Volume 18: Issue 1/2 Autumn / Winter 2017

First Person Plural — dissociative identity disorders association

"Rainbow's End"

Charity Registration Number = 1056602 (formerly 1109464)

First Person Plural...

- *is pioneering, being one of the longest established (1997)complex dissociation specialist organisations in the UK;*
- *remains the only UK national survivor-led membership charity working exclusively for and on behalf of people affected by DIDs*
- *works in collaboration & co-operation with ESTD-UK, TAG, The Survivors Trust, The Pottergate Centre, The Clinic for Dissociative Studies, RAINS & other groups with a similar ethos, for the purpose of achieving shared aims.*

Kathryn, Melanie,

Lesley (p/t administrator) and all First Person Plural's Trustees

wish our members,

the best for this (maybe difficult)

Christmas & New Year Season

BUMPER DOUBLE ISSUE

Inside this issue

Melanie Goodwin,
Chairperson, F.P.P.

Chair's Letter

Dear All,

I am so glad I am not a squirrel. I have one who has spent the last few weeks burying walnuts all over mine and the neighbours' gardens. However does he remember where he buried them? As, to a casual observer, it would appear to be very random. Drifting towards the age where forgetfulness is accepted, even expected I find it so hard being yet again pigeon holed because I am in this age group so therefore it is normal. Having spent my whole life trying to present some continuity of thought that includes knowing where things are, using many coping strategies rather than relying on smell, it feels somewhat over simplistic to put it down to age. It negates how we have managed, often very successfully but at enormous cost to energy levels, to maintain a semblance of normality only to now have it trivialised or that is how it feels to us all.

FPP have made a very tough decision to temporarily put on hold the development of any more Peer Support Groups. The ones already established will continue for now and there is a new one about to be launched using the FPP model with further input from us as well. We are still going to support anyone who would like to start a group using the FPP model and plan to pick up our own project again as soon as we are able to give it the time we know it will take. We are fortunate to have an FPP member who has considerable experience in this area working alongside us.

The support app is very exciting and moving forward. We know it will involve a lot of work. I have received some really helpful ideas about the content and there is still time to send me yours. This resource needs to be flexible enabling it to meet a wide range of needs. One way of ensuring we fulfil this remit is to have as many ideas as possible to consider. We have received so much positive feedback. This includes a developing inpatient service showing interest in having input into the project.

We continue with the training as well as becoming more involved in other agencies projects. It is a much less isolating world than it was twenty years ago. Kathryn and I attended a Trauma Innovation day in York, a follow on from some training about trauma informed support groups Kathryn had attended a few weeks earlier. FPP has been invited to be involved in a day about trauma at Birmingham University; are contributing to writing a course for a recovery college based in the East; and will be fulfilling an invitation to speak at a Hearing Voices meeting next year.

"….. tough decision to temporarily put on hold the development of any more Peer Support Groups. ….. "

Chair's Letter continued

All these things are new and such positive, progressive steps forward. I am getting so much from working with others and learning a lot along the way. However, we are trying to be careful to pace ourselves as every invitation feels like something we want to be involved in.

We had a lovely 20th birthday celebration in July. We were very touched that members and others (including clinicians who we have worked professionally with for a long while) came along to join us in our celebrations making it such a memorable day. Many travelled long distances to be there.

Our thanks go to Carl Hodson and the Howling Wolves Community Choir who gave a wonderful performance, followed by leading us all in a natural singing workshop.. which had everyone either joining in or watching. A great deal of fun was had.

Finally, a big thank you from Kathryn and me for the flowers and chocs we were presented with. We were both very moved by this gesture of appreciation. The flowers lasted a lot longer than the chocolates.

Warm wishes to all

Melanie

"…..big thank you from Kathryn and me for the flowers and chocs….."

A...B...C ... of D.I.D. *By Anon*

A – Acceptance – When you begin to accept your parts, that they all have a role and a reason for being present things become easier.

B – Bravery – You have been brave to get to this point, to live through what you have, to seek help, to accept you need help or support, and you are brave to get through each day in recovery, whilst learning about yourselves and making different choices and facing challenges.

C – Compassion – Try to foster some compassion for yourselves, parts may be hard to accept and be difficult to come to terms with, but if you have compassion for your system and what they struggle with or how they behave it breaks down barriers to being able to walk forward with them and work towards common goals more easily.

D – Dissociation, - despite causing many problems now, has helped you to get to where you are now, and there is a lot of hope that complex dissociative disorders do not mean you cannot live a full and meaningful life.

"...there needs to be someone who helps to guide and lead everyone to aim for the best outcomes for you all……"

E – Expression, - it can be helpful to find an expressive outlet for your emotions, particularly for younger or more troubled parts: dance, sports, writing, painting, poetry, colouring, make up, clothes, colours – being yourselves.

F – Feelings – As difficult, scary and distressing it may seem, being able to connect to your feelings, holistically including beginning to connect to what other parts may hold for you, has many benefits. It may be overwhelming at times, but you have to be able to feel, to experience life fully.

G – Grieving – Throughout life, particularly a life that has encountered many traumas, allowing yourself to grieve for losses, or even things you have never had can be the most cathartic, painful but ultimately liberating experience.

H – Hard work – It can be tough getting through each day with blank periods of time, or with desperate efforts to stay grounded that don't quite work, or losing part of something you really needed to stay engaged with. Also, hard work when you find yourself somewhere alien and don't know why you are there or how, keep working hard. It is all hard, but it will all be worth it.

I – Integration – When you reach a point where your parts are beginning to connect to some degree so you can share and enjoy each other's talents and abilities and qualities, that are all yours to enjoy. You can begin to experience things more as a whole.

J – Juggling – It is hard enough in this day and age to do everything you are supposed to and be in the right place at the right time with the right things you need. But to even begin to manage this while coping with DID is a mammoth task, and trying to do it is hugely commendable, for those who achieve it.... **Please share your methods!**

K – Kinaesthetic – Learning through movement and being aware of your body, do you sit a certain way when dissociated in a different part, could your stance and posture tell you that you are about to switch, and could changing it help ground you?

L – Leadership – Who in your system tries to lead, who parents the younger parts, who looks out for the parts who struggle the most with staying safe. Like all families, teams, groups, gangs or however you view your system, there needs to be someone who helps to guide and lead everyone to aim for the best outcomes for you all, who takes control of decisions whilst involving and hearing everyone and who helps your system strive for what is needed.

M – Mantras – Have a mantra that you create for you and your system, something you can say internally or out loud to reassure and encourage your parts and help yourselves stay safe and grounded, incorporate what it important and comforting to you all, not what others may think is right.

N – Noticing – A person who notices, is a person who looks. Track or journal or record about your dissociative experiences, are there days, times, or triggers that increase switches, or is it becoming evident one part keeps coming forward when certain situations happen? Stay as informed as you can.

O – Options – You have options and choices now, who do you tell about your parts and how, how do you manage your condition, do you want treatment and therapy or is the support from loved ones OK for now, do you want to look into a job, do you want to try something you haven't done before....

P – Planning – Crucial to come before options, but I couldn't rearrange the alphabet! Planning, when you have parts is key, what in the day you have planned might present a problem for who, have you got your grounding items, have you made sure you have got what you need if things get difficult. Planning is also crucial before doing new things, is it something everyone would cope with without too many triggers, have you planned what you will do to cope if anyone struggles with things etc. If you fail to plan, your plans may fail.

"….if you have compassion for your system and what they struggle with or how they behave it breaks down barriers..."

A...B...C ... of D.I.D. *By Anon* *continued*

Q – Questions – How do you deal with questions about your presentations or your condition? I find it depends who I am talking to, a professional who is reluctant to recognise DID, I might explain things as a set of symptoms and not really hammer the term Dissociative Identity Disorder, if it is a close friend I put a summary of my experiences in layman's terms, if it is someone who doesn't need to know or I don't wish them to and they are purely curious, I hold a boundary, and they don't know.

R – Reality – What goes on for everyone day to day is individual, variable, and may be OK for some parts and distressing for others, staying connected to the realities of a situation can really help. All the way from "Where are we?" and "What date is it?" to "She didn't say she was angry, she said she was frustrated, and we worked through it" – Checking the reality of a situation both dissociation wise, and perception wise can really help make things easier, and feeding this back to your system in some way can help too.

"...X - Xenial - (Definition: Hospitable….; friendly.) ….."

S – Senses – Using your five senses are really good ways to ground yourselves quickly, and a lot of them can be used subtly, even when in public. Hearing – music or calling a familiar safe person, Sight – Looking at pictures or reading through words you find comforting, Smell – Finding a smell (or smells if different parts have different preferences) that grounds you: grounding through smell is the quickest way to ground, Touch – an object that is textured or weighted may help or something warm or cold, Taste – Strong tastes can help to ground, such as sour sweets or spices. It is individual, and may vary even within your system as to what may help, but try to explore and work out what is useful.

T – Time – If you can try to keep a track of when you lose periods of time it can help you build a picture of what is happening for you. Also bear in mind treatment for dissociative disorders takes time, with patience and persistence there is a lot of hope.

U – Understanding – It is very difficult to find professionals, or even people from everyday walks of life who have an understanding of dissociative disorders. However, awareness is slowly being raised, and if you feel able to when you are with people who are safe to share with, try to help them understand what your experiences are and how they could help you. The greater understanding they have, the more likely people are to be able to help you and provide you with the right kinds of support. Also understanding doesn't have to be informed, understanding can be on a human level, someone just noticing your difficult days – even if they don't know why, or recognising your achievements, even if they can't comprehend how much hard work went in, is still a great thing.

V – Vulnerability – It sounds like something you may never wish to be associated with, being vulnerable doesn't sound like something to strive for – but sometimes it can reap rewards and not be a negative. There are two sides to vulnerability... if you don't take that chance to talk to someone who is at the library every time you go, who browses the same books as you, you may never find that you may have found a great friend. It is a risk that they may not respond as you hope, but they may do. Vulnerability is allowing yourself to be at risk of your fears being confirmed, whatever they may be - "No one will like me" – You don't know until you take a risk in that respect, and without being vulnerable you cannot disprove your insecurities either. Vulnerability may feel scary, especially when in our lives it often has a connotation with danger or weakness, in fact being vulnerable at certain times can ultimately be a great strength.

W – Worth – You and your system are worth fighting for, whether it is you fighting for you, or someone else, keep going. You have got this far, and you deserve better. We all know there isn't a lot of help and support available for DID and dissociative disorders currently, and we know many clinicians are disbelieving and invalidating at times, but it is worth continuing, as at some point there will be something that enables a change in your life – even the smallest things can make huge differences. You are all worth giving yourselves a chance.

X – Xenial – (Definition: Hospitable, especially to visitors. For example, the relation between a host and guest; friendly.) Well I scraped the barrel for this one, but felt it was quite appropriate, when a part has tried to help in any way they can, or done something they enjoy or you have all benefitted from – try to recognize the good within that, as well as the difficulty or confusion or more difficult feelings that may stem from that as well. Try to accommodate your parts and their needs, as denying them that tends only to make things more difficult.

"...if it is someone who doesn't need to know or I don't wish them to and they are purely curious, I hold a boundary, and they don't know. .."

Y – Years – It does take years: recovery, diagnosis, recognition, therapy, treatment, healing but ultimately you have survived the worst years, and although it may not seem so when everything is chaotic and scary, taking the time to get things right at the stage you can access and understand yourselves, will enable you to have better years to come.

Z – Zealous – (To be active, devoted or diligent) Within treatment for dissociative disorders you need to be proactive and dedicated to recovery. Therapy doesn't help just because you have walked through the door on time and chatted for an hour, therapy is all the time. It is remembering your therapist saying how difficult one of your parts finds something, ahead of that happening and putting safeguards in place, it is thinking and reflecting on sessions/experiences – both good and bad, it is willingness to accept and change things, it is feeling scared and carrying on, it is talking when you want to say nothing and saying nothing and sitting with the tears when you feel like talking. When there is no support, and no therapist and no understanding it is working with yourselves, using everything you have in you and everything you know about you to get through to the next day, and keep going.

My many selves: how I learned to live with multiple personalities

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Emma Young meets a woman with dissociative identity disorder and discovers what happens when you lose your sense of being an individual.

Until she was 40 years old, Melanie Goodwin had no memory of her life before the age of 16. Then, a family tragedy triggered a cataclysmic psychological change. Suddenly she was aware of other identities inside her, and the barriers between them were crumbling. The different identities belonged to her, Melanie felt, but 'her' at different ages, from three years old to 16 and on into adulthood. These ages were not random. Amid the confusing, terrifying mingling of different voices in one consciousness came memories of child abuse, the first episode occurring when she was three, the last when she was 16. "I have no proof," she notes. "I have to go with what I believe happened, and my reality."

"...I*f you're in a totally impossible situation, you dissociate to stay alive. Trauma can freeze you in time.* ....."

Melanie has what used to be called multiple personality disorder, which is now more commonly referred to as dissociative identity disorder (DID). The change in name reflects an understanding that it's more than just changes in personality that are involved. Memories, behaviours, attitudes, perceived age – all can switch together.

"We" – she generally refers to herself as 'we' – "had lots of adult parts. Development should be seamless... But because we didn't grow up naturally, we would update ourselves... Finally, there were nine different adult parts, each managing a stage of our abuse-free adult life."

Living with DID can be "hell", she says. It is a breakdown of an aspect of everyday existence that the rest of us take for granted – our sense that we are one individual self. For Melanie, the abrupt awareness of her many different identities warring inside her was overwhelming. How could she possibly find a way to accommodate them all?

Melanie is talking from a sofa in a quiet consulting room at the Pottergate Centre for Dissociation and Trauma in Norwich, UK. The centre is run by Remy Aquarone, an analytical psychotherapist and a former director of the International Society for the Study of Trauma and Dissociation.

Over a 30-year career, Aquarone has worked with hundreds of people with a dissociative disorder. In most cases, he says, they have a history of childhood abuse, generally starting before the age of five. In an attempt to cope with the traumatic experiences, the theory goes, the child 'dissociates' – it splits itself into parts. One part endures the abuse and contains the horrific emotional and physical impacts; another part exists afterwards. Or, there might be one part that endures the abuse, another that gets the body back to its bedroom, and another that goes down to breakfast in the morning. If the abuse goes on over years, and also if different scenarios and perpetrators are involved, many different parts may splinter off. It's the dissociation that allows the child to keep going. In fact, "it's the ultimate adaption system. It's using your unconscious cognition to adapt your way of thinking and behaviour in order to be more safe," Aquarone says.

Melanie describes it this way: "If you're in a totally impossible situation, you dissociate to stay alive. Trauma can freeze you in time. And because the trauma is ongoing over years, there are lots of little freezings happening all over the place."

Not everyone who endures childhood abuse – or any other form of ongoing major trauma –develops a dissociative disorder. Based on his work, Aquarone says there's another critical factor involved: the absence of a normal, healthy attachment to an adult.

"...the abrupt awareness of her many different identities warring inside her was overwhelming. ...."

In the field of developmental psychology, 'attachment' has a specific meaning: it's a bond that forms between an infant and a care giver who supports and looks after that child, emotionally and practically, while also helping that child to learn about and manage his or her responses. Without that bond – prevented by bereavement, neglect or abuse – a child undergoing a trauma is left to fend for itself.

Reflecting on people with DID as a group, Melanie says: "What we didn't learn as small children is a parent metaphorically holding you and helping you learn how to manage yourself."

Infants who do develop secure attachment go on to cope better generally with life, says Wendy Johnson, a psychology professor at the University of Edinburgh. "First of all, they're better at dealing with other people in a way that is successful. Their relationships tend to be smoother. They tend to earn more money, be better appreciated and recognised by others, and get into less fights. They also tend to experience life more smoothly, so it's more pleasant to them."

This is not to say that our personalities are set for life in those early years.

My many selves: how I learned to live with multiple personalities *(cont)*

A relatively stable environment, in terms of relationships and work, helps to maintain a relatively stable personality. "I think the fact our environments tend to have a lot of stability to them contributes to the consistency that we tend to display," says Johnson. But if these external influences change, we can change too.

Parenting, losing a job – these kinds of major life changes can provoke behaviours that surprise us, as well as changes in traits such as conscientiousness and extraversion. It's no wonder that young adulthood frequently involves a major questioning of identity, adds Johnson, as this is so often a time when lots of things – home, surroundings, friends – are in flux.

Without the unified sense of self that attachment and stability brings, dissociated identities can make someone's personality appear to swing wildly. Melanie has an anorexic part, and a part that attempted suicide twice because the pain of the barriers coming down felt unbearable. Her three-year-old part is easily scared by things that remind her of past traumas – like a scent or a man's way of walking – and in these situations she will freeze or even hide. On the other hand, the 16-year-old can be flirty.

"...I know I got married. But I watched and observed it rather than being fully engaged. ....."

It makes sense that Melanie will behave differently depending on 'who' is to the fore in her mind. She is not acting like her three-year-old self, or even remembering what it was like to be three. She is that three-year-old – until another identity comes to the fore.

Because memories of time spent in one identity are not always accessible to others, some people with DID 'lose' chunks of time – they feel as though they're often jumping forward days or even weeks. "Some people go off and have affairs. Well, they're not really affairs, because they have no memory that they're married," Melanie observes.

For her, the effect is that she has no sense of the order in which things have happened in her life: "As babies, you get born and you have a timeline that goes through your whole being. If you get fragmented, you don't get that timeline."

Her memories are further blunted by the subduing of normal emotional reactions – which are essential, both she and Aquarone say, to helping a person cope with severe trauma.

But this lack of emotion didn't end when the abuse stopped: it had become the way Melanie's brain worked. "I know I got married," she says, for example. "But I watched and observed it, rather than being fully engaged."

People with a dissociative disorder often report feeling very superficial, says Aquarone. "And in a way, they are, because the essence of who you are is held inside." For most of us, our memories, enhanced by the emotions we felt at the time, provide a personal chain that reaches all the way back into childhood, providing a sense of self-continuity. "I can refer back to my behaviour as a teenager, for example," he says, "and hold on to a bigger picture [of myself]... The price of [dissociation] working is that... there's no tracking back to see how things were." Being with people – whether family or old friends – with whom you have plenty of shared memories stretching right back can enhance that sense of an ongoing self persisting through the years. But the problem with relying on connections with people from the past, of course, is that old friends can move away – and people can die.

One psychological benefit of religious belief may be that, in theory, a relationship with God, with all its associated memories, can extend from early childhood through to death, and no matter where you are on the planet, it is there. As Aquarone says, "You can't take it away – and it transcends where you are."

"...She is not acting like her three-year-old self,..... She is that three-year-old …. "

There are other ways to help connect your present 'self' with the past. Psychologists used to think that nostalgia – the use of memory to sentimentally hark back to good times in the past – was negative and harmful. But there is now work finding the opposite. In fact, nostalgia seems to foster a sense of the self continuing, and enhances a sense of belonging in the world.

This sense of a single, consistent self through time helps people to navigate life, and the social world in particular. But if it can be strengthened – and weakened – by experience, or lost altogether in DID, does it reflect the real you?

"Consider the musical 'Grease', where Sandy sheds her goody-goody persona to become a leather-clad, pelvis-thrusting bad girl. Surely all this smokiness and gyration is Sandy. But just as surely, this is a performance designed to gain the approval of her peers, not the 'real' Sandy."

The case of Sandy is highlighted in a review paper by Nina Strohminger and colleagues at Yale University on the concept of the 'true self', not just in relation to people with DID but to anyone at all.

My many selves: how I learned to live with multiple personalities *(cont)*

Or, suggests Strohminger, consider the case of a man who's very religious and has homosexual impulses. "His religion prohibits him from acting on [them]... so every day he's fighting them," she explains. "Who is the real person? Is it the person who is resisting the homosexual impulses, or the person who has them?"

The answer, she's found, is that it depends who you ask. "When you ask liberals, they say, 'Oh, it's the person with homosexual impulses.' But ask conservative people and they say, 'It's the part of him that wants to resist these impulses.' It all boils down to what you value. If you think it's okay to be gay, you're not going to see anything wrong with those deeper impulses."

Strohminger isn't aware of any work that has asked someone experiencing this kind of inner conflict what they actually think. "But from everything I've observed in my studies, the prediction would be that... [whatever] you are projecting on to other people, the same standard would hold for you as well.

"… "Our results run counter to centuries of thought from philosophers and neuropsychologists." ….."

"I'm a psychologist, not a metaphysician," she adds, "but if you wanted to draw some metaphysical conclusions, you'd have to understand that when normal, everyday people are thinking about their own identity and the identity of other people, this is informed by their own values and circumstances." In other words, it's all relative.

Strohminger has found that there is, however, one aspect of a person's typical pattern of behaviour that, consistently, is rated as being most fundamental to who someone is – even more so than their memories, or whether they're extravert or introvert, placid or easily driven to excitement or anger.

She started with thought experiments. In one, she asked volunteers to imagine other people changing in a variety of ways. And it was alterations to their moral traits – their relative honesty or dishonesty, loyalty or disloyalty, and so on – that the volunteers felt most changed them as people.

Next, Strohminger turned to families of people with dementia, which can involve not only memory loss but also changes in personality and moral sense (sometimes negative changes, such as a shift to pathological lying; sometimes positive ones, such as greater kindness). The relatives reported that it wasn't when their loved ones lost their memories that they became a 'different person', but rather when their moral sense altered.

"Traditionally, morality has not been given much attention in scholarly work about the nature of personal identity. Rather, it was thought that memory and distinctive characteristics, like your personality, is what made you," Strohminger says. "Our results run counter to centuries of thought from philosophers and neuropsychologists." Melanie says that some parts of her do seem to have a different moral sense. But she traces this back to varying life experiences for each part, and to the anchoring of some in past decades when different attitudes prevailed.

And people's moral sense can change over time, notes Wendy Johnson. "I do think there are people who realise where they went wrong, and who decide they are going to be different, and they become different," she says.

The fundamental heart of who we are – as far as other people are concerned, at least – can change therefore. This suggests that the solid, fixed sense of self most of us have is at least partly an illusion that allows us to avoid the mental distress that comes with multiple identities. And as the experiences of Melanie and others with DID show, this illusion is a vital one.

"..."Who is the real person? Is it the person who is resisting the homosexual impulses, or the person who has them?".."

It was about four years after her parts started fully emerging that Melanie, who worked as a librarian picked up a book called The Flock by Joan Frances Casey. She realised that, like Casey, she had DID. She raised the idea with her husband of more than 20 years. "He said, 'You know what: that makes sense.' Because, he said, he'd say to me one day, 'Do you want a coffee?' And I'd say, 'Yeah, I'd love a coffee.' Then, the next day, 'Do you want a coffee?' And I'd say, 'You know I don't drink coffee, I'm allergic to it!' The 16-year-old can't drink coffee and I love coffee. He used to say he never knew what he was coming home to. I never understood what he meant by that!"

Is it surprising that she was married for so long to someone who didn't realise there were different parts inside her? "[Now] he thinks it's mad he didn't pick up on this... But he loved me. And I was a good mum, in a practical sense... I was good at copying how other people behaved." Unlike some people with DID, Melanie does feel that she has a dominant, leading part, whose age matches that of her body. Is it possible, though, to say that the 'real' Melanie is not the three-year-old who's easily terrified, and the 16-year-old who flirts, and the 64-year-old who's sitting on the sofa in Remy Aquarone's consulting room, talking eloquently about a sense of being that she now realises is so different to most people's?

Good treatment has made a big difference. The first step was for the disorder to be correctly diagnosed, however, as DID can appear to be

My many selves: how I learned to live with multiple personalities *(cont)*

many other things. People who hear the voices of parts may be labelled schizophrenic; people who switch between depressed and excitable parts may be diagnosed with bipolar disorder; people who hide in a hospital because their identity is a terrified three-year-old may be thought to be having a psychotic episode; people whose emotional states seem to shift drastically might be diagnosed with borderline personality disorder.

And in the UK, at least, DID is a controversial diagnosis. It is listed in both of the main psychiatric manuals used around the world (the Diagnostic and Statistical Manual of Mental Disorders, produced by the American Psychiatric Association, and the International Statistical Classification of Diseases and Related Health Problems, produced by the World Health Organization). But in practice, says Aquarone, there can still be reluctance among psychiatrists to accept it. DID is now thought to affect perhaps 1 per cent of people (about the same rate as schizophrenia), yet there have been claims from sceptics that perhaps patients are simply acting out different identities, and that a proneness to fantasy explains the entire disorder.

"..."We are not one, but we all agree to live harmoniously together," ....."

Brain imaging work supports the idea that people with DID are not acting, and there is other research refuting such claims. In 2016, for example, a team at King's College London published a study of 65 women, including some diagnosed with DID. They concluded that the women with DID were no more fantasy-prone, suggestible or likely to generate false memories than those without a diagnosis. According to the authors, this result challenges the core hypothesis of the ˜fantasy model".

Melanie is now a director of First Person Plural, a dissociative identity disorders association, and she frequently talks to psychologists, psychiatrists, GPs and care workers, spreading the word that DID is real. She and Aquarone recently helped to organise the first conference on services for people with trauma-related dissociation. It brought together clinicians from the NHS and the private and voluntary sectors. One of the big challenges, they note, is that it can take many months of therapy with a specialist in dissociative disorders to help a patient, but this is generally only available privately.

This was the kind of therapy that changed everything for Melanie, she says. When the barriers between the parts began to break down, she was overwhelmed. It took a strong bond with a therapist who could help the parts to talk to each other and respect each other for the 'war' inside her to begin to settle down.

For ten years after her different identities began to break out, Melanie found it impossible to manage anything beyond the fundamentals of life. Then, as she learned to listen to the parts and the stories they had to tell, 'we learnt to share the one life between us'.

When she felt able to start going away again for nights with her husband, the child identities inside her would help to gather what she needed. 'Everybody would help pack. So we'd have to take things for the three-year-old, like teddies and comforters, and I'd end up packing three or four bags, because everybody had to bring their things.' But still, if they got to their destination and she found she didn't have the right clothes for that moment, she couldn't go out. At any given moment, it could have been an eight-year-old who was to the fore in her consciousness, or the 16-year-old, and they just wouldn't go out unless age-appropriately attired.

At one point, she used to allow the 16-year-old to "dress the body", as she puts it, and get it to the library where she worked: "We'd cycle, because of course the 16-year-old couldn't drive." This was on the understanding that the adult would have the day at work, then she'd give the younger parts time in the evenings. "They'd get to do the things they couldn't do in the day – from the little one having Smarties and watching Teletubbies, to making things, playing with teddies, doing a jigsaw.

"Over time, we began to understand what was happening as a whole," she adds. In a threatening situation, perhaps someone walking into the library in a way that triggered awful memories, "I could talk to the little ones and say, 'I'm going to keep you safe... the library's a safe place. Just allow me to stay still and see if we really are in danger, and I promise you if we are, I'll handle it.'"

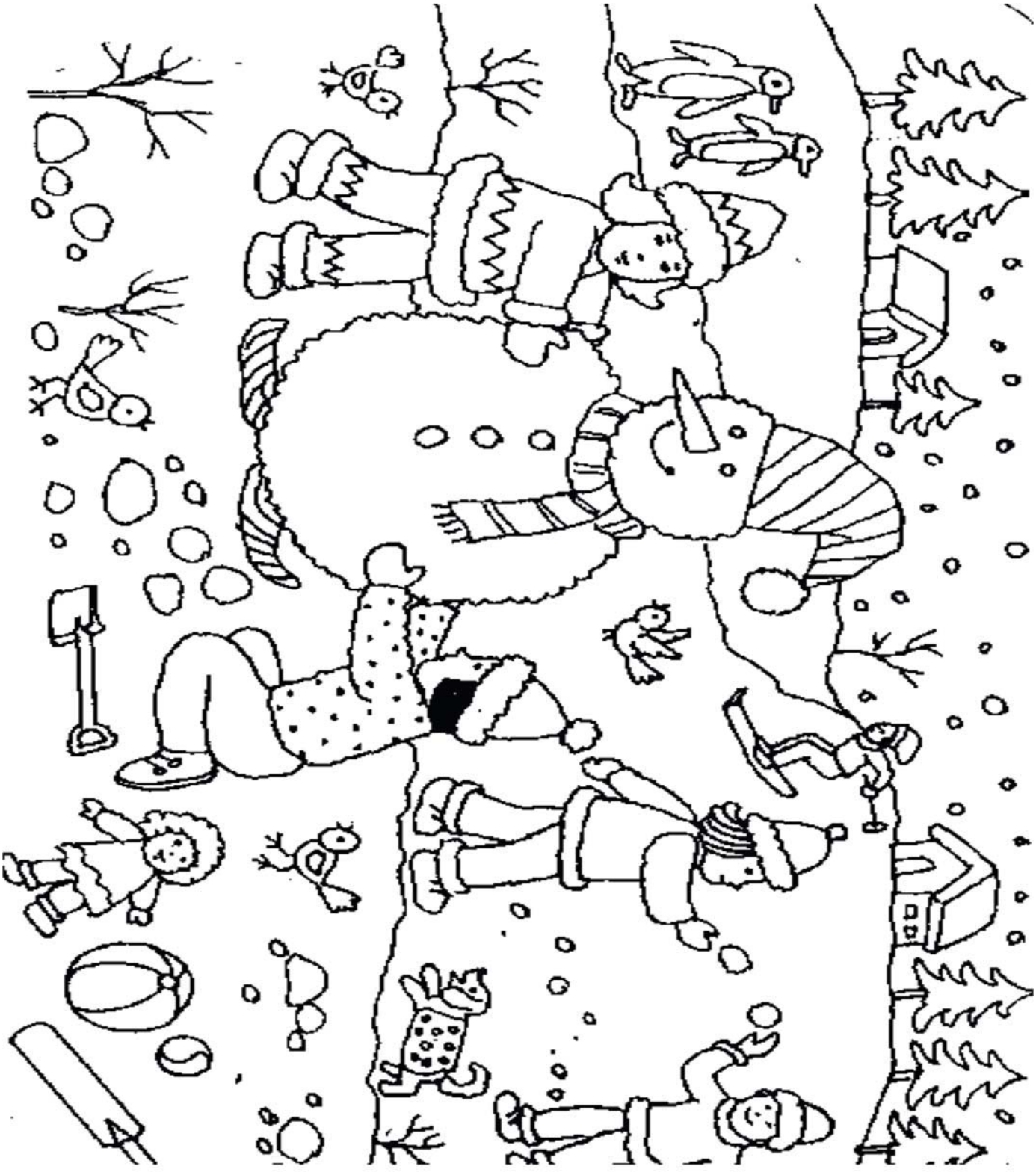
Now, the parts are all still there, but they coexist. "We are not one, but we all agree to live harmoniously together," says Melanie. "Which works well most of the time."

Emma Young is an award-winning science and health journalist and the author of Sane: How I shaped up my mind, improved my mental strength, and found calm. A former reporter and editor for New Scientist, working in London and Sydney, she now freelances from an attic in Sheffield. As E L Young (in the UK, Emma in the USA), she is also the author of the STORM series of science-based thrillers for kids.

"...women with DID were no more fantasy-prone, suggestible or likely to generate false memories than those without a diagnosis.."

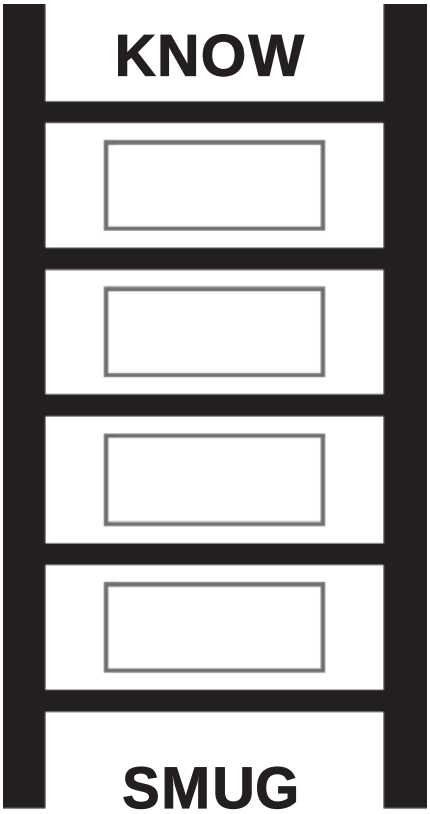
PLAY

A Picture to Colour



CENTRE

WORDLADDER



Climb the ladder from SMUG to KNOW by changing just one letter on each rung to make a new four letter word

Possible answer to WORD LADDER:
SMUG,SNUG,SNUB,SNOB,SNOW,KNOW

Mince Pies Recipe

ask a big person for help with using the oven

350g plain flour
100g caster sugar
225g butter (cold)
300g mincemeat
a pinch of salt
1 egg (for brushing)
Icing sugar (to sieve over at end)

⇒ Pre heat the oven to 180C or 355F or Gas Mark 4

⇒ Put the flour in a large mixing bowl

⇒ Cut the butter into small squares and add to the flour.

⇒ Rub the flour and butter together using your fingertips and thumbs until there are no obviously large bits of butter left and you have a breadcrumb consistency

⇒ Add the caster sugar and salt to the bowl and bring the pastry together into a ball - this might take a while, don't be tempted to add any liquid

⇒ Once it's together in a ball, knead for a short time

⇒ Rub some butter into a 12 hole bun tin

⇒ Take ping-pong sized balls of pastry and press them into each hole. Remember to leave some pastry to make lids.

⇒ Spoon a dollop of mincemeat into each pie

⇒ Take a smaller quantity of pastry and flatten in your hands and cover each pie with this lid

⇒ Beat the egg and brush the top of the pies - this will help them go a lovely golden colour

⇒ Bake for about 20 minutes.

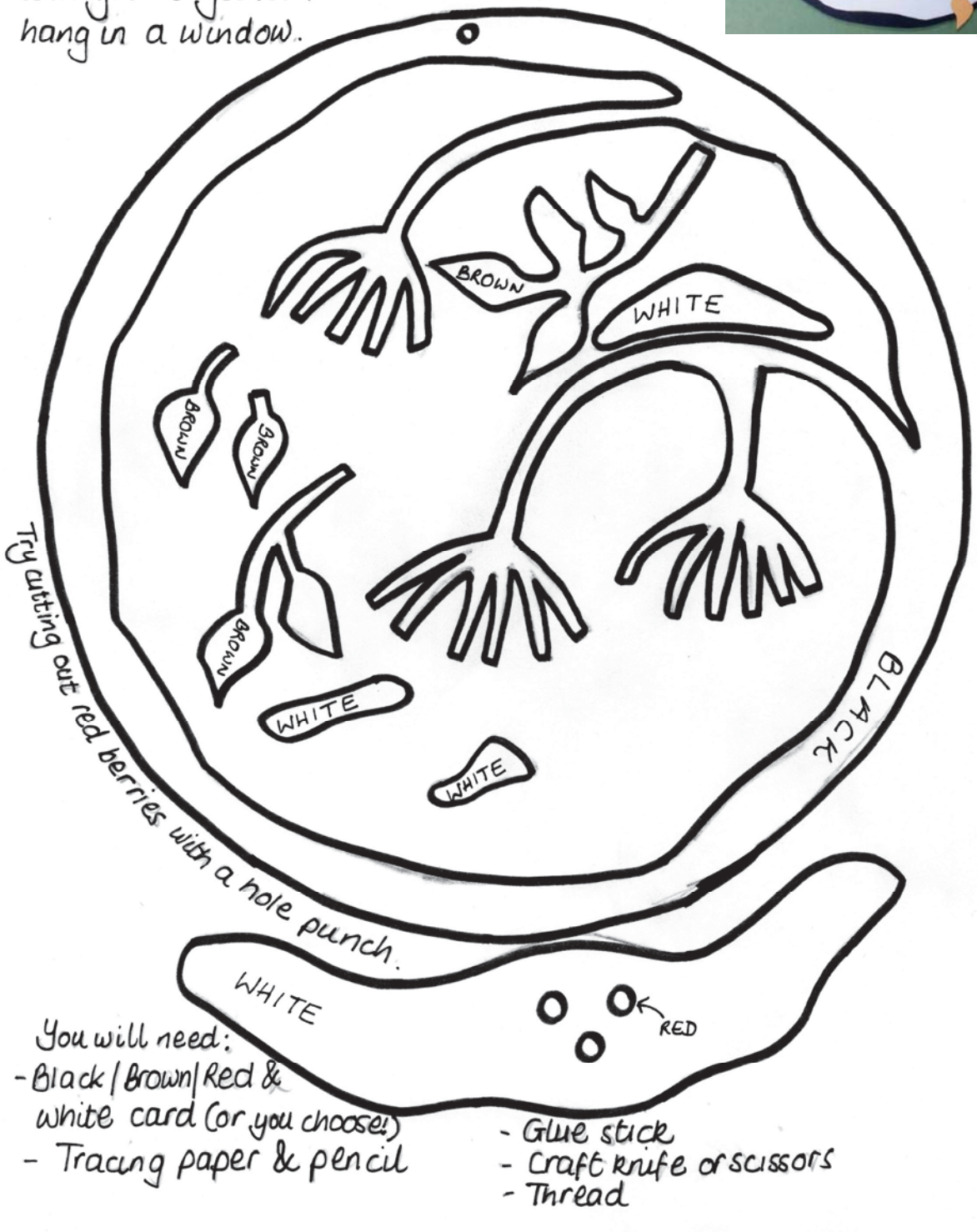
⇒ Once you've taken them out of the over and left to cool for 5-10 minutes you should take the pies out of the tin and place them on a wire rack to cool completely

⇒ Just before you plate up, dust the pies with icing sugar.

⇒ Enjoy!

WINTER WINDOW DECORATION

Use the template to trace the parts onto coloured card. Carefully cut out and glue together. Insert thread and hang in a window.

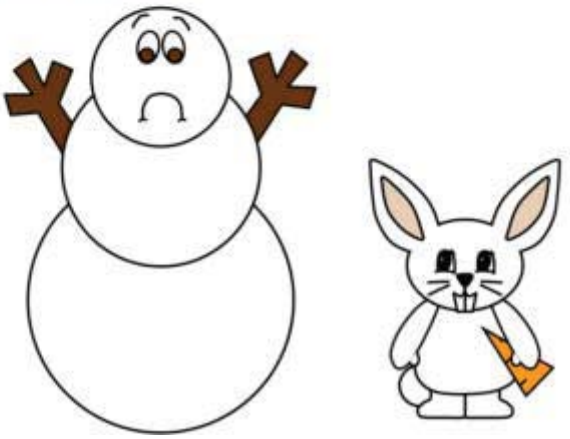


Try cutting out red berries with a hole punch.

You will need:
- Black / Brown / Red & white card (or you choose!)
- Tracing paper & pencil
- Glue stick
- Craft knife or scissors
- Thread

Chubby Snowman

There was a chubby snowman
And he had a carrot nose
(put fist to nose like carrot)
Along came a bunny
(2 fingers up for ears)
And what do you suppose
(hands on hips)
The hungry little bunny
(rub tummy)
Was looking for his lunch
(hand to forehead, looking)
He grabbed that snowman's carrot nose
NIBBLE! NIBBLE! CRUNCH!!
(Pretend to eat carrot)



Snow Kisses

If you go out when it's snowing
And look up to the sky
You'll feel lots of safe kisses
As the snowflakes flutter by

"May Light always surround you;
Hope kindle and rebound you.
May your Hurts turn to Healing;
Your Heart embrace Feeling.
May Wounds become Wisdom;
Every Kindness a Prism.
May Laughter infect you;
Your Passion resurrect you.
May Goodness inspire
your Deepest Desires.
Through all that you Reach For,
May your arms Never Tire."

— D. Simone

"I hope that in this year to come, you make mistakes.

Because if you are making mistakes, then you are making new things, trying new things, learning, living, pushing yourself, changing yourself, changing your world. You're doing things you've never done before, and more importantly, you're Doing Something.

So that's my wish for you, and all of us, and my wish for myself. Make New Mistakes. Make glorious, amazing mistakes. Make mistakes nobody's ever made before. Don't freeze, don't stop, don't worry that it isn't good enough, or it isn't perfect, whatever it is: art, or love, or work or family or life.

Whatever it is you're scared of doing, Do it.

Make your mistakes, next year and forever."

— Neil Gaiman

Summary Research Report

by Michele

I am a person living with DID and have recently undertaken some research exploring the controversy and misdiagnosis surrounding the disorder as part of a FdA Counselling Studies degree. I thought it might be of interest to 'Rainbow's End' readers to share the results of my research given that it revealed discrepancies between what the participants living with DID and the clinicians treating it stated. The research was small scale and limited to 5,500 words which, given the breadth and depth of the subject, proved restrictive.

An unanticipated finding was the unanimous accordance by clinicians that DID exists. No clinician referred a DID patient because they did not believe in the disorder.

54% of people living with DID affirmed that the disorder had been validated by the medical profession in contrast to 46% who stated to the contrary. Furthermore, 70% of DID participants strongly agreed and 30% agreed that DID was a controversial disorder. This consensus of opinion was shared by interviewee and attachment based psychotherapist, Sue Richardson who stated that it is a...

> *'result of the same social & political context which has kept child sexual abuse hidden along with the backlash and controversy deliberately created by false memory groups & those who may have a vested interest. The backlash plays into what people would prefer to believe'.*

"...65% of clinicians who were confident in recognising the symptoms of DID . .."

Interestingly, despite such indication of doubt and controversy, the majority of DID participants stated that the trauma preceding their diagnosis was believed by clinicians treating them. Further, 80% of clinicians asserted that DID is consistent with a trauma model and 20% claimed its consistency with a socio cognitive model.

All of the participants living with DID were receiving treatment, 40% were receiving private treatment, 10 percent were on medication and 50% were receiving NHS treatment. 85% of clinicians reported experience in the dissociative field compared to 15% who had none, a finding supported by 75% of clinicians who had not felt the necessity to refer a client with DID to another clinician due to deficiency of skill compared to 25% who had. These findings were further supported by 65% of clinicians who were confident in recognising the symptoms of DID compared to 8% who were not and 27% who were able to do so with some confidence.

Likewise, 57% were able to identify the five dissociative disorders on the dissociative spectrum compared to 31% who could not and 12% who were unsure.

Despite this apparent proficiency in the field, diagnosis was delayed with 45 percent of sufferers being diagnosed within 0-10 years; 11 percent being diagnosed within 11 to 20 years; 11 percent being diagnosed between 21 to 30 years; 0 percent between 31-40 years; 11 percent between 41-50 years and 22 percent receiving no formal diagnosis, a finding that was anticipated due to secondary research supporting controversy surrounding DID and its misdiagnosis.

In exploring whether delay in diagnosis was attributable to a lack of awareness of the screening instruments employed to diagnose DID, an unexpected, modest 18% of clinicians stated no awareness compared to 82% who were aware. However, despite the majority of participants being aware of these screening instruments, only 25% expressed proficiency in using them compared to 75% who didn't, an anticipated result due to the prevalence of misdiagnosis. These findings were echoed by Sue Richardson who stated:

> 'DID is not often considered as part of a differential diagnosis due to lack of training & accurate screening & assessment. And it takes time for a paradigm shift to take place to trauma-orientated practice'.

"...result was unanticipated as my presumption had been that most people with DID self-diagnosed due to prolific misdiagnosis..."

However, despite this lack of proficiency in applying the screening & diagnostic instruments, 40% of sufferers had been assessed using the DES, 10% DES Taxon, 30% SCID-D and 20% had received no assessment. This result was unanticipated as my presumption had been that most people with DID self-diagnosed due to prolific misdiagnosis.

In addressing the efficiency of assessment instruments DID participants' responses were mixed. 2 stated all screening instruments were efficient, 2 supported the assertion that the SCID-D is the most proficient at diagnosis, 1 remarked that the DES does not account for the transitory nature of symptoms and 1 remarked that they were not really efficient. Exploring a similar question with clinicians the overwhelming majority (12 participants) asserted that the screening instruments were a useful tool in identification but not in diagnosis. However, interviewee, Dr. Colin. A. Ross of the Colin A. Ross Institute in Dallas disagreed. He stated:

> 'The DES, DDIS, MID and SCID-D are all valid and reliable measures for diagnosing dissociative disorders. The problem is that most clinicians and researchers don't use them. Most clinicians don't use any kinds of scales or measures in their practices'.

Only 3 clinicians commented on the diagnostic reliability of the SCID-D. 1 clinician commented that the SCID-D needs updating in line with DSM-V and that it would be beneficial if there was a similar instrument to reflect the ICD-11 codes when they are published.

One unanticipated finding was the affirmation by 59% clinicians who stated that they would be able to clearly distinguish DID from schizophrenia, borderline personality disorder and bipolar compared to 14% who stated they would not, 9% who professed some confidence and 18% who declared they did not believe in a label. These findings run contrary to the experiences of most DID participants, 70% of whom were misdiagnosed. 60% of these received a misdiagnosis of borderline personality disorder, 30% schizophrenia and 10% bipolar. These findings were anticipated and supported in secondary research.

In questioning whether the clinicians had admitted to misdiagnosing a client, 33% stated they had, 27% stated they had not and 40% were unsure. Interviewee Dr. Colin A. Ross remarked:

'DID and BPD overlap a great deal and commonly co-occur – the problem is that most clinicians who diagnose BPD do not recognize the DID. The symptoms of DID and schizophrenia also overlap a lot – the DSM-5 criteria, structured interviews and self-report measures of psychosis cannot differentiate psychosis from dissociation very well. People with DID on average report more first-rank symptoms of schizophrenia than people with schizophrenia in multiple studies'.

"...findings run contrary to the experiences of most DID participants, 70% of whom were misdiagnosed.. .."

In determining whether misdiagnosis is attributable to lack of training in the subject at primary qualification level for the clinicians, 45% stated they had received training and 55% stated to the contrary. This result was anticipated although the percentage for those who stated they had received training was higher than expected. In questioning whether insufficient training is responsible for misdiagnosis, interviewee Dr. Colin. A. Ross opines

'this is the major factor' whilst interviewee Sue Richardson states it is

'very significant – especially being taught that it is rare & not having training in assessment'.

Both Dr. Colin A. Ross and Sue Richardson allude to the fact that clinicians are taught that DID is rare yet a significant 59% of clinicians affirmed their awareness of the global proliferation of DID, compared to 23% who were not aware and 18% who were somewhat aware. All participants thought that DID was a treatable disorder. With regard to whether DID is curable, 40% believed it was; 30 percent believed it wasn't and 30 percent were unsure.

When reviewing this research, it is important to recognise that it is very small scale and measured against studies that are not current. However, its findings suggest, there have been some changes in the past thirty years albeit small that merit further investigation. The findings surrounding the controversy and misdiagnosis of DID are significant in that although the issues inherent in its presentation remain evident, changes are occurring. These are most notable with respect to its validity, knowledge of its symptomatology and aetiology, and recognition that it is a global phenomenon. Lastly, it is interesting that there appears to be an evolving expertise in distinguishing between DID and the Axis I disorders bipolar and schizophrenia and Axis II borderline personality disorder. Further research is needed to address why screening instruments remain a controversial means of assessment and diagnosis and clinicians are ill-equipped to implement them.

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Ross, C. A. (1987). 'Inpatient treatment of multiple personality disorder', *Canadian Journal of Psychiatry,* 32, 779-781.

Ellason, J.W., and Ross, C.A. (1995). 'Positive and Negative Symptoms in Dissociative Identity Disorder and Schizophrenia: A Comparative Analysis', *The Journal of Nervous and Mental Disease*, 183 (4), 236-241.

Ross, C.A. & Norton, G.R. (1989b). Suicide and parasuicide in multiple personality disorder, *Psychiatry*, 40 (2), 186-188.

Ross, C.A. (1990c). Comment on Garcia's 'The concept of dissociation and conversion in the new ICD-10', *Dissociation*, 3, 211-213.

"...there appears to be an evolving expertise in distinguishing between DID and the Axis I disorders bipolar and schizophrenia and Axis II borderline personality disorder. ….."

Speaking Out for Change *by Sarah Lake*

Sarah Lake was asked to present as an expert by experience at a conference 'Creativity in co-production: Celebrating and inspiring collaboration between clinical psychologists and people with lived experience of mental health problems' organised by British Psychological Society.

My initial experience of DID was extremely frightening- I couldn't stop vomiting and had severe abdominal pain. Vertigo appeared from nowhere, I was experiencing voices and strange visual distortions, I couldn't remember what I had been doing or saying and when I went out I would often become disorientated. I felt as if I had lost control of my thought processes and that my body no longer belonged to me.

My family told me my behaviour was erratic. Whilst undertaking a degree that was relevant to my work as a family support worker, a module focusing on domestic violence and child abuse suddenly catapulted me back into past experiences and opened up a Pandora's Box of voices and other parts clamouring to have their say.

My GP referred me to the wellbeing service and it was here that my journey into the world of mental health began…Like Alice falling down the rabbit hole; I have met some amazing people and some people that have added to my sense of shame, bewilderment and confusion. My referral to a counselling centre was fortuitous; The director of the centre is knowledgeable in the area of trauma and dissociation. During the ensuing months she supported me to begin to identify significant events in my past and recognise the impact they were suddenly having; helped me to understand my experience and supported me to work towards regaining some sense of myself as a valuable person. Without her I fear I would have become completely lost.

She supported me throughout my assessment and diagnosis at the Pottergate Centre for Trauma and Dissociation. The assessment validated my experience and I felt so relieved. The process felt calm and was carried out at a pace that I could cope with. My GP was sceptical however, questioned my diagnosis and asked for a second opinion, referring me to my local mental health hospital. I began to feel like a fraud but I knew I wasn't making it up- why would I put myself through all this for some silly act of make believe? This GP later said to me that I would get better when I wanted to.

"….I have met some amazing people and some people that have added to my sense of shame, bewilderment and confusion.."

My assessment with a psychiatrist at the hospital was in stark contrast to my assessment at the Pottergate Centre. I was asked to recount traumatic events in a short period of time which felt re-traumatising; I was not given enough time to recover before the end of the session. I felt disorientated and unstable as I left my appointment. As part of this assessment I had a visit from the outreach team. Despite my best efforts I spent all night beforehand scrubbing my house because a very socially anxious part took over. When the nurse arrived she commented that my house was clean and tidy which was an indicator that I was coping well and I didn't need another visit. She didn't ask me any questions that would have helped me communicate my daily struggle with different parts and how they were taking over my life. Following this visit I spent days in bed feeling hopeless and struggling with the sense that I was disappearing.

My experience of the mental health system has been that it is chaotic and lacking in communication. I have been pushed from one team to another, forcing me to use several appointments to get yet another

mental health worker up to speed, resulting in the fact that I have spent four years showing that I am engaging rather than accessing the support I need.

In an effort to regain some control over my life I enrolled in Recovery College and applied for the Peer Support programme. I felt that maybe I could put my previous professional experience to good use and it might be a positive step forward. During my placement a team member made derisory comments, following an appointment with a service user. She knew that I was a service user myself. I found this incident both traumatic and triggering. Disillusioned by the worker's attitude to the people in her care, I was unable to complete the course. I understand the need for humour in managing adverse situations but this worker was inappropriate and unkind. It left me thinking why does she work here?

Since then I have felt coerced into taking anti-psychotic medication by being told that if I didn't co-operate there is nothing else to help me, even though there is no indication that these medications help the symptoms of DID. Because of this I suffered a horrible six months of being in an automaton like state followed by months of trying to cope with the fallout from parts that had been suppressed and unable to communicate. I was made to feel as if I wasn't trying hard enough when I complained that I didn't think this medication was helping me.

"...because I see a therapist I am not considered a priority by the NHS but there are limitations to what therapy can offer....."

At no point has anyone contacted my therapist to discuss my wellbeing or to gain insight into my condition, even though she is clearly on my contacts list and has been the one constant professional person in my life. The NHS staff I have encountered have taken me at face value during my appointments- I have adult high functioning parts- no one has ever explored the difficulties I face managing my traumatised child parts or some of the frightening parts, how they affect my daily life, my sleep patterns or my mood or what they need in order to feel safe or manageable.

At no point has there been any exploration of alternative support that might be available. Looking at some basic needs around managing my social anxiety and isolation would have been really helpful because this condition strips you of what you previously believed to be true about yourself and leaves you floundering. I feel that because I see a therapist I am not considered a priority by the NHS but there are limitations to what therapy can offer me; it cannot help me monitor medication or offer me a place of safety if I am feeling suicidal.

The therapy I receive is something I have to pay for and is a massive financial commitment at a time when I have lost my income because of my mental health. For the vast majority of people with DID, access to long term therapy is impossible because of the costs involved.

I am hoping that in becoming part of my local NHS focus group, mental health services can begin to move towards a greater understanding of the needs of people affected by DID and how to implement treatment. At the end of the day we are a group of people that have been traumatised and need support over time to regain our sense of trust and involvement with others. Being part of the focus group has enabled me to meet with professional people on an equal footing to discuss some of the difficulties we have encountered and our hopes for the future.

It has also helped me to think about the services we need. DID is a developmental disorder and I think a much more holistic approach needs to be taken towards us. Greater collaboration between the NHS and the voluntary sector is crucial to gain a greater understanding and to provide a knowledgeable support network. Long term therapy is needed to address disorganised attachment patterns and subsequent behavioural needs. It is important to recognise that different parts often have conflicting needs and emotions. Art or play therapy for child parts, carefully included as part of the therapeutic journey, might be a big step forward to alleviating the pain of parts stuck in a traumatic past. A specialist clinic for trauma related mental health problems would give people the chance to access professional expertise in a supportive environment.

"...DID is not something that can be addressed quickly; it takes time to unravel, understand and treat. . .."

That takes me to the obstacle in accessing the treatment we need. Lack of funding dictates that teams are working on empty trying to address complex needs. Time constraints add to individual pressure and create an atmosphere of stress and negativity which is then passed onto people trying to access services. DID is not something that can be addressed quickly; it takes time to unravel, understand and treat. In the current financial climate, I am not sure that the statutory sector is equipped to meet the needs of this group of vulnerable people. I hope that will change in the future

Independent Inquiry into Child Sexual Abuse - The Truth Project

Representatives from First Person Plural attended a meeting organised by The Survivors Trust to enable up to date feedback that could be disseminated to those who are considering contributing their experiences to The Trust Project.

If you feel you might be able to become involved we would encourage you first to read through the online information at the IICSA website and talk with your therapist / others who you trust.

Why talk to the Truth Project?

- At this relatively early stage of The Truth Project complex dissociation, DID is not receiving the recognition that we know it should
- As part of the final report there will be further recommendations as to the gaps in resources available for all victims of childhood abuse, this is an opportunity for those with DID to speak out about the lack of understanding and therapeutic help available for them.
- It will help us to gain better recognition
- The more people with DID who speak to the Truth Project the more likely it is that recommendations relevant to us will be made

"...We want to be as inclusive as possible in our Truth Project. ....."

Who is eligible?

- Anyone who was sexually abused as a child in an institutional setting like a care home, a school, a hospital or a religious, voluntary or state organisation including the military
- Anyone who first came into contact with their abuser in an institutional setting
- *Anyone who was sexually abused as a child and reported their sexual abuse at any time to a person in authority for example a police officer, a social worker or a teacher where the report was either ignored or not acted on properly*

At the meeting our representatives heard that **this last eligibility category is intended to be wider than might initially appear.** For instance, did you disclose the abuse as a child or adult to a doctor, mental health worker or similar and was your disclosure ignored, inappropriately never referred to again or dismissed as irrelevant to your presenting problem.

Did this lack of attention to your disclosure result in you receiving unhelpful or inappropriate diagnosis, treatment or care;; treatment or care that was unnecessarily re-traumatising? Did it mean that the abuse continued despite your disclosure? The key is whether someone in authority while working for an organisation who owed you a duty of care failed to protect you when you either directly disclosed or showed signs of abuse. The IICSA website states "We want to be as inclusive as possible in our Truth Project. If you want to share your experience, but are not sure whether this is within the scope of the Inquiry, please contact us *(i.e. IICSA)* so that we can advise you."

What support is available?

- Your own support person can be with you at every stage of this process
- You will also be assigned a trained inquiry support person
- If you wish they will support you before, during and after you make your statement
- They will be in a supportive role throughout their time with you not as a therapist

FPP knows how hard this whole process will be for every single person who decides to do it. We hope it will also be empowering to know you will be heard in a non-judgemental, fully accepting, supported environment and that your statement could help to change things for the better.

For full details: -

https://www.iicsa.org.uk/victims-and-survivors/how-share-your-experience

"….The key is whether someone in authority while working for an organisation who owed you a duty of care failed to protect you. .."

Contact the Inquiry Team

If you wish to ask a question about the Inquiry or if you have information to support our investigations please get in touch:

Call our Information line on 0800 917 1000.
Open weekdays 8am-8pm, Saturdays 10am-12pm
Calls are free and do not show on your bill.

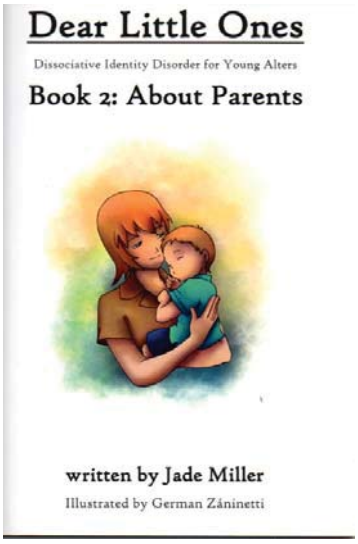
Email us: share@iicsa.org.uk

Write to PO Box 72289, London, SW1P 9LF and pay for postage

We aim to respond to all calls, emails and letters within 15 working days.

Book Review *by Kathryn*

"Dear Little Ones - Book 2 : About Parents" - Jade Miller



This short book is a follow on to Jade Miller's original "Dear Little Ones". It is written for her young alters and uses language that little ones will understand. Beautifully illustrated by German Zaninetti it talks honestly and gently about when parents don't know how to love their children or choose not to protect them or even hurt their children.

Wonderfully written uses simple words and short sentences, it is designed to help inside little ones to understand and work through the feelings they may have as a consequence of not being loved in the way they needed to be. It suggests how young alters can love and be loved by other parts inside, so everyone feels better and less empty and hurting.

"...written for her young alters and uses language that little ones will understand..."

Christmas isn't Merry for Everyone
Suggestions for Coping

- Be kind to yourself - It's OK to have sad, angry or disappointed feelings about Christmas and what it brings up for you.
- Don't succumb to catastrophic thinking: Just because it's like this now, doesn't mean it always has to be; What are you in control of? What could be different? What resources do you have?
- Look after yourself: Watch alcohol consumption, try and eat healthy food, get enough sleep, sunlight and exercise.
- Watch your triggers: Think about what may feel difficult for you from past experiences and devise ways to manage your response.
- Remember you're not alone: It may look like others are having a great time, but many are coping with difficulties of their own; what you see is not always the whole story.

The above request is included in this issue after Dawn from the production company consulted First Person Plural and spent some time talking with Melanie about her ideas; and learning about DID and related matters from Melanie, including FPP's ethos of non-exploitation, and non-sensationalism of people with DID by the media and press. None-the-less we publish the flyer for information only, not as a recommendation. Individuals who think they may like to be involved should contact Crackit Productions direct. We advise that before doing so you read FPP's online guidelines for speaking to the press/media at http://www.firstpersonplural.org.uk/news-media/press-guidelines and talk it over with someone you trust.

"...FPP's ethos of non - exploitation, and non-sensationalism of people with DID by the media and press. .."

First Person Plural : dissociative identity disorders association
Charity Registration Number : 1056602 (formerly 1109464)

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Next issue published Feb 2017
Contributions can be sent anytime

Guidance for contributors:- Without contributions there can be no newsletter. Contributions can be sent in at anytime, It's less work for us if you can send by email to newsletter@firstpersonplural.org.uk. (but sending by post is ok too). We want your stories, resources, personal experiences, articles, coping/survival tips, poems, snippets, puzzles, jokes for the Play Centre, attributed quotes, artwork, incl. photographs. If contributions are your own work we will assume that by sending them in for consideration for inclusion in Rainbows End you are giving us permission to publish. If not your own work, you must declare it is copyright-free or be accompanied by the author/artist's permission for us to publish. Articles should usually be between 500 and 1500 words. Wish to contribute a longer article? Contact us first to discuss. Other written material can be shorter than 500 words. Pictures & photos must be smaller than A4. We can only use images that will not lose detail when commercially printed but if you are not sure please send in anyway and we will do the checks. Send an SAE if you want original returned.

About this publication

Rainbow's End is an information and mutual support newsletter for FPP members, back issues are also available for viewing by anyone visiting the FPP website. It is not a substitute for individual therapy or professional supervision, nor is it a replacement for other networks of support. Unless specified contents do not necessarily reflect the views, opinions or endorsement of the charity, its trustees or the editor.

My Dear Friend..... *By Lesley*

You were the one who stuck by me when, many years ago I dodged the diagnosis labels, scattered freely and liberally by professionals; the insults hurled by people who should have known better; the whispers in social circles. You accepted me as me, whoever I was at that moment. Neither of us understood but that didn't matter to you. You kept me grounded; turned nightmare psychiatric assessments and confinements into adventures.

"Oh cocktails!" you declared one evening, as a nurse entered my room with a tray of drugs. We laughed when it should have been inappropriate to do so, we cried for no obvious reason. Our friendship endured life's storms – from the intensity of those first few years, to the dilution of us both moving to different parts of the county. Yours is the name I can shout at my saboteur when I hear the words "You won't ever have any friends. They will always leave you. You are high maintenance .."

Now we are both older, and you my dear friend are frail and forgetful. I find the words you cannot remember, hold your hand as we walk through the park. I listen to your worries of being invisible to your family who have your best interests at heart but don't know you. I want to help you but I don't know how. All I can do is reassure you that right at this moment you are doing okay. I can distract you with amusing stories and anecdotes. You taught me well.

Now should be my time to look after you, but I am not your family and they don't know me as you do. Our remaining time together is short. One day soon you will not remember me, but I shall never forget you.