The Divided Self:

a clinical and theological study of Dissociative Identity Disorder, with implications for pastoral care.

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M.Theol (Qualifying research project)
Melbourne College of Divinity, 1999

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Synopsis.

This paper argues that the Dissociative Identity Disorder diagnosis is a legitimate and helpful but not comprehensive model for looking at sufferers' experience and assisting them towards wholeness, and that Christian theology and pastoral practice can offer valuable complementary perspectives and resources.

First, it documents a Cognitive Behavioural Skills Training group for sufferers, identifies subjective dividedness associated with a weak sense of self as the major feature, and demonstrates that some of the associated problems can be addressed by training and practice. An environment where there is realism about the handicaps, validation of the experience of DID, and openness to the associated spiritual issues promotes trust and healing. Reflection on the group experience highlighted the admiration , hope, love and sense of commonality that emerged for the writer.

Second, the paper addresses the controversies surrounding the disorder which can paralyse a helper. DID is a valid and useful diagnosis, and misdiagnosis has serious results; but all descriptions of it must be seen as conceptual models. Most explanations of causation are systemic, and relate to the poor development of the self. DID is usually caused by child abuse, explained in terms of an invalidating environment. Recognising that it is usually not possible to verify abuse allegations, we can still minister effectively by relating to the whole person and the separate personae.

Thirdly, it notes evidence from various disciplines which support the idea that human nature is essentially unity in diversity, and DID is part of a continuum of experience. The individual is one person, but formed in systems and always in process. She is also a separate person, but the goal of differentiation is to enable covenant relationships. Theologically, this is based on the Trinity, where love is the principle that both unites and differentiates. The love of the Trinity is the starting point for understanding God's presence with us in suffering, and for dealing with the problems raised by the gender of God. From the nature of God emerges the necessity of love in order to become

human and to be healed from the consequences of distorted love. Salvation is seen as integration around Christ, in community and with an eschatological dimension.

Fourthly, pastoral strategies must be based on this principle of love. They emphasise commonality, mutuality, inclusiveness, covenant and shared discipleship, and willingness to relate to both the whole person and her parts. Inner Healing offers some perspectives that challenge purely psychiatric interpretations, but has some significant deficits. Some guidelines for supporters emerge from the group experience and the theological reflection.

Pastorally, it is more helpful to understand DID as a normal pattern of response carried to extremes, rather than an "illness", and to be fellow-travellers rather than clinician and client. However, the desire to normalise the DID experience should not minimise the suffering and damage. Love is expressed in various modes by the church. Pastoral care does not reject, but complements the psychiatric approach, and can be an invaluable context for healing and wholeness for the divided Self.

Introduction.

During 1996-7 I co-facilitated, as a nurse-therapist, a cognitive- behavioural skills training group for women diagnosed with Dissociative Identity Disorder (DID). It was auspiced by Karinya Counselling Centre (Syndal, Victoria) and DID Vision. The experience taught me a great deal which has influenced my clinical and pastoral practice, but it raised many questions.

Most pastors encounter people with dissociative disorders in churches, though they may not realise it. These people suffer greatly, but often are hard to help and seen as "mad, bad, and dangerous to know". Pastoral carers are left feeling guilty and frustrated. Pastors frequently respond by handing them over to psychiatrists, or by avoiding diagnostic categories and using purely pastoral and "religious" interventions. Too often, we hope they will go away.

There are many controversies about the DID experience, its causes and meaning. It raises questions about the unity and integrity of the self, with a range of theological and pastoral implications. It asks what salvation means to divided selves and thus, I will argue, all of us. Pastoral carers, struggling to understand and help the sufferer, can be paralysed by the range of opinions and approaches. They can withdraw from helping or give inappropriate care. A workable understanding is needed on which to base a ministry of pastoral care.

My experience with the DID group led me to explore these problems using the method of critical correlation, trying to maintain integrity as a clinician, an aspiring pastoral theologian, and a practising pastoral worker.

This essay aims to:

- document the group experience and some of its practical implications
- clarify some of the controversies surrounding DID in order to provide a workable if not definitive understanding for a pastoral carer
- explore questions about the nature and salvation of the Self, from a theological perspective
- suggest pastoral strategies that arise from the experience and the associated reflection.

The four sections of the essay reflect these aims but they necessarily overlap.

My central argument is that the DID diagnosis is a legitimate and helpful but not comprehensive model for looking at sufferers' experience and assisting them towards wholeness, and that Christian theology and pastoral practice can offer valuable complementary perspectives and resources.

As the process commenced with a clinical situation, the language used is somewhat clinical, using diagnostic terminology and regarding the group as a "patient population". As the essay proceeds it modifies that way of looking at people, to adopt more pastoral notions. For lack of a satisfactory name, I usually refer to the group under consideration as DID sufferers, though I dislike the medicalisation and the implication of passivity. I do not regard the women I work with as only or primarily "patients", but as unique individuals who I have come to love and respect. As most DID sufferers and nurses are women I use feminine pronouns for both groups.

Section I.

Report on Cognitive- behavioural Skills Training Group for women with Dissociative Identity Disorder. [1]

The group members were women with strong dissociative features, all of them describing abusive childhoods and, in about half the cases, abuse in ritual cult settings. Each had been diagnosed with Dissociative Identity Disorder (DID) on clinical grounds.[2] An average of five attended each week. Ages ranged from 20 to 50, with most in the middle of that range. In spite of their disabilities most were in employment.

22 women were involved over the two years (1996-7), with 16 completing at least one semester module and 6 completing the year-long course. All of them came to the group with great fear , and problems with trust and identity, so we felt this drop-out rate was quite good for this disorder.

Rationale.

The members were referred because, although they needed and were engaged in intensive 1:1 psychotherapeutic work, they lacked some basic cognitive and behavioural skills to tolerate such work, to regulate their emotions, or to manage their everyday lives. Our purpose was to teach skills in a setting dedicated to this task, while offering general support.

Course format.

Each session consisted of members' reports on their use of skills, and teaching of new concepts and strategies, rehearsing, and setting homework tasks. The contract was to be a learning group, not a psychotherapy or support group, though it was not always possible to keep that distinction clear.

The facilitators.

In my eight previous years of work as a nurse-therapist in a private acute psychiatric unit, I had worked with many abuse survivors with dissociative features. I was a theological student at the time, studying pastoral ministry. My conscious desire was to be a "wounded healer" whom God could be healing and using.

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[1] Sources: my journals and records, clients' self-assessments and course appraisals.

[2] American Psychiatric Association, *Diagnostic and statistical manual of mental disorders(fourth edition).* Washington, DC*:* American Psychiatric Association, 1994, p. 484-7 (known as DSM IV).

A former colleague, Shirley Kidd, an experienced clinical psychologist and group facilitator, was co-facilitator. Our excellent personal and professional relationship was an important factor in the group experience.

Theoretical basis.

The cognitive-behavioural approach had not been widely used with this disorder and we were not aware of another such group in Melbourne.[3] It has some similarities with Schema Focused Cognitive Therapy [4] , where one therapist combines cognitive, behavioural, interpersonal and experiential techniques.

The teaching content was based on Linehan's Dialectical Behaviour Therapy.[5] It was the first psychotherapy to be clinically demonstrated as effective with Borderline Personality Disorder (BPD) patients, and features a combination of individual psychotherapy and skills training. We needed to modify Linehan's manual to allow for the differences between Americans and Australians, DID and BPD, residential and non-residential settings, and to allow us to operate with integrity as Christians. We felt we needed to be more respectful of the individuals' rights and ability to choose to work towards change.

The crucial feature for DID sufferers (compared with BPD) is subjective dividedness (a more accurate term than multiplicity), which is one cause of the weak and fragmented sense of self that causes the problems described below.

We had to understand their difficulties in this light , and take it into account in all our interactions. [6] Often some alters (the term I will use for the presenting parts or personae) already had particular skills. As the women consciously practised skills such as objectivity, these skills were shared throughout the personal system (the term for all the alters that make up the person). In fact this helped break down the amnesia within the system and gave the alters something in common. Group members who kept homework journals were more able to report, and spread the information through the system, than others.

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[3] PsycLit search found only four references to cognitive therapy for DID.

[4] A. Beck and A. Freeman, *Cognitive Therapy of Personality Disorders.* New York: Guilford Press, 1990. They address the Core Beliefs or Schemas that trigger high levels of disruptive emotion and shape behaviour into long-term self-defeating patterns.

[5] Marsha M. Linehan, *Skills Training Manual for Treating Borderline Personality Disorder.* NY: Guilford Press, 1993).

[6] For example, Linehan's manual is very insistent on reporting of homework, with sanctions applied if it is not done. In practice, often the presenting alter did not seem to have taken down the task or practised it, and we had to allow time for the alter who knew about the homework to emerge. Sometimes she never did, but it was clear that the skill was being used

Typical problems of DID, and how they relate to course content.

We presented DID, not so much as an illness, but as an effective adaptive mechanism. Dissociation had enabled sufferers to survive intolerable stress but had limited their repertoire of other skills. The problems are common to most people to some degree, but for this group they can be disabling. Similarly, the skills taught are helpful to most people, but are particularly needed by those who have not learnt them in childhood, due to traumatic circumstances.

There were four major areas in the course, relating to the problems associated with the weak and fragmented sense of self. These can be grouped as:

1. Confusion about what is real, and the significance of events. For those with DID there is acute confusion about identity: who am I? what do I really think or feel? is there anyone inside? Under stress this is often expressed as depersonalisation, or "splitting", when a distressed alter withdraws entirely leaving a different one to take over.

Core mindfulness skills increase the ability to consciously experience the self and the world.[7] The core mindfulness skills of Observing, Describing and Participating with Awareness underlie all the course, and are constantly quoted. Eventually they become an automatic response that enables the woman to take control of her reactions. Objectivity is the basic skill needed, and members reported improved functioning after a few weeks of the core mindfulness skills, even before the more specific training began.

2. Chaos in relationships; eg intense, unstable relationships, panic and dread lest they finish, frantic attempts to avoid abandonment, attraction to abusive men, and unhealthy dependant relationships. Others' behaviour is frequently misinterpreted so they feel rejected, confirming their poor self-image. They are constantly exploited because their poor sense of self means they have greater problems with personal boundaries in every sense.[8]

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[7] They start at a much more basic level than anything I have seen in a hospital therapy group, with exercises such as paying attention to the feel of your feet on the floor, or describing a shoe. Some found these very threatening and were initially unable to do them. This showed us very quickly how handicapped these people are in everyday life.

[8] Sharon E Cheston, "Counseling adult survivors of childhood sexual abuse". *Clinical handbook of pastoral counseling* vol. 2. Ed. Robert J. Wicks & Richard D. Parsons. Mahwah, N.J.: Paulist press, 1993, pp 478f.

Interpersonal effectiveness skills help to be more realistic about interactions. They help to get needs met, deal with unwanted demands, and develop strategies that maintain respect for self and others. This often brings great insight into their patterns, and how they maintain abusive relationships, and gives skills to change.

3. Unstable emotions. Feelings are unpredictable and very labile. Typically there is trouble dealing with anger, either denying it or over-reacting. Depression, anxiety, and episodes of hypomania are common, and emotions feel out of control.

Emotion management skills focus on improving control of feelings. Members start with learning to identify what the feeling is, how strong it is, what it is related to, and how rational it is. They learn to identify primary and secondary emotions in any situation, and avoid the spiral into an emotional whirlpool. They practise specific methods to give them breathing space to assess situations before reacting.
These skills must be practised when <u>not</u> in crisis: they need to become automatic.

4. Behaviour that causes problems eg very impulsive behaviour, self-abusive acts including suicide and para-suicide attempts, shop-lifting, addictions, obsessive behaviour.

Distress tolerance skills teach them how to tolerate panic, pain and stress feelings and gives them time to find more effective solutions.[9]

It will be clear that this course has limited aims. It is only a component of therapy.

<u>What is distinctive about this group?</u>
These are life skills that most people could profitably learn, based on Dialectical Behaviour Therapy. It included stress management, anger management, goal setting, assertiveness training, Rational Emotive Therapy, and Transactional Analysis. What made this group different?

1. <u>The major handicaps</u> the members have in these areas due to failure to complete psycho-social developmental stages, (particularly identify formation) and faulty thinking. For instance, the whole idea of having rights is a struggle for them to understand. Self-respect is a foreign concept. There is little ability to be objective, though sufferers are often very intelligent. This degree of handicap needs to be held in

[9] Linehan p.60

tension with the pastoral attempt to normalise their experience and identify with it at some level.

2. The composition of the group. Most had never met another person with DID, and it was a validating experience. The clients valued the group experience as highly as the didactic content. The group itself became a primary arena for practising new skills, such as assertiveness. It became a safe place and some had their first conscious experience of switching between alters there, or learned to process their resistance. They learned from seeing others practise and progress, and helped each other with shared problems that we, the facilitators, were not familiar with at first. The humorous side of DID could be shared, which helped diminish the sense of hopelessness.

3. Openness to spiritual issues.
As a matter of integrity we informed both referring therapists and clients that we had a Christian basis, and spelt this out early in simple statements, affirming the safe love of God, our nature as fallen bearers of the image of God, with free will, and our belief in God's ultimate justice. We encouraged them to feed their spiritual growth and prayed for them outside the group.

We expected that different alters would have different attitudes to God, and that some would be very hostile. Being open about this relieved the tension. Spiritual issues were usually raised by members, not leaders. Most believed they had some Christian alters, and spiritual issues were important for many. Of sixteen appraisals, one said she struggled with the Christian content, one asked for more, and most found it "about right".

Issues included the judgementalism or simplistic answers of church friends, questions about why God had not rescued them, whether God could or would ever value them , the fact that some abusers had been church members, the inner tensions they felt between Christian and non-Christian alters, and how they could worship with integrity. Some saw Jesus as dangerous because he was a male.

Women abused in cults had problems with Christian symbols where these had been perverted. Sometimes God had been used as a threat. Survivors of cult abuse seemed to need the experience of non-exploitative love and faithfulness from Christians

without much god-talk for a while. They have to abandon an old false image of God before trusting a new one.[10]

The women often helped each other, by sharing their own struggles with these issues. They knew things we did not. For instance, cult survivors believed that satanists can take things like their hair to use in curses against them, so are obsessive about cleaning hair brushes. I overheard one woman explaining, to the amazement of another, that she was free of that fear now because Jesus had greater power. Another explained how her core alter was a Christian and was praying for and talking to her other alters, believing that eventually they would all submit to God.

In summary: by being (or becoming) realistic about sufferers' handicaps, by validating and normalising their experience of life, and allowing ventilation of associated spiritual issues in a supportive Christian environment, the group allowed trust and honesty to develop between members (including facilitators). This experience was rare and healing for sufferers, and it provided an environment where specific skills learning could occur.

Outcomes.

The members were asked to fill in a self- appraisal on four areas (see Attachment 2) at the beginning and again at the end. By then, they subjectively felt much more in control, more self-aware, and able to tolerate difficult feelings. They had received positive affirmation about their changes, except from some abusive family members who had lost their control over them.

For those who persisted and practised, there were major changes. The married women reported greatly improved communication, and at least one marriage was rescued, while two others felt able to get married. Others were coping much better at work. The four who regularly harmed themselves stopped doing so, two with eating disorders developed more balanced patterns. At least one has come back into fellowship with God, brought order into a chaotic home, and successfully returned to study. A paranoid woman was still very sensitive, but was stopping to evaluate whether people are really attacking her, and rehearsing ways of dealing with recurrent stresses.

[10] Some alters claimed loyalty to the cults that abused them. They were sometimes disruptive to the group, but these alters were so different to their usual ones that it was fairly clear to the group what was happening and we were able to confront it.

The non- Christian members seemed to have become less hostile. The fact that we provided the service out of Christian love, and were respectful of their positions, made an impact.

The individual therapists report that their clients are making much faster progress in therapy because they have these skills.

When they could reliably moderate emotions and choose responses, their emotions, both negative and positive, did not need so much suppression. They became more emotionally alive.

Once they were not so afraid of losing control or dissociating, they were more willing to process both explicit and somatic memories. The alters began to reveal themselves and their functions, and integration work was able to proceed in some cases. The most basic benefit was a more coherent sense of a self with enduring characteristics, rights and responsibilities.

A year later the therapist who referred many of the group informed me that most are still actively using the skills.

Reflection.

We knew so little about such a very complex area, that we could have made dangerous mistakes. We were driven to prayer and to a commitment to keep our lives clear before God, trusting him to use us, and asking him to protect us from causing harm. We needed to *be* Christian rather than imposing an agenda to convert them. We became ever more convinced that we were engaging in a spiritual battle (Eph. 6:12) and that there were evil forces opposing us. In retrospect I feel as if we walked through a minefield of potential disasters, with God's protection.

The group experience left me with a strong sense of commonality with the members. It broke down the sense of "spookiness" that most people feel about DID, as I realised that the mechanisms they over-use are ones I use also. I developed great admiration for their bravery and breadth of skills in daily facing tremendous difficulties. My sense of hope grew as I saw the members make real changes. I learned much from them about courage and integrity as we explored very fundamental issues of identity and truth. The group became a place of love, a place where we all could tell our stories, not just as "patients", but as wounded healers. The mutuality of pastoral relationship became as important as the use of clinical and didactic skills.

The experience also raised issues about DID itself, causing me to ponder the meaning and validity of the diagnosis, and question the connection with recovered memories of childhood abuse. It also raised theological issues. I will turn to these questions in turn.

Section II. Controversies that can paralyse the helper.

As we worked with DID sufferers and engaged in peer supervision with some of their therapists, we experienced dividedness ourselves. The therapists spoke of multiplicity as something like an objective reality. Our experience convinced us subjectively that we were indeed dealing with different alters, not just different moods or roles. We saw children whose feet did not touch the floor, angry men, rebellious adolescents, seductive women, & terrified victims: we heard voices change, vocabularies differ dramatically, writing and posture and clothing styles vary. They often convinced us that they did not remember previous events. One woman needed glasses for older personae but not young ones, but was not apparently aware of this.

However there are major controversies among psychiatrists, and in the wider community about the meaning and validity of the diagnosis and its various therapies. Christian counsellors offered a range of interpretations and approaches. Sometimes we felt (and were treated as if) we were "crazy" to enter this unbelievable world of DID.

History.

Though dissociative phenomena were reported throughout history (interpreted according to prevailing cultural beliefs) the first full medical description of a case appeared in 1865. Freud's early work proposed trauma as the cause of "hysteria" but he abandoned this under some pressure. Early this century Janet laid the foundation of most current theories, seeing dissociation as an adaptive mechanism in the face of unmanageable trauma. However from the 1920s the symptoms were psychoanalytically reinterpreted in terms of repression and object relations theory. Few cases were reported until the 1980s, when there was an explosion of numbers; about 20,000 cases were diagnosed in that decade, and numbers continue to rise. These figures can be interpreted in very different ways.[11]

Ten years ago in Australia, MPD (DID) diagnoses were extremely rare, and I had not seen one made in the hospital setting until about 1996. Obviously symptoms will be interpreted according to the beliefs of the psychiatrist. I still see many doctors cautiously diagnosing patients as Post-Traumatic Stress Disorder or Borderline

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[11] Isobel Cote, "Current perspectives on multiple personality disorder." *Hospital and community psychiatry* vol. 45, no. 8, August 1994, pp 827ff.
Note that Multiple Personality Disorder in DSM III has been reclassified as Dissociative Identity Disorder in DSM IV.

Personality Disorder, depression or psychosis, who clearly meet the DSM IV criteria for DID.[12] This may be because powerful influences in the profession oppose it, and it is still politically risky.[13] Recent reports criticising some "recovered memory" techniques, and litigation against therapists, will inevitably produce more stringent professional guidelines for practitioners.[14]

Is DID a valid and meaningful diagnosis?

Colin Ross, who wrote the nearest thing to a "standard text" in a contentious field, robustly demonstrates that DID is as valid a diagnostic category as any other in the DSM system.[15] He refutes the false distinction between "real" and "phoney" cases at two levels. First, there is the central paradox that "DID is not literally real. It is not possible to have more than one person in the same body... However, DID is a real disorder that can be treated to stable integration."[16] The psychiatric symptoms are real; the "alters" are not literally separate persons but aspects of the one personality which have dissociated and developed to adjust to trauma. Nevertheless they can be effectively *treated as* persons.

Second, Ross points out that the DSM system is phenomenological , and has removed theories of causation from the criteria sets for most disorders. "Mental disorders are real because their diagnostic criteria sets have face validity and diagnostic reliability." Thus "an iatrogenic case of DID is just as 'real' and 'genuine' as one with an onset in childhood."[17]

If DID is a legitimate diagnosis, the common misdiagnosis has treatment implications, because the divided sense of self is not addressed.[18] Flash-backs are "managed" by

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12 For useful differential diagnosis tables, including their research origins, see Christopher H. Rosik, "Misdiagnosis of MPD by Christian Counsellors: vulnerabilities and safeguards." *Journal of pastoral theology* vol. 23 no.2, 1996, pp.75-80.

13 I have heard senior consultants speak extremely scathingly of doctors who believe recovered memories. It can be professional suicide for a less well-established psychiatrist to oppose them.

14 Report commissioned by the British Royal College of Psychiatrists, 1998, unpublished; quoted by Libby Lester, "Sex abuse memories 'bogus' ", *The Age*, 17-1-98, p.1,4.

15 Colin A. Ross. *Dissociative Identity Disorder*. 2nd edition. New York: J.Wiley & Sons, 1997. His "twenty-five errors of logic, argument, and scholarship in the skeptical literature" (pp 228-235) makes an impressive case.

16 Ross 1997, p 62.

17 ibid p 63.

18 The Australian Association of Multiple Personality and Dissociation claims that there is an average of 3.6 prior misdiagnoses. (Information pamphlet, 1993.)
A Canadian study found an average of 6.8 years of psychiatric treatment before diagnosis of DID. Margo Rivera, *Multiple personality; an outcome of child abuse*. Toronto: Education/Dissociation,1991, p.10. DSM IV agrees with this estimate; see Appendix 1, p 486.

reality orientation instead of being supported and explored so that the information they supply can be integrated into conscious (cf traumatic) memory. Often patients are medicated into quiescence, making them feel re-victimised. Some have told me that medication slowed down their bodies but the alters were terrified and took it in turns to stay awake. I have certainly witnessed incredible toleration for sedation in DID patients. Electro-convulsive therapy, contra-indicated for DID, is experienced as an attempt to kill the presenting alter.

Is a clinical diagnosis helpful?

Should we "label" such a person with a medical diagnosis at all? We may wish to see her as a unique individual, without the reductionist preconceptions that a diagnosis may bring. We prefer to see her problems as essentially personal and spiritual, not "medical". However an accurate diagnosis brings several benefits. It protects from inappropriate treatment for "illnesses" such as schizophrenia. The "label" also provides a helpful explanation and relieves the fear of insanity, gives hope and access to appropriate wholistic treatment. We must remember that such a diagnosis is simply a description in standardised categories, that enables appropriate responses. It does not have to imply illness, or madness, reduce the person's identity to the "label", predict her behaviour or determine her future.

Ross himself recognises that "multiplicity is a normal organisational principal of the human psyche... But in the western industrialised world the executive self has suppressed all the other part selves." He suggests that we radically redefine "normal", to allow us all to recognise our inner selves (a theme in Section III), while maintaining the need for a DID diagnosis to assist towards congruence and integration of these selves, for those who are disabled by their dividedness.[19]

Models of reality.

It is helpful to realise that any explanation of DID experience, whether framed in terms of introjects, abreactions, adaptive behaviours, somatic memories, inner mapping, tools for dealing with specific situations, or alternate personalities, is essentially a hypothetical model, a way of talking.

Rosik (p. 77) notes that DID is generally under diagnosed but is over diagnosed by some Christians, especially Pentecostal counsellors, because of their world view, counter-transference needs, and own experience of altered states.

[19] Colin Ross, "The dissociated executive self and the cultural dissociation barrier," *Dissociation*, vol. IV, no. 1, 1991.

Note that shamans of various animistic groups value and foster dissociation and address many DID concerns in other language, eg soul loss, spirit intrusion, breach of taboo. Ross 1997, p.9.

> ...models are concerned with discovery, with opening up the unintelligible to intelligibility, with generating new hypotheses and suggestions, with enlarging what is known and accepted. Second, models are concerned with behaviour, with how something works, with systemic structure; thus the content of a model is the network of relations it displays. Third, models are at the same time both true and untrue, they invite existential commitment, but in a qualified manner. While believed to be appropriate, they are also held to be partial and inadequate. [20]

Enthusiastic advocates (both for and against the DID description) often seem to lose this distinction. We need to know we are using metaphorical language, but be able to engage the inner system "as if" it has independent personalities;

> the therapist must simultaneously develop an empathic understanding of the beliefs and self-perceptions of the various alters.... and not be drawn into taking literally what is essentially a creative and adaptive delusion.[21]

The debate over aetiology of DID.

Most authorities consider that severe chronic trauma or neglect in early childhood *caused* the disorder (or other pathologies). Others label DID an iatrogenic disorder, an artifact created by therapists with suggestible clients, and dismiss most abuse allegations.[22] There is a whole range of interpretations in between. Ross thinks that the fundamental problem is that of attachment to an abuser, which is necessary for the child's survival, but intolerable given the abuse; dissociation is the way of maintaining the attachment system. [23]

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[20] Sally McFague, *Metaphorical theology.* Phil.: Trinity Press, 1991, p.92.

[21] Rivera p.15.
This understanding of models is helpful in addressing the theological problem raised by the apparent co-existence of Christian and satanic parts. The problem becomes a non-issue if they are not literally separate persons.

[22] I. Hacking. "The invention of split personalities". *Human nature and natural knowledge.* Ed. A. Donovan et al. Dordrecht, Neth.: Reidel, 1986.
H. Merskey. "The manufacture of personalities: the production of multiple personality disorder." *British journal of psychiatry*. vol. 160, 1992. pp 327-340.
Note there have also been factitious cases, parallel to Munchausen's syndrome in medicine.

[23] Ross 1997, pp. 64ff.

A useful explanation of many of the features seen in adult survivors refers to the "invalidating environment", of which sexual abuse would be an example.[24] The child was not give consistent feedback to construct a stable sense of self, which was expressed graphically in dissociation, and subjectively emerged as lack of identity, autonomy and control. Neither could she construct a reliable picture of the wider world or how others will react, so she learned to treat each situation as potentially dangerous. The invalidating environment arbitrarily controlled emotional expressiveness, especially any negative affect, and contradicted or trivialised the child's subjective experience. Therefore she always felt inadequate and a "fake". As an adult she says "I don't know who I am."

We used this explanation in the training group because it does not depend on remembering specific traumas. The women could frequently relate specific difficulties to invalidating aspects of their early environment and did not usually use this to place blame or avoid responsibility for change.

All these explanations are systemic, in that the symptoms are formed in the context of a system, usually a family which fails to provide the basic requirements for developing a coherent and unified sense of the self. 1:1 psychotherapy, and the cognitive -behavioural training described, are effective only as they address this divided sense of self.

The strongest consensus in the literature, reflected in the DSM IV entry, is that some people, particularly those who are naturally easily hypnotisable and fantasy-prone, find dissociation and alter formation an effective way of coping with intolerable stress. Child abuse is the most common form of such trauma.[25]

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[24] Linehan p.3.

[25] R.P. Kluft, "Multiple personality disorder: a legacy of trauma". *Severe stress and mental disturbance in children,* ed. Cynthia Pfeffer. Washington, D.C.: American Psychiatric Press, 1996.
pp 673ff.
A survey of PsychLit abstracts and the resources of the Mental Health Library at Royal Park, Melbourne, for "Dissociative Identity Disorder" and "dissociation", found this view held by almost all the writers, mainly mental health professionals.
I have not dealt with the view that DID symptoms are basically the result of demon possession, as it is outside the main streams of Christian and psychiatric opinion.

The abuse debate

In American studies, 97% of DID patients allege they were abused, usually sexually and incestuously, sometimes by satanist cults.[26]

Vehement supporters of the survivors believe and encourage the abuse allegations and often subscribe to conspiracy theories involving powerful people in paedophile or satanic cult networks. They believe in the validity of recovered memories, encouraging recovery methods such as hypnosis, and often (especially those not psychologically trained) take a very literal view of the separate existence of the personalities .

At the other extreme are members of the False Memory Syndrome Foundation, formed in 1992. They are equally vehement supporters of the "victimised family" and believe that the memories are suggested by therapists with their own agendas. They often deny the existence of multiple personalities or DID as a valid syndrome. They cite experiments indicating that memories recovered during hypnosis are more likely than other recovered memories to contain fictitious material.[27]

I have had considerable exposure to both attitudes, and can sympathise with both, because people's lives are ruined by both abuse and false allegations. I have seen allegations destroy the family, the pastoral carers, and the church. The more bizarre accounts of ritual abuse, or organised paedophile groups, are frequently dismissed because there is seldom external evidence. Believers, of course, respond that these perpetrators are so well organised they can hide their traces, or have deliberately confused their victims. Some cases have been independently verified,[28] and there is a clinical body of research that differentiates between the results of satanist and "ordinary" sexual abuse.[29] Often there is no way of knowing, and it is very difficult to be objective when you are involved with hurting people.

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[26] F.W. Putnam et al. "The clinical phenomenology of multiple personality disorder: review of 100 recent cases." *Journal of clinical psychiatry* vol. 47, 1986. pp 285-293.
R. Schultz et al. " Multiple personality disorder: phenomenology of selected variables in comparison to major depression." *Dissociation* vol. 2, 1989. pp 45-51.

[27] George K. Ganaway, "Dissociative Identity disorder: toward an integrative theory", *The international journal of clinical and experimental hypnosis,* vol.XLIII, no. 2, 1995, p. 130.

[28] eg B.Snow and T. Sorenson, "Ritualistic child abuse in a neighbourhood setting". *Journal of Interpersonal violence,* vol. 5, no. 4,1990, pp 474-487.

[29] M. Kaye and L. Klein, "Clinical indicators of Satanic cult victimisation" in *Dissociative disorders: 1987. The proceedings of the fifth international conference on Multiple Personality/ Dissociative states.* Ed. B.G. Braun. Chicago: Rush University, 1988.

It is important to separate out the different components: beliefs in satanic cults, demon possession, child abuse, dissociation, multiple personalities, post-traumatic stress, or recovered memories, do not have to be combined. It is not usually necessary to make a judgement about what occurred in a particular case in order to help clinically or pastorally. Neither is it necessary to literally believe in co-existent persons in one body, to be able to enter the world of the divided self, and minister there. The sufferer needs a therapist who will join her "internal system and work at a micro-level within the system".[30] She needs supporters who will believe *in* her and the validity of her beliefs.

Some therapists are adamant that the memories must be recovered and believed for healing to occur. They assert that traumatic repressed memories are stored differently to explicit memories, and have power to sub-consciously control the person until they are faced and "decontaminated" into explicit memories which the adult can process.[31] Some neurologists dispute this claim.

Certainly care must be taken. There is danger in provoking memories before the person is able to tolerate it; memories will emerge when the time is right.[32] It is possible to do considerable psychotherapy, cognitive restructuring to improve life skills, and spiritual care without seeking explicit abuse memories.[33] But neither should they be suppressed. As people retell, and actively experience the events and associated emotions, they "re-member" the part of themselves that was traumatised. "Re-membering is the way we put ourselves back together."[34]

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[30] Ross 1997, p. 67.

[31] James G. Friesen, *Uncovering the mystery of MPD.* San Bernadino, Cal.: Here's Life Pub., 1991, ch.6. This book appears to be widely used by Christian counsellors.

[32] One of my students began to recover memories after she became a Christian and felt safe for the first time.

[33] Cheston pp.462-477.

[34] J.Jeffrey Means, "Hear no evil, see no evil, speak no evil: learning from our work with trauma-related disorders". *Journal of Pastoral Care,* vol. 49, no. 3, p303.

Conclusion.

After exploring the literature and discussing the issue with many practitioners and clients, I have concluded that DID is a valid and meaningful diagnosis. It is beneficial to the sufferer when accurately made, because it focuses on the divided self rather than suppressing the secondary symptoms. The conceptualisation of different presentations as representing "alters" seems to allow effective therapy from a person-centred stance (whether Christian or secular humanistic), better than any other, because it allows the helper to enter the sufferer's inner world and address the core problem of the divided self. It allows us to engage with the felt experience and inner conflicts of the person in a respectful way that seems less "pathologising" than other approaches.

I concluded that ritual and other abuse occurs all too frequently, but memories may also be contaminated. It is important that therapists and carers accept and support the person with abuse memories. At the same time they should keep an open mind about recovered memories, and be scrupulous about not suggesting their content.

We can use the diagnostic system for its value, while remembering it is limited. Sufferers need to retrain the mind in more truthful and rational patterns, and learn skills that give survivors control over their daily functioning. We must recognise the handicaps suffered, while refusing to pathologise the person. Pastorally, it is more helpful to understand DID as a normal pattern of response carried to extremes, rather than an "illness"; to accept the sufferer realistically as an individual with problems, and to be fellow-travellers rather than clinician and client.

I suggest that a combination of 1:1 psychodynamic therapy with cognitive-behavioural training and spiritual care, gives balanced care. We can and do look for God's grace to be active in broken lives, and I will return to this in Section IV.

Section III. Theological/ philosophical issues raised by DID

1. Questions about the self.

Most of us have a clear enough sense of ourselves from two standpoints. First, we feel ourselves to have/ be a continuing inner unity, in spite of different moods and internal conflicts, and changes over time.

Second, we feel ourselves to be a discrete entity, with boundaries with the rest of the cosmos, though we may sometimes experience a sense of identification with others or the world. Psychologists regard differentiation as an essential part of healthy development.

For DID sufferers, both of these aspects are severely compromised. They experience an inner confusion of voices, and do not know who they are. At the same time they have poor differentiation and boundaries, are unable to separate themselves from parents, partners, and especially cult attachments. They feel themselves to be externally controlled. Being part of the cosmos is a dread of being "digested", not a hope of communion.

I want to take up these issues of the unity and integrity of the self.

1a. Am I one person? [35]

Many recent writers in various disciplines propose that everyone has an essential multiplicity. William James described "a multitude of selves which constitute the empirical me".[36] Crabtree postulates a core "toolmaker" who creates sub-personalities.[37] Schwartz writes of an "inner family" operating by systemic rules in every person, where DID is but an extreme manifestation of a universal phenomenon,[38] citing

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[35] I am not here debating the relationship between physical and mental properties, or biblical categories of body, soul and spirit. Suffice to say that "the Bible's central thrust is ... the whole person as a spiritual bodily creature." Evans p.148.

[36] T.W. Mitchell, *Medical psychology and psychical research.* Lond: Methuen, 1922, p.146

[37] Adam Crabtree, *Multiple man: explorations in possession and multiple personality.* Lond: Holt, Rinehart and Winston, 1985, p 249.

[38] R.C. Schwartz , *Internal family systems therapy.* NY: Guildford Press, 1995, p.57.

research in neuropsychology, computer science and artificial intelligence.[39] Many therapies, using differing vocabularies, recognise that "experiencing ourselves as many selves" is widespread, not necessarily pathological, with creative potential.[40]

Looking specifically at dissociation, it is well established that most if not all people are capable of dissociating under sufficient pressure, and some do it regularly as an adaptive mechanism; I speculate that near-death experiences of leaving the body may be dissociation. [41] It is helpful to sufferers and others to normalise DID as part of a continuum of dissociative/ hypnotic processes; it invites them back into the human race.

These writers envisage a more-or-less enduring set of selves, in contrast to post-modern writers who emphasise the self in flux.

> "Under post-modern conditions, persons exist in a state of continuous construction and reconstruction... Each reality of self gives way to reflexive questioning, irony, and ultimately the playful probing of another reality." [42]

Process theology shares the belief of Family Therapy that "persons are inherently socially constituted".[43] As a world view it has problems: it threatens to dissolve the Self by reducing it, like everything else, to a series of occurrences (as does Buddhism[44]). Identity is only a pattern of experiences, as in behaviourism it is only a pattern of behaviours. Just as "you can't step into the same river twice" (or even once!), you cannot meet the same person twice. This shakes the basis for secure

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[39] R.C. Schwartz, "Our multiple selves: applying systems thinking to the inner family", *Networker* March-April, 1987. pp. 25-31, 80-83. Schwartz speculates that the parts are identified with independently functioning modules in the brain. p. 26.
The physiological effects are documented in D. Spiegel and E. Vermetten, "Physiological Correlates of Hypnosis and Dissociation" in *Dissociation: culture, mind and body.* Washington, DC: American Psychiatric Press, 1994.

[40] Jean Rumbold, O*ur many selves,* unpublished essay, Melb: 1992.

[41] A similar distancing was reported among prisoners arriving at Auschwitz.
Victor Frankl, *Man's search for meaning.* Lond.: Hodder & Stoughton, 1964, pp.14f.
For the research on the continuum of hypnotisability and dissociation, see
Eric Vermetten et al, "Dissociation and hypnotisability" *Trauma, memory and dissociation,* ed.J. Douglas Bremner and Chas. R. Marmar. Washington: American Psychiatric Press, 1998.

[42] Kenneth J. Gergen, *The saturated self.* NY: Basic Books, 1991, p82.

[43] Larry Kent Graham, "A pastoral appropriation of family therapy" , *Journal of pastoral psychotherapy* vol. 1(1), Fall, 1987, p.5.

[44] "Buddha has spoken thus: "O Brethren, actions do exist, and also their consequences, but the person that acts does not....There exists no Individual, it is only a conventional name given to a set of elements." Quoted by Derek Parfit, "Divided minds and the nature of persons", *Philosophy: time, self and freedom,* ed. A Hanley, J. Bigelow, A. Townsend & B. Faust. Churchill, Vic.: Monash Distance Education Centre, 1997, p.128.

identity, personal responsibility, meaningful relationships, commitment, law, morality or forgiveness.

However there is an important truth here. Identity may not simply "be" a set of events or behaviours, but the Self is certainly in process, formed and modified in systems of relationships.

This essential principle of multiplicity can be supported theologically. Scripture (1 Cor 12, 15) and science declare the same principle of diversity making up a unity, whether a body, an ecosystem, a cosmos or a church, and the resurrection life continues this glorious diversity where all comes to potential (1 Cor. 15). The most fundamental statement the Scripture makes about humanity is that we are made in the image of God (Gen. 1:27). If the Ground of all Being , the most basic Fact of all, is fundamentally unity-in -diversity (which is what the doctrine of the Trinity asserts)[45], this suggests a unity- in- diversity in humanity.

First, this may refer to the fact that humanity is male-and -female, and the immediate context (Gen. 1:27, 2:24) supports this. Second, humanity is also composed of many individuals. Anderson, following Barth, describes "co-humanity" as the original, and also the ultimate, form of mankind. Adam only knew (differentiated) himself when he found his counterpart in Eve.[46] Buber says " I require You to become; becoming I, I say You."[47] Jesus' prayer was for human unity like that of the Godhead (John 17: 22).

However, the *imago* could also imply that the God-imaging *individual* also has a fundamental multiplicity. The Persons (*personae*, in Tertullian's vocabulary) of the Trinity have an "essential" existence (Rahner) but in the historical process they exhibit different roles, functions and contexts. Similarly, our different personae are called forth by different needs or situations. I am "a different person" when I am with my children, regardless of whether I am doing motherly tasks. The values I hold as a mother sometimes conflict with those I affirm as a clinician.

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[45] The Nicene creed, formalised at Chalcedon in 451AD but dating at least from Cyril of Jerusalem (c. 315-387), affirms the deity of each Person and the belief that there is but one God. Athanasius (296-373) asserts the necessity that "the Divine Triad be summed up and gathered into a unity... and by that Unity I mean the all sovereign God of the Universe..... For thus both the Holy Triad and the holy preaching of the Monarchy will be preserved."
Documents of the Christian Church, ed. Henry Bettenson, Oxford: OUP, 1943. pp.26, 32 in 1990 edition.

[46] Ray S. Anderson, *On being human: essays in theological anthropology.* Grand Rapids, MI: Eerdmans, 1982. pp.45, 73, 172.

[47] Martin Buber, *I and Thou.* trans. W. Kaufman. Edin: T&T Clark, 1979, p.62.

Yet the Persons exist in one *substantia,* with a unity of love in their inner relationships (especially clear in John's gospel) and shared purpose in the "economy of salvation"(Irenaeus).[48] Similarly I, like the DID sufferer, exist as "one substance", an "essential" self. I experience inner unity as these personae become more congruent in their values and purposes, and more aware and accepting of each part's needs and value in my life as a whole; that is, as I love myselves. I will return to this point in discussing the self and salvation. Subjectively, memory is the main guarantee of continuing identity, which is why recovered memories are so important to the DID sufferer.

I conclude that I am one enduring person, but that I exist as diversity- in- unity, formed in systems and always in process. This is equally true for the DID sufferer.

A qualification.

Having said that the *imago* implies the capacity for relationship, we should not restrict it to this, nor define personhood in purely social terms. This would leave the personhood of an infant to be determined according to the willingness of the community to socialise him or her, with serious implications for abortion, infanticide, and breeding for harvesting organs or labour. It is a view taken to its extreme by satanic cults who are consistently claimed to breed foetuses and babies for ritual sacrifice. Cult survivors believe they only exist because the cult, abrogating the right of God, has decreed they should; not because they have any personal rights.[49] Biblically, "being a person" derives from God's action (Gen 2:7) and from the whole image (Gen. 1:27), including capacity for emotions, reasoning, creativity, communication, morality and volition, but not defined by any of these. The very things that have traditionally defined personhood- "actions, choices, consciousness, values, freedoms, reasons, purposes, sociality, unity"[50] are those in which we are like God. This is the basis of human dignity and responsibility.

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[48] eg 1 Cor. 12:4-6, 2 Cor. 1: 21-22, Gal. 4:6, Eph. 2:20-22, 2 Thess. 2:13-14, Titus 3:4-6, 1 Peter 1:2. Alister E. McGrath, *Christian theology: an introduction*, Oxford: Blackwell, 1994, pp 209, 247-269.

[49] Historically it has been the church's view of the soul that has led to the banning of infanticide, abortion and slavery.

[50] Evans p.11.

1b. Am I a separate person?

This is a major point of division in contemporary spirituality. Most oriental religions, nineteenth -century idealism, and the whole New Age movement, picture reality as an all-inclusive Oneness where the subject-object distinction is dissolved. Crabtree's "tool-maker" or "ultimate self" is not directly knowable, and he, like Jung, the mystic Gurdjieff, and the poet Walt Whitman, finds "it cannot be separated from the Spirit / Oversoul/ One" (roughly, Jung's Collective Unconscious) or "All-that-Is".[51] Transpersonal psychology follows the same route. In contrast, the monotheistic religions start with God as self-existent, self-revealing, creating, maintaining and relating to the universe and individuals within it. Christianity asserts real differentiation of the creator and creation.

There is also differentiation within the Trinity. Each Person of the Godhead is separate, needing to choose submission (Phil 2:5-8, Luke 22:42) and to glorify each other (xx), and capable of real inter-personal love. Imaging this, we assert our separate existence; this should not be confused with western "individualism at any price", but affirms that we bring a meaningful Self into community. As love both binds and differentiates the Trinity, it does the same for the individual person and for the church.

Christianity assumes a self that is *in some sense* a continuous entity, separate, free and responsible:
separate because it can enter, or refuse to enter, into relationships, including friendship with God. (James 4:4) though it is constituted in community;
free because it can make real choices, though all sorts of factors influence those choices (Josh.24:15); [52]
responsible and continuous because those choices are evaluated by a holy God (Rev. 20:12), who nevertheless understands the limits to our understanding (Ps. 103:10-14).

Though are "in process", we need a continuing self-concept in order to achieve differentiation. DID sufferers are handicapped here. Recognition *as* a self (Rogers' "unconditional positive regard") is required to work towards self-actualisation.

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[51] Crabtree pp. 243, 255.

[52] Joshua asks Israel to consider their history and choose who they will serve.
The theological debate about predestination would be relevant , but is omitted for space reasons. My conclusions would tend away from Calvinism.

Related to the issue of autonomy is the need to belong. Individuation is not only about separation, but the balance between autonomy and intimacy. We need the security of love to develop both.

The relevant theological paradigm is covenant, which, says Barth, was the goal of creation and characterises all God's relationship with his creation. We are determined as humans by our existence in covenant relation with God.[53] We can look to God's knowledge, love , calling, and acceptance of the individual. My election affirms my Self.[54]

The primary experience of covenant should be in the family, but when this fails, as it often does for abuse survivors, the church needs to provide a safe home to belong and belatedly individuate.

Am I a separate person? Yes, but the goal of differentiation is to be able to freely enter into covenant relationships. This is usually problematical for the DID sufferer.

2. The Trinity .....

The Trinity has emerged as the integrating paradigm for understanding the self. It also illuminates other aspects of DID experience.

2a. Trinity and the problem of pain.

"God is love", affirms 1 John 4:16, in what almost seems to be an ontological statement. The social theory of the Trinity allows us to conceive of the love that constituted the Godhead, before eternal Father-Son-and-Spirit expanded the scope of that love by creating what was other than, and completely unnecessary to, God. The love that made the worlds accepted the cost involved; the incarnation, and supremely, the cross (1 John 4:8-10) where the Godhead experienced death.

This must be our starting point when we face the questions about theodicy, inevitably raised by child abuse. Abused women often picture God as cruel, uncaring, or disapproving and rigid.[55] Their anger at God needs expression because a relationship cannot be built on pretence. I find Moltmann's theology of the suffering of God most

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[53] Karl Barth, *Church dogmatics*. III/1, Edin: T&T Clark, 1936-1962, p.231.
[54] R. Anderson pp.162f. I do not mean election in the strict Calvinist sense.
[55] Donna Kane, Sharon E. Cheston & Joanne Greer, "Perceptions of God by survivors of Childhood sexual abuse", *Journal of Psychology and theology* vol. 21, Fall 1993. pp 228-237.

helpful: we have to know God is *with* us in our pain, before we can trust him with our pain.[56]

Jesus demonstrates God's suffering love. As the fulfilment of the ideal of Isaiah's Servant, he also serves as a model of patient suffering and faithful obedience to God, which survivors can relate to. I sometimes need this model, when supporting them becomes too emotionally difficult. God asks me to bear their pain to facilitate their healing. As a servant I can incarnate God's love and balance their perception a little.

2b Trinity and the possibility of healthy self- love.

The love which constitutes and binds the Trinity includes deep knowledge (John 8:55, 10:15) and is expressed by glorifying each other (John 15:14, 17:4f). The dis-integration of DID sufferers can be seen as failure to know and love their different parts. Much of the pain of the DID experience arises from the disowning, rejection or even attempting to kill certain parts, and many therapies attempt to accommodate all parts.[57]

If love is necessary to God, we can assume it is necessary to become truly human, and especially to be healed of the consequences of the distortions of love. It seems that when each part experiences God's love (usually through people), it opens the possibility of understanding, acceptance, forgiveness and love for the others.

2c. Trinity and the gender of God.

We noted that the unity-in-diversity of God is specifically related to the *imago* being male-and-female (Gen. 1:27). God is not male or female but personal and relational; God is love. Abused women often have trouble relating to a God who is perceived as a male or a father, and at least need this misunderstanding removed. Some counsellors emphasise the femininity of God in images such as the mother hen [Matt. 27:37] or Sophia, and use only feminine pronouns for God.[58]

However we cannot avoid father- language simply because there are abusive fathers. And mothers abuse too; in fact survivors are often just as angry at their mothers. We rob people, whether we obscure God the perfect mother (Is.49:15) or the awesome and understanding father [Ps. 103:13]. Both mother and father images about God challenge and correct our ideas of parenthood, masculinity and femininity. The biblical strong Father is revealed as nurturing and emotional (Psalm 103:13), our

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[56] Jurgen Moltmann, *The crucified God.* Phil.: Westminster, 1974.
[57] Rumbold p.3.
[58] Kane et al, p. 237.

Abba-Daddy (Mk. 14:36, Rom. 8:15). The motherly Lord who comforts (Isaiah 66:12-13) is also like a mother bear, a figure of holy anger (Hos. 13:6-8). Correcting false gender images of God can remove some unnecessary obstacles to enjoying God's parent care.

3. Salvation for our divided selves.

Salvation in Christ offers us *renewal* of the self "in knowledge in the image (Gk: e*ikon)* of its Creator "(Col 3:10). We have a new birth (John 3) and are being transformed into the likeness of Christ (2 Cor. 3:18) who, as the true *eikon* of God (Col.1:15) shows us what a self was meant to be. Jesus the true man is the model for Christian maturity (Eph. 4:13) and we are exhorted to "put on the new nature, created like God in true righteousness and holiness" (v.24).

For the DID sufferer, the experience of New Birth and the indwelling Holy Spirit can provide a new focus for unifying the parts. As the parts, with their needs, agendas, abilities, and functions, relate to Jesus, they seek to obey him and become like him, to live within his agenda of kingdom life. Like a group of people with a common passion and cause (indeed, like the Trinity), they achieve a unity of purpose and congruence in behaviour that does not deny the differences but exploits them for common goals. They become more like each other as each becomes more like Jesus.

This idea of salvation as integration around the person of Christ has illuminated one aspect of salvation in Christ for all of us. We all are diverse selves, with irreconcilable needs and desires. The New Testament teaching about the spirit and the flesh (Rom. 7&8, Gal. 5) polarises this; but opposing desires can both be legitimate. In the process of discipleship we learn to bring our needs and decisions to the light of Jesus, and find his example, and his kingdom's priorities, show us the way forward.

Jesus is the magnetic centre to which my own conflicting elements can be drawn like iron filings, to find the pattern, the inner harmony, which is my true and unique identity in him. He becomes "the still point of the turning world" for me personally. The DID situation simply focuses the question and answer of Bonhoeffer:

> Who am I? This or the other?
> Am I one person today, and tomorrow another?.....
> Who am I? They mock me, these lonely questions of mine.
> Whoever I am, thou knowest, O God, I am thine.[59]

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[59] Dietrich Bonhoeffer, *Letters and papers from prison.* enlarged edition. NY: Macmillan, 1972, pp. 347f.

Σοτεριαι (salvation / healing) of the *whole* person is needed. It means the restoration of true humanity, through the faithful humanity of Jesus. "He is the source of health because he himself has been made health for us (in his resurrection) even as he was made sin for us."[60] If all that is fallen is to be made new in Christ, there is eschatological hope for the damaged body, emotions, intellect, and spirit of the DID sufferer.

Salvation is not just individual self-renewal. It involves transforming lost individuals into the people of God. It is God's acceptance in Christ that affirms my personhood, the Holy Spirit's empowering that helps me begin to actualise the *imago Dei,* the communion with other redeemed selves that provides the systemic context for sanctification.

Conclusion

It seems there are balances to be sought in understanding the Self. It is socially formed and always in process, yet has an enduring existence. The individual is separate from others and not just a drop in the ocean of being, but can only exist as a self in relationships. God is distinct from creation, yet it is as the Spirit indwells us we find our true humanity, centred on Jesus Christ and modelled after the love within the Trinity.

Understanding that God is neither a distant deity, nor an abusive "male" figure, helps us receive comfort, acceptance and also correction, as from a perfect loving parent who suffers with and for us.

The pastoral implications of some of these points will emerge in the final section.

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60 R. Anderson p.173.

Section IV. Pastoral care

Christian writers usually, though certainly not invariably, tend to accept the theory that distinct personalities are formed in response to abuse.[61] This is especially true of those with a strong theological position on "spiritual warfare" (as understood by many charismatic groups). Some even baptise each of the alters as they are "converted".[62] Because Inner Healing is the best-known of the few explicit methods developed for pastoral counsellors, I have described and discussed it in Appendix IV. The pastoral approach which follows is based on general pastoral princples, the lessons learned in the DID group, and the theological reflection, values and assumptions of Section III.

Pastoral care and psychiatry.

There are important differences between the disciplines of psychiatry and pastoral care. The aim of the DSM system is to categorise, to highlight differences, to define what is normal so that the abnormal is clear, and to avoid both neglect and inappropriate treatment. I have already affirmed the value of accurate diagnosis. Medical systems must categorise people, but often this obscures their uniqueness as whole persons. Medical models tend to divide humanity into powerful clinical experts in diseases and their treatment, and passive patients, those who are treated.

"We treat persons as objects in order to say what personhood means, but we do so as persons".[63] The concern of Christian pastoral care is to highlight our common humanity and especially our oneness in Christ. It aims to include, not exclude. Its goals are maturity in Christ (Eph. 4:11) and restoration of the true self in the image of God. Its metaphors are about shepherding rather than treating, journeying together rather than issuing maps. It offers a new, non-medical narrative, where people are more than victims or patients, but, like us all, fallen image-bearers in a process of salvation. We change the questions; not "what is wrong with her" but "what happened to her?", "how is this affecting her now?", "what resources does she have ?"

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[61] For an example of those who reject recovered memories, see
Reinder Van Til. *Lost Daughters: Recovered Memory Therapy And The People It Hurts.* Grand Rapids: Eerdmans, 1997.

[62] Neil T. Anderson, *Released from bondage.* San Bernadino, Cal.: Here's Life Pub., 1991. p209.

[63] Francis Bridger and David Atkinson, *Counselling in context,* Lond.: Harper Collins, 1994, p. 127

Jesus himself is our model of the wounded healer.[64] Instead of professional distance we risk pastoral companionship, which

> emphasises the primacy of lived experience. We do not say that simply because a person is considered mad that his experience is invalid. There is validity because it is human experience and is worthy of serious consideration. We listen and we share, with give and take, that heals the giver and the receiver... It's a ministry of presence and needs a particular kind of person, someone calm, non-judgemental and non-demanding... you learn how to be this kind of person.[65]

There are sometimes tensions between the two ways of being. My experience as a nurse-therapist in a hospital, rather than a doctor, has helped bridge the gap between clinical and pastoral care. The nurse has objective clinical frameworks to guide her. But like the pastoral carer, she learns about, and seeks to help, the troubled person in a context of an ongoing relationship at a number of levels, not just a clinical interview. She engages with the whole person, at meals, activities, in group discussions, with the family, in counselling and in casual social interactions. The pastoral carer does all these; and in addition, and crucially, worships and prays with her as a sister. Both are damaged people experiencing salvation, seeking God's resources to live, responding to God's love in Christ.

Though there are differences in emphasis between the disciplines, we have identified significant common ground. Ross conceptualises many alters but one person. Many therapists draw attention to the essential multiplicity and systemic formation of all people. (Section II) The trinitarian understanding of the *imago dei* (Section III) points to the same conclusion: *diversity- in- unity is an essential rather than pathological condition of humanity*. This conclusion validates the pastoral approach described above, based on common humanity.

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[64] Henri Nouwen, *The wounded healer*. NY: Doubleday, 1972.
[65] Ojitha Goonetilleke, "We can help mentally ill people", *Victorian Baptist Witness*, Dec. 1998, p19.

Accepting the *diversity* within the person permits carers to engage with each presenting alter at her stage of development, rather than only relating to an "acceptable" adult part.[66] The supporter must befriend each alter, not criticise or slander any; see that each has a function, but encourage each to consider the needs and ideas of the rest of the system. The aim is inner congruence, love and respect, like that of the Trinity, rather than merging of alters. This approach shows each alter that she, and the other parts, are worthy of respectful love; this can be an amazing revelation.

Accepting the *unity* of the person means the supporter relates to the whole person in love, affirms that God loves the whole person, and encourages "whole-self" choices and taking responsibility for actions. When a survivor's personal boundaries are respected and strengthened, her subjective sense of being a separate and unified person is developed.[67]

Modes of pastoral care for DID sufferers in the church.

The church, like the Trinity and individual, is a unity-in-diversity; many individuals built together (Eph. 2:20-22), many cultures, both genders, many conditions (Gal. 3: 28) , many gifts (1 Cor, 12). Christ ministers healing love to the damaged person through his whole body, in many modes. The many faces of Christ's body allow the wounded woman to chose those who can help at particular times.

The context for effective pastoral care must be covenant love, expressed in respectful acceptance of the woman and her experiences and pain. Church must be a "safe place" at every level. She needs to feel "believed in", though, as I concluded in Section II, carers may not be sure of past events.[68]

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[66] When the supporter has got to know different parts, she can help them with stage-appropriate experiences. A frightened child part may need encouragement to play "let's pretend" safely, a seductive adolescent part may need feedback about the effects of her behaviour, an over-compliant part may need permission to be assertive. The goal is for each part to grow up in a healthy way.

[67] H. Cloud & J.Townsend, *Boundaries.* Grand Rapids, Mich.: Zondervan, 1992.

[68] Pastors, like therapists, must be alert to avoid any abuse of the power inequality in the relationship. Many survivors are subtly re-victimised and feel forced to conform in churches.
Means, p.297.

1. The designated supporter.

A pastoral person who is not the therapist (and usually not the Pastor), but who makes themself available over a long period as a friend and primary contact person, can be of immense value.[69] The principles of cognitive-behavioural therapy, as seen in Section I, can be learned and informally applied by supporters and this gives invaluable practice for the sufferer. However the *experience* of non-exploitative love with appropriate boundaries, offered by a long-term supporter, is of even greater value in helping sufferers move belatedly through the developmental stages.

"One of the few really solid findings (in) decades of research... is that a therapist's ability to show genuine empathic acceptance is a key determinant of his ability to help his client". [70] Similarly, genuine acceptance in Christ's name is the pastoral carer's greatest strength, and is more important than talking about God at first.

Supporting a DID sufferer is emotionally and spiritually demanding. A survey of supporters revealed great appreciation for the survivors. Supporters identified many challenges for themselves: isolation, anger, boundary problems, fear, challenges to their beliefs, sadness. They identified education, appropriate supervision and support as major needs.[71] The carer needs to be prepared to face the depths of evil and danger in the world, and his or her own dark side.

> The cycle of violence can only be stopped by those whose character can tolerate the knowledge of good and evil in themselves, and thus can have compassion for others in their ambiguity.[72]

This self-knowledge must lead to constant openness to the conviction and transformation of the Holy Spirit. Spiritual direction and professional supervision are both appropriate and essential. A prayer group gave us inestimable support.

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[69] Carol Jackson, "Supporting people with multiple personality / ritualistic abuse: initial findings from members of the Australian Association of Multiple Personality and Dissociation", *Research forum* vol.4, no.1. Melb., R.M.I.T., 1994, p. 32-38. "This study shows the crucial role that supporters play in the survivors' day to day existence." p.38.

[70] Bernard G. Guerney *Relationship enhancement*. San Francisco: Jossey-Bass, 1982 p.42.

[71] Jackson, pp. 34-37.

[72] James N. Poling, "Child sexual abuse: a rich context for thinking about God, community and ministry". *Journal of pastoral care* vol. 42, 1988, p.60. This quotation was originally about counselling perpetrators but it applies to helping survivors also.

1a. Issues for supporters and sufferers.

I turn now to lessons learned in the DID group. Awareness of these may help supporters to avoid mistakes, and appreciate the difficulties their friends may be having with the supporter's behaviour towards them.

We developed long-term relationships with a number of women with dissociative patterns. In this context a number of issues emerged regularly, with implications for pastoral relationships. Working with many other people with difficult childhoods who would not be diagnosed as DID, I am more and more aware that many of the same features and pastoral approaches apply to them also. There is a continuum of experience in this sense also. We found:

- People who have experienced great rejection and believe themselves to be failures, are likely to be very sensitive to judgements. Keep checking what they have heard and what emotions have been stirred. When talking about God, be careful not to make him sound condemning. We can gently challenge paradoxical cognitive distortions such as "The abuse was my fault" and "I am not responsible for my behaviour".

- People who received confusing messages through chaotic childhoods, and who experience alters with different values, are likely to be ambivalent about many areas. Try to let all views have a fair hearing so that decisions are owned by the whole person. This helps break down the inner walls and move towards congruence. It is important, as in all relationships, to make sure they are making their own decisions and owning their choices.

- Assertiveness is often confused with violence, feedback with rejection, and love with sex (so always talk about safe, or respectful, love) . We must constantly clarify these areas in our relationship.

- Supporters are often confused by testing behaviour. There is deep ambivalence between the desire for acceptance and conviction that she is an unacceptable person. Tell your friend you expect this. Try to be consistently accepting of the person while setting boundaries on unacceptable behaviour. People often think therapists and pastors have complete autonomy and power, over-value our judgements and blame us if they fail. Trust develops slowly and is lost very easily.

A helper cannot afford to be insecure or easily hurt, but must calmly ride out these episodes, apologising if necessary and remaining available.[73]

- Abuse survivors often have great ambivalence towards authority, so give instructions gently and respectfully, make decisions collaboratively. We found that explaining the group "rules", which were very directive in the manual, aroused great hostility. We learned to discuss "rules" as ways to make them feel safe, emphasising respect, confidentiality, and safety for all. Pastoral carers need to set boundaries on contacts and behaviour, but do it collaboratively.

- Abuse survivors are often very out of touch with the body, find it hard to attend to it, invalidate its feelings and needs, feel it is not reliable, even hate it. This is readily understandable in view of their over-use of dissociation as a way to avoid things happening to their bodies. Most find sexual urges terrifying and feel their bodies are betraying them.[74] They often have great problems with mirrors. Be very sensitive about referring to their appearance, even with compliments. Never touch without an invitation, and avoid anything that could be construed as sexualising the relationship.

  Activities which ground them in the concrete world are valuable. Encourage enjoyment of sensations and activities like cooking and gardening.

- Ambivalence about some of their alters was often expressed in the group. Some wanted to kill, punish or suppress "bad" or weak parts, but generally they came to see that all parts have to be heard, acknowledged, healed, and learn to co-operate. We saw "Susie's" abusive, loud-mouthed alter confess that "he" was modelled on the original abuser in order to protect the system, but now that his role was acknowledged he was willing to let God be the Protector: this proved a turning point for her.

- There are trigger words and objects that cause withdrawal or "switching". Each person has their own and a supporter should be alert and remember them. Common words we found were *sacrifice, ritual, anger, rights, needs, satan, demonic.* Other triggers are mirrors, animals, anniversaries and festivals, Easter and Christmas, equinoxes and solstices, hair, bodily fluids, any uninvited touch or

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[73] Cheston p 461.

[74] Joan Coleman, "Presenting features in adult victims of satanist ritual abuse", *Child Abuse Review* vol. 3, 1994, p.86 .

invasion of privacy. Conflict is a very common trigger , so we had to take great care, talking them through the initial panic, and processing what happened. A pastor needs to do this individually and when conflict occurs in church groups.

- There is incongruity between words and body language: acting has become a survival skill. Watch the subtle body messages constantly.

- It is hard to stay with one's primary emotion. People often move quickly to guilt, fear or anger about the fact that they felt the primary emotion. Often the primary emotion is repressed because it has not been safe to express it.
  Overt support and gentle questioning can help people work back to the primary emotion and discuss the beliefs involved (Rational Emotive Therapy).[75]

- Transference is a major issue. Survivors may seek to replay old conflicts and relationships in an attempt to resolve them, or to prove again to themselves that they are evil or unacceptable. Carers need to process such episodes carefully and calmly. We need good supervision to manage the inevitable counter-transference.

- Dividedness is a powerful and crippling secret. Be open and accepting about human dividedness, expect a range of feelings about any issue. Be matter-of -fact about para-suicidal thoughts & acts. Normalise fears, affirm courage and the skills they exhibit, validate the emotions they own.

  Be open too about the fact that we are all in process. This allows for hope and the possibility of change.

2. Bible Teaching.

A thoroughly trinitarian theology in preaching and worship helps divided people to appreciate the *diversity* of God and thus themselves. Trinity is "a doctrine of divine relations, including relations with the created, redeemed and sustained."[76] With increasing wholeness, there seems to be a parallel ability to relate to each person of

[75] Many group members named this insight one of the most helpful and liberating features of the course.

[76] Carol Saussy, "Faith and self-esteem", *Journal of pastoral care.* vol. 42, No. 2, 1988, p.125-137.

the Trinity.[77] Trinitarian teaching also shows the healthy *unity* within God, and that congruence in love is our model, not monolithic oneness.

Survivors often believe God is judgemental or uncaring. A text like "Honour your father and mother" can be perceived as God supporting abusers: in the context of the patriarchal extended family, it served to prevent abuse or neglect of elderly parents (Prov. 19:26, Matt. 15:4-7). The biblical "abomination" of incest (Lev. 18: 6-18) is very clear; v.17 prohibits incest with a daughter or step-daughter.

On the positive side, images of God as parent present his protective care (Deut. 1:30-31), pity (Ps.103: 13) and tenderness (Is.49: 15, 66:12-13). Great concern for children is expressed (Matt. 18:1-6, 1Tim. 5:8). There are pictures of good parenting (Matt. 7:9-11, Job 1:45), including training (Prov. 22:6) and encouragement (Eph. 6:1-4. Col. 3:18-21). Feelings of helplessness and anguish are allowed expression (Ps 142:4-5). Jesus himself is an example for those who must radically change their relationship with their original family (Mark 3:31). [78] Jesus' sufferings provide a powerful point of contact with God. Eph. 4 presents an inspiring goal- maturity in Christ- and many pointers to achieving it, especially "speaking the truth in love" (v.15). The songs of women like Hannah and Mary, celebrating the Lord who lifts up the oppressed, speak deeply to abuse survivors.

Teaching about forgiveness must not be used to short-circuit the expression of righteous anger. Abuse survivors are only too ready to "forgive" to avoid facing the reality of their betrayal. Forgiveness may be the end of the process: it is not the beginning.

Triumphalism in teaching, worship and the church ethos generally, marginalises abused people. Preaching should not reject negative emotions but put them in their biblical context. Anger at God or fear of spiritual abuse should be accepted, not suppressed.[79] The occasional mention and condemnation of sexual abuse can be very affirming for those for whom it has been unmentionable in a Christian context.

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[77] One woman could not relate to the Father because her father, a clergyman, abused her. Jesus was feared once she realised he was a human male, so she only related to the Holy Spirit for many years. As healing came she learned to approach each, which further released her from her fears. "If Jesus was a non-abusive male, all men are not evil."

[78] Marshall S. Scott, "Honour thy father and mother: scriptural resources for victims of incest and parental abuse", *Journal of pastoral care* vol 42, 1988, pp.139-147.

[79] Christopher Rosik, "MPD: an introduction for pastoral counsellors", *Journal of pastoral care*, vol. 43, no. 3, 1987 p.297f.

3. Worship.

Worship is often a context for information, but at heart it is a response to God that then produces spiritual formation. When God's holiness is appreciated, the worshipper's sin and need is highlighted, not to bring condemnation but to lay hold on grace. The survivor may acknowledge for the first time the reality of attributes such as holiness, righteousness and mercy, and feel, perhaps for the first time, basic human emotions of gratitude, reverence, awe without terror, humility without self-denigration, and joy. Worship heals partly by making the worshipper more fully human.[80]

For those who have satanist cult experience, it seems important to pray and praise specifically in the name of Jesus, as generic words of praise can be confused with other objects of worship. Liturgies can be triggering for cult survivors who have experienced parodies of communion, baptism, marriage, etc. It is wise to show them the building and accoutrements and explain the ceremony beforehand, assist with spiritual preparation and give support during the service. In time the sacraments can become signs of hope and healing for them. Personalised services renouncing ties with abusers or cults[81], or affirming the person's integrity in Christ, or incorporation in a new community, can be developed together and be significant times of healing.[82]

There are many biblical images of God that derive from women's experience, which should be included in our mental image and our praying, preached about and incorporated in public worship. This will enable some women to relate to God more easily, and perhaps find healing from the wounds of poor parenting. The use of gender-neutral language about humans, and God where appropriate, may remove some unnecessary barriers.[83]

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[80] D.E.Saliers, "Worship and celebration". *Dictionary of Pastoral care and counselling,* ed. Rodney J. Hunter. Nashville, Tenn.: Abingdon, 1990, pp.1339 f.

[81] Kraft p.100.

[82] One woman said "Every time I celebrated a good Eucharist I felt I was unmaking the rituals of my childhood... I had been taught kinesthetically... now I felt by doing the rituals right and with my heart fully devoted to God, I was unmaking the deeply ingrained lessons of my childhood."
Patricia L. Pike and Rich.. J. Mohline, "Ritual abuse and recovery: survivors' personal accounts", *Journal of pastoral theology* vol. 23, no.1, 1996, p 53.

[83] A sample: God is like
* a mother giving birth. Isaiah 42:14. The whole "new birth" image of the New Testament implies a picture of God, and especially the Holy Spirit, as a mother (Jn. 3:3-8, 1 Jn 3:9, 4:7, 5:4, 5:18).
* a nursing mother (Is. 49:15, 1 Pet. 2:2-3).
* a comforting mother (Is. 66:13, Hos. 11:3-4, Ps. 131:2).
* a pregnant mother (Is. 46:3-4).
* a protective mother bird teaching her offspring to fly (Deut. 32:11).

4. Modelling.

In the group, members were very interested in the facilitators' relationship. They observed us being friendly, vulnerable, teasing, affirming and correcting each other. These were areas of difficulty to them and sometimes they misinterpreted, assuming we were angry or hurt because they would have been. It was helpful to see us process our relationship in front of them. Pastoral carers should provide new models of healthy relating for the DID sufferer to observe, including how to process conflict.

5. Discipling.

Discipleship can be seen as the process and experience of entering into salvation. For the dis-integrated person, "sanctification" has to do with integration of conflicting parts, especially in terms of beliefs, and values, "taking every thought captive to obey Christ" (1 Cor. 10:5).The Self, as well as being formed genetically and in systems, is trans-formed by choices, thoughts and behaviours. Paul exhorts us to be pro-active in personal transformation based on submission to God (Rom. 12:1-2). A DID sufferer who becomes a Christian needs mentoring and help to develop spiritual disciplines in her life.

6. Community- walking the discipleship road together.

We have noted ideas of the socially constituted self and the importance of covenant. In the church these are lived out, not so much in Sunday services, as in small groups. A small group can function as a new "system", a "household of God" (Eph. 2:19) where healthy psycho-social development can occur. The DID sufferer needs many I-Thou relationships to rebuild a Self, not just a professional therapist. There they can meet God: "if Christ exists at all in this world, he exists as community"[84] and invest the Self in covenant relationships.

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* a protective mother hen (used by Jesus, Matt. 23:37).
* a mother bear enraged by danger to her cubs (Hos. 13:6-8).
* a housewife who looked for her lost coin (Luke 15:8-10)
* a midwife (Ps. 22:9).

*The Wisdom of God is personified as a woman (Prov. 1:20): "she" is closely associated with God , the Word, and with Christ.

There are passages that combine male and female images:

* Is. 42:13-14 the warrior and the labouring woman
  Is. 63:15-16 the trembling womb and the father
* Deut. 32:18 the rock fathered you, God gave you birth

From my article "God as mother: it's a feminist plot", *On Being,* vol 24, no. 9. 1997, p. 34.

[84] Dietrich Bonhoeffer, *Sanctorum communio.* Lond.: Collins, 1967, pp. 61f.

If a group offers respect, support, prayer, unconditional acceptance, and clear boundaries, it can be literally life-saving, especially during the period of disorganisation when memories are emerging. The primary supporting person will need to prepare and assist the group to be sensitive to the issues raised in section I (p. ?), and negotiate how much they are to be told. A small group could eventually be trusted enough to share the supporter's burden.

Such a community is necessary to support the lifestyle changes needed as she grows in health and discipleship. Many DID sufferers abuse substances for pain relief, and carers should expect reversions to these until distress tolerance methods are established. Many work in prostitution, not because they enjoy sex, but because they think that is all they deserve, or are determined to make men pay for sex, or to sustain themselves when they are too unstable to maintain other work. Some report having been programmed for prostitution as income for the cult. Changing these beliefs and behaviours takes years and requires long-term support.[85]

If the woman has a family its members will need considerable support also. DID places huge pressure on them and many marriages collapse. There are likely to be practical needs in financial, housing, child-care, health and employment areas, and here Christian community can be demonstrated.

7. Referral

The pastoral carer needs to recognise the unique value and also the limitations of the pastoral role. Referral to a specialist psychiatrist, psychologist or counsellor, one who accepts the disorder but is scrupulous about recovering memories, and who recognises the spiritual dimension, is an important mode of care. It is good to have a collaborative relationship with a treating psychiatrist; for instance, knowing what their preferred emergency methods are enables a carer to coach the sufferer in a crisis.[86] It is worth finding expert therapists, because DID has a good prognosis with appropriate treatment, if the patient can tolerate the initial distress.[87] Here continued pastoral support is vital. Referral to family therapists or marriage counselling will probably be necessary, once there is some stability in the system.

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[85] Discussion with Helen Stock, "Matthew's Party", St. Kilda, Victoria. Oct. 6,1998.

[86] See Attachment 3 "First Aid Kit".

[87] R. Kluft, "Personality unification in multiple personality disorder: a follow-up study", *Treatment of multiple personality disorder* ed. B. Braun. Washington, DC: American Psychiatric Press, 1986, p.31-60. Ross 1997, p263, calls DID "the most treatable severe psychiatric disorder".

8. Advocacy.

Heeding the prophetic call to "do justice", the church must address the systematic abuse of the powerless in our societies. We say we abhor child abuse but do not protect victims before or after abuse. This may mean attending court, providing refuge, taking political action, or treating offenders. It will not make us popular.[88]

9. Presence and Prayer

One does not have to accept every story about cults to recognise that DID work is spiritual warfare. We are fighting with the sufferer for her soul, her very self: not that we should use this vocabulary with her, as it is very likely to be misunderstood because sufferers frequently assume that they are evil and belong to the devil.

A belief that God is somehow present in the situation is all that keeps some sufferers alive, and that can be mediated in surprising ways. One woman holds on to the fact that when she fearfully crept into a church, the priest heard her confession and offered her communion. Just identifying with her anguish, being there as a symbol that God suffers with her in her pain, may be the most powerful sign.[89]

In this battle, prayer is crucial. Subjectively, it has symbolic value, it provides a context of meaning, it directs us to God as the source of our identity and hope, it energises our faith. Objectively, Christians believe that it somehow cooperates with God's action in the world and the life of our friend. We pray because we are driven to it, and because we believe prayer changes things (Ps.50: 15).

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[88] Rivera, p. 20.

[89] "(The pastor) was not afraid to look at my experience... to be in that traumatised place with me, a witness to my pain and a constant reminder of the healing power of God's love."
Pike and Mohline, p. 48.

Conclusion.

The experience of the DID group began the process of challenging my perceptions of DID as a particularly frightening mental illness. It highlighted many of the specific problems of DID sufferers. I came to identify the underlying problem as subjective dividedness, due to a disturbed development of the sense of self . Cognitive-behavioural skills partly addressed these specific problems, giving improved functioning in daily life, better relationships, increased ability to feel emotions without losing control, and a stronger sense of self. The group environment allowed realism about the handicaps, validation for members' experiences, openness about the spiritual issues involved, and real affirmation of the people, which made trust, and a measure of healing, possible. Many of the lessons learned by relating closely to a group of sufferers can be applied in the pastoral situation.

Historically and currently there are controversies about DID. Ritual and other abuse really occurs and contributes to dissociative disorders, but memories may also be contaminated. It is important that therapists and carers accept and support the person with abuse memories.

I concluded that within the DSM framework DID is a valid, meaningful and useful diagnosis. The conceptualisation of different presentations as representing "alters" is only a hypothetical model, but seems to aid effective therapy, because it allows the helper to enter the sufferer's inner world and address the core problem of the divided self.

We can use the diagnostic system for its value in gaining appropriate treatment, while remembering it is limited. I suggest that a combination of 1:1 psychodynamic therapy with cognitive- behavioural training and spiritual care, gives balanced care. Not all "Christian" approaches are equally helpful and I have particularly critiqued Inner Healing. However we do not need to resort to a medical model; we expect God to use his people for healing.

Evidence from various disciplines supports the idea that human nature is essentially diversity-in-unity, with DID as part of a continuum. I concluded that I am one enduring person, but with multiple aspects, formed in systems and continually in process; and that I am a separate person, but the goal of differentiation is to enable me to enter covenant relationships. Theologically this conclusion is based on the three-in-one Godhead, where love is the principle that both unites and allows differentiation. Trinitarian theology illuminates what it means to be human.

The love of the Trinity is the starting point for understanding God's presence with us in suffering, and for removing the false problem of the gender of God.
Salvation can be seen as integration of the whole self around Christ, in community, and with an eschatological dimension.

Pastoral Care must be based on this principle of love. It emphasises commonality, inclusiveness, covenant and shared discipleship. It accepts the unity of the sufferer as the basis for respecting their boundaries and relating in love to the whole person. The diversity of the sufferer is also respected, allowing us to love and engage with each part.

There are some tensions between pastoral and clinical descriptions and modes of care. Pastorally, it is more helpful to understand DID as a normal pattern of response carried to extremes, rather than an "illness", and to be fellow-travellers rather than clinician and client. Still, the desire to normalise the DID experience should not minimise the very real damage. We must recognise the handicaps suffered, while refusing to pathologise the person.

Care is expressed in various modes in the church. A designated support person can help the sufferer to practise new living skills, but more importantly, give a new experience of love. In Christian community she can observe healthy ways of relating, and find a new "family" to grow up within. Worship can help healing and spiritual formation. Trinitarian Bible teaching can set the framework for accepting ourselves and approaching God. Referral and advocacy are important ways of relating to the outside world.

Loving pastoral care by the church, as a diverse group of divided Selves who nevertheless are experiencing unity in Christ, offers much to the DID sufferer. It does not reject, but complements the psychiatric system, and can be an invaluable context for healing and wholeness for the divided Self. For this to happen, pastoral leaders must make themselves and others familiar with psychological theories about DID and therapeutic approaches such as Cognitive Behavioural Therapy, as well as thinking theologically about what it means to be damaged humans in a process of healing. This will deepen their ministry to their communities and congregations, DID or not, and their own identification with all who suffer brokenness.

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ATTACHMENT 1.

Read over the description of the four common features of abuse survivors. How great a problem do you have with each of these? Does it cripple your life, is it clearly a problem, or is it no worry at all?

* Assess the severity of the problem from 1= "not a problem" to 5= "absolutely terrible problem, dominates my life every day". Write the number on the dotted line.

*Write a brief description about each of the four areas.

1. Confusion about self eg feel empty, who am I? what do I really think and feel? Under stress, can lead to briefly losing touch with reality; splitting; beliefs that situations or people are real when they are not; feeling out of contact with the inner or the outer world. score .....

2. Chaos in relationships. eg intense, unstable relationships; panic and dread lest they finish; frantic attempts to avoid abandonment; testing of new friends; picking up abusive men; unhealthy dependant relationships. score .....

3. Unstable emotions. eg feelings are unpredictable, swing a lot. Trouble coping with anger- either deny it or over-react. Depression, anxiety, maybe sometimes feeling high and out of control. score .....

4. Behaviour that causes problems. eg very impulsive behaviour; self- abusive acts; overdoses; shop-lifting; addictions; obsessive behaviour. score .....

ATTACHMENT 2.

FIRST AID KIT.

List typical crisis situations you need to tolerate.

Some will be in the environment- eg the morning rush, bad news...

.....

.....

Some are within you- eg a flashback.

.....

.....

Outside things trigger inside crises eg a crying child may trigger your child part to feel distress. An unexpected demand may trigger your protector to take up arms. The more aware you are of your "buttons" the more you can chose your response.

.....

.....

There are different kinds of distress that you need to tolerate, so you need a range of strategies. Which kinds of distress situations may they help? Note that if you can see the distress coming, you have a wider range of strategies to choose from. It is better to practise several at low levels of distress, than wait for the real emergency. But try to have at least one you can rely on in a crisis.

My emergency strategy is.....

1. Distracting methods

Activities- do something else. Count something.

Contributing- do something for others. Comparison- seeing your situation in perspective.

Emotion change- think about another situation that generates another emotion.

Push away- either physically or by blocking.

Think hard about something else- ground yourself by observing and describing.

Sensation- eg the ice cube, tapping hand.

Good distractors for me are.....

.....

2. Self-soothing methods.

Remind yourself that you deserve care, and can do soothing things for yourself.

Soothe the five senses, especially the ones that are raw at that moment.

Eg if quarrelling in the next flat is upsetting you, talk rationally to yourself about it then put on nice music to soothe your hearing. Pat yourself.

My effective self-soother is ....

3. Improving the moment methods.

These are about changing the immediate situation, by changing how you see it, or how you respond.
Imagery- going in to a safe pace.
practicing coping in your imagination.
take charge- mentally turn down the volume or the speed on the
TV that is playing your life.
My best imagery is.....

Meaning- asking what purpose this suffering has in my life.
.....
.....
Prayer- a kind of radical acceptance, asking for courage and wisdom, rather than "why me?" or "make it stop".
My prayer .....
.....

Relaxation- accepting reality with the body communicates to the mind. You need a quick technique and a longer method.
Quick method.....
Long method .....

One thing at a time- you just have to deal with this moment, not the past or future.
Vacation from coping- planned and brief.
What regularly builds up? How could I plan a vacation?
.....

Encouraging yourself as you would someone else. What would your therapist say?
.....
I can change how I cope with stress by .....

4. Thinking of the probable results of tolerating or NOT tolerating this distress.
What kinds of situations do you have enough time and rationality to do this? Even in crisis can you say "No, that would cost too much"?

The thing that motivates me to tolerate distress is.....
.....

5. Awareness as a path to self control.
Observing your breath exercises.

Half-smiling exercises.
Awareness exercises- participating one-mindfully.

Exercises I can use effectively are ....

ATTACHMENT 3.

INNER HEALING.

Inner Healing is probably the most well-known approach to counselling abuse survivors in Christian, particularly charismatic circles. It appears to be strongly influenced by Jung and often uses psychoanalytical methods.[90] The emphasis is on identifying and resolving the wounds of the past, especially by visualising Jesus there. The "guarantee" of genuineness is the Holy Spirit's ability to reveal both causes and treatment of inner wounds. "Deliverance" (ie from demonic possession or oppression) is a major method.[91]

Commonly memories are recovered using some form of relaxation or guided imagery, including pre-birth experiences.[92] I witnessed a woman being guided to "walk back down the steps with Jesus", in a way that seemed indistinguishable from hypnotherapy. However effects such as the fluttering eye-lashes and changed breathing were explained as signs of the Holy Spirit, rather than an altered state of consciousness. The counsellor involved would have rejected hypnotism as such.

The "inner child" seems to be taken very literally. When memories of hurts are described, the person is often encouraged to visualise Jesus there and hear what he would say. This message is frequently a reassurance of his love, cleansing, forgiveness and power, and an instruction to forgive the perpetrators of the hurt.[93]

Authoritative prayer in Jesus' name is always used, based on Jesus's authorisation of his disciples to expel demons and heal diseases (Luke 9:1-2). Kraft recommends praying against intergenerational, prenatal, and life-stage curses and traumas. He simply declares these (assumed) curses to be broken and announces deliverance.[94]

Another tool is "breaking soul ties", especially those involving possessive parents, Satan and the occult or sexual partners.[95]

<u>Evaluation.</u>

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[90] John and Paula Sandford, leading figures in this movement, were Jungian psychologists. For their views on Archetypes see their *The Transformation of the inner man.* South Plainfield, N.J.: Bridge, 1982, ch.16.
[91] Chas. H. Kraft, *Deep wounds, deep healing.* Ann Arbour, Mich.: Servant Pub., 1993. p 105f
[92] Kraft. p126
[93] Rita Bennet,, *How to pray for inner healing*. Eastbourne, UK: Kingsway, 1991, p59, 64-67.
[94] Kraft pp.100ff.
[95] Bennet, p85.

The confident use of Scripture, faith emphasis, and apparent success in many cases, and the fact that it offers techniques which can be used by lay people, makes Inner Healing attractive to helpers and sufferers.

However there are some concerns. The use of lay people, with no theological or psychological training, to deal with extremely complex life-and-death matters, concerns me; both clients and helpers are at risk.

Inner Healing writings tend to be anecdotal, make many unsupported assertions, or use unsound exegesis.[96] There is very dubious scriptural bases for soul ties, generational and pre-natal demonisation or curses, use of visualisation, or the practice of baptising separate alters.

The suggestion that Jesus was there during the abuse often arouses great anger in survivors. They ask, quite reasonably, "So why didn't he stop it?" It is equally dangerous to construct a false picture where Jesus "really" rescued them. He did not rescue them because God created a world where humans have free will and can cause suffering. But he did not stand idly by: he died for that sin, took that pain, and can redeem that situation.

There are problems with asking what Jesus would say or do in the scene. Visualisation and guided imagery are not necessarily reliable ways to discover the real problems. They lend themselves to leading questions and active imaginations, and contamination by fears, desires or other memories. Sometimes dreams corroborated by "words of knowledge" have been used to make false accusations.[97]

Some encourage survivors of child sexual abuse to receive forgiveness for having attracted sexual attention or having enjoyed any part of it.[98] This unfairly shifts part of the blame onto the victim. Pronouncing forgiveness implies there was sin, as distinct from pronouncing cleansing, which implies having been defiled.

There is a risk of attributing all the person's problems to the particular "revealed" event from the past, and looking for a "quick fix". They may gain emotional relief and

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[96] One of the great disappointments of this research was the poor quality of the exegetical methods found. Proof texts depend on poor translations, are taken out of context, used as "magical" guarantees or combined in illegitimate ways. All these appear in Bennet, pp. 85f. but examples abound in the Inner Healing literature.

[97] Neil Anderson p. 220f.

[98] Sandford pp. 97f.

insight, but DID sufferers have many deficits in their psycho-social development that need long-term support and retraining. A process of discipleship is needed, and some writers recognise this.[99]

Inner Healing can be critiqued on most of the same grounds as psychoanalysis.[100] My disquiet lies in its supposedly "Christian" presuppositions: the conviction that God wants to heal everyone;[101] the belief that Christians simply need to use the authority God has given to produce inner healing[102]; and the assumption that the Holy Spirit will protect from deception and inevitably correctly reveal both cause and solution for each problem.

Scriptures like "he (the Holy Spirit) will lead you into all truth", are treated as universal promises. This "faith" seems to underestimate our damaged rationality, fallen will, mixed motives, and psychological complexity, both as helpers and DID sufferers.

Experience, and biblical examples like Paul's "thorn" (2 Cor. 12:7-19) show that not all people are healed in response to believing prayer. I have heard several women report being further damaged by simplistic use of Inner Healing methods.

The discernment of spirits is extremely difficult (1 Cor. 12:10 calls it a spiritual gift) and there is great danger in trying to expel an alter, as Friesen admits.[103] In older accounts, what now appears as DID was treated as demonisation. (However this should not necessarily lead to the assumption that demonisation never occurs. Scriptural accounts such as Mark 5:1-20, and some modern experiences of exorcisms are usually dismissed only on *a priori* grounds.[104])

Groups such as Wholeness through Christ use Inner Healing in a broad therapeutic and Christian framework. The real danger occcurs when it is taken very literally and used as the only model by self-appointed counsellors who are not theologically or psychologically aware.

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[99] Kraft p.102

[100] For example, see C. Stephen Evans, *Preserving the person.* Downer's Grove, Ill.: IVP, 1977, ch.3.

[101] Kraft p.21

[102] Kraft p.100

[103] Friesen,p.222.

[104] I have not witnessed a successful exorcism but have heard accounts in India from both exorcists and those delivered. I have also met psychiatrists, not necessarily charismatic or even Christian, who accept that demonisation is rare but real. I have experienced alters attached to satanic cults who certainly presented like evil spirits, but I have not felt sure about the exorcism option.

Inner Healing may not fulfil all it promises, but this does not mean the pastoral carer must resort to the clinical approach. Inner Healing does highlight some important issues:

- abuse and rejection in childhood do cause long-lasting damage and need to be faced, and healing sought from God.
- we are often driven by thoughts and motives that are hidden from ourselves: this echoes the Pauline concept of indwelling sin and the struggle of Romans 7.
- we are involved in a spiritual struggle, however one describes that. There is always the tension between trusting God and looking for other sources of relief or gratification.
- true healing comes from a loving God. We can ask him for wisdom to discern the way forward, and must work in dependence on God. Prayer must be central in working with DID.
- methods such as exploring the past, visualisation, dream work, journalling, use of symbols and liturgies, and encouraging a decisive break with anything occult or sinful, can be useful at times.