel we don't have to pretend we are OK to everyone in the room.

I think it does help telling the right people but we are having to learn (the hard way) that if people don't understand, it is their problem, not ours. Easy to say, not so easy to believe.

I don't think there is an easy answer to knowing who or how to tell but I think we each have to find out own way.

Special General Meeting

At the Special General Meeting which was held on 16th April the following resolution was passed unanimously. That First Person Plural adopts changes to it's constitution as follows: To replace the current clause C with the following:

"The Charity's objects ("the objects") are:-

(i) The relief of sickness, in particular by provision of support and information to adult survivors of trauma and abuse who experience dissociative distress, their friends, family and carers;

(ii) To promote a better understanding of dissociative distress among health and social care professionals and to improve service provisions leading to better health outcomes;

(iii) The advancement of education of the general public in order to promote a better understanding and acceptance of people who experience dissociative distress."

Thank you to all who attended and voted or returned a proxy vote. Following the meeting the required paperwork has been forwarded to the Charity Commission. As the newsletter goes to press we anticipate hearing soon that our application for registration as a charity has been successful. Copies of First Person Plural's revised constitution are available on request.

Reflecting on the adult – child relationship (Part 2)

by Kate Evans Insiders

Healing Imagination

"Positive thinking, for people who are dissociative, is nurturing the insiders"
Sue Richardson

Hi. We insiders finally got through to Kate that we want to write about healing and the imagination ourselves, and not have her do it from outside. Because the imagination seems to be where we live – with its own laws, like – you can make what you want happen by just imagining it or writing it down. Lots has been written about this is just what we find best.

We children are starting off. There's a lot of us, but Kate's put us in little sub-groups, by age. We get to know each other better, enjoy hanging out together and no one has to be alone. It's nice when Kate spends time with us in imaginative activities – she just thinks of us and we join in. Like out game of rounders where we all cracked up when Kate and some of the Apparently Normal Personalities hobbled onto the field – they're almost geriatric. Or when we all sang songs together.

It's nice too when Kate has one to ones, just being, or doing something calm. And when we panic, sometimes now Kate sits us on her lap and soothes us and gives us biscuits. That's good, and also when she makes us a healing mantra for what we're especially scared of, and we can repeat it till we've taken it in. And, girl, is it a relief she's giving us stars for trying to be calm, etc. and not trying to discipline us with scary stuff – all she knew, till her therapist taught her.

We also mostly have a special hobby each, as well as painting and colouring in, and some of us have pets. And the twelvies formed an activist group and rescued broiler hens. Kate's learned a lot from "Poppies on the Rubbish Heap" by Madge Bray, about abused children healing. One of us who'd lived under awful pressure went to one of the places in Madge Bray's book and chilled out a lot. The book on harmonising the inner family helped too.

Kate wants us to add that the small baby got happier when she was regularly fed morning, night and midday, while the toddlers and littlies love kisses, cuddles and hugs – and their bottles.

We teenagers and young adults spend more time with close friends and chilling out , and take the major role inside and outside.

<u>Meetings</u> Kate's learned to have meetings whenever "she" feels upset, for it's always one of us. We speak out, argue, shout, bitch, laugh, cry and can move on. We also have meetings for major decisions and also when we can't sleep – often works. Daily or more frequent meetings are the basis of our shared lives.

<u>Deciding who does what</u> This is when you decide who's best to do something difficult. We decide which group of us will do it and what the rest of us will do. It helps to stop, for instance, children bursting into bureaucracy with a child's understanding, or vulnerable teenagers being triggered when out.

<u>Pairing</u> We use pair bondings a lot. We just write down the two names side by side. Close friendships of those who had the same experience are basic, and if they can do something positive together, better still. For example, we had two exploited lovers working at a womens aid refuge, which turned their depression to positiveness. Pairing of insiders with opposite experiences can be helpful – a toughie with a kindie, or a speedy with a slowie.

<u>List-meetings and pairings</u> When something is panic making we pair everyone who can't do it with someone who can. Generally, Kate knows when a pair feels right. The person helping has to be strong enough to hold the panic, fear, depression etc for the other. List pairing has also been helpful when we go out into a triggering area.

<u>Inner scenery</u> We didn't have a safe place for years – just a house that was intermittently raided. Then, in a difficult time, two of us became Golems (huge creatures created to save people from oppressors). We smashed the sabotage / perpetrator half of the inner world and the UN cleared it up. Since then we've felt safer, worked on patches of wilderness and a little indoors.

We have a healer around, who helps the really hurt ones especially when they emerge, and also comes in times of trouble with magic healing and helping powers and beautiful songs. In addition we have a Buddhist and a protector gardener.

We use the imagination for getting anger out, too. We used to visualise doing the worst atrocity we saw to the person we were angry with – nothing to do with even thinking about doing it in the outside world. Now the insiders just punch the person responsible for their torture. Girl, does it feel like freedom!

Our world is much happier too, since we dropped the "saboteur" approach. If someone is harming others, we try to investigate and understand, not blame and label. Contracts operate by reward, not punishment. Mostly its because we are in agony, or don't understand others are in pain, or because it takes time to change. Some of us were so petrified by the abusers we sided with them and need to share our terror. The children play up when they're bored, and all of us need things to do. The teen boys who joined in the abuse are on a separate re-education programme, and, at the time of writing, live separately and on contracts.

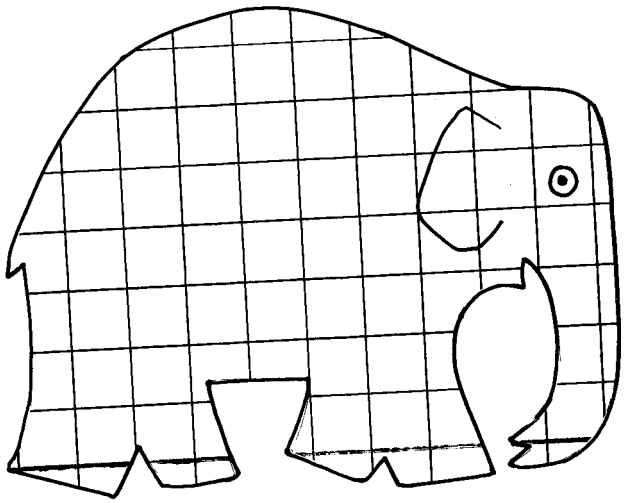
We want to end by saying that we're just like traumatised children, teens and adults in the outside world – we need listening, understanding, clear and firm boundaries, support and teaching, loving kindness and fun.

Dear Lizzie,

I am not nine but I am 10 and my name is Jane. I am not writing to you with a book idea but to tell you that we like Harry Potter books too because outside people [Muggles] can't see us either. We also like Snow White and the Seven Dwarfs because that is about little people too but I expect you have already ready that one. So we don't really know which books to tell you about but we will say hello to you instead.

From Jane

PICTURE TO COLOUR



Hi Lizzie,
I'm Anxi (pronounced Anksi) and me and my mates are groovy 9 – 11 year old pre-teens and we love Anne of Green Gables too. The other author we read is Arthur Ransome of Swallows & Amazons. We've just finished reading through the whole series by each of them and now we've started again. They are the greatest. Love from

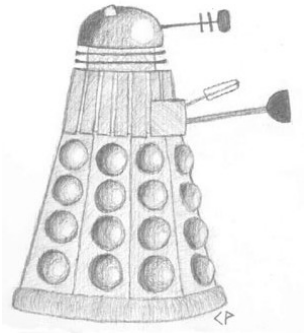
Anxi

CENTRE

Joke

What did the Dalek with D.I.D. say when it was confronted by one of it's old enemies?

DISSOCIATE! DISSOCIATE!



Made up by Angela and the others

MY FAVRIT GAME *by Daisy but Lucy did help me*

To play this game there aint much you need
Some scissors and glue and a catalog (or two)
Theres adverts for them in most magazines (them comics they do for grown ups an teens)
You fill in the paper. Its not hard to do
Then you just wait for them all to come thru (The waitings the hard bit)
I get myself comfy and flik thru the pages
Pick out the things I like – the right ages (not the body age – my age)
Pretty dresses – lacey and white
Woolly jumpers – cheerful and bright
A doll with ribbons in her hair
Dolly bath, pram, pushchair
Lots of games, books and tapes
Teddy bears – all sizes an shapes
Hundreds of cars an a big wooden garage
Princess Barbie with a horse an a carriage
I pull at the pages an rip them right out
I don't get told off cos theres no-one to shout
Then my scissors cut neatly round
All the lovely things I found
I don't stop till ther all glued down
Pretty lilac dressing gown
Party shoes and lotsa socks
Girls world with golden locks
Fur trimmed coat
Flowery jacket
Barbie blanket
A tennis racket
Cleaning set with a broom and mop (sometimes I don't know where to stop)
A dolly house I really like
Roller skates
A mountain bike
By the time I'm done the books are in shreds
My paper a mass of pinks blues and reds
Lilacs and yellows
A little light green
No black
No grey
No brown to be seen
I make up stories in my head of how things could've been instead
The people I'm with would all have wings – cos there so perfect
(they'd buy me these things
And they'd buy me lots more besides
Just thinking about it warms my insides)
They'd read me stories
Cook me nice food
Only tell me off if I'm naughty or rude
Daytrips and holidays
Walks in the park
A cat that meows an a dog that says bark
I'd be the envy of all my frends (who cares if it's only pretend)
A tingly feeling creeps into my heart
When I look over my work of art
A contented sigh
Then, you know what I do?
I tear my masterpiece in two
Screw it up and throw it away (I can do it again another day)
Tidy up
It was lots of fun but whatever you say, when it's done, it's done

Dissociative Identity Disorder Awareness Quiz

Answer TRUE or FALSE (answers on pp 13-14)

1. Dissociation describes the process in which feelings, thoughts, behaviours, sensations, perceptions and memories which are usually associated with each other become disconnected and separated?
2. Dissociative experiences always mean there is something wrong?
3. Dissociative Identity Disorder is the same as Multiple Personality Disorder?
4. It is a Personality Disorder?
5. Dissociative Identity Disorder is included as a legitimate diagnosis in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSMiv) published by the American Psychiatric Association?
6. Neither Multiple Personality Disorder nor Dissociative Identity Disorder is included as a legitimate diagnosis in the current edition of the International Classification of Mental & Behavioural Disorders (ICD10) published by the World Health Organisation?
7. Many psychiatrists and other mental health professionals do not believe that Dissociative Identity Disorder exists?
8. People who have Dissociative Identity Disorder have more than one person living in their bodies?
9. DID is experienced the same way by every person who has the condition?
10. Some alter personalities are so completely separate that they are able to establish independent lives without each other's knowledge?
11. All people who have DID have always known they have other personalities?
12. Many people with DID are able to hold down a job, be a good parent or take on other responsible roles in society?
13. Effective treatment for DID is often not available through the NHS, even when the condition is correctly diagnosed?
14. A lot of people who are eventually diagnosed with DID have had their condition misdiagnosed more than once before getting the help they need?
15. There are psychoactive drugs for the effective treatment of DID?
16. All people who have DID were sexually abused during childhood?
17. In DID there is always a 'good' Dr Jekyll-type personality and an 'evil' Mr Hyde-type personality?
18. Effective treatment for DID usually involves 2 to 10 plus years of talking therapy with a recommended frequency of 2 to 3 sessions per week?
19. The goal of healing for all persons with DID is to fuse the different personalities into one whole personality i.e. integration?
20. DID is rare?

Connect and Refocus

Writing exercises to help change self-harming or other contra-healing behaviours

by marynus

When I was first introduced to these exercises I was very scared and could not see how we could possibly do it but they have proved to be a wonderful tool. If you are not in a place to try them now, save this because when you are ready I'm confident they will work for you too. You can try them with just one part answering but I found them to be most effective and revealing if the system can work on them together. Look at the behaviour you are having trouble with and apply as many of the questions that fit. I was amazed by what came up for us – perhaps you will be too. This is not something to complete in one sitting. I was told that if I'd finished in a couple of hours then I didn't work very hard on it. So take your time and persevere. My experience in applying this to my life is when you have finished it you know you have finished.

1. Identify the behaviour you wish to change.

2. Connect with the part of yourself that engaged in this behaviour AND examine your role as "host" and how you did or did not participate.

3. If the behaviour were words, what would it have said?

4. What purpose did the behaviour serve? What are more appropriate alternatives?

5. How might you have used friends, support network, therapy, journaling, art, music, any other activity differently in the time before the troublesome behaviour occurred?

6. At the time of the behaviour is there any way in which you confused the past with the present? How so?

7. How is this behaviour detrimental to your healing and recovery?

8. Explain what you plan to do to orient yourself and your parts to the safety of the present?

9. State three things you honour and value about your recovery process and your survivorship?

10. Explore in several sentences your commitment to safety, and to life.

11. If you are unable to contract for your safety and the safety of others at this time what is it you feel you need to become an active participant in your recovery

    A) From your system or particular parts?
    B) From your therapist?
    C) From your doctor, psychiatrist or other professional supporter?
    D) From your partner, friends, relatives or others in your informal support network?

12. List physically or emotionally non-hurtful alternatives to the troublesome behaviour and how you plan to prevent the behaviour being repeated

13. State three issues / treatment goals you plan to address in upcoming therapy sessions.

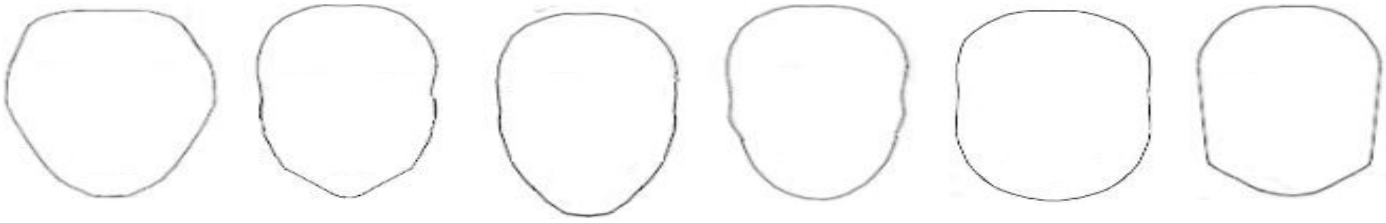
The First Person Plural Display Project

Create a mask(s) to celebrate your recovery and survivorship and/or your support & work for dissociative survivors. We will assemble your creations with others to produce a FPP mobile display

At the Members Open Meeting in April those attending were invited to create masks which will be assembled into a First Person Plural mobile display. Eight masks were completed for the project on the day. We now invite all members to participate in this exciting project. Each member may create up to three masks

How to create your mask(s)

Choose up to three outline face shapes from those below:-



Diamond ***Heart*** ***Long*** ***Oval*** ***Round*** ***Square***

Write to us at FPP Mask Project, PO Box 2537, Wolverhampton, WV4 4ZL to tell us your choices

We will send you face-sized white cardboard cut-outs matching your chosen shapes. You will also receive a form on which you can select a background colour on which you wish your mask(s) to be mounted; give us permission to use your creations in the display (and album) and tell us a little bit about what your mask(s) means to you.

Use drawing, painting, collage, colour in or other art methods to create your masks on the cut-outs. If you use collage it must not be too bulky because we will be laminating each creation – pictures cut out from magazines are okay, using fabrics isn't. If you wish you can sign your mask but you do not have to.

Return your completed mask(s) to us. We will mount them and laminate them and once we have enough will assemble them into the display. We may at a future date also photograph the display and each individual mask to compile an album which we will sell to raise funds.

The committee looks forward to your participation in this innovative membership inclusive project!

Answers to Dissociative Identity Disorder Awareness Quiz

1) TRUE : For most of the time, most people experience all these aspects of their experiences as connected so that they are able to tell a complete and rich story of significant life events and have a continuous sense of time and reality. During dissociation aspects of experiences become disconnected from each other which affects the person's ability to give a complete narrative and may distort their sense of time and reality.
2) FALSE: Everyone dissociates sometimes. If we didn't we'd never be able to cope with all the stimuli that our minds and bodies are exposed to. Dissociation helps us to 'ignore' un-needed or distressing stimuli and comes into its own as a survival mechanism when a person has to deal with traumatic life events. Dissociation is only a problem when it has become maladaptive e.g. when the person reacts as if all or much of their life is traumatic when there is no longer any need to do so.
3) TRUE : The two terms are used to describe the same condition but most professionals working in the field of dissociation prefer the term DID as being a more accurate description of what is occurring.
4) FALSE : The use of the term Multiple Personality Disorder has led to this misunderstanding. The condition (whichever term is used) has never been classified as a Personality Disorder.
5) TRUE : Dissociative Identity Disorder appears in DSM IV as one of five dissociative disorders. It's DSM IV code is 300.14
6) FALSE : Multiple Personality Disorder is a legitimate diagnosis included in ICD10. Its ICD10 code is F44.81. The description of MPD in ICD10 is similar to the description given for DID in DSM IV. They are the same condition but ICD10 has not changed the name of the condition to Dissociative Identity Disorder.
7) TRUE : Unfortunately, despite the condition being recognised by both DSM IV and ICD10 which for the most part psychiatrists accept as tools of their trade, there is still a lot of denial and ignorance about DID by them and other mental health professionals.
8) FALSE : One person per body is nature's rule. Each alter personality of the person with DID may experience themselves and each other as an individual person and indeed may convincingly present to outside others as a whole individual person, but each is, in fact, a part of only one whole person. Each part having been 'split off' and isolated through the process of dissociation.
9) FALSE : DID is a very individual disorder. No two people will have exactly the same experience of it though clearly there may be common elements of the experience. No two systems of alter personalities are identical, though there may be similarities e.g. similar roles taken by alters within two different systems. Note: the word 'system' is a collective noun used to describe all the alter personalities of a person with DID.
10) TRUE : It is not common for two completely separate independent lives to be lived over any extended period in the external world but it does happen. Alter personalities in the same system frequently describe their lives as very different from each others but this is because each is experiencing only one aspect of the person's current life or because the alter personalities are 'trapped' in a former period of the person's life or because they have a complete 'imaginary' internal life and history which they confuse as being objectively real.
11) FALSE : It is not uncommon for people with DID to be completely unaware of their other personalities. However, most do express a feeling that they are different from others even if they can't say how specifically and most are aware of having some emotional, mental health and/or unexplained life difficulties.
12) TRUE : Many people with DID hold highly responsible jobs and do them well. A diagnosis of DID says little about a person's ability to be a good parent and many people with DID raise their children well. Most of the people who manage and do voluntary work for First Person Plural have DID or other complex dissociative disorder. How functional a person is in their everyday life is not a good measure of the severity of their DID or their need for help.
13) TRUE : It is a disgrace that DID is often not treated effectively within the NHS even after the condition is recognised. Specialist assessments for DID are also hard to come by on the NHS. There are patches of good practice but it is not uncommon for people with DID to have to fund their own assessment and therapy. Many can't afford to so are either left to languish in a statutory mental health system which neglects their needs or some few lucky individuals find appropriate free or low cost help from voluntary sector services.

14) TRUE : People with DID commonly meet diagnostic criteria for other more well known mental health problems. It is not uncommon also for people with DID to also have depression, anxiety, post traumatic stress and even occasionally co-morbid psychotic type mental health problems. When combined with mental health professionals lack of knowledge and scepticism about DID this means that misdiagnosis is common for people with DID.

15) FALSE : There is no medication specifically for DID however some people with DID find pills help with some of the symptoms and/or benefit from drug treatment for co-morbid conditions such as depression. Medication of all kinds should be used with caution and careful monitoring in people with DID because it is known that individual and idiosyncratic reactions to pills and potions are common in this group. Text book prescribing is not recommended.

16) FALSE : Sexual abuse in childhood is a common history for people with DID but it is not the only one. Other forms of childhood abuse or repeated traumas may also be precursors. It is now thought that attachment difficulties are a better way of understanding the childhood roots of DID. Children who are frequently abused are at high risk for attachment difficulties but not all children who have such difficulties have been actively abused. Such factors as neglect, alcohol or drug misusing parents, maternal post natal depression or other illness can also lead to attachment difficulties which in turn may lead to the child developing DID. However, it should be noted that DID does not occur in all children who have attachment problems. Indeed, it doesn't always occur when there is repeated frequent sexual or other abuse in childhood**.**

17) FALSE : If you answered True you are the victim of a misconception largely created by Hollywood fiction and selective media portrayals of real people with DID.

18) TRUE : The International Society for the Study of Dissociation has published guidelines on the treatment of DID which state that 'the optimal primary treatment modality for DID is usually individual outpatient psychotherapy'; 'recommended frequency of sessions for the average DID patient with a therapist of average skill and experience is twice a week… With some patients a greater frequency of scheduled sessions (up to three per week) aids the patient in maintaining the highest possible level of adaptive behaviour.'; 'Early … reports on treatment outcome showed that over 2-3 years of intensive outpatient psychotherapy, patients could reach a relatively stable condition… However, most therapists now see 3-5 years following diagnosis as a minimum length of treatment, with many of the more complex patients requiring 6 or more years….' Some people with DID working with less experienced but competent therapists (or those unable to offer the optimum frequency of sessions) have needed 10 plus years of therapy.

19) FALSE : This fallacy is based on out of date information. Experts used to recommend that the goal of treatment should be integration, indeed the above quoted guidelines in an earlier edition stated this. The current edition is somewhat more circumspect under a heading "Integration as an overall goal of treatment". It now states that 'treatment should move the patient toward a sense of integrated functioning'. The fusion of the different personalities into a unified whole person (i.e. integration) is not always necessary to achieving a sense of integrated functioning or for the person to lead a happy life. For some, integration is the best thing but if the system of alters is communicating effectively and working co-operatively there can be a sense of integrated functioning without fusion. Some people with DID make an informed choice not to fuse alters because the familiarity (and possible advantages) of being a system of alters is preferable to the unknown quantities and qualities of functioning as a whole person.

20) FALSE: No one knows for certain the prevalence of DID in the general population but informed estimates put it at 1%. This is a similar prevalence to schizophrenia and no-one considers that to be a rare condition. More than one study in different countries (including England) has put the prevalence of DID in the psychiatric in-patient population at approximately 6%. What is relatively rare in the UK (and elsewhere) is having your DID correctly diagnosed but this is not the same as saying DID is rare. ICQ10 (mentioned in an earlier answer) states that DID (which it calls Multiple Personality Disorder) is rare and partly because of this professionals receive insufficient (or indeed any) training in the assessment and identification of DID and thus don't diagnose it. In a tragic feedback loop low levels of diagnosis falsely justifies ICQ10's statement that Multiple Personality Disorder is rare and so the myth of rarity is perpetuated.

Report from TAG Conference

The Trauma and Abuse Group held their conference "Translating Theory in to Practice – Attachment, Trauma and Dissociation" at Swanwick in Derbyshire on 22nd-24th April. Kathryn and Melanie from the Executive Committee attended and delivered a paper on the training and awareness raising work First Person Plural is doing. The half hour paper which was repeated was well received by both groups and there was much appreciation for the work First Person Plural is doing to bring the voice of survivors into the training of professionals.

Remy Aquarone and William Hughes of the Pottergate Centre in Norwich delivered a series of plenary sessions in which they introduced the role of attachment theory and brain science in understanding the world of the dissociative trauma survivor. Using simple language the two plenary speakers helped delegates, who came from a range of backgrounds and experience, appreciate how these theories can be used to inform practice and assist the recovery of survivors.

Each plenary session was followed by small discussion groups and this feature of the conference enabled delegates to share their own thoughts and experience to support each other's learning. The discussions with the same group of people throughout the conference also helped to make the conference feel more inclusive and safe.

During the conference TAG held its Annual General Meeting at which its newly acquired registered charity status was announced.

At the United Kingdom Society for the Study of Dissociation AGM which preceded the start of the TAG conference Kathryn Livingston was elected to the UKSSD Committee in the role of FPP representative.

Kathryn has also recently been elected onto the committee of the Wolverhampton Sexual Abuse Forum. She has additionally been honoured to accept an invite to join the Adults Sexually Abused in Childhood Expert Group which will have an influential role in the Department of Health, Home Office and NIMHE Victims of Violence & Abuse Programme led by Professor Cathy Itzin.

POEMS and RHYMES

Tanka by Paula Puddephatt

Tentative at first -
Two dogs entering the sea.
Soon both are at war
Against the incoming tide,
Enjoying every moment

Monkeys & oceans by Paula Puddephatt

'Concrete monkey' &
'ferocious oceans'
perfume & colour her poetry
as she dances with her lover
to the rhythm of the fax machine.

POEMS and RHYMES

We are finding it hard to cope at the moment because things happening on the outside and it has reminded us of another time when we were struggling and we had a dream which felt so real that we wrote a poem about it. We realise that, like us, it is a tricky subject for a lot of people but we wanted to share it with you.

God sent us an angel in a dream
by Angela and the Others

God sent us an angel in a dream,
He came to see us late at night.
No halo shone above his head,
He had no wings, no gown of white.
No soft white clouds, no heavenly choir,
No harp was cradled in his hands.
He hovered gently in the air –
Then, softly, he began to land.

God sent us an angel in a dream,
He wore brown clothes, had short cropped hair.
Do angels shave? His face was rough,
He pulled us close and held us there.
He wanted more, like all men do,
(We really didn't like that part).
He pulled away, he let us go,
He knew the pain deep in our heart.

God sent us an angel in a dream,
He met our friends and walked around.
He laughed and joked and drank their wine,
And smiled at us from time to time.
We didn't see him float away,
He didn't say he had to go.
We ran outside but he was gone
With nothing left on earth to show –
An angel is watching way up there,
God sent him down to say "I care"

Jealousy by 63

Unabated it consume all who transgress,
Transgressor if you had insight you would abhor,
How erodes the core.
Why allow, connive, with intellect,
Remove all compassion, dignity, self-respect.
It embroils emotions, aspects of personality,
Eats away periodically, as terminal cancer would.
Insecurity for all who endure,
Jealousy will remove, vision.
Sightless, yet observant,
They wander aimlessly, oblivious,
Living, dark nightmares beyond,
tunnel vision sight.
They shall never observe, reality,
pure light.
Mankind shall absolve you, your
plight, your night.
Thy obsession will engross,
engulf, finally,
Disarticulate, too late,
remonstrate.
What shall remain, voidable shell,
Pearl been extracted, living hell,
Too late now, quell.
From envy, greed, will flourish,
need.

29-Jul-00 by anon

My self-esteem has gone
My confidence damaged.
My past experiences have almost
Destroyed me, but I guess
I've learnt how to manage.
You see, when someone
Abuses you, doesn't matter who,
The self-destruction that
Continues pulls you through.
But I guess when the door is
Shut and the people gone
Away. You notice what you've
done to yourself to help the pain
fade away, but it never seems to
last as long when you hurt
yourself long ago, you have to do
it more often, so the real pain
will never show