DISSOCIATION AND DID
RESOURCE GUIDE

CAROLYN SPRING
reversing adversity

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WHAT IS DISSOCIATION?

by Carolyn Spring

DISSOCIATION – STATE OR STRUCTURE?

There are lots of ways to describe dissociation and one of the reasons for the confusion surrounding dissociative disorders is that it can refer both to an experience – when we feel that we are drifting off into a fog, or we switch to another part of our personality – or to the fundamental state and structure of our mind. So to say that we dissociate can refer to something that we do or something that we are. Here are a number of ways in which dissociation has been described, and some quotes from professionals working in the field:

DISSOCIATION IS:

- a fairly common and normal response to trauma
- a creative survival mechanism
- a way of mentally blocking out unbearable thoughts or feelings
- a defence against pain
- an instinctive, biologically-driven reaction
- a splitting-off of mental functions which normally operate together or in tandem
- a normal process which starts out as a defence mechanism to handle trauma, but which over time becomes problematic
- a way of distancing or disconnecting ourselves from the awfulness of trauma
- a failure to integrate or join up information about the environment and our self

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- an alteration in consciousness which often feels like being detached or disconnected from the environment or our self
- an automatic and reflexive response based around survival from extreme threat
- a way to cope with irreconcilable conflicts in our mind (such as being abused by someone we love)
- a way of having conflicting emotions by keeping them separate in different parts of our mind
- a way of escaping psychologically when we cannot escape physically
- an automatic response when we are faced with overwhelming emotional or physical pain
- a coping mechanism for surviving overwhelming trauma
- 'a disruption in the usually integrated functions of consciousness, memory, identity, or perception' (APA, 2000, p.519).
- 'a lifesaving response to overwhelming life experiences' (Haddock, 2001, p.21)
- 'a partial or complete disruption of the normal integration of a person's psychological functioning' (Dell & O'Neil, 2009, p.xxi)
- 'a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of body movements' (ICD-10, WHO, 2010)
- 'a compartmentalisation of experience: Elements of a trauma are not integrated into a unitary whole or an integrated sense of self' (Van der Kolk et al, as cited in Dell & O'Neil, 2009, p.108)
- 'a protective activation of altered states of consciousness in reaction to overwhelming psychological trauma' (Loewenstein, 1996, p.312)
- 'an unconscious defence mechanism in which a group of mental activities split off from the main stream of consciousness and function as a separate unit' (O'Regan, as cited in Haddock, 2001, p.11)
- 'its purpose is to take memory or emotion that is directly associated with a trauma and to encapsulate, or separate it, from the conscious self' (Haddock, 2001, p.11)
- 'mental flight when physical flight is not possible' (Kluft, as cited in Sanderson, 2006, p.187)
- 'a major failure of integration that interferes with and changes our sense of self and our personality.' (Boon et al, 2011, p.8)

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DISSOCIATION AS A RESPONSE TO TRAUMA

Dissociation is an entirely normal response to overwhelming trauma. It is a way of us surviving something that otherwise would be unbearably painful, by narrowing down our consciousness, and failing to 'join up' the different strands of an experience, such as our actions, our memories, our feelings, our thoughts, our sensations and our perceptions. So we may have only an emotional memory (eg terror, disgust, shame) of what happened in a traumatic event, but no 'visual' record ('seeing it' in our mind's eye). Or we may have a vivid mental picture of what happened, but it is disconnected from our feelings, so it is as if it didn't affect us: we feel numb or nothing. The traumatic experience is 'unintegrated' and it takes on a life or identity of its own, separate from our main stream of consciousness. For the rest of our lives, we may have difficulty making a connection between what happened to us and how we felt about it at the time, or its impact on us in terms of how we feel or behave now. We may even struggle to connect with the fact that it happened to us at all.

DOES EVERYONE DISSOCIATE?

Some researchers believe that everybody experiences dissociation to a degree, and that dissociation exists on a continuum, ranging from mild to severe.

At the mild end of the spectrum the mind 'dissociates' unimportant information so that we can concentrate on the task in hand. This is a narrowing of attention to focus only on what is essential. Getting lost in a book is a choice to 'dissociate' away from external distractions. Similarly, 'highway hypnosis' is the name often given to the kind of lost-in-thought state that people can fall into when driving a familiar route. Consumed with their thoughts, they are driving perfectly safely and are ready to respond immediately in an emergency, but while 'on autopilot' their attention is focused inwardly on what they are thinking about rather than on the scenery. As a result they may miss their turning or arrive at their destination thinking, 'How did I get here so soon?'

In both of these examples, this is not a response to threat: in fact, it is the direct opposite, as it only occurs when the threat-level is low and there is a relative sense of 'safety' in the environment. For that reason some researchers do not think that this is the same kind of dissociation as is caused by trauma and which can lead to dissociative disorders. But many people do see it as existing on the same continuum as more problematic forms of dissociation and say that it is therefore a

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very normal, natural part of the way that our brain is designed to operate.

This kind of 'alteration of consciousness', where attention is directed on a specific task and away from other stimuli, can also be practised deliberately, for example in prayer or meditation.

PROBLEMATIC DISSOCIATION

Chronic, problematic, 'pathological' dissociation develops when there is repeated threat or trauma, especially when it starts at a young age, and when there is inadequate support or soothing from an attachment figure (usually a parent or primary caregiver).

This kind of trauma-based dissociation is an automatic, biologically-driven mechanism that is usually an involuntary response and which acts as 'mental flight when physical flight is not possible' (Kluft, 1992).

Probably the greatest risk factor for developing a dissociative disorder in adulthood actually comes not from the degree of severity of the trauma, but from having a 'disorganised attachment' pattern. This comes from being cared for in infanthood by a caregiver who is persistently 'frightened' or 'frightening' (Main & Hesse, 1996).

FACTORS WHICH MAKE CHRONIC DISSOCIATION MORE LIKELY

Childhood trauma does not automatically lead to a dissociative disorder. The greatest resilience factor is a secure attachment pattern. According to Christiane Sanderson, factors that increase the risk of developing a dissociative disorder include:

- The severity of the abuse
- The degree of coercion and pain
- The younger the child at the onset of abuse
- The longer the abuse goes on for
- Abuse by an attachment figure – betrayal trauma ('The need to reconcile the impossible: that the parent is both frightening and nurturing, both monster and rescuer.' (p.184))
- The presence of alternative realities (for example, nightly abuse versus daily normality)
- Social isolation during the abuse (no attachment figure with whom to process the experience, so it remains dissociated)
- Society's taboo on speaking about the abuse ('The child almost needs to push the experience outside of his

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consciousness in order to ensure that the CSA is not verbalised to others.')

- Reality-distorting statements from the abuser (such as 'That didn't happen; you were dreaming.')
- The perception of the abuse as trauma (eliciting fear, horror, pain). (Sanderson, 2006, p.185)

HOW DO DISSOCIATIVE DISORDERS DEVELOP?

Dissociative disorders develop as a result of dissociation being used as a survival strategy repeatedly during childhood. It is as if a 'groove' or 'track' in the mind is formed – in other words, certain neural networks are strengthened, and the mind develops with a propensity for dissociation as a coping mechanism for all kinds of stress, not just traumatic stress. Using dissociation repeatedly means that a child is unlikely to develop alternative coping strategies. This therefore affects their emotional and personality development.

The nature of dissociative identity disorder is that the trauma is hidden from view, 'dissociated' behind usually quite strong amnesic barriers in the mind. For this reason people can be well into middle or even late adulthood before these protective barriers disintegrate and clear evidence of a dissociative disorder is manifest.

MORE INFORMATION

http://www.nhs.uk/Conditions/dissociative-disorders/Pages/Introduction.aspx

http://patient.info/health/an-introduction-to-dissociative-identity-disorder

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THE SUBJECTIVE EXPERIENCE OF DISSOCIATIVE IDENTITY DISORDER

Sometimes I find myself somewhere and I don't know how I got there or where I've been, don't know how I am really, feel unreal, like in a dream. I feel like that now. I don't know who I am that's writing this. I'm not real, whoever I am. I feel like I'm ten different people squashed into one, all collapsed down like a concertina. I don't know where I start and where I end. I don't know where the inside of me is. I don't know if I'm really me or I just think I am. It's the strangest feeling. How can I not know who I am?

Carolyn Spring 2009

A KEY PROBLEM: DISSOCIATIVE IDENTITY DISORDER IS OFTEN HIDDEN

One of the major difficulties of dissociative identity disorder is that it is so often a 'disorder of hiddenness' (Howell, 2011, p.148). Many people with DID have grown up in an abusive family environment where they are sworn to secrecy and where hiding becomes a way of life. In adult life, the stigma and sense of shame around both sexual abuse and mental illness is a strong deterrent to making our history and condition known. And implicit to DID is a disconnection from or avoidance of both the trauma and the dissociated parts of our personality.

It is not surprising that many people with dissociative identity disorder do not appear to people around them as if they are suffering from any kind of mental health problem. Even spouses and partners can be kept in the dark for many years and it is very common for people with DID to hold down responsible and often highly-skilled jobs where colleagues and employers hold them in high esteem for their professionalism. The need to hide our struggles can be a major part of having DID. A large number of people with

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DID are private to the point of secrecy about their disorder, as shame is such a central facet. The 'signs and symptoms' of DID can therefore be non-existent to many people.

WHEN DISSOCIATIVE IDENTITY DISORDER BECOMES OBVIOUS

For some, this seeming normality continues until a particular stressor or life event precipitates a sudden and debilitating breakdown, where the exterior veneer of 'normality' is ripped away and dissociative and post-traumatic symptoms become very evident. Others may struggle at a lower level for many years, holding everything together during the daytime, whilst nights are chaotic and disturbed. Some people are so traumatised and have had so little appropriate treatment that they are long-term, 'revolving-door' patients in the psychiatric system and in some cases require 24-hour care: dissociative identity disorder exists on a huge spectrum and whilst the same underlying mechanisms of surviving trauma are at work, they are expressed differently depending on a number of factors including level of support, economic status, other comorbid conditions, physical health, education, temperament and personality.

DISSOCIATIVE IDENTITY DISORDER: PARTS OF THE PERSONALITY

Someone who has dissociative identity disorder may have distinct, coherent identities within themselves that are able to assume control of their behaviour and thought. When they 'switch' to these parts, they may be totally unaware or they may be conscious of themselves acting and talking in a manner different to normal. They may feel that they are just watching what is happening from a distance, incapable of intervening, as if it is not really 'them'. They may or may not be aware of these 'alter personalities', who may present with different names, mannerisms, gender identity, sense of age etc. These 'alters' or 'parts' very often have a different way of perceiving and relating to the world as well as different characteristics, memories, sense of identity, and emotions.

Switching to another part can sometimes be very subtle whilst at other times it is very obvious to an observer: there can be dramatic changes in tone of voice, body posture, use of language and levels of eye contact, to name but a few obvious signs. The person with dissociative identity disorder however may not be aware that it is happening at all. They may just have a

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sense of losing time or incoherence about who they are and what they have been doing. They may pick up the conversation at the exact point at which they left it several minutes previously, before they switched, with only a vague sense of 'missing' something. They may appear to have fazed out temporarily and put it down to tiredness or not concentrating; or they may appear disoriented and confused. For many people with DID, switching unintentionally like this in front of other people is experienced as intensely shameful and often they will do their best to hide it.

MULTIPLE SYMPTOMS RATHER THAN 'MULTIPLE PERSONALITIES'

In practice, the vast majority of people with dissociative identity disorder do not obviously present as if they have 'multiple personalities'. Instead they present for treatment with a number of symptoms. Some of these are dissociative or post-traumatic in nature, such as flashbacks, hearing voices, 'body memories' and so on. But many symptoms may appear to be non-trauma-related, such as depression, substance abuse, eating disorders and anxiety.

Paul Dell (Dell & O'Neil, 2009) argues convincingly that the externally-observable

'signs' of switching between personality states are only a very small part of what dissociative identity disorder is like in practice. He says that instead it is characterised by 'highly frequent intrusions into executive functioning and sense of self' (p.227) and that these 'intrusions' occur more frequently than switching, perhaps as much as one hundred times more often.

'DISSOCIATIVE INTRUSIONS'

These 'intrusions' may take a 'positive' or 'negative' form, i.e. they may be 'additions' or 'subtractions'. For instance, a flashback is a sliver of memory that is an 'addition', an extra piece of information entering consciousness; conversely, amnesia is where memory has been taken away or subtracted so that it is no longer conscious. Similarly, an intrusion may be related to sensation, in either its 'addition' or 'subtraction' state: for example, pain that is felt that comes from the past (often

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called a 'body memory') is an intrusion that is an 'addition', whereas the loss of sensation or even full anaesthesia and being unable to feel a part of the body is that same sensation but as a 'subtraction'.

Dell also argues that dissociation affects every realm of our lives: 'There is no human experience that is immune to invasion by the symptoms of pathological dissociation. Pathological dissociation can (and often does) affect seeing, hearing, smelling, tasting, touching, emoting, wanting, dreaming, intending, expecting, knowing, believing, recognising, remembering, and so on' (p.228).

FULL DISSOCIATION VERSUS PARTIAL DISSOCIATION

Dell makes a distinction between 'full dissociation' and 'partial dissociation'. In both states, remnants of dissociated trauma 'intrude' or push through from the unconscious into conscious awareness: these include flashbacks, and the many thoughts, feelings and sensations which suddenly come, unbidden, into our awareness, such as memories, smells, emotions, etc. 'Full dissociation' is when dissociative intrusions are fully excluded from consciousness, so we are not aware of them: they come to one part of the personality, but not another. They are therefore experienced only when a switch to another part of the personality has taken place and there is amnesia for the main 'host' or main part of the personality for what that other part is experiencing, thinking, or feeling.

'Partial dissociation' however involves intrusions that are only partially excluded from consciousness, and involves the person being 'disturbingly ... aware of the involuntary, ego-alien intrusions into his or her executive functioning and sense of self' (p.228). Dell argues that the majority of the symptoms of dissociation occur with 'co-consciousness', i.e. with partial awareness, and that the classic portrayal of dissociative identity disorder 'is so skewed that it constitutes a serious misrepresentation of the disorder' (p.229).

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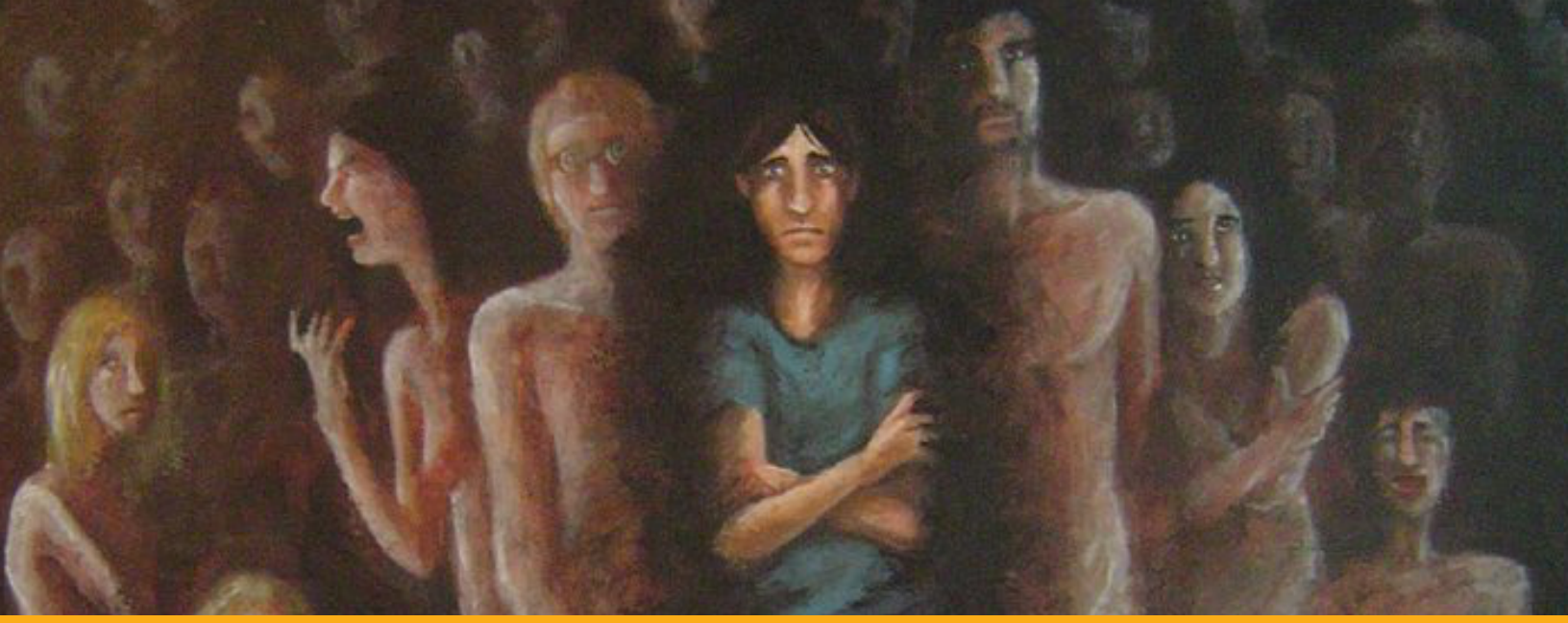
SYMPTOMS OF DISSOCIATIVE IDENTITY DISORDER

Dell suggests a list of 29 symptoms which he argues more realistically represent the symptoms of dissociative identity disorder:

- General memory problems
- Depersonalisation
- Derealisation
- Posttraumatic flashbacks
- Somatoform symptoms
- Trance
- Child voices
- Two or more voices or parts that converse, argue, or struggle
- Persecutory voices that comment harshly, make threats, or command self-destructive acts
- Speech insertion (unintentional or disowned utterances)
- Thought insertion or withdrawal
- Made or intrusive feelings and emotions
- Made or intrusive impulses
- Made or intrusive actions
- Temporary loss of well-rehearsed knowledge or skills
- Disconcerting experiences of self-alteration
- Profound and chronic self-puzzlement
- Time loss
- Coming to
- Fugues
- Being told of disremembered actions
- Finding objects among their possessions
- Finding evidence of one's recent actions.

'SOMATOFORM' SYMPTOMS OF DISSOCIATIVE IDENTITY DISORDER

Dell's list is a huge improvement on the stereotyped and minimalistic criteria in diagnostic manuals. He also mentions 5 'somatoform symptoms', meaning symptoms related to the body, and other clinicians such as Ellert Nijenhuis stress the fact that somatoform symptoms are just as important as psychological ones in dissociative disorders. For example, people with dissociative identity disorder often are physiologically hyperaroused–wound-up physically, with an exaggerated startle reflex, and hence they may find it very difficult to relax and to sleep. There are frequent gastrointestinal problems, chronic medically-unexplained pain, and a high incidence of autoimmune-related disorders such as chronic fatigue syndrome, fibromyalgia and rhemuatoid arthritis.



WHAT IS DISSOCIATIVE IDENTITY DISORDER (DID)?

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WHAT IS DISSOCIATIVE IDENTITY DISORDER?

Dissociative identity disorder (DID) is neither a personality disorder nor a psychosis. It is certainly not the same as schizophrenia, with which it is often mistaken.

DID is simply a creative survival mechanism for coping with overwhelming and chronic childhood trauma.

IS DISSOCIATIVE IDENTITY DISORDER THE SAME AS MULTIPLE PERSONALITY DISORDER?

Its previous name of Multiple Personality Disorder was misleading, as it suggested that in dissociative identity disorder the person has multiple personalities, as if several different people are living in the same body. This may be what it subjectively feels like to many people with DID, but it is not the objective truth. Rather, the personality of the one person is comprised of many 'parts' 'that are not yet functioning together in a smooth, coordinated and flexible way' (Boon et al, 2011): the one, single person does not have a unitary, single sense of self, but perceives themselves to be multiple. They may also be experienced by others as such, with different 'parts' becoming at times quite autonomous and identifying themselves with different names. The 'parts' that make up the whole that is a person with dissociative identity disorder may perceive themselves to be of different ages or different genders, and will have in subtle or obvious ways very different

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ways of perceiving and relating to the world around them. It is therefore easy to see why it is thought of in terms of 'multiple personality', but a more accurate rendering is that the person with DID has multiple parts of a single personality, even though it often doesn't feel this way.

WHAT CAUSES DISSOCIATIVE IDENTITY DISORDER?

Dissociative identity disorder is almost exclusively caused by repeated childhood trauma in the absence of appropriate parental support and is a way of coping with that trauma, rather than being a lifestyle choice or simply a variation of 'normal' experience. The personality is experienced in a disconnected way via separate 'parts' or 'alters' because of conflicts between those parts, and a failure in psychological development to 'integrate' or join together the different facets of personality, memory, identity, behaviour and feelings.

Most people achieve a unitary sense of self in the course of normal psychological development, so that as an adult they are aware that they are the same person they were as a child, the same person they are now looking back on being a child, and the same person who exists in all the different roles in life, such as parent, partner, work colleague, friend and family member. Most people can 'shift gears' between these different parts of their personality without thinking about it, and retain a single sense of themselves and their identity whilst operating in these different roles. They do not lose a clear sense of 'I' either across their different roles in life, or across the lifespan. But someone with dissociative identity disorder may find this much more difficult – they may not have a sense of a thread running between all the different parts of their experience, a single, core sense of 'I'. Furthermore they may experience intense conflict between different 'parts of the personality' and may experience some degree of amnesia or lack of conscious awareness when 'switching' to a different part of themselves.

It is important to realise that the different parts of the personality in dissociative identity disorder usually exist because of this conflict and because of the unbearable intensity of their feelings. A large part of recovery from DID involves resolving these conflicts so that there is no longer any need to remain separate, with knowledge and emotions partitioned off in discrete sections of the mind. This is the essence of 'integration' – bringing together parts of the self that have become and remain separate.

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WHAT IS DISSOCIATIVE IDENTITY DISORDER LIKE?

Although everyone with dissociative identity disorder is unique, often they share certain characteristics with others with DID, and this is especially true in terms of the way that the different parts of the personality are structured. This concept of conflict can be seen at a fundamental level in terms of two main types of parts within a person's internal 'architecture'.

There are usually parts who try very hard just to get on with normal life, who want to be seen as normal, participate in family and work life, and do not want to be identified either as mentally ill or as having a history of trauma or abuse. This conflicts hugely with other parts of the personality whose main function or role has been to try to protect the person from the kinds of abuse or trauma that they suffered as a child.

Whilst parts of the personality that do normal life often have little or no memory or acceptance of having been abused as children, trauma-orientated parts tend to be overly focused on what happened and can at times be consumed with both their feelings about it and their sometimes frantic attempts to prevent it from happening again: to them it can feel as if the abuse is ongoing despite in most (but not all) cases having ceased many years previously. There is a fundamental struggle for these parts to be able to differentiate between past and present. As a result, they can be hypervigilant to threat, wary and mistrustful in relationships, and find it difficult to relax and even sleep: they are on constant high alert. Their behaviours make perfect sense in the light of the kinds of things that happened to them as children – usually extensive and repeated abuse of an often extreme nature – but without clear consciousness of that trauma history, it rarely makes any sense to the 'adult' parts of the person.

These parts are just trying to carry on with life and their survival strategy has been to keep knowledge and awareness of the abuse out of mind, along with the feelings that should go with it. Often this strategy is so successful that they have either partial or total amnesia for their abuse. It is therefore highly confusing and distressing when the forgotten trauma 'intrudes' into consciousness in the form of flashbacks, 'body memories' and triggers: it simply feels as if they are going 'mad'. It is often only when these intrusions become unbearable – when they thwart the strategy of forgetting, avoiding and just getting on with life – that people will seek help and begin to

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accept that they may have a traumatic history and a dissociative mind.

This basic conflict between two different types of 'alter' or 'parts of the personality' is described in a theory of the development of dissociative disorders called 'structural dissociation', developed by Onno van der Hart, Ellert Nijenhuis and Kathy Steele and expounded in their book The Haunted Self (2006). They refer to two main types of 'alter' or 'parts of the personality' in dissociative disorders: ANPs (Apparently Normal Personalities) and EPs (Emotional Personalities). ANPs are avoidant of trauma and often phobic of relationships and emotions, whilst the EPs are stuck in so-called 'trauma time' with the abuse they suffered as a child repeating as if on a permanent loop in their minds: it has never been fully acknowledged, thought about, and integrated into the whole of their personality.

Suzette Boon describes dissociation as:

a kind of parallel owning and disowning of experience. While one part of you owns an experience, another part of you does not. Thus, people with dissociative disorders do not feel integrated and instead feel fragmented because they have memories, thoughts, feelings, behaviours and so forth that they experience as uncharacteristic and foreign, as though these do not belong to themselves.

(Boon et al, 2011)

This is what often characterises DID: a simultaneous owning and disowning of the trauma, constant struggles with denial, and a corresponding confusion in identity.

IS DISSOCIATIVE IDENTITY DISORDER ALWAYS OBVIOUS?

Dissociative identity disorder can often be bewildering to both the person who has it, and people around them. It does at times present dramatically, with switches between parts of the personality being very obvious and quite disconcerting, especially to people who do not understand the reasons for it or the way in which the dissociative mind is structured. However, Richard Kluft emphasises that dramatic presentations of dissociative identity disorder are the exception rather than the rule. He argues that 'only 6% make their DID obvious on an ongoing basis' (Kluft, 2009, p.600). Elizabeth Howell similarly refers to DID as 'a disorder of hiddenness' (Howell, 2011, p.148) and there is growing consensus that the representation of dissociative identity disorder in media

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portrayals such as Sybil is a caricature that is not based on the real experiences of the majority of people with DID. Most in fact do their best to hide their symptoms, in accordance with the function of the 'apparently normal' (ANP) parts of themselves, which is to avoid reminders of the trauma, as well as other parts of the personality. In a society in which there still remains huge stigma and discrimination for having any form of mental illness, overtly demonstrating the dissociative parts of one's personality is arguably 'maladaptive' as it often leads to rejection, shame and mockery.

People with dissociative identity disorder exist on a huge spectrum. Some are able, at least most of the time, to maintain both a family and work life and may even do so brilliantly. Others are severely disabled by their condition and in the absence of adequate treatment have little or no control over the trauma-based (EP) parts of their personality and their switching between these parts. One of the enduring legacies of childhood trauma and abuse is difficulties in managing feelings (affect regulation) and given the insistent, pervasive nature of intrusive dissociative symptoms such as flashbacks, as well as difficulties with sleep, it is hardly surprising that daily life can be extremely difficult for someone with dissociative identity disorder.

WHAT IS THE OUTLOOK FOR DISSOCIATIVE IDENTITY DISORDER?

There is however a very positive prognosis for people with dissociative identity disorder. With the right treatment – which is generally held to be long-term, individual, outpatient-based, phase-oriented psychotherapy (see Treatment Approaches article) – there is a very good outlook for at least partial recovery. The main work of therapy is to increase co-operation and decrease conflict between the various dissociative parts of the personality, to work through the underlying trauma so that it no longer intrudes into consciousness from dissociated parts of the mind, and to foster secure attachment through the therapeutic alliance. The main difficulties for people with dissociative identity disorder are accessing appropriate treatment that will be stable, consistent and long-term enough, especially when dependent on NHS provision.

MORE INFORMATION

http://www.nhs.uk/Conditions/dissociative-disorders/Pages/Introduction.aspx

http://patient.info/health/an-introduction-to-dissociative-identity-disorder

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For dissociative identity disorder (DID) to develop, there is usually chronic trauma in early childhood along with significant problems in the child-parent relationship.

Dissociative identity disorder does not happen in a vacuum: it does not result from a chemical imbalance in the brain, and is not caused by faulty genes. There may be biological, social and environmental factors which increase people's vulnerability to developing a dissociative disorder. But more than anything, DID develops as a result of trauma and disorganised attachment.

RISK FACTORS FOR DEVELOPING A DISSOCIATIVE DISORDER

Some researchers propose that there are three factors which might increase the likelihood of someone developing a dissociative disorder:

1. Biologically, some people may have a greater tendency to dissociate, or they may have organic problems in the brain which makes it harder for them to integrate (or associate, as opposed to dissociate) their experiences.
2. Young children's brains are less mature than adults, and they are more susceptible to develop a dissociative personality because their sense of self and their personality are not very cohesive – they are still developing. They are less able than adults to cope with and integrate traumatic experiences. So the younger a person is when they experience trauma, the more likely they are to develop a dissociative disorder.
3. Children who lack emotional and social support are more likely to develop trauma-related dissociative disorders. If they are growing up in a toxic or

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neglectful family environment where they are not supported to cope with difficult feelings and situations, they are more likely to use dissociation as a way of dealing with trauma. It is less likely that they will be able to 'integrate' it into their autobiographical narrative (the story of their life), if they have neither the words to talk about it, nor anyone who is willing to listen and to care for them in it. Traumatic events are therefore likely to remain 'out of mind', or in other words dissociated.

TWO PRINCIPLE PATHWAYS TO DISSOCIATIVE IDENTITY DISORDER

According to research, there are two main factors which lead to a dissociative disorder: trauma, and disorganised attachment. Or put simply, trauma which happens repeatedly, especially abuse caused by an attachment figure (caregiver) or where that person is either 'frightened or frightening'.

But dissociative identity disorder seems to develop only as a result of childhood trauma. Often the symptoms of a dissociative disorder do not become apparent until adulthood, but it is generally felt that trauma which occurs solely in adulthood will not result in a dissociative disorder. It may well result in post traumatic stress disorder (PTSD), but dissociative identity disorder is a developmental disorder as well as a post-traumatic one. Some people argue that for it to develop, the trauma needs to be chronic (i.e. it happens a lot) and it needs to have begun by the age of 8 years old, and probably even younger. One of the reasons for this is that DID is intimately associated with attachment, and attachment patterns are being formed especially in the first three years, providing a template for the rest of life.

Richard Kluft offered a theory of the development of dissociative identity disorder based on four factors:

1. The capacity for dissociation.
2. Precipitating traumatic experiences that overwhelm the child's non-dissociative coping capacity.
3. Specific psychological structuring of the DID alternate personalities.
4. Perpetuating factors such as lack of soothing and restorative experiences, which necessitate individuals to find their own ways of moderating distress.

(Kluft, as cited in Chu, 2011)

Elizabeth Howell (2011, p.xvii) says:

Dissociative identity disorder is usually the outcome of chronic and severe childhood trauma, which can include physical and

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sexual abuse, extreme and recurrent terror, repeated medical trauma, and extreme neglect.

However, it is important to note that the overwhelming trauma for a child may not be deliberate and malicious. She also notes:

Parental illness, depression, or problematic attachment styles may be psychically overwhelming and lead to disorganised attachment. In addition, medical trauma may be dissociogenic. For example, some dissociative patients have reported histories of chronic medical problems and hospitalisations that involved severe pain and unavoidable separations from well-meaning parents. (p.xvii)

So dissociative identity disorder is not always caused by intentional and malicious abuse, but on the vast majority of occasions it is. One team of researchers (Brand, Classen, Lanius et al, 2009a) found that amongst their patients with dissociative disorders, 86% reported a history of sexual abuse and 79% a history of physical abuse. It is possible that the percentages are even higher than this, because amnesia for trauma is one of the main symptoms and indeed diagnostic criteria for DID: many more might have reported abuse had they been able to recall it. •

HOW TO FIND A THERAPIST FOR A DISSOCIATIVE DISORDER

by Carolyn Spring

Individual psychotherapy is the treatment of choice for dissociative identity disorder (DID) according to the treatment guidelines issued by the ISSTD (International Society for the Study of Trauma and Dissociation). But just because one-to-one therapy is demonstrably highly effective (Brand et al, 2009), it does not mean to say that it will happen automatically. In many areas of the UK, people have battled unsuccessfully with the NHS to get the therapy they need, and so rather than starting to recover, people with dissociative disorders may spend years in a treatment wilderness, alone and receiving little or no help.

HOW DO I GET HELP?

This is the most frequently-asked question I've ever been asked. Whilst many people who come across my work are aware that their problem falls somewhere on a dissociative or post-traumatic spectrum, what they are usually less aware of is how to find appropriate treatment. A common misconception is that the NHS is the only route. Most of us have been brought up to assume that this is the case – after all, if you have a chest infection or recurrent nosebleeds or want to change your method of contraception, you go to your GP; if you are involved in an accident, you go to A&E. We are all aware that you can

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try to register with an NHS dentist if one is available in your area, or you can pay go to private. Some people are used to paying privately for osteopathy or to see a chiropodist. We are not quite so sure what to do in the case of mental health.

When I had my first major breakdown in 2005, I resisted talking to my GP about my symptoms at all. It felt too shameful and I was worried about what would be detailed on my medical records: a potential future black mark for employment or health insurance purposes. Eventually I did open up to a GP but only once I had started seeing a counsellor privately: it took several months of therapy for me to overcome the stigma and the fear and to be able to 'confess' to my doctor that I was receiving counselling and that I had been sexually abused.

At many levels, my GP was great: very understanding and supportive, available in emergencies, discerning in her prescribing. She knew nothing at all about dissociative identity disorder (she asked me repeatedly to tell her what DID stood for and how to spell it) but her ego was not threatened by her ignorance and she subscribed happily to the concept that the patient is the expert on themselves. Worryingly, however, during one of my particularly difficult patches, her powers to help appeared particularly limited: 'I don't want to refer you to mental health services,' she said. 'You're in enough of a state as it is.' It was a rather damning indictment on the reputation of our local NHS psychiatry team. 'They won't do anything for you,' she explained, somewhat apologetically. 'You're better off sticking with your private counselling and avoiding them.' Then, with a wry, mirthless smile: 'You'll get through this. I know you will.'

In these circumstances, I seemed to have little choice other than to continue to seek help privately, but many people feel trapped into following a route set by the NHS. There is a belief that 'This is the way it is', and experts with letters after their name will decide what is wrong with you and how you should be treated on the basis of a 15-minute consultation. Sometimes it works, but it can be an incredibly disempowering and even shaming experience. Many psychiatrists do not believe that dissociative identity disorder exists, have not been trained to recognise let alone diagnose it, and shoehorn people into the 'therapeutic interventions' that are offered locally. For many, with the Government's emphasis on the IAPT scheme (Improving Access to Psychological Therapies), this is limited to 6 to 12 weeks of Cognitive Behavioural Therapy. A number of people

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I have spoken to have been 'encouraged' to attend a 'therapeutic community'. One person with dissociative identity disorder and a First Class degree spent 6 months in one – learning to wash up, as she pointedly told me. She received no individual therapy during that time.

Looking back at my situation in 2005, I didn't know much about therapy or counselling at all. I just hadn't come across it previously, so it didn't occur to me to seek it out. I spent a year crashing around in chaos and relational turbulence until eventually someone pointed me in the direction of a counsellor 20 miles away. I was desperate and hopeless and at the end of myself. I assumed that counselling lasted 6 weeks or so, at tops 6 months. That first round of therapy went on for just under ten years – so I now know that therapy for dissociative identity disorder is not quite so 'brief'. But that referral to a counsellor was life-changing and a turning point for my mental health. Things did get worse before they got better in many regards, but from that initial assessment meeting I at least had hope: 'I think I can help you' the trainee counsellor said to me before she left, little knowing what she had let herself in for.

A lack of awareness about the existence of therapy, let alone an understanding of the jargon or how to go about accessing

it, is a massive stumbling block for many dissociative survivors, who in their understandable ignorance feel that the NHS is their only option. I now encourage people to seek out professional therapeutic help from the private or voluntary sector wherever possible. However, I readily acknowledge that there are a number of hindrances. Denial is probably the principle barrier: until people come to accept that there is a problem, that the problem is not going to go away by itself, and that the problem is big enough to need dealing with, few would consider worthwhile either the effort, the expense or the sheer pain of therapy.

And many struggle with an inherent sense of unworthiness: do I really deserve to take an hour or two or more (including travelling time) out of my busy week, impacting perhaps upon my partner or children or my job, to sit down with

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someone and talk just about me? It can feel an incredibly selfish thing to do. Of course, it's not – it's absolutely essential for recovery. But many hear in their heads the vile accusations of abusive caregivers from the past: 'You're so selfish', 'It's wrong to need', 'Me, me, me!' and it can take some people years to actually allow themselves the space, the time and the expense of seeking therapy.

And then there are a raft of logistical hurdles to overcome: how will I pay for it, how will I get there, how will I arrange time off work or find childcare, how will I find a suitable therapist, how will I find someone who knows about trauma or dissociation, how will I overcome my agoraphobia or OCD, how will I find where I'm going when I'm switching, how will I manage the build-up and survive the aftermath?

These are all real and pressing concerns and are experienced by many, many survivors. If people persist in thinking that they are not worth helping, or that no-one will believe them, or that therapy is impossibly expensive or risky or 'wrong', then those beliefs in themselves will determine the outcome: they won't even start to look for help. If you believe that you are bad, what's the point? There's nothing that can be done. But if you are able to say, 'I am not bad – I am traumatised and I am experiencing various symptoms of unhealed suffering for which help is available somewhere', then you can start to break the problem down into bite-size chunks to make the impossible possible.

HOW DO I FIND A THERAPIST?

Firstly, where to look? It is a sad reality that only a small proportion of counsellors and therapists are aware of dissociation, but that number is growing year on year.

There is much debate about whether you need to find a therapist who is experienced in working with dissociative disorders, or whether you need to find a therapist who is capable of working with dissociative disorders. In an ideal world, in my opinion, trauma and dissociation would be part of the curriculum for all trainee therapists, regardless of modality. That's not currently the case and so the

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main vehicle for acquiring the requisite knowledge and skills is CPD (continuing professional development) – ongoing training after initially qualifying. As in all fields of work, you can't get the experience except by getting the experience. I have worked with a number of therapists, some of them more skilled than others, and some of them more experienced than others. There is no clear linear correlation in my experience between someone's ability to help you and their qualifications and training – at least on paper.

My baseline starting point for working with a therapist is that they are grounded and mature as human beings, that they have compassion and are able to communicate it, that they are humble and not on an ego or power trip, and that they are a safe pair of hands. They must be willing to learn, to develop their skills, and they must be open to skilled and preferably specialist supervision. For me, it is their humanity and their safety that are key – skills can be acquired, but character and disposition less so. Are they able to remain calm and grounded in the green zone when the client is triggered into amber or red? Are they able to cope with what they hear? Are they able to maintain professional boundaries and act in the client's best interests at all times?

Personally I would never consider working with someone who is not properly qualified and is not a member of a professional body, bound to an ethics code, and who is properly insured and acts professionally. These are the basics of good therapy and should never be skidded over because someone seems 'nice' or 'experienced'. Working with trauma and dissociation is demanding work, and if the foundations of ethical, professional clinical practice are not in place, then that for me would be a red flag.

There are various counselling directories through which you can search for a counsellor therapist, including those run by professional bodies. As a starting point you can try:

BACP: https://www.bacp.co.uk/search/Therapists

UKCP: https://www.psychotherapy.org.uk/find-a-therapist/

Counselling Directory: https://www.counselling-directory.org.uk/

Sensorimotor Psychotherapy Institute: https://account.sensorimotorpsychotherapy.org/home/directory-eu/prUK.html

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HOW MUCH DOES THERAPY COST?

Many people believe that therapy is always expensive. While it is true that the usual rate for an hourly session can range from £30 to £75 or more, it is always worth checking with individual therapists to see if they offer reductions for low income, operate on a sliding scale basis or will even counsel for free. Many will negotiate dependent on your circumstances. When money is tight, another option is to approach local Rape Crisis centres, who are often able to provide low-cost counselling, at least for a time-limited period. Various charitable groups also often provide subsidised services, including the national mental health charity MIND who have regional offices throughout the UK. Even if there is no apparent therapy provision near you, charities or counselling centres may know of other people you may be able to approach in the locality. It does take some effort, but it is worth it in the long-run.

DIFFERENT THERAPEUTIC APPROACHES?

The jargon associated with psychotherapy can be very off-putting and difficult to overcome. In this article 'counselling' and 'therapy' or 'psychotherapy' are being used as interchangeable terms, but many people make a distinction between them. Counselling tends to refer to more short-term work for generalised issues, and psychotherapy assumes longer term work with more complex or specialised issues. Just as survivors may dislike being labelled, the same can be true for professionals working in this field and it is best to treat everyone as a unique human being and actually talk to them to find out how they view themselves in relation to you.

There are some psychologists also working in private practice, but the majority are usually found within the NHS. In essence their approach may not differ much from that of counsellors and therapists, but they have arrived at their current position via a slightly different route, with a degree or doctorate in counselling or clinical psychology and they may be registered with the Health Professionals Council. Psychiatrists are a different breed altogether, being medically qualified doctors who have specialised through further training in psychiatry. Very few of them will have undertaken any kind of therapy for themselves and tend to focus on diagnosis, prescribing medication or directing services – it is fairly rare that a psychiatrist will engage in one-to-one therapeutic work, although they do exist! If you pursue therapy privately, you may never come into contact with a

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psychiatrist – which some feel is a good thing, but there are some wonderful psychiatrists out there too!

The range of 'modalities' or 'approaches' used by counsellors can be extremely confusing: cognitive behaviour therapy, psychodynamic, Gestalt, existentialist, person-centered, dialectical behaviour therapy, sensorimotor psychotherapy, humanistic, Rogerian, Adlerian, psycho-synthesis, integrative … to name but a few. In reality, the label means different things to different people and only by talking with and perhaps even meeting a counsellor can you really gauge whether you would feel comfortable with their approach.

There is currently no specific recommended modality or pathway to working with dissociative disorders, and although you may be better off working with someone who is already experienced in this field, the important thing is the relationship you form with them and their willingness to treat you as uniquely you rather than according to any preconceived idea. People with dissociative identity disorder exist on a wide spectrum and no two are the same, so it is important that therapists with prior experience don't assume that you will think and feel and react and behave the same way as their last dissociative client did! It is often recommended that they seek specialist supervision when working with dissociation and complex trauma, but this is their responsibility, not yours, although it is a reasonable question for you to ask.

And this is the important point: that it is okay for you to be picky and to choose your therapist yourself. You do not have to operate on the basis of 'I have to take what I'm given' – you are the client and it is essential that you are comfortable working with the person that you choose. This is often the downside of receiving therapy via the NHS, in that you do get what you're given and have very little choice in the matter. One of the most helpful aspects of private therapy is being able to exert some element of 'control' (as opposed to powerlessness) in pursuing what you need. It is perfectly appropriate to contact a number of potential therapists and to 'interview' them to see whom you would feel happiest working with.

This aspect of 'choosing' is very difficult for many survivors. It may feel ungrateful to turn someone down – 'After all, shouldn't I be thankful that they're willing to help me at all?' – but you don't have to make your mind up there and then. You don't have to accept the first therapist who agrees to meet with you, and it is

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equally okay to change your mind after a few sessions. Being in control and being able to choose is a really important part of recovery, and if you don't feel safe or able to work with someone, if they make you feel trapped or ashamed in a way that you cannot challenge, then it is okay to stop seeing them. Therapy is supposed to make you feel better, not worse! Too many people get 'stuck' working with someone with whom they cannot form a 'working alliance' because they feel that it must be their fault – for being relationally defective or 'difficult' in some way. But we need to accept that not everyone gets on with everyone, and that's ok. A good therapist will explain this in the early stages and give you the freedom to work with them or equally to say that you don't want to come any more. You don't need to worry about hurting their feelings!

THE CHALLENGES OF LOOKING FOR A THERAPIST PRIVATELY

One of the realities of many dissociative identity disorder survivors' lives is that due to trauma having had a profound effect on their ability to work and manage life, often they are at the lower end of the socioeconomic ladder. In other words, they don't have much money! The benefits system is intrinsically shaming and is based on you continually having to prove your entitlement. This can infect a survivor's thinking so that they do not feel entitled to therapy (especially if they are having to pay for it themselves), and they can feel powerless and without choice.

People higher up the socioeconomic spectrum are generally more comfortable, through experience, with paying for services. They may pay for a cleaner, or pay privately for dentistry. They may engage professional services such as solicitors to buy or sell a house, and they are used to engaging tradesmen to service the boiler or replace the carpet. In short, they are more used to paying people to do things for them, and therefore more comfortable with expecting a standard of service and being valued as the customer or client. For some survivors, it can be difficult to transition into this mentality when paying for therapy: for some it is a new concept that they deserve a certain level of service, and that the therapist is not just doing them a favour by agreeing to see them. This should be the case even for a reduced fee or no fee at all; otherwise the survivor can feel in an unhelpful 'one-down' position that replicates old abuse dynamics.

Many clients struggle with a sense of shame and embarrassment in having to pay for professional help. Especially in an area such as counselling, it can feel 'weird' to have to pay someone to listen

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to you, and potentially to care about you. A helpful way of looking at it is that few counsellors make much money out of their work, because most of it goes on training, supervision, books, insurance and room hire, to name but a few principle costs. Especially with dissociative survivors for whom forced prostitution has been an issue, the exchange of money for 'attention' can trigger a lot of issues. For some it can be helpful to see the counselling fee not in terms of 'buying attention' but as a way of making it possible, by the provision of insurance and supervision and room hire, to ring-fence that time and the relationship to allow you to meet regularly. It is perfectly normal to struggle with this issue, and perfectly acceptable to talk about it at any point in the therapy.

'INTERVIEWING' A THERAPIST

When 'interviewing' potential therapists, it can feel as if there are 'rules' and it is difficult to know what the 'rules' are. One person asked me if it is okay to see someone for an initial session and go away to decide whether you wanted to continue. Of course it is! Choice and free will are essential foundations. It is okay to ask questions – any questions, and you can ask things directly and in some cases you will need to. For example, you need to ask about things such as the frequency and length of sessions (some people offer

fixed 50 minute sessions, others an hour, and still others are more flexible and will work for longer if appropriate). It is also a good idea to ask about the cost and how payment should be made, what length and frequency of holidays the therapist takes, what qualifications and experience they have (particularly in working with dissociation), which professional bodies they are registered with (if any), what their approach to working with people is … and anything else that pops into your head! Direct communication is difficult for many survivors, and so if it is too difficult to ask face-to-face then at least pose your questions in an email. Counsellors will not be offended at you asking these questions; in most cases, they will be grateful.

In making your decision about who to work with, it is important that you take into consideration all of the parts of your personality (however distinct or 'fuzzy')

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and make the decision with input not just from your more thinking-based parts, but from your emotional ones too! There are parts that are likely to be hypervigilant and wary, and it is important to take on board what their 'antennae' are picking up. Sometimes it will be a case of reassuring them that their fears are unfounded; but you must also take very seriously what they are feeling, as ignoring their concerns will certainly be counter-productive in the long-term and may blind you to potential dangers in the short-term. Whatever qualifications and experience a therapist has, they are still fallible human beings and just because they are a member of a professional organisation does not guarantee that they are entirely safe. It certainly lowers the risk, but you should never trust someone on the basis of external data alone – trust takes time to develop and it is okay to be wary and to go slowly.

DO YOU HAVE TO TALK ABOUT YOUR TRAUMA?

Many survivors have very understandable fears around what they will have to disclose about themselves in an 'assessment' session. Some feel that they need to tell the therapist everything about themselves in order to be 'fair' to the therapist. However, this is not the case. You need to strike a balance between respecting your own privacy, and especially your parts' right to privacy and safety, and saying enough to ensure that the therapist is sufficiently informed about your needs and likely treatment path.

If the therapist feels that they are not competent or sufficiently trained to work with you, they will say. But even if you don't want to say anything at all, that is okay too. Again, you need to feel safe and in control. Many survivors blurt everything out, because they feel that if they don't then they are somehow lying or being deceptive, only for that unwarranted disclosure to cause problems for other parts of themselves as they then feel exposed and vulnerable. Therapists do not require a full life history in the first session, and especially where trauma is concerned, it is not wise to start down that path until there is enough safety in the relationship to keep things stable.

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DIFFERENT THERAPY APPROACHES

Therapists working from certain schools of thought (eg psychodynamic) will place more emphasis on past events, whilst others (eg Gestalt) may focus more on how you are in the 'here and now'. It is certainly therefore not essential for you to disclose an entire life history, which can be a relief for many whose histories are either traumatic or muffled by amnesia.

There is a wide range of opinion about how to work effectively in clinical practice with dissociative disorders. Some people believe that you should work only with the presenting 'adult' and that parts should be dissuaded from appearing, as it is felt that this reinforces the dissociation and is unhelpful therapeutically. My most successful therapeutic work has been with therapists who have been willing to talk to 'all of me', however I present. At the same time, my therapy has never focused specifically on the presentation on parts, focusing instead on resolving the underlying trauma, and so it has always been a balance. If you feel strongly that you want parts to participate in therapy (and not everyone does) then obviously it is important to establish with potential therapists that this is how they work. An open-ended question such as 'What would you do if one of my parts came out?' is a helpful way to establish where a therapist is coming from without it being a leading question!

BE PERSISTENT

For some people, finding a therapist just 'happens', as someone is recommended to them or they find their details almost by accident. For others, it is a long, painful task with many discouragements. But the key is to keep looking, and to keep trying. Even seemingly insurmountable obstacles, such as a lack of money or transport, can be overcome over time or through asking the right questions of the right people. 'Not yet' is a good stance to take when faced with an obstacle: 'It's not yet possible, but I'm going to keep on trying.'

Certainly the benefits of long-term, individual therapy are worth waiting for. If the NHS is able to provide that therapy, then all well and good. But no-one should feel that that is their only option. We know only too well that there are hundreds if not thousands of therapists in this country who are passionate about what they do and are willing to work with people in the most extreme of circumstances, because they want to see people recover. Help is available, even though it may sometimes be hard to find. Don't give up! •

HELP, I'VE GOT DID! NOW WHAT ...?

by Carolyn Spring

It's scary to think you've 'gone mad'. It's scary to think you have some serious, incurable 'mental illness'. It's scary to not understand what on earth is going on in your brain.

And perhaps what's even scarier is finding out that what is 'wrong' with you has a name: dissociative identity disorder.

I spent so much time wondering what was happening to me, and I was so desperate to find the answer, that I didn't spend any time at all figuring out what would come next. I was so fixated on finding the right 'label' that I simply didn't have a plan at all for what to do when I found that label.

This is true for lots of people. We get a diagnosis (officially, unofficially, definite, or suggested) of dissociative identity disorder (DID) and there's relief that finally now the problem has a name. And then ... and then we have no idea what to do next.

We may assume that once we know what it is, help will follow. Maybe we didn't know how to get help for something whose name we didn't know; surely, then, help will quickly follow once we name it ...

But it doesn't seem to work that like. DID is a double-edged sword. On the one hand, understanding your symptoms within the framework of DID can be really helpful – you can begin to understand why your brain behaves the way it does, you have an overarching narrative to explain your experience, and you know (at last) that you're not alone.

But that doesn't mean that any medical professional you speak to will have heard of

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DID, let alone be prepared to accept it as a diagnosis, or even provide 'treatment' for it.

And anyway, treatment – what treatment?

DID is not like a broken leg, where the problem is obvious: here's a bone, and it's broken. It needs to heal. To help that process, medical professionals operate on it or set it back in alignment, hold it in place, protect it with a cast, tell you to rest it, and then allow a natural process to ensue: if the conditions are right, the bone will regrow.

Then there are conditions like cancer. In most cases, this doesn't resolve itself. It needs to be aggressively treated, targeted with drugs or radiotherapy or chemotherapy. If you don't, it's reasonably likely that the cancer will take over and win, and you'll die. Treatment is usually essential.

Where does DID fall on this spectrum? Give it some rest, a bit of support, and it will naturally heal? Or does it need tackling aggressively so that it doesn't get any worse, perhaps ending up as full-blown 'insanity'?

The neat answer would be to say that it lies in between. But I don't think that's true. Because I don't think the analogy between DID and physical illness works at all. I don't think you can easily place psychological trauma within the paradigm of physical illness and what some people call 'the medical model'.

With broken legs, there's been damage to a bone. It's snapped. With cancer, there's a proliferation of cells with faulty DNA, multiplying out of control.

But DID is neither of these.

Dissociative identity disorder is not sickness.

DID is the adaptations our bodies and brains make to growing up in a perpetually threatening environment. They are what our brains and bodies *are supposed to do*. They haven't malfunctioned. They're not ill. They just weren't ever supposed to suffer that kind of trauma.

This is important: *DID is not an illness.* Some would argue that it's not even a disorder, and I understand why – because it's the brain doing what the brain is supposed to be doing. That's not a disorder, is it? No, it's not – but the *effects* of it are 'disordered', in that they lead to symptoms in our everyday life that we'd rather not have (flashbacks, anyone?) I can live with calling it a disorder but I can't live with calling it an illness. (Others are free to disagree.)

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So in my way of thinking we can't approach 'treating' DID like we'd treat a broken leg or cancer. The physical health/mental health analogy just doesn't work.

DID is exactly what the brain is supposed to do when it's faced with chronic trauma. The difficulty is that it leaves us with brains that adapted to a dangerous, life-threatening environment, but which are not so good at chillin' out once that threat has passed.

So our brains adapted to danger, but now we're not in danger any more, they behave in ways that are out of place and (to say the least) inconvenient. So the trick is to get them to *adapt again* ... to safety.

That's the crux of the task ahead of us. We have to learn how to feel safe in our bodies again. And that's what 'treatment' in the form of therapy is all about:

- It's about resetting our nervous system, turning down the sensitivity of the brain's smoke alarm, which is set to react to the merest whiff of smoke.
- It's about bringing our front brains online to calmly and patiently assess threat, rather than the trigger-happy reaction of our back brains which operate according to the mantra 'better safe than sorry'.
- And it's about finding a way of filing all of our traumatic memories so that they don't keep bothering us in flashbacks and body memories. They keep coming into consciousness because they're trying to alert us to the potential for danger.

So we need to reassure our brains that the danger is past, that we've heard the warnings, thank you very much, but that everyone can calm down and go to bed, because the war is over.

An interesting question then is: why doesn't this process, this readjustment to life after the war, happen naturally?

Actually I think it probably does for a lot of people, and so over the long-term they don't present with 'mental health difficulties'. We're only ever going to notice when it doesn't happen. But there's a sliver of hope in there – I think a lot of

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people who experience (at least 'low' levels of) trauma actually do recover from it 'naturally', that is without intervention. That says to me that recovery is standard operating procedure. It's not something that we've got to artificially create – we just have to remove the blocks that are stopping it from happening.

One of the things that I've consistently found is that we ourselves are often the main impediment to recovery. That's not therefore to blame us for not recovering – blame sucks, so let's not go down that route! – but I'd suggest it's part of the syndrome, that we get stuck in a vicious cycle: Abuse from outside sources has stopped, but we actually perpetuate it ourselves because it's what we're used to. It maintains the status quo, and 'familiar' always feels safer to our primitive brains than does 'unfamiliar'. And it's so normal to us that we might not even realise that we're doing it.

But tune in and listen to your inner dialogue. What do you say to yourself? What's the background commentary on everything you do and feel? Are you your biggest supporter, or your greatest enemy?

For many years, my inner dialogue was led by the most negative, critical and abusive voice imaginable. Eventually I realised that it was a projection of my mother and other abusers. But it was inside my head. And it was constant. It was a relentless stream of self-loathing. I hated myself for everything I did, thought, felt and wanted. When I had longings to be loved or understood, I despised myself and shamed myself for those feelings. When I made a mistake, I berated myself for my stupidity. When I tried to imagine success or a happy life, I reminded myself caustically that I didn't deserve it.

It was incessant, this self-abuse. Over and over again. All day long. Beating myself up. Hating myself. Wanting to hurt myself. Wanting to kill myself. Feeling deeply ashamed of who and what I was. Never wanting to be me. Never giving myself a break. Always on my case, always criticising, always finding fault.

Eventually I came to realise that we can't recover from abuse if we continue to abuse ourselves.

I was spending a lot of time and effort wanting therapy, paying for therapy, going to therapy. I wanted to 'be better'. I wanted rid of my symptoms. I wanted life to be less painful. I wanted someone to come and cuddle me and love me and wrap me up in kindness, to make everything alright.

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And yet at the same time I was abusing myself. It sounds crazy now – such a contradiction, such self-sabotage! And it's one of the most distinctive elements of DID – the conflict within ourselves: parts of us pulling in one direction, parts pulling in another. And I was so used to that ambivalence, that paradox, that contradiction, that I didn't even notice it. *Doesn't everyone hate themselves like this?* I remember thinking.

If we want to recover from the effects of trauma, we have to stop traumatising ourselves. If we want to be able to feel safe again, we have to provide an atmosphere of safety, within ourselves. That is an essential, foundational step. Only if we're willing to work towards that will any 'treatment' we receive be effective. Otherwise, it will be a case of one step forwards, and two steps back.

Often survivors blame the therapist or the therapy (or the absence of therapy) for a lack of progress, when actually we're sabotaging our own efforts. Looking back, most times when I stalled in therapy and failed to make progress, it wasn't because the therapist was getting it wrong, or the therapy was poor, or we weren't using the latest whizz-bang therapeutic technique. It was because I was continuing to abuse myself.

We cannot learn to feel safe, and readjust to a safe environment, if we're sleeping with the enemy. It just doesn't make sense for our bodies and brains to lower the threat level and let our guards down, while the danger remains imminent. That's often why we don't make progress.

If we want to live without the after-effects of trauma – where our brains and bodies are geared to protect us from danger – then we have to remove the sources of that danger. Trying to feel safe while the abuser is still in the room is a futile exercise. How much more when the abuser is within our own *head*?

So we have to resolve our own self-abuse. We have to learn how to be compassionate and gracious towards ourselves. We have to – despite how much we might squirm even at the sound of it – learn how to love ourselves. We have to give ourselves the safety we need. *This* is the first step in recovering from trauma. There are many more, but a journey of a thousand miles begins with that first step. •

MAKING THE MOST OF THERAPY

by Carolyn Spring

You've come a long way. Misdiagnoses, mistreatment, maltreatment even – but eventually you're here. You've found a therapist willing to work with you – either privately or on the NHS – and so now you're expecting it just to happen. Right?

Wrong! Getting good therapy is an essential step in recovery from complex trauma and dissociative disorders but just turning up doesn't, in and of itself, make things 'better'. Therapy is not something that is 'done' to us, like radio therapy. It's not a case of sitting comfortably and letting the therapist do the work. In fact, in many ways, it's exactly the opposite. For therapy to be effective, we need to actively engage in it. But however much we know we might need it, however much we hope it will be effective, it's still the case that therapists have been to 'therapy school' to know what they're doing but we haven't been to 'client school' to know how to make best use of it.

And, let's face it – there's not much of it. It might be for just an hour or two a week, minus holidays, minus cancelled sessions due to illness or bereavement or accident. It may last just six weeks or six months or two years – however long it's for, invariably it's not long enough. So it's imperative we make the most of those precious hours we have, however few there are. Because, ultimately, research shows (Brand et al, 2012) that therapy is effective and for many of us it's not only our best chance but our only chance to get life back together again.

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So what can we do to make the most of therapy?

1. MAKE IT A PRIORITY

The first session or two can seem vitally important but it's easy to slip into an easy complacency once we're underway. We have a lot of reasons, unconsciously, to want to avoid it – we're vulnerable, we're talking about difficult subjects, it's bringing up painful feelings – and occasionally that means that we don't give it the priority in our week that it deserves. Right from the off, I put my sessions in my calendar weeks or even months in advance and everything else had to flow around it, even working full time. It was over seven years before I first voluntarily skipped a session – and that in itself was therapeutic because I was going on my first 'proper' holiday. But apart from that, my sessions take priority over everything else in my calendar. However ill I am feeling, however badly I slept, however busy I am at work – my sessions take priority. Everything else can wait: healing cannot.

2. GET IN THE ZONE

My sessions don't start at 10.30am on a Tuesday morning. My sessions 'start' in one sense on a Monday evening. These evenings too are usually sacrosanct – time to journal, to think, to plan how I'm going to use the session. And the next morning, I try wherever possible to allow myself space before the session starts, and after it has ended. When I had young children, that space was created by leaving early and going to sit in a coffee shop for an hour beforehand to 'get my head together'. I would read through my journals from the week before, my journals from during the week, I would sketch out things I needed to focus on. Whenever I skimped on this, whenever I didn't take the time to pull myself out of 'normal' life and allow myself some time in this emotional airlock, the sessions were never as productive. Sometimes, out of avoidance, I would find myself getting busy with stuff that I really didn't need to be busy with, and then, finding myself running late, I would speed to therapy and turn up in a hyperaroused state. It was never the best way to start, to already be out of my window of tolerance.

Punctuality is key. When my therapy was an hour's journey away and accessible only via The World's Busiest Road, I would leave two hours for the journey, just in case. Occasionally, an accident or hold-up meant that I did only arrive with minutes to spare – if I hadn't left so early, I would have missed my session entirely.

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Most of the time I had an hour to kill but I could use it productively sat somewhere with my journal, planning my session. Better early than never.

3. PLAN HOW TO SPEND YOUR SESSION AND TAKE THE DRIVER'S SEAT

It can be galling to realise that your therapist is not omniscient and even more galling if they operate on a 'led by the client' basis and are waiting for you to kick things off. Before I understood it, sometimes it struck me that perhaps my therapist was senile – could she not remember what we talked about last week? Sometimes I thought it was because she was disgusted – she could remember only too clearly what we had talked about last week. Sometimes it seemed that she was lazy – why couldn't she make more of an effort and think up something to say rather than always relying on me?! And sometimes I thought that she was just clueless and didn't know what to say.

All of those assumptions were wrong. She was waiting to see what I would bring. Grasping that helped enormously because then I realised that the responsibility to plan was mine, or at least jointly mine. And so it became a matter of priority for me to spend my time between the sessions figuring out how I was going to make best use of the session – not sitting passively by, waiting for the therapist to 'magic' me better. It became a collaborative effort, which in turn reduced the power differential between us. I wasn't in 'child' mode, waiting for the 'grown up' to know what to do, no matter how 'child-like' I felt at times, especially when switched to traumatised parts of myself. I was responsible for my own recovery and so I had to take seriously each week the issue of what I wanted to accomplish and how best I wanted to use the time. I had to see myself as the driver and use the therapist as the navigator. I was deciding where we were going and I was putting my foot down to get us there. The therapist was there to guide me and shout directions. When we worked like this, it was a productive journey.

4. RESPECT THE 'THERAPEUTIC FRAME'

It's not a phrase that we are taught about in the normal course of events: the 'therapeutic frame'. It's most definitely part of the 'therapy school curriculum' (for at least some schools of thought) but it's an important concept for us as clients to grasp too. It can be thought of as the 'implicit rules' for therapy but some of the

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rules are explicit too, such as the session times and days. In our culture of CityLink vans and Tesco deliveries, we are used to selecting our 'slot' and then changing it up to 24 hours beforehand if it no longer suits. But therapy doesn't work like that. We need to respect the frame: when it happens, where it happens, how often it happens, how it happens. This isn't a hair appointment that we can rearrange at a moment's notice. It's a good thing that we allow it to be a fixed point in our week, and for everything else to flow around it, because it establishes within us what is important, and perhaps for the first time we value ourselves by valuing our therapy.

And it's a good thing that we keep the boundaries of this set-aside time: this is our time to talk in a way that we don't talk the rest of the week. This isn't a social chat, nor a stiff, professional interaction. This is a relational encounter where we have a different set of rules, where it's okay to disclose, where it's okay to be self-focussed, where it's okay for parts to come to the fore, where it's okay to feel and express emotions. But there are a thousand ways that we can sabotage this therapy and attack the frame – we can be late, we can be distracted, we can be sulky, we can fail to pay, we can 'forget' to come, we can attack the therapist, we can leave early, we can refuse to engage, we can pretend to be open, we can mess about and play a role. But none of that will help us to recover. If we respect the frame, we respect ourselves.

5. ENCOURAGE OTHERS TO RESPECT YOUR THERAPY

At first, before he trained to become a therapist, my husband didn't have a clue what it was all about. He was left at home, literally holding the baby, while I went off to 'do drawings' and 'have a nice a chat'. He simply couldn't imagine what went on in my sessions. During a period of huge stress for both of us, at times he succumbed to thinking that it was all a bit self-indulgent. Fortunately, he loves me and fortunately he is quick and eager to learn and once he began to understand the nature of the work – a 'cosy chat' is as far from reality as possible – he began to be supportive of my need for therapy and he began actively to protect this time too. Not everyone will have such understanding and supporting partners or family and it's a tough battle to have to face, albeit a necessary one. It is vital, where possible, to construct boundaries around your therapy times and to elicit the support of everyone and anyone in doing that. It's hard enough to face your own ambivalence at going back to that

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scary room with the scary therapist to talk about the scary things ... it's even harder if a partner has 'accidentally' stayed late at work and won't be home in time to babysit. Difficult conversations need to take place, a commitment from both of you (including, where old enough, your children) that this is important, that this matters, that it will help, that it's a priority, and that it's okay for you to commit the time to it. Feeling guilty, feeling 'selfish' for taking out this time, doesn't benefit anyone.

6. DO THE HARDEST WORK BETWEEN SESSIONS

In our avoidance, how often do we get to the end of a session and sigh with relief that that's over with for another week, and we can put it all out of mind again? It's a helpful tool to be able to segment our experiences like that – to a point. But recovery comes through challenging our habitual avoidance of all things traumatic, in order to resolve them. And contrary to popular belief, that resolution doesn't come in the therapy session alone. If you have a two-hour session, or two one-hour sessions during the week, that still leaves you with 166 hours where you can make progress. So much of the therapeutic work is about changing the wiring of our brains, these neural networks of habits and automatic responses that we have lived with for decades. The therapy session itself can be a catalyst for that change but new neural networks get laid down through repetition. Saying once in a therapy session, 'It wasn't my fault' will make a difference, but not as much as will saying it a hundred times during the ensuing week. Journalling, thinking, writing, drawing, meditating, considering, dreaming ... our brains can be busy and creating new connections all week long. We can do the work of therapy outside the session by implementing what we have discovered in the session, by reinforcing those new truths and realities.

In one Sensorimotor Psychotherapy session, I enjoyed the benefit for the first time of standing up straight, lengthening my spine, and feeling strength and power and competence in my body. It was a striking experience, as my therapist guided me to mindfully notice the different parts of my body and to imagine myself strong and capable. Previously, when I stood up, I felt weak and helpless and panicky. This was a simple exercise and yet it was a breakthrough moment for me. But the real progress was through my reinforcing it dozens of times the following week, by practising 'standing', by doing the exercise over and over and over again. I practised it for weeks and months

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and years, until I had a habit ingrained in my neural networks, a resource that I could draw on at any moment. I could stand up in front of a room of people – in front of a whole auditorium of people! – and feel strong, and capable and competent. And all because I had taken that initial spark in that one single therapy session and repeated and reinforced it again and again and again until the change was there, in my body, as a memory, as a habit.

The same is true for journalling. Very often I would leave a session with one dominating thought from the session to consider in the following week. 'It wasn't my fault.' There was this magical moment in therapy, this moment of revelation, a peeling away of my worldview and the sneak peek of a new vista. But I had to reinforce it afterwards. So I would go away and journal. I would write reams and reams and reams on whether it was my fault or not, what the arguments for and against were, what it felt like to think it wasn't, what the reality of my innocence made me feel. Thousands of words, thinking it through, considering it, contemplating it, turning it over in my mind. And when I hit a hurdle, when something jarred and would not lie flat and smooth within me, that then became the focus for the following week, and that session would have fresh impetus and direction. Each week, building on the next, by laying foundations and fetching bricks, so that at the start of every session the materials were at hand, the ground was prepared, and I was ready to build.

7. HONOUR AND GUARD YOUR RELATIONSHIP WITH YOUR THERAPIST

It's easy to think of your therapist as a 'professional', where 'professional' means they are not really human, and it's just a job, and they don't really care, and they have no feelings to hurt. Certainly, you're not responsible for your therapist's feelings, and you shouldn't hold back on talking about what you need to, for fear of upsetting them. But they are still a human being. You can't build a relationship of collaboration and mutuality unless you treat them fairly. You expect confidentiality of them but how many times do you slag them off to your friends or undermine them or mock them? How many times does your disdain for them leak out like gravy from a pie? Do you make it hard for them to work with you? Do you turn the therapy into a battle? Are you goading them to reject you?

There may be many understandable reasons – not least your trauma, not least a background of disorganised

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attachment, not least the stress of your current circumstances – why at times you hate your therapist with passion. But they are just a human being too and, regardless of their efforts to show 'unconditional positive regard', it's so much easier for them to help you if you don't fight them all the way. If you can honour your relationship with them, if you can guard it by treating them with dignity and respect, if you can be quick to apologise and quicker to forgive, you will gain in the end.

I'm not talking about turning a blind eye or being abused by a bad therapist, an unprofessional or an exploitative one. I'm talking about meeting the good one halfway and showing them that you respect them and that you're not out to destroy them. They hold a lot of anxiety much of the time in this work – the anxiety of your self-harm or suicidality, the anxiety of whether they're retraumatising you by going too fast or too slow, the anxiety over whether they've said the right thing or done the right thing ... I see it from both sides, with a husband who is now a therapist.

Everyone works better and relates better from a place of safety and one of the first mentalising exercises you can do – without going overboard and taking responsibility for them and worrying about them or caretaking them – is to consider how you are with your therapist, and whether you're making it safe for them to work with you, or whether they're distracted or on edge because of your threats.

Nor can we do the work unless we're willing to relate. We can't hang around at the edges, wearing a mask, saying what we think will please or placate. This is therapy. This is where things get said, feelings get felt, reality is faced. It's not a place for emotional snakes and ladders, playing games with the therapist, trying to avoid saying anything real, trying to hide all emotion, trying to keep one step ahead. That was the way I had to be as a child, to survive. But therapy required that I was willing to engage, that I was willing to be honest – with the therapist and myself – and that I was willing to be challenged. Admittedly, it was something that took me a while to learn. But the therapeutic relationship was something that I had to commit to, to stick with, to be honest about, rather than picking it up and discarding it after a few sessions or months because I didn't feel it was working. Why wasn't it working? What was going on? Had I talked about it? Had I tried to work it through? Some relationships, of course, can't be worked through. But many of them can, and we need to learn how.

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8. DON'T UNDERMINE THERAPY BY CONTRADICTING IT THE REST OF THE TIME

We want to live free from abuse, but we continue to abuse ourselves. We want to develop secure attachment, but we continue to be pulled around in insecure-ambivalent relationships. We want to put up boundaries with our abusers, but then we invite them to stay. And we go back into our session the following week, and we hang our head in shame, and we feel the full force of our self-frustration as we say, 'I'm not making any progress.'

I used to think that I would be able to get something sorted in therapy, and that it would spill magically over into 'real' life. I would talk about some trauma, understand what distorted belief it had led me into, and then the 'ping!' moment would magic into being wonderful new behaviours. But eventually I realised that the 'ping!' moment in therapy is often just the start. I had to make active choices to reinforce that by my actions the rest of the week. I had to start choosing not to abuse myself, not to let my abusers near, and to distance myself from people who sought to control and use me. Very often I had to change my behaviours first, whilst still struggling with the concept, before the 'ping!' moment really landed.

But what never worked was pursuing one course of action in therapy, whilst undermining it elsewhere. I didn't want to live in the hyperarousal of attachment insecurity, the up-down, love-hate of borderline relationships. I didn't like how I became around certain people – the pull they had on me, the submission they tricked out of me, the way my mind got fixed on where they were and what they were doing. I tried compromising and tried just talking about it in therapy, without doing anything about it. But of course it didn't work. And it infected my therapeutic relationship, making me nervous and twitchy about that, making me 'see' abandonment when it wasn't there. It affected the work I was trying to achieve. I had to make hard decisions, cut off dead branches, steer clear of the nettles. Anything else would undermine what the sessions were for. There had to be congruence between my intentions in therapy and my actions in the rest of life.

9. LEARN

Psychoeducation helps. It really, really helps. At the time of the abuse, did you freeze and do you feel bad now that you didn't do

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anything to fight back or escape? You need to understand the freeze response. Is your heart pounding and your brain has gone blank and you can't find your words? You need to understand about triggers and the front and back brain. Does your therapist's holiday feel like a threat to your very existence and when she comes back are you both delighted to see her and a ball of rage? You need to understand about disorganised attachment.

So much of the time, we beat ourselves up because we don't understand trauma, we don't understand about dissociation, and we don't understand about attachment. And yet almost all of our behaviours and beliefs are logical in the light of these three subjects. I felt powerless when night after night I couldn't get to sleep because I couldn't seem to calm down. Once I understood about hyperarousal and the sympathetic nervous system, I stopped feeling so bad about it. It didn't instantly solve the insomnia, but it stopped me 'fearing the fear' – the vicious cycle of anxiety that keeps us locked into a fight-or-flight response. Once I understood that dissociation is a normal and natural response to trauma, I stopped feeling that I was such a freak. Once I understood that the out-breath activates the parasympathetic nervous system and helps to regulate our arousal, I began to feel that there was something that I could do to manage my distress.

Often we go into therapy with the expectation that it will be like visiting the hospital or the GP – that the expert, the white coat, will know what they are talking about, and we just have to give blood, or flex our knee, or say 'aaah', and everything will be alright. But therapy isn't like that. The more we understand about dissociation, the more we understand about trauma, the more we understand about attachment, the easier we will find it to understand ourselves. And the more we understand ourselves, the more we will value ourselves as ingenious survivors who are courageous and resourceful, rather than as the screw-ups that we so often think we are. Psychoeducation helps teach us to have self-respect, and it teaches us tools for managing our distress that we didn't learn as we grew up. Sometimes that education comes within a therapy session, from the therapist, but we have 166+ hours a week where we can work on this stuff for ourselves, and keep the sessions for the application of that knowledge. Knowledge is power, and power is what we need to overcome the disempowerment of trauma.

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10. DON'T LET GO OF THE REST OF LIFE

It's important to prioritise therapy but it's important to keep it in balance, too. Therapy is there to help you re-engage with life and conquer the world. It's not there as a substitute for life. Don't give up supportive friendships because now you have therapy; don't quit work because you want to focus exclusively on therapy; don't stop going out and having fun because every night you're journalling for your session. Keep everything in balance, and everything in perspective. You don't want to spend five years in therapy, and then at the end of it look up and realise that you've lost the life you've been trying to build. It's good to keep focused on the work that you're doing in therapy, but don't become so problem-saturated that there's no outlet for your steam. The things that you work through in therapy need to be worked out in real life; therapy is where you get to practice and figure out your relating, but you need real relationships in real life to put it into action.

Therapy is our springboard for life. It's important that we use it to launch ourselves into real living. Sometimes our therapy becomes all we have, because our lives are so deprived. But then it is through therapy that we must increase our relational and experiential wealth, because therapy won't last forever and it's only a poor imitation of the rich life that we have ahead of us. •

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by Helen

I was abused by my dad, and also my grandad. And in many ways, I want to just leave it there and not say any more, because every time I say it a huge cloud of fear comes up and a voice screams in my ear that none of it really happened. It's like, for a moment, my heart falls into my feet and I'm overcome by this terror that I really am just making it up, and that there's something terribly wrong with me that I would do such a thing. And then, usually seconds later – but sometimes it can be hours later – I remember the facts: that actually my father is in prison, that he did actually abuse me as well as other people, and so I'm not making it up at all. And yet I still wish I were, and it all feels that it happened somewhere else – somewhere outside the glass bubble that I live in most of the time.

I had a rocky childhood. The details are hazy but it seems that my mother had a mental breakdown shortly after I was born and was hospitalised. I went into foster care briefly, and then to my paternal grandparents. My grandad abused me then, and continued to do so whenever he had the chance until I was about 11. For the first five years of life, I flitted between foster care, my grandparents' house, living alone with my dad, and living with both my parents. I can't remember when the abuse by my dad started. It was just always part of knowing him. He also took me along to 'parties' where other men abused me too. I don't remember the details, and I don't want to remember them.

I grew up knowing, or rather believing, that there was something wrong with me.

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I never felt that I fitted in. I thought I was 'weird'. I always thought that people were looking at me and judging me. I struggled to make friends because I never really trusted that anyone would want to be friends with me. I didn't feel that I had the right to have friends, and I never wanted to bring friends home. I hung out with groups of girls at school where I tried to fit in by blending into the background and not drawing attention to myself. I downplayed all of my abilities in case I stood out – I didn't want to be seen to be doing well, because I didn't want to be seen at all. I remember scoring highly on one particular maths test in school. I came top of the class, and I was mortified. From then on I worked really hard to try to figure out how many questions to get wrong, to make sure I did well enough, but not too well. Secretly, I enjoyed maths, and I enjoyed being at school, because it was such a welcome break from being at home. But I sabotaged my academic success because it felt too dangerous to do well.

My memories of childhood have a strange bleached quality about them. I don't remember feeling happy or sad. On the whole I don't remember feeling anything at all. It's like I was just a zombie, walking through life, eyes to the floor, and trying not to notice what was going on around me, and trying not to be noticed. I can

remember endless sessions with skipping ropes with friends when I was in late primary school. I can't remember enjoying it, but I can't remember not enjoying it either. It was as if it was just a way to the pass the time and passing time was what life was about. I'm beginning to realise now how sad that is, but it's just how it's always been.

I left school at 16 with a reasonable set of O'Levels and got a job that my father had arranged for me in the bank. I went to work like a robot for years and years and years. I did what I was supposed to do, talked to as few people as possible, made sure I didn't make mistakes – which was easy as the work was so menial – and came home and promptly forgot about it. I mean that almost literally: I worked at that bank on and off for nearly twenty years but I can barely remember a single day of it. I suspect now that a different part of me went to work, did what needed to be done, and then I came home and switched back to 'me'.

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The problem I have with saying that is that I have never really known who 'me' is. I spent most of my life feeling that I am just a shell, and that there is nobody on the inside, like the lights are on but nobody's at home. I've always felt that I'm just housesitting myself, waiting for the real owner to come home, but for some reason they haven't and I've ended up taking up residence in a body that doesn't belong to me. But the postman comes to the door, and assumes I live here. I've been housesitting for so long that everyone assumes I live here, and to outsiders nothing is amiss. But deep down on the inside I feel a fraud and a fake, like I shouldn't be here and sooner or later I will get caught out.

I married when I was 18, to the first person who'd ever shown any interest in me. He was from Head Office, a fair bit older than me and I have no idea why I said yes. It's not that I liked him, but it's not that I disliked him earlier. I was painfully shy when he courted me, but he seemed to like that as he had a big ego and wanted everything to be about him. I was just a trophy for him, to prove (I think mainly to his parents) that he could find a wife and be normal. He was actually fairly obnoxious most of the time, and a lot of people didn't like him, but I didn't mind either way. That was always my problem: I didn't mind. At times he did drive me to distraction, but he didn't abuse me, except perhaps verbally, but then I would just go very still and stuck on the inside and it would all happen a long, long way away. Life continued in this glass bubble, separated from the petty nastiness of my husband but also from all the good things in life. I knew that this wasn't normal, but I didn't know what the alternative was and I didn't for one moment think that there was anything that could be done about it.

All through my twenties and thirties, life just happened. I had two children, whom I loved with my actions, but I struggled to feel anything for them in my heart. The feelings just didn't exist. I was dutiful as a stay-at-home mum. I suspected my husband of having affairs, but I didn't feel much about that either. I rationalised that I didn't blame him – who'd want to stay faithful to me? – and that it was better not to kick up a fuss. I didn't really expect him to love me, so it didn't shock me when he didn't.

Life ticked on in this empty, dull nothingness until my children left home. And then suddenly it felt that I'd been holding everything together for their sake, and I hadn't realised how much tension there had been on the inside of me to do that. For twenty years I had got up every day, done what I needed to do, and went to bed. I never asked myself

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how I felt about any of it, because I didn't feel much about anything. I was the Robot wife, the Robot mother, and I don't even today really understand why suddenly I cracked when my youngest child left home. I just did.

I don't remember clearly what happened; I only really remember what people told me about what happened. Apparently my husband had come in from work one today to find me staring into space, unresponsive. At first he thought it was a migraine, and left me alone. Then as the evening wore on and he couldn't get any response from me come bedtime, he became a bit concerned. But he went to bed, expecting me to follow when I felt like it. The next day he woke to find me sitting in the same position. He called 999 and when the ambulance arrived, he left for work. He was already running late. I was in a psychiatric unit for two weeks before I really became aware of what was going on. The nurses told me he'd visited me once but it seemed that he couldn't cope with the whole thing, and claimed that he was busy dealing with a crisis at work. Even now, I think that's a reasonable explanation as the banking crisis was in full motion and I didn't really expect anything of him.

I found the experience of being hospitalised deeply, deeply distressing, in a way that I hadn't ever really felt emotions up to that point. Something about being locked up despite not having committed a crime, being peered at through the window of the door, and losing all privacy and sense of ownership of yourself ... it was like I'd coasted through my life in neutral, and this was an emergency stop. I hated it, more perhaps at that time even than I'd hated the abuse. With no disrespect to the other 'inmates', I was in a ward where people were screaming, and hurting themselves, and talking incoherently, and I was continually scared, both by some of the other patients, and also by some of the attitudes of the staff. There were one or two genuinely caring nurses but there were also more than one or two who seemed to get a kick out of removing our 'privileges', of suddenly deciding we were a suicide risk and so not allowing us to shower. I later realised that some of the dynamics of that psychiatric unit replicated the dynamics

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that I'd experienced during the abuse as a child. And for me personally, at that time, it seemed to shatter open the glass bubble I'd been living in – where everything was distant and remote and unfeeling – and I was face to face for the first time with my raw emotions about what had happened to me.

But I was faced with a dilemma. On the one hand, I was having a serious mental breakdown where I was being assaulted day and night with emotions that I hadn't even known could exist; on the other, I needed to 'act normal' to get out of the hellhole prison of a psychiatric unit. It would have been more tolerable if I'd been offered some kind of treatment or hope for recovery, but it was very clear from the start that I was to be kept on the ward until I no longer posed a 'risk' to myself. This all seemed very bizarre to me, as I'd been admitted in a near catatonic state, a kind of dissociative trance. At no point had I self-harmed or threatened to kill myself. But it was almost as if, because the doctors didn't understand what was wrong with me, I was put in the category of 'suicide risk' because then at least there were some protocols. So I had to prove that I was fine in order to leave, and yet, the longer I stayed, the harder I was finding it to cope. Really, I just wanted to go home, to my own bed, my own house, and to familiar surroundings, and be allowed to cry for a while. But I soon learned that that wasn't the right thing to say.

Eventually, after two months, I was discharged, and my husband made the effort then at least to come and collect me. He was sheepish, but very very distant. It was clear that he just wanted me to get on and sort myself out so that we could go back to normal. He hadn't enjoyed having to cook for himself while I'd been gone, and the evidence seemed to point towards him having lived on takeaways and pub grub.

I did my best to pull myself together and act normal. My GP was kind and actually very helpful – she pointed me in the direction of a charity offering counselling and was the first to suggest the words 'dissociation' and 'trauma'. My motivation in starting counselling was to avoid ever being hospitalised again: that was all. I had no real idea that I could actually begin to live. I had no idea that the trauma of my childhood could be resolved.

The biggest problem early on was my misperceptions of counselling. I treated it almost like the courses I'd had to complete at work: this is the right thing to say, this is the right thing to do, this is how to react. I spent the whole time trying to double-guess the counsellor and

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figure out what she wanted me to say. But mostly I couldn't read her and I remember my frustration growing that I couldn't get it 'right'. Was I supposed to talk about my feelings, or put those feelings to one side for a moment? Was I supposed to talk about my childhood, or was I supposed to focus on my sources of resilience in the here and now? Was I supposed to get upset that my husband hadn't visited me in hospital, or realise that only I could give myself the care I needed? For a long time, I wasn't working those issues through. I was just trying to figure out what my counsellor wanted of me.

The hardest parts were when she 'noticed' me. It's very hard to be sat in a room with a person for nearly an hour, when you're the only person they're looking at, and you're the only person they're listening to. It went against everything that was second nature to me: not to be the centre of attention, not to make a fuss, just to blend into the background. I kept wondering if I'd be better off having group therapy – surely, then, it would be easier to hide?

After a little while, my counsellor pointed out that whatever I talked about, I 'minimised'. I didn't understand the word, and even when she explained it, I didn't understand what she meant. It seemed to imply that when something was a big deal, I made it a little deal. I simply couldn't understand where she was coming from. The thing we were talking about wasn't big, so I wasn't making it any smaller – it was just the size it was, which was insignificant. Then she kept pointing out how much I denied everything. I denied that anything bad had really happened, that I'd been affected, that I had any feelings. She said it was like trying to handle a bar of soap: as soon as we got near to something, it would slip through my fingers. I wasn't conscious of doing anything to make that happen – it's just the way it was.

I read up on dissociation, and I figured that my GP must have been mistaken. Because there wasn't actually anything wrong with me, and yes it had been a difficult time when I'd given evidence in Court against my father (along with three girls outside the family whom he'd also abused), leading to his conviction and imprisonment. But it hadn't affected me because ... because it hadn't. And I didn't switch to other parts of the personality, and I had no amnesia ... apart from the things that I couldn't remember. But that's different, surely? It was about six months into counselling before my counsellor leaned forwards very earnestly halfway through one session and said, 'I need to tell you what's been going on in our sessions ... '

LIVING IN A GLASS BUBBLE

by Helen

And apparently, what had been going on was that, after ten or twenty minutes each week, my whole demeanour would change, my voice would change, my body posture would change, and I would start talking in an animated, out-of-character way, with great passion and energy and even rage, sometimes incoherently, about stuff that had happened as a child. Over the next twenty minutes or so I would change again and again and again. And then, as if someone had snapped a light switch, with about ten minutes to go, the normal 'me' would return, and I would complete the sentence that I had started half an hour or more previously.

I looked at my counsellor with great scepticism and disbelief. Why was she saying this? Why was she making this up? I always knew that my sessions were a bit vague, and I could never really remember what we'd talked about from one week to the next. I deliberately didn't think about them between appointments. But that's normal, isn't it? Who would want to think about a therapy session after a therapy session? That was my logic. How could I really have this chunk of lost time right in the middle of the session? And was I really talking and acting the way she said I was?

It seemed crazy, and it filled me with an overpowering dread that I would end up back in a psychiatric unit again. That is probably why I went into flat-out denial, and skipped the next two sessions.

The problem I had was that counselling was touching a nerve. It was awakening something on the inside of me that had long felt numb and dead. It felt in some small way that I was becoming alive, and breaking out of my glass bubble. And that filled me with dread, but it also was quite a tantalising, addictive feeling, because it was so different to anything I'd ever experienced before. It was quite a tangible conflict on the inside of me. I was terrified of what might happen if I kept going to my sessions, but deep down I was even more terrified of what might happen if I didn't.

One of the things that confused me when I compared my experiences to others that I read in books and in Multiple Parts was that after returning home from the psychiatric unit, I went back into a mostly numb, empty kind of existence again. I wasn't emotionally out-of-control – my emotions were tightly in control, locked up inside me again. I just felt a lot of the time that things happened around me, but a long way away from me, on the other side of the glass bubble. It felt like there was a gap, a buffer, and sometimes I'd struggle to tell if something was really happening or if I was just dreaming it. Eventually I figured out that this is what

LIVING IN A GLASS BUBBLE

by Helen

'derealisation' and 'depersonalisation' were all about, and it began to sit a bit more comfortably.

But still I denied the presence of other parts of the personality, or alters. It turned out that these parts of my self that had suffered the abuse were so tucked away on the inside of me, so disconnected, that I had a complete mental block for them, and total amnesia when they were 'out'. After a couple of years my therapist arranged, with my permission, for me to receive an assessment and much to my surprise (even now) I was diagnosed with dissociative identity disorder, although it was acknowledged that the main symptoms that I experienced were depersonalisation and derealisation. The parts came out in therapy, and there has been growing evidence that they come out at night, or when I'm home alone for several days at a time – because I lose sense of time, and I can't remember what I've done or where I've been. But it's like my mind is holding my dissociativity as a secret even to myself.

My main GP, who was aware of trauma and dissociation and used those terms, has continued to be supportive, but when she's away, as she was on a maternity leave for a year, it's been more problematic. The other partners at the surgery are much more cynical and don't believe in DID. I suppose I ought to feel outraged by that, but I don't: because I don't really believe it for myself either. I guess I'm at a place where I won't expect someone else to believe something that I'm struggling to believe myself. My counselling has continued and I think it's really hard work for my counsellor, because I'm so shut down emotionally – at least until I switch – but she's being patient with me and teaching me to be patient with myself. Finding words to describe my experience has been enormously helpful, and I've benefitted hugely from reading about dissociation and all of the resources that Carolyn produces. I still feel alone, but I think that's more part of the trauma and part of the disorder now. I have hope for progress – I don't know if I can say 'recovery' because I don't know what recovery looks like. I've never had a life other than this dysfunctional one that I'm trying to fix, and I struggle to imagine anything better. But there is growing within me a quiet determination that I'm going to learn to live outside my glass bubble, and that I won't be so shut down forever. I do believe there's hope. •

THE TRAUMA TRAFFIC LIGHT

by Carolyn Spring

WHAT IS TRAUMA?

Trauma is not just about having a bad day. Trauma is about being flooded and overwhelmed. It's a threat, real or perceived, to our bodily integrity, and as I would put it, it's life-threatening powerlessness. To understand trauma, we need to understand what goes on in the body at the moment of trauma and how the physical impacts of trauma are rooted in basic, primitive responses shared by many animals, including us as mammals and humans.

This physical survival system is founded in our autonomic nervous system, which is geared towards responding to threat and promoting our survival. It's different to the central nervous system, comprising the brain and spinal cord, which we mostly have voluntary control over. The autonomic nervous system is primarily unconscious – it's what goes on without thinking, even when we're sleeping, 24 hours a day: it keeps us breathing and digesting and pumping blood around our body.

This autonomic nervous system has traditionally been divided into two main branches: the sympathetic nervous system and the parasympathetic nervous system. These two branches tend to work in a complementary relationship to one another – they help to balance the body and keep its homeostasis. Generally speaking, the sympathetic nervous system ramps us up ready for action: it's engaged in the fight and flight response. And the parasympathetic nervous system slows us down: it's there

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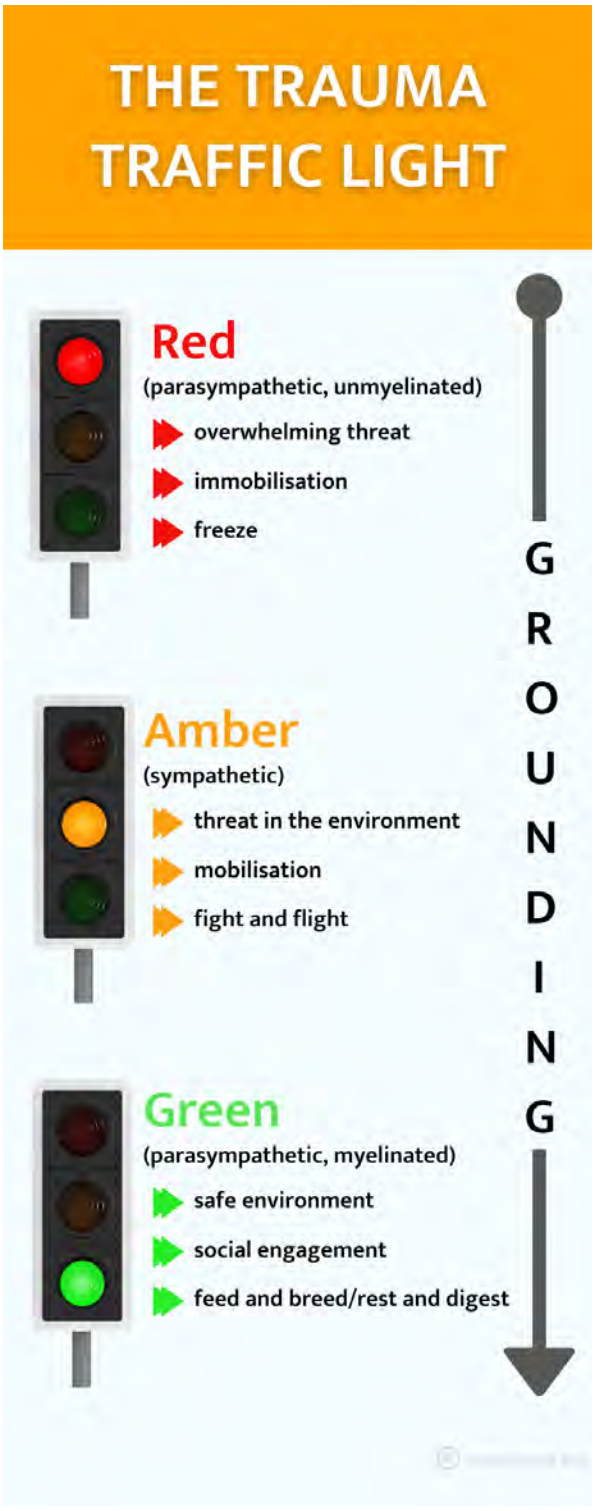
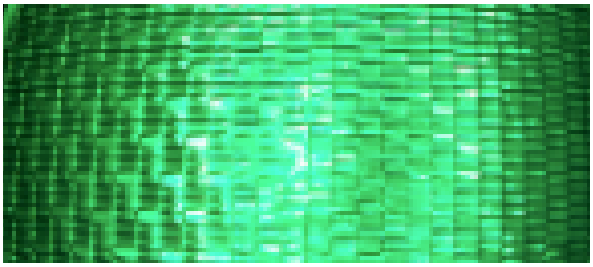


to 'rest and digest' or 'feed and breed' as some people call it. So you could say that the sympathetic nervous system is like an accelerator, and the parasympathetic is like a brake. Throughout the day the body is constantly adjusting, accelerating and braking, placing us in a dominant state of either sympathetic or parasympathetic nervous system activation, in order to respond optimally to the demands of life we are facing at any given moment.

AND WHAT IS THE TRAFFIC LIGHT?

Keeping the driving analogy, we could talk about this in terms of the 'trauma traffic light', or rather three physiological states that the body can shift gear between, depending on levels of threat or security in the world.



First of all, there's the green zone. The body enters this state when all is well with the world, when we perceive our environment to be safe. In this case, our body and brain automatically gear us up to be able to focus on people. It is what has been called the 'social engagement system'. We can chat, we can play, we can work, we can

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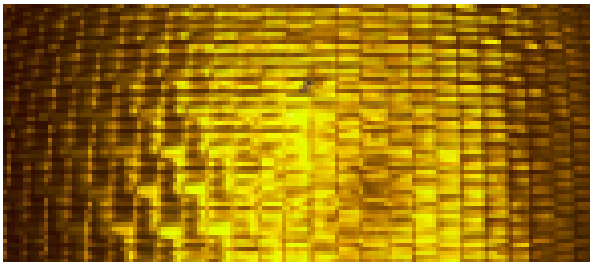
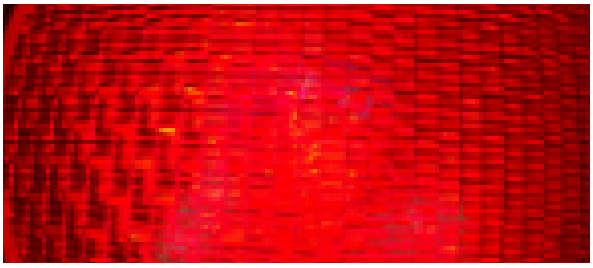
feed, we can breed – we can do life! This is a state of predominant parasympathetic nervous system activation, and it's a good thing: we're chilled out and relaxed, we feel safe, and we can get on and explore and conquer life. But this is a state that many trauma survivors find it difficult to achieve consistently or for long periods of time.



Instead, many trauma survivors find themselves frequently triggered into the **amber** state of alert. The body and the brain perceive some kind of threat in the world: perhaps a near-miss on the motorway, an unexpected knock on the door in the middle of the night, the sounds of a disturbance with raised voices, the approach of a mugger or other assailant.

The amber state can also be triggered by reminders of trauma from the past, or psychological threats, events we perceive to be life-threatening: losing our job, our partner getting sick, social rejection. When this happens, our body gears us up automatically to respond to this challenge – it mobilises us to do something to survive, and it engages the fight-or-flight responses of the sympathetic nervous system. There is a cascade of neuro-electrical and chemical responses in the body and the brain, and we enter a state of mobilisation – we're ready for action.



But what if we can't handle what comes our way? What if the threat is too great? What if we can't escape from the assailant, or we don't have the resources to survive? When we are overwhelmed, our body switches into **red** alert mode. It assumes that this is a critical, life-threatening event. And so it switches from the sympathetic nervous system back into the parasympathetic nervous system ... which sounds a little confusing! After all, this isn't a time to rest and digest or feed and breed, is it? No it's not, and this paradox is explained by the presence of two distinct pathways in the parasympathetic nervous system. The red zone utilises the unmyelinated ventral vagal circuit rather than the myelinated dorsal vagal circuit used by the green zone.

In this red alert state, when the body perceives that it can't do anything active to survive (fight or flight), the body goes into an immobilised state. Again, there is a cascade of chemical and neuro-electrical changes in the body, and we go into

THE TRAUMA TRAFFIC LIGHT

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'freeze' – complete shutdown. The vagus nerve is activated, our heartrate drops, and we enter a state of feigned death. This red alert response is designed to help us survive by fooling a predator into leaving us alone, and it comes with certain physiological benefits such as reduced pain perception and an altered (narrowed) state of consciousness. Psychologically it is a state often referred to as 'dissociation'. This red alert state is intended only for very occasional, life-threatening experiences, but it becomes an automatic response in a lot of people who have suffered extensive childhood trauma – especially those who have developed a dissociative disorder.

Both states of amber and red are toxic to our long-term physical health, as I explain in detail on our Trauma and the Body online training. This means that it is imperative that we learn how to 'ground' – how to calm the body down and move it from a state of freeze and immobilisation in the red zone, through to a state of fight and flight and mobilisation in the amber zone, back into the safety and peace of the green zone. In fact 'recovery' from trauma could be conceptualised in simplistic terms as retraining the body and the mind to live the vast majority of the time in the green zone rather than in amber or red. •

DIFFICULTIES WE FACE AS SURVIVORS

by Various

BOUNDARIES GETTING OUT OF CONTROL WITH A THERAPIST

I've always been considered 'needy'. I have a habit of getting involved in really intense relationships, and at various times I've been labelled as 'borderline'. I'm beginning to understand it more in terms of attachment, which feels less shameful than being told that there's something fundamentally wrong with your personality. But most of the time I hate being me. The biggest difficulty I have is managing the relationship with my therapist. I feel like I'm too much for her a lot of the time, and I'm not sure how to handle the boundaries. Some of the time it feels so persecutory when she doesn't respond to a text or an email in between sessions, and we've got into a mess several times when I've been texting or emailing her increasingly frequently. Then she gets to the point where she can't deal with it any more (because I'm sending dozens of messages a day) and she tries a different approach, with no contact in between sessions. Usually I go into meltdown for a while, feel punished, and withdraw.

On the one hand I know that I push and push and push. On the other, I wish she would just hold the boundaries more firmly. But I know that I can be pretty insistent, and I lash out at her a lot. I don't normally get this angry in my relationships, but the therapeutic relationship seems to bring it out in me. She says that this is all part of the work, but I worry continually that I'm going to overstep the mark once too often and it will all be over. At the same time, although I try not to do it, I feel myself having to test the boundaries.

by Various

Does she really mean I can't contact her at weekends? What about the times when I've done it and she's responded? Does she mean I can't if it's not serious, but I can if I'm suicidal? I can't cope with the grey zones in that–I'm continually driven towards black or white and all or nothing. I mostly think that I'm just a bad person, and that I'll never be able to have a normal relationship with anyone. But again she keeps reassuring me that there are lots of people, with similar histories to me, who act and think just like I do, so I'm not alone. I don't know whether I feel reassured by that or not. I just wish I could stop. – **By KW**

INTIMACY

I love my partner very much, but a lot of the time I don't feel anything for her. It's like I'm just shut down emotionally and I can't evoke any feelings for her at all. In my head I know that I'm really lucky to be with her, and she's really supportive and loving towards me. And it's not that I don't like her, or that she annoys me. It's just that I can't feel anything for her. I'm numb and empty. Sometimes we try to make love and nothing happens, or if everything physical works then I'm not present emotionally.

I don't want to hurt her, and she does get hurt sometimes because she says it's like making love to a mannequin. She wants to feel that I'm present with her emotionally but I just go far, far away inside myself whenever we get intimate. I go through the motions. I feel like a robot. Sometimes the only way to get myself to feel anything is to inflict pain on myself – I wouldn't call it self-harm as such, because I'm not trying to hurt myself. I'm just trying to see if I can actually feel anything. I sometimes think it would be fairer if I just split up with her so that I'm not such a disappointment and so inadequate–she deserves better than me. But whenever we talk about it, she insists that she doesn't want me to leave, and I do love her in my own way. – **By LM**

DIFFICULTIES HIDING DISSOCIATION AT WORK

I work in a school as a teaching assistant and mostly I enjoy my work, but I find it really difficult to hide my dissociation. I think a lot of my colleagues think I'm just a bit eccentric. I sometimes can't remember what people have said to me, so people think I'm very scatty, but at other times they know I can be really organised. I try to write lots of things down to cover for my memory problems. It's just really disorientating because I might be in a staff meeting and someone might be doing a health and safety briefing or something normal and mundane like that, but then I get triggered (and I don't even know what by a lot of the time) and I go all vague and fuzzy, sometimes for hours afterwards. It's like I fall into a hole within myself and everything goes far away. I know that it's

by Various

called depersonalisation and derealisation but those terms don't describe how distressing and scary it is.

The worst part is not wanting anyone else to notice. I don't want to lose my job. I don't want people to think I'm nuts. I've got colleagues that I really respect, and I wish I could be like them. Sometimes I find it hard to do even really basic tasks, like laminating and cutting – it's like I lose the use of my fingers and my hand/eye coordination and I become all clumsy. I usually make an excuse, like I need the toilet, or I go and get involved with some children doing something else, but it's the sense of embarrassment that's the worst. Work helps keep me grounded and it's something to look forward to (I hate the holidays) so I desperately want to stay working but I get tied up in knots not knowing whether to say anything to someone about my difficulties, or whether that might make things worse. – **By CF**

DIFFICULTIES WITH TRUST

I've always had trouble trusting people. I remember being at school, maybe the first year of secondary, and a teacher laughing at me in front of the whole class and saying that my problem was that I just don't trust anyone and that I needed to stop being so paranoid and negative about people. It made me feel that there's something very, very wrong with me that I can't trust people. But then at other times, I figure that of course I don't trust people – because so many people have hurt and betrayed and abused me. I swing between justifying myself for why I don't trust people, and desperately wanting to.

It's becoming a real problem in therapy. I know the whole thing is supposed to be based on me being able to trust the therapist enough to tell her stuff, and to open up about how I feel, but I just can't do it. I feel like she must constantly be thinking that I'm making it all up, that I'm attention-seeking, that I am just lying to her. And then I get all screwed up trying to figure out how on earth I'm going to prove to her that I'm not. While I'm doing that, the clock keeps ticking and I'm sitting in silence wasting the session.

I'm afraid to like her. I'm afraid to need her. I'm afraid that I'll open up about how I feel and that then she'll think I'm stupid. I'm afraid that if I tell her the stuff that goes on in my head, she'll say I can't come any more. But the worst thing I'm afraid of is telling her some of the really bad stuff, and then her actually believing me – and it mattering to her. I'm stuck in this forwards and backwards feeling of desperately wanting her to believe me, and needing her help, and then spending each session wanting to run like crazy out of there. – **By PF**

by Various

ETHICAL DILEMMAS WHEN DISSOCIATION MIGHT AFFECT OTHER PEOPLE

I'm a paediatric nurse and I think I'm good at what I do. I love my work – it's what keeps me going. It means the world to me. But I worry that I shouldn't be working at all. I'm fine when I'm at work – it's as if there's a part of me that comes and takes over, and this 'Apparently Normal Personality' just gets on with my job, stays calm, and everything is fine. But as soon as I get home I go to pieces. I live alone, so no one else sees it, but when I'm off work I'm all over the place, switching to all these different child parts and half the time I'm co-conscious for it, but half the time I'm not. I dread doing something that will expose my secret. I'd be devastated if anyone at work found out what it's like for me at home.

At work I'm so capable, but at home I sometimes can't cope with the smallest things. At work I don't mind at all being in meetings with male superiors. At home I can't even cope with the gas engineer coming around to service the boiler – I'm terrified of him. Given that my work is with such vulnerable children, I worry that it's not ethical for me to be working. But at the same time, so far nothing has affected my work. But what if it does? I'm worried that if I say anything, no one will understand and I'll be given some label of 'mental illness' and treated as if I'm mad, with no allowance for how well I do my job. It's just so hard to explain to anyone that I can be super-competent AND super-incompetent: it depends which part is out. The problem is that I feel like I'm living a double-life, and I'm terrified in case I switch to a traumatised part while I'm in the middle of looking after these really sick babies. I couldn't live with myself if something happened to them because of my dissociation and the anxiety of that is driving me over the edge. – **By SU**

NOT KNOWING HOW TO STOP AVOIDING TRAUMA WORK

I've been working with my current therapist for about three years. We've done lots of really helpful stuff to help me be able to calm down when I'm triggered, and we've worked with lots of my parts to improve their understanding and acceptance of each other. We're much better at internal communication and cooperation and I don't lose time very much any more. So there's been a lot of progress, although it feels like it's taken forever to get to this point.

We've talked a lot for months now about 'phase two', about how, now that I've got a good foundation of skills in 'phase one' with safety and stabilisation, it could be time to face some of the trauma head on

by Various

and try to resolve some of it. I still get awful flashbacks, nightmares and body memories, and I don't want to live like this for the rest of my life. I feel like I've been plateauing for a while, so I really want to move forwards, and it makes sense that we move forwards and look at the trauma. But it scares the life out of me too. I get in such a state before every session if we say we're going to face it, and then the session becomes just about getting grounded again. We'll do that for a few weeks and I can spiral downhill rapidly, so then we figure it would be better not to push it, and we back off again. It's really frustrating.

We've started looking at some of my 'core beliefs', of the kinds of things I believe might happen if I start talking. I've realised that I've always believed that they will come and 'get' me if I 'tell'. I can just about grasp with my adult head that they won't now (they're dead) but it's like I can't get that information through to my younger parts. The fear is just so overpowering – it feels like a matter of life and death. One thing that has been really helpful is my therapist saying that I've kept myself safe from the trauma all these years by avoiding it, so avoidance is a habit, and it's one that's been seared into me because of survival. We're starting to do some visualisations of what it might be like to talk about stuff and for it to be okay, to try to convince my back brain and my parts that it's not a matter of life and death. But I'm just taken aback at how powerful the fear is. – **By JH**

FEAR OF GOING MAD

My biggest fear is of going mad. I don't want to be locked up in a mental hospital and never let out. I'm always afraid that I'll get sectioned, and then be unable to convince the powers that be that I'm okay, because it would be like the denial trap – 'Ah, so you're in denial that you've got a problem ... that proves that you're mad.' I've found it easier the more I've understood about trauma and dissociation to try to believe that I'm not mad, and that I'm not going mad – I'm just traumatised and distressed, and my body and brain are on high alert to try to keep me safe from being abused again. But when you're being bombarded with flashbacks and body memories and your thoughts are racing at a thousand miles an hour, it's hard not to feel you're mad.

If you try and tell people that you have different alters and that some of them are a different gender, and have different names and ages, then they really do look at you as if you're mad. How do I know that I'm not actually just mad? How do I know that I'm not making all this stuff up? I don't want my kids to be taken away, and I don't want something on my record that stops me having a career, once I can cope with work again. When I've lost time and I don't

by Various

know what I've been doing for the last few hours, I'm not so much bothered about what it is that I've been doing as I'm really upset that I'm being 'mad'. It's almost like an obsessive, ruminating thought that just goes around and around – it's quite ironic, I suppose, but I guess the fear of being mad is what I think is sending me mad! – **By TM**

BEING HYPER SELF-CRITICAL AND LACKING COMPASSION FOR PARTS

I've understood in the last year or so that all my parts are part of 'me', even though they don't feel like it, but what I can't seem to be able to do is to feel anything positive towards them at all. All day, every day, I just hate them. I absolutely loathe them. I wish I could kill them all. They cause me nothing but trouble. I see other people celebrating their parts and being really proud of them, but I just feel this overwhelming sense of shame and dread about mine. Then I feel really bad that I'm so negative towards them, because I wouldn't want to be that negative to any real person.

There are a number of parts that I'm aware of who just cry a lot and, instead of feeling any compassion for them, I just want to scream at them to shut up. Then there are a group of older teenage parts who make me cringe with embarrassment, because they're full of themselves and they're antagonistic and typically arrogant teenagers. I just feel unreasonably irritated at them! They get me into all sorts of trouble, like drinking too much and spending money that I haven't got, so I'm constantly feeling angry with them.

My therapist says that I've got to be more compassionate and understanding towards them, but I don't know how because it's such an overwhelming feeling of hatred that I have towards them all. My therapist says that I need to be less critical towards myself, but I'm ashamed of being like this – wouldn't everyone? He also says that they have done a truly valuable job in helping me survive and keeping me alive, but although I feel like I'm supposed to be grateful, most of the time I think the cost is too high and I just wish they hadn't. I feel that surely I'm the only person who hates my parts as much as this, but again my therapist says that I'm not and that it's quite common, that it's a way of distancing from the trauma and that it's

by Various

too scary for me just now to dare to accept them because it feels like they'll take over completely. He says they won't, but I don't trust him – not yet, anyway. – **By MW**

INTRUSIVE FAMILY

My parents didn't abuse me, but there was still a lot that was really screwy about my upbringing and my family. My parents divorced when I was four, and I didn't see my dad properly for a few years, and then after a couple of years my mother remarried and I've always had a difficult relationship with my stepdad. I was abused by my maternal grandfather, amongst others, and I never told anyone – firstly because it never occurred to me to want to share such a horrible, awful secret; and secondly because I didn't feel close enough to either of my parents to talk to them.

They became aware of the abuse I suffered when I ended up in a psychiatric unit for 6 months in my early twenties. I had had several bouts of 'depression', and I've also been diagnosed with an anxiety disorder, but it never seemed to occur to any of the professionals working with me to ask about the possibility of abuse. It was only after a particularly serious suicide attempt a couple of years ago when I ended up being sectioned and detained that the truth came out. I was very fortunate – one of the psychiatric nurses had been on one of Carolyn's courses and immediately identified my switching, 'regression', flashbacks and reliving of the trauma as a problem with dissociation. The psychiatrist was then very open and got some further input before diagnosing me with dissociative identity disorder. It was horrendous and a relief all at the same time.

After being discharged, I managed to get low-cost counselling from a voluntary organisation that has also been trained by Carolyn, and I've been promised long-term, open-ended therapy. I've really landed on my feet. So the problems I'm experiencing aren't based on getting a diagnosis and the right treatment, as they seem to be for most people. Instead, one of the biggest difficulties I have is my family being really intrusive. My mother wanted to be involved in every care meeting while I was sectioned, and there was nothing I could do (so it seemed) to stop her being there. I tried asking her to let me deal with it on my own, but she said I wasn't in a fit state of mind to be able to make my own decisions. For some reason, that felt really shaming and, after she said it, all the suicidal feelings came back with a vengeance for a few days. The best thing about the counselling I'm getting now is that I'm being treated as an adult, with a right to make choices about my life, and I've been assured that no information will be passed to my family at all.

by Various

It feels a lot like I'm being blamed for being 'mad' and causing some kind of stigma to my family. They want me to be 'better' as quickly as possible, and they're very resistant to the idea that my symptoms have been caused by the trauma of sexual abuse. They keep insisting that I'm mentally ill and they talk simply in terms of a chemical imbalance (despite not having a clue what they're talking about). They keep threatening to make a complaint that I'm not on stronger medication, and keep saying that I'm going to become overly dependent on my counsellor if I keep seeing her. They view her as a threat to them in some way. My mother knows when I have counselling, and always texts or messages me straightaway afterwards to ask how it went and what I talked about.

Increasingly I'm realising that although my family might mean well (or at least that's what I'm trying to convince myself), their intrusiveness isn't normal. I'm going to have to deal with it if I'm going to live healthy and free. I don't quite understand it yet, but it feels like I'm being really controlled and that I'm being invited to pretend that the abuse didn't happen, because it makes them uncomfortable. I keep trying to find a way to get the space I need, but increasingly I'm beginning to think I'm going to have to move away or get some distance from them if I'm going to recover. Both my parents are really dismissive of my diagnosis and print stuff out from the internet about how it's a fad and it doesn't really exist. That really doesn't help. – **By CC**

HOLDING ONTO HOPE

I've really appreciated reading articles on Carolyn's website and in particular her book *Recovery is My Best Revenge*. Both do give me hope for recovery. I desperately want to recover – I hate my life being so disrupted in the way that it is, and I want to be 'normal'. I don't accept that I have to have therapy for the rest of my life, or that I'm always going to be a suicide risk, or that I'll be in and out psychiatric wards forever. That's what I believe mentally. But what's really hard is holding onto hope when I'm in a dip. Sometimes it's something stressful in my day-to-day life that triggers it, but sometimes it's just that it's so exhausting to have a dissociative disorder. I go through phases when I'm hardly sleeping, night after night. I struggle to look after myself in terms of eating properly. I lose so much time, and life just spirals out of control for weeks on end, and managing that every day means that I get exhausted with it. And when things hit a dip like that, it's really hard to hold onto hope. It's like a big black cloud descends on me and I can't see the sun any more, and nothing I do about it seems to make things any better.

DIFFICULTIES WE FACE AS SURVIVORS

by Various

A friend points out to me that I just need to get through it because the clouds do always clear eventually, but while it's so dark I can't imagine it getting any better. When I'm in that frame of mind, I get really itsy about anyone trying to encourage me or give me hope – it makes me quite angry. I suppose I get a bit self-pitying, but I just feel alone in it all and it doesn't feel that anyone understands. It makes it hard for anyone to help me because I just push people away. So when I most need help from people, I'm least able to receive that help. What I'm really looking for from them is that sense of hope, for someone to reassure me that it will be okay eventually, because hope becomes like oil and just runs through my fingers. Over time I've learned to write down how I'm feeling and look back at the positive stuff that I've written down at better times, and that has really helped, but it takes extraordinary effort to make myself do that. – **By RB**

CAN WE HEAL?

by Carolyn Spring

It was just as we were packing away on a training day. A lady with dark hair walked away, then came back, and now was suspended in mid-motion, as if stuck in approach-avoid. I caught her eye and smiled and, brimming with emotion, she came towards me. 'Can we heal?' she asked, quivering with the significance of what she was saying, as if her very life depended on it. 'Can we really heal?'

I could well understand the agony in her eyes. I lived for many years overwhelmed by trauma, the symptoms of unhealed suffering. And if recovery is impossible, then why are we even trying? When despair grips us so tightly, when everything is so painful inside that suicide feels the only reasonable course of action, then knowing whether or not healing is possible is fundamentally a matter of life or death.

And recovery from trauma is hard. It took a decade for me fully to regain a sense of equilibrium, to be able to get up on a morning without feeling that I couldn't face what lay ahead. Many times I strayed right up to the edge of the chasm and even though I chose not to throw myself in, it's still a wonder that I didn't stumble in. And I have met many, many severely distressed people whose daily lives are filled with the agony of both remembered and unremembered trauma, who try so hard to heal and yet who are constantly being pushed down both by their symptoms and the oppressive circumstances of post traumatic life around them.

I have met and engaged with people who face not just childhood trauma but now breast cancer too; people who regularly are raped by their partners; people

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whose children are in care; people who still are being abused by criminal gangs masquerading as their family. I carry with me on a daily basis a deep empathy for the suffering I see all around me. And I have experienced it myself. So when I pose the question 'Can we heal?' there is nothing glib about my response.

It is so difficult to heal, because trauma is plus-sized, affecting everything on a big scale. It upscales our emotions, our suffering, our sensitivity to the world. It makes us hypervigilant, jumpy and irritable. We race at a hundred miles an hour or are stuck still on the spot. It narrows our window of tolerance and makes it difficult to manage our emotions. 'Affect regulation', the ability to manage our feelings, is a skillset that we should have learned implicitly as babies and children. Our brains are wired by the early experiences we had of distress and soothing with our primary caregiver. In families where the parent sensitively attunes to the baby and soothes the distress, the baby's conscious front brain learns to dampen and inhibit the emotional, unconscious, survival-based back brain: the pathways are formed in our early years, through thousands of tiny interactions with a caring other, who soothed us and taught our brain how to soothe itself. But when there is neglect or abuse or the chronic failure of a primary caregiver to act as an emotional thermostat, our brains don't learn how to manage distress, and our emotions became big and scary and uncontrollable to the point where many of us switched off from them completely.

Why is trauma so difficult to recover from?

- It impacts our ability to manage our feelings
- It is dissociated and takes on a life of its own
- It is a whole-body experience
- There is a lack of social support for survivors
- It is 'crazy-making' with various impacts in brain functioning
- Good diagnosis and treatment are rare
- It affects multiple realms of functioning

For most of us, trauma didn't happen in a vacuum: we developed a dissociative disorder not just because of horrific events visited upon us in the dead of night, but because of developmental deficits, because of the lack of a consistent, attuned caregiver. Very often we grew up in a family context where not only was the trauma allowed to take place, but where we received no care afterwards either. We dissociated from the trauma, but so did the adults around us: parents, wider family, teachers, social workers, medical staff. No one saw or intervened or treated it as real. It didn't form as a narrative in our life, and instead we were

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left alone with it, where the only option was to secrete it away in tiny pockets of our mind. We didn't rock the boat; it wasn't talked about.

There, in these recesses of our mind, it grew its own life, separate from our main consciousness, and we became a stranger to it, until suddenly in adulthood it demanded to be heard. It expressed itself then as an alien living inside us: a 'not-me' part of the personality, the unremembered trauma with now an existence and memory of its own. And so the trauma feels like something that takes over, like Bruce Banner becoming the Incredible Hulk, something that we cannot predict or manage or avert. How can we recover from something that seems to have a life of its own, that we don't understand, that feels so definitely 'not-me', uncontrollable and horrific?

The trauma plays out for us as a whole-body experience, like being possessed by aliens. We experience so many bodily symptoms: pounding heart, sweaty palms, digestive upsets, nausea, chronic fatigue, unexplained pain, headaches, insomnia, palpitations, diabetes, back ache, menstrual difficulties. Few of us grew up understanding the link between the body and the mind, and so these symptoms seem strange and unconnected – not only are we sick, but we're mad too. How can we recover when we're so sick, when we feel like we're floating outside ourselves, when we're hungry but we don't know it, or we're full but we don't know it, and when only alcohol or tablets or self-harm work as a way of calming ourselves down? How then can we heal?

Having grown up in dysfunctional families, many of us lack the support from family that we need to recover. We look longingly at other people with their Christmas and Easter get-togethers, the mother who helps with our children, the father who weeds the garden. The happy family is a myth for many, of course, but people who have been severely traumatised need increased social support just for the basics of life, for cooking and cleaning and shopping, and yet often they are surrounded by people who continue to abuse them or disregard their boundaries.

And trauma doesn't add up. We don't remember trauma as a nice, neat narrative with a beginning, middle and an end. Instead we remember it as dissociated fragments: the feelings, but with no visual memory; 'illogical' repulsions to sounds or smells; fear or sweating or shaking to a creaking floorboard, the smell of toothpaste. We don't understand why we're behaving the way we are – *where did the last few hours go? where did this*

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shopping come from? why have I just flown into a rage with my boyfriend? – and we feel unreal and spacey, as if floating outside ourselves (depersonalisation) or that our surroundings are dreamlike and colour-bleached (derealisation). Time plays tricks on our mind – everything has slowed down, or the last week has been a fast-forward blur. We don't understand that parts of our brain shut down during trauma or a flashback, while other parts are supercharged – we just feel that we've gone crazy, that we're losing our mind, that there is something fundamentally wrong with us as people. How on earth can we recover from this?

And then in the media we hear that we are mentally ill, that we need medication, that there is something wrong with our brain. But when we go for help, no one seems to agree on our 'diagnosis' – are we schizophrenic or bipolar, do we have post traumatic stress disorder or is it borderline personality disorder? Are we depressed, are we anxious, are we having a panic attack, do we have OCD? Are we simply attention-seeking? What's wrong with us that we are so 'ill' that no one even really knows what is wrong with us, let alone what drug we need to treat this 'chemical imbalance' that *obviously* we have? Which chemicals are unbalanced? By how much? No one seems to know. We are just mentally ill and there's no cure. In fact, we're even too ill to receive treatment – there's no one that can treat us in our NHS Trust (we're too complex) … How can we recover from this if no one has ever heard of a dissociative disorder or they say it's made up, an American fad, not something that exists in the UK?

And trauma affects so many realms in our life: it stops us sleeping, affects our eating, destroys our relationships, screws up our career, erodes our sense of self, affects our parenting, makes us sometimes dangerous to drive. It can feel as if every room in our house is flooding while we're trying to pump water out of the cellar. It affects us physically, emotionally, spiritually, relationally, vocationally. We often feel submerged by it, and all the while society is telling us that we're imagining this water, or that we're causing the flood to get attention, or that we're just a wet-house kind of a person and we can't expect to recover. Is this all true? Is there really no hope for recovery?

It was one of the beliefs that I had to fight hardest to overcome. In the early days I was struck by the latent belief that recovery wasn't an option. At times I felt disloyal for asking if it were. I believe now that recovery involves a lot more than 'integration' – the fusion of separate self-states into a unified sense of self – and that 'integration' does not

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even necessarily represent recovery. But in those early days, the prevalent viewpoint I encountered was 'I don't want to integrate.' Recovery was equated with integration and integration was equated with murdering parts of the personality. But that logic didn't hold for me.

I was quite simply saying: *I want to live a life that isn't dominated by the symptoms of unhealed suffering; I want to be able to sleep at night, and sleep without nightmares; I want an end to this medically unexplained pain; I want to be able to remember who I am and where I've been and what I've been doing; I want to be rid of this incessant sense of dread, of impending doom; I want to be able to cope with stress by staying present and by being able to soothe my own emotions; I don't want to feel as if my guts are on fire with terror and shame; I want to be able to relate healthily to others; I want to enjoy my work and not keep going off sick; I want to like who I am; I want to regain my physical health; I want to go for walks in the woods without being triggered; I want to have hope for the future; I want to be well.*

And yet the messages I received, even from some professionals, were: *You're a multiple and you need to celebrate that; you need to get people to understand you and make allowances for you; life is hard; recovery from extreme trauma is simply impossible.* At a level, it all rang true: this was my experience on a daily basis, and because other people had walked further along this path than me, I bowed to their wisdom. But over time I began to realise how much it was keeping me in the role of a victim. Yes, my life was hard, but complaining about that wasn't actually making it any better. No, people didn't really understand or truly empathise, but people are people. Yes, I did experience myself as multiple, dissociated personalities, but I knew that was because of trauma, not the way I was born.

No, my GP hadn't ever heard of dissociative disorders and just wanted to prescribe medication, but I could still build a good, supportive relationship with her. Bemoaning my existence wasn't changing my existence.

I began to realise that at core my experience of trauma was one of extreme powerlessness, and that powerlessness had a bigger grip on me than I had ever acknowledged. It was telling me now to sit still, do nothing (the freeze response) and accept that I deserved to be trapped in this eternal cage. The best I could hope for was an occasional visit, to be fed scraps through the bars, for people to feel sorry for me: that was what powerlessness promised. No wonder I felt so miserable.

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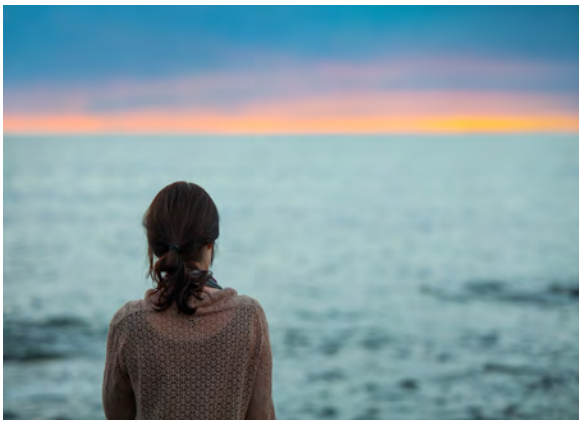

Eventually I realised that the cage was a projection of my psyche rather than a literal, physical reality. And so then I had a choice: I could rail against the unkindness of the world that was so unsupportive to me in my cage, or I could focus my energies on living outside the cage, and convincing my brain that the cage wasn't there. In the end I chose the latter.

A key for me in this was attachment theory and the work in particular of Mary Main and the Adult Attachment Interview. Main was surprised to find that some people in her study broke the mould: some people who had had terrible childhoods, who ought according to theory to have insecure or disorganised attachment, instead had secure attachment, and their own children, measured at 12 months in the Strange Situation Protocol, also had signs of secure attachment. Why? What was different about them? How had they managed to step outside their cages?

Main proposed that attachment history is not attachment destiny, that 'the stance of the self towards experience' is the greatest determinant of our attachment security. The key to our lives is not what has happened to us, she suggested, but how we view what has happened to us, and the beliefs we have developed about ourselves and others as a result of those events. The adults with earned secure attachment had been able to reflect and step back from their suffering. In effect, they were able to say, 'The reason my mother didn't love me was because of my mother – not because of me.' They were able to reflect on the beliefs they had grown up with – beliefs which had formed the bedrock of their internal working models – and choose which to accept now and which to reject. They had been able to look at the bars of their cage and say, 'When I was a child, I was powerless to get out of the cage, but now I'm an adult I am free to make choices, and I choose not to live in this cage anymore.'

This for me was dynamite, exploding the bars of my cage. For the first time I saw that some of my beliefs had been helpful in childhood, to survive the trauma, but were unhelpful now as an adult. As a child, the best way to survive was to be still, to submit – to do nothing that might incur further harm. That belief had grown with me through my teens, my twenties,

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my thirties, an unacknowledged mentor directing my every path, reinforcing a ubiquitous sense of powerlessness and victimhood. I had believed that I was bad, and unloveable, and cowardly, and weak – beliefs that had been unconscious, and had always gone unchallenged. I believed them because they were true, and they were true because I believed them. But for the first time I realised that as a child during the abuse, it had been adaptive to take that submissive position, to blame myself rather than being angry towards my abusers. That was why those beliefs were so powerful, so resistant to change – they had been etched into my psyche by trauma and suffering. But they weren't helping me now. 'The stance of the self towards experience' was the key to stepping out of that cage, and starting to believe that I was no longer powerless, not only to live well, but also to recover.

After attachment theory I came across Bethany Brand's long-term research into treatment outcomes for dissociative disorders. It showed unequivocally that psychotherapy was effective in reducing trauma symptoms, including self-harm and suicidality – the very things we turn to when the distress is unmanageable and we feel that recovery isn't possible. Alongside it, the research of Eric Baers and team looked at various hindrances to recovery, things like comorbid diagnoses, secondary gain, and lack of social support. As I read it, it occurred to me that if we can identify the hindrances to recovery, we can work at removing them. Recovery is not a dream so much as it is a plan.

Why is recovery possible?

- The powerlessness that says 'we can't' is a symptom of trauma itself but is now an outdated belief system
- The 'stance of the self towards experience' is more important than the experience itself in determining outcome
- With reflection we can change our belief systems that were adaptive in childhood but are now outdated
- Research indicates that positive outcomes are possible, as well as detailing hindrances
- The brain wants to heal
- The impacts of trauma are logical

My fundamental belief about recovery was that the brain wants to heal. I have an underlying optimism about the human condition. Do we believe that the body and brain are susceptible to disease, that it's only a matter of time before we succumb – a negative trajectory? Or do we believe that our biology is little short of miraculous, and even our immune system a work of art? I grabbed with both hands the idea that our brains kept us alive during the trauma, that dissociation was

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a gift. It helped us survive the otherwise unendurable, doing just what we needed to do at the moment of extreme stress – lowering our heart rate to prevent cardiac arrest, flooding the bloodstream with analgesic opioids, providing escape through derealisation and derealisation so that we could float above our bodies rather than inhabiting their pain. This is amazing – this is what our bodies and brains do when they are most under pressure, even as children. They know how to survive, instinctively. So we can trust them now to help us survive, and we can trust them now to help us recover.

The more I understood about trauma and dissociation, the more logical my symptoms appeared. I realised that I hadn't gone mad, that my brain wasn't falling apart, but in fact my mind was trying to heal. Flashbacks were horrific, yes, but they were the pieces of the jigsaw trying to fall into place so that I could have in explicit memory a more comprehensible narrative for the things that had happened to me. If my clever, thinking, explicit front brain could understand how I had been abused, it could think and reflect and plan how to keep me safe in the future – self-defence classes, erecting boundaries, appropriate caution and risk assessment – rather than depending on my implicit memory, my survival-based over-reactive back brain. So this breakdown wasn't a sign of insanity; it was a sign of my brain trying to heal, and rearranging the pieces to try to make sense of senseless abuse. I began to understand even my chronic fatigue as a way of trying to ensure that I didn't have heart failure from operating non-stop in the amber alert state, being permanently ready to run or fight, my body's way of saying, 'Rest now!' It all came down to how I framed it – again, 'the stance of the self towards experience'. The impacts of trauma were logical, and so they could be reversed and dealt with one at a time in a logical, stepwise manner too.

And I realised that the people who had abused me didn't want me to recover. They wanted me to be seen as 'the crazy one', with an incoherent account of 'recovered memories', which the false memory brigade had worked so hard to discredit. I had always been told not to tell. And for a long time I had obeyed their dictates, because it was too unsafe not to. But eventually I realised that I was angry, really angry, at what they had done to me, and so I had to find something productive to do with that anger. For decades I had turned that anger against myself – hating myself, hurting myself, abusing myself. At times I had turned it against others too. But the anger didn't go away, because it wasn't achieving its aim of keeping me safe. I had to change my target, and use it

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to exclude from my life those who had hurt me. The first purpose of anger was safety, and safety was the first step in recovery. When I started to form a narrative of the things that had happened to me, I was overwhelmed with fury and a need for revenge. But I began to realise that recovery is my best revenge, and that believing that I could recover was the most potent act of rebellion I could perform. If I really hated what they had done to me, then I needed to use the energy of that anger to recover from it. There was nothing, I realised, that would offend them more. I couldn't hurt them back physically – that would make me no better than them, an abuser – but I could hurt them by pursuing the opposite that they wanted: goodness, compassion, healing, love.

It was fine as a concept, but could I actually put it into practice? Much hinged on what I believed about myself, whether victim or survivor. The resilience of the human spirit is well documented not just in books and films but in real lives as well: combat veterans like Ben Parkinson who lost limbs and suffered a traumatic brain injury but recovered to kayak down the river Yukon; terrorist victims like Malala who even as a teenager went on to be a global activist for women's and girl's rights; disabled people like Stephen Hawking who outlived his terminal prognosis of motor neurone disease to become one of the greatest physicists of all time. If other people could overcome adversity, could I? It hung on adopting an identity other than as a victim. There was a period during which it was important for me to identify as having DID, because denial had kept me from accepting it and facing the reality of my condition. But as time went on I realised that it was important to see myself as being more than a victim of trauma. I had to have interests and relationships and aspirations outside of DID. Trauma narrows your life, restricting you to what feels safe and familiar, and I realised that I was being restricted in my view of myself – 'I am Carolyn Spring and I have DID'. I had forgotten how to be anyone else and had become dominated by my symptoms. So on the one hand I had to fully engage with the reality of DID, whilst on the other holding it lightly and believing it to be temporary and only part of who I am.

I also had to decide that I wanted to get better. This seemed a ridiculous thing to say – of course I wanted to get better! But did I really? Recovery would involve a day-by-day fight, a battle, a struggle. Was I willing to do that every day and not give up? Secondly, recovery would bring with it new challenges: increased responsibility, life in the unforgiving 'real world' amongst people who don't talk about mental

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health let alone understand dissociative disorders. I would need to develop new coping strategies rather than relying on dissociation. I would need to toughen up. I would need to feel my feelings. I would need to live a life beyond therapy. I would need to develop a life worth living. All of these things, on the surface, were positive things, but trauma gets you into the habit of saying, 'I can't' and of playing it safe. Recovery would mean taking risks, getting rejected, failing and being misunderstood. Recovery isn't for everyone, I realised, because not everyone wants what recovery offers: freedom from symptoms, yes, but life lived without the protection of dissociation and switching too.

How do we recover?

- By believing that we can, which is an act of rebellion against those who abused us
- By developing an identity beyond that of victim
- By choosing to pursue recovery
- Through perseverance and patience
- By stopping abusing ourselves

So I had to want to recover, and I had to believe that I could recover. It was one thing to believe it when I was feeling upbeat and optimistic. It was another to keep believing it when life threw me yet another curve ball. And it took a lot of retraining of old habits: the temptation to say, 'But it's not working!' rather than, 'It's not working yet.' Faith and patience is a difficult combination to mobilise every single day, but Edison invented the light bulb after ten thousand failed prototypes, and recovery comes when we keep on keeping on. Recovery is not something that is done to us, or that magically happens to us because we've had some 'treatment'. Recovery is something that we doggedly fight for every day, and it's the fighting for it that shapes us into the person who is recovered, not any wave of a magic wand or particular therapeutic approach.

Perhaps the biggest change came when I decided to stop abusing myself. It is a great irony that we bemoan the symptoms of abuse in our life, and then continue to inflict abuse on ourselves. I realised that I used the past as an excuse to abuse myself; I used my diagnosis as an excuse to abuse myself; I used my feelings as an excuse to abuse myself. Of course it makes sense to hate yourself when you've been forced as a child to perpetrate abuse on other children. It makes sense, but it's just perpetuating that abuse. It's counter-intuitive instead to show yourself compassion, and break the cycle of abuse. I eventually realised that if I really did hate what had been done to me, then I couldn't continue to do it to myself. Either I wanted to recover, and live a life free from abuse, or I could choose instead to

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continue to abuse myself and not recover. The choice came to me, as stark as a fork in the road, and although it took much persistence to kill off old habits, refusing to abuse myself any longer was the single most important step I took in my recovery journey.

So can we heal? Yes we can, because 'the stance of the self towards experience' is more defining than the experience itself. We can heal if we really want to heal, and if we commit ourselves to healing, by no longer abusing ourselves. We can heal if we believe that we can heal, and mix faith with patience. Trauma has logical impacts and those impacts can be reversed one at a time. Recovery is not easy, but it is possible. And recovery is our greatest act of rebellion against the people who abused us: recovery is our best revenge.

I hope the lady with the dark hair is reading. •

TEN ROADBLOCKS TO RECOVERY

by Carolyn Spring

1. BELIEVING THAT RECOVERY ISN'T POSSIBLE

'Recovery is impossible. Even the use of the term 'recovery' is cruel, taunting people who cannot recover with the false hope that it is, and shaming them in the process.'

So said a fellow delegate at a recent conference, enraged at my mantra that 'recovery is possible'. And I used to agree with him. Everything I had ever previously known about 'mental illness' – erroneously – was that it was incurable and progressive. It was a revelation for me to read the century-old writings about 'dementia praecox', later labelled 'schizophrenia', that gave birth to this misinformed orthodoxy. It took me even longer to separate out 'mental illness' from 'mental distress' and realise that my symptoms were post-traumatic in nature and simply the clamourings of unhealed suffering. It took me longer still to realise that our brains and our bodies are designed to heal, and that we can co-operate with that process.

It was Janina Fisher, amongst others, who opened my eyes. Referring to the survivor of trauma, she wrote: '... if she had the ability as a small child to survive these terrible experiences, then she has all she needs to recover from the symptoms of those experiences.' It helped change my perspective of myself, from a defenceless

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victim, powerless, devoid of resistance, to a resourceful survivor, courageous and persistent. We survived the real thing, unremitting trauma itself, when we were children. So surely now as adults, with support, we can survive its aftershocks. I began to believe in recovery firstly because I understood the logic of it, and secondly because I began to experience it myself. I began to understand recovery, not as a 'treatment' that is done to us, but as an orientation of my heart, as something that I can take hold of, because I'm powerless no longer. Recovery is possible, but only if we believe it to be so.

2. BELIEVING THAT I AM MENTALLY ILL AND 'CRAZY'

To suggest that DID is a mental illness is to suggest that something has gone wrong in the brain, that some form of medicine may be needed to treat it, that this 'illness' may recur, and that it may even be contagious. Likening mental distress to physical illness is inadequate because it pathologises our normal, human suffering and places it squarely in the medical model, at the whim of doctors and 'experts' who can label our experiences as abnormal. I came to realise – eventually – that nothing had gone wrong with my brain: my brain did good. It helped me survive the unendurable by switching off, by limiting my awareness, by refusing to join up as a whole what is too much for a child's brain to bear.

I came to realise that my brain isn't sick. It's what happened to me that was sick – and arguably the people who did what they did to me. My brain just reacted in the best way it could to keep me alive, and to keep me sane. DID is an adaptation to an abusive or traumatic environment. But once that environment changed – once, as an adult, I became safe – I needed to set about the process of re-adapting my brain to a different environment, one where it didn't need to be so focused on threat and trauma and pain. That is the process of recovery, to mould my brain to a new, non-traumatic environment, not to mend it from dysfunction or cure it from illness. My brain had to learn to focus anew on exploration and relationships and joy. Dissociation was logical when I was a child in an unsafe environment. It only became illogical when I persisted in it as an adult in safe surroundings.

3. DISEMPOWERMENT BY THE RECOVERY PROCESS

My life is my own now. I am an autonomous human being – an adult – with the right to make choices and decisions about my own life. But that belief was a long time coming. As a child I had few, if any, choices, and abuse stripped me of my free will. Recovery has involved becoming the adult I am, and gaining my freedom to act as I want to: a victim no longer, but a survivor with self-agency.

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In this process of recovery, therefore, it was paramount that I was not disempowered by the very people and institutions that were meant to be helping me. Am I given choice, or are my choices made for me? Am I disempowered by an 'expert', someone with all the knowledge and all the power, who doles out a 'treatment' to me that I don't even understand? Or am I empowered by a skilled but humble human being, coming alongside me, not one over me but with me, on a level?

I have been extremely fortunate in the people who have helped me. They have empowered me to discover my own agency, my own ability to act, to find my own identity and forge my own destiny. They have insisted that I sit in the driver's seat: they have held the map, and only occasionally pulled the emergency brake. Had I been disempowered by 'experts', I might not have learned that I am in charge of my own recovery, and that my life is my own to choose now.

4. MAKING EXCUSES FOR BAD BEHAVIOUR

All of us want to behave badly, at least some of the time. After a lifetime of neglect, of not being noticed, of pain going unsoothed, it is a powerful thing to receive comfort and attention and care. We start to discover the unspent rage within us, the greedy grabbing entitlement that says that the world owes us, because of what happened to us. It's hard to blame our abusers, so mostly we blame ourselves. But then we begin to blame others – our GP, our counsellor, our partner, our friend. We hold them culpable for the acts of others, events from years ago. We unleash our outrage, behaving badly, and then we justify it with, 'It wasn't me ... I don't remember ... It's not my fault ... I can't help it.'

But recovery is not recovery if we assume the role of the perpetrator. Recovery demands that we take responsibility for the behaviour of all the different aspects and parts of ourselves. It was an easy-out for me to let my 'Dark' part smoulder and growl; it was expedient to let my teenage parts seethe with adolescent angst. It was harder to accept that their behaviour was mine too, and that by connecting in to these disowned parts of me I was going to have to acknowledge that I wasn't always the person I wanted to be. But this is recovery too: becoming more than our symptoms, our struggles – becoming who at core we aspire to be. Recovery is about becoming whole as a human being, the best human being we can be, and not using our suffering as an excuse to impose suffering on others.

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5. VIEWING TRIGGERS AS GREMLINS, NOT GUIDES

Triggers came unbidden, unwarned, unwanted: and suddenly *bam!* I was triggered. Before conscious thought had chance to intervene, my body engaged in a fight-flight-freeze response. Back came the terror, the powerlessness, the rage: the visceral memory of childhood trauma. It was terrifying to endure, but eventually I learned that triggers are not a sign, as I so desperately feared, that I was mad. Triggers are merely signposts to what has yet to be integrated in my memory and experience. They are a conditioned response meant to help me, to keep me safe, to avoid something that caused me harm in the past.

But our survival-based back brains aren't smart – they generalise, they extrapolate, they guess: preferring to err on the safe side, they identify a superfluous detail, like 'beard', as a signal of impending threat. Our back brains can't deduce (yet) that lots of men have beards, and that beardedness is not a good predictor of abuse. So it screams a warning at us now, until our front brains can assimilate new data from our now-safe environment, where beardedness is simply a personal grooming preference that speaks nothing of the motivation to perpetrate: like the colour red, or the sound of footsteps, or the odour of sweat, or the feeling of cold.

But triggers came with such overpowering affect, an echo of the feelings I had at the time. So I avoided them at all costs. It took a long time for me to recognise that by doing so I was ignoring their vital message. Triggers are clues about what is still dissociated. I used to complain often that I couldn't remember what happened to me, but then I discounted the hints, stored in procedural, implicit memory, that triggers offered me. Recovery involved accepting triggers as messengers, and learning to listen to the message that they brought, rather than building a life of distraction and noise.

6. BELIEVING THAT I AM A VICTIM

When I was young, I was overwhelmed by trauma so huge that my brain couldn't deal with it. I was a child then – of course I couldn't deal with it. But trauma has a tendency to freeze in place the self-perceptions we held at the time, and many of us struggle to update our 'mental maps', our 'internal working models', with the new information that tells us that we are children no longer, that we are overwhelmed no longer, and that we can and must now make decisions to act.

Slowly it began to dawn on me that recovery would remain forever out of reach if I continued to see myself as a victim, or as a child, overwhelmed and

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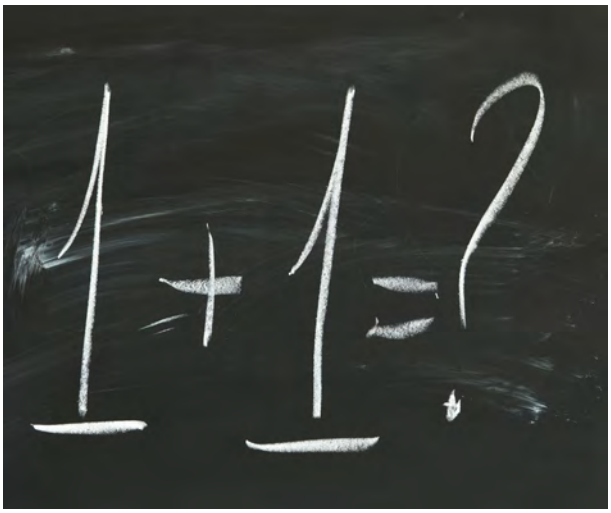
powerless. I had to teach my brain instead that things are different now, that new resources are available, that 'it's not happening now'. I had to see myself not as a powerless, pathetic victim (urgent and primeval though that belief was), but as a resourceful, resilient survivor. It didn't come naturally at all: I had to work at it. I couldn't choose what happened to me as a child, but I could choose how I viewed myself now as an adult who survived that.

Later I learned about Attachment Theory, which teaches us that 'the stance of the self towards experience' (Main, 1991) is paramount, that it's not what happened to us that dictates our destiny so much as how we view ourselves. And I began to realise that recovery was tantalisingly near: because if it is rooted in how I view myself and my experiences, rather than the experiences themselves, then I have some power over it. No one can dictate to me how I should think about myself (although many still try): it's entirely up to me. I am who I believe I am: spirited survivor, not voiceless victim. And that is the very basis of recovery.

7. BELIEVING WE'RE THE SUM OF OUR SYMPTOMS

The experience of DID has been at all times both strange and overpowering. I experience blanks throughout my day – 'microamnesias' where I've switched to



another part of the personality, and the integrating strands of memory haven't carried through to my main stream of consciousness. I feel depersonalised and derealised. I smell memories – odours not from the here-and-now, but from the there-and-then. I experience 'body memories'. I feel myself slipping into a deep well within myself, and the voice that emanates from my mouth sounds child-like and confused. I observe my surroundings as through a tunnel, detached and out-of-control. This is the reality of my subjective experience of DID. It's not hard to see how our 'symptoms' – these experiences born of the disintegrating effects of trauma – dominate our vision, our hearing, our thoughts, our sense of self, our volition. Knowing that we are different, we seek out others who share our 'sanity'. It's a relief to find others who experience life like we do. It's a relief to know that we are not alone, and maybe not so crazy after all.

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But recovery insists that we keep our sights set also on the beyond, not just on the now. Our symptoms are real and valid and true. But there is also a beyond, and recovery insists, even in the chaos and turbulence and stupor of dissociation, that we retain the knowledge that our symptoms are the symptoms of trauma, and trauma can be healed. It doesn't feel like it, when the entirety of our self is consumed in the shudder of a frightened four-year-old part of us. It doesn't feel like it when the pain and distress is intolerable. But recovery means that even in the midst of our misery we begin to 'mentalise' – to step back from our here-and-now, this-is-it experience, and see that there is a wider perspective and that what we are feeling now, we will not always feel, and that other states of mind exist, which we will experience at other times and on other days.

We have to believe that we are more than the sum of our symptoms. When we settle for anything less, we limit our recovery, because we allow ourselves to be defined by what happened to us: the oversensitisation of our neurobiology and the fragmentation of our sense of self. Recovery means that we connect the dots between all the different parts of ourselves: the different experiences, emotions, outlooks; the desires, and hopes and fears; and we become the person that we truly are, the whole that is greater than the sum of all its parts. I had to believe that I was more than a collection of symptoms, and forge forwards into the entirety of my being.

8. FIGHTING BATTLES WE CANNOT WIN

For so long, life with DID felt like a battle that I could never win. It was a daily onslaught by a sly, invisible enemy. At first I underestimated how much effort would be required of me to fight through to a place of healing and recovery. It has taken years, and life continued to happen even while I fought: I got sick, others got sick, I had money troubles, relationship troubles, career (or lack of it) troubles, family troubles. I realised eventually that life will not always give us a break while we fight to recover. I was struggling on so many fronts, and eventually I realised that I could not fight and win every battle that came my way. I had to concentrate my efforts, and learn to walk away.

But I wanted to fight. I wanted to fight for justice, of the 'criminal justice' kind. I wanted to fight for treatment and support, for compensation or an apology. We all have our battles. Others fight for the right treatment for the right length of time from the right people; for understanding from the Benefits Agency; for fair treatment from employers; for compassion from family and friends. They are worthy battles.

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Of course what happened to us as children was wrong; of course we were let down by non-abusing bystanders; of course society shouldn't have let it happen; of course we deserve fair treatment and long-term support and all of our human rights now. But we can't fight every battle every day. Sometimes we have to prioritise.

And sometimes we feel that our recovery is contingent on others: that we will recover if our abusers go to jail; or if we get the 'right' therapist (usually an NHS one); or if we are awarded Personal Independence Payment. Some of these battles are worth fighting, because they are taking ground en route to overall victory. But sometimes we are so caught up in the need to fight – the trauma response of fight, flight and freeze – that we don't stop to think about whom we're fighting, and why, and what the outcome might be. Sometimes the only person we hurt with our fighting is ourselves. What Judith Lewis Herman referred to as a 'survivor mission' is undoubtedly a major part of recovery, but sometimes we're fighting because we're angry, instead of fighting to recover. If we can focus our energies on recovery, we'll find strength later for other battles.

9. PURSUING AVOIDANCE

When I was a child, the only thing I could do – literally the only thing – was to push away the consciousness of what was happening,

stuff the feelings down into a chasm of emptiness inside, and avoid, avoid, avoid. It's a good strategy, and it worked. It still works now, and sometimes it's essential: when we're at work, or responding to the demands of everyday life, it's a good thing to avoid the trauma, so that we can go on with living. But avoidance was my only strategy for dealing with the trauma. It didn't occur to me that the trauma could be resolved, not just avoided.

Avoidance comes in many forms, perhaps the most potent of which are intellectualisation and fantasy. With the former, we talk about DID, we read about DID, we research DID, we hypothesise about DID. Anything other than facing the trauma, and working it through. We try to drown out the trauma with a multitude of words. With fantasy, we live in a complex world of 'alters' and 'littles' and 'systems' and 'hosts', elaborating what

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is undeniably real – the polyfragmentation of DID and complex trauma – until our self-representation becomes in itself a form of avoidance. We have picnics, play games, watch cartoons – but it can become our sole focus and we avoid working through traumatic memory, or building secure attachment, or mentalising, or learning to regulate our emotions.

Younger parts are real: I had many of them. Through them I learned to have feelings, to 'go there' a step at a time with the trauma narrative. Through the detachment of being not-me, I could explore concepts of my self and my family and my upbringing that were otherwise too overwhelming. Each of my parts had a function and a purpose. But each also contained a temptation: to avoid the hard edges of adult life, to avoid – as adult, me-me – the reality of the trauma and the tidal wave of emotions it brought with it. I had to work against avoidance – I still do.

I had to commit myself to doing the work, pulling the pieces together, integrating the dissociated fragments, owning this trauma as my trauma, owning these feelings as my feelings. I had to learn that these echoes of the trauma would not kill me and that I could face it myself: that I didn't need to switch to another part of my personality at the first whiff of a feeling. I had to ask myself why I couldn't be vulnerable myself, rather switching to a four-year-old representation of myself to ask for help. When my focus was solely on 'being DID', solely on mapping 'who's who' rather than engaging with these disowned parts of me, then the avoidance was a dead-end and I didn't move forwards.

10. PERPETUATING THE ABUSE

I never saw myself as an abuser. It was a horrific thought. I hated everything that had ever been done to me, and never would I want to do that to another human being. And I haven't. Not to other people. Only to myself.

The irony was lost on me for a long time: here I was, paying privately for therapy, committing hours every week to the sessions themselves, the travel, the journalling, the preparation. Because I wanted to recover: recover from abuse. And there I was, abusing myself at every juncture: self-harm, criticalness, perfectionism, neglect. Compassion, let alone self-compassion, was a strange concept for me: I had experienced so little of it that I didn't really know what it was. When I experienced compassion from others, at first I assumed it to be a trick, part of the grooming process. Over time I began to realise that it was genuine. The harder part was to show compassion towards myself. It was so much easier – so much more natural! – just to hate myself.

TEN ROADBLOCKS TO RECOVERY

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Frustration erupted easily within, at my many failures, my many struggles, my seeming inability to 'snap out of it' and 'get a grip'. It was only through accepting that dissociation was logical and that I had done the best I could do, at the time, to survive, that I began to be able to offer – grudgingly at first – any empathy or grace towards myself.

But it transformed things. It meant that on any given day, I could struggle, I could fail ... but I didn't then need to add to the struggle by beating myself up for it too. Sometimes the greater pain is the pain we cause ourselves, with our acerbic tongue, our punitive self-loathing. The names we call ourselves: 'failure', 'loser', 'idiot'. The rage we unleash upon ourselves when we feel feelings of neediness, or weakness, or vulnerability. It's all we used to know: that was the environment we grew up in, where soft words and tender words and kind words were rare. But that's not the environment we have to live in now, and we don't have to play victim to ourselves and our own self-hatred. We can learn to show ourselves understanding and compassion, kindness and patience. It didn't happen overnight. It didn't happen, with me, for several years. But I have become convinced that recovery from abuse only and ever comes through putting a stop to the abuse, and especially the abuse that we direct at ourselves. I'm not pathetic, an idiot, stupid, crap. I am a survivor of awful abuse. I did my best to survive it, and I'm doing my best now to recover from it. I'm doing ok. I am ok: to be able to say that, surely, is one sign of recovery. •

RECOVERY IS MY BEST REVENGE

by Carolyn Spring

Is recovery possible?

That's the question that everyone is asking, even when they're not asking it. After a breakdown, perhaps after years in the mental health system, do we have to simply accept that we're broken and that we'll always be broken, or is it possible to live a life where we're back in control again, where we're living as we want to live, where life has purpose and meaning? And what about revenge? What about that indelible desire for retribution and justice that is etched on each of our souls? Does recovery imply that what happened didn't really matter, that our abusers can get away with it scot-free, that we should just 'forgive and forget' and 'move on', as so many people exhort us to do?

When I brought out my first book, I thought long and hard about a title. In the end I settled on *Recovery is my Best Revenge* because implicit within those words are two concepts that I hold very dear. Firstly, the belief that recovery is possible – it really is possible – and I know because I have experienced a significant measure of it: I am here, I have survived. Trauma is neither a life sentence nor a death sentence. It can be processed, and we can recover. And the second concept is the self-evident truth that it's not okay that I was abused and traumatised the way I was. Recovery does not make up for what I experienced. It does not erase the past. What happened to me was wrong, and the desire for revenge is, I believe, a wholly righteous one. It's the part of us

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that stands up in the midst of evil and says, *That ain't right!*

But my revenge has been found not in becoming an abuser myself, but in becoming the best human being that I can be: the kind of human being that my abusers definitely were not, and the kind of human being that they didn't want me to be either. I want to live as a human being, not an inhuman being. And I want to live the kind of life that helps other people to live as human beings too.

But to live with recovery as your best revenge, you have to believe that there is hope for recovery from trauma. If recovery is not possible, then it is so much easier just to slide into the lazy evil of abusing others as your way of coming to terms with what happened to you. But I believe that recovery is possible and that we can in fact choose compassion, both for ourselves and others, rather than abuse.

But I do believe that trauma leaves indelible scars, and in order to recover we need to understand what it has done to us. Because trauma is not just a bad thing or even a series of bad things that happened to me in a vacuum, one cloudy day in August 1976. Trauma is something that shaped my brain just as it was developing. It impacted directly on my growing neural circuitry. It made my amygdala, my brain's 'smoke alarm', more sensitive to incoming threat. It limited the connections between my thinking front brain and my survival-based back brain, making me more reactive to that threat. It affected the internal working models I was building of the world I lived in. It destroyed my sense of self, and my sense that I had a right to be alive.

Trauma breaks down the normal integration, the normal joining-up of thoughts, memories, feelings, behaviours, perceptions and sensations. Our memories are disjointed and held as somatosensory fragments. Our feelings don't integrate with our memories. Our thoughts don't integrate with our behaviours. And trauma has a profound effect on our autobiographical sense of self, as we see in my own experience of dissociative identity disorder (DID). I grew up without an integrated sense of self: all the different aspects of my experience and my self-identity did not join up together into a coherent whole. So I developed with what is vividly but inaccurately described as 'multiple personalities'. Walt Whitman, the American poet, expressed it well – he said, 'I am large; I contain multitudes'. 'Trauma is not just a 'bad experience' that I haven't been able to get over. Chronic trauma in childhood is a way of life and a way of learning. It defines the way that our brains

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organise and understand information. Recovery is a slow, hard process, and it cannot be achieved in six sessions or even six months. Because trauma by its very nature is disintegrative, disconnecting and disempowering.

Trauma is also disconnecting. At a profound level, trauma impacts our relationships. It teaches us that even the people who should have nurtured us and cared for us – even they can use us and abuse us. The trauma of abuse teaches us that we exist to manage the feelings of others, and that our own feelings must be blocked out of awareness to cope with that. It teaches us that to go on living with 'good mummy' who irons our clothes for school, we must shut out the consciousness of 'bad mummy'. So we grow up with a very one-sided view of people, as either angel or demon, as either good or bad, but not as a complex mix of both. We carry a profound mistrust of people into relationships for the rest of our lives: the expectation that what you see is not what you get: the expectation that someone's comfort, or affection, or praise, is a prelude to abuse. And so in our therapeutic relationships, your smile or greeting, or expression of delight, feels like a form of grooming – it feels like the prelude to abuse, and we square up to you with fight, or run from you with flight, because unwittingly you have triggered deep within us a vision of our abuser.

Trauma disconnects us not only from other people but also from ourselves, and these are the conflicts that can tear us apart on the inside – in my case, with DID, where the parts of my personality are pitched against each other: the parts of me that want to carry on with daily life and are apparently normal, who cope with the trauma by avoiding it and denying that it ever really happened, and the traumatised, emotional parts of my self who are stuck in the trauma, raw as a knife edge, because the trauma has never been brought into consciousness and processed and experienced as being over.

Trauma is also profoundly disempowering. I believe that the very essence of trauma is powerlessness. It is that unavoidable, inescapable overwhelm of suffering that we can do nothing about. Some of us learn that it's best never to struggle, to just accept the freeze response and lie still until the danger passes. Perhaps by freezing, perhaps by submitting, it will be over with more quickly and we will be hurt less in the process. Lie still until the danger passes … But then, in our minds, the danger never passes, and so we live our lives inhibited by an eternal learned helplessness. We feel inept and incapable and stupid and weak, because when it really mattered, when our lives were at risk, we couldn't even move a muscle. So we feel terribly disempowered by that, as if it means that in the rest of life

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we will be incapable too. And we think: 'What's the point?! What's the point in trying to recover when I'm too helpless and powerless and stupid and weak to be able to do it?'

Breaking out of that mindset has been my journey over the last decade. I have had to work hard at breaking out of that learned powerlessness. I have had to work hard at overcoming my fundamental mistrust of other people. I have had to work hard at learning to live in a joined-up way where I'm in touch with all of me: where I can stretch backwards to the me-that-was, whilst also stretching forwards into the me-that-can-be. That's been a battle – a deep, deep struggle. But I can say with all honesty that there is a point to it all, because there is recovery from trauma and I'm living it. I'm doing things now that I never thought would be possible, even just a few years ago.

But – and there is a big 'but' – for there to be recovery, we need other people. It was 'other people' who caused the damage in the first place, and I believe that we need other 'other people' to help repair it now. And that's where therapists come in. Because therapy can help to provide the 'someone' that is needed to move a trauma survivor like me along in life, out of the realm of flashbacks and body memories and nightmares and freeze, and

into a place where we can both think and feel: a place where we are not just plagued with intrusive thoughts and images and memories that we cannot face alone, but where we can start to mentalise and think about the trauma rather than just reliving it. Therapy can provide the place for us to begin to feel the feelings that were frozen at the time, rather than those feelings coming out in somatic symptoms alone. Because one of the unacknowledged realities of trauma is that it carries with it a devastating retinue of physical impacts, everything from heart disease to cancer, to diabetes to rheumatoid arthritis, to ME and fibromyalgia. This is one of my biggest areas of ongoing struggle. In my life, physical ill health has been as much a problem as mental ill health has been. But it's an area, again, where therapy has made a difference more than drugs have. Because so much physical ill health has its seeds in the trauma that we suffered as children, and as I've faced that and dealt with it, so my physical health has improved as well. There is no mindbody split – that's a false dichotomy, and in reality we live as integrated wholes, whatever Descartes had to say about it.

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I've had in therapy a 'safe enough' place, a 'secure enough base' to begin to explore who I really am. Trauma told me that I am a victim, but through therapy I've become to see myself as a resilient survivor. I survived horror without support as a child. And now as an adult I can transform that suffering into compassion both for myself and for others.

Therapy has been life-changing for me. But when I walked into my therapist's office in May 2006, she was just a trainee with very little experience of counselling let alone dissociative disorders and organised and extreme abuse. If we go by some of the textbooks, she shouldn't even have started seeing me. Of course I didn't present in that first session with 'multiple personalities'. I did my best to 'act normal' so that I didn't drive her away, because after a year of floundering around in the midst of a breakdown that hit me out of nowhere, towards the end of that first session, she looked me in the eye and said with a fierce but kindly determination, 'I can help you'.

Those four words transformed my life. Because for the first time, I'd found someone who didn't run away from me, who didn't disbelieve me, who didn't tell me that I just needed to pull myself together. She said, 'I can help you'. And she was just a normal human being, without much training, without much experience. And yet she has had a significant impact on my life.

For many of us, the experience of trauma has been such a lonely one, so isolating, that the biggest shift for us is when someone is just present, and promises to remain present, while we work things through. The presence of another human being is transformative. This therapist has listened to me, and heard me speak of things that I thought were unspeakable. And through that, she has helped me to realise that I am just a human being, just like her. I am not a label, I am not a mental health patient, I am not a victim. I am just a human being, just like her, but one who has had some extreme experiences of suffering which have not yet had the opportunity to heal.

And it can be easy to talk about 'suffering' and 'trauma' as if it's some ethereal, nebulous pseudo-event. But really we're talking about real things happening to real people. I tried to dissociate from the trauma I experienced, to say that it didn't happen, and it didn't happen to me. But it did, and recovery has come through accepting those experiences as my own, rather than pushing them away.

Of course this therapist didn't have much experience of dissociative disorders

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and ritualised and organised abuse. But in many ways, all the reasons why she shouldn't have started work with me are the reasons why she's been so successful in working with me – because she's been humble, and open, and curious, and willing to learn: all the things I've needed to be to rediscover who I am, too, and heal from this suffering. She wasn't such an 'expert' that she could afford not to listen to me. She wasn't such an 'expert' that she tried to do anything more at first than just be a safe person, a witness, a reassuring presence. She was open-minded, and despite her lack of direct experience, she was actually incredibly wise. And she had a great deal of integrity – she was solid, and grounded, and right from the start, she treated me with a dignity and a respect that had been rare in my life.

I was manifesting very strange behaviours, but she didn't treat me as if I were strange. And yet of course it is very strange when someone switches to another part of their personality for the first time, when they start talking with a completely different tone of voice, with different facial expressions and a different way of holding their body. But she saw through my symptoms and my behaviours and she saw me as a person. And in over 8 years now, she has never for one moment treated me as anything less than an equal human being who deserves to be listened to and respected.

What she seemed to instinctively grasp was that all my symptoms, and all my behaviours, were communications. They were me trying to tell my story, trying to speak when I had been forbidden ever to tell. They were my dissociative unconscious desperately forcing itself into consciousness. They weren't a sign of my madness – they were a sign of my sanity, because my mind wanted to heal. She understood, and I began to understand, that DID is a sane response to some very insane things that happened to me in childhood. After all, how is a child to survive those kinds of experiences, except by chopping them up into more manageable little chunks, and hiding them away in boxes in our mind that we try never to open? What better way to cope with uncopeable realities than by saying that they're not real, by saying that they didn't happen – or at the very least that they didn't happen to me? And she has coaxed that communication out of me, and given me a place to speak.

Many, many other people in my life ran away from me during this time. I think, deep down, they were afraid of my suffering, and they didn't know how to handle it. I'm so grateful that my therapist didn't run away. She has never rescued me, and nor has she ever abandoned me. At times, the pressure to run was huge. She was hearing me not just retell but many times relive some of the most horrendous, atrocious

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forms of abuse. When I have been unable to face my trauma, and I've escaped in my head and I've dissociated, she's had to face it down all by herself. She hasn't had the luxury of dissociation. She hasn't had the luxury of overdosing or getting drunk or self-harm or overwork. She's just had to be able to sit with the unbearable suffering of another human being and feel it – every last ounce of unbearability and pain. She's had to draw on all her own internal grounding strategies, her self-soothing strategies, her mentalising capacity, to be able to deal with what she's heard. She's had to hold onto her faith in the universe and her faith in humanity and her faith in the process of therapy that this stuff can heal.

And by doing so, she has shown me that there is another way to deal with trauma other than by dissociating from it. She has shown me that there are things that we can do to manage our emotions when they threaten to overwhelm us: there is breathing and mindfulness, there is nature and birdwatching and sunsets and stargazing, there is comedy and friendship and holidays and sleep. She has shown me that I can stand back from what happened to me, rather than being sucked into endlessly reexperiencing it. She has shown me that I can hold it in my mind as an event that happened to me, that I can think about it and I can feel the feelings I have about it. I can hold it in mind rather than pushing it out of mind with dissociation. She has shown me that I can feel its feelings rather than avoiding them through numbing or minimising or self-medication or self-harm.

She taught me that feelings are meant to be felt and thoughts are meant to be thought and that dissociation doesn't achieve either. She has shown me that if I can both think and feel at the same time, then my hippocampus – my memory system's 'context stamp' – can tag the memory as 'over', that it has happened, that it's in the past. She has shown me that it's okay to have feelings – even strong feelings – about the things that happened to me. She has shown me that it's okay for me to express those feelings, and that I can choose good ways, rather than destructive ways, to express those feelings.

And she has done all of these things, not through some application of heavy

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textbook theory and a thousand CPD hours, but through the quality of who she is as a human being. Of course I believe that textbooks and theory are important, and that CPD is important – after all I spend a lot of my time delivering CPD and studying textbooks! But I believe the fundamental difference that therapists can make to people like me is in who you intrinsically are. It's your character, ultimately, that counts. The theory, the textbooks, the CPD – they are incredibly useful tools. But it's you as a person that counts, and therefore how you use those tools. I believe that 'good enough' therapy requires a 'good enough' therapist who is a 'good enough' human being.

Are therapists peddling a technique? Or are they fundamentally restoring someone's sense of dignity and respect as a valuable and precious human being? Suzette Boon says:

The therapeutic relationship is the most important vehicle in the treatment of patients with complex dissociative disorders. Patients heal from their early interpersonal trauma in a safe therapeutic relationship that respects healthy boundaries.

The good news there is that patients – clients – do heal. And we achieve that through at least three things. Firstly, you can help our brains to see that the trauma is over. It won't work if you don't believe that this is so. If you can't see that the trauma is something that happened to us but that it is not us; if you are intimidated or entranced by our labels, and you forget that we are just a traumatised human being – no more, no less – then you won't help us see that trauma is something that happened to us, but that it doesn't need to define us. What we're experiencing is just a flashback, it's just a feeling, it's just a body memory. Don't let trauma intimidate you. The trauma is past; we just need our brains to realise it. So the first step is that your brains realise it too.

Secondly, you can help us to develop 'earned secure' attachment. We have missed out on the ability to mentalise, to think about our thoughts, to stand back from ourselves and our experience and notice it rather than being in it. Peter Fonagy says that mentalising is being able to see ourselves from the outside and other people from the inside. Many of us as trauma survivors struggle to do that, because there was never an 'other' to see from the inside; there was never an 'other' who could help us to see ourselves from another perspective. Therapy provides that opportunity – to think about our thoughts, and to begin to see the filter through which we see the world and ourselves – what Bowlby termed our 'internal working model'.

RECOVERY IS MY BEST REVENGE

by Carolyn Spring

I have had to change my view of myself: from someone who was chronically overwhelmed and disempowered, to someone who survived – a survivor in the very best sense of the word. I went through the worst, as a child, on my own: I survived that. So I can surely survive this, now, as an adult, with support. I am resilient – because I didn't give up, I haven't given up, I keep going. The post-post traumatic worldview accepts the reality of what happened, but it also accepts the reality that we survived what happened, that we are amazing, that our lives have value, and that we are precious, resourceful, courageous human beings.

And we have also missed out on the ability to 'affect regulate', to manage our emotions and feelings. Dissociation is what you do when you don't have any other affect regulating mechanism to deal with this overwhelm of feelings from trauma, but then dissociation becomes the only tool we have to manage our feelings, so we need to build up other means of regulating our emotions. This happens, as Allan Schore puts it, in right brain to right brain attunement. It's bad enough that we have experienced such awful suffering in the first place, but that suffering is compounded by our inability to be soothed in our distress. When we feel that there is no soothing, then we will continue to dissociate and the trauma will never be processed and healed. But if we can learn to manage our distress, if we can 'regulate' our 'affect', if we can learn to receive comfort from others and to self-soothe in ways that do not block out the pain, if we can learn to sit with the pain until it passes … then we *can* overcome our suffering.

And thirdly, you can help us to make meaning of our lives and our experiences that is 'post-post-traumatic'. Living in a post-traumatic worldview, we believe that everything is dangerous and that we have no tomorrow. But it's not enough to try to develop a sanitised worldview, one that pretends that the trauma wasn't there or that it didn't happen. I live with the reality of my scars, without a family, whether I like it or not. Much better is to develop a post-post-traumatic worldview – one that can integrate the safe and the unsafe and say: 'Bad things happened, but

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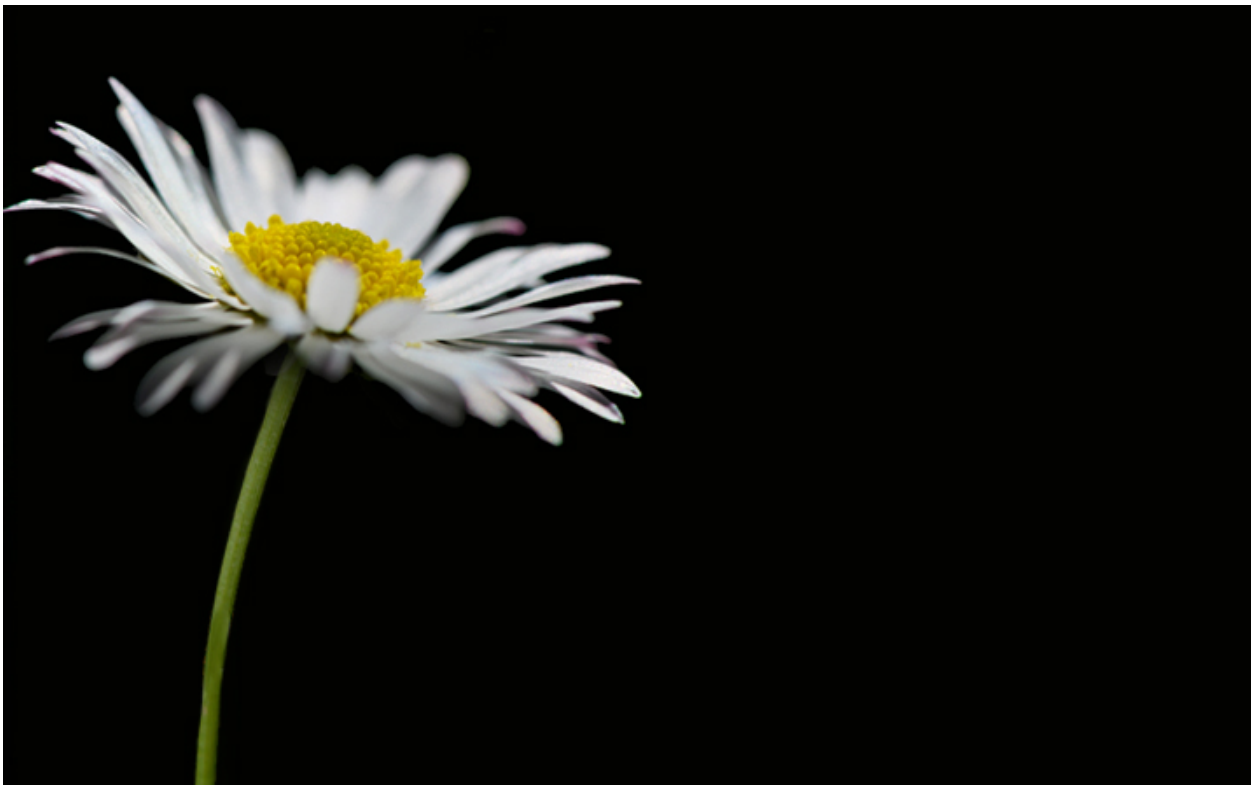

I also overcame them and if they happen again, I can overcome them again.'

Bad stuff happens and it can drive us crazy. But we can also survive the bad stuff, and we can overcome its scars. We are not 'mad people' with labels, we are just traumatised human beings. You as therapists don't need to be experts. You need to be compassionate human beings who are safe, and who will treat us with dignity and respect as equal human beings who are able to recover from our experiences, because we have already survived them. You just need to come alongside us. You need to provide good enough therapy as good enough therapists who are good enough human beings. You need to be able to sit with us in our unbearable suffering and neither rescue us nor abandon us. You need to be able to step back from our trauma and recognise that it is our trauma, not yours, and that it has happened but that it is no longer happening. You need to see our trauma as something that happened to us, not as something that defines who we are. And you need to believe that there is recovery from trauma, because there really really is: recovery can be our best revenge. •

DEVELOPING COMPASSION FOR PARTS

by Carolyn Spring

She is the hated child, sitting across from me, mocking me.

I didn't write this, but when I read it, in an email sent to me by a fellow survivor, the words resonated with my own self-experience. And many of us know it: the dirty, persistent self-hatred that we have for ourselves, these 'parts' of ourselves that we have so needed to disown that many of them have become completely 'other', separate, 'not me'.

In dissociative identity disorder, our divided psyche exists because our experiences were so traumatic and overwhelming that we couldn't 'integrate' them. Instead, we hold these discrete self-states as separate strands of our consciousness. Over time, many of them took on autonomous, distinct characteristics and developed into 'alter personalities'. It is a way of distancing ourselves from the trauma; it is also a way of distancing ourselves from our feelings, our vulnerabilities and our needs.

At first, my awareness of these 'other' parts of me was via other people, who recounted to me what they had said, what they had done, in those time blanks where I was unaware. Even then, I pushed it away. I didn't really want to know. It sounded mad – it was mad! – and I didn't want to hear that a 'young' part of me calling herself 'Diddy' had been distressed

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and distraught. I didn't want to hear that a belligerent, 'adolescent' part called 'Switch' had been wanting to self-harm. I didn't want to know that an unnamed part had sat for hours twiddling the thread of a blanket, impervious to touch or words or eye-contact. I was less disturbed when I found that in my time blanks I had been writing, or cleaning. But even then I didn't really want to know what happened when I wasn't 'here', when I wasn't 'myself'. Perhaps if I didn't know, it would just go away.

After my breakdown in 2005, the not-knowing became more difficult as the time-blanks increased and the invisible activities made themselves visible in the aftermath of overdoses or fugues. Lost in the countryside, I still had to navigate myself back again. The emotions still had to settle and they lingered like reflux in my soul. The not-knowing about who I was and what I did when 'not-me' was convenient at first in evading the embarrassment of my actions but it soon became inconvenient. It caused stress to people who cared about me and did nothing to help restabilise my life.

So I had to start to figure out who these other 'parts' of me were, and I didn't want to. Firstly, there was the denial – 'They're not real, I'm making it up, you're making it up'. Then the avoidance – 'Just ignore them and they'll go away.' And then the sickening reality that there really were times when I didn't know what I was doing and yet there was this trail of evidence that I'd been doing something and it wasn't at all the kind of thing I usually did … I eventually hit up against the obviousness of 'me-not-me' and realised that I had to take it seriously, had to face it and confront it and deal with it, rather than pretending like a toddler that peekaboo makes you invisible.

But I hated them. I really, truly hated them. I did not want to be vulnerable as 'Diddy' any more than I wanted to be twisted-up as 'Switch'. I just wanted to be me – capable, competent and professional me. Except, starting in 2005, I seemed to have lost that capable, competent me and my days were a mashed-up existence of here-and-not-here, in-and-out, me-and-not-me. I thought for a while that if I denied these 'others' strongly enough, then they really would go away and leave me alone, and back would come Competent, Capable Carolyn and all would be well with the world. Except it didn't quite happen like that. I'd had a breakdown for a reason, and there was no going back.

So I had to get to know them. Even 'the hated child, sitting across from me, mocking me.' To be honest, all of them were hated; it felt as if most of them were

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mocking me. There was the high-speed chatter of acerbic criticism; the intolerant disgust of silent pouting; the delirious scream of all-out rage; the silence of stuck-still terror. These were the voices of the 'others' – to a degree embodied in my imagination, but ever-present, like white noise, oppressive and unalone. I wanted it to stop. All day long: screaming. All day long: a wail of unmitigated suffering. All day long: the hotbreath snarl of the malicious critic, exposing yet another failure.

I knew that they were not 'real people' with three-dimensional bodies. I also knew that they were not just 'voices' or a clattering of meaningless, disconnected thoughts. I knew, without knowing the right name for it, that these were parts of me. But I also knew that to talk about them as real would invite the noose-label of 'schizophrenia' and that its inevitable medication would give no space for thought or processing or reason. I had to hold my parts as 'feeling real' whilst accepting that they were not – that they were parts of me, not other people, and not psychotic intrusions either. And all the time, on the outside, look normal.

Therapy started the dialogue. It was curious at first to realise that this person sitting opposite me had just been conversing with me, but me-as-other-me. At first, I tried not to think about it. It felt too shameful. But over time, as I realised that she wasn't fazed by it, and that I wasn't being shamed for it, or punished, I began to allow the reality to sink in. It was undeniable. There I sat, with just void stretching behind me for the last twenty minutes, and she was telling me things that I-as-not-me had told her, that only I would know. She had clearly been talking to me, just not me-as-me. And it was startling to be told about these nuances of me-as-not-me: familiar characteristics, but stretched taut, like a rubber band.

Switch was clearly a part of me but an extreme version: vulnerable, prescient, outraged, hurting. He could communicate what I was feeling deep in my guts, in a way that I hadn't even begun to recognise for myself, let alone share with another. He carried memories that I did not, with a sharp, high definition reality to them, especially the emotions. He knew other

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parts of me. He was able to lean forwards into relationship in a way that I could not. So my first real introduction to this Switch part of me was as he was reflected back to me from my therapist's experience, and then my husband's. It took a long time to be able to hear it, and accept that this was me, albeit me-as-not-me, that they were referring to.

Then came internal dialogue. It seemed utterly stupid to begin with. How are you supposed to 'communicate inside'? At first I held back not so much out of ignorance for 'technique', and fear that nothing would happen, but more out of fear that it would. I still didn't want to accept that I had 'parts'. What if they did indeed talk back to me? Would that prove I was mad? I read others' accounts and it seemed like some people could hold an open dialogue, saying things to themselves and clearly hearing a reply. It didn't work like that for me. I had to hunt for the sense inside. I had to learn to finely adjust my antenna and seek out the signal.

The communication within was more in the rumble of shifting tectonic plates, more in the pain that streaked suddenly upwards, more in the wave of emotion that stung my eyes. Only gradually was I able to begin to put these sensations into words. It took a number of years before I could look inside, listen, and then say, 'I think Switch is feeling …' Communication is not easy. But it is essential.

Words have always been my thing, so I let words run riot to aid this internal dialogue. I would journal daily, sometimes several times daily, and let a rip-roaring splurge erupt from within me – writing anything, everything, asking questions, answering them, going with the flow, using imagery, writing out imaginary dialogue, seeking an impression from within. It didn't have to make sense. I was just showing myself that I was willing to search for myself, that I was willing to listen to myself, that I was willing to hear.

Sometimes I would use more than words – diagrams and headlines of elusive thoughts drawn together on A3 sheets of paper with interconnecting lines drawn in different colours: anything to get my usually-dormant right brain into action. The purpose wasn't the end product: the purpose was the communication. Sometimes I would 'lose time' as another part took over; other times I would be vaguely aware that I wasn't quite 'myself', that I felt distant and derealised, and that I was observing myself write.

Sometimes, when that happened, I didn't know what it was that I was writing, until I read it through again afterwards. It became a way of practising switching

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in and out of parts whilst remaining co-conscious – allowing myself to be the whole of me, and be conscious of being the whole of me, rather than squirrelling myself away into shameful obscurity.

And she sat across from me, the hated child, mocking me. Gradually I learned to just let her be, and not try to change her. Not try to blot her out, or punish her for existing, or shame her into submission, or silence her with threats. Maybe she could just be. I realised what an abuser I was – to myself. Everything that I hated about the people who had dealt atrocities to me, I was doing to myself. I would shout at myself, hiss at myself, punish myself, yell at myself, torture myself, demean myself, humiliate myself, shame myself, scold myself, hurt myself, hate myself. I would do everything to myself that had been done to me by others. And if I was honest, I wanted other people to treat me well. I wanted them to love me. I wanted them to be kind towards me and give me a break. But fundamentally, towards myself, I wanted to be an abuser.

Then these two words, whispered in therapy, proffered as an alternative viewpoint: *self-compassion*.

I heard them, and nothing registered. They made no sense. I had a tonne of compassion – for others. Very little for fools (admittedly) but a lot for people who were hurting. And yet, strangely, I had none for myself. It hadn't even occurred to me that I could have it for myself. Compassion was what you had for other people – why would you have it for yourself? It felt selfish, and greedy, and indulgent, and glib. *Self-compassion*? Wouldn't that make me more bad? If I loosened the leash, if I gave myself a break, if I showed kindness and concern and empathy and love, wouldn't I be allowing the devil within me to take over and go berserk? I needed to be harsh towards myself: it was the only thing that held back my evil. I needed to criticise myself: who knows what mistakes I would make if I didn't punish myself cruelly for each tiny one. I needed to shout at myself: if I didn't, laziness would consume me and I would lay forever in an unwashed sprawl of slobbery on the sofa. When did compassion ever play a part? I survived what I survived because I had parents who loved me by beating me when I was bad, by punishing me when I was slack. They girdled my ego with criticism to keep it in check. That is how you're supposed to motivate, and restrain, and control, and direct. It worked for me …

Except, of course, it didn't. I grew up with DID. I grew up wanting to kill myself. I grew up with a self-loathing so massive that daily I plotted my own self-destruction. But old habits die hard. When you've been

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abused as a form of 'discipline', to make you 'good', it's hard to break away from the brainwashing that tells you that it was for your own good, and that if they didn't hurt you then you would be even 'badder' than you already are.

Believing that I was fundamentally bad, I accepted my parents' harsh discipline of me as love, which is what they said it was. I accepted that if they hadn't censured me for dropping 1.25% on a French exam, the next time I would have failed completely. When I won a place at Cambridge University, my mother comforted me: 'You didn't get in because you're clever. You only got in because you worked hard.' Had she not punished me for the failed marks in French, I wouldn't have been so industrious, and then I wouldn't have been able to trick the system to gain a place at a University where I wasn't clever enough to be. I had a lot to be grateful to her for.

And I accepted her techniques. Every failure, every missed punctuation mark on an essay, every question that I didn't immediately know the answer to, I berated myself for being lazy and stupid. And it worked. I did well. Until it didn't work, and I had a breakdown. Until I could bear being abused no longer.

It was several years into therapy though before the irony struck me: the irony

that here I was, week after week, session after session, trying to put myself back together again, trying to heal from the abuse. I was trying to rebuild myself and integrate myself and establish a secure base within myself to go out and conquer the world, rather than accept defeat and commit suicide. I was trying to heal from abuse, and all the time I was still abusing myself. Still snarling at my struggles, still flipping out at a drink spill, still growling at my imperfections. Abuse, abuse, abuse. Back at me came this therapist, who wouldn't abuse me, wouldn't run me down, wouldn't growl at me or shout at me or shriek at me like a banshee, wouldn't accept that it was all my fault, wouldn't accept that I should have done something, wouldn't accept that I deserved it. I kept fighting her but eventually she began to win. They get you in the end, these therapists. They keep at you with their insistent, patient, pesky tenacity. They keep treating you with 'unconditional

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positive regard' and eventually you just have to throw your hands up and accept that you're never going to change their minds, because they're just too damn stubborn. An irresistible force meets an immovable object and *ker-bang*! suddenly it's *your* worldview that is changed.

What would it mean for me not to abuse myself? What would it mean for me to treat myself as I'm pleading for other people to treat me? What would it mean for me to draw a line in the sand, step over it, and say that I'm not going back? That the abuse is over, that I won't let anyone else abuse me now, not even me? What would that look like? What would it mean? At first, it just meant terror. It was all unthinkable. It was a trick. It must be. Abuse was the one constant in my life, a reassuring backdrop. Awful – yes. Unbearable – of course. And yet always there. I couldn't imagine life without it. What would my voices say all day long? What would some of them do? I couldn't imagine it. I didn't want it. Better the devil I knew … Powerlessness told me that I couldn't change it, that I couldn't live in a new world, a free world, a world without abuse. I can't. I didn't know why; I just knew it was true – I can't. Then that collision again, where I had to admit that my feelings are just feelings, and are meant to be felt. And truth is truth and is meant to be believed. And sometimes, just sometimes – 'never the twain shall meet'. So on the one side, I felt that I couldn't imagine life without abuse. I felt that I could never manage to show myself compassion, and draw near to these other parts of me. And then the skull-cracking realisation that I wasn't powerless – I was powerful. I was powerful enough to keep ruining my life by perpetuating the abuse. And I was powerful enough to develop new habits, too, and end it.

'It is what it is' became a bit of a mantra. But I couldn't just say it – too many years of Sensorimotor Psychotherapy taught me this – no, I had to say it with a shrug of the shoulders. Not any shrug of the shoulders either. That shrug of the shoulders. That particular shrug of the shoulders that I learned as a way of resourcing myself, the feeling that I 'installed' in my memory of being competent and capable and able to choose, that I was my own master and commander, that I was in charge of my life, and if I didn't want to go there, didn't want to do that, didn't want to take that abuse any more … I just needed to do an upside-down smile and that shrug of the shoulders and say, 'It is what it is' and walk away. I could fail at something, mess something up, get something inside-out kind of wrong, and at the end of it I just needed to sigh, smile upside down, shrug and say, 'Oh well, it is what it is.' End of. No more beating myself up. Just a shrug of my

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shoulders and a keen, heartfelt attitude towards myself of self-compassion and 'It's ok.'

Slowly, my attitude towards some of these other parts of me began to change. Perhaps there was nothing wrong with Diddy for being little, and vulnerable, and for needing. Perhaps it's normal to need. Perhaps I don't have to get cross with her like my mother got cross with me, to keep her neediness in check. Perhaps if I just sit down next her to her, sidle up to her, put an arm around her … perhaps then she might stop crying and she might be able to catch her breath and to be. The part of me that stiffens in shameful horror at spilling a drink: perhaps instead of the tirade inside that I feel at the stupidity, the clumsiness, the idiocy, the carelessness … perhaps instead I could just smile, and shrug my shoulders, say, 'It is what it is … ' and help to clean up. And perhaps then the other parts, the ones who flail me furiously that I'm not good enough, and I don't do enough, and I don't know enough, and I'm not working hard enough … perhaps they'll learn from me and loosen up too. Perhaps we could all aim to work together a bit more. Isn't that what healing, and recovery, and integration is all about?

She sits across from me still, but she doesn't mock me as much. Slowly she's learning that I understand and that I care and that I won't hurt her. I won't hate her any more. At times I still get frustrated with her, and I don't get it right. But then it's her turn to roll her eyes, shrug her shoulders, and say, right back at me, with less than a growl but not quite yet a smile, 'It is what it is.' •

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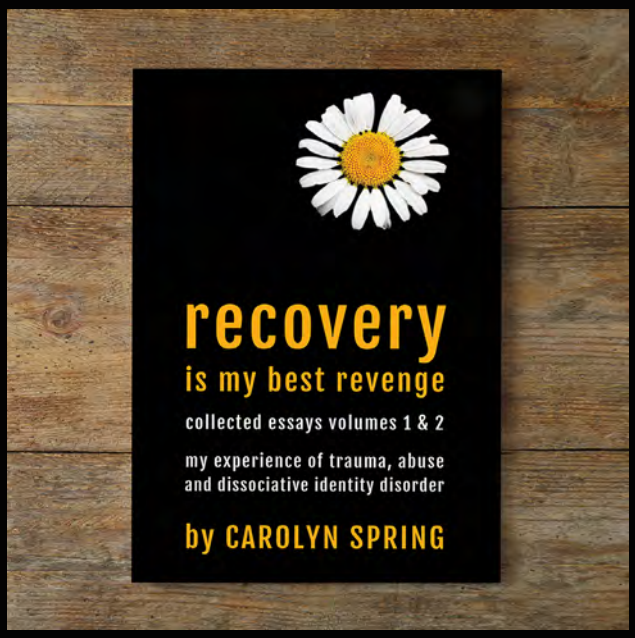

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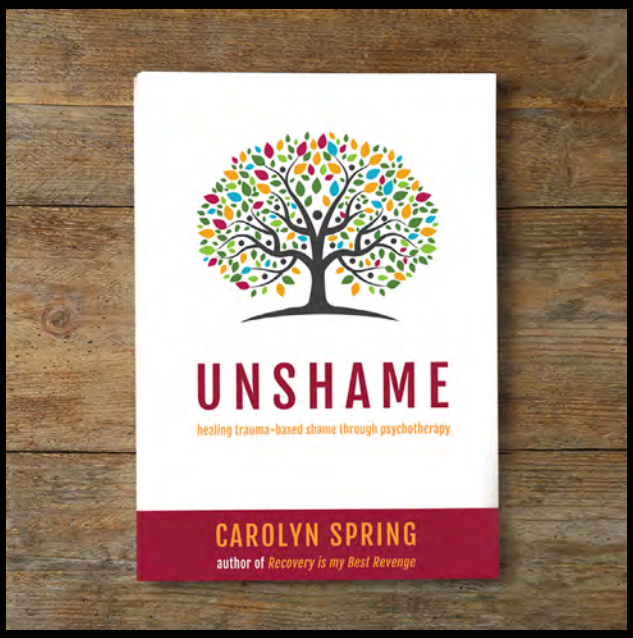

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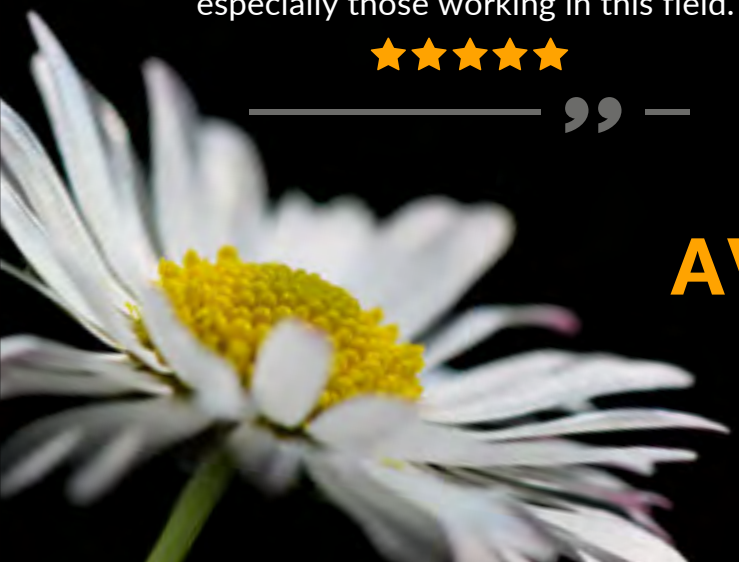

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