MANY VOICES

WORDS OF HOPE FOR PEOPLE RECOVERING FROM TRAUMA & DISSOCIATION

Vol XVII, No. 5 October 2005 ISSN 1042-2277

In This Issue:

Inpatient or Outpatient?

PLUS: Therapist's Page on Art Therapy



In the Hospital

I have DID right now i'm in a hospital again i've been here before for months upon months this time though only two weeks and i'm leaving in four days each and every time i'm here i/we learn new things about ourselves we put together more and more pieces of the puzzle the puzzle that we are

i have DID
hospitalizations no longer
scare us
they strengthen us
they help us become
a beautiful picture puzzle
one we actually
like
to look at

By SJS

M٧

Many Voices (ISSN1042-2277) is published bi-monthly at Cincinnati, Ohio Copyright 2005 by MV Co. All rights reserved. Editor/Publisher Lynn W. Send subscriptions manuscripts and correspondence to PO. Box 2639, Cincinnati.OH 45201-2639. Phone (513)751-8020. Email, LynnWire manyvoicespress.com. U.S. subscriptions. \$36 yr Canada. \$42US. Elsewhere, \$48US. This publication is designed as an information exchange for treatment providers and survivors of trauma and dissociative disorders. Neither its editor nor its layperson contributors are engaged in the practice of medicine. This publication should not be construed as medical advice concerning any specific facts or circumstances. The contents are for general information purposes only. Please consult with competent professionals concerning your specific questions.

Being Invisible

By Vicki et al et al

eing invisible is not being seen...it is a protective defensive position that I have taken since I was little. When I was little I would just hide so no one would find me. I would get away from all the yelling and screaming. I would curl up in a ball and make myself as small as possible....so I couldn't be found...or seen...and I learned to stay very quiet. We have littles that can do that now...they curl up and make themselves very small, even in the big body, but they know they cannot be seen. Or we used to put a blanket over our head and then no one would see us...we couldn't see anyone else so we knew no one could see up either...it is like hiding.

We can be invisible by dissociating.....going away to someplace else in our mind or switching from one person to another. These are usually little ones.....one will take over for another and then we don't remember what was said....it is like we are not there.....sometimes we stare off is space or just go away. We don't always know where we have gone....it is like lost time...but we know we have been away for a while.....and there are things that we have missed.

Being invisible is looking straight ahead and NOT looking at

anyone...we think if we don't look at anyone they won't see us. We do that a lot now....when bigger. We don't look someone in the eye...so we think they cannot see us....it is a pretend game we play with ourselves. Being invisible is hiding in the house and isolating and not talking to anyone and staring off into space, like a trance. We use our body a lot to be invisible...we tuck ourselves in and make our self very small.....we sit up on the chair with our knees grasped and our chest rounded and our head tucked in....almost like a ball.....and we get very small so no one can see us....and we cannot see anyone else.

One key is not having others see you....we do that by being very quiet, not making eye contact.....looking away and just pretending we are not there. We are good at this...it is easy for us to do.

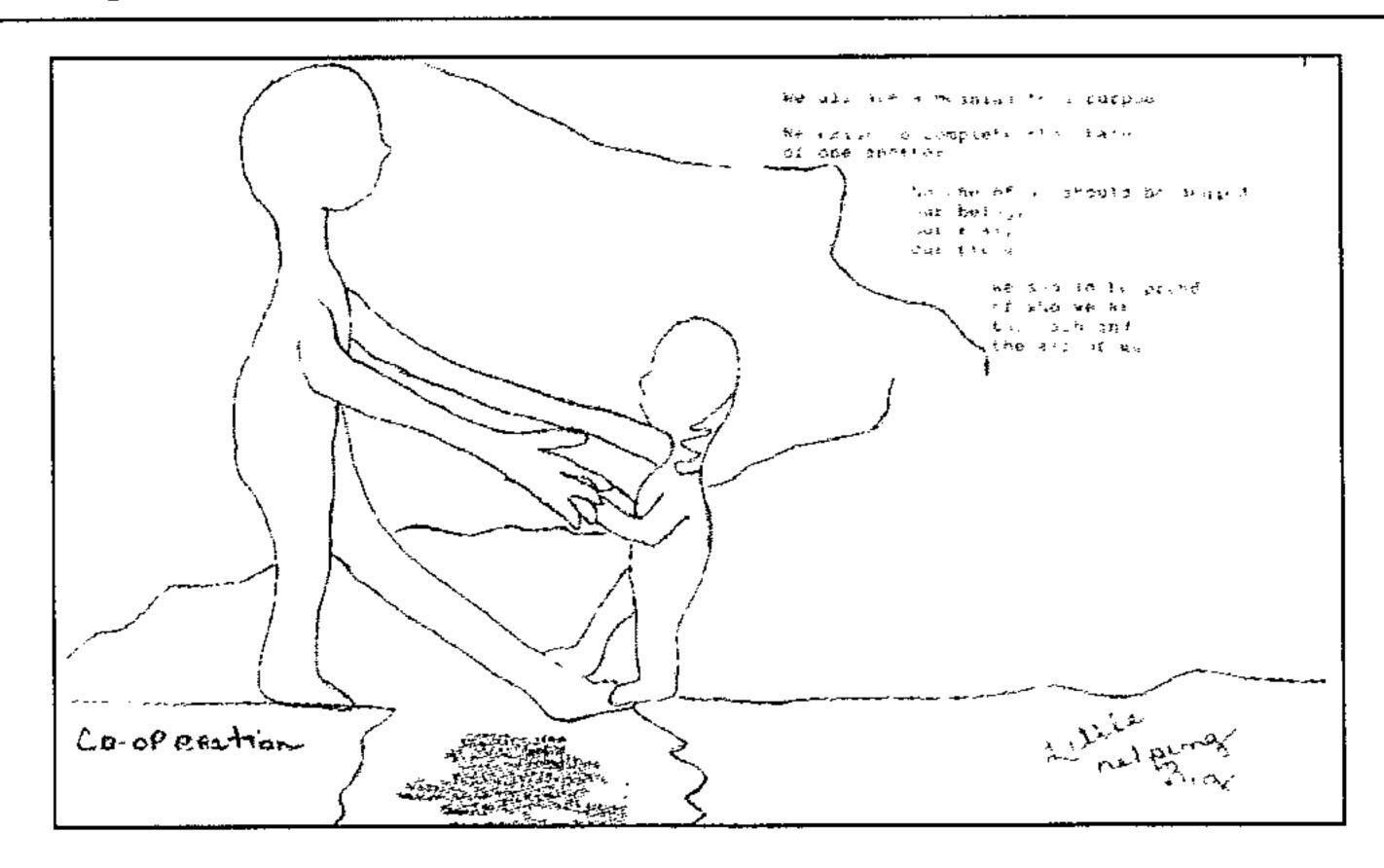
We wanted to be invisible when we were little so we wouldn't get hurt by daddy or mommy either. When they yelled we just were silent...meaning we were really scared. We didn't know what would happen next...and if we were invisible nothing could happen to us....we would be protected from the bad things. We would lay very still in the bed and not move and pretend we were asleep so daddy would not

bother us, but he did anyway.

We still think that now...in our head. One place that we are invisible is the Temple....we pretend to be invisible there because we don't know all the prayers... if we stare ahead we feel that no one can see us. We know this isn't true, but we pretend it is true. Another place we can be invisible is group, especially when someone does anger work with the red bat.....we don't like the red bat...it scares us...cause we think we are going to be hurt. And we are not sure Donna and Mike can protect us....so we hide behind a pillow, we cover our ears, we stare off in space....and we basically go away and are invisible. It helps to protect us and keep us safe.

Being invisible means being safe...it is protected from the bad things in the world...from the hurts and the pain...when we are invisible we don't feel...we are numb or we just feel nothing. It is sort of a state of suspended animation where nothing bad can happen...and we are protected from all evil and bad...and hurt. It is safety and security when no one can see you...and you cannot see anyone else either.





Tragedy on the Gulf

Iknow I speak for all MV subscribers in expressing our grief for those who were battered by Hurricane Katrina a few weeks ago. The death toll in Mississippi, Alabama and Louisiana is unknown as I write here, but sure to be far, far more than it should have been. We know that the people at River Oaks Hospital in Louisiana are OK...both staff and clients. But there are many others from the MV family, past and present, whose situation remains unknown. If any of you have information, please send it here.

Traumatic events like Hurricane Katrina take a toll on all of us...especially those of us who are a bit 'on the edge' anyway. Emotional outbursts, sleeping problems, depression—all these are probably pretty normal for such an incredibly-stressful time. We need to be gentle with ourselves and others until the situation stabilizes – which could be weeks, months, or years depending on how directly you and your loved ones were affected.

Most of us who were not in the hurricane zone want to help—but may not know where to start. Donations of money are certainly needed and will be needed for a long time (tho choose your charity wisely.) MV subscribers who don't have extra funds to donate to the Red Cross or Salvation Army might consider donating usable clothes or possibly some time to your local shelter. Whatever you can do to help stabilize the community nearest you will help calm this wounded nation. So give what you can in time, material or even prayer.

If some of you want to write or draw out your feelings or experiences of this event, we would like to give you a place to share them. Just send your creative work to Many Voices, PO Box 2639, Cincinnati, OH 45201. Non-subscribers will receive a free copy of the issue their work appears in.

I only wish there was a way to gather the caring feelings of all associated with MV, and send it in a giant bundle to those who suffer. Peace be with you all.

Lynn W., Editor

MANY THANKS TO OUR FRIENDS!

Del Amo Hospital - Torrance, CA

Call Francis Galura: (310) 784-2289 or (800) 533-5266

River Oaks Hospital - New Orleans, LA

Call Martha Bujanda: (504) 734-1740 or (800) 366-1740

Sheppard Pratt Health System - Baltimore, MD

Call Kimberly Colbert: (410) 938-5078 or (800) 627-0330 x5078

Timberlawn Mental Health System - Dallas, TX

Call Tamara Jones: (214) 381-7181 or (800) 426-4944

Two Rivers Psychiatric Hospital - Kansas City, MO Call David Tate: (816) 356-5688 or (800) 225-8577

Women's Institute for Incorporation Therapy - Hollywood, FL

Call Larry Spinosa: (800) 437-5478

These organizations are not affiliated with this publication and have no control over its contents. Many Voices and its staff have no influence on their operations.

If you know of clinics or conferences that need flyers, please call us!

We received so much great response to this special issue on hospitalization, some pieces will appear in our December issue. Look for more info then! - Lynn W., Editor

BEST THERAPY FOR US: A SAFE CUDDLE



LUCILLE

The Importance of Familiar Faces and Spaces

By Kimberley D. Bertrand

have been placed in inpatient settings about fifteen times both before and after my diagnosis of MPD (or DID). I have never found the hospitals helpful. Most times I have helped myself to get better, and it was not the doctors, therapists, and social workers that guided me to a healthier path.

I am one of those Multiples who have used self-injury, ie, cutting, as a way of dealing with many feelings and emotions that were very confusing and scary to me. Because of these actions, many people who loved me or were responsible for my safety would feel scared and place me in the mental health unit or state hospital. I understand their fear, and sometimes it was justly placed. However, an inpatient setting may not be appropriate for Multiples for many reasons.

I have been in very few hospitals that take the MPD diagnosis seriously. When they do, it is rare but good, though often times, the entire staff isn't educated about it. There are always a few individuals who, maybe while meaning well, have treated me as if I am lying or making up my whole situation.

I lived a life of fear for a long time where I could not trust others, could not even trust my memory at times as to what happened to me, what was real and what was not. Going into an inpatient setting was not easy. It was full of strangers who wanted me to do things I didn't want to do, and take medication I was scared to take.

Worst of all, however, they wanted me to stop "trying to be sicker than I was" because I believed I was a multiple. Because of this attitude, I was afraid to tell the doctors what was really going on inside for a long time and they just assumed I was cutting myself and going in and out of the hospital for attention, not because of any real problem. Years later, I found out that they also thought I would never get better. But I did and I have, though not from their wisdom and expertise.

I also think inpatient settings are not a good place for multiples who self-injure. Self-injury is not easily understood, and is a scary thing for those who do not do it or understand it. They immediately want to protect the person from herself and have the actions stop. Most times, self-injury is not life threatening. When it is not life threatening, the person does not need to be hospitalized.

I also find that people who selfinjure tend to be highly influenced by others who self-injure. It's easier to do it, and rationalize that it's ok when others around you are doing the same, instead of learning to talk out the feelings that are causing the urge to self-injure.

I have never found an inpatient setting that was of more help than my personal therapist and my newly created family and friends. They understand me better and support me more than strange doctors ever did. Most doctors just want to put me on more medication and already have preconceived ideas about what is wrong with me.

I think for most multiples, it is important to be around people they trust, to be around familiar faces and spaces, and to be understood and most of all, believed, by those they are living with. I have personally never had that experience in an inpatient setting. I never had that experience

with my own family, either, but as I have gotten older, gotten away from the abusive tendencies and created my own family, I have found the love, the trust and respect I not only deserve but have a human right to.

The closest situation I have had to being believed in an inpatient setting was a situation in which I feel I was exploited for being a multiple. The doctors and therapists said they believed me and continually wanted to bring out the other alter personalities instead of dealing with the main personality. This caused me to dissociate more often than I needed to and seemed to be more for their personal interest and enjoyment than for any beneficial help to me and my situation.

So for these reasons, I believe working with a good therapist and being around those who have my best interest at heart and who know me well is a better alternative than being in an inpatient setting. I have gotten stronger, gotten better and made more progress out of the hospital than I ever have in it. I would strongly encourage any multiple who is about to go into the hospital to reconsider this decision and see if other arrangements can be made.

However, if it is a life-threatening situation and you have no friends or family who have your best interest at heart, then I believe the hospital is always the best if not the only choice. If nothing else, the hospital will keep you safe, though that is probably the most it will do as well.

MV

DISCLAIMER: When our client-subscribers write about hospital experiences and their understanding of the professionals' behaviors, they are stating their own opinions, not those of MV. We have no way to verify these statements. We also have no way to verify the statements made by professionals describing their facilities and treatments, which we are including in this issue for your information. As always, MV articles are for sharing information only; no one at MV is a trained medical professional. If you as a client have concerns about some of the opinions that appear in this issue, please discuss them with your therapist.

MV October 2005 Page 5

The Women's Institute of Incorporation Therapy Why Should I choose the WIIT Program?

- * Safe
- * Small
- * Experienced
- * Well Staffed
- * Treats Only Females
- * Focused And Structured
- * Treats Only Trauma Survivors
- * Non-Traumatic By Design & Function
- * Treatment Does Not Depend On
- * Medications
- * Located In A Licensed Psychiatric Hospital
- * Accepts Most Health Insurance
- * Competitive Self Pay Rates
- * Accepts Medicare

WIIT—The Women's Institute For Incorporation Therapy—is located in the Hollywood Pavilion, Hollywood, Florida. The closest airport is Fort Lauderdale International. Amtrack and bus service both have stops in Hollywood.

The Pavilion is a two story, free standing psychiatric hospital, accredited by the Joint Commission On Accreditation of Healthcare Organizations. It's a Medicare provider and accepts most forms of health insurance. Patients are admitted under the care of a Board Certified Psychiatrist.

The WIIT Suite shares the ground floor with the Administration Offices. The entire rest of the patient population is upstairs on the second floor. A locked elevator separates WIIT from the rest of the hospital. WIIT patients are never co-mingled with any of the non-WIIT patients for any reason.

There are no time-out rooms or restraints on the WIIT unit. Neither are chemical restraints used to control our population.

There is an unlocked door onto a patio so the women can go outside and chat or smoke between scheduled functions.

William B. Tollefson, Ph.D. has been guiding and shaping this program since 1992. Our Clinical Director, Patricia Richards, LCSW, has been with Dr. Tollefson since 1995. Our therapists and techs are female. Someone is always in attendance with the women. Therapy is conducted seven days a week by specially trained masters-level therapists, not nurses or techs.

We are not a dual diagnosis program. We are not a "track" in a general psych population. We are a discreet psychological trauma program. No more than ten (10) women are together in community and group therapy. The focus is not on their symptoms but the trauma and their internal selves. So all of the communication, therapy and projects are valid for everyone and a very supportive and productive atmosphere is created.

Our goal is to stabilize our patients through education, internal healing and resolution. Since our patients need to be cognitively clear and emotionally available to themselves, we don't use Benzodiazepines or antipsychotics on our unit.

The following letter, "Searching For My Hero" by Kay V., is taken from the WIIT alumni newsletter Enlightened Choices:

"I've been in recovery from my trauma for two years now. Recovery can be an odd thing. Out of the blue I get clues to whatever has not been addressed. I am feeling my feelings. Life has been good. Something was bugging me. I mean really bugging me. I was looking for something, but what? I didn't know what to do, so I did what I do best. I wrote.

I sat down and wrote my question on a page. What am I searching for? After seven pages of possibilities, I came across my answer. It wasn't a something but a someone. Ever since I was a little girl, I have sought someone to save me. I couldn't save myself, so I needed an adult to help me. None came. I needed someone to slay my dragons, exorcise my demons and keep me safe. All fairy tales had heroes.

Back then all heroes weren't great.

The heroes I had to choose from were seriously lacking in character. Each came from a tormented background, totally dysfunctional in relationships. They were so one-sided and focused they must have been dissociative. I wanted one.

Feeling the need to continue past this quest into adulthood, I saw for the first time the people I selected as heroes let me down. First I placed them high on a pedestal. I waited for them to perform the miracle of making me a strong, confident woman. One thing about idols, they always fall down. My Dad, husband and even preachers sooner or later disappointed me. Disappointment meant they fell off the perch I placed them on and fell right on top of me. I was so careful in placing my trust that it hurt even more when my hero didn't pan out. It wasn't their fault. They didn't know they were to be heroes.

I was becoming confused because I was doing so well. For the first time in my life I had a purpose. I walked with confidence. I was still looking for that hero. My dragons were slain, my demons gone. All my fears had been faced and set aside. Wait a minute! How did that happen? I did it! It was me all along. I was given tools to work with and I used them. I faced my darkness and it was no longer dark. I am my hero! There is no need for pedestals.

I could never have done this without all the help and information given me by Dr. Bill, Pat and Kathy. Thanks guys. I like living normal."

For further information about the WIIT Program we encourage you to see our web site at www.wiit.com or call (800) 437-5478. We also encourage you to purchase Dr. Tollefson's book "Separated From The Light" at www.wiit.com/book.htm or by calling (866) 641-2221.

All past issues of Enlightened Choices are available at www.enlightenedchoices.org

Therapist's Page

By Patricia Prugh, ATR, CGP

Patricia Prugh, ATR, CGP Senior Art Therapist, Sheppard Pratt Hospital has specialized in trauma recovery art therapy programming for the past fifteen years. She presents nationally and internationally and is the recipient of numerous grants and awards for her clinical and artistic work. For further information she can be reached at pprugh@sheppardpratt.org.

Why Art? Celebrating the Connection between Visual Art and Healing.

study, a way of experiencing the self, a way of communicating the experience, a way of owning one's past, present and future. The vastness of the roles art plays in our lives is indiscriminant and unrestricted.

Art is available to anyone and everyone. It is an agent of information, affirmation, challenge and change. There are no rules in how one creates art but there are guidelines, techniques, and universal understandings, which can provide enhanced creative experiences and deeper connections to the creative source — the self.

Survivors of trauma often struggle with finding words, which adequately articulate the depth of their overwhelming experiences. These experiences may become intrusive. fixating, and trance mutated. This kind of experiencing and reexperiencing can be felt across the domains of sensory, perceptual, affective and cognitive functioning. Art expression is a way to begin objectifying these kinds of phenomena by recognizing and respecting that, they are primarily internal and not easily subject to external validation. Art provides a language or symbol system of the domain to express the same very complex internal feelings. Through the creative outlet of art making the artist can confront his/her subjective struggle by giving form, structure and constructive expression to inner and outer chaos and conflict.

Art and healing is available to all people. It is not bound by cultural, educational or financial limitations. Kenzabro Oe, Nobel Laureate, said 'in the very act of expressing oneself there is a healing power, a power to

mend the heart...in the arts we create. though we come to know despair - that dark night of the soul through which we have to pass - -we find that by actually giving it expression we can be healed and know the joy of recovering; and as linked experiences of pain and recovery are added one to another, layer upon layer, not only is the artists' work enriched but it's benefits are shared by others..." Artwork created in the sanctity of one's journal, canvas or sculptures are of equal value. Imaging from what is within and creating a responsive artwork can be therapeutic unto itself. When this is not therapeutic, it is imperative to listen to the messages and step back from further engagement with the artwork until after adequate processing.

Listening to the messages coded in our artworks provides us with the opportunity for a more empathic engagement with the self. A code is a language system that transmits messages, in this case a nonverbal language. Artworks engage symbols and metaphors as mechanisms for coding. Art therapists well versed in the multiple dimensions of trauma experiences actively engage the art process and product as a place for multilevel listening and responding to these nonverbal statements. The skilled trauma art therapist can help to guide the artist to greater selfunderstanding and explore art techniques specific to their nonverbal dialogue. Art therapy provides an opportunity for the artist to explore and challenge him or herself from a supportive, non-judgmental, analytical process. Art therapy can provide a bridge to the words.

Listening to the messages

All creative arts expressions hold a message. The message might be very loud and easily identified, or it may be very soft and require the artist to sit very quietly and listen from within. Sometimes the message becomes accessed several days or even weeks after having created the artwork. Creative arts processes do not require immediate understandings. Trust the process.

Some ways to pursue your dialogue:

Identify Feelings –Allow yourself to explore the emotional experience you have when looking at the finished work. How do the lines, colors and forms make you feel? Is it somber, sad, overwhelmed, anxious or angry? Is it producing several different feelings? Can you see and feel them separately? Can you see them together? What is the relationship between these feeling?

Finding the Narrative - Does the artwork bring forward a story? What would the theme be? Who would the story be about? Let your imagination work with you. How does the story symbolize you? Sometimes you can give the artwork a title and that will be the opening. Sometimes you can use responsive journal writing. Give yourself permission to sit with your works even when the narrative does not come forward. Always respect your process.

Exploring Deeper - Create a new expressive arts piece in direct response to the first one. Enlarge one area of the work and let that become a new composition. Do that again. Look deeper each time.

Let the story evolve. Sometimes it will be of more valuable to make the image smaller, to contain it with formal arts elements, or to embed it into a new image. Explore a series around a single theme. Integrate a series into a single piece. There is no need to rush through the process. Over time the personal meanings in your artworks can change. Let yourself see, feel and explore the changes. Let yourself heal through the process.

MV October 2005 Page 7

The Ultimate Betrayal

by Michele Michaels

There are many ways to be betrayed: You tell a friend a secret, only to find out the next day that it's been shared with everyone within a twenty mile radius of your home; you discover that your husband's late nights at the office really involved candlelight, soft music, and his secretary; you grew up in a household where violence and sex were second nature. All of those situations would, no doubt, hurt like crazy. But there are few betrayals that come close to matching abuse from the person you've depended on to help you—your therapist.

My therapist, Ted, and I started working together in the late summer of 2002. I'd had a short run at the agency, but the woman who was assigned to me didn't know the first thing about DID and it was a huge waste of time. Ted was an older man, whom I liked right away. Although I didn't trust people at first, it didn't take long before he started making me feel like he really cared about my progress and about my life.

It started innocently enough. He gave me his e-mail address and told me I could contact him any time. Not wanting to be a pest. I made sure that it wasn't more than once a week. But after a few months, he started e-mailing me, just to see how I was doing. This is when our friendship began. And, since I'm very reclusive (from avoidant personality disorder), he was useful to get me out of the house. We would go to coffee on Saturdays or lunch on Sundays. We would meet at the park instead of the agency. We would e-mail and IM every day. When I walked into the agency and he came to get me, there was no doubt that his eyes lit up with excitement. He was truly happy to see me! That made me feel indescribably important...something I wasn't accustomed to.

Months went into years and we only grew closer. On New Year's Eve of 2003, I decided to tell him that I was attracted to him. At first, he was very hesitant, but the more we talked, the more pre-occupied he seemed to become. We would meet at the park, I would only wear a skirt on the bottom, and he would have me expose myself. Then, one October day in 2004, he came to my house with lunch and we ended up having sex in the bathroom. After that, so many different feelings began to emerge.

On one side, I was thrilled that he wanted me sexually. I had been raised to

believe that my entire important rested on my seductibility and sexuality. So having him want me sexually only fed my completely depleted sense of self-esteem. One time ran into once a month and then more frequently. It was a very confusing time for me. So confusing, in fact, that, at the beginning of this year, I went into a deep psychosis that lead me in and out of the hospital three times in two months. The third time, I had an almost successful suicide attempt, was in a coma for a few days, and then transferred to a local psychiatric hospital.

When I got out, the first thing I wanted. was to make sure Ted was still as interested in me as before. At this point, I had sunken so low that I needed to feel wanted—I needed him to want me. And he did. It didn't take long before he was coming over to my house to have sex or having me expose myself in the corner of the room during therapy at the agency. At times, it was exactly what I wanted, because I equate my worth with my sexuality. Having him want me made me feel valuable. But, on the other hand, when I needed a therapist—when I needed Ted to act like my therapist—sex got in the way. Therapy stopped. Oh, sure, he'd try to stay on the subject of my flashbacks or whatever I was struggling with, but the conversations inevitably turned to sex. I had no support. I wanted to die. And the things he was doing sexually became increasingly humiliating.

During all of this time, I had often asked Ted for a different therapist. But Ted had had sex with another client five years prior and, I believe, was afraid to let me go because I might tell. So, whenever I would ask for a new therapist, he would respond, "No one else can help you." Because he could sign and I'm deaf, and because he'd treated DID before, I believed him.

Another thing he often said to me was that, if I told, he would simply say I was mentally ill and seeking attention. We used to talk about this and he said it jokingly, so I didn't take him seriously. He would say, "Oh, you're mentally ill. What do you know?" To which I would response, "I have news for you, Ted, so are you!" We'd laugh and then move on to other subjects.

But on a fateful day in June 2005, I knew he was coming over for sex. I love him, but it was hurting me. He'd told me he would say I was lying and, based on my past experiences growing up, I was sure everyone would believe him and just think

I was looking for attention. So, in an attempt to prove I wasn't making it up, I hid my webcam and videotaped it onto a CD-ROM that morning. After Ted left, I called my husband, who then took the CD down to the police station and reported it

After the detective watched the tape and read some of our e-mail conversations, he headed off to the agency and confronted Ted. Sure enough, true to his word, he tried to tell them that I was very sick, borderline, and attention seeking. That's when the detective mentioned the video and Ted immediately responded. If don't want to talk to you. I want a lawyer, and they whisked him off to jail.

It's been two months since that fateful day and we're still in the middle of finding out what will happen to him. Another woman has come forward to say that Ted did the same thing to her five years ago His plea date is Sept. 6, 2005. Many people say to me how great it is that he's been caught or how happy I must be that "justice has been served." But, you know what? I'm not. In fact, if I could go back, I wonder if I would have told on him. I'm not sure why I did Perhaps parts of me were just tired of being used. At any rate, since this whole situation came up, my life has gone downhill. I struggle with flashbacks, nightmares, lots of lost time, deep depression, suicidal thoughts, and the feeling that I betrayed him. It's a hard situation to look at with a different perspective. But one thing's for sure: it was an unhelpful scenario. I've been through many types of betrayal. However, when I go to a person to try to learn how to get out of the victim role and I end up being victimized, that has to





be the ultimate in betrayal.

The Trauma Disorders Program Sheppard Pratt A not-for-profit behavioral health system

The recent events in the Gulf states following hurricane Katrina are once again likely to push trauma disorders into the public consciousness. Society's awareness of trauma frequently follows the bimodal pattern of PTSD: intrusion into the consciousness of the images of the overwhelmed, damaged, and traumatized with an increase in public awareness and concern with demands for action for the victims. Usually this is followed by periods of numbing and/or amnesia with withdrawal of interest, fatigue about trauma, and/or frank skepticism and disbelief. The 9/11 events and the priest sexual abuse scandals have seemed to follow this pattern. There has been less consistent societal awareness of the psychological trauma that afflicts a significant subgroup of the Iraq veterans.

Trauma challenges one's sense of safety and control in the world. One feels more vulnerable and uncertain about life being safe, orderly, and predictable. "Just world" assumptions- that good triumphs over evil; that God looks out for the innocent; that right and fairness will prevail; that the world is a "good" place; that things turn out for the best- may be damaged as well. Trauma may lead people to challenge their values and beliefs, and even change their life direction.

Risk factors for developing PTSD after a traumatic event include having been previously traumatized; life-threat during the trauma; prolonged, multiple violent and/or assaultive traumas; witnessing grotesque effects of trauma on others; traumas occurring earlier in life; prior psychiatric disorder; poor social supports; dissociation and certain physiological reactions at the time of trauma. Even so, we cannot predict which person will develop PTSD due to a specific trauma and who will not.

After a trauma, it is important to continue normal routines, if possible, especially those that relate to health such as exercise, diet, and maintenance of a normal sleep cycle. It may be tempting to "numb" oneself with alcohol or drugs, but this is likely to worsen, not help, long-term resolution of the trauma reaction.

Professional help is warranted for trauma-related symptoms if they do not diminish over time. In particular, professional intervention is needed if stress-related symptoms interfere with normal endeavors of life: work, school, relationships, and other normal activities of living. Treatment for PTSD and related disorders includes individual, group, and family therapy, as well as medications.

> By Richard J. Loewenstein, M.D. Medical Director of the Trauma Disorders Program at Sheppard Pratt Reprinted from Help and Hope: When Bad Things Happen

To receive a copy of this booklet in its entirety, contact the hospital at <u>www.sheppardpratt.org</u> and complete a request for literature. If you would like more information on the trauma specific inpatient, day hospital and outpatient program at Sheppard Pratt please call the Outreach Coordinator for the Trauma Disorders Program at (800) 627-0330, x 5078.

> The Staff of the Trauma Disorders Program at Sheppard Pratt wish to extend our sympathies to those individuals so affected by Hurricane Katrina. Our thoughts and prayers go out to all, especially our friends and colleagues at The New Orleans Institute at River Oaks Psychiatric Hospital. We extend our hearts and hands in hopes that we may contribute to your wellbeing and honor your enduring valor.

MV October 2005

Retreat to the Hospital

By Jeanne P.

have been in therapy now for a little over three years. Things started getting real intense for me as soon as I started getting memories of incest and ritual abuse about two years ago. I was diagnosed as DID about a year and a half ago.

During the past two years I have been hospitalized a number of times for various reasons and for different lengths of time. While I don't think too many people would understand this, I imagine many of you readers will.

The first time I was voluntarily hospitalized because my therapist was going on vacation and I didn't think I could handle it. She was gone for a week and I stayed in the hospital for two weeks. Separations from my therapist are still tough but I'm glad they no longer necessitate my being hospitalized.

Other times I have been hospitalized because I was a threat to myself. I needed a safe place to go to keep myself from hurting myself. Interestingly to me, the self-destructive urges and suicidal thoughts usually stopped as soon as I was admitted. That says to me that much of my self-destructive thoughts and behavior are about not feeling safe—from myself or in the world.

I have also used longer hospitalizations to retrieve large quantities of memories in a relatively short period of time. This was rarely my intent upon being admitted but my unconscious seems to use every perceived safe opportunity to pass on to my conscious the source of pain and terror. If I'm in a safe place, with a safe person, I will usually get memories and/or switch into some alter who normally feels too unsafe to surface.

On almost every occasion when I've been hospitalized, a major issue has been that I haven't wanted to leave the hospital. It took me a while to figure out why but now it makes perfect sense to me. My kids thrive on being taken care of, on having someone present (usually, depending

on the realities of hospital staffing) who is paying attention to what and how they're doing, and on being some place where they don't have to pretend or hide. Transitions from the hospital to home have always been difficult, at best.

Of course, the hospital setting has not always been ideal. Many staff members were unsure of how to interact with me or accept my being a multiple. And not all staff members (or other patients) could handle hearing my memories or witnessing my pain. But my inside kids are pretty intuitive and rarely goofed in choosing who they could disclose to and be safe with. It helps that, except on one occasion, I always went to the same hospital and came to know the staff members and knew ahead of time what to expect and who to seek out for help.

All of the experiences I have mentioned so far have been in the "open unit" of the adult psychiatric unit. On one occasion, I was admitted to the "secure unit" and it was a nightmare. I felt abused and violated and left after 2-1/2 days even though I didn't feel ready. It was especially frustrating because the only reason I was admitted to that unit was because of hospital policy that all admissions after 5PM on a Friday be to the secure unit. I sent a poem I wrote about that experience to the medical director. While he did not respond to me directly, I have heard through the grapevine that the "shit hit the fan" and for that I am grateful. I felt like I got heard.

My last hospitalization was just two weeks ago and I was there for three weeks. I went in because I felt like I couldn't go to the depths I felt like I needed to go in my therapy and continue to lead my life. I was able to go much deeper in my work which, ironically, made it even harder to return to the rest of my life. But I still feel like I made the right decision.

I realize that most hospitals (including the one I've gone to) are set

up for crisis intervention and designed to stabilize the patient. I have, quite successfully, used them as an adjunct to my treatment process. I give some credit for that to the hospital itself, and a great deal of credit to my determination to do whatever I need to do to get my needs met. I have some very determined alters who know how to get the system to work for them and regard the primary intent of the psychiatric unit as fairly irrelevant if they see a way to be there and get some of the help they need.

I have talked to many people who have very negative, abusive experiences with hospitals and about the best advice I can give is to trust your gut and get out if you've found yourself in a non-supportive environment.

We all deserve to get what we need to heal. And if crawling into the cave (the hospital) to get out of the storm for a while is healing, I support it. and if we sometimes cannot take care of ourselves, we should be congratulated on recognizing it and asking for help. Making the decision to be hospitalized is a very difficult and courageous decision.



By Teenager of the Little Birds

Page 10 MV October 2005

The New Orleans Institute Treatment Programs at River Oaks Hospital

Editor's Note: As many of you know, The New Orleans Institute, an important treatment center for trauma patients, was impacted by Hurricane Katrina a few weeks ago. The website offered the following announcement:

River Oaks Hospital has evacuated its facility. We have relocated to Lakeside Behavioral Health System in Memphis, TN. Patients and staff are safe and doing well. We can be contacted at: Lakeside Behavioral Health System, 2911 Brunswick Road, Memphis, TN 38133. Phone numbers: 800-232-5253 or direct at 901-213-1623. www.riveroakshospital.com

I spoke to administrators at River Oaks (in Memphis) after the hurricane, and everyone is doing well. Decisions on their next step were pending when I spoke to them, so I would suggest you call the above number for program information, to be appropriately directed. MV wishes the entire staff the very best future. – Lynn W., Editor

Special patients — Special Care

Since 1989 thousands of individuals from the US, Canada, Europe and South America have received the specialized care offered at River Oaks Hospital, in a nonthreatening and safe therapeutic environment. Specialized treatment is available for individuals suffering from trauma-based disorders (childhood or adult onset), compulsive behaviors, eating disorders and post-traumatic stress. Treatment is available in three levels of care: inpatient, partial hospitalization, and outpatient. Impaired Professional evaluations are available for compulsive-behavior disorders.

Intensive psychotherapy (individual and group interventions) is used for the stabilization of depression, anxiety, and addictions as well as to identify and provide resolution for the cycles of self-destructive behaviors, dissociation, and relationship difficulties. The programs also facilitate the resolution of long-term developmental deficits and blocks manifested as personality disorders. Specialized treatment for eating disorders, chronic chemical dependency and sexual compulsivity is also available. The programs address life-interfering, relationshipinterfering and therapy-interfering behaviors with an emphasis on adaptive coping responses.

Patients receive a full day of treatment services within the structure of a safe and trusting therapeutic

community. Our goal is to provide a respectful, protected and empowering environment in which patients can pursue the work of healing.

Treatment Program Philosophy

We are dedicated to providing a safe, non-revictimizing, healthy environment to allow individuals to heal. Each individual is treated with respect and compassion in an intensive, state-of-the-art program that effectively combines psychotherapy and pharmacology within a therapeutic community.

Renowned, Specialized Treatment Team

Our staff includes many licensed therapists well known across the country for their specialized expertise. The treatment team includes psychiatrists and other medical doctors, psychologists, master's level social workers, dietitians, psychiatric nurses, expressive therapists, and educational instructors. Each professional is highly trained and skilled in the treatment and management of individuals with trauma issues, compulsive behaviors and eating disorders. A safe and structured environment is established within which patients, with the assistance of the clinical team, can successfully work to regain control of their lives.

Trauma Recovery Program

The New Orleans Institute Trauma Recovery Program focuses on enabling clients to break the trauma bond which has controlled thoughts, feelings and behaviors. The client will then process and face fears which can eventually result in relief of traumarelated symptoms, as well as integration of the dissociated aspects of the experience and of self.

This program addresses the dissociative state by utilizing the grief model called "Reliving, Revising and Revisiting." After forming a trusting, safe relationship with the primary therapist, the individual "revisits" the trauma. As they begin to feel the trauma of their childhood and to reassociate cognition and affect, information-reprocessing techniques are utilized to restructure their sense of self, in relation to "what was done to them." The adult's capacity to reason and the child's capacity to feel are slowly integrated, resulting in decreased destructive behavior, enhanced capacity to relearn a constructive sense of self, the ability to socially interact competently, and the ability to solve problems.

An individualized treatment program is developed with input from the client and referring professional.

While under the direction of a psychiatrist, the treatment team operates within a truly linear system where all members are equal, providing a safe refuge for patients.

MV October 2005 Page 11

Hospital Work: Life on the Inside

By Sahara

When I was 18 I entered a Psychiatric Hospital for the first time. That was over twenty years ago in 1984. The reason I went inpatient was because I was feeling suicidal. My therapist at the time gave me two choices: check into the hospital, or she would talk to my mom about me being suicidal. I was deathly afraid of my parents knowing anything was very serious. My abuser threatened to kill me, my horse, and my friend that he also abused. I complied and went in without telling my parents I was going. A friend and I went to Pizza Hut after school that day and then she took me in. It was scary and relieving at the same time. I wouldn't have to deal with my dad who was so critical.

Times were really different then. Hospital programs were thorough and lengthy. I was there a little over 3 months on the adolescent unit. I adjusted easily and worked their "program", gaining priveledges as I increased compliance. I don't feel like I worked so much on the sexual abuse, but just on feeling like living again. At that point I was called "Borderline" because I had been cutting. Basically the program was group therapy daily and on weekends as well as individual therapy. We also had Art Therapy, PE, Music Therapy, Biofeedback. The things that stick out in my memory are:

- during my psych testing the doc asked me the similarity between lots of things. It was pretty easy, except for the similarity between a fly and a tree. I couldn't come up with the answer that they are both living.
- attacking a mattress that represented myself. Calling it a whore, and telling it how much I hated it.
- trying to climb into a therapist's lap when she took me to the gym to calm down.
- cutting my wrist with a paper clip to get my doc to give me meds. He told me if I didn't settle down he was going to move me to the adult unit where "the real crazies are."
- a twelve year old girl who wanted to have a baby so someone would love her.
- going home on pass for the weekend and overdosing just before I returned to the hospital.
- a near riot starting by some kids who wanted out.

 my anorexic room mate driving me nuts because she wouldn't stop exercising.

I was functional pretty much for the next year or so, but ended up going inpatient to the student center at Texas A&M for observation for 3 days. I was suicidal and I think I had overdosed on some OTC Tylenol or Advil. I just basically studied and slept. I called my old therapist and asked her how to get out. She said "you know the drill. They want to be sure you are safe." They put me on an antidepressant for a couple of weeks but didn't continue it.

I was "hospital free" for the next eight years. We moved to a small town in the middle of nowhere and I pretty much lost my identity. My salary dropped 90% and I was 27 yo and started having flashbacks. I started therapy in a town 30 miles away and didn't bond very well with the therapist. I did bond with a professor of education who had no counseling skills and made my symptoms worse. My husband was not very supportive. I became severely depressed. I kept talking about "running my car of the road." The professor called an occupational health counselor (services were basically nonexistent there.), and they decided I should be taken into custody. I tried to make a contract with my therapist, but she wouldn't do it. I was in an observation room with the light on and no access to the bathroom without an escort. A camera was running. It was humiliating and frustrating. Fortunately, a true social worker who knew what she was doing realized that I did not need to be inpatient and was able to stay safe with my therapist. I was out of the hospital in 8 hrs and had to pay the \$600 bill for someone else's mistake. I had PTSD symptoms around police in uniform for several months after that.

Again, I was hospital free for about 5 years. I had begun working on the abuse issues and had a good therapist that would see me several times a week and even every day sometimes. I ran away to medical school and all was terrific for 2 years until the judge ordered mediation on my lawsuit against my abuser.

Eight months later I nearly died in a suicide attempt and checked myself into the local crisis unit. I spent 3 weeks there until my mood was stable again. They had lots of group therapy and it was mostly geared to drug and alcohol problems. There was no individual

therapy. Basically, we got up at about 8 and had breakfast, then had group at 9, a break, then another group. Lunch then one or two more groups during the day. My therapist worked about ten minutes from where I was staying and she had said she could come by to see me, but she never did. That made me really sad. I felt like I needed the time for individual work. This hospital did not acknowledge my multiplicity. Whenever I brought it up they told me that was work for my therapist and me. One of the excellent things they had at this hospital was psychodrama. The therapist that led the group was incredible! I learned something from every single session. I just can't say enough about it. Psychodrama was held two days a week. I even prolonged my hospital stay to get in one more session.

The best hospital experiences I have had have been at River Oaks Hospital in New Orleans. I expect that the hospital is not there anymore after Hurricane Katrina. There is a similar program in Kansas City at Two Rivers Hospital. They have specific programs for Trauma, Eating Disorders, Sexual Disorders (Perpetrators).

I chatted with lots of people online who had been to River Oaks before I made the decision to go. That helped tremendously as it allowed me to know what to expect going in. Before I went to the hospital I had to be sure it would be covered by my insurance. That took about three to four days to get worked out.

My husband drove me to New Orleans to check me in. Not out of support, but because he didn't want to spend money on a plane ticket. When we got to the hospital they gave me lunch and I started signing papers. Mostly consent forms for treatment and insurance were the bulk, but there were also forms that said I agree that they wouldn't release me if I was a danger to myself or others. I was a bit nervous about that. I felt like I was giving up my freedom. My husband freaked about that. I had to calm him down. After all the paperwork I said bye to my husband and I went to the unit. My bags were left in the office to be checked for anything dangerous or illegal, and then they were given to me to unpack.

The unit was ok. I came on a Saturday I think so there wasn't much going on. There were people visiting with their spouses. They showed me my room and then introduced me to some people in the common room. There were four or five

Continued on Page 12

Life on the Inside, Cont'd.

staff members around. They gave me a notebook to look at that had stuff about the program as well as a safety contract I had to copy in my own handwriting and sign. The notebook also had a list of about 300 affirmations in it. They told us to pick 10 that meant something to us and write them out. We were to recite them at least 3 times a day. Also they had us write and draw a very detailed "Safe Place" to be ready at any moment. This was a really important task to help calm down after hard work.

After I unpacked I was told the rules. Just having got there I was on "Close Observation". That meant I had to stay within 15 feet of a staff member and let them know where I was at all times. Everyone who comes into the Trauma Unit starts out on "CO" until they can assess your level of safety. I also couldn't go in the kitchen without a staff member.

The first night I went to the end of the day group. I don't remember exactly what they called it but it was basically. How was your day? What was something good that happened? What was something that you could improve on? State an affirmation. (You don't have to believe it.) We went around the circle and everyone answered those questions. They had a similar group in the morning except it was – How was your night? What is a therapy interfering behavior you can work on? ..And of course the ever-loving affirmation .

We had a very intense Trauma group for 3 hours three or four days a week. Someone would share their work with the group. It was heart wrenching. It was also insightful in that we heard other people with trauma histories similar to our own. People signed up to work in Trauma Group. The first thing they asked you to do was a detailed life history and share that with the group. One thing that is really notable is that people actively planned to work in group. There was some negotiating as to who would go when among us. People that were soon to be discharged wanted to finish up.

We also had music therapy, art therapy, relapse prevention group, DBT Group (Dialectical Behavior Therapy), and daily individual therapy. And of course the morning and evening groups. We had Ceramics on Saturdays and a Spirituality group on Sundays. We also had educational groups about relationships and intimacy.

Basically, I felt like I did about 4 months work in 3 weeks. The environment was very supportive so it was safe to do difficult work. For me it was better to go to River Oaks to do difficult work because my

I was having a crisis or major depressive episode. I went back to River Oaks the following year around the same time (Halloween). It was again equally helpful. I ended up going for a third year, I think, just for a couple of days.

Each time I went, I came in with an idea of what I wanted to work on. My therapist and I talked about what my goals were before I went. Some of the techniques I learned there I still use. Especially the affirmations, safeplace, and relapse prevention group materials.

I want to mention the fact that there were perpetrators there. These guys that were there when I was were also abuse survivors. They were not violent as I saw them. I knew them before their crimes. One guy was in for repeated indecent exposure, and another I didn't know exactly what for. I wasn't afraid of them though. I have to say I did have compassion for the one man, but was a little wary of the other. There wasn't any time that I felt unsafe.

For the most part the staff was excellent. If a group got too intense we were allowed to leave. I guess I did quit a bit of that, though it didn't seem like it to me at the time. The staff was very approachable and compassionate. They were there to walk around the grounds and talk with us if we were really upset. The mantra was "Pace & Contain".

The only problem I had with River Oaks was a billing one. That was really frustrating b/c it is difficult to deal with money when you are depressed as most of us know. The hospital changed computer systems while I was there and I think that's where the mix up happened.

I wouldn't have changed a thing if I had the opportunity. The Trauma Program at River Oaks is well thought out and administered. I would go in once a year to work if I had the opportunity. So much can be accomplished in a brief time. The work is definitely intense and I have to say I was exhausted each time I came home. The biggest thing I want to communicate to everyone is that going into this type of program is an opportunity – not a set back.

<u>MV</u>



Seasonal Affective Disorder

For a long time I thought I was a survivor of satanic ritual abuse, partly because my mood takes a dramatic downturn in late October every year. Even if I have been doing well prior to that point, around Halloween I become obsessed with thoughts of suicide and I feel miserable. Sometimes I feel totally unable to function.

As I explored my childhood abuse history in therapy, it became clear to me that SRA was not a part of my past. Instead, I have Seasonal Affective Disorder (SAD) and the shorter days in October trigger a serious depression in me every year. I continue to feel awful through the month of November, and usually start feeling better in December, with all of the holiday lights, and I continue to improve in the new year.

There are two things that have helped me cope with this condition: getting a light box and going to therapy more frequently. A light box puts out intense, full spectrum light which helps to make up for the deprivation of light from the outside. In October and November, I generally sit in front of the light box for about 20 minutes in the morning. Using the light box in the evening is not recommended due to its potential to provide energy and perhaps even a jittery state in users, which may make it difficult to go to sleep. I never noticed this effect personally, but apparently it is fairly common.

My other way of coping is to go to more frequent therapy sessions. Generally I go to therapy twice a week, but during the difficult times, for example when I am thinking about suicide, I go three times a week. This is a lot, but it is cheaper than going into the hospital. I have had 4 short-term hospitalizations in the last 14 years and I know how costly they can be. Last fall I felt so awful that I was intent on hospitalization, but my therapist talked me out of it. It turned out that dealing with my problems in therapy was not only cheaper but more effective than hospitalization.

I believe that my SAD pattern is not typical in that I am much better by January. I think the depression generally lasts longer for other people, who tend to get better in March or even in May. It is also possible to have SAD in the summertime, in which case the heat can trigger symptoms. This is not as common as winter SAD, however.

By Mary Katherine Powers

Two Rivers Psychiatric Hospital in Kansas City

Premier Specialty Programs Treat Trauma-Based Disorders, Neurobehavioral Conditions and Dual Diagnosis/Addictions

A life-shattering event such as rape, a serious accident or the murder of a loved one can deplete the coping abilities of anyone. A unique program at Two Rivers Psychiatric Hospital in Kansas City, Missouri, offers help for individuals who have suffered an overwhelming life event. Additionally, treatment is provided for people who have been subjected to ongoing trauma, such as childhood abuse or neglect.

"Our clients have a wide array of symptoms that are a result of unresolved traumatic experiences – from substance abuse, eating disorders and overuse of prescription drugs to physical complaints, anxiety and depression," says Nancy Harrel, Director of Two Rivers' National Center for Trauma-Based Disorders Program.

"The program's core philosophy is empowerment," Ms. Harrel continues. "When something overwhelming happens to you, you lose your sense of safety both inside and out. We help our clients feel safe again by teaching emotional regulation and self-soothing skills."

The intensive inpatient program combines group and individual psychotherapy with pharmacology. Staffed by a multidisciplinary treatment team with expertise in trauma-based disorders, the program

stresses mindfulness – teaching clients to be more present in the moment. "This helps clients work through underlying unresolved trauma so they no longer need negative coping skills," Ms. Harrel explains.

The Two Rivers National Center for Trauma-Based Disorders Program draws clients from all over the country. Although it is Two Rivers' best-known program, it is not the only premier specialized program available at the hospital. Others include the Comprehensive Neurobehavioral Inpatient Treatment Program for Children and Adolescents, the Dual Diagnosis/Addictions Recovery Program, and the Renaissance Program for people over the age of 55.

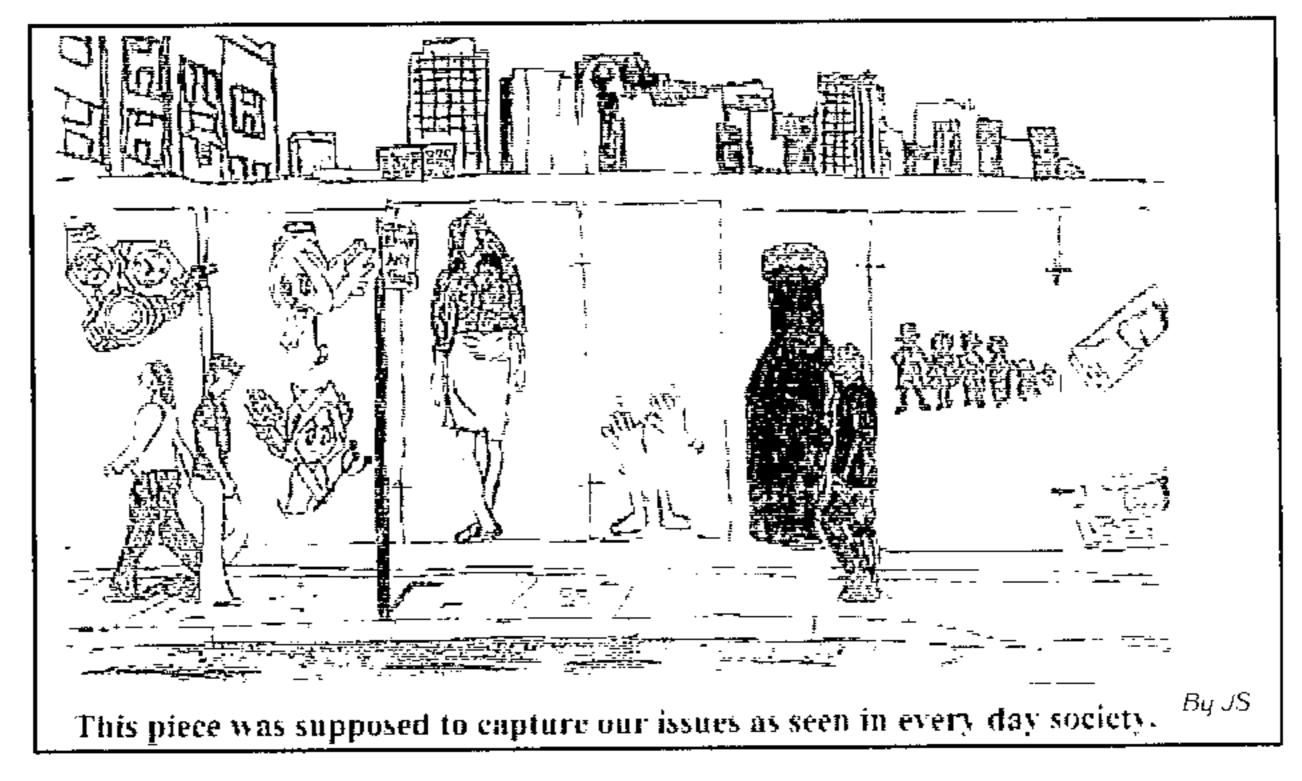
Most children and adolescents who are admitted to the Comprehensive Neurobehavioral Program have been in and out of treatment. With symptoms like repetitive rage behavior, impulsivity, very short attention span and pathological aggression, many have a history of neurological disease, toxic exposure during gestation or head injury. "We use complex EEG and neuropsychological testing to help confirm their diagnosis," says Linda Berridge, the hospital's chief executive officer. "We offer a milieu designed to help these children focus on their treatment, which combines individual,

group and family therapy and medication."

The Dual Diagnosis/Addictions
Recovery Program is for adolescents
and adults with both an addictive
disorder, and a behavioral health
issue, such as depression or bipolar
disorder. It offers a combination of
inpatient, day hospital and intensive
outpatient treatment. Following an
intensive diagnostic evaluation,
patients receive hands-on,
multidisciplinary treatment that
combines 12-step programming with
individual and group therapy and
patient education.

About Two Rivers Psychiatric Hospital

Two Rivers Psychiatric Hospital is a national leader in comprehensive behavioral health care and is committed to providing the highest quality care in an atmosphere that nurtures healing and growth. The staff has diagnostic and therapeutic expertise in disorders afflicting persons of all ages. Therapeutic modalities include psychology, social work, psychiatry and expressive therapies like art, music and psychodrama. The hospital accepts most commercial health insurance plans, Triwest, Medicare and Missouri Medicaid. For more information call 800-225-8577 or 816-382-6300.



A Patient Speaks Out

I have learned so very much from MANY VOICES. I have a mental health problem. For over ten years I was misdiagnosed. In 1995, after a hysterectomy, I started having disturbing dreams. During the day images kept creeping up in my mind. I thought I was going crazy. The dreams (flashbacks) seemed so real but I knew it could never have happen to me. I thought I was watching too much TV or had a warped imagination. Before I left the hospital the flashbacks became real to me when I saw my face and the face of a close friend of the family and felt the physical pain.

I immediately thought I was having a nervous breakdown. Maybe I was working too hard (I was Director of computer operations of a large firm). Maybe I needed a vacation.

The flashbacks got worse and worse so I contacted a therapist who said I was just depressed about the hysterectomy.

Weeks later I was no better - so I called the Center for Mental Health at the local hospital. That therapist sent me to a Mental Health facility for six weeks. I was traumatized. Why was I there? Why was I taking so much medication? I became a zombie. Upon release from that institution. I returned to the local therapist who decided EMDR was what I needed for months. During those months I was admitted to the local hospital (mental health floor) because of suicide attempts. PTSD was my next diagnosis. The voices in my head were taking over me. More medication was prescribed. Szofrania was added to my list of diagnosis.

I had to leave my job and it took a toll on my marriage. Denial, confusion, no self-esteem, massive weight gain and different meds ruled my life. I was sent to the state hospital because I was so lethargic and in total denial. I felt useless, dependent on drugs and in a total unconscious state. There were many overdoses and stomach pumping along with loss of hours and days.

Eight years later and in a different state I met a therapist who diagnosed me as DID. What was DID? No – not me DID! I can't be a Sybil. I was sent to DelAmo Hospital in California where I came to realize that the voices I was hearing were parts of me that needed to talk. I couldn't believe that there were so many inside family members that took care of me during the sexual and physical abuse. How could he have hurt me when he always said he "LOVED ME."

After three visits to DelAmo I have accepted my DID, journal with my new inner family and am co-conscious with one family member. I have learned names and the reason each one was created. I am now ready to come off my cloud and accept the fact bad things happen to good children. I attend a great DID group weekly and now see a therapist who specializes in DID.

It has been a long hard journey but I now know I am not CRAZY.

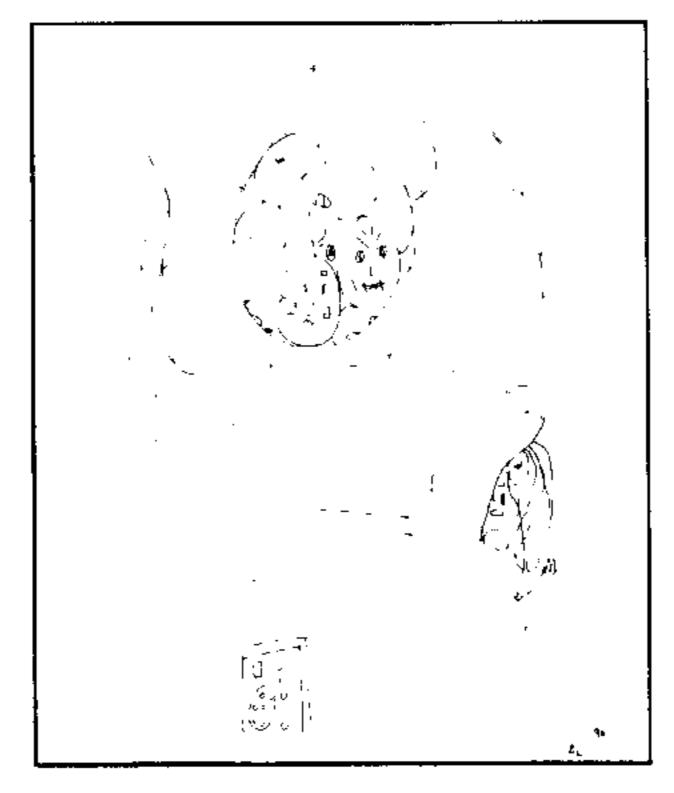
I am on disability Medicare and have been told that I have only 80 in-patient days left for the rest of my life. That really scares me. I am 56 years old and I know I have a lot to learn on my continuing journey. What happens if I need to be readmitted into a hospital for a "tune-up" or if I run into a bolder in the road during my journey? I have to watch how many days I use. Medicare only allows 190 in-patient days for a lifetime per patient. The government spends millions of dollars keeping "The BAD MEN" in jail (which mine is not – he lives a nice life with his other pedophile friends golfing every day.) Why does the government give the victim only 190 days to get better? What can I do to change this? I would be willing to come forward to speak on this issue but I don't know where to start or who to contact. I have tried e-mailing my senators, Medicare and AARP for help with no reply.

Thank you for being there for all of us who now know we are DID and for those to follow. We are out there struggling to walk over stones and many boulders as we continue our long journey in this very bumpy world.

Sincerely,

Jeanne B.

MV



Del Amo Behavioral System Trauma Programs

Del Amo is a 166-bed private psychiatric hospital in Southern California. Its individually tailored programs encompass needs such as crisis stabilization, trauma-based disorders, borderline personality disorder, PTSD, dissociative disorders, eating disorders and sexual addiction, among others.

Del Amo's Program for Trauma Stabilization and Resolution includes acute inpatient, partial and support group services. Average length of stay is two weeks for the inpatient program and two weeks for the partial program. It utilizes a multidisciplinary focus to facilitate increased ego strength, stabilization and growth.

The National Treatment Center Trauma Partial Hospitalization **Program** may be used as either a step down level of care for those previously inpatient, or as a way of preventing unnecessary inpatient hospitalization. All patients are prescreened for appropriateness by a qualified professional. Discharge planning is implemented upon admission to ensure our patients will be successful in follow-up care once they have completed the program. Del Amo's Trauma Program is based on The Trauma Model developed by Colin A. Ross, M.D. whose Ross Institute administers the program. Learn more about Dr. Ross's work at his website, www.rossinst.com

A variety of cognitive therapies is offered to assist patients in correcting their general cognitive deficits as well as specific cognitive distortions related to anger, shame, identity, sexuality and relationships. In addition, a variety of experiential treatment modalities are offered to assist in development of an integrated sense of self. These activities also are helpful in developing socialization skills, reality testing, and affect tolerance and regulation.

We are an approved provider for most insurance companies and managed care systems, Medicare and MediCal.

For further information, including articles, suggested books, seminar lists, therapy referrals and workshop speaker information please call 1-800-533-5266. www.delamotreatment.com

My Favorite Art Form-Collage

By Donna Holzem

I've always had talent(s) when it comes to art. It does seem to run in the family, though I'm the only one who has chosen to succeed at being a 'starving artist,' or should I say an aspiring artist.

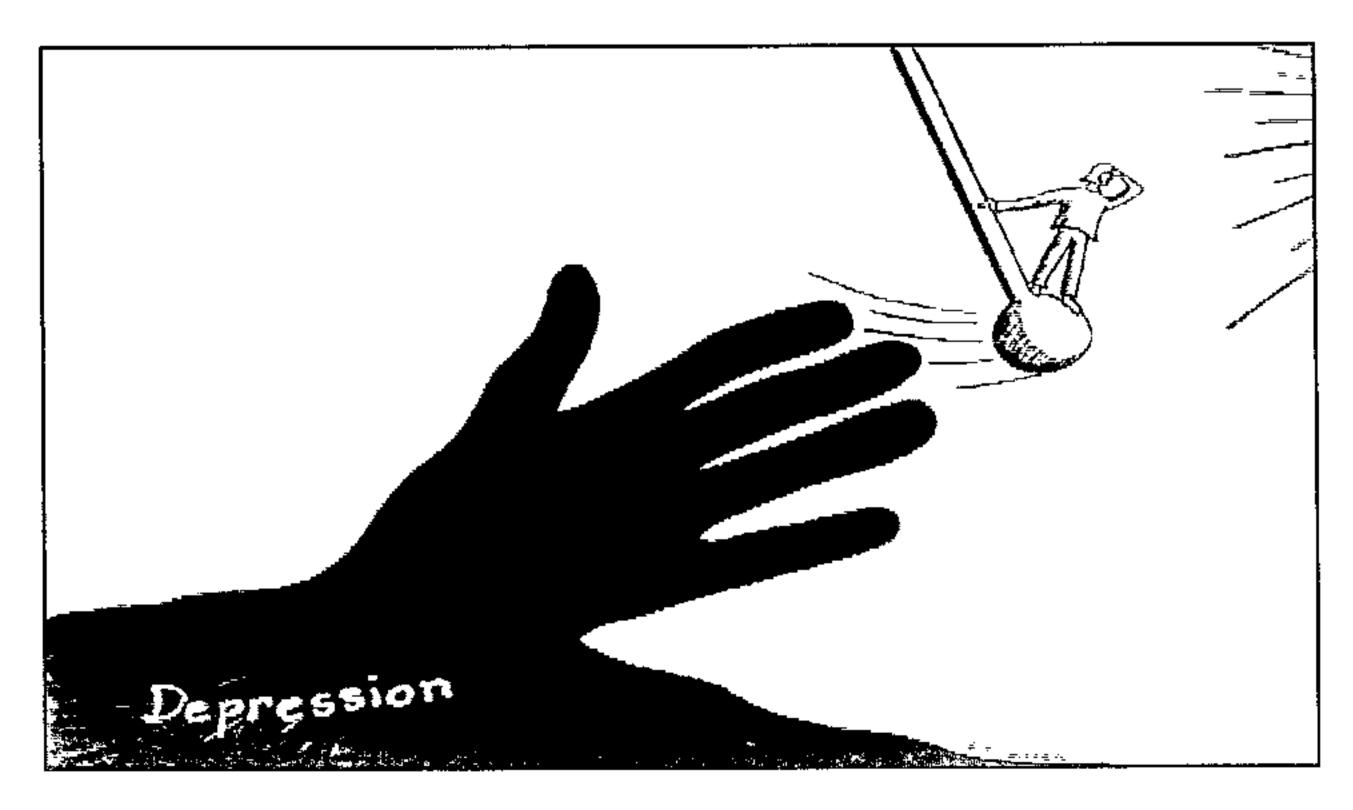
Even though I have always had artistic flare, it took me well into my recovery; my late twenties, to realize that the collages that I had been doing for homework both inpatient and outpatient were art. My treatment team, including my Psychiatrist, therapist, and occupational therapist all realized this art form fit me like a glove.

I have self-portraits of all my selves, including Sixteen, Seven, My Little Ones, and My Insatiable One. Seven was my most complicated piece, especially because she emerged as a persecuting alter more than ten years after I'd been living with my other parts. I assumed Seven was an adult because she said all the verbally abusive things that grownups said to all of us. Each attempt at choosing pictures to be used, from my 3-drawer file of pictures and word clippings kept coming up with children and an occasional baby. Finally I weeded out those pictures that were too young and was left with 6, 7, 8 even 10-yearold girls all doing something fun. Running through the sprinkler, playing dress-up, holding kittens and puppies, and playing at the part etc. The only words used in this collage were

"Imagine Getting More Comfort", "Somebody Loves You", and "You are Important, You are Loved." For months, Seven wanted the matted and framed-in-gold artwork placed on an easel in a predominant place in my home, so that I would see her every time that I walked by. Seven is now placed in a focal location in my studio above my computer and sewing machine. I do not include Seven in Art Shows because she is not comfortable being away from home for a month at a time. I make every effort to respect the feelings of each of my parts. This means that Sixteen's collage has been in Art shows, as well as My Little Ones and My Insatiable One depicted in a state of recovery, but does not include the more graphic collages done while I was doing Abreactive Therapy.

The Journaling that I have done since I was sixteen years old has become not only a coping skill but an art as well. I have one journal that I have titled Both Ends of The Kite String. This particular journal has every other page lined so that it opens to a collage or water color painting on the left and corresponding journaling, affirmations, famous quotes and Native American folk tales on the lined pages. The lined pages also include a sampling of my poetry.

Editor's note: An example of Donna's collage talent is shown on the cover of this issue.



Timberlawn Trauma Program

The Timberlawn Mental Health
System in Dallas, Texas is a
comprehensive and integrated system
of psychiatric and substance abuse
services for adults, adolescents and
children. Timberlawn is the only
psychiatric hospital in Texas
recognized in the USNews and World
Report list of top hospitals in the
country.

The Timberlawn Trauma Program is under the direction of Colin A. Ross, MD, an internationally renowned clinician, researcher, and author. The program, based on his Trauma Model, emphasizes the effects of trauma as multiple symptoms expressed by multiple diagnoses. Timberlawn treats all disorders related to unresolved trauma and attachment issues. This would include but is not limited to: Borderline Personality Disorder, Post Traumatic Stress Disorder, Acute Stress Disorder, Depression, Panic Disorder, Substance Abuse, Somatization Disorder, Dissociative Disorders. Obsessive Compulsive Disorder, and Eating Disorders. The treatment goal is to help individuals improve their adult functioning by helping them to stabilize and continue their recovery with new tools learned in the inpatient setting. Healing takes place at the level of processing and integrating feelings, thoughts, and perceptions and re-framing cognitive distortions.

The multidisciplinary treatment team of licensed professionals includes referring therapists and psychiatrists, working closely together to insure continuity of care. The Timberlawn Trauma Program is committed to preparing clients for reintegration into society. While in the program patients are expected to be responsible for their behaviors and committed to treatment. Most insurance, HMO's and PPO plans are accepted. We are also a Medicare and Medicaid 21 and under provider. Financial counselors are available to assist with your arrangements.

For information or referrals, please call 214-381-7181 or 800-426-4944. Or visit the website at www.timberlawn.org

<u>WV</u>

Thanks for Sharing!
Please keep sending your
wonderful art and writing!
Your work helps others heal!

December 2005

Living in a so-called "normal" world. Challenges and rewards of being in recovery. What it's like to feel better! ART: A favorite winter scene.

DEADLINE: October 1, 2005.

February 2006

Feelings in Therapy. Anger & Rage. Love for Therapist. What do you experience? How do you tell? How does a "good" therapist respond? ART: Express an emotion, visually. DEADLINE: December 1, 2005.

April 2006

Feeling Lonely? How do you cope? Survivor Retreats. Support Groups, Conferences, Online experience. ART: A comforting scene. DEADLINE: February 1, 2006.



Share with us!

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

Subscriptions for a year (six issues) of MANY VOICES: \$36 in the U.S., \$42US in Canada, \$48US elsewhere. Back issues always available, each issue 1/6 yearly price. Enclose the form below (or a copy) with your check, and mail to MANY VOICES, P.O. Box 2639, Cincinnati, OH 45201-2639. Phone (513) 751-8020. Web: www.manyvoicespress.com

MANY VOICES

NEW!
We now accept
American Express
Visa &
Mastercard!

VISA

NameAddressCity/State/ZIP
☐ I have a Dissociative Disorder ☐ Professional/therapist ☐ Relative/Friend Subscription type: ☐ New ☐ Renewal ☐ Gift Send full list of past themes Full yr(6 iss)'89'90'91'92'93'94'95'96'97'98'99'00'01'02'03'04'05'06
Specific issues or preferred start date:
1 year:\$36 in U.S.: \$42US in Canada; Elsewhere, \$48 in U.S. Currency drawn on a U.S. Bank Make check payable to MANY VOICES & send with this form to

MANY VOICES, PO Box 2639, Cincinnati, OH 45201-2639
CHARGE IT! (Please print clearly) (circle one) VISA MASTERCARD AMERICAN EXPRESS

Cardholder's Name:	
Acct.#	Exp.DateTotal:\$
Signature:	Today's Date