A Pastoral Commentary on Dissociative Disorders

Written for pastoral counselors, chaplains and pastors: Issues surrounding Multiple Personality Disorder-- or more recently, Dissociative Identity Disorder-- particularly with antecedents of cultic ritual abuse, present unique challenges for providers of clinical pastoral care. The application of process theology, appreciation of a broad range of God ideation, awareness of child and adolescent spirituality, and a biblical hermeneutic that includes object relation theory and anthropology, are all areas to which pastoral care can assert primary claim. Issues surrounding cultic ritual abuse should be subject to pastoral consultation and approached with non-anxious skill and clarity. This latter will become increasingly important as these issues meet the scrutiny of popular media and anxious Christian groups with which dissociative persons may have connection.

Written by a psychiatric chaplain to help pastors deal with the incidence of Multiple Personality Disorder, this book has since found a following among secular therapists and survivors concerned with religious issues. Deals straightforwardly with such issues as suicidality, ritual, sexuality, gender inclusive religious language, mythology, alters and faith development, prayer and trance states... just to name a few. This is probably not the best book for those who consider themselves "conservative Christians.

MANY VOICES/MULTIPLE CHOICES:
Resource Guide to DD Treatment, Education and Support

This is a groundbreaking book for clergy working with MPD patients in the same way Putnam's book became the basic text for therapists. It is written with "a pastor's heart" and expertise won on the battlefield. I expect it to spark questions, creativity and controversy. My hope is it will also raise the quality of discussion.

Fr. Joseph Mahoney
Chaplain, Harper Hospitial

Required reading for pastoral counselors working with dissociation... a good resource for using scripture with abused persons.

Elizabeth S. Bowman, MD, STM
Indiana University Medical School

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ISBN: 0-9644088-0-5 Pastoral Theology

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ISBN: 0-9644088-0-5
Library of Congress Catalog Card Number: 94-93896
Cover illustration by the Observers.

First printing, November 1994
Published by
Clinical Pastoral Services
744 McCallie Avenue, Suite 516
Chattanooga, Tennessee 37403

Second printing, March 2009
Published by
New York Books
PO Box 596
Scottsboro, Alabama 35768

Preface to the Second Printing

It is a humbling thing to read something one wrote almost 15 years previously. Most people are happy to see such documents fade from print into posterity. I am no exception. The field of disociative disorders has evolved, and so have I.

When it became apparent that the demand for *A Pastoral Commentary on Disociative Disorders* was such that it would need to be reissued, I also balked at the daunting task of preparing a revised, second edition.

Wise counsel has provided me with an alternative. Reprint the book as the artifact that it is: a text written for clergy by a young, earnest hospital chaplain in the early 1990s. If it still serves a purpose: so be it.

Howard W. Whitaker+
Director of Pastoral Services
Greystone Park Psychiatric Hospital
Feast of All Saints, 2008

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Preface

A pastor of my own denomination called me one morning. She is a woman of enviable courage, skill and pastoral identity. I have seen her bring great pastoral presence and common sense into settings of intense chaos and restore peace and clarity with a few words. Prophet, priest, mother and teacher, she is living witness to the holy intimacy and security people may find in God as Mother.

But this day, her voice was tingled with an iciness, fear and indignation that made me want to hide as though I was responsible for a great wrong. With hard consonants she demanded to know, "What in the hell is going on here?"

As her story unfolded, it seems a young woman, the wife, mother and daughter of an extended family in her congregation had received a diagnosis of Multiple Personality Disorder. There were charges of childhood sexual abuse. There were overtones of dark, mysterious cultic practices. Every piece of the story that emerged was, if possible, stranger than the last. She believed in her parishioners; it couldn't happen in this family.

She went to the hospital to visit the young woman from whom the stories were being generated. While she was listening to the patient, the pastor became convinced she was speaking with "two other persons...an eight year old girl and her twelve year old brother." She believed their stories as well. She walked numbly out to the dark parking lot.

On this November night, the pastor, now sobbing uncontrollably, made the one hour trip back to her rural community with all her car windows open and the cold wind whipping across her face. She quickly parked her car and ran into her church. Illumined only by the light of the sanctuary lamp above the reserved sacrament, she curled up on the floor by the altar and shook. She was convinced she had "gone crazy" as well. After a sleepless night, she called me. Indeed, what is the hell is going on? What was she supposed to do now?

She is not alone in asking the questions. For reasons that are social and cultural, as much theological and psychological, the

phenomenon of Dissociative Identity Disorder--popularly still known as *Multiple Personality Disorder*--has broken out of the obscurity of the psychiatric hospital. Shelves in popular and religious bookstores are filled with accounts and explanations. Talk shows feature titillating tales of victims and accused. Made for television movies have portrayed persons with the disorder and major celebrities have begun to speak of their "selves" in new ways. In courtrooms, dissociation is rapidly becoming a common defense for criminal actions. Church pastors and pastoral care providers to the mental health community are beginning to see the reflection of this attention in the populations in which they minister. There is nothing in seminary textbooks that even begins to address "multiple personalities," recovered memories, ritual abuse and the chaos and fragmentation persons and their families experience in dealing with these issues.

So this is a monograph for pastors. I am a pastor, and it is written in religious language. Psychiatry and psychology are languages of middle class providers and the insured. Religion continues to be the language of the masses, particularly those unable to access the cutting edge of mental health care. It is an attempt to provide some very preliminary pastoral answers to some basic questions and cite some resources for more help.

This is not a book about *how* to treat dissociative disorders. I refer to core texts in issues regarding the treatment of dissociation. My own position is that the *pastoral* role in the treatment of DD is unique, and is actually a role with the larger relational systems of mental health workers, alters, therapists, friends, family and community. *Primary* therapy with persons with a dissociative disorder would not be the normal province of the pastoral counselor or chaplain. If you are a pastor who really wants to *be* a therapist, perhaps you should consider retraining. For clinicians who may be reading, you should not find any new clinical material here, but I hope you do find some ways to be more comfortable with faith material. I believe you would find a working relationship with a local pastor to be professionally rewarding.

This is not a spiritual self-help book for persons with dissociative disorders. But like therapists, teachers, cab drivers, parents and children, sometimes we all hear things better when we "overhear" them said to others. If you are a person with a dissociative disorder: welcome. My first suggestion is that you read this with your

therapist or a supportive friend. I hope you find something affirming within these pages. Knowing some of my own clients will read this book, I am uncomfortable about the wary, third person tone with which it occasionally speaks of some very holy and human persons who have taught me so much. I need not tell *you* about the difficulty in dealing with changing perspectives, multiple points of view and the use of language. I am doing the best I can. I am still learning.

This book is more of a pastoral letter, written for clergy, chaplains, and pastors who wish a very general introduction and orientation to faith issues frequently encountered in the treatment of dissociative disorders. My hope is to give you food for the journey so that you may better live out the ministry to which God has called you.

Those who publish know the pain and embarrassment of having their thoughts "frozen in time" on the printed page. I will be delighted when my thoughts will be eclipsed by something more sophisticated. As our understanding evolves, I hope someone can write from a pastoral perspective without continually battling images from TV talk shows, frightened faith communities and alienated survivors. I hope someone will compile a real textbook on pastoral care and dissociation.

While not an academic work, this is a resource work of which footnotes, rather than being parenthetical documentation, are an integral part. The layout is intentionally Chicago format so that footnotes and text appear on the same page. I urge readers to consult the referred works for more information and resources.

I hope the present attention on the *affective presence* of persons with MPD/DID will prove to be a passing fad. While the symptomatology is very real, as is the misery it causes, I hope the way we think about dissociative states will continue to evolve. This evolution can already be seen historically as we move from the "possession states" spoken of at the turn of this century, to "multiple personality," to the present, less sensationalized "Dissociative Identity Disorder."

For pastors who find themselves in the position of the one mentioned above, I believe God has lain upon you a great responsibility. Remember who you are, and whose you are. And get some supervision. You are about to go on a holy pilgrimage. It is likely to be a long, strange trip.

H.W. Doc Whitaker+
Feast of All Saints, 1994

Thou whose almighty word chaos and darkness heard,
and took their flight...
Hymn, John Marriot

Chapter 1
INTRODUCTION
Pastoral Care in a Mental Health Setting

The need for spiritual care for psychiatric patients has long been affirmed in medical and nursing texts.[1] The pioneer studies in pastoral care and mental illness are the works of Anton Boisen.[2] The inclusion of a v-code for "religious or spiritual problem" in *DSM-IV*[3] is witness to the recent movement in the psychiatric community toward incorporating psychoreligious and psychospiritual problems

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[1]*e.g.*, Martha Liening, "The Spiritual Needs of the Psychiatric Patient," in Lois Dunlap (ed.) *Mental Health Concepts and Nursing Practice,* Chapter 7, New York: Wiley, 1978. A more general nursing work is Sharon Fish and Judith Allen Shelly, *Spiritual Care: the nurse's role,(*and *Companion Workbook)* Downer's Grove, IL: InterVarsity Press, 1979; on spiritual assessment as part of the nursing process, see "Spiritual Distress," in Lynda Juall Carpenito, *Nursing Diagnosis: Application to clinical practice,* 3rd Edition, (Philadelphia: J.P. Lippincott, 1989) p. 710ff. For psychiatry, Edgar Draper, *Psychiatry and pastoral Care* (Englewood Cliffs, NJ: Prentice Hall, 1965) continues to be a mainstay. R.J. Lovinger, *Working with religious issues in therapy* (New York: Jason Aronson, 1984) and Paul Pruyser, *The minister as diagnostician* (Philadelphia: Westminister Press, 1976) are frequently cited works from psychologists.

[2]Anton T. Boisen., *Exploration of the Inner World: A study of mental disorder and religious experience* (Chicago: Willet and Clark, 1936) and *Out of the Depths* (New York: Harper and Brothers, 1960). *also,* articles reprinted in *Vision from a Little Known Country: A Boisen Reader,* Glenn H. Asquith, ed., (Decatur, GA: Journal of Pastoral Care Publications, 1992). Boisen was both a pastor and a psychiatric patient and used his experience to reflect upon the nature of religious ideation, delusion and the Christian tradition.

[3]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* American Psychiatric Association, Washington, DC, 1994, p. 685.

into treatment.[4] In the field of Multiple Personality and Dissociation, the need for spiritual exploration of the disorder is attested by a diverse range of clinicians.[5]

In its simplest concept, the term "spirit" can be equated with the Hebrew concept of "breath of life," transcending all physical dimensions and giving definition to being, significance, relationship, redemptive change and release from suffering. Religion may be generally understood as ritual or institutionalized practice that may act in support of one's spirituality. The assessment of religious and spiritual orientation and the availability of pastoral services for patients are addressed as JCAHO Standards for Accreditation for Mental Health Facilities.[6]

In contrast to the increasingly popular, but exceedingly vague term "spirituality," this work will try to address what James Fowler describes as *faith.* Fowler conceives of faith as a dynamic process of disposition in which we construe our conditions of existence. Faith is how we find and maintain coherence. Faith includes primal, limbic, unconscious and emotional elements, as well as cognitive knowing. Faith connects our soul to what we value most and to that which we acknowledge as transcendent power. "...it attempts to make sense out of our mundane everyday experience *in light of some accounting for the ultimate conditions of our existence.*"[7] Faith provides a potency

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[4]David Lukoff, Francis Lu and Robert Turner, "Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems," *The Journal of Nervous and Mental Disease,* Vol. 180:11, 1992, p. 673.

[5]Marion Bilich and S.D. Carlson, "Therapists and Clergy Working Together: linking the psychological with the spiritual in the treatment of MPD", paper presented at the Ninth Annual Conference on Multiple Personality/Dissociative States, Chicago, November 1992; Elizabeth S. Bowman and William Amos, "Utilizing Clergy in the Treatment of MPD: A Non-Clergy Therapist Guide," *Dissociation,* VI.1.47-53. Works from James Friesen, representing an evangelical viewpoint, and Colin Ross, from a broader, mainline position, are cited elsewhere in this paper.

[6]Joint Commission on Accreditation of Healthcare Organizations, *The Accreditation Manual for Mental Health, Chemical Dependency, and Retardation/Developmental Disabilities Services:* standards AD.5.1.2, AL.2.4.8, PI.7.2.1, Oakbrook Park, IL, 1992.

[7]James W. Fowler, *Faith Development and Pastoral Care,* (Philadelphia: Fortress Press, 1987) p. 56. See also Fowler's "Healing Spirit: Psychiatry and the dynamics of faith," Oscar Pfister Address, American Psychiatric Association, Philadelphia: 1994.

and motivation. Faith provides goals as behavioral guidelines tested and connected across generations. Faith gives a sense to why we are living at a given time and place. There was a time when concepts like "belief" or "religion" or even "spiritual life" may not have been separated from faith. However, in this modern era, they need not be confused.

MULTIPLE PERSONALITY AND DISSOCIATION

The incidence and study of Dissociative Disorders(DD), and particularly Multiple Personality Disorder(MPD), has entered a renaissance of sorts over the last 15 years. The general agreement is that dissociation is a normal process, initially used defensively by an individual to psychically defend against traumatic experience. Over time, the process evolves into maladaptive and pathological forms. There is wide divergence of opinion as to how the pathology should be conceptualized and treated. The texts of Richard T. Kluft,[8] Frank W. Putnam,[9] Bennett G. Braum[10] and Colin A. Ross[11] are seminal in the field.[12] The activity of the International Society for the Study of Multiple Personality and Dissociation(ISSMP&D)[13] serving mental health and allied professionals and the Sidran Foundation[14] for people

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[8](ed), *Childhood Antecedents of Multiple Personality Disorder*, Washington, DC: American Psychiatric Press, 1985. Dr. Kluft also edits the journal *Dissociation.*

[9]*Diagnosis and Treatment of Multiple Personality Disorder*, New York, NY: Guilford Press, 1989.

[10]*Treatment of Multiple Personality Disorder*, Washington, DC: American Psychiatric Press, 1986.

[11]*Multiple Personality Disorder: Diagnosis, Clinical Features and Treatment*, New York, NY: Wiley, 1989.

[12]I submit the reading of any two of these to be required as introduction of basic treatment issues. As a body of knowledge, they will hereafter be referred to in this paper as "core texts."

[13]5700 Old Orchard Road, First Floor, Skokie, IL 60077-1057. Publishes Journal *Dissociation.* While this organization is primarily driven by psychiatry, a broad range of multi-disciplinary membership is represented.

[14]2328 W. Joppa Road, Suite 15; Lutherville, MD 21093. Sidran Press and allied Bookshelf distributes catalog of relevant publications.

Of the many newsletters for survivors, I recommend *Many Voices*, PO Box 2639, Cincinnati, OH 45201-2639.

with dissociative disorders and their supporters are witness to the breadth and depth of the issues.

Current research shows dissociative disorders may affect 1% of the general population and somewhere between 5-20% of people in psychiatric hospitals, many of who have received other diagnoses.[15] The incidence rates are even higher for survivors of sexual abuse. Women present for treatment ten times more frequently than men. However, this discrepancy is thought to be a function of the way the pathology manifests in gender roles. If, for example, male combat veterans suffering from PTSD and male prison populations were to be factored, the incidence rates might have more parity with those of women.

If these statistics are correct, given the realities of scarce resources and managed care, the bulk of persons effected by dissociative disorders will be seen, not by esoteric specialists in highly controlled settings, but in generalized populations of state mental health systems, community mental health centers, charitable and church-based social agencies, and by community pastors. Some will remain unidentified and untreated, although the effects of dissociation will be felt throughout their families and social systems.

THIS PRESENTATION

I will state some perceptual bias. As the presenter, I am a Caucasian male, married, a parent and a priest of the Episcopal Church. I am a Southerner and Appalachian by background, raised in the culture of the "Bible Belt." It is a region where culturally--as well as theologically--religion is “in the water.” My early training was in health care institutions where religious issues were naturally part of treatment planning. However, during advanced and supervisory residencies, I served as chaplain in a private, militantly secular institution on the east coast of the United States. To paraphrase the Johannine Jesus and Paul the Apostle, much of the time I felt like I was in the hospital, but not of the hospital. My stance has been to use this liminality, rather than fight it. I work out of a theoretical structure based in Bowen/Kerr Family Systems. This approach has served me well as chaplain to the treatment milieu.

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[15] *Multiple Personality & Dissociation*, an introductory brochure published by Sidran, ibid.

Consistent with their culture, many of my in-patients on the east coast, and their milieu, could be described as persons who are lapsed or estranged from Roman Catholic religious practice.[16] Pastors will recognize that those who are most shackled to religion are those who reject its practice. The families of origin for these persons may have been active or merely socio-cultural Roman Catholics. If these dissociative persons understand themselves as victims, their abusers were frequently religiose. Many of these persons have received judgmental, non-accepting, and at times abusive treatment at the hands of religious institutions. Yet, almost all continue to struggle with a sense of the spiritual and transcendent.

These persons frequently reflect the individual piety of the pre-Vatican II Roman Catholicism in which they received their religious formation. Their initial pastoral care issues are frequently concerned with the antecedents of the disorder and are clustered around casuistry,[17] agency, guilt and victimization by another they may have perceived as moral authority. It is a faith orientation that values thought and discipline. These persons are frequently isolated from the support of a faith community and the narrative of the historic church found in holy scripture. Pastoral interventions are frequently bound up in ritual and directive assignments made possible by heavy transference to the pastor as priest.

Increasingly, my private consultations are with individuals, groups and families from evangelical, free-church traditions. These persons are usually quite grounded in a faith community. However these communities frequently "bear one another's burdens" and are "watchful" to the point of becoming enmeshed, hyper-vigilant, and fearful about experience that violates the norms of conservative Christian sub-culture. In these faith communities, religion is a social and emotional experience. Initial pastoral care issues frequently concern a community's reaction to a patient as manifested in gossip,

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[16]I feel the need to remind readers that this chapter addresses the <u>context</u> of my presentation. Obviously, I am not suggesting that Roman Catholicism is somehow linked to a psychiatric diagnosis, only that within the context of pastoral care of middle and working class Baltimore, the "cultural language" of Roman Catholicism was what most of my patients "spoke." Had I trained in another part of the country, that cultural language might have been Lutheran, Southern Baptist, Mormon, New Age, etc.

[17]*Defined: In moral theology, casuistry is the art of determining right and wrong in particular cases where general norms (ethics) are not precise enough.*

fascination or repulsion, accusations of "demon possession," and the doubts about the ability of secular, "humanistic" disciplines to address spiritual problems. This tradition places heavy authority in holy scripture. Pastoral interventions are frequently based in re-teaching the role of Christian community, education--both about dissociation and relationship systems, and functioning as an interpreter and intermediary between treatment team and community.

While a particular religious orientation does not necessarily make a MPD/DD patient more susceptible to generating religious issues, the language in which those issues are presented is a function of the patient's religious background. All these tensions inform my pastoral work in subtle ways.

I frequently speak of persons with MPD/DID as "patients." I realize this gives a clinical distance and coolness to my writing. It also means that much of my experience to date has been with persons who are severely compromised by their disorder, have the means to pay for treatment and seek most of their professional support from a hospital based facility. My observation as chaplain to the milieu has been that the systemic relationships between those who have keys and name badges, and those who do not, are intense and complex. Mental health is a relative term and all struggle together. This is both blessing and curse.

I speak of inter-disciplinary treatment teams, because they have been a feature of my clinical culture. I believe teams are the safest, most effective treatment modality for persons with MPD/DID and those who work with them. The character structure and intense affect of these dissociative persons, along with their several dissociated sets of perceptions and issues, can make confusing and excessive demands from solo practitioners. As a clinician allied with trauma survivors, I have learned the rite of passage lessons about over-involvement.[18] As staff chaplain in an institution, I have repeatedly

[18]There is perpetual debate about the role of therapeutic relationship in the treatment of MPD/DD. By nature, the pastoral relationship is somewhat different-- all the pastor has is the relationship to work with. However, I suggest many of the same dynamics apply. For examples in support of MPD/DID requiring extraordinary extensions on the part of clinicians, see the narratives of patients in B.M. Cohen, E. Giller and Lynn W. eds, *Multiple Personality from the Inside Out* (Lutherville,, MD: Sidran, 1993); important recent discussion of this issue is found in P. J. Kinsler, "The Centrality of Relationship: What's *Not* Being Said," and the responses of C. Comstock, C. Fine, J. Olson, R. Sachs, M. Torem and W. Young, *Dissociation, 5.3. p166-181.*

witnessed the reality of secondary post-traumatic stress on clinicians and their families.[19] Working in a team can make the difference between therapeutic and untherapeutic interactions and theologically speaking, is the best stewardship of limited human agency in the healing power of God. Behind the chaos, these persons are intelligent, driven, creative, *extremely human* beings. As a pastor, I suggest these persons come to us for help, but also have something to teach us about our own corporate and individual humanity. They deserve better than pastors who are defensive, angry, frightened, burned-out and doubt their own efficacy.

Consciously and unconsciously, I think of these patient/clients as being "she," only because at this point in process, women have presented for treatment and pastoral care vastly more often than men.

I write because spiritual and supernatural experience seems to pervade the lives of those who dissociate. There are historic, psychodynamic and practical reasons for this. Persons--or at least dissociated parts of persons--often end up in spiritual practices that value supernatural experience or "feel" like past religious experience. This is true even if that experience was abusive. Dissociative persons are frequently spiritual nomads. They wander from one faith community to another in search of something they never seem to find. These persons reach out to People of God--as individuals and communities. As they do, I am beginning to see much confusion, some misadventure and frequently some casualties as a result.

Faith communities have an obligation to give sanctuary and practice hospitality, particularly “on behalf of the widow, the orphan and the sojourner,” who exemplify the alienated, vulnerable and humiliated in our midst. Survivors of severe, chronic, ritualized or sadistic abuse fall well within this profile. The marginalized have more often than not confronted and disrupted the comfort and sensibilities of the People of God. If for no other reason than our discomfort, we should recognize them as prophetic reincarnations of

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[19]”Secondary PTSD” and “Vicarious Victimization” has been well discussed in a variety of literature, but refers to the cognitive and affective changes noted in counselors working with trauma survivors. Counselors may experience symptoms not unlike those of the survivor, including numbing, avoidance patterns, intrusive thoughts and in some cases dissociative symptoms. See I.L. McCann and L.A. Perlman, “Vicarious Traumatization: A framework for understanding the psychological effects of working with victims,” *Journal of Traumatic Stress,* 3:191-149 (1990); J.D. Lindy, *Vietnam: A casebook,* (New York: Brunner/Mazel, 1988).

the risen Lord. Faith communities must do a better job in offering safe hospitality and sanctuary to persons who dissociate.

As a Christian priest, I respect the power of the evil that can fragment and destroy human life. But I also know that "the Light shines in the Darkness, and the Darkness cannot overcome it." I have chosen to stand with the Light.

SOME DISTINCTIONS IN APPROACH

I wish to describe two major orientations to the pastoral task that are operative in most regions of the United States. I do this, not to promote one over the other, but raise awareness for pastors of the need to assess the relative strengths and weakness of their own orientation.

Counseling refers to a non-medical function, the aims of which are to facilitate and quicken personality growth. Persons seeking counseling are usually suffering internal and interpersonal disruptions in their life. A counselor is someone who is not emotionally or socially involved in the counselee's relationship systems who can offer a degree of objectivity and privacy.

Broadly speaking, *pastoral* counseling and the *pastoral counseling movement* grew out of this country's fascination with psychology and its return to religious institutions, both in the period following World War II. The early work of the Association for Clinical Pastoral Education(ACPE)[20] has had the most significant influence on the pastoral counseling movement. Through its training programs, seminarians and pastors learn pastoral skills grounded in psychology and psychotherapeutic technique, and are required to relate those to their own theological foundation. The training makes much use of personal history and is carried out under intense supervision. Pastors operating out of this orientation generally use a fairly structured process to explore the relation of the counselee's God to the counselee's life issues. The counseling goal can either be support or insight oriented. Some names frequently associated with this movement are Hiltner,[21] Clinbell,[22] and Oates.[23] Professional

[20]1549 Clairmont Road, Suite 103, Decatur, GA 30033-4611.

[21]Steward Hiltner, *Pastoral Counseling,* (Nashville: Abington, 1947).

[22]Howard Clinbell, *Basic Types of Pastoral Counseling,* (Nashville: Abington, 1966).

[23]Wayne Oates, *Pastoral Counseling,* (Philadelphia: Westminister, 1974).

organizations associated with this orientation are Association for Clinical Pastoral Education(ACPE), American Association of Pastoral Counselors(AAPC), [24] College of Chaplains(COC)[25] and the Association of Mental Health Clergy(AMHC).[26] All of these provide some degree of certification and quality control of their membership. Academic activity associated with this movement is found in ACPE and AAPC training centers and most mainline denominational seminaries.[27] Two professional journals associated with this orientation are *The Journal of Pastoral Care* and *Pastoral Psychology.*

As a generalization, *Christian* counseling or *Biblical* counseling operates out of a more conservative and evangelical tradition that has remained largely separated from the pastoral counseling movement. Mainline Protestants and people involved in the pastoral counseling movement often bristle at the label "Christian" being applied broadly to what in effect is a largely conservative, North American religious sub-culture. On the other hand, Evangelicals have felt the pastoral counseling movement is too dependent on secular disciplines, naive as to an individual's ability to understand and correct his or her problems and has ignored the Word of God as the standard for behavior. Pastors from an evangelical orientation have preferred an approach more focused upon the effects of humanity's sinful nature, the availability of forgiveness and the final authority of Biblical teaching and the saving work of Jesus Christ. Strongly directive, obedience and salvation are frequently stated goals. Some names frequently associated with the orientation are Collins,[28] Adams[29] and Minirth.[30] There is relatively less certification and attempt at quality control for "Christian counselors."

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[24]9504a Lee Highway, Fairfax, VA 22031-2303.

[25]1701 East Woodfield Road, Suite 311, Schaumburg, IL 60173.

[26]12320 River Oaks Point., Knoxville, TN 37922.

[27]Organizations in the pastoral care movement also include caregivers of non-Christian faith traditions, particularly Judaism and Universalist.

[28]Gary Collins, *Christian Counseling: A comprehensive guide,* (Grand Rapids, MI: Baker, 1980).

[29]Jay E. Adams, *The Christian Counselor's Manual,* (Grand Rapids: Baker, 1973).

[30]Frank Minirth, *Christian Psychiatry,* (Grand Rapids, MI: Revell, 1977).

American Association of Christian Counselors[31] is the primary support organization. Professional journals associated with this orientation are *Journal of Psychology and Christianity* and *Journal of Psychology and Theology*. The academic centers are Rosemead Graduate School of Professional Psychology and Fuller Seminary. Minirth-Mieir clinics have been opened in several regions and "Christian Therapy" units are operated in some hospitals by an evangelical organization known as Rapha. Giving strong emphasis to the biblical doctrines "priesthood of all believers" and "bearing one another's burdens," there is increasing use of lay pastoral counseling ministries. The most widely know of these is Stephen Ministries which sponsors a two week training period, after which church members return to their congregations to practice their people-helping skills.

I simply note here that the orientation of a pastor will influence his or her worldview and pastoral identity in relationship to a patient with MPD/DID. The various nuances, and sometimes incompatibility in theology, will emerge throughout this work. Emerging also will be my own position that helping dissociative persons, families and mental health professionals raise and process their religious and spiritual issues is more important in the work of divine reconciliation than witnessing to a doctrinal position.

PSYCHIATRY AND RELIGION

Presely[32] has suggested that secular clinicians respond to patient/clients' religious concerns with avoidance, eradication or integration: Avoidance discourages or postpones processing these issues. Eradication violates patient's rights, as well as professional ethical codes.[33] Despite a sizable literature on the need for considering

[31]2421 West Pratt Avenue, Suite 1398, Chicago, IL 60645.

[32]D.B. Presely, "Three Approaches to Religious Issues in Counseling," *Journal of Psychology and Theology*, 20, 39-46, 1992, cited in Bowman and Amos, *ibid.*

[33]American Psychiatric Association, "Guidelines Regarding Possible Conflict Between Psychiatrist's religious Commitments and Psychiatric Practice," *American Journal of Psychiatry*, 147, p. 542, 1990. Also, American Psychological Association, "Ethical Principles of Psychologists and Code of Conduct," *American Psychologist*, 47(12), 1597-1611.

religious aspects, integration of the two disciplines is rare.[34] Bowman,[35] Bilich,[36] and Bergan[37] are examples of secular clinicians treating MPD/DID who advocate turning to clergy for collaboration in order for the therapist to maintain therapeutic neutrality.

When secular clinicians do wish to use religious ideation, they tend to do so from inside their own discipline on their own terms. For example, from the psychoanalytic literature, currently Rizzuto,[38] is widely used, as a study in God ideation and character development.

Some clinicians defensively attempt to separate spirituality and religion. There are others who discourage religious exploration as "relapse" activity. Unfortunately, this is not without foundation. Abusive personality and religiosity seem to go hand in hand. Pastors may remember Neufeld's research indicating positive correlation between attitudes of Protestant fundamentalist parents and known abusers.[39] These abusive attitudes are frequently reinforced by conservative, hierarchical theologies which stress judgment and control "from above."

The witness of persons who have been judged, shamed, exploited, abused or abandoned in the name of religion is quite real. Not too long ago, the Christian Church probably burned dissociative persons at the stake for being possessed by the devil or practicing affectively powerful witchcraft. There are modern counterparts to such reaction. But caring communities of faith *can* provide decisive support for persons in healing from dissociated trauma. Education for all involved makes this a safer, more humane enterprise.

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[34]*e.g.,* D.B. Larson, A.A. Hohmann, L.G. Kessler, K.G. Meador, J. H. Boyd and E. McSherry, "The Couch and the Cloth: The need for linkage," *Hospital and Community Psychiatry,* 39, 1064-1069, 1988.

[35]Bowman, *ibid.*

[36]Billich, *ibid.*

[37]A.E. Burgin, "Psychotherapy and Religious Values," *Journal of Clinical and Consulting Psychology,* 48, 95-105, 1980.

[38]Ana-Maria Rizzuto, *The Birth of the Living God: A psychoanalytic study,* Chicago: University of Chicago Press, 1979.

[39]Neufeld, *Religious Education 74:234-244 (1979),* currently cited by E. Bowman, "Religious Issues in the Therapy of Abuse Survivors," presented to the American Psychiatric Association Sesquicentennial Meeting, Philadelphia, PA, May 21-26, 1994.

There are secular clinicians who struggle with unresolved religious issues of their own. The patient's religious material tends to elicit either positive or negative counter-transference, often leaving therapists unable to address these issues without interjection of their own hostility or enthusiastic commitment.[40] These otherwise very competent clinicians are quickly de-skilled by talk of spiritual discipline, disembodied spirits, ritual practices, near death experience, Bible study, mystical knowledge and relationship with a personal God. Yet, this is the experiential reality of many of their patient/clients and must be processed. Dissociative persons and therapists deserve better than to have this reality defensively ignored. Awareness of a conceptual framework for pastoral care can empower therapists with either the tools to explore these issues with a patient, or the liminality with these issues to seek adjunctive consultation. Again, education makes for safe empathic alliance and a safer, more humane environment.

[40]Paul Pruyser, "Assessment of the Patient's Religious Attitude in the Psychiatric Case Study," *Bulletin of the Menninger Clinic,* 35, 272-291.

I bind unto myself today, the strong name of the Trinity;
By invocation of the same, the Three in One, and One in Three.
St. Patrick's Breastplate

Chapter 2
MULTIPLE PERSONALITY DISORDER
A pastoral and theological foundation

Some may wonder why it is important to establish a theology. After all theology in and of itself does not heal and often it can even hurt. Offering a hurting person a theological answer is like giving a starving person a cookbook. But theology is a way of thinking about God and reality. It is a way of organizing experience so that we might become more aware of God's knowledge, presence and acceptance of us. Family systems theorist Murry Bowen taught, "Structure binds anxiety." Theology is an act of survival, a way of structuring and naming the chaos, binding our anxiety so that we may continue our life. Naming was power in ancient theologies. To apply a name, or reveal one's name to another, was both a spiritual and political transaction.

A striking example of organizing chaos and binding anxiety has been the development of a cultural anthropology around Multiple Personality Disorder over the last 15 years. Almost establishing its own "religion," both core texts and popular books use words such as *alters, hosts, switching, children, triggers, safe places, inside, out, ritual abuse* and other terms in new and confusing ways. Rituals such as *abreaction, talking through, finger ideomoter signaling,* and *alter journaling* among others, have been developed. Applying these conceptual terms to the reality of dissociative persons and their therapists did not heal anyone. Like some theologies, it can even be argued that these constructs actually regressed many dissociative persons and made their healing more difficult. But being able to name what was happening to them in their heads and in their offices has helped dissociative persons and clinicians organize the chaos and bind anxiety so that life could go on.

For pastors, I suggest that the ability to think theologically about a problem organizes chaos and binds anxiety. In the next two

chapters, I will give a basic presentation of the dissociative process involved in MPD/DID and begin the application of some theological concepts of my own. I want to be clear that this is *my* theology. I offer it only as an example of *one* way to reflect theologically about a slice of reality. It helps me bind my anxiety. Readers are invited to develop their own.

MULTIPLE PERSONALITY DISORDER

DSM-R-III-R lists MPD as an affective disorder, specifying two criteria:

> A. The existence within the individual of two or more distinct personalities or states (each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and one's self).
>
> B. Each of these personality states at some time, and recurrently, takes full control of the individual's behavior.[41]

An earlier, more textured definition comes from Ludwig:

> the presence of one or more alter personalities, each presumably possessing differing sets of values and behaviors from one another and from the "primary" personality, and each claiming varying degrees of amnesia or disinterest for one another. The appearance of these alter personalities may be on a "co-conscious" basis (i.e., simultaneously coexistent with primary personality and aware of its thoughts and feelings) or separate consciousness basis (i.e., alternating presence of the primary and alter personalities with little or no awareness or concern for the feelings and thoughts of each other), or both.[42]

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[41]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders(Third Edition- Revised)*, 300.14, Washington, DC, 1987.

[42]A.M. Ludwig, J.M. Brandsma, C.B. Wilbur, F. Bendfelt, F., H. Jameson, "The Objective Study of Multiple Personality, *Archives of General Psychiatry, 26,* 298-310, 1972.

From one of the better introductory texts in the field:

> MPD appears to be a psychobiological response to a relatively specific set of experiences... Although there are competing theories of the genesis of MPD, the most compelling and clinically useful model is based on evidence that repeated childhood trauma enhances normative dissociative capacities, which in turn provide the basis for the creation and elaboration of alter personality states over time.[43]

From a self-help manual, written by a survivor of childhood abuse and self described multiple personality:

> Well, imagine a bus, with the "host" or main personality as the bus itself. Inside the bus, passengers are sleeping, reading, playing, or looking out different windows. Sometimes a passenger will climb into the driver's seat to direct where the bus goes and what it does, often without the bus's knowledge or consent.[44]

NAME CHANGE: DISSOCIATIVE IDENTITY DISORDER

As this is being written, the American Psychiatric Association has approved the new *DSM-IV*, the revised edition of definitions and guidelines for treating psychiatric disorders in the United States. This revision has renamed the disorder Dissociative Identity Disorder(DID). Those supporting the change submit DID, as a label, is less flamboyant, less susceptible to media sensationalism and exploitation and thus might be easier for patients to accept. Additionally, DID more accurately reflects the dissociated memory process, rather than implying the "existence of several people" in one body. DID might lead to more accurate diagnosis, phenomenological

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[43]Putman, *ibid*, 45.

[44]Sandra J. Hocking and Company, *Living with Yourselves: A survival manual for people with multiple personalities*, (Rockville, MD: Launch Press, 1992), p. 1.

conceptualization and research with individuals with severe childhood onset dissociative post-traumatic conditions.[45]

TREATMENT AND INTERVENTIONS

Because few therapists knowingly treated this disorder before the 1980's, anecdotal and undocumented clinical reports generally have served as guidelines for treatment. Generally speaking, an eclectic approach, borrowing from psychodynamic, cognitive and family systems therapies may form the core of the treatment plan. This is augmented by pharmacological support and adjunctive therapeutic interventions from the disciplines of social work, art, child life, occupational therapy, education and pastoral counseling, among others.

The goal of treatment is to retrieve and integrate memories and emotions that have been repressed and remove the amnesic barriers that separate them. In some measure this means creating an inner-environment where these memories, emotions, and the functional styles used to cope with them, can co-exist. Core texts speak of abreactive techniques for therapeutic re-experiencing of trauma. Autobiographical works speak in continuums of fusion, integration, coexistence, awareness and management of internal systems.

Wide reading and multi-disciplinary contact are absolutely essential for any one seeking understanding of this complex phenomenon. Knowledge of the core texts is mandatory. Ongoing reading of current research is helpful as new information is emerging monthly.

While many texts suggest there is no reason that a competent pastoral counselor cannot successfully provide primary or consulting therapy for multiple personality,[46] there are some special challenges.[47]

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[45]Discussion for and against the name change can be found in *ISSMP&D NEWS,* 11:4, 1993. Draft recommendations for *DSM-IV* can be found in *ISSMP&D NEWS,* 11:5, 1993.

[46]see Ross, *ibid,* introduction to chapter 11, p214 for a helpful discussion.

[47]Most core texts speak of the transference/counter-transference problems peculiar to MPD therapy. In addition, a helpful work is James A. Chu, “Ten Traps for Therapists in the Treatment of Trauma Survivors," *Dissociation,* I.4, 1988; a good general work on its title subject is Harriet Goldhor Lerner, *Women in Therapy,* New York, NY: Jason Aronson, 1988.

The unique character structure of MPD/DID patients can easily overload those of us who are less adaptive with barrages of relational roles and constant testing of boundaries. My presumption is that professionally responsible care and treatment of these patients requires the presence of an inter-disciplinary team. While I do not recommend solo work for pastors in MPD/DID, at the very least, clinical practice requires familiarity with basic, available information, as well as appropriate and knowledgeable supervision.

Clinical chaplains and pastoral counselors can offer a unique perspective and resource on spiritual issues effecting MPD/DID patients, their families, therapists and treatment teams. Often pastoral support for the interdisciplinary treatment team is critical.[48] This is particularly true in the treatment of MPD/DID where professional skepticism, debate and isolation contribute to self-doubt, burnout and impair therapeutic interaction.[49] The religious issues of individual professionals are easily evoked, particularly in cases of reported demon possession, cultic ritual abuse and clergy sexual abuse.

Guilt, fear, moral agency, demon possession, "damnation," good and evil, religious "triggers,"[50] sexual ethics, justice, suicide, truth, validity of memory, trust and the basic safety of being in relationship with life are recurrent themes these patients and their helpers bring to pastoral professionals. Awareness of the issues, as well as our limitations from within the human condition, can help professionals position ourselves for appropriate, non-anxious pastoral care.

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[48]E.S. Bowman and W.E. Amos, *ibid,* p. 50; H.W. Whitaker, "Response to the Critical Issues Committee" (Letters to the Editor) *ISSMP&D News,* 11.5, 1993; see also J.H. Florell, "Inter-professional Teams and Relationships," *Dictionary of Pastoral Care and Counseling,* 593, Nashville, TN: Abington, 1990.

[49]P.F. Dell, "Professional Skepticism about Multiple Personality," *Journal of Nervous and Mental Disease. 176,* 528-531; E.G. Attwood, "The Impact of *Sybil* on a Patient with Multiple Personality Disorder," *American Journal of Psychoanalysis, 38,* 277-279, 1978; O. French, and P. Chodoff, "More on Multiple Personality Disorder (letter). *American Journal of Psychiatry, 144,* 123-125, 1987; R.P Kluft, "The Prevalence of Multiple Personality Disorder" (Letter to the Editor), *American Journal of Psychiatry, 143,* 802-803, 1986; P.S. Ludolph, "How Prevalent is Multiple Personality?" and reply of E.L. Bliss (Letters to the Editor), *American Journal of Psychiatry, 142,* 1526-1527.

[50]*Defined: emotional, even dissociative reactions to external stimuli,* e.g., *sight a hooded vestment or smell of candles causing recall of ritual context of abuse.*

THE VALIDITY OF REPORTS

Beginning with its prologue, the *Gospel According to John* seems terribly concerned with witnessing to the truth. Yet as it winds its way into the passion narrative, John's characters seem more confused than illuminated by Jesus' revelation of truth. When Jesus is brought before Pilate, he again explains reality and truth as seen from the sacred mind. An exasperated Pilate protests, "Truth!...what is that?"

It is a question that haunts patients, families, friends and clinicians. The memories are there. They are like a dream. They are more real than life. The very body "remembers" them, replete with smell, sound, taste and touch. Yet there is frequently no physical evidence; little, if any, corroboration; and much denial on the part of family members and others accused. "Do you believe me?" is an inescapable question asked by survivors of abuse. What is truth?

At issue is: can recovered memory by adults of childhood abuse be taken as fact. As if the rich psychodynamic mix of childhood, parental image, sex, violence, good and evil, life and death were not enough, more banal influences must be considered, including: clinician bias for advocacy, rescue operations or victimization; private and institutional greed in the marketing and availability of a treatment protocol; and secondary gain--such as attention seeking or avoidance of responsibility--on the part of a complainant. Considering adult memory reconstruction in MPD literature, one commentator concludes:

> Reconstruction is a dynamic process, and situations and events are frequently not what they appear to be nor as they are reported. The literature reviewed (in the article) points to the potential influence of unwitting motives such as guilt, rage, and competitiveness, as well as what might best be described as contagion in the circumstances of inquiry. Clinical improvement following painful abreaction does not necessarily affirm the accuracy of the described events...

> Uncertainty on the part of the therapist and the patient, however burdensome, is often the only honest option.[51]

The draft text for the *DSM-IV* recommends:

> Patient's recall of child abuse experiences, as well as their recall of other experiences, may mix literal truth with fantasy. The therapy does not benefit when the therapist tells the patient that his or her memories are false. Neither does therapy benefit when the therapist tells the patient that his or her memories are the literal truth. A respectful neutral stance on the therapist part, combined with great care to avoid suggestive and leading interview techniques, seems to allow patients the greatest freedom to evaluate the veracity of their own memories.[52]

As the human drama of confrontation with abusers-- frequently accompanied by legal action-- is played out, survivors begin to wonder whether or not what they have reported is empirically true. Parents, educators, even religious communities and their leaders have been accused of horrendous crimes. The vast majority of these reports cannot be corroborated. At the same time, we can be sure that many of these stories are *literally* true: Incredible abuses are inflicted upon children. Others may be psychic truth: metaphor for actual abuse.

At best, we have to admit that the memory is not an operation of machinations like a tape recorder or video cam-corder. Memory is largely impressionistic. Yet memory is *sacred.* Memory is what makes us capable of reflection and gives us the ability to make choice for change. It is a divine gift meant to connect us to people and places that give us identify. Elie Wiesel reminds us that memory is meant to create bonds rather than destroy them. Memory is what connects our past to our future, our ancestors to our children. "To remember is to ...convey meaning on our fleeting endeavors. The aim of memory is to restore its dignity to justice."[53]

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[51]Fred H. Frankel, "Adult Reconstruction of Childhood events in the Multiple Personality Literature," *American Journal of Psychiatry,* 150:954-958, 1993.

[52]"Draft of 'Recommendations for Treating Dissociative Identity Disorder,'" *ISSMP&D News,* 11.5, 1993.

[53]Elie Wiesel, *From the Kingdom of Memory,* (New York: Summit, 1990) p. 194.

A central concern relative to validity of recovered memory is how a therapy may be contaminated by iatrogeneic[54] interview techniques. This may be best analogized by pastoral theologians and counselors as eisogesis-- (*ant.* exegesis) the reading into a biblical text the meaning which one wishes to get out of it. As living human documents, MPD/DID patient/clients are vulnerable to eisogetic suggestion. Persons diagnosed with dissociative disorders are considered hypersensitive, imaginative, extremely creative, of above average intelligence and highly suggestible.

At this writing, the discussion could not be considered complete without mentioning groups that question the validity of dissociated memory and particularly raise issues of ethical and forensic concern. Among the most vocal of these groups is the False Memory Syndrome Foundation.[55] This is a relatively new organization, founded by distressed families who feel they have been falsely accused, and the professionals who work with them. Much of the commitment around this organization seems to be personal rather than professional.[56] FMSF questions the whole phenomena of "repressed memory," suggesting that such memory only emerges during suggestive therapeutic program, typically produces decreased coping abilities on the part of the patient and continuing dependency on the very program that evoked the "memories." This group also points to the devastation loosed on families who may themselves become the "the victims" if memories of incest, sexual abuse and involvement in satanic rituals are false. FMSF provides reference and access to research, resources and support that is rarely mentioned by most writers in the field of dissociation.

At the same time, the tone of FMSF material is shrill, derisive and emotional-- for example, likening memories of sexual abuse and

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[54]*Defined: Iatrogenic induction refers to the exacerbation of the dissociative process by acknowledging and working directly with the alter personalities of a patient.*

[55]3401 Market Street, Suite 130, Philadelphia, PA, 19104. Publishes newsletter, distributes articles and books, and promotes scientific research and legal support for "secondary victims (those falsely accused)."

[56]FMSF's executive director has revealed that their daughter, herself a professor of psychology at the University of Oregon, accused her father of having molested her as a child. ["Personal perspectives on the delayed memory debate," *Family Violence and Sexual Assault Bulletin,* 9.3(1993).]

SRA[57] to UFO reports. Despite a flair for drama and sarcasm, FMSF has shown little interest in its own academic research and suffers from poor public relations.[58] Perhaps the next few years will see FMSF settle into a less adversarial, more studied position that will provide much needed balance in the debate about memory.

Two credible names that do show up in the solid literature associated with skepticism of recovered memory are Ganaway[59] of the Ridgeview Center for Dissociative Disorders and McHugh[60] of Johns Hopkins University School of Medicine. Ganaway suggests a number of alternative explanations for what might be happening when clinicians hear a patient "retrieve memories." One is that these accounts are essentially "screen memories" for other events whose content is derived from culture and media induced fantasy. The purpose would be either to creatively enhance or defensively block more prosaic memories from the therapeutic process.[61]

RECORDING RELIGIOUS HISTORY

The drawing of a comparison with the literary criticism of holy scripture may be helpful. The record of biblical narrative is the Christian community's tool for "remembering." Pastoral theologians may recognize the distinctions between narrative accounts (Ger.: *Geschichte*) and historical accounts (Ger.: *Historie*) in biblical criticism. The former is history-as-significance, the latter, history-as-

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[57]*Defined: Satanic Ritual Abuse. A full discussion appears in Chapter 7.*

[58]*e.g.,* A prominent board FMSF board member resigned in 1993 after giving an interview to a Dutch journal of pedophilia in which he described sex with children as a "reasonable choice for the individual." (Stephen Fried, "War of Remembrance," *Philadelphia,* Jan 1994, pp.66ff; J. Geraci, "Interview: Hollida Wakefield and Ralph Underwager," *Paidika: A Journal of Pedophilia,* 3.3 (1993).

[59]See George K. Ganaway, "Alternative hypotheses regarding satanic ritual abuse memories," paper presented at the 99th Annual Convention of the American Psychiatric Association, San Francisco, CA, August 19, 1992.

[60]See Paul McHugh, "Multiple personality disorder,' *Harvard Mental Health Letter,* September, 1993.

[61]G.K. Ganaway, *ibid;* see also Ganaway, "Historical versus narrative truth: Clarifying the role of exogenous trauma in the etiology of MPD and its variants, *Dissociation,* 2.4, 205-220.

fact.[62] While neither is more accurate than the other, narrative is more enduring and a better vehicle for instilling identity. Legends, sagas and myths are not the opposite of truth. Because they transmit the emotionality of an event and record how participants were changed as a result, such stories are truer than fact. These stories carry the interpretation that gives meaning, purpose and identity to God's people.

Further parallel can be drawn from the various literary strands that comprise the Judeo-Christian record. The worldviews of the J(Yahwist), E(Elohist), P(priestly code) and D(Deuteronomist) are all woven together in the Pentateuch.[63] Deuterographs-- repetitive material presented in a different perspective-- exposed in *1* & *2 Chronicles* and *1 Samuel-2 Kings;* sections of *Deuteronomy* and *Exodus-Numbers, etc.,* are all included in the canon of scripture. Form criticism of scripture recognizes that different presentations of material-- sagas, hymns, curses, laments, wisdom, poetry, law-- all serve different functions in preserving the identity of a People-- and must be considered as a whole.

History is not only mediated by the way it is recorded, but by the way it is interpreted. John Cassin, drawing upon the writings of Origen, Gregory of Nazianzus, Jerome and other early Fathers, developed a hermenuetical theory that sought to classify scripture by its "sense." His fourfold senses of scripture were literal (historical), allegorical (mystical), anagogical (eschatological) and tropological (moral). Modern scholars have subdivided and multiplied these categories. For example, distinctions are now made between allegory, typology, parable and midrash. The point being, that at many times and places in history, people have interpreted and reinterpreted their religious traditions. The purpose is always to create a harmonious co-inherence of the ancient stories to our own religious experience.

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[62]*eg.,* That Jesus was a man who lived in the 1st Century, taught as a Rabbi, and was executed, is an objective statement of historical fact. That he was the Son of God, cannot be so verified, but is an interpretive statement about the significance of other's experience of him as a person. This permits the assertion of the Resurrection, miracles, etc. which are true in terms of being significant for a people, which may not be true in the sense of history as fact. English approximates the German usage in the adjectives *Historic* and *Historical.* See Van Harvey, *The Historian and the Believer,* New York: the Macmillan Company, 1966.

[63]See Martin North, *A History of Pentateuchal Traditions* (Englewood Cliffs, NJ: Prentice Hall, 1971), chapter 4 and *Translator's Supplement.*

In the New Testament, three of the four gospel accounts of Jesus' ministry are considered "synoptic." They give collateral but variant perspectives on many of the same events, while other events may be remembered dramatically differently or only mentioned in one or two accounts. Why do Paul's Letters to the early churches stand at such variance to the account of his ministry in Acts? Does the paranormal experience in John 21 depict the same event described in Acts 2? The variety of these accounts is witness to the variety of perception and interpretation inherent in oral history. Some accounts were never "validated" for the canon of scripture. The Christian church probably would make very different decisions today about the validity of these accounts in light of modern biblical criticism.

The point to be made is that all these different aspects, fragments, points of view and styles of remembering our past must be read together, in conversation with each other; supporting, critiquing and informing each other; in order to understand the truth of who a People are and what their relationship is to God.

Dissociative persons and those who work with them may recognize an appropriate analogy. If we can hear patient narratives of abuse for the purpose of discovering how those narratives effect their spiritual life; if we can listen and help reflect on how the stories fit into tradition and experience; then we can resist the temptation to be drawn into forensic exploration of whether and how something really happened.

Then God said, "Let us make humans in our image,
according to our likeness.
Genesis 1:26

Chapter 3
FURTHER THEOLOGICAL FOUNDATION
A fragmented and dissociated existence

The disjointed, fragmented experience of life for persons with multiple personality is well attested in all basic texts. Self-descriptions of the pain, frustration and confusion inherent in multiplicity is eloquently presented in a collection of writings entitled *Multiplicity from the Inside Out.*[64] On the editorial page of *Dissociation,* Kluft frequently normalizes for clinical practitioners this erratic and mercurial existence.[65] In response to environmental stimuli, changing demands, or unexpected stress, one alter personality may go to work; another fix supper and do housework; another attend a therapy session; another go to a bar and come home with a date; and yet another wake-up the morning after with a hangover and a partner they have never met. With amnesic barriers separating these fragmented aspects of self, "Healing from MPD is like putting a puzzle together without seeing the picture on the box."[66]

DISSOCIATION AS RESPONSE TO FRAGMENTED EXPERIENCE

Hypocrisy seems to be a familiar theme in the narratives of my patient/clients. As a people, it seems we do not turn out to be who we say we are. We do not do what we say we believe. It does not help

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[64]Barry M. Cohen, Esther Giller and Lynn W, ed., Lutherville, MD: Sidran Press, 1991.

[65]*e.g., R.P.* Kluft, "The Darker Side of Dissociation," *Dissociation, III.3.,* 125, 1990, *ibid,*

[66]Annie R., from the preface of *Multiple Personality from the Inside Out*, p. vii, *ibid.*

that we live in a dissociated and duplicitous culture. Our national lore speaks of freedom, opportunity and possibility. The reality, particularly for clients on disability and on the lower end of the social and cultural chain, is not consistent with the dream. We watch television sit-coms portray reasonably functional families that bear only slight resemblance to any we know. These shows are sponsored by advertisers whom we know tell us half-truths. Our culture reinforces the values of keeping secrets within our families and within ourselves, of conformity rather than individuality, of social pleasantries rather than honesty. We live with the functional myth that the world is a safe, Norman Rockwell kind of place; even though the evening news tells us otherwise.

Traditional religious institutions are of little help. We spout civic and religious pieties, dogmas and creeds that frequently only remind us of what we want to believe and wish were true. The notion of *credo*--literally: "I set my heart toward"--speaks more to longing than to fact. In the New Testament, John of the Pastoral Epistles is forever exhorting the community to the way it *should* live in sweet coexistence: "Little children, love one another... there is no fear in love, for perfect love casts out fear...God is love."(Chapter 4)

Those of us who actually are committed to living in Christian communities have found the task considerably more complex. As we learn to grow and perhaps to love ourselves and others in our humanity, there is a cost: We must learn to be aware--to stay associated--with the darker side of our own and others' humanity. Those who make the commitment to therapy or spiritual direction become aware of this shadow reality. The contextual reality in which we learn to love *does* contain terrible fear, and anger to the point of rage. There is confusion and chaos as we work and re-work our worldview and sense of reality. There is violence and pain as we are continually torn apart and made anew over and over again. Why aren't we all crazy with anger, fear, exhaustion and confusion?

JUNG'S READING OF JOHN THE ELDER

Some of us are. In his *Answer to Job,* Carl Jung used a comparison of the biblical *Epistle of John* and the *Revelation,* assuming the same author for both works. First we have a youthful John, extolling a seeming state of perfect love and communion with a God in whom "is no darkness at all."(1 John 1:5) This John seems

self-righteous and arrogant, the gloating leader who can make us feel guilt and longing at the same time. Jung was not impressed. He though this John to be at best naive, and probably a repressed, dissociated tinderbox of rage ready to blow... perfect love indeed! Jung presents his argument based on *Revelation* with the now elder John's vision of holy warriors and the "wrathful lamb" exacting bloody retribution, hateful vengeance and deadly judgment. This once peaceful and devout person is now ready to "throw that woman Jezebel on a sick bed and strike her children dead." This person with an intense relationship with God, in brutal in-breaking of revelation now engages in endless blood-thirsty fantasy. The Son of Man appears holding a sickle and the ignorant are herded into the wine press of God upon which Christ treads with his robe "dipped in blood." As the "Whore of Babylon" is eaten by wild beasts and thrown into the fire, the John who once sweetly preached "one cannot love God and hate neighbor," is now a half-crazed, apocalyptic prophet who cries, "Rejoice over her...for God has avenged you on her!"

How can one be so filled with love as the writer of the Epistle, be so filled with malice in the reporting of *Revelation*? Jung postulates that John made every effort to practice what he preached to those to whom the Epistle is addressed. It was in doing so that he so repressed all negative feelings, emotional injury and disappointment. The repressed and dissociated cauldron bubbled and brewed until it burst forth upon him in Revelation. His Christ image, strangled by unconscious negative feeling, turned unto a savage avenger. Such may be the price for the religiously committed person who is open to unusual extensions of consciousness.

The moral of the story for Jung: As a totality, the self is, by definition, always a *complexio oppositorum.*[67] As creations of the holy, our *complexio oppositorum* is a mirror image of God. It is the willful dissociation and malicious ignorance of God's, our own, and others' character complexity that posses the real evil.

THE COMPLEXITY AND MULTIPLICITY OF GOD

Jung continued to define the parameters of God and humanity as created *complexio oppositorum* through his study of the book of

[67]*e.g.*, Conscious v. Unconscious, thinking v. feeling, introvert v. extrovert, light v. dark, good v. evil, masculine v. feminine.

Job. As we know, Job is a righteous person who becomes the object of sport between God and the satan. As he struggles with affliction abandonment and pain, Job becomes convinced that God is the author of his unjust suffering: "Though I wash myself with snow water...yet thou shalt plunge me in the mire."(9.30ff). Jung's first thesis is that Job comes to believe that he can see the ambiguity, an *antinomy*-- a totality of inner opposites-- at work in his creator. The composition of opposites is, psychologically, the seat of Yahweh's great power, dynamism, omniscience and omnipotence. Job has found out a great and powerful secret.

Like Dorothy and company peering behind the curtain at the Wizard of Oz, Job's glimpse of God radically changes the balance of power. "Without Yahweh's knowledge-- and contrary to Yahweh's intentions--the tormented though guiltless Job had secretly been lifted up to a superior knowledge of the Divine which (even) Yahweh himself did not posses."[68] Yahweh had always--though unconscious to motive-- guarded against self-disclosure and the curious exploration of creatures by forbidding objective inquiry and the making of images. But Job's demands for an explanation of his suffering had created the very obstacle that now forced Yahweh to reveal his true nature.

To be unaware of one's true nature is to be controlled by a force unknown, one's shadow. But since the relationship between God and human community was as yet developmentally immature, God was not yet conscious of the dissociated emotional complexity of his own divine motivations. Yahweh did not know enough to consult his own omniscience.[69]

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[68]C.C. Jung, *Answer to Job,* p. 66.

[69]As an aside, Jung knew firsthand something of good and evil being part of the same entity. While evidence is conflicting as to whether he was really working for the Swiss secret service, he did in fact, edit the journal of the official Nazi backed psychological organization. In this journal, Freudian theory was dismissed as "a Jewish phenomenon" and not applicable to "Aryan Mentality." While some biographers argue that he was trying to keep his position open in Germany to help Jewish psychiatry, others suggest his own "shadow" prevented him from admitting he was wrong in many of the things he said or wrote during this period. (See Aniela Jaffe, *From the Life and Times of C.G. Jung.*) Jung himself might have said he was unconscious to his complex motivations for doing what he did. This is the same argument he makes for God.

There are any number of Jungian texts written for the pastoral care market. Morton T. Kelsey, *Christo-psychology,* ((New York: Crossroads, 1988) is a good introduction. Gretchen Sliker, *Multiple mind; healing the split in psyche and world,*

That part for which Jung's God lacked insight--the divine backside--was that aspect that is jealous, suspicious and often violent. Jung identifies this aspect of God with the satan and goes to great lengths to portray how this doubting thought manifests itself in the doubting, accusing parts of God's character. Job sensed this could be the only explanation for what Yahweh had done to him. And it was to this that he called Yahweh's attention. The multiplicity of Yahweh's nature had been exposed.

Yahweh's response. It is this turn of events, the true nature of God in *complexio oppositorum* having been exposed, that causes Yahweh to suddenly break off the cruel game in which Yahweh is engaged with Job, and make a blustering, defensive appearance in Chapter 38. In so doing, he also affirms Job's assessment of the divine character: "Job has spoken of me rightly."(42:7-8)

Although not aware himself of process theology, Jung felt, "whoever knows God has an effect of him."[70] The confrontation with Job changes Yahweh's nature by meeting the holy need to engage in self-judgment for the injustice committed against Job. This comes by way of yet another hereunto dissociated aspect of God, Divine Sophia.

According to Jung, Yahweh became so fascinated with his omnipotence in creation that he had dissociated from Wisdom altogether. Without Wisdom, without the ability to look into the Divine omniscience, Yahweh falls for any insinuation by the suspicious aspect, the satan. Jung positions Job as a figure touched by the pre-existent Sophia to complete an anamnesis of dissociated Wisdom. This is a *déjà vu* experience for Yahweh.

Confronted by a human creature who will not back down, Yahweh remembers a pre-existent knowledge. It is now Yahweh who has to wrestle. It is now Yahweh who has to suffer. The previously dissociated Sophia realizes God's thoughts by clothing them in material form... and God becomes flesh.

(Boston: Shambhala, 1992) offers a Jungian critique to fusion goals of traditional MPD protocols. Jung's own *Memories, dreams and reflections*, (New York: Random House, 1962) is classic spiritual auto-biography.

[70]*Answer*, p. 29.

GOD AS A MULTIPLE PERSONALITY

The idea that God is multi-dimensional and affectively complex is certainly not new to God's People. Muslims have one hundred names for God; Hindus recite one thousand. The point is not accuracy, but rather the complexity of the character of God.

While the Doctrine of the Trinity[71] has been used, of late, in conversation with multiple personality,[72] biblical exegesis and doctrinal history would suggest that multiple, affective images of God pervade scripture and tradition. Varied metaphor and simile is certainly accessible in the Psalter: righteous judge*(7:12);* governor*(8:1);* shepherd*(23:1);* friend*(25:13);* light*(27:1);* shield*(28:8, 84:10);* safe place*(28:10);* castle*(31:3);* king*(47:7);* helper*(54:4);* great bird*(57;1, 61:4);* stronghold*(59:19);* strong tower against an enemy*(61:3);* crag*(71:3);* sun*(84:10);* father*(89:26);* protecting bird*(91:4);* rock*(95:1);* song*(118:14);* lantern*(119:105).* Is it any wonder that *Psalms* is frequently the favored scripture of those in distress?

Divine feminine images abound in scripture: e.g., *Proverbs 3:13-20; Isaiah 42:14, 49:15, 66:13; Matthew 23:37; Luke 15:8-10.* God as Divine Wisdom, *Hagia Sophia,* is frequently spoken of in Hebrew scripture, usually prophetic in tone: "Wisdom cries aloud in the streets; in the markets she raises her voice... how long, O simple ones, will you love being simple? How long will scoffers delight in their scoffing and fools hate knowledge?" (*Proverbs 1:20-22)* "For Wisdom opened the mouths of the mute, and gave speech to a new born people."*(Wisdom 10:21);* see also passages like *Wisdom 10:15-19; Ecclesiasticus 51:13-22*). Dame Wisdom's behavior

> runs directly counter to the socialization expected of a proper lady, who is taught to be rarely seen and even more rarely heard in the sphere of public activity.

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[71]By *Trinity,* I mean not only the traditional formula of "Father, Son and Holy Spirit," but modern attempts to capture the mystery such as 'Creator, Redeemer and Sanctifier"; "Word, Presence and Power"; etc.

[72]Elizabeth Power, *Managing Ourselves: God in our Midst,* Brentwood, TN: E. Power & Associates, 1992. This is an excellent workbook for Christian persons with multiple personality, developed by the MPD/DD Resource and Education Center; PO Box 2346, Brentwood, TN 37024-2346.

> Assertive, insistent, and noisy: according to modern definition, Wisdom is a woman but no lady![73]

God is recognized as *Spirit* thought the Old Testament: *e.g., Genesis 1:1-2; Exodus 31:3; 35:31; Numbers 11:17-29; 1 Samuel 16:13-23; Psalms 51:10-11; Isaiah 11:2, 48:16; Job 33:4* ; and as *Word, breath, Lord,* as well as appearances as *Angel of the Lord, fire, wind,* etc.

More to the point, God in the plural form is referred to frequently, even when the intent is to assert the Unity of God, as in the *Shema:* "Hear O Israel, the Lord is our God"-- literally "our Gods," *Elohenu (Deuteronomy 6:4).* "Remember your Creator in the days of your youth" *(Ecclesiastes 12:1)* is literally "remember your Creators"-- *Eth-Bor'eka.* The first chapter of *Genesis* uses the first person noun for God in the plural form: *e.g.,* "God said, 'Let us make humanity in our image and likeness.'"*(1:26).* The same form occurs, though linked with a singular verb in *1:1-2.*

This discussion could continue. But it should simply be noted that even the early record of Israel's changing circumstances, relationship and experience of God reflects some confusion about the form and affect of divine presence. It should then not surprise us to find some of the same character complexities within those created in God's image. Commenting on humanity's over-extension, an exasperated Creator laments, "Behold, they have become like one of *us...* "*(Gen. 3:22)* Survivors need to remember that they are holy and sacred creations of God. They and God are of the same complex, multi-dimensional stuff.

DISSOCIATION AS HOLY GIFT AND SACRED IMAGE

Experience of dissociation and indwelling spirits was apparently taken for granted by Hebrew prophets such as Jeremiah and Ezekiel. Jesus of Nazareth raised some suspicion about his ability to stay focused in one persona. The Pharisees charged that Jesus was possessed by a devil. The defense offered in the gospels is *not* that he was not possessed, but that he was possessed by the Spirit of God. *(Mark 3:22-30).* His relatives though he was "beside himself" *(Mark*

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[73]Virginia Ramey Mollenkott, *The Divine Feminine: The Biblical Imagery of God as Female,* New York: Crossroad, 1993.

3:20-27, KJV, RSV), which incidentally was the same observation Festus makes of his old friend Paul.*(Acts 26:24, KJV)*

Dissociation was valued as a spiritual gift within the early Christian tradition. Paul speaks of spiritual gifts, including wisdom, knowledge, distinguishing between spirits, speaking and interpretation of tongues. *(1 Corinthians 7:7-11)* The mystics dissociated during prayer, some with outer body experiences. They were valued and protected by their communities. Power points out one would to be somewhat dissociative to experience such phenomena.[74]

We are all created with the sacred ability to dissociate-- to effectively disconnect memory from an event. Dissociation exists on a continuum of severity. Forgetting where we put our car keys, watching television or "losing one's self" in a book, classical forms of prayer and meditation, "losing time" while driving down the interstate, all speak of the benign ability to dissociate ourselves from our immediate surroundings. At the other end of the continuum is the chaotic dissociation experienced by persons with severe MPD/DID.

The extreme and pronounced use of dissociation allows a traumatized child, faced with an otherwise hopeless situation, to "go away" in their head. By this process, a child dissociates from thoughts, memories of sensation and emotion, and perceptions of incredible abuse, while going about the minimal, but important, work of staying alive and growing up with as little developmental damage as possible. As the brain processes information and directs tasks, the gift of dissociation allows the child to stay focused on the task at hand, which is to survive. The traumatic memories of abuse stay stored behind amnesic barriers, carried by alters whose only function is truly that of suffering servant.[75] The core of who the child is as a person--*theologically, the soul*--has been protected from destruction.

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[74]*Ibid*, p. 26.

[75]See the prophesy of the suffering servant from Isaiah 53. The prophecies from "third" Isaiah contain powerful language of vindication, deliverance and ingathering. The servant was seen as a corporate personality, an individual who represents all the features of Israel's election and mission. Gender correction and use of scripture will be discussed later; but this could be important reading to do *together* with a patient.

BOTH BLESSING AND CURSE

However, it is important not to over-romanticize dissociation. Clinically, it is labeled as pathology because of its negative and powerfully disruptive effects on the lives of persons who have little conscious control over its use. As with other holy gifts, dissociation becomes both blessing and curse. Dissociation becomes reinforced and conditioned as a coping mechanism. Because it is such an effective tool, children may automatically use it whenever they feel threatened, even if the anxiety-producing situation is not abusive. The ability to live without the total awareness of pain can become the inability to deal with unpleasantness. After a period, these dissociated mental states take on identities and functions. By the time a child reaches adulthood, conscious awareness of reality can be severely fragmented. Although described as "alters," "parts," "identities," etc., they are all aspects of the one person.

As alternate "personalities" can be created to store abuse and stay safe, so can they be evoked to live a life of victimization and act out behavior that is unsafe. Instead of existing in service to an innocent child, alter personalities seem to take on lives of their own. A host personality[76] walks into her kitchen and finds the remains of a teenager's party. She walks into her bedroom to find clothes in her closet from a buying spree of which she has no memory. There is a gun in her glove compartment purchased in her name; she hates guns. Her children telephone from store and ask why she drove off and left them at the checkout counter. Spouses and lovers are confused as to with whom they are in relationship. "Forgetting to mail a check" takes on new meaning.

Empirically, there are not really two dozen "people" living in the body of one; but, emotionally, dissociative persons may speak of feeling "possessed"... of "someone else being in control." Incarnation takes on new meaning. That holy gift which once saved a life, now seems to work continuously to undo it. For a survivor who dissociates and juggles multiple identities, life is definitely out of control.

Persons come to pastors for spiritual direction-- help in how to make themselves more vulnerable to and aware of the presence of God. But who is this God? How does one have a relationship with

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[76] *Defined: The alter who "has executive control of the body the greatest percentage of time during a given time."* (Kluft, cited in Putnam, ibid, p. 107)

God when their reality is always changing? Who or what can God be for them? Where has God been?

THE PROCESS GOD: REALITY AS PROCESS

In working with people who are living with multiple and dissociated reality, I have found God to be most clearly revealed as relational, affective and in constant process. Israel's God is a multiple personality. With them, God can be present as One with extreme affect and multiple presentation. Process theology works out of the metaphysical philosophy of Alfred North Whitehead.[77] Whitehead, himself a research physician, drew religious existential analogy from the systemic relatedness, perpetual change and evolutionary development of the human organism. Existence is not made up of static substance and permanent categories, but rather a string of occasions in a field. Ultimate reality is the temporal process of creative change.

For persons living with multiple and dissociated identities, reality is neither static or permanently organized. Existence *is* a string of occasions in a field. Life *is* a continual process of change and adaptation to external stimuli. More than Whitehead could have possibly imagined, for some persons, the most unchanging aspect of life is its continual, cyclical, relentless change.

Later process theologians, notably Charles Hartshorne,[78] assert that God does not exist in splendid isolation from this ongoing process, but is rather its very essence. The conceptualization is *Panentheism,*[79] literally that everything exists in God.[80] God's life is

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[77]Alfred N. Whitehead, *Process and Reality: An Essay in Cosmology,* New York: Harper and Row, 1960. Whitehead's thought resonates with other thought from post-Quantum and Relativity Theory; see N. Bohr, *Atomic Physics and Human Knowledge,* New York: John Wiley and Sons, 1958.

[78]Charles Hartshorne, *A Natural Theology for our Time,* LaSalle, IL: Open Court Publishing Co, 1967; *Philosophers Speak of God,* with William L. Reese, Chicago: University of Chicago Press, 1953; *Man's Vision of God and the Logic of Theism,* Chicago: Willet Clark, 1941.

[79]Hartshone, *A Natural Theology, ibid,* p.20-21. As distinguished from *pantheism,* "Panentheism" is Hartshore's term.

[80]*c.f. Acts of the Apostles 17:28:* "God in which we live and move and have our being..."; *Colossians 3:3:* "...hid your life with Christ within the life of God."

inextricably bound to the lives of us who have been created and the events of our world. The analogy would be that the world is God's body, and that God is at the world's center-- its mind or soul.

Some dissociative persons relate that they draw strength from knowing that God does not change (even as they do). However, many more seem anxious to prehend God "at all times and places."[81] God needs to be able to break in upon their reality and meet them on the road according to their emotional and developmental needs. This revelation will be different according to whether it meets those aspects of a dissociative person which are most identified with a frightened preschooler, arrogant adolescent, concrete thinking 5th grader, sexualizing teenager, bullying persecutor, helpless victim, scolding abuser or wise inner-helper.

God's ability and willingness to be with us at all times and all places accounts for God's intimate "knowledge"[82] of us, as God prehends and suffers with creation in its misery and tragedy. Our life is not accidental to the life of God, but is constitutive of it. We can defer to God, because God alone is truly made vulnerable by what moves us. God cries as we cry. God is abused as we are abused. Such interpenetrating empathy gives new possibilities for survivors working out their theodicy, as the Cross is raised to metaphysical dimension.[83]

GIVING SANCTUARY

"My ancestor was a wandering Aramen who descended to Egypt. There he sojourned with a small band..." so runs the shema, the ancient historical credo of faith found in Deuteronomy 26:5. Salvation history can be followed by the thread of recognizing the stranger at our gate, understanding that they are sent by God, and making ourselves vulnerable to have them "sojourn among us" for a while.

The desert in which Abraham and Sarah lived was not always conducive to human life. Travelers needed to be looked after, given

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[81]Incidentally, what can be agreed upon at all times and in all places constitutes one classic definition of the word *catholic.*

[82]The biblical notion of the word *knowledge* refers, for example, both to Abraham's sexual relationship with Sarah and to his experience of Yahweh.

[83]Hartshone, *Philosophers, ibid*, p.15.

sanctuary in which to collect, strengthen and perhaps reorient themselves during their journey.

When Abraham sits by the opening of his tent in the heat of the day, he looks up and sees three strangers standing in front of him. In the tradition of the People of God he runs to meet them, bows low and says:

> "if I have deserved your favor,
> do not pass by my humble self without a visit.
> Let me send for some water so that you may wash your feet
> and rest under a tree;
> and let me fetch a little food
> so that you may refresh yourselves
> so that you may continue on that journey which has brought you my way."[84]

Hospitality and in the desert is a matter of life and death. It has always been work in concert with God to preserve life. It has been undertaken by People of God, not because we are superior, but because we remember our roots, because God has preserved our life...we are all sojourners.

> "You shall not oppress a stranger;
> you know the heart of a stranger;
> for you, too, were strangers in the land of Egypt."[85]

It was this ancient tradition that informed Jesus' injunction, *"as you did it to one of the least of these, you did it to me."* It was this ancient tradition that early Christian communities built upon when providing for the most vulnerable and dis-empowered people of the community. We are all holy and sacred creations, and our highest communion with God is the recognition of that holiness and sacredness in one another.

This involves at least two immediate challenges for pastors and pastoral care teams who look up to find dissociative persons at their tent. The first challenge involves a shift away from a self-definition or perception of power and expertise to a recognition of shared powerlessness and helplessness.

The second challenge amounts to no less than a conversion. *While maintaining strong personal and professional boundaries,* the pastor is challenged to shift from a rigid, privatized, therapeutic model of care, to a more collegial model of care. Stated differently,

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[84]*Gen. 18:1-5.*

[85]*Ex. 23:16.*

throughout this work I suggest that the boundaries and authority required for pastoral intervention will ultimately need to be carried by the *personal authority* of the pastor, rather than by professionally defined, external rules. Throughout this work I make no apologies for the difficulty of this stance, but rather insist that it best be carried out with supervision and preferably in the context of a faith community.

LETTING BE

The most revealing words in the Old Testament are recorded when God speaks to Moses from the burning bush: "I *am* what I *am*." God is revealed primarily through the notion inherit in the verb *to be.* As creations, self-portraits of God, we are all multi-dimensional. But first, we simply *are.* We are unrepeatable, unique, creations of a God who has unconditional love and connectedness with us. The image of God as artist and poet are most expressive in God's creation and human prodigy. This *imagio Dei* is not lost to the person who dissociates as a response to trauma. Dissociation may be the holy's clearest--though problematic-- manifestation. As pastors, it is vital that we first accept that dissociative persons *are*--in all their complexity--simply who they are.

Of course there is more. The God of Israel was not content to make static clones of God's self. The God translated as *Elohim* in the Old Testament narratives was also--along with the Yahweh manifestation--the great *I AM,* but with Elohim there is the feel of a majestic God who is always evolving and becoming. Elohim seemed to want his people to grow and change in response to and in relationship with challenge. This is the verb *to be* in its transitive form: *Becoming.* As reflections of the image of God we not only find sacredness in our *being,* but in our ability to *become, to be* in continual process.

Survivors need to understand that they *are* gifted and that this gift is but one sign of their holiness, their very sacredness in the heart of a God who cares for them, is joined to them both in their *being* and *becoming,* and cannot abandon them. Caregivers need to also be aware that this gift is something of sacredness and holiness and treat it with awe and respect.[86]

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[86]*cf.* God's protection of Adam and Eve from both self-knowledge and consequences of their actions. *(Gen. 3:7,21)* Clinicians are often too invested in their own insights, quick to rip away the fig leaves, much less willing to help those under their

care clothe themselves against the emotional elements until they can respond in a healthy manner. A classic role of pastoral care is to respect and model stewardship of holy things. This would include the psychic defense of dissociation.

When I was a child, I spoke like a child, I reasoned like a child, I thought like a child...
Paul's First Letter to the Church in Corinth

Chapter 4
CHILDREN AND FAITH DEVELOPMENT
Pastoral care of "child" and "young adult" alters

Because the abuse and terror causing dissociative identity was based in childhood, the narratives from persons with MPD/DID can be like responses from the unique worldview of a developmentally arrested, vulnerable child. Stated differently, "alters" are generally "child alters" created and arrested in response to childhood trauma. The task of mapping the system[87] is covered in core texts. At minimum, a pastor should listen for ways in which a child, adolescent and young adult might understand and experience their faith through these worldviews.

Transference and counter-transference issues--always acute in pastoral relationship with MPD/DID clients anyway--can make it extremely difficult not to antrophroporhise child alters, particularly for clinicians who enjoy working with children. If one role of a child alter is diversion from threatening experience, certainly clinicians can be diverted from an intended interaction with a dissociative person by getting caught up in "playing with children."

That having been said, if the *whole* of who a person is to be taken seriously, *all* aspects must be treated with respect in order to heal. This includes those aspects of a dissociative person who hold the identity and worldview of small children. I will first offer a theological foundation for taking this childhood negotiation seriously and then suggest some tools with which to handle the material.

CHILDREN AS MEMBERS OF THE HOUSEHOLD OF GOD

Only in the last century have we "discovered" childhood. Adolescence was not particularly noted until 1904, when Hall[88] decided adolescent thought patterns were just short of pathological

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[87]*Defined:* refers to the process of identifying and diagramming the various alters, their perceptual ages, roles, reasons for existence and relationship to each other.

[88]G. Stanley Hall, *Adolescence,* two volumes, 1904.

and urged speedily intervention least further chaos be inflicted upon adults.

Western culture has seemed to relate to children mostly as small adults--a handy size for child labor in mine shafts, grooming horses and harvesting produce. The more common problems of having children around--like their seeming inability to do the will of bigger people--could in time simply be beaten out of them.

Even in our contemporary sophistication, children confound us. Sometimes we understand that they are special. Then sometimes we want to fix them so that they are not so special. Adults seem to spend a lot of energy saying things to children like, "You need to be more serious and responsible!" or "You're not a baby anymore, you need to grow up!" These are not so subtle ways of saying we want kids to be more like us. It seems like children aren't valued and taken seriously for who they are and what they can contribute, but what they can become. "What *are* you going the be *when you grow up*?"

Even when "normal" children grow up, they do not always do so in the same ways or at the same rate as their bodies. The idea of a child being trapped inside the body of an adult is not really that bizarre. Whole popular psychologies have grown up around the "child inside" and dissociative survivors of childhood trauma are not the only people who love watching Tom Hanks in *Big.*

Throughout much of the Old Testament, children were of value just as they were.(Psalm 127:3) God's promise and blessing was their heritage. People looked upon the arrival of a child as a sign of divine presence.(Genesis 4:1) Isaiah's vision was of the reign of God being led by a small child.(Isaiah 11:6) The palmist observed that it was out of the mouths of children that God's mercy was truly acknowledged... and the unjust judged.(Psalm 8)

In the Christian story, God comes to the world, not as a mighty warrior on clouds from the east...but as a small child whose advent was ignored by all but simple farmers and mystics. To those who know about children, that is not surprising.

Then, as today, many people forgot about the divinity and sacredness of children. Typically, they considered children too small, too inexperienced, too ignorant, too unimportant to belong to the reign of God. In contrast, Jesus seemed to go out of his way to affirm the more ancient tradition, re-establishing the place of children in community. Some of his rare, open displays of anger were reserved for people who tried to keep children away.(Mark 10:13-16)

Perhaps for this reason, children seemed to immediately know Jesus. In the Gospel account of Jesus' triumphant entry into Jerusalem, it was primarily the children who recognized him and shouted, "Hosanna to the Son of David."(Matthew 21:15) And when the religious leaders questioned Jesus about the children's "unseemly" shouting, he answered them by quoting the 8th Psalm.

Jesus used childhood to define the criteria for entrance into the kingdom... "whoever does not accept the kingdom like a child will never enter it.(Luke 18:17) Whoever receives one of them in my name receives me.(Matthew 18:5)

Jesus thanked God for revealing to children what was hidden from learned and wise adults.(Matthew 11:25) Perhaps it was revealed to children because adults could not handle such reality. This is not some overly romantic, Victorian view of childhood, but rather one that stresses the inclusion and responsibility of children in God's household. Children, like adults, are first children of God.

Whatever it is that we are all supposed to have to approach God, children already have it. Children know they are dependent upon God and cry *Abba* naturally. Adults have to re-learn that behavior. If adults were abused as children, developmentally they may have to re-learn as children. We cannot grow up without attention to our childhood and its God.

GATHERING INFORMATION

David Heller developed an interview schedule which collects God image data for children ages four to twelve.[89] His methodology includes play tasks such as role playing with the child's image of deity around family scenarios, communications with the deity and exploring how the deity interacts with the world. For example, after having a child draw his or her conception of deity, Heller would have the child answer questions about what was going on in the picture. At one point, children might be asked to act out with a family of dolls how that family might interact with the deity around certain types of situations. After having normalized inquiry about the child's God ideation, more direct questions can be asked about feelings(are you ever scared of God?), belief in relation to other figures (is God as real, less real or more real that the President?), relationship (you think God

[89]David Heller, *The Children's God,* Chicago: University of Chicago, 1986.

might feel differently about you than _____) and communication (write a letter to God). His accompanying texts summarizes findings around common religious themes, age themes, gender themes and personality themes.

Heller's whole interview schedule might take a long 4-5 hour structured play day. I have usually just used parts of the schedule as needed over several sessions. I have been most appreciative of Heller's ideas about role playing and acting out scenarios with the child and the child's God, as well as his thematic differentiation around age and gender.

Vignette. Janice is a 42 year old professional and DD patient. She was raised in the midwest in a strict Lutheran family. She has good memories of Sunday mornings and youth group activities. However, she also has memories of being sexually molested within a church context. This manifested itself in fear and avoidant feelings about church.

Her therapist is a Roman Catholic lay woman who was absolutely convinced of the benevolence and availability of God and church. Nevertheless, no amount of suggestion, modeling, discussion or argument seemed to convince Janice. Part of Janice badly needed to be let into the church. Another part was not going to let that happen. She and her therapist requested consultation because Janice very much wanted "back into the church... to hear the bible stories and sing the hymns again."

In discussing her relationship with God and church, she told me God refused to even speak or reveal himself to her. When I asked her to draw, her God image was of a deity who stood blocking the door of the church. She was resistant to any exploration of this image because "he has his back toward me and I can't talk to him or tell anything about him."

"God's showing his ass," I observed.

Janice-the-strict-Lutheran was horrified. Then she switched and several adolescents (The Youth Group) came out giggling.

Slowly we were able to do a number of things. Using storypanel (comic book) techniques and scriptural warrant, we were able to imagine a church where Jesus was the door *(John 10;7,9)* and would let Janice into the church. This was, however, a very different sort of church and Janice's internalized God wasn't having any part of it. Over the weeks, [he] skulked around the outside of the church like a scorned adolescent (Janice's storyboard has him peering in the windows). But Janice was inside. It was a state of grace.

Janice was very directive about what she wanted from me during this time. "I want to read the bible stories with you." By this she meant she wanted to read the Gospel stories of Jesus' teachings and miracles. With God looking in the window I explored the stories with The Youth Group. We met twice a month for six months.

I hope the time will come when the youth group alters can invite Janice's God inside with them. But for now, Janice is continuing with her therapist and has found a church community where she sings in the choir and listens to her bible stories on

Sunday mornings. "God waved at me through the window the other day...he thinks it's ok."

ORGANIZING INFORMATION

James Fowler is well know for his work in "faith development" through the life cycle. As alluded to in the first chapter,[90] Fowler has some particular understandings of "faith" that are existential in dimension, transcending notions of belief, religion and even spirituality. Building upon the work of Erik Erikson, Daniel Levinson and Carol Gilligan, he understands humans as

> "language-related, symbol-borne and story sustained creatures. We do not live long or well without meaning. That is to say, we are creatures who live by faith. We live by forming and being formed in images and dispositions toward the ultimate conditions of our existence.[91]

Faith development in this context is understood as a process through which we experience growth through the ways we make moral and religious meaning in our lives.

Relying heavily on the work of Fowler and Kohlberg, Christian educator Mary Wilcox[92] has devised a training aid for understanding faith styles or approaches of persons at various ages and stages of development. The following will be an outline of faith development "stages" using the Wilcox visual aid and narrative based in Fowler.

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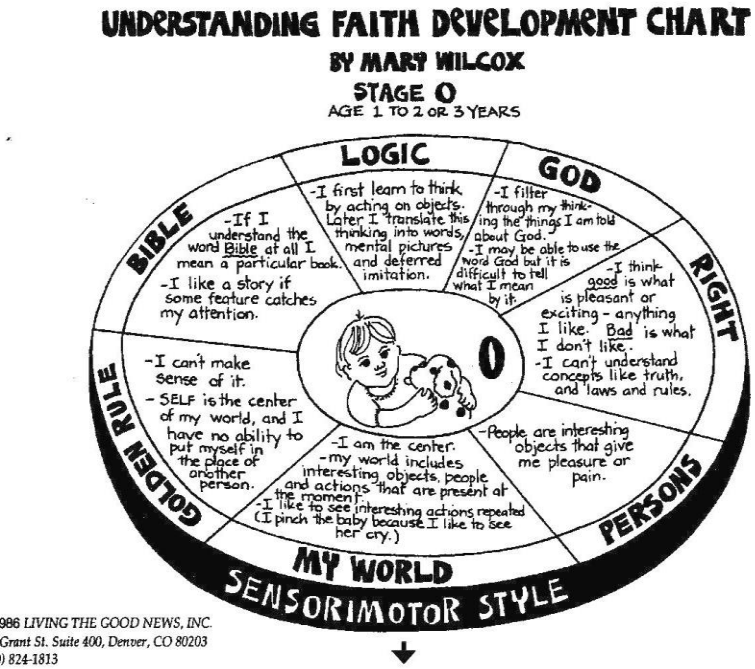
[90]Please see my previous discussion on page 7 of this work.

[91]James W. Fowler, *Becoming Adult, Becoming Christian: Adult development and Christian faith,* (New York: Harper, 1984), p. 50. Fowler and his team at Emory have done a massive amount of writing and presentation, however in this context I would recommend *Faith Development and Pastoral Care,* (Philadelphia: Fortress Press, 1987). See also Fowler's "Healing Spirit: Psychiatry and the dynamics of faith," Oscar Pfister Address, American Psychiatric Association, Philadelphia: 1994.

[92]Mary Marks Wilcox, *Developmental Journey: A Guide to the Development of Logical and Moral Reasoning and Moral Perspective,* Nashville: Abingdon, 1979. An excellent wall chart for teaching based on Wilcox is the *Understanding Faith Development Chart,* published by Living the Good News, PO Box 18345, Denver, CO 80218. Similar work, using Erikson, Clark and Satir can be found in *The Family Inside: Working with the multiple,* Chapter 3: "MPD and Lost Developmental Stages," 44-67, New York: W.W. Norton, 1992.

(O.) Sensorimoter style/Primal faith. Faith and selfhood begin in utero in symbiotic relationship with the mother. As we move into the world, we begin a pre-cognitive, pre-language assimilation of knowledge about our environment. Whether researchers wish to use the language of Erikson's basic trust/mistrust or Tillich's being/non-being, during the first year there are hard won lessons involving



interaction with primary care givers. We make of these our primitive symbols of faith. Our pleasant or unpleasant experiences in relation to these objects will comprise our primitive experience of that which is greater than the self. If all goes well, we begin to prehend some distinctions between other and self, even as we discover we cannot control the other. The image of God that we will carry into early childhood will be a mixture of this experience of rigidity and grace; arbitrary harshness and nurturing love; as well as presence and absence. There is no appeal to scripture or tradition. Faith begins and ends with the self, and the reaction of others when acted upon as objects by the self.

When working with dissociative persons, it is not unusual to stumble upon parts of their personality that project the affect of a frightened, solitary, pre-language child. Male pastors particularly might want to ponder what they would do if faced "in the flesh" with a strange, frightened, 18 month old toddler around their church. Some positive things one might do include trying to speak very quietly and non-anxiously; try to find and connect the child to more familiar people and surroundings where the child feels safe. Some negative things might include trying to pray with or pastorally instruct the already upset child, or of course, invading the child's person by hugging or touching. When initially presented with alters whose affect and body language suggest they are of this age I try to suggest they are welcome, I am glad to see them and they are no trouble for being "here." They can come whenever they need to and bring anybody they need to feel safe with them. I can also call upon help from other parts of the personality to help me interact with the child. Playfulness may be helpful, but it is not the first concern.

Concern, consistency and safety are what a child needs from God at this age. As an other "object," this is what they need from the pastor as well. Remember, it is at this age that very young children sit up in their mother's arms, point at the pastor in the narthax and proclaim, "God." Carry the transference gracefully.

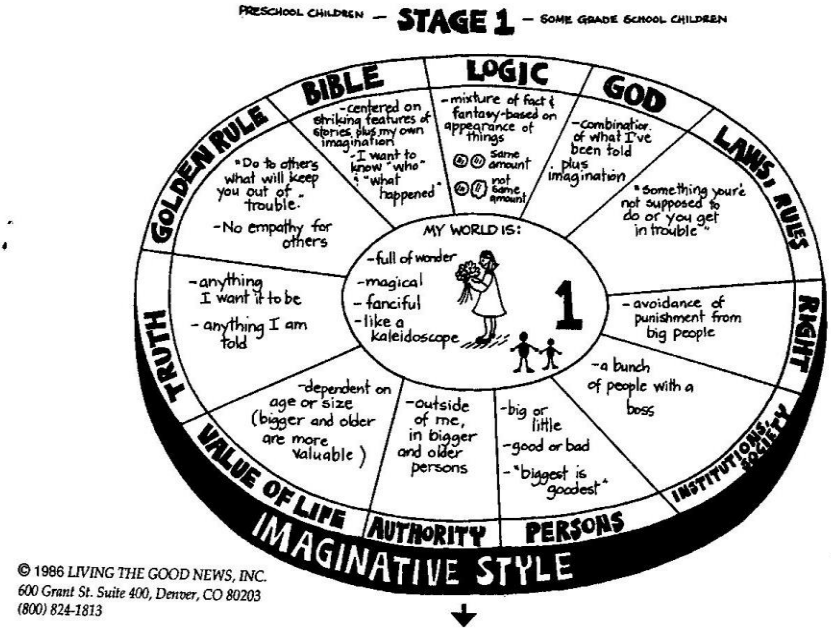
1. Imaginative style/Intuitive-Projective faith. Around age two, language begins to mediate relationships between the self and other. The self is no longer the exclusive inhabitant of the child's universe, but the self is still the center. "Everything is here for Me. Everything that happens, happens for Me."

Vignette. Karen was in crisis late one night. She was alone on a long motor trip, returning from New England. A full moon had emerged, throwing frightening shadows across every surface. She drove as fast as see could, but could not outrun them. As the moon rose higher and higher, brighter and brighter--seemingly getting more and more powerful--the younger children inside her became more and more frightened.

But through the side window, on the chrome edge of the side mirror, the refraction of the moonlight made the sign of the cross. As she looked in the rear view mirror, she could see the image of a man in a white robe--obviously to her to be Jesus--reflected on the rear fender of the car. Held in a "field of love between Jesus and the cross" the frightened child parts were reassured of God's presence and power and allowed their host to continue her night drive in peace. God had sent these "signs...just for me!"

That a six year old is *the* exclusive subject of God's concern is not strange at all--to a six year old. Why would God have anything

better to do? The are many worse things for one's self esteem than being close friends with God.



Children at this age (3-6) think about God a lot, particularly in relation to them around issues of power, presence and death. It is a naive egocentrism. Will God keep me safe from bad dreams? Can I see God in the air? Can I see heaven? Is Grandpa with God in heaven?

Language also begins to feed the imagination. This is the age we associate with "fairy tales" and children generally use these stories to organize faith constructions of good and evil, power and powerlessness. This is a particularly good age to use bible stories, simply telling the stories and letting children draw their own interpretations. Children can seem obsessed with these stories and attach easily to details adults sometimes miss.

Vignette. Ann is a 34 year old DID patient, working class, hostile and street smart. Yet, since being molested by her pastor at the age of 12, she has had a history of becoming attached to, and then being sexually abused in, small, itinerant, Pentecostal sects. She was currently looking for yet another church. While mainline churches did offer safety and accountability, she was attracted to the excitement and emotionalism of the Pentecostal sect churches. She was referred by her exasperated social worker.

I floundered badly in our second interview, trying to engage her anger around gender and sexual/political issues ("if Joseph and Mary's child had been a girl, do you think all those preachers would have abused you?") She understood ("Hell no, of course not!"). She had no use for more anger, yet could not tell me what she needed. "What the hell kind of preacher are you, anyway?" she asked, "Why can't you just tell me about Jesus."

"Tell me about the Jesus you want to hear about."

She tells, with great detail, the story of the raising of "Jairus' little girl." (Luke 8:41-42, 49-56) While doing so, she switches to a child alter. With great childlike delight, she relates how "Jesus throws everybody who is hollering and yelling out." When she comes to the part where Jesus addresses the girl, she speaks very expressively, with wide-eyed wonder. "He didn't yell or preach or shout or anything... he just very quietly said to the girl, 'little girl, get up"... and then he tells the grown-ups they have to feed her."

Spiritual direction continued around finding a quieter God and what she might need in the way of being fed.

For all the imaginative child's appreciation of story, they are not very good reporters of narrative pattern and factual detail. Instead, they construct stories affectively, symbolically, episodicly, easily co-mingling fantasy and fact. But it is in this rich appropriation of images and meaning that the pastor can attach messages of hope, guidance and reassurance.

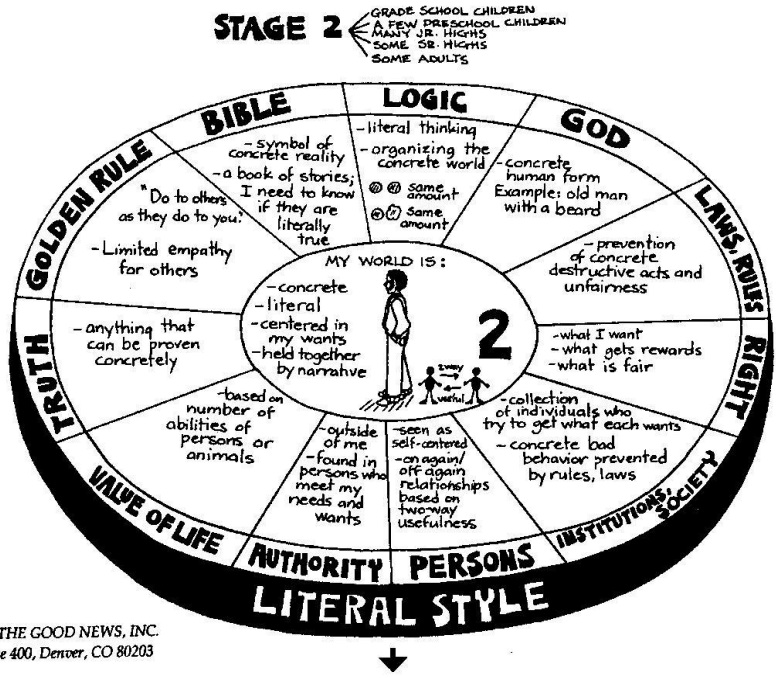
Direct God images are a combination of what a child has been told, augmented by the child's imagination. Thus, very basic re-education may be needed for dissociative persons who ask questions such as: "what is God like?" "Does "he" have a penis?" "Will "he" ask me for sex like my real Father?" "What does it mean for Jesus to come inside me?"[93]

Pastors working with dissociative persons will hear aspects of their personality that crave "signs" from God, delight in the wonder of angles flying through the night and plead to hear stories "one more time." Pastors should respond age-appropriately to the material they are hearing. Good, positive--even magical--faith images and stories

[93]Elizabeth S. Bowman and William Amos, "Utilizing Clergy in the Treatment of MPD: A Non-Clergy Therapist Guide," *Dissociation*, VI.1.47-53.

will provide a core deposit of ego strength which will be needed time and time again during the long process of therapy. If working with boys or young male alters, this may include mythologized violence (*e.g.*, Star Wars, David v. Goliath). Take heart, at this age it is more important that the good guys win out over the evil guys (and the little people over the big people) than to purge all violence in the name of political correctness.

2. Literal style/Mythic-literal faith. There comes a time in a child's life when we no longer can believe in Santa Claus. Piaget called this the age of "concrete operational thinking" and this quest for a linear, orderly predicable world takes precedence over all else. Cause and effect is not only understood, but becomes the rule for cognitive organization (It worked yesterday!). Fact can not only be differentiated from fantasy, but once recorded, seems itself immortal(But you said!). Welcome to the literal world of the pre/early adolescent.



Story and narrative are still important and it is persons of this age who, having discovered the structuring of plot and meaning, become consummate storytellers. They will tell you who they are by telling
stories about themselves (Well...I have this friend...and she asked me to keep a secret...). Yet, they cannot reflect on these stories from outside the narrative. Fowler frequently says of them "they tell us about themselves from the midst of the flowing steam of their life...yet, they cannot step outside the flowing streams of their stories...they cannot yet construct an integrative *story of their stories.*"[94]

Persons of this worldview might anthropomorphize God in authoritarian terms of *stern judge* or *wise ruler*. It is this same need for reliable, linear predictability that can cause distress for these persons as they find the righteous are frequently not rewarded nor the wicked punished. It is this sort of incongruency that can--if intellectual honesty is tolerated in the household--cause a phase of "eleven year old atheism."

If such honesty is not tolerated, then persons can dissociate later adolescent and adult tasks from faith constructions. For example, in my region of the "bible belt" south, it is not unusual to see highly competent doctors, teachers, lawyers and engineers who are capable of complex, abstract, even ambiguous cognitive processes, but who are members of fundamentalist faith groups with very literal religious ideation. These persons frequently present to pastors in the midst of broken interpersonal relationships during mid-life. Having gained success by sophisticated cognitive performance in their occupation, they fail miserably when they try to carry over simple machination of information into relationships that require ambiguity, emotional intimacy and awareness of interior emotional process.

Persons in the later stages of this orientation--because of their lack of "interiority"--frequently stumble upon scripture as an *external* source for authority. When asked about "the bible," these persons will not speak of imaginative stories or even heroic characters, but rather about the guidance they receive in how to act in their own lives. The Bible becomes a self-edited book of rules. For example, the biblical book of *Proverbs* is frequently cited by these persons ("Spare the rod, spoil the child). A wider, more sophisticated appreciation of this

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[94]Fowler, *Faith Development*, ibid, p. 61.

worldview might be represented by a reading of the cynical and sarcastic wisdom literature such as *Ecclesiastes* ("Vanity, vanity, all is vanity!).

I have found that work with dissociative clients who have alters operating from this early adolescent orientation, again mirrors the more banal pastoral care of the parish community. Pastors are too familiar with adults who have unfinished developmental business in this stage. They tend to be the contemporary incarnation of rule bound Pharisees and seem to gravitate to church committee work. One knows their presence immediately by how quickly everyone's anger surfaces.[95] It is not so much that they are manipulative, as that they are single-minded, as if they had blinders on.[96]

The lack of awareness in the pre and early adolescent can be disconcerting for the pastor. As our wise elders used to say: It's just a stage. As most parents of adolescents understand, one cannot *make* someone grow-up. One can make space and environment to *allow* someone to grow-up. In the language of repentance, the penitent has to be given room to turn around.

This is also the developmental stage Kegan has called "the imperial self." Pastoral care with dissociative persons with alters operating out of this stage can lovingly exploit this by focusing on strengthening the ego, on one's uniqueness and talents as created by God. It is good that some part of the person can point out the rules written into creation. It is good that some part can "look out for" those who cannot look out for themselves. It is good that someone

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[95]It might be good for pastors to remember that practically all candidates for ordination--regardless of age--are at this stage of faith development at the time they enter seminary. It is only by separation, poverty, full-time study, spiritual direction, and the support and confrontation of a primary community that any achieves any awareness of an interior life. Persons outside of holy orders obviously find this conversion too. But it is a more oblique, lengthy, hopefully kinder process.

[96]Many attribute to adolescence the quality of manipulativeness. As a priest who regularly works with this age, I do not find the malicious intent or the emotional sophistication present in these young persons for "manipulation." It seems more accurate to say that "others" are perceived as *objects* about which the adolescent can predict behavior. *e.g.,* He or she knows that they can walk into a room and say "1,3, 5," and an adult is most likely to say "2,5,7." The affect seems reptilian--straight from the R-complex brain. While we may mourn this inability to relate to another as a person, it seems more accurate to say this is a developmental problem rather than a moral or character problem.

understands loyalty and justice. "To do judgment and justice is more acceptable to the Lord than sacrifice." *(Ps. 21:3)*

The door out of this stage seems to be hinged on the external referenting to others. There will come points where others cease to be merely rounded objects whose behavior the preadolescent predicts. The time will come when there will be some awareness and investment in the other's perspective. The pastor can look for opportunities to redirect the pre/early adolescent's keen observational powers of others into the self.

An interlude and word on stage transition. Having detailed three developmental stages, it seems wise here to speak to the dynamic of stage transition. At least in terms of one's faith development, it is not always helpful to speak qualitatively about a person *ascending* from one stage to the next. There is no "right place" one is supposed to be at a particular period in one's life. However, if ones tries to, for example, parent, from an imperial/literal perspective, there are certain problems that can be expected. People may have little appreciation of art and story without an accessible imaginative perspective. The persons in our culture who seem to be the "best adjusted," "happiest," and have the best "spiritual life, friends, intact families..." are frequently those planted firmly in an interpersonal/conventional style. The issue seems to have more to do with whether one's style matches one's task, whether one has access to a variety, a repertory of styles, and whether one can make transitions easily without dissociation.

3. Interpersonal style/ Synthetic faith. Fowler's use of the word synthetic here does not mean artificial, but rather the pulling together of disparate elements: a synthesis. This is made possible by the radical shift in cognitive process from concrete to abstract thinking which occurs in adolescence. It is as if the adolescent is able to dissolve the wall between the literal and imaginative styles. The resulting compound seems to supercharge the mind and give it wings. For the first time the mind is able to grasp the notion of systemic processes.

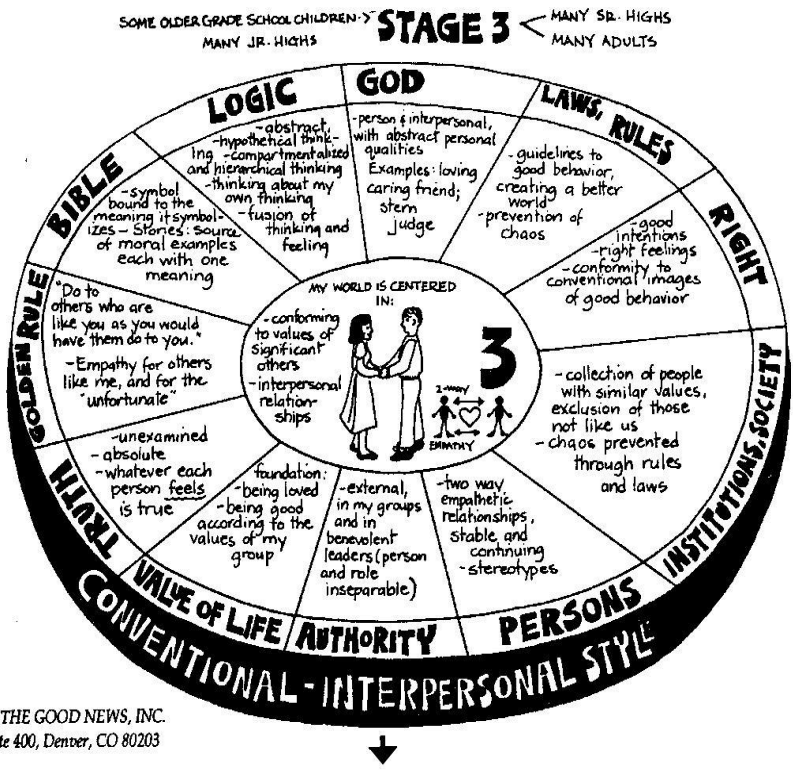
It is also the first time the person can step outside of the self and reflect back on what one sees. This self-consciousness also makes possible empathy for others as the person begins to engage in mutual perspective taking. Fowler frequently sums up this mutual perspective taking with a couplet:

I see you seeing me...
I see the me that I think you see...

And its reciprocal:

You see you according to me...
You see the you you think I see...[97]

With this self-consciousness comes a new interest in interiority of self and others: emotions, personality patterns, reactions, significance of body language and life experiences. Saint Augustine writing about his own adolescent self-absorption wrote, "And I became a problem to myself."



[97]Fowler, ibid.

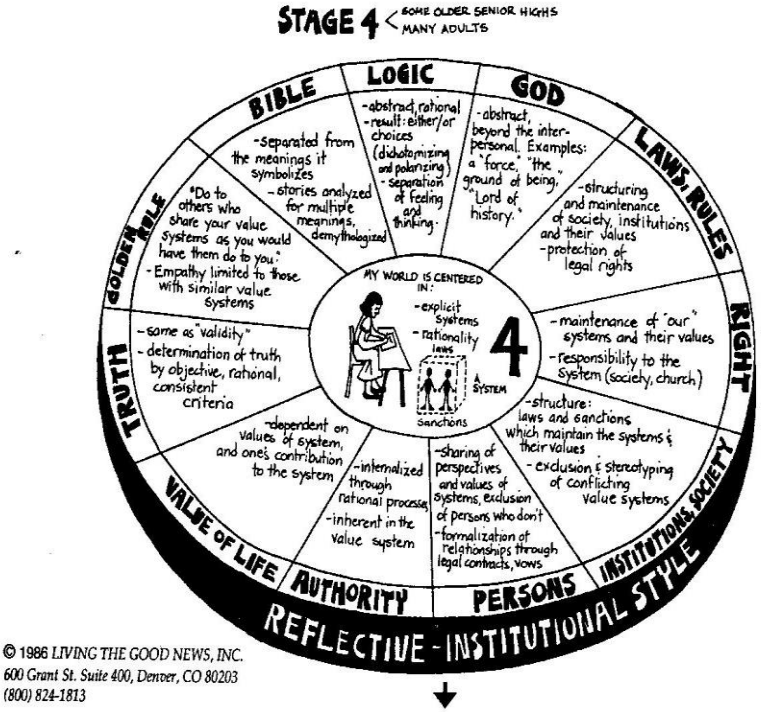
The idea of community and living together are theme wit large in this stage. Persons in this stage seem to move in herds. It is often said, an adolescent without friends is an adolescent in trouble. Curiously, mid-adolescents seek a particular kind of identity from others, a differentiation which may best be thought of as the *stabilizing* identity from a peer group, rather than the *distinct* identity of self. For dissociative persons, this can best be thought of as raising an empathic awareness of others inside and fostering the idea that all parts are needed to work together in concert.

Just as adults in a parish may hold an ideal of faith community as romanticized extended family, the dissociative person may fret over why "all the people inside me can't just agree on something!" Yet, it can be said of this stage that we can best be in relationship with God by being in relationship with others. Pastors may find it most helpful to counsel along themes of common membership, and building up the body of Christ. Commissioning for ministry of inclusion and care among differing parts according to gifts may be helpful as well. This may be particularly helpful when a part feels threatened by the presence and diverging opinion of another. The composite construction of differences and the tolerance of ambiguity are big faith issues for adolescents. The learning lab for these issues is the system of inter-personal (perhaps *intra*-personal) relationship.

As religious authority, pastors will need to be able to give "permission" for persons at this stage to release literal faith objects, criteria and symbols. "Does God really have to be a *he* like it says in the creed?" "Do I really have to *honor* my father and mother who have abused me?" "I can't pray to God as my *father*... can I just pray to Mary?" Replacing literal terms with abstract ones is usually appreciated here: *e.g.*, higher power, redeemer, life-force. Persons may need some help de-mytholgizing scripture and religious traditions in such a way that these things still retain their power without their linear constriction.

Most significantly in the pastoral care of persons with dissociative disorders, this stage empowers the person to set-up dialogue with disparate parts of their lives, creating a composite whole. It is in this quest for identity that one creates what Fowler calls "the story of my stories." It is in our "story of our stories" that we begin to draw a tacit (as opposed to explicit) meaning of our life.

4. Reflective style/ Individuative faith. It can be said there is an over dependence on mutual relationship in the synthetic/interpersonal stage, so much so that boundary violations are common and there is a constant risk of fusion with others. The reflective/individuative stage, then, represents a revitalizing of the ego into an "executive" function. There emerges a "differentiation of self" behind the many personae the person wears when animating relationship with others. This is accomplished by being able to reflect on one's life processes from the perspective of a third person. This perspective provides the basis for personal authority apart from one's relationships and roles.



Perhaps the Jungian notion I am after here is that of *Self*. Particularly with dissociative persons, the affirmation and love of self spoken of in the gospels should be affirmed. Theologically this is not the same thing as the selfishness of the ego in earlier developmental stages. Hebrew thought conceptualized the essential *self* as that part of us that could truly know God: the *soul*...that which could discern the eternal. In post-exilic writing, synonyms could be *spirit* or *heart*, "the seat of intelligence and emotion in humanity."[98] In the New Testament, the synonymous use of spirit or soul to the inner self begins to appear as a matter of course.[99] Thus Jesus could say, "Do not concern yourselfwith those things which can harm the body, but rather those things which can destroy the soul."[100]

Paul of Tarsus devotes his Letter to the Church in Galatia to exploring this tension between spirit, which brings freedom; and flesh, which offers nothing but slavery. For Paul, the concept of flesh includes sins of the mind: hatreds, jealousy, envy.[101] Separating things of our selfish nature, he was able to discern the true self within him and identify that true self as the Word of God re-embodied within him: "It is no longer I who live, but Christ lives within me."[102]

C.G. Jung developed the same conceptualization for modern psychology with his archetypes of ego, the conscious "I" part of us as differentiated from the *Self*, our genuine, authentic and complete potential. Jung understood the Self as being like a vessel filled with divine grace.[103]

But it was Fritz Kunkel, building upon Jung's work, who saw the Self as the source of attributes such as the capacity to love, ability

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[98]c.f. Job 20.3, 32:18, Isaiah 57.15, Daniel 5.20. G. Adman Smith, *The Book of the Twelve Prophets*, v.II, p. 241, characterizes spirit as the inner self "their conscience and radical force of character." cited in Alan A. Richardson, *A Theological Word Book of the Bible*, New York: Collier, 1950, 1962, p. 234.

[99]Mark 2:8, 8:12: Luke 1:80, John 11:33, 13.21; c.f. also Luke 1.47, Mark 14.38 Acts 17:16 and possibly Hebrews 4.12. In Pauline literature, 1 Corinthians 2:11, 2 Corinthians 7:1, 13; possibly 2 Corinthians 2:13, 1 Corinthians 5:4 Cited in Richardson, *Word Book*, ibid.

[100]Matthew 10:28, 16:26; Mark 8:36.

[101]Galatians 5:19-21.

[102]Galatians 2:20.

[103]A very accessible presentation of the thought of C.G. Jung can be found in Morton Kelsey, *Christo-Psychology*, New York: Crossroads, 1988.

to sacrifice for others, and the ability to lead others for their benefit and not for the ego's own egocentric gratification. (This is the very essence of *agape*.) He saw the connection with Christian ideas about humanity's relationship to God.

> The Self is the creative energy and purpose of the creator manifested within us; for this reason, to live from the Self as our center, is to live in accordance with God's Will. Sin, on the other hand, is the egocentric deviation of the ego from the Self.[104]

In this stage, there is also a return to objectification of values and commitments, though it is now taken with mastery over systemic processes. It seems important to know and to state what one believes in.

For dissociative persons breaking with the internalized voices of the past, pastoral care in this stage needs to acknowledge, trust and support this battle-worn self-authorization. Figuratively, it is as if the pastor's task is to stand on a balcony with the dissociative person and look over the history of their life. Intellectual stimulation around the human condition--along with honesty about our weaknesses--is sought as a way to integrate triumph with failure. Thus, pastoral care with person at this stage should provide both confessional and wailing wall.

Because of new awareness of both personal power and personal weakness, persons at this stage may teeter between feelings of grandiosity and worthlessness. Pastoral care and hopefully faith community can provide a reality check without reimposing external expectations and authority. There is a danger of "spiritual elitism," excluding others who have not reached this particular mountain top.

5. Dialectical style/conjunctive faith. For Wilcox, few adults of any culture or orientation ever truly attain a fully integrative worldview. Those that do we tend to call wise and holy--like Mahatma Gandhi or the Dali Lama. For Fowler, an even more complex orientation (Universalizing Faith) lies beyond from which we can live within the mind of God. But many of us from time to time are at least temporary residents of some plateau where our experience of ultimate reality involves the integration of opposing values. This was

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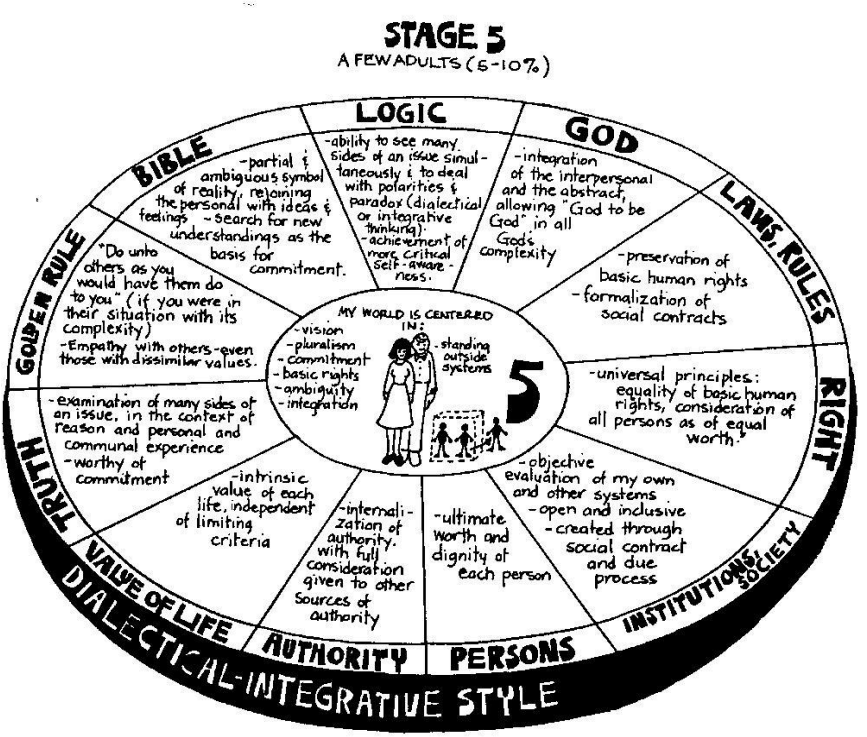
[104]Cited in Sandford, John A., "A Summary of the Psychologies of C.G. Jung and Fritz Kunkel," appendix to *The Man Who Wrestled with God*, New York: Paulist Press, 1974, 1987, p. 128.

the vision of Nicholas of Cusa[105] who developed the idea of God as the coincidence of opposites wherein all are reconciled.

Fowler lists four hallmarks of the transition to conjunctive faith: 1) the awareness of the need to hold together polar tensions; 2) understanding of the paradoxical nature of truth; 3) and embrace of Paul Ricour's "second naïveté" where one can empathize, identify and submit to abstract mythical constructs of reality without feeling threatened, which 4) allows for the affirmation of truths of traditions and communities other than one's own. People living out of a conjunctive faith will be neither "true believers" or leaders of holy wars.



[105]Nicholas of Cusa (1401-64, German cardinal and philosopher. His principal work *De Docta Ignorantia* (1440) was a defense of his two principles "docta ignorantia" (the road to Truth requires intuition leading beyond reason and by necessity to the principle of contradiction) and "coincidentia oppositorum"(wherein all contradictions meet).

For someone of conjunctive faith, "doing the will of God" might seem like co-creating with God in a mysterious way--almost as a peer--living continually in the presence of God "without shame or fear." Yet with the now full awareness of their--and perhaps God's--shortcomings. The person operating out of this orientation knows that they are a complex mixture of good and evil, that they are both life givers and killers, that they create *weal and woe*... and that in this wholeness and complexity they are both loved and of the same substance as God.

For dissociative persons, this distinction might be best thought of as the shift from an executive ego being embedded in and functioning on behalf of a personality system, to the whole system having an *ego*... capable of exercising executive functions be itself.

OTHER WAYS OF ORGANIZING AND INTERPRETING FAITH MATERIAL

I will briefly introduce two other schema for organizing and interpreting faith material.

James Hopewell and narrative worldview. By the time older adolescent/young adult ideation appears, the nuances of specific faith traditions become more apparent. Rather than become bogged down in deciphering denominational doctrines and polities, I have found a narrative interpretation tool developed by James Hopewell[106] for use in congregations to be helpful. Hopewell based his interpretation upon Northrope Frye's[107] schema for mapping the worldview of various genres of Western literature to the four compass parts of comedy, romance, tragedy and irony.

While neither theologians nor literary critics, certain dissociated aspects of MPD/DID patient/clients have very particular worldviews from which they negotiate their experience. These worldviews shade their spirituality and accurate pastoral care requires a pastor be aware of, and if possible make empathetic connection within the same worldview as the patient.

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[106]James F. Hopewell, *Congregation: Stories and Structure,* (Philadelphia: Fortress, 1987)

[107]Northrop Frye, *Anatomy of Criticism,* (Princeton, NJ: Princeton University Press, 1957)

Hopewell Worldviews

	Canonic	*Gnostic*	*Charismatic*	*Emperic*
NARRATIVE FEATURES				
Motif	Sacrifice	Integration	Adventure	Testing
Body Scenarios				
{Personal}				
1) Situation	Hubris	Ignorance	Weakness	Bondage
2) Response	Surrender	Enlightenment	Tarrying	Honesty
3) Resolution	Justification	Peace	Empowerment	Love
{Social}	Vice	Discord	Conventionality	Oppression
	Righteousness	Wisdom	Charism	Justice
	Judgment	Harmony	Transformation	Community
{Cosmic}	Principal./powers	Illusion	Perpetuity	Absurdity
	Passion	Process	Signs	Science
	Kingdom	Union	Day of the Lord	Regularity

COGNITIVE FEATURES				
Authority	God's revealed word and will	Intuition, esoteric wisdom	Personally manifested evidence of God	Data objectively verifiable through five senses
Focus of Integrity	Scripture	Trustable cosmos	God's Providence	One's person
Valued behavior	Obedience	Inner awareness	Recog. of blessings	Realism
CONCEPTS				
God	Father	Ground/Force	Spirit	Ultimate concern
Jesus	Savior	Living Symbol	Lord	Teacher
Evil	Devil	Ignorance	Demons	Demonic
Time	Linear	Cyclical	Premillennial	Amillennial
Bible	Word	Allegory	Program	History
Minister	Messenger	Guide	Exemplar	Enabler
Eucharist	Memorial	Sacrament	Presence	Agape
Church	Covenant	Pilgrimage	Harvest	Fellowship
Gospel	Salvation	Consciousness	Power	Freedom

The task is not to engage in theological debate, but rather to listen for the *tone* of a patient's remarks. For example, a patient speaking of their suicidal thoughts or trials at the hands of an internal "persecutor" as a "sacrifice to God" will not be as open to language about growth through adventure or "the hero's journey" as a patient more romantically inclined. A patient who feels "oppressed" by the demands of milieu will likely feel even more oppression if a chaplain speaks the language of sin, justification and judgment. A patient who is committed to the idea that a midrash introduced in therapy by her therapist has some hidden, esoteric meaning may not easily be redirected by someone's personal assurance that God is with her in her suffering. A patient who desires the presence of the Lord Jesus may not be open to a "tree of life" imagery as a tool for recognizing God's presence. The more secularized twelve-step programs not only speak of God as "higher power," but as "good, orderly force." New age literature as well as classic Christianity speaks of "Being," "Life" and "Light."

Vignette. Diane is a MPD patient who has been in the mental health system for several years. A periodic inpatient, she is currently working through an intense stage of recovering and processing traumatic memory with her therapist. It is Friday night, she is very frightened and will not be seeing her therapist until Monday morning. Because of the cultic/ritualistic nature of her memories, she does not appropriate traditional religious images very well. However, she is a very spiritually aware person, well read, and knows Christian tradition. We are talking about how cold, alone and frightened she feels. She is having the familiar "big black hole" flashbacks and doing some very rapid switching.

At one point, she mentions "I can't find the light." I ask her to tell me about the light. "The light is my friend... I can trust the light... it's warm, it's like I can go up inside the light... it can't make me safe, but it makes me feel better." It sounds like a God image to me. I ask for a story about when she's seen the light.

She proceeds to tell me an incredible story of repeated sadistic abuse from her days of boarding school, "...but if I could just turn my head and twist around so I could see the sun coming through the window, I felt like I would live...".

"The light shines in darkness...", I observe.

She adds, "And the darkness never understood it." I recognize this now from an intellectual alter who likes the prologue of the *Gospel of John*.

In MPD/DID pastoral care, several of these worldviews may be articulated in one interview. It is important for the pastor to be able to non-anxiously "track" the patient through this spiritual labyrinth. It is helpful for many dissociative persons to know they do not have to feel the same way about their spirituality all the time. I have used the complete Hopewell inventory with a group of highly functioning DID clients who where able to find aspects of themselves at several

different points on the grid. They could then use this information to better articulate their needs for spiritual direction or religious form.

Paul Pruyser and pastoral diagnosis. Pruyser was a psychologist who wrote the very influential *The Minister as Diagnostician*[108] in an effort to get pastors to reclaim their unique diagnostic perspective and be more deliberate about including spiritual assessment in their work. The fifth chapter included seven themes that have become foundational for later models of assessment. They are as follows:

Awareness of the Holy (What is sacred...been experienced)
Providence (God's intention...hope, trust)
Faith (Affirmation and commitment)
Grace or Gratefulness (Given and received kindness and generosity)
Repentance (Agency and change)
Communion (Relationships, isolation)
Sense of Vocation (Involvement in life, alignment with the divine)

Pruyser never meant his schema to be used to label people. Rather, he envisioned the diagnostic process as a dialogue between the pastor and those who would seek to know the nature of their condition within the human community. I have found its strength to be its relentless quest for what really lies behind the camouflage of religious language. The themes are broad enough to provide good discussion material for chaplains charged with the responsibility for "spirituality groups." They are also helpful "doors" in which to enter inter-disciplinary treatment team discussions. A patient's capacity for receiving grace; their ability to self-evaluate, assume responsibility and allow change; or their sense of isolation; are all legitimate therapeutic concerns which pastoral care can address from its perspective.

[108]Paul Pruyser, *The Minister as Diagnostician,* (Philadelphia, Westminister Press, 1976)

I will feed them in good pasture... I will feed them in justice.
Ezekiel 34:15-16

Chapter 5
SOME ISSUES FOR PASTORAL CARE
Keep safe that which has been entrusted to you (1 Timothy 20-21)

I will very briefly discuss some of the more common issues and resources that have risen in my work with patients, clients, staff and students.

JUST GOOD PASTORAL CARE

Much has been made of the axiom that MPD/DID therapy is nothing more that good therapy with new awareness. The same can be said of pastoral care with dissociative persons. However, pastors by the way they are accustomed to functioning in congregation and community, may be in a particularly unique position to help dissociative persons.

First, pastors are used to the dynamics of working with systems. Therapists frequently work one-on-one or with couples--even within the context of family therapy. Pastoral care, however, always involves the oversight of whole families and relationship systems. Nodal events in the life cycle such as baptism, marriage and death are events that take place in families and communities. Pastors quickly learn that they cannot "take care" of several hundred individual relationships with parishioners. But pastors can watch over a few dozen relationship systems, helping train those systems to take care of themselves. The theological concept is *episkopos*--oversight.[109] The image is that of shepherd. The shepherd has

[109]επισκοποσ, the Greek root referring to oversight, inspection and accountability. (1 Timothy 3:1-7; Titus 1:7-9) To oversee, one must be "above," not in the sense of power, hierarchy or superiority, but in the sense of "flying above the turbulence." In Pauline theology, oversight is a spiritual gift.

responsibility for a flock as a whole system. Occasionally, the shepherd may need to go search for a single stray, but he or she always retains oversight of the whole unit.

Using a model that addresses systems, memory and character complexity, it has been affirming for me to note there is little about pastoral care within the context of MPD/DID that cannot be applied to pastoral care in general. My work in dissociative disorders has made me a better pastor, better able to understand the complexity of the human condition. Persons with MPD/DID are ultimately whole people. I suggest the best pastoral care is grounded in relationship with the patient as a whole-- albeit complex-- person. Occasionally, the pastor may need to go search and provide individual care in service of a particular aspect of the whole. But like the shepherd, the responsibility is for the complex, whole unit.

Secondly, pastors learn to be flexible in role and relationship. The Apostle Paul speaks of being all things to all people. While this carries its own risks, the reality of systemic leadership is that a pastor may have one role with an administrative board, another with a bible study group, another with a problematic parishioner, another with someone recently widowed, another with the traditional "women's guild," another with younger "thirty-something" families, another with a young couple receiving pre-marital counseling and yet another with that couple's parents.

Flexibility in pastoral role is as important with a dissociative patient as it is with a congregation. It is high privilege to be chosen as pastor, priest and teacher to persons who are gifted, creative, complex, spiritually articulate and have survived through long suffering. They need different things from us at different times, while at all times trusting our basic integrity. The dissonance we feel in relationship is likely our own. I have had my anger pricked by "troublesome," rapidly switching inpatients and asked the tired staff question, "What is it you need from me?" I have learned much from the repeated answer, "I need you to be yourself."

The immediate implications are:

- The pastor cannot take care of the patient. The pastor can help train the patient to take care[110] of themselves;

[110]The image I suggest is steward: οικονομος, from which we get the word economic. A steward is entrusted with the conservation and dispensation of resources justly; also manager, guardian, one who is over the house.

- The pastor gives oversight to the whole person--and their relationship with themselves and God, rather than becoming enmeshed in individual aspects. This is related to the difference between *process* and *content* in family systems thought.
- The pastor is flexible in role and relationship;
- The pastor is firmly rooted in personal and pastoral authority.

However, there are some unique twists. While invasive pastoral interventions are best worked out in resonance with a multi-disciplinary treatment plan, there is some general eclectica that pastors may find helpful as they first enter into alliance with dissociative persons.

REMEMBER WHO YOU ARE

Because a patient may be confused about identity, it seems particularly important for pastoral clinicians to remember who they are themselves. I once knew a bishop who constantly reminded his presbyters, "Don't forget your collar. Don't get so wrapped up in the psychologies and sociologies of religion that you 'sell your birthright for a bowl of porridge.'" In adjunctive pastoral care and counseling, pastors should remember the necessity and uniqueness of their role and the boundaries of their professional discipline. Good stewardship of human resources suggests we minister out of the gifts we have been given and direct the person to other disciplines when appropriate.

Perhaps it is helpful to remember the pastor's classical roles: The *prophet* makes known the petitions of the people before God and makes known God's presence before the people. The *priest* acts as transferential parental figure who has moral authority to hear one's pain, validate the evil of abuse, sanctify the healing process and pronounce absolution. The *spiritual guide*, or shaman, carries out the role of Hermes, walking in the chaos between humanity and the divine, discerning and helping to interpret experience.[111]

[111]Classical mythology defines chaos as a vast, turbulent sea of primordial matter that separates humanity from the divine. It is dangerous because it is undifferentiated. But it is not, in and of itself, evil. Hermes was the Greek god of travelers, merchants, thieves and the erotic-- also the root from which we get *hermeneutics:* the solemn interpretation of sacred texts.

In interdisciplinary contexts, clear identity will help avoid being triangled into conflicts between dissociative persons and their primary therapists or, if in the hospital, their treatment team. The ability of some MPD/DID patient/clients to split well meaning support personnel into competing factions has been noted in basic texts.[112] Growth and healing are often demanding and unpleasant. In his *Confessions*, a young Augustine is remembered for pleading, "Save me Lord, but not yet!" We all frequently wish to be saved from the rigors of our salvation. It is only a normal human response for dissociative persons to wish to be saved from the redemptive hope an active therapy represents. It may be important to process how a patient's spiritual life is being impacted by the demands of treatment, but this is different than a patient asking a pastor to "take sides' against a therapist, treatment team or protocol.

PASTORING THROUGH THE CHAOS

A pastor may never know exactly who the patient or parishioner "is" at any one time. The chameleon-like ability of an MPD/DID patient to "switch" in adaptation to venue, topic of conversation or change in mood can easily cause confusion, fragmentation and frustration in someone attempting a normal interaction. Reflecting on a series of interactions may seem like looking at a series of abandoned, half-opened boxes that have never been fully explored. Events may be recalled from several perspectives with differing sets of pastoral issues. Some alters may remember events, feelings and reflections, others may not. Transference and counter-transference dynamics will be different for different alters.

The experience is chaotic. It is helpful to remember that confusion, fragmentation and frustration are the *reality* in which the patient lives. Since God accepts people as they are, it is not a bad stance for pastors. While not encouraging switching, an accepting, non-anxious attitude toward "whoever shows up" and whatever spiritual issues and developmental level the patient presents is generally appreciated by the patient. In their own way, the patient is presenting an aspect of their life for pastoral care. We are created with a desire that all our developmental and spiritual needs are met and our soul will cry out in whatever way necessary when it is not fed.

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[112]*e.g.*, Putman, *ibid*, 271-274.

Pastors will need to be mindful and aware of which "part" of a person is presenting for care and respond appropriately. On one hand, the pastor bears the primary responsibility for awareness of the whole. Pastoral theology has always affirmed wholeness and completeness of personality. I suggest the extreme chaotic and mercurial qualities of the pastoral care alliance can be minimized by focusing on the person as a whole, rather than becoming caught up in the parts.[113] An overemphasis on the "differences" of alters, having "favorites," or fascination with the phenomena of multiplicity sends a subtle message to the patient that they are more valued for their pathology than as a whole person. Well known in psychoanalytic circles is the tale of Scheherazade, in which the lady must keep the emperor intrigued from meeting to meeting in order to preserve her head.[114] The fable is frequently reinacted by well meaning clinicians. The complexities of these problems and the specific vulnerabilities of a pastor can best be dealt with in supervision.

CLICHÉS, DOCTRINE AND OTHER DEFENSIVENESS

Pastors should be aware of our innate need to defend God's honor by the use of doctrinal positions, religious clichés and other methods we may use to minimize our own discomfort in the presence of those who struggle.

For example, Sr. Avé Clark, OP, cautions against two clichés that frequently pop up in pastoral care. The first is to "offer up this suffering." Such can be misunderstood as asking for an act of violation to be offered to God as a gift, or in some other way to give blessing to the abuser or the abuse. A healthier way seems to be to listen calmly, acknowledge the intrusion upon the sanctity of the victim and unravel the feeling in a caring and respectful way. Secondly, she cautions against trying to find reasons or trying to make sense of the abuse. "I think it is a terrible waste of time and human

[113]These issues are covered well in all core texts. However, I particularly recommend Putman, *ibid*, for a first presentation. Ross is joltingly helpful in reminding therapists that alters are "devices" and not real people.

[114]After 1001 nights, the emperor cannot live without the mystical and resourceful lady and ends up married to her.

energy to try to make sense of being abused. It will never, never make sense."[115]

Congregational pastors may find themselves bound to doctrinal positions or worldview. Because the God served by the pastor does not tell people to immolate themselves or slash their arms does not give a pastor the right to invalidate a frightened person's experience. A congregational pastor who cannot tolerate hearing another's pain, questions or experience of God should work out a scheme of referral to a clinical pastoral counselor. The focus should be the patient's experience of God, not the pastor's. Pastor and patient being able to experience and explore together is much more important to the patient's healing than defending God's honor. One need only look to Job's well meaning tormentors for examples of how not to defensively go about pastoral care.

SEXUALITY

Issues of sexuality, sexual orientation and sexual activity are issues of spirituality and are frequently presented to chaplains and pastoral counselors. There are few areas where the pastor is expected to speak with more moral authority than the area of human sexuality. Yet, frequently this is the area where Christians in general--and pastors in particular--are the least comfortable with exploring and accepting their basic sacredness and commonality with God.

As with many other parts of the human experience, persons with MPD/DID can live out--or act out--these issues with some intensity. As alters may have been "created" to carry the sensations and memory of sexualized violence and abuse, these aspects of the person continue to play out their scripts in disruptive ways.

Pastors may need to refer if they find their personal or pastoral positions clashing loudly with the patient's experience of reality. A good knowledge, comfort level and acceptance of pastoral issues relative to gay and lesbian persons, adolescent and young adult relationships, and some sensitivity, wisdom-- and perhaps even humor-- when hearing material around indiscretions can be immensely appreciated by persons who feel confusion--and perhaps shame--over their actions or identity. This means pastors should have given some

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[115]*Lights in the Darkness,* Williston Park, NY: Resurrection Press, 1993. Available from Sidran.

prayerful thought to their own sexual theology and the just and proper use of sexuality as a sacrament of God. [116]

After sexual identity, the issues I hear most about are those involving involuntary arousal; complicity or secondary gratification in sexual abuse; and the misappropriation of sexual activity as an act of violence.

Survivors may speak of the deep shame, not only of remembering their sexual abuse, but confusion and deep self-condemnation over developing a sexually or psychologically gratifying response. I am of the belief that our sexual response is not a matter of will. It seems deeply encoded in our genetic make-up and is more to be associated with the creative and sacred, God-driven, impulse toward sustenance and evolution. That a person, especially a child, can be forced to be an object in sexual activity is sinful act of willfulness against the sacredness and dignity of a human being. That the victim so used can be stimulated into sexual arousal is an involuntary response of the victim's biological design. That a victim can have God's erotic power *pirated* from their stewardship and misused against their will imputes no sin to the victim.

As important as this concept is for women, it may be even more important for male survivors of sexual abuse. Culturally, we seem unable to understand the concept of a male being raped. Culturally, it is as if the involuntary response of penile erection implies willfulness and consent to a sexual act.

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[116] I'll suggest some reading: two older, general works: Urban T. Holmes, *The Sexual Person: The Church's role in human sexual development,* (New York: Seabury, 1970) is early, tentative and conservative, but a helpful bridge work in the development of modern sexual theology. James B. Nelson, *Embodiment: An approach to sexuality and Christian theology,* (Minneapolis: Augsburg, 1978) is the next step. There are a number of good, recent works out about sexuality and spirituality. A good start might be Carter Heyward, *Touching Our Strength: The erotic as the power and the love of God,* (New York: Harper and Row, l989). For pastoral counseling issues relative to gay men and lesbians, Gail Lynn Unterberger, "Counseling Lesbians: A feminist perspective," and Richard Byrne, "Pastoral Counseling of the Gay Male," both in *Clinical Handbook of Pastoral Counseling, Volume 2,* (New York: Integration Press, 1993). Elizabeth Stuart, ed., *Daring to Speak Love's Name: A gay and lesbian prayerbook,* (Hamish Hamilton, 1993) is a collection of supportive prayers and liturgy.

RELIGIOUS AND SPIRITUAL ALTERS

There is a divergence of thought about the role of "spiritual alters" in MPD/DID. There are frequently adolescent alters who articulate age-appropriate facination with religious issues. There are "old men" or "old women" alters, wizards who seem to hold great spiritual secrets. There are "demons" and "angels," "spirit girls" and "spirit boys." There are voices who seem to be introjections of religious persons in the dissociative person's past-- these could be positive or negative. There are Internal Self-Helpers (ISH) who, though passive and emotionless, seem to overview the life process and hold the information and insight about the patient's personality structure as a whole. This role of transcendence and inner-guidance have lead pastoral and secular clinicians to question the relationship of the ISH to the presence of the Holy Spirit.[117]

My best advice is to consider the range and motivations of various presentations from the patient before jumping to any conclusions about alters with great spiritual insight. Particularly in the case of ISHs, a detached observing ego is not an entirely new concept in analytic psychology. In some cases, religious alters may prove to have no better moral center that some religious people. On the other hand, I can think of many times when ISHs have been so helpful to clinicians and patient/clients that it I would have no problem with describing them as the very voice of God.

I think a good question for supervision is whether a pastor is unconsciously encouraging the development of an alter that can present faith concerns and engage the pastor in conversation. Were this a normative type of pastoral counseling, we might not question the development of a "spiritual side" of a counselee. However, in the context of a DID patient, this conceptualization needs to be balanced with the need for communicating across dissociative barriers and promoting the faith resources of the whole person.

Many have suggested a severely compromised patient may relate to their therapist as a "helper alter." I would further suggest,

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[117]ISHs are covered in most core texts. See also, M.A. Adams, "Internal Self-Helpers of Persons with Multiple personality Disorder," *Dissociation, 2,* (1989) p. 138-143; R.B. Allison, *Minds in many Pieces,* (New York: Rawson, Wade, 1980); Christopher H. Rosik, "Conversations with an Internal Self-Helper," and the responses of J. Ondrovik, D. Hamilton and C. Comstock, *Journal of Psychology and Theology,* 20.3 (1992) p. 113-128.

particularly when a pastoral clinician is in adjunctive role, that much of the interaction between pastor and patient may be internalized and processed as if a "spiritual alter." That a patient may have a weak ego structure and appropriate anything supportive in their path is a function of the disorder. This neither makes the pastor the greatest spiritual director in the world nor the patient a socio-path. Sometimes it's hard to know whose character structure is causing the most mischief.

On one hand, most of us have mentors and teachers whose wisdom we can "play in our head" when we need them. On the other hand, if a highly dissociative patient reports they have conversations with the (not physically present) pastor in the middle of the night when the patient is scared, it may be time for some supervision. I once saw my name on someone's personality system map in her therapist's office. It was a very humbling experience.

RELIGIOUS TERMINOLOGY AND TRIGGERS

It is common for dissociative persons to react strongly to certain religious terms or concepts if they were abused in religious settings. Dissociative persons may report persons from their abusive systems were known by a religious name;[118] religious symbols such as the cross or chalice may hold alternate meaning;[119] patient/clients may report particular phrases were used during active abuse.[120]

The initial, fearful reaction of pastors may be to shield the patient from stimuli that triggers discomfort. Indeed there is nothing pastoral about gratuitous use of religious language that is misunderstood or causes pain. However, it can helpful to reflect with the patient that *they* have presented for pastoral care or counseling. It is *they* who have asked you to help *them* process religious issues, a role in which the pastor is comfortable and knowledgeable. Identify the impasse and call upon the patient to help you with how best to proceed. Dissociative persons are excellent, experienced and highly

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[118] *e.g.,* a patient may report a cult educator was named "Mary" or "Lamb."

[119] *e.g.,* Eucharistic symbol and action may be problematic as satanic ritual is constructed as a parody of that liturgy. I do not immediately introduce myself as a "priest."

[120] *e.g.,* A patient may report she was ritually raped while perpetrators or observers incanted "Father, Son and Holy Ghost."

motivated problem solvers and in time, usually between sessions, can generate various compromises and solutions.

Usually, I am asked to remain consistent with my tradition, but be patient and open to reflection, discussion and explanation as the counselee explores her own feelings around language and begins to develop new meanings for herself. This exploration may occasionally trigger flashbacks and abreactions. Non-anxious presence and guidance per core texts will help process material as necessary, ground the patient and return her to the present.

SELF DESTRUCTIVE IMPULSES

By self destructive impulse, I mean those motivations (including instructive auditory hallucinations) that manifest in cutting, burning and other self-mutilation, some eating disorder activity, pulling out of hair, wandering around in sub-freezing weather, and other--usually pain inflicting--activity. I will distinguish this type of behavior from suicidal behavior that I will address elsewhere.

Jerome Knoll has written several papers on self injurious behavior, comparing much of what we see in dissociative disorder patients with the ecstatic states and flagellation recorded in the lives of medieval mystics--primarily adolescent and young adult women.[121] In both instances:

- The self-injury is done in a heightened state of emotional arousal with the goal of achieving altered consciousness;
- there is an important public component--the wounds are displayed and in turn society responds, simultaneously caring for and protecting as well as criticizing and denigrating the person;
- the person is considered not fully responsible for the behavior because of ecstatic(medieval) or dissociative(modern) state;
- society provides symbolic meaning by societal values: otherworldliness(medieval) and passage through childhood(modern).

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[121]The list that follows is adapted from *PTSD/borderlines in therapy: Finding the balance,* (New York: W.W. Norton, 1993) p. 89-97. See also, J. Kroll and R. De Granck, "The adolescence of a 13th century visionary nun," *Psychological Medicine,* 16, 745-756(1986); and J. Kroll and R. De Granck, "Beatrice of Nazareth: Psychiatric perspectives on a medieval mystic," *Cistercian Studies,* 24, 301-323(1990).

Kroll also makes two distinctions, "more of content than form:"

- The experience of the medieval person was guided by the image of the crucified Christ, while the modern person is haunted by the image of a violated child.
- The medieval ascetic self-mutilated to remove mental and physical interference to union with God. The modern dissociative patient self-injures (in the same way a substance abuser with PTSD might self-medicate): to interrupt flashbacks, painful affect, and intrusive auditory hallucinations.

It is a curious mix of replaying old experience and seeking gratification of need. Kroll observes this places us in a double bind: if clinicians are sympathetic to the self-injurious behavior, we somehow feed the person's pathological need to be both cared for and denigrated. If we focus on the narcissism inherent in the behavior, we do injustice to the intense protest and struggle of a person horribly violated.

In-patient chaplains and pastors working closely with a treatment team can enjoy the luxury of by-passing much of the confusion, simply because the bulk of safety considerations belongs to other disciplines. I find that if I can remain reasonably non-anxious and non-reactive to the content issues in self-injurious behavior, I can approach the patient from a stance of pastoral curiously rather than frenzied concern or defensive condemnation. "Tell me about God at the very moment you cut? ...right after you cut? ...after you 'wake-up?' Does God feel you cut?" I get an amazing range of images and answers that serve as doors into the patient's spiritual life and attempt to build prayers, meditations and cognitive correction to replace self-inflicted pain as the only means of analgesia.

INSTRUCTION AND CONFRONTATION

If I miss anything from the old label of "multiple personality disorders," it is the notion that these survivors have adapted to life precisely by way of a *personality disorder.* Like the typological characters in Bunyan's *Pilgrims Progress,* these alter presentations *negotiate life*--the word used in the King James Bible means something like *in conversation with*--in distinctive and maladaptive ways. How they see, understand and respond to the world around them may have defended them from unbearable pain at one time. This

adaptation is no longer always helpful to them and frequently makes them their own worst enemy... sort of a Lupus of the personality. Having no confidence of their own, they dependently seek “magic” from religion. They aggressively manipulate others for approval. They testify to special relationship of “what God has done--or not done--for me.” They abuse the gift of anger, imbuing it with contempt and manipulation. They “flee when no one pursues.” Having a Pharaoh for their God, they make unreasonable demands on those around them, continually requiring the world to make “bricks without straw.” Though not addressed to dissociative disorders, the writing of Wayne Oates on pastoral care of personality disorders has been a valuable reference.[122]

Pastors should meddle gently in confronting these life patterns with DD clients. Give the person a safe place to be. Honor the struggle without being drawn into it. In conversation, be aware that a whole person, “other parts,” at some level are listening. Enlist their help if needed. Make suggestions as to how alters can work together. For example, “I think little kids might be scared when the TV preacher comes on.... is there anytime when you (is there anybody who) feel (s) like laughing when he comes on?” “The idea of vengeance in that psalm seems to frighten you... is there a another part of you that might like to see people get what they deserve?”

Some alters seem particularly malicious and invite challenge and power struggle. When a pastor must challenge a difficult alter, it should be done supportively. Like working with other character disorders, go with the resistance, reflect, agree, flatter... if necessary. Dissociative pioneer Pierre Janet is said to have allowed an alleged demon to "rant and rave as he pleased."[123] Over time he then enlisted the demon's cooperation with him in treatment of the "possessed" patient. "To force the devil to obey me I attacked him through the sentiment which has always been the darling of devils-- vanity."[124]

Core texts generally agree that persecutory alters are either frightened, bullying children or interjects of past abusers. Reflect with

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[122]Wayne E. Oates, *Behind the Masks: Personality disorders in religious behavior,* (Philadelphia: Westminister Press, 1987). A more general Oates work is *The Religious Care of the Psychiatric Patient,* (Philadelphia: Westminister press, 1978).

[123]T.K. Oesterreich, *Possession Demonical and Other,* (Seracaus: Citadel Press, 1921, 1974), p. 113.

[124]*ibid.*

the patient within the developmental schema and worldview in which the concern is presented. Empathetic alliance is prayer. Model God. Remain vigilant to boundary violations. Remain aware of your own emotional responses to the patient. These responses are God's gift to you, tools to help you reflect on the relationship. Back away. Think about other times when you have had the same reaction. Get supervision. Remember people are complex. There are some parts of you that aren't that great either.

MPD/DID AS A FEMINIST ISSUE

Rivera is an example of feminists from within a clinical discipline who have looked at violence against women and children, and particularly those manifesting MPD/DID, as a consequence of social structures in which male types of power over women and children is institutionally integrated.[125]

She cites the following summary from the literature: That the issue of multiple personality is embedded in the issue of child abuse, particularly the sexual abuse of young girls. Nine out of ten people with MPD/DID seen in clinical settings are women. Of the alters presenting, vulnerable child, sexually seductive or compliant personalities tend to be female, while aggressive and persecutory personalities tend to be male. These adaptive roles, while extreme, are stereotypical of those lived by women in a patriarchal society.

Rivera suggests reframing multiple personality/identity as a social and political issue. Such reframing would open inquiry beyond individual victims, allow study of cultural configurations which allow exploitation of women and children, and promote efforts at prevention.

At the very least, all pastors should give some thought to how the male dominance of religious culture over the centuries colors their own presentation in an issue in which the treatment milieu is largely inhabited and driven by women. Male pastors are quite vulnerable to slipping into gender roles--as well as pastoral roles--dictated by a dissociative person's past experience.

However, I think closer to Rivera's concern is an issue of justice: *Why have our psychiatric hospitals become women's ghettos?* And what would the God/dess of the prophets have us do about it?

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[125]Margo Rivera, "Linking the Psychological and the Social: Feminism, post-structuralism, and multiple personality," *Dissociation,* II.1, p.24-31.

TYPE AND LENGTH OF PASTORAL INTERVENTION

These strategies assume pastoral care in an adjunctive role with dissociative persons for whom faith tradition is a major, prior source of support. Time limited, goal defined interventions around specific issues generally works well. The character structure of many trauma survivors leads them to push boundaries. Over-involvement, triangulation and the emergence of a "second therapy" can be avoided by good communication as part of the treatment team.

Bowman and Amos specifically suggest six to eight one hour sessions, repeated in clusters as needed over the long period of therapy.[126] Many pastoral clinicians report that ongoing regular sessions once each month give the structure and focus needed over the long term without causing dependency.

My experience is that clinicians educated to a medical model tend to give positive feedback for specific, focused interventions. Dissociative persons seem process oriented and frequently respond more positively to less intense, more consistent, steadfast pastoral care over the long term. I suggest the latter to be more resonant with the Hebrew notion of *hesed*-- steadfast loyalty. God shows *hesed* to Israel, not in over-functioning by constant manifestation and saving action, but in consistent, faithful, even measured presence. The God of Isreal does not impress me as being an over-functioner, and I believe this to be a good model for pastors as well.

RITUAL AND LITURGICAL RESOURCES

"Ritual is the means by which people in community make tangible in symbol, dramatic gesture, word, and song what they have come to believe is the hidden meaning of their experience in relation to the world, to others, and to God. Humans are ritual-makers."[127]

It is a frightening thing. Survivors who have been abused by religiose people in ritualized settings seek often out religious ritual in healing. More explicitly, they will find religious ritual. Many dissociative persons end up quietly on the periphery of established, traditional congregations. Others may attach to religious groups

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[126]Bowman and Amos, *ibid*, p.51.

[127]Urban T. Holmes and John Westerhoff, *Christian Believing*, New York: Seabury, 1979, p.66-67.

involved in highly emotionally charged worship. They may find people to perform exorcisms. They may throw in their lot (and financial resources) with any sect that can ritually articulate some meaning or purpose that gives them identity. The issue then for the treatment team should be not whether to use this religious ideation (that decision has already been made by the patient), but how to reframe it in such a way to be safe and supportive to therapy.

In pastoral context, I understand liturgy and ritual to be sacramental in nature and inextricably tied to the faithful experience of a community that gathers to celebrate it, making physically manifest the power and love of God. The power and focus of liturgy is in the *action of the community,* rather than incantation, form or objects being acted upon. Ritual and liturgy can only make sense if our reflection begins not with objects and words, but with the sacred people who gather to use them in celebration of God's grace. This is the position of most modern sacramental theology and stands in contrast to medieval and magical understandings of rite and liturgy.

In clinical context, I suggest the power of liturgy and sacrament be tied to the power of hypnotic suggestion.[128] Core texts illustrate high vulnerability of dissociative persons to hypnotic suggestion and some describe the dissociative process itself as self-hypnosis. Various forms of hypnotic technique abound in the treatment of dissociative disorders. These range from structured use by skilled therapists in abreactive work and safety suggestions to casual use by hospital personnel for milieu management. Hammond[129] has emerged as a leading voice of clinical hypnosis and has cautioned

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[128]Pastors may draw the following parallel: while wearing ritual clothes (white shirt and tie, habit, clerical collar, prayer shawl, *etc.*), walk into a room and intone the following incantation: "Let us pray." Those present will close their eyes and try to block out all but the sound of the pastor's voice. They will try to lose all awareness of themselves in time and follow the pastor's voice through images and affirmations that put them in touch with a transcendent power that knows them and cares for them....

Any use of hypnotic technique in pastoral care should be restricted to safety suggestions and prayer. Retrieval of repressed memory by hypnoses is a complex and controversial subject, beyond the scope of this work.

[129]D. Corydon Hammond, ed, *Hypnotic induction and suggestion: An introductory manual,* (Des Plaines, IL: American Society for Clinical Hypnosis, 1988) and ed, *Handbook of Hypnotic Suggestion and Metaphor,* (Des Plaines, IL: American Society for Clinical Hypnosis, 1990).

against widespread use of hypnotic techniques by people untrained to use them. Specifically, I have heard him warn in workshops that hypnosis by any other name (guided imagery, meditation, etc.) is still hypnosis and should not be undertaken in a clinical context without proper training and supervision.[130]

While as a clinician I have come to agree with Hammond's caution, as a priest, I can not simply refuse to pray with dissociative persons if they request prayer and experience it as helpful. However, I do have new awareness of things happening on many levels during prayer and ritual action. If I consider that a patient may be continually moving in and out of hypnotic trance regardless of my intent, the notion of the "power of prayer" extends well beyond piety. There is growing interest in medical hospitals for chaplains using hypnosis in stress reduction and pain management.[131] With the radical shift in treatment delivery in most in-patient facilities, the time has come to open the inquiry by chaplains in psychiatric milieu as well.

There are healing rites available in most Christian faith traditions and several New Age modalities. Clinically speaking, these may exploit the positive effects of the power of suggestion,[132] cognitive reorganization,[133] and ego enhancement,[134] induced through the altered consciousness inherent in classical forms of prayer. These rites speak of cleansing, wholeness, liberation and empowerment; *can, when appropriate,* employ sacramental acts such as laying-on-of-hands and anointing; employ positive visualization and mythology appropriate to the patient/client's religious system. Theologically speaking, these rites are sacraments-- outward and visible signs of inward and spiritual grace.

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[130]Hammond is vice-president of the American Society of Clinical Hypnosis, 2200 E. Devon Avenue, Suite 291, Des Plaines, IL 60018. ASCH offers training, supervision and certification.

[131]Ann Williams and Donald B. Douglas, "A Course in Hypnosis for Chaplains," *Journal of Religion and Health,* vol. 33, No.4. 353-363. Pastors may recognize the names of Ann and Barry Ulanov, both of whom edit this unique journal.

[132]Durkhiem, E., *The Elementary Form of the Religious Life,* Allen and Unwin, London.

[133]Van der Hart, O. *Rituals in Psychotherapy: transition and continuity,* Irvington Publishers, New York, NY.

[134]Erikson, E., *Toys and Reasons: Stages of the ritualization of experience,* W.W. Norton, New York, NY.

Other uses of liturgy and ritual may include baptism, fusing rituals and naming rites for alters. The topic of exorcism will be discussed later. Use of feast days and occasional celebrations may be helpful. For example, some churches are celebrating the Feast of the Holy Innocents *(*December 27: *Matthew 2:13-18)* in remembrance of victims of childhood abuse. Bilich and Carson describe a renaming ceremony in which an alter who had been depersonalized by being told that he was a computer, claimed his humanity and vocation by receiving a name from a Christian community.[135]

Ritual may be particularly important to Jewish patient/clients. Jewish history is of a People who have be persecuted, abused and exiled through much of their existence. Yet they survive because they are Israel, God's Chosen People. Their identity is remembered by ritual and narrative. If people cannot keep ritual practice and recite the narrative, if they cannot ritually remember, they can forget who they are. This was the great concern of religious leaders of Israel during the exile and Diaspora-- "How shall we sing the Lord's song in a strange land.?"

With Jewish dissociative persons who have dissociated great chunks of their formative childhood experience, honoring the ritual needs of identity are extremely important. "Remember your ancestor was a wandering Aramen... Remember you were once a slave in Egypt... Remember Amalek who sought to annihilate you." Wiesel reminds, "Jews live and grow under the sign of memory...to forget is, for a Jew, to deny his people... and to deny himself."[136]

For the dissociative Jewish person who has experienced childhood trauma in a family setting, conflicting demands of remembering, justice, family, and the elusive enjoyment of sacred life make great demands upon resources of faith. Hear feminist writer Lorrie Sprecher:

New Year's Prayer

"I dreamed the gates of heaven were closing and I wedged in my head like a doorstop. Now I have a headache and amnesia.

I have sinned against life, oh God of life. I have sinned against the Danish modern furniture in my mother's living room.

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[135]Bilich and Carson, *ibid.* These two authors, a psychologist and clergy respectively, are working on a coming book on the transforming power of love through faith community in the healing of trauma survivors.

[136]Elie Wiesel, *ibid,* preface.

I dreamed that heaven clanged shut on my head, leaving dent in the back which I swear you can still feel, the kind that infants have before their skulls freeze over like an ice-age. I cannot remember my childhood.

I have sinned against the religion that made my life. Oh God of life, I do not mean to be ungrateful, but I was never comfortable in my parent's house. I have sinned against my life.

I remember being afraid of everything. I do not remember growing up. I only remember being here. That is not enough.

I have sinned against my life by not remembering it.

Please inscribe my name in the book of life anyway because I'll remember it when I see it written down...

I have sinned against life, oh God of life. Once on Yom Kippur I stole a prayer shawl from the temple and used it as a motorcycle scarf. I stood in the hall of my mother's house and said, I have stolen this scarf, because on the day of atonement you admit what you have done. And my mother said, you cannot steal on Yom Kippur, you have not stolen it, I will return it tomorrow. But I knew that I had stolen it, and that I alone must atone for keeping my neck warm.

Every day is a day of atonement. I prefer to call it "the day of beating myself up." On this day I must atone for everything and forgive everyone the way I'd like to be forgiven.

But I cannot atone when I am still angry, and I cannot forgive what I don't remember. Each year the gates of heaven close before I know forgiveness." [137]

I have strong feelings that Jewish dissociative persons need to see a rabbi for their pastoral care. Yet, there are times when that may not be possible or appropriate. Jewish chaplains are not as numerous as one might like; rabbis with active interests in psychiatric pastoral care, as well as women in the rabbinate, are even more rare. As it takes some knowledge to even make a good referral, some references[138] and a good collegial relationship the local Jewish faith community should be developed.

While ritual action is inherently "religious," sometimes a broader view of when and how to incorporate ritual function is

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[137]Lorrie Sprecher, *Anxiety Attack,* "New Year's Prayer," (Ithaca, NY: Violet Ink, 1992) p. 1.

[138]The introductory article in Rodney J. Hunter, ed., *Dictionary of Pastoral Care and Counseling,* "Jewish Care and Counseling: History, traditions and contemporary issues," and associated pieces, (Nashville: Abingdon Press, 1990) are solid. A good anthology is Joseph Telushkin, *Jewish Literacy* (New York: William Morrow: 1991). The address for the National Association of Jewish Chaplains(NAJC): Mt. Zion Medical Center, PO Box 7921, San Francisco, CA 94120.

helpful. Beck and Metrick[139] provide discussion and worksheets for designing rituals around secular life themes. I have used this work with a patient to design a "Ritual for the Casting Off of Depression," in which she was able to crystallize the self healing task by the taking off of a heavy coat. This work is rich in ideas for guided imagery.

ON THE SUBJECT OF "CONFESSION"

Not to be overlooked, on several levels, is the rite of Reconciliation, or what used to popularly be known as "Confession." Chaplains in an inpatient facility are often bombarded with requests to "hear my confession." On one level, this may mean the classical use of the sacrament as self-examination and the church's absolution in a spiritual discipline. I still find this to be the case in ongoing pastoral counseling. But, I have come to believe that for most in-patients, this request is a form of testing. What I seem to be hearing from persons wishing reconciliation to God through faith community is not, "Bless me Father, I have sinned," but rather "can you really hear me, know who I am, and still accept me... *What have you to do with me, Jesus of Nazarath?"*(Mk 5:7; Lk 8:28).

The priest must show unconditional acceptance and positive regard, while at the same time taking the person confessional material seriously. I believe what is called for is immediate reassurance and pronouncement of God's acknowledgment, acceptance and reconciliation. What seems helpful is the acting out God's *availability and willingness to be present* in helping the patient achieve mastery over her person (regardless of casulisty). There is some part of the person that needs to hear this.

However, some other part of the person will likely mount a vigorous protest that the pastor "doesn't understand how bad I really am." If there is resistance to accepting grace and absolution, under cover of penance,[140] the confessor[141] can explore with the patient what

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[139]Renee Beck and Sydney Barbara Metrick, *The Art of Ritual: A guide to creating and performing your own ceremonies for growth and change,* (Berkeley, CA: Celestial Arts, 1990).

[140]*def: Penance, understood dynamically, focuses on making real the forgiveness of the failure.*

[141]*def: classically, one who hears the confession of the penitent and gives instruction and absolution.*

steps or action the patient believes would be helpful in making restitution and reconciliation. While there may be *verbal* resistance to *verbal* reassurance of the patient's basic goodness--on another level the *acting out* of respect and *reverence* toward the disociative person by one who comes in the name of God will speak far louder than words.

As in any pastoral encounter regarding confessional material, the priest will need to help the penitent differentiate shame from guilt, and desires for punishment from the desire to learn and grow from mistakes. Alters will be able to appropriate growth and healing from this rite in direct proportion to their acceptance of themselves as unconditionally loved, yet predisposed to "screw-up" (*i.e.*, sin--merely the human condition). Those more aligned with the super-ego will have to be appeased by transaction before those more concerned with conscience can grow and learn. Expect those aligned with the more shadowy aspects to act out.

It seems particularly helpful for any victim of abuse that the priest validate that what happened to the victim was evil. While survivors may have heard over and over again from their therapist that they were betrayed and violated, hearing this from a moral authority in a religious setting becomes, in every sense, *Gospel*. Once that is established, then can begin the process of unraveling the strands of guilt, shame, dirt and victimization. Classically, absolution should be withheld in favor of instruction when a priest hears the story of a victim, rather than a perpetrator. However, contemporary spiritual directors might consider erring on the side of compassion and work backward towards teaching.[142]

This rite may also be helpful in reconciling alters to each other or to the host. An alter operating out of a more developed morality may be able to understand reconciliation as empowering grace: the gift of being made aware of a weakness and being given the opportunity to overcome it.

CARE AND EDUCATION OF CHURCHES

While most psychiatric patient/clients have family support, MPD/DID patients frequently have--many should have--separated from their families or origin. Identification with and participation in a

[142]*eg.*, Margaret Guenther, *Holy Listening: The art of spiritual direction*, particularly Chapter Four: "Women in Spiritual Direction," p109-140, Boston: Cowley, 1992.

healthy faith community--serving as a surrogate family--can take on great importance. God did not create us to live in isolation; we cannot be human by ourselves. Pastoral counselors and chaplains can be a valuable translator, mediator and emissary between a treatment team and the patient's faith community. Bowman and Amos specifically list consultant and educator as an appropriate function of clinically trained clergy and many of the following suggestions come from their work.[143]

Pastoral counselors and chaplains can approach a church or other faith group in a less threatening manner than psychiatrists, psychologists and social workers. A church that feels less alone will be less likely to ostracize, abandon or try bizarre interventions on their own. Some basic education about the etiology and psychopathology of the disorder, boundary management, and the necessity of creating a wide support group might be a start. Intervention in ill-timed instructions for forgiveness, judgmental stances against suicide gestures, anger at God, repulsion by religious symbols, healing rites in which male elders gather to lay on hands, teachings about evil which may feed magical and pandemonic constructs, shame, gossip, stigma, sexual and suicidal actions, are just some of the other issues that may emerge.

Early intervention and continual contact payoff for patient, team and faith community. Given what sometimes seems like a contagious quality of dissociation and memory recovery in some pockets of our culture, normalization and education about dissociative disorder may become a public health issue in which the church bears a particular burden.

Vignette. An evangelical church group presented in my office, wide-eyed, demanding that I see a friend of theirs. They had found themselves involved with a young woman, who very articulately and graphically reports satanic ritual abuse. She was unsafe, frequently violent, and spent much time in a facility that was not skilled in her diagnosis. She could also be a very sweet, endearing, person. As I began to talk with them, I heard the familiar reports of demon possession, programming, human sacrifice, etc. I also heard how it was negatively effecting the function and relationships within the group, marriages and families involved.

I was able to set up a relationship with this group whereby I give pastoral and clinical supervision to their interactions with the patient and help them process their own issues as they are generated. We work a lot on just what they, as a Christian community, can signify for their friend about God's love and healing power. What is it God can transmit through them that speaks of the forgiving, transforming, life giving power of the eternal, rather than the degradation and conflict of humanity. At this point, the patient has a healthy support group, the members of which are less anxious and have families of their own. They understand their role as a witnessing, supportive Christian community, rather than a crusading Christian posse involved in the rescue of

[143]Bowman and Amos, *ibid*.

ritual abuse victims. *I have never seen the identified patient.* I don't need to, the Body of Christ--the social manifestation of the risen Lord--is caring for her.

In a similar case, a church group felt I was too clinical and "not really a believer." Within a year, two of the group members began showing dissociative symptoms of their own and entered treatment with Christian counselors who "specialize in MPD and cult abuse." One of these had an inpatient experience before she could be referred to a more appropriate treatment team. The stress in the families has been incredible. There have been other related problems recently within the church. I am continually saddened and angry over what I understand to be the unnecessary human cost of the second case.

CARE AND EDUCATION OF TREATMENT TEAMS

For the treatment team, the clinical pastor can work with the team's counter-transference around the patient's religious involvement. This may be particularly important when that involvement is outside traditions the team may be familiar with. Highly stylized language may need explanation and clarification. Dissociative persons involved with charismatic Christian groups may tell a treatment team that they want to be anointed with oil, or are "struggling with the demon of depression," or present as "in the spirit." That may mean different things to patient and team. A reorientation and some "permission giving" for handling idiomatic expression as anthropological data may be helpful in bringing the treatment team's anxiety about "religion" down to a workable level. In either case, a reorientation of the treatment team from an ideological to an anthropological stance toward the patient's religious ideas is frequently the best intervention.

Assessment as to whether a patient's religious ideation is normative and appropriate to their faith tradition is often helpful. Psychiatric chaplains are familiar with the problem of patients who may operate from Eucharistic and Incarnational traditions being clinically labeled as grandiose or psychotic because they relate they "feed on Jesus," "have Christ within me," or "I am God." Obviously, some people believe they are possessed by demons, they do swallow crucifixes, and some have detailed plans for how perform miracles or destroy creation in judgment. But as Elizabeth Bowman reminds her colleagues, "When you've got a theological issue, I think you need a theologian."

I suggest that if approached by a clinician for private consultation, the pastor should try to untangle the strands of religious issues generated in the patient's treatment from pastoral issues being generated in the professional's spiritual life. Being trained largely by scientific models, medical, nursing, and social work professionals--

even most psychologists--sometimes assume they are engaged in a *corporeal* enterprise in which *they* manage tangibles to create a treatment outcome. Treatment teams go about their work, healing the sick, freeing the captives and driving the devils from people's lives, perhaps occasionally invoking the name of God, but never really with the pastoral and spiritual perspective inherent in the prophets, the Christ and his apostles, or the community they left behind. Jesus instructed his disciples to let such people continue, "For whoever is not against you is for you."(Luke 9:49-50)

Occasionally someone stumbles upon the insight that healing is a *spiritual* enterprise that only manifests itself in tangible, corporeal ways. Pastors can help by listening wisely and affirming quietly that healing is from God. We can also direct clinicians to the incredible privilege, and responsibility they share as co-creators and "stewards of the mysteries of God." The physician who boasts "I can heal," is as in need of pastoral care as any one else. There will come times when the chaplain can quietly inquire of the physician about the one to whom he or she belongs and to just whose vocation the physician is giving incarnation.

REPENTANCE AND THE PROFESSIONAL

The debate continues to rage over recovered memory, dissociative disorders, treatment modalities and protocols. Some clinicians seem rigidly closed, polarized in their arguments.

I know of professionals who seemed engulfed in the treatment world of MPD and "cult abuse" several years ago. They had no trouble finding patients, colleagues, administrators and other supporters that for a wide range of secondary interests helped push them toward professional positions that have not withstood the light of critical study. They have not left themselves open to changing treatment patterns and good research coming out of the major training centers that might have tempered their zeal. As managed care and professional accountabilities continue to tighten the parameters on treatment, they feel forced to preside over barely efficacious treatment they themselves can no longer defend.

I know of other professionals who have steadfastly refused to consider the possibility of complex patterns of dissociation being a common adaptive mechanism to prolonged, repeated childhood trauma. They diagnose presenting patient/clients as schizophrenic,

borderline personality or bi-polar and treat with grim determination by heavy-handed pharmacology, parental and punitive intervention and electro-convulsive therapy. When patients do not show improvement the professional angrily responds with more drugs, more rules and more ECT.

While the context (MPD) may be novel, these are only manifestations of hubris, greed and pride that have been the subject of pastoral concern for thousands of years. Human empires in the flesh of practices, treatment teams and national reputations have been built on early therapeutic and ideological positions. These positions are reinforced by staffing, financial and sometimes legal pressures against "changing one's mind." The notion of turning and taking a new direction is strangely absent as a possibility in the minds of many treatment professionals. And yet, turning, changing one's mind, adopting a new understanding is exactly what they want from their patient/clients.

The pastor of a treatment milieu should foster an attitude and environment where repentance, growth and change are not only possible, but normative, even expected.

VOCATIONAL AND SOCIAL ADVANTAGE

Dissociative persons often ask why they should "get well" according to someone else's definition. If they can dissociate and be well paid to teach school or sell real estate and then come home and enjoy their family or write a book, why should they risk losing their ability in treatment. If dissociation is a divine gift hard won, why should they give it up? Who will they be after they do? There are no easy answers.

Many people with DID have built whole lives, even careers around their dissociation. They are excellent teachers of children as there are parts of them that are still children. They can be courageous police officers, soldiers and fighters, as they can split off parts of themselves that do not feel fear. They are spell-binding actors and entertainers, as parts of their personalities have been "performing for their life" since a very early age. Their "many eyes and many ears" give them enviable perception as writers and artists. Their complexity gives them the ability to perform complex roles ranging from compassionate corporate executive officer to street wise prostitute that would overwhelm "mere singles."

We admire teachers, leaders and heroes that can "live on the edge," so we don't have to live dangerously ourselves. We praise artists and actors that can evoke deep emotion from us, emotion that we do not have the courage to evoke or follow on our own. We practically venerate adaptability, single minded devotion, survival instinct and attention to detail. Highly functioning persons with DID can do all this and more, yet we insist on defining them by their pathology. In our quest to make them "normal" we have at times systematically imprisoned, disenfranchised, infantilized, impoverished, electro-shocked and drugged some of the most creative and enduring of our species. They may have suffered sinful, sadistic inhumane treatment in the formation of their identity. That gives us no right to demand they be made "normal" because they make us uncomfortable.

The notion of stewardship for one's being before God has been the most helpful for me in giving pastoral perspective. How does one best give account to God for their divine life--albeit with the amendment of dissociation. Given that God's gifts always seem to have their dark side, how does one best manage what they have been given? Balance and discipline are needed.

The pastor can tell a patient: You can be the best teacher of adolescents in the world, but you cannot teach--or will teach the wrong thing--if you suicide. You may be a brilliant artist, but no one can experience your insight if you do not function well enough to write. You may be a great actor, but who can see you perform if you are in four-point restraints. You may be the best mother, most creative executive or expansive theorist in your field, but you will squander these gifts as surely as Samson if you let the disorder have more power than your self.

INTEGRATION V. FUNCTIONAL DISSOCIATION

On one level, this is an issue of clinical ideology, and thus has to be worked through individually according to the goals of the patient and the treatment team. Much has to do with whether one is working from a model of eradication, integration or management of dissociation. Much has to do with the severity of the disruption to a person's life. For clients who are less compromised, "household management" conceptualizations such as Elizabeth Power speaks of (and exemplifies!) seem to make perfect sense. In many ways,

pastoral counseling with such a person would seem little different than with someone not dissociative. For clients who dissociate and engage in activity that is counterproductive, dangerous or harmful to themselves and others, the answer is more complex. For persons severely compromised by invasive memories, depressive and persecuting states of being, suicidal thoughts and disruptive behavior--more aggressive interventions would seem to be in order.

On another level, it is important to realize that at present dissociative treatment is being driven by psychiatry, which by orientation works out of a model of eradication of pathology. Not all dissociative experience is pathological. Clinicians who only see severely compromised dissociative patients in an in-patient, hospital setting will rarely recognize anything but pathology. Clinicians who see only outpatients whose dissociative experience is secondary to other problems of living may have a very different, less "hostile" stance toward dissociation. At the very least, it could be said that dissociation is pathological only in direct proportion to the negative effect it has on one's relationships and skills for living.

"I CAN'T PRAY"

Prayer is always a tool in formation, and its creative use seems to be especially appreciated by persons who struggle with MPD/DID. Yet, when they ask about a patient's prayer life, chaplains, pastoral counselors and spiritual directors frequently get pained and puzzled looks. We hear often the words, "I can't pray... I don't think I know how any more... the *'children'* pray, but God doesn't listen to *me*."

For example, the idea of communication and relationship with God may get mired in theodicy questions. Many survivors of abuse who come to us for direction in prayer find themselves "stuck" in circular notions of child-like petitions to a deity who is supposed to magically intervene on their behalf. And if that deity can be so inclined and influenced, then where was Divine intervention when it was really needed! "God must not be pleased with me... perhaps I do not deserve to be helped... I am bad." Pastors for whom a relationship with a recklessly forgiving, graceful God is otherwise a very real part of their life seem quick to interpret circular arguments about prayer as willful ignorance and resistance rather than the fear and innocence of a child. I suggest God might be the best defender and teacher of holy

ways and that the pastor's best stance is to model patience, grace and provide some specific methods for prayer.

I usually try to expand on the notion of what prayer is. Catechisticly, prayer is responding to God by thoughts and deeds, with or without words. For example, one of the most elementary, classic forms of prayer is *adoration,* an old word that has nothing to do with groveling before the deity, but rather offering our hearts and minds to God, asking nothing but God's presence. Standard therapeutic tools such as drawing and journaling can easily be interpreted in this way and offered as prayer. In early work with trauma survivors, I am particularly fond of the gentleness found in the work of Kathleen Adams on journaling.[144] Very basic forms such as alpha poems and clustering can be used to open or close pastoral sessions by understanding them as prayer language or structuring them into more traditional collects. This can introduce or reinforce the idea of prayer being a process God sets in motion within us, rather that something we must undertake to please God. *Likewise the spirit helps us in our weakness, for when we do not know how to pray, the Spirit personally makes our petitions for us in groans that cannot be put into words.*[145]

From my own tradition, Martin Smith offers a guide to meditatively praying with scripture.[146] Exercises by Anthony DeMello and others from a more eastern tradition can be used.[147] My experience with highly functioning disociative clients in spiritual direction is that they have great aptitude for Ignatian form and with good support and instruction can creatively enter into prayer with scripture quite easily. I am often struck with the diversity, range and individuality of prayer life reported by DD clients. Clinically, I will admit this type of prayer could be considered a form of trance induction. Pastorally, that does not make God any less present. All the more reason for a knowledgeable anchor, guide and teacher to accompany persons on the journey. Ignatius was convinced of the presence of God in all action. For this prayer form, as well as

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[144]*The way of the journal* (Lutherville, MD: Sidran, 1993) and *Journal to the self* (New York: Warner), both available from Sidran.

[145]*Paul's Letter to the Church in Rome,* 8:26.

[146]*The Word is very near you,* (Cambridge, MA: Cowley Publications, 1989).

[147]*e.g.,* Anthony de Mello, *Sadhana, a way to God: Exercises in eastern form,* (Garden City, NY: Image, 1984).

instruction in *lectio* prayer, I have found it helpful to work from a personalized, stepped instruction sheet and practice with a client until they are comfortable. At all times, my stance reinforces the client's natural power and ability to discern the presence of God within themselves and within the story or image they are using.

The use of "affirmations" as a type of short, one line mantra is prayer that can be woven in through the activities of the day. The Jesus prayer is classical mantra, however Guethner has suggested something more specific for the person's spiritual deficits, for example, "I am clean... I am clean... I am clean..."[148]

I believe we all pray, just like we sleep, eat and dream, because it comes naturally... because we must. It's the way we are made.

SOME OTHER RESOURCES

Elizabeth Power offers a workbook, *Managing Ourselves: God in our midst,* for persons with MPD/DID.[149] This resource is insightful, sensitive and very well done. It does reflect its author who is Protestant and Southern. It presents a biblical spirituality and could be a bit overwhelming for someone just starting to name spiritual issues in recovery. I find it helpful to ask a patient to do specific exercises as issues emerge, rather than just present the workbook to them. In her second workbook, *Managing Ourselves: Building a Community of Caring,* Power draws analogy between the personality system and the frequently contentious early Christian communities addressed in the biblical epistles. She frequently focuses on building positive, dynamic *association* rather than obsessing over dissociation, and managing agreement rather than conflict. Power is a person with MPD/DID and a relational systems consultant to groups and businesses. Her highly successful corporate work is an extension with external organizations of what she teaches the DID community about internal organizations.

Avé Clark, has written *Lights in the Darkness: For survivors and healers of sexual abuse.*[150] The text includes many references to

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[148]Guethner, *ibid,* p.

[149]Brentwood, TN: E. Power and Associates, 1992; also *Managing Ourselves, ibid.* Both available from Sidran.

[150]Clark, *ibid,* p. 89

PTSD/MPD, and has many gentle and helpful remarks addressed to sexual abuse survivors and their companions. Clark, a Roman Catholic religious sister and sexual abuse survivor, writes from her heritage and religious tradition in the same way as does Power. She is particularly helpful in presenting prayer and spiritual poetry. The following is her "survivor's rosary... my ten mercy beads" which she uses for insomnia and night terrors:

> Lord, walk with me.
> Lord, be gentle and help me be gentle with my pain.
> Lord, show me your mercy in the ordinary events of each day.
> Lord help me rest and stay calm.
> Lord, fill my emptiness with your presence.
> Lord, comfort my aching spirit and help me to comfort others.
> Lord, let me close my eyes and sleep in peace.
> Lord, teach me to take time with myself.
> Lord, be my constant and loyal friend.
> Lord, help me to be valiant.[151]

Joel Brande has adapted the twelve steps for "The Twelve Spiritual Steps" to be used with survivors of childhood trauma.[152]

> *One. Power vs. Victimization.* We admit that we are powerless to control victimization and the destructive use of power and seek the help of a good higher power (God as individually understood), to gain positive power in our lives.
> *Two. Seeking Meaning.* We seek to discover meaning in our traumatic experiences and look to God, as individually understood, to help us find meaning.
>
> *Three. Trust vs. Shame and Doubt.* Burdened with distrust, shame and doubt, we seek God's healing and help in order to trust.
>
> *Four. Self-Inventory.* We acknowledge to ourselves, to God, and to another human being, our shortcomings and

[151]*Ibid*, p. 87-88.

[152]*Twelve Spiritual Steps*, Columbus, GA: Trauma Recovery Publications.

shameful secrets. We seek his help to heal our shame, accept our positive qualities, and change our negative ones.

Five. Anger. We seek God's help to understand anger, control its destructiveness, and channel it in constructive ways.

Six. Fear. We seek God's help to relinquish "the wall" around our emotions and his protective presence during moments of terror and risk.

Seven. Guilt. We seek God's help to face guilt, to make amends when possible, to accept his forgiveness and to forgive ourselves.

Eight. Grief. We seek God's help to grieve those we have lost, face our painful memories and emotions, and let our tears heal our wounds.

Nine. Life vs. Death. We reveal to God and to someone we trust all remaining self-destructive wishes and, with his help, make a commitment to life.

Ten. Justice vs. Revenge. We seek God's help to pursue the cause of justice, to gain freedom from revengeful wishes and plans, and for a desire to be channels of his forgiveness to those we once hated.

Eleven. Finding Purpose. We seek knowledge and direction from God and surrender ourselves to his leadership in order to find a renewed purpose for our lives.

Twelve. Love. We seek God's love in our lives, to help us renew our commitment to friends and family, love those we have found difficult to love, and to help those who have been victims as we once were.

I have noticed several patient/clients bringing in material from the *Kabbalah*-- a collection of Jewish mystical philosophical writing

from the 7th-9th century.[153] I find this somewhat problematic when patient/clients obsess on "hidden meanings" and "signs." Nevertheless, a patient's offering should be honored and the writings do make good use of images such as the "Tree of Life" for one's story. These writing generally support the idea that everything exists as part of the Deity; that humanity can be united with God through piety and moral conduct; that evil does not exist in itself, but is rather a perversion of good; and that evil can be overcome by prayer, repentance and similar acts.

THE USE OF MYTHOLOGY

Mythology is used here in the classical, positive and functional sense in speaking of the Transcendent in terms of the immanent. Both individuals and cultures use mythology to bypass cognitive structure, to make sense out of experience and differentiate good from evil. Our myths are our picture images of reality. Sometimes we outgrow our images. Bultmann described a program of demythologizing biblical narratives in a modern age.[154]

Persons healing from severe abuse carry their own mythology; they may understand themselves-- or "internal parts" may understand themselves-- as Satan's Bride, the Little Bad Girl, the black sheep, *etc.* The introduction of supportive myths, that is *re*mythologizing, may be a function of pastoral care. Some examples: from culture-- The *Star Wars* trilogy[155] or *The Hero with a Thousand Faces*;[156] from children's literature-- *Runaway Bunny* (God in the maternal role)[157] or *The Lion,*

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[153]A discussion of Kabbalah and various kabbalistic systems is far beyond scope here. In addition to mystical experience, these writings contain mythological elements, magic, reinterpretations of biblical and talmudic passages, prayers, neoplatonic ideas and messianic speculation. See, Z'ev ben Shimon Halevi, *School of Kabbalah,* (North Beach, ME: 1985); A recent modern anthology is *The Kabbalah: Stories from the Jewish mystic.* Better done, and soon to be reissued, is a popular work from Lawrence Kushner, *Honey from the Rock,* New York: Harper and Row, 1977.

[154]Rudolf Bultmann, *History of the Synoptic Tradition,* New York: Harper and Row, 1963.

[155]George Lucas. Actually better on film: CBS Fox Video, 1980.

[156]Joseph Campbell, *Hero with a Thousand Faces,* New York: Harper and Row, 1949.

[157]Margaret Wise Brown, New York: Harper and Row, 1947.

the Witch and the Wardrobe;[158] from MPD cultural literature-- *The Silver Boat*[159] and *Turtleboy and Jet the Wonderpup*;[160] and at some point, encouraging patient/clients to write or storyboard their own myths.

From the earliest days of Christianity, sacred myth and legend of saints and heroes have served as inspiration to followers. Jerome of the Desert, John of the Cross, Francis of Assisi, Theresa of Aliva and Theressa of Lisieux, are examples of difficult mystics who where not always understood by their contemporaries. In a context of pathology, Kroll has alluded to ecstatic states, eating disorders, and self-mutilation practiced by medieval ascetics which today sound very familiar and would be cause for a PTSD/Borderline/DD diagnoses.[161] Joan of Arc[162] with her visions and voices of Saints Catherine, Margaret and Michael--as well as her powerful charisma, sexual ambiguity and adolescent defiance--remains a favorite of my patient/clients, as does Birgid of Kildare.[163] For dissociative persons from catholic traditions, it might be well to inquire early about confirmation names and from a position of pastoral authority, make healthy additions, deletions and corrections to what is largely household or folk religion.

One of the most widely used resources for sacred myth and legend is the Judeo-Christian canon of holy scripture. Some possibilities for use of scripture will be presented in the next chapter.

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[158]C.S. Lewis, New York: Macmillan, 1950. (nicely done on PBS/Wonderworks Video)

[159]Ann Adams, Cincinnati: BSC Publications, 1990. (available from Sidran Bookshelf)

[160]L.J. StarDancer, H.P.L. Kelseyville, CA: Publishing, 1989. (available from Sidran Bookshelf)

[161]Jerome Kroll, *PTSD/Borderlines in therapy: Finding the balance,* (New York: W.W. Norton, 1993) p. 91-94.

[162]There is a great body of ecclesial-historical work on Joan, but perhaps the most accessible introduction to her character remains George Bernard Shaw's later biographical preface to *Saint Joan,* (Baltimore: Penguin, 1921, 1951).

[163]A good feminist treatment of Celtic spirituality that includes good Briget and Mary material is Mary Condron, *The Serpent and the Goddess: Women, religion and power in Celtic Ireland,* (New York: Harper/Collins, 1989).

Tell me what you find in the Bible, and I will tell you what you are.
Oskar Pfister, **Christianity and Fear**[164]

Chapter 6
USING SCRIPTURE AS A RESOURCE
A thematic reference

I do not mean to suggest by this section that pastoral clinicians should use scripture as a "pill" to be dispensed to those in great pain. However, there are many dissociative persons who are already committed to religious traditions that use the Judeo-Christian canon of scripture. There are others for whom the transferential authority of the Word of God, or the honest reflection of experience of God's people, is very powerful.

The previous section on images and age appropriateness also applies here, as does general admonitions about respecting people's experience of holy ground. That having been said, there are few more satisfying pastoral tasks than to help seekers find nourishment in interpreting these ancient writings in ways that are perhaps new and redeeming.

That there are women in salvation history of great power and witness; that the prophet Elijah and the Apostle Paul thought of suicide; that Saul perfectly acts out paranoid schizophrenia; and David-- in both psalm and action--seems bi-polar; that favored people of God frequently have intense ambivalence toward God and the role of the deity in their life; that God loves justice and frequently evokes justice through reversal of those lowly and those mighty; that the Light shines in Darkness, and the Darkness will never overcome it...all these are frequently new understandings for people as they seek spiritual understanding from scripture.

Because the text itself is readily available, scripture can serve as handy guided meditation, prayed together, referenced over the telephone or, with preparation, as a trance induction tool.

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[164]Oskar Pfister, *Christianity and Fear: A study in history and in the psychology of religion,* trans. W.H. Johnson (New York: Macmillan and Co., 1948).

A WORD ABOUT LANGUAGE

A combination of Bible and word processing programs give search and replace capability to pastors in communicating texts to persons who would not otherwise be able to hear them. I have frequently assigned the reading of the Psalter, replacing "Lady" for "Lord," and "Light" or "Life" for "God." This affectively changes the way the Psalms read. Rather than offended, I believe God is amused and perhaps relieved. Saussy reminds us that *God* is a male word that is merely accepted in most parts of our patriarchal culture as gender-inclusive. The fact that the female word, *Goddess,* would be considered pagan speaks to the distortion of our language and concepts of Deity. "Perhaps most men and women are not able to use the word *Goddess* to name the presence of the Holy One. Yet perhaps everyone would agree that *Goddess* connotes aspects of Deity this *God* does not evoke."[165]

However, exchanging one anthropomorphic metaphor for another may also cause problems. For example, a feature of some MPD/DID narratives is the reported history of Satanic Ritual Abuse; such abuse is frequently reported as female upon female. In such case, referring to God as "she" might not be helpful.

Modern feminist biblical scholarship has never been more available and will continue to critique and inform the church into the future.[166] However, Geunther suggests "simply" reading the gospels with a woman's eye and attending to what is rarely addressed in sermons and teaching:

> ...I ask the retreatants (usually women) to retell from memory the story of the woman who anointed Jesus. Unfailingly, the group effort reproduces Luke's version: "a woman in the city, who was a sinner... stood behind him at his feet with her tears and began to dry his feet with her hair. Then she continued kissing his feet and anointing

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[165]Carroll Saussy, "Pastoral Care and Images of Self-Esteem," in *Clinical Handbook of Pastoral Counseling, Volume 2,* Robert Wicks and Richard Parsons, eds., (New York: Integration Books, 1993), p. 363-389.

[166]*eg., The Women's Bible Commentary,* Carol A. Newsom and Sharon H. Ringe, eds., Louisville; Westminister/John Knox, 1992; also, Virginia Ramey Mollenkott, *ibid.* Among many others, works by Elisabeth Moltmann-Wendel, Phyllis Trible and Elisabeth Schuessler-Fiorenza are easily available and have been found helpful.

> them with ointment" (Lk. 7:37-38) Then I remind them of Mark's telling of the same story: "A woman came with an alabaster jar of very costly ointment of nard, and she broke open the jar and poured the ointment on his head."(Mk. 14:3-9). We sit for a moment with the picture of these two women, our sisters; the (presumably sexual) sinner crouched weeping on the floor and the unnamed woman standing tall, *a prophet* anointing a king. Then we smile and weep simultaneously at the irony of Jesus' words: "Wherever the gospel is preached in the whole world, what she has done will be told in memory of her.(emphasis added)[167]

It is probably best to experiment with several translations, including a conjointly written paraphrase. However, some patient/clients may already have preferences. Experienced church pastors will understand from experience that change in preferred biblical translations are rarely gratuitous and frequently ill-advised.

What follows are *some examples of types* of uses that one could submit scripture. What I am describing is a *way* of using scripture, rather than prescribing particular passages for particular issues. Nor will all issues be active for all dissociative persons. It will still be most helpful to listen closely to the patient's narrative and use the images and issues *they* generate. The following examples might also lend themselves to the charge of "proof texting" and removing scripture from its context. I can only ask that those who are offended remain open.

Images for safe places

A common hypnotic technique used with trauma survivors to help restore interim control and protect from over-stimulation is the creation of the image of a "safe place." Such might be recalling a physical safe place like grandmother's kitchen, or the creation of a mythical safe place through guided meditation or hypnotic suggestion. The following are examples of how scriptural images might be used.

Psalm 23: I worry about the "he lays me down" part, but many still find the idea of "green pastures" quite comforting. This has been particularly true with persons from rural areas who know pastures and

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[167]Guenther, *ibid*, p.127.

can be protected by animals who graze there... for instance, several patients have found abusers are scared of large animals like horses.

Psalm 31: "In you, O Lord, have I taken refuge, never let me be put to shame... you are my rock and my stronghold, a castle to keep me safe."

Psalm 91: She who dwells in the shelter of the Most High, abides under the shadow of the Almighty. She shall say to the Lady, "You are my refuge and my stronghold, my God/dess in whom I put my trust."

Matthew 11:28: "Come unto me all you who are weary and burdened, and I will give you rest."

Mark 10:13: "Let the little children come to me; do not stop them;"

One Body, Many Parts[168]

While it may be a cliché to say that persons in distress are "at war with themselves," this may be one way dissociative persons describe their internal conflicts. There are alters who have different positions and perspectives on how to proceed with therapeutic issues. The Apostle Paul frequently addressed communities of faith who did not agree on how to live with each other. He tried to teach the notion of individual selves as being part of one body and who could find peace with each other through nurtured relationship with God.

Romans 12:4-5: "Just as each of us has one body with many members, and these members do not serve all the same function, so in Christ we who are many form one body and each member belongs to the other."

> Now the body is not made of one part, but of many. If the foot should say, "Because I am not a hand, I do not belong to the body," it would not for that reason cease to be part of the body. If the whole body were an eye, where would the sense of hearing be? If the whole body were an ear, where would the sense of smell be? but in fact God has arranged the parts of the body, every one of them, just as God wanted them to be. If they were all one part, where would the body be? As it is, there are many parts, but one body. The eye cannot say to the hand, "I

[168]For this line of thought-- the interior spiritual life of MPD as analogous to life in early Christian community-- I am indebted to Elizabeth E. Power, *ibid,* p.12.

> don't need you!" And the head cannot say the feet, "I don't need you!" *(1 Corinthians 12:14-22)*
>
> For he himself is our peace, who has made the two one, and has destroyed the barrier, the dividing wall of hostility... His PURPOSE was to create in himself one human being out of two, thus making peace, and in his body to reconcile both of them to God through the cross, by which he put to death their hostility. *(Ephesians 2:14, 16)*

Calls to community from the Hebrew scriptures call also be helpful: *e.g.,* Psalm 133: "O how good and pleasant it is, when kindred live together in unity."

Giving Voice to the Speechless and Sight to the Blind

There may be frightened alters or fragments who surface but cannot speak or hear or see. Hopefully there are other alters who "were watching" and can help fill in gaps and recover memories. However, a collateral approach might be to empower sightless and speechless ones to perceive what might have been happening around them.

Jeremiah 1: 1-10: A "word of the Lord" was heard by a young child, appointing him as a prophet. The child protested "Ah, Lord God, I do not know how to speak, for I am only a boy." God touches his mouth and gives him speech.

Isaiah 6:1-8: A similar call story, with the accompanying action of the prophet's guilt being removed and sin blotted out.

Wisdom 10:21: For Wisdom opened the mouths of the mute and gave speech to a new born people.

Mark 9:14-29: (Perhaps not as desirable as speaks of physical convulsions.) A boy is brought to Jesus who has a spirit that keeps him from speaking. Jesus relieves the boy of the spirit, lifted the boy up and he was able to stand.

Luke 18:31-43, Mark 10:46-52: Blind Bartimaus. Also John 9:1, Mark 8:22, Matthew 9:27, 20:30.

Depression

Most MPD/DID patient/clients experience depression and it is believed that the depressed affect of some parts of their personality is

actually the function of particular alters. As always, avoid power struggles; normalize the affect.

Psalm 13: “How long shall I have perplexity in my mind, and grief in my heart, day after day? ...Look upon me and answer me, O Lord my God; give light to my eyes, lest I sleep in death...”

Psalm 88: "I am counted among those who go down to the pit; my life is at the brink of the grave...

Psalm 91: "You shall not be afraid... of the plague that stalks in the darkness, nor of the sickness that lays waste at mid-day...

Suicidality(reasons against, shame over, obsessions about)

More conservative pastoral theologians often tell people they will go to hell or suffer God's eternal displeasure if they kill themselves. A less defensive reading of scripture will not bear out this understanding,[169] God need not be used as a threat in order to keep someone alive. A pastor’s ability to be non-anxiously present through suicidal crisis, seems to be very helpful. In MPD/DID patients, suicidal alters tend to be cognitively “locked in” to task. Argumentiveness and scolding seem to feed everyone’s frustration. Power struggles are almost always non-productive.

This does not mean a pastor has to be neutral about whether someone kills themselves. Concern for the host and safety contracts as per core texts are the order of the day.

As with any other patient, pastoral clinicians might explore the repercussions of suicide through the generations of the family. Particularly when the patient is a parent, we might discuss the patient's calling to defeat evil and death so that their own children do not suffer as they themselves have.

Deuteronomy 30:19: "I have set before you life and death, blessing and curse; therefore choose life, that your decedents may live..."

Philippians 1:23-26: Paul wrestles with life and death. "I do not know which that I prefer," but concludes that he needs to live in order to be in relationship with those he loves. "My desire is to depart and be with Christ, for that is far better; but to remain in the flesh is more necessary for you. Since I am convinced of this, I will

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[169]James T. Clemons, *What does the Bible Say about Suicide?*, Minneapolis: Fortress, 1990. *ibid*, "Biblical Perspectives," p. 40-58 in *Perspectives on Suicide*, James Clemons, ed., Louisville; Westminister/John Knox, 1990.

remain...". The idea of being sacrificed or of offering one's self up as a sacrifice seems to appear now and again. The cognitive correction of Romans 12:1 of such being a *living* sacrifice has sometimes been helpful.

Elijah knew something about suicidal ideation: "...It is enough; now, O Lord, take away my life, for I am no better than my ancestors." (1 Kings 19:4) God does not collude, but sends angels with food and instructions to watch for God to pass by... an event, incidentally, that culminates in Elijah experiencing God not in wind, fire and earthquakes, but as a still small voice. (4:12)

Defense/Justice/Vengeance

Pietistic notions of Christian peace have come very close to killing love precisely because we have misunderstood anger to be a deadly sin. MPD/DID patients have frequently dissociated angry parts that they have misconstrued as "bad." Opening dialogue with these alters frequently requires affirmation of their role and enlisting their further help and vigilance.

Theologically, anger is not a "sin," nor is it the opposite of love. Anger is better understood as a "feeling signal" that things have gone terribly wrong in a relationship. Righteous anger, and the changes it calls forth, are therefore gifts from God for self-protection, challenge and creative altercation.[170] Anger expressed honestly is an intimate mode of relationship; anger suppressed is dissociation. Buber decided that anger was much closer to love than the avoidance of feeling for the other.[171] It is important to have the quality of relationship with God where one can express anger. It is only after one can expressively "blame God" that the full force of blame and anger can eventually be directed at the right people.

God is frequently angry in Hebrew scripture; that is why we can say that God is Love. That is why we can pray to God to avenge our anger and restore justice.

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[170]"Anger is a tool for change when it challenges us to become more of an expert on self and less of an expert on others." Harriet Goldhor Lerner, *The Dance of Anger,* (New York: Harper and Row, l985), p. 102. For theological foundation see Beverly Wildung Harrison, "The Power of Anger in the Work of Love," in Ann Loades, ed., *Feminist Theology: A Reader,* (Louisville, KY: Westminister/John Knox Press, 1990), p. 194-214.

[171]Martin Buber, *I and Thou,* trans. W. Kaufmann, (New York: Scribner's, 1970), p. 67f.

Psalm 26: "Give judgment for me, O Lord, for I have lived with integrity;"

Psalm 27: "When evildoers came upon me to eat up my flesh, it was my adversaries and foes who stumbled and fell:

Psalm 28: "Repay them according to their deeds, and according to the wickedness of their actions;"

Psalm 94: "O God of vengeance, shine forth! Rise up O Judge of the world; give the arrogant their just deserts!"

Psalm 109: "Hold not your tongue, O God of my praise; for the mouth of the wicked, the mouth of the deceitful, is opened against me." Judges 4:17: Jael, wife of Heber, invites Sisera into her tent, covers him with a rug, brings him warm milk, bids him sleep... and then takes a hammer and drives a tent peg into his temple, "until it went down into the ground." The warrior Judge Deborah prophesied such (4:9).

(With caution) 1 Kings 18:20: Elijah's Triumph over the Priests of Baal. This is (R) rated, do be careful about the suggestion of slashing at the end, but otherwise frequently emotionally satisfying.

Hope/Identification/Security

Psalm 91: You shall not be afraid of any terror by night... of the plague that stalks in the darkness, nor of the sickness that lays waste at mid-day... there shall no evil happen to you. You shall tread upon the lion and adder; you shall trample the serpent under your feet..."

Psalm 121: "I lift up my eyes to the hills; from where is my help to come... The Lord who watches over Israel will neither slumber nor sleep..."

Psalm 124: "If the Lord had not been on our side, let Israel now say... then they would have swallowed *us* up alive... (but) *we* have escaped like a bird..."

Psalm 126: "When the Lord restored the fortunes of Zion, then were we like those who dream... Those who sowed with tears, will reap with songs of joy... Those who go out carrying the seed, will come again with joy, shouldering their sheaves."

Psalm 129: "Greatly have they oppressed me since my youth, let Israel now say... but they have not prevailed against me."

Zephaniah 3:14-15: “Shout for joy, daughter of Zion...Yahweh has repealed your sentence and turned your enimies away...you have nothing more to fear.”

Truth

Dissociative persons and those who struggle with them must live in the tension of truth being factual, solid and fundamental, versus truth being revelation, of one mind with God, and thus dynamic. We are tempted to whine with Pilate, “Truth! What is truth?” (John 18:36) In the New Testament, the use of *truth* is always positive, and frequently costly. In the Gospel of John, the truth is always bound up in God and thought to be the Holy Spirit.

John 8:32: "...and you will know the truth, and the truth will make you free."

John 14:16-17: “And I will ask the father and he will give you another advocate to be with you forever. This is the Spirit of Truth, whom the world cannot receive, because it neither sees him nor knows him. You know him because he will be with you (or among you).

John 16:12-13: I still have many things to tell you, but you cannot bear them now. When the Spirit comes, he will guide you into all truth...

Pauline notions of truth tend to be rigid and hard. But Paul did understand continuing revelation: 1 Corinthians 13:11-12 : "When I was a child, my speech, my outlook and my thoughts were all childish. Now that I am grown, I am through with childish things. Now we see only puzzling reflections in a mirror, but then we shall see face to face. My knowledge now is partial; then it will be perfect, like God's knowledge of me."

From a pastoral family systems practice: separation

MPD/DID patents frequently feel bound in family functioning. We learn behavior in families and those behaviors are passed from generation to generation. That does not mean we cannot learn to differentiate ourselves from our families.

Ezekiel 18:2-4: "What do you mean by repeating this proverb concerning the land of Israel, 'The parents have eaten sour grapes and the children's teeth are set on edge'? As I live, says the Lord God, this proverb shall no more be used by you in all Israel."

Mark 3:21-35: “Thinking he was crazy, Jesus’ mother and brothers come to take him away. Jesus replies, “‘Who are my mother and my brothers?’ And looking around on those who sat about him, he said, “Here are my mother and my brothers! Whoever does the will of God is my mother, brother and sister.”

Matthew 10:34-39: "Do not think I have come to bring peace on earth; I have not come to bring peace, but a sword. For I have come to set a son against his father, and a daughter against her mother... and a person's foes will be those of their own household."

Memory

2 Peter 1:13: "I think it is right, as long as I am in this body, to refresh your memory..."

"There are two equal and opposite errors into which our race can fall about the devils. One is to disbelieve in their existence. The other is to believe, and to feel an excessive and unhealthy interest in them. They themselves are equally pleased by both errors, and hail a materialist or a magician with the same delight."
Screwtape[172]

Chapter 7

"SATANIC RITUAL ABUSE"

"Get behind me, satan!"

As bizarre as this monograph has been to write so far, I am about to take another twist through the darker side of humanity. As a priest, the notion of children being abused by "satanic cults" has been the most spiritually challenging and emotionally draining aspect of ministering to persons involved in DD treatment. I feel compelled to say, in defense of positions many people in the field took on this issue just a few years ago: "you had to be there." Particularly for clinicians who were isolated from collegial support and review, the effect of hearing these reports from a single intelligent, articulate client could be staggering.

I suppose I was lucky in that I first heard reports of SRA while an intern from patients in a state hospital in which they were being treated for chronic schizophrenia. It is not that as a person of faith, the reports did not frighten me. They did. But I had no access to the MPD/SRA "template" for understanding these reports, and thus was able to deal with them largely as a language event. When I started residency at Sheppard-Pratt in Baltimore (and even then, not on the DD unit), I was then in the position of hearing literally *dozens* of these stories at any given time. I believe because of the sheer *bulk* of what I was hearing, I was able to place these narratives in some sort of contextual focus.

I am *not* suggesting that any of these reports are in and of themselves fictitious. I *am* suggesting that religious and many mental health professionals made some unfortunate choices in the early ways they chose to conceptualize and react to what was reported.

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[172]C.S. Lewis, *The Screwtape Letters,* preface, New York: McMillian, 1961

A BRIEF OVERVIEW

Reports of “Satanic Ritual Abuse” (SRA) began catching public and professional attention during the early 1980's. Clinicians were told of multi-generational cults who worshipped Satan and involved their own and others’ children in highly violent, sexualized religious rituals. These rituals involved altars, fire, chanting, human and animal sacrifice, gang rapes, burials, impregnation for the sole purpose of offering the fetus, ingestion of blood and semen, and cannibalism. Drugs, intrusive phone calls and TV messages, as well as post-hypnotic suggestion linking trigger-words and symbols to memory, were some of the terrorist methods used to control victims as they walked among the living. These groups operated under strict secrecy and included highly placed members from church, education, health, government and community, as well as the victim’s parental authority. Stories involving the complex mix of abuse, sex, religion and power began to rock communities around the country and became instant media fodder.

Pazder may have been the first to introduce the term "ritualized abuse.” He defined the phenomenon as "Repeated physical, emotional, mental and spiritual assaults, combined with a systematic use of symbols, ceremonies and machinations designed and orchestrated to attain malevolent effects."[173]

The generic quality of this definition was helpful for a while. MPD/DID certainly has antecedent in severe, repeated, emotional trauma. But clearly, it was not helpful to irrevocably bind the disorder with a particular interpretation of the abuse, or with the motivation of the abuser(s). A child can be systematically abused and traumatized by any variety of families, churches, schools, cults, lodges, societies and other organizations. It could be argued that there are groups that engage in New Age, Wicca, occult, even satanic, practices which do not abuse children. Accusations involving pastors sexually abusing counselees and children are not yet referred to as "Christian Ritual Abuse." Therapeutic misadventures in the area of DD treatment are not yet referred to as “Psychiatric Ritual Abuse.”

However, even the use of the term “ritual” still sent researchers on a cold trail collecting data from the history of religions and the existence of religious and pseudo-religious cults. Clinicians

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[173]Lawrence Pazder and Michcelle Smith, *Michelle Remembers*, New York: Congdon & Lattes, 1980.

who took a supportive stance toward dissociative persons reporting "ritual abuse" suddenly found themselves the object of scorn by peers who branded them as "witch-hunters" and purveyors of satanic-conspiracy.

The last year or so has seen the welcome refinement of definition toward the term "Sadistic Abuse."[174] Rather than being the domain of "religion" this development places the clinical focus on the extreme violence, torture and sexual perversion that lies closer to the center of victim's experience. For the sadist, deception, terrorism and mind control of the victim are just as important as the infliction of pain.

A REVIEW OF THE LITERATURE

Treatment issues are difficult and controversial enough without adding a sensational qualifier that seems to further polarize professionals from all disciplines. Nevertheless, pastoral counselors, chaplains and pastors will be approached more often for consultation on MPD/DID cases involving "satanic ritual abuse." There is no critical mass of consensus or practice on this issue. Therefore, I will cite a range of authorities and resources, after which I will make some suggestions for a pastoral position.

The works of Friesen, a doctoral level pastoral therapist,[175] Ryder, a licensed clinical social worker,[176] and Spencer, a survivor[177] are representative of books available through popular distributors. All are used to support the existence of widespread SRA. All are recommended reading for pastors wishing to familiarize themselves with the issues. Friesen has drawn particular ridicule from many clinicians because of his treatment approach grounded in "spiritual warfare," demon possession and exorcism. Ryder includes many survivor and witness accounts.

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[174]Jean M. Goodwin, "Sadistic abuse; Definition, recognition and treatment, *Dissociation,* 2/3: 181(1993).

[175]James G. Friesen, *Understanding the Mystery of MPD* and *More Than Survivors, ibid.*

[176]Daniel Ryder, *Breaking the Circle of Satanic Ritual Abuse,* Minneapolis: CompCare Publishers, 1992.

[177]Judith Spencer, *Suffer the Child,* New York: Simon & Schuster, 1989.

In professional literature, consistently thorough historical research appeared by Goodwin and Hill.[178] These authors published early accounts of the existence and wide practice of satanic ritual from pre-inquisition, primary sources.[179] Their *historical* research is frequently cited by others support of *contemporary* claims. While Goodwin and Hill themselves took little position, they pointed out that dissociative persons who describe satanic rituals face the same credibility problems that 20 years ago would have confronted a patient who was recounting scenes of sadistic incestuous abuse. An open, middle of the road stance was urged and recommendation made for a framework that considers other interpretation than adjudicating "fact" or "delusion."[180]

Taking a broader, exploratory stance, Sakheim and Devine[181] edited a collection of research on Satanism and child abuse. Contributors include pieces from religious historians, law enforcement, social work, psychology, and psychiatry as well as two survivors. Perspectives include Lanning,[182] from the FBI Behavior Sciences Unit, noting that it is simply not possible for thousands of satanists to abuse, and even kill, tens of thousands of victims year after year. The complexity of a conspiracy that included the mayors, police

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[178]Jean Goodwin and Sally Hill, "Satanism: Similarities Between Patient Accounts and Pre-Inquisition Historical Sources," *Dissociation,* March, 1989; Jean Goodwin, Sally Hill and Reina Attias, "Historical and Folk Techniques of Exorcism: Applications to the Treatment of Dissociative Disorders," *Dissociation, III.9,* June, 1990.

[179] "As early as the fourth century, the elements of the satanic mass were well described: 1) a ritual table or altar; 2) ritual orgiastic sex; 3) reversals of the Catholic mass; 4) ritual use of excretions; 5) infant or child sacrifice and cannibalism often around initiation and often involving use of a knife, and ritual use of: 6) animals; 7) fire or candles; and 8) chanting. Extending the historical search from 400 to 1200 AD yields only a few new elements: 9) ritual use of drugs, and 10) of the circle, and 11) ritual dismemberment of corpses." *ibid,* from the abstract, p. 39.

[180] "...We cannot be certain to what extent accounts by observers either in historical or clinical contexts represent witnessed sadistic sexual practices, including homicides, witnessed awe-inspiring theatrical simulations, the effects of drug use and hypnosis or some combination of all of these and other perceptions." *ibid,* p. 43.

[181]David K. Sakheim and Susan E. Devine, *Out of Darkness: Exploring Satanism and Ritual Abuse,* New York: Macmillan, 1992.

[182]Kenneth V. Lanning, "A Law Enforcement Perspective on Allegations of Ritual Abuse," Chapter 5, p. 131, *Out of Darkness, ibid.*

departments and leaders of hundreds of communities across the country would have to be staggering. One of his more interesting postulates is that some activity may actually be grounded in child sexual abuse rings that carry a cultic gloss to reinforce terror and silence. The volume is extremely well balanced, mandatory reading for those involved in the pastoral care and counseling of dissociative persons reporting SRA.

Exhaustive, to the point of being labored and confusing is a "special issue" devoted to SRA from *The Journal of Psychology and Theology*.[183] *JPT* is published from the evangelical perspective, and its presentation is largely reflective of its origin. As the issue's guest editor observed

> Some of the competition to obscure truth is not coming directly from competing religious cults, or the obviously worldly intrusions and distractions, but comes from and is created within our own midst. What is comfortable in an evangelical Christian subcultural system is not necessarily biblical or Christian.[184]

Thirty articles are presented which focus on philosophical, forensic and ontological concerns relative to satanic cults and reports of SRA. The arguments are loud and degenerative as presenters and respondents *repeatedly* debate demonology, theory and belief systems. I felt most of the articles had a distanced, doctrinal and academic tone. I found myself wondering if the presenters and respondents even knew and actually worked with dissociative patients. Although there are some good presentations (including a critique from Elizabeth Bowman), the strongest parts of the collection are the reference bibliographies.

During the Spring of 1994, Lloyd deMause and the *Journal of Psychohistory* weighed in on the debate. The issue includes a very good introductory review by David Lotto, a nice summary on credibility from Jean Goodwin, and an interesting, though somewhat heavy-handed, interpretation by deMause. As with the *JPT* issue, the bibiography is strong.

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[183]Fall 1992, Volume 20, Number 3. Biola University, Rosemead School of Psychology, 13800 Biola Avenue, La Mirrada, CA 90639-0001

[184]Martha L. Rogers, ibid, p. 179.

I recommend two works out of many that shifts the focus from the claims of SRA to the claims-makers. Hicks,[185] an anthropologist has suggested that the current hysteria stems from fundamentalist churches fighting heresy spread by satanic cults, combined with gullible local law enforcement agencies trying to decipher reports of child abuse. (He could have added local politicians exploiting popular fear.) Once the hypothesis of a satanic cult is made, it takes on the quality and dynamic of "urban legend."

Victor,[186] a sociologist draws analogy between the "satanic cults" and other socially constructed labels that have fueled moral crusades and "witch-hunts" throughout history. The overview suggests that the confusion of fundamentalist clergy, police, satan hunters, communities concerned about child-abuse, local and isolated social work or mental health professionals, all being disseminated through small-town media and televised talk-shows has fed the hungry public's, voyeuristic "darker side." Any pastor who has weathered an emotional, moral crusade waged in a small community will understand that there are many kinds of victims. I recommend pastors draw on what they know of human nature in community and do some wide reading before drawing any conclusions.

Core texts minimize the issue by relating SRA to treatment issues. Ross, writes as one open enough to spiritual phenomena, but asks such be discussed in rational, empirical fashion from a treatment-outcome perspective.

> I have talked with Satan many times, as well as with many of his servants and underlings; in every instance, I judged the entity to be a psychological construct created by the patient's own mind. Clinically, I deal with demons just as I do with any other persecutor personality: by forming a treatment alliance, reframing the demon's cognitive errors, negotiating system trade-offs with the demon, empathizing with the demon's pain, correcting the host's cognitive errors about the demon, and working to bring the demon into the therapy as a life giving source of energy and self-assertion.[187]

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[185]R. D. Hicks, *In Pursuit of Satan: The police and the occult,* (Buffalo, NY: Prometheus, 1991).

[186]J.S. Victor, *Satanic panic: the Creation of a Contemporary Legend,* (Peru, IL: Open Court, 1993)

[187]Ross, "Critical Issues," *ibid,* p. 4.

Ganaway submits his experience that patients exposed to "specialized SRA treatment" approaches have continued to remain significantly impaired and that the pubic obsession with the issue has lead to the development of a "cottage industry" in the treatment of reported ritual abuse survivors who are "exploited by therapists, lay individuals, and special interest groups who compulsively seek outside validation for their idiosyncratic belief systems."[188]

Emotion spikes very high on both sides of this issue. Goodwin has suggested that therapists' incredulity toward patient's reports of abuse is a counter-transference issue "rooted in personal defenses... Physicians can be counted on to routinely disbelieve child abuse accounts that are simply too horrible to be accepted without threatening their emotional homeostasis."[189] It should be noted that those who accept accounts of widespread SRA uncritically are themselves not immune to counter-transference issues. Believers--whose own homeostasis might be threatened by disbelief--might be those persons whose religious ideation is based in rigid, dualistic and highly emotional constructs.

SOME PASTORAL CONCERNS

I have three concerns about raising the specter of widespread Satanic Ritual Abuse within the context of MPD/DID. They fall roughly within the areas of theology, pastoral care and holy reason.

***A Theological understanding of Satan*.** Theologically, those who support the widespread existence of SRA offer texts such as *Ephesians 6:12*-- "For our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms." They then cite the presence of alters who identify themselves

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[188]George K. Ganaway, "Some Additional Questions," Journal of Psychology and Theology, 20.3, 1992. See also, "A Psychodynamic Look at Alternative Explanations for Satanic Ritual Abuse Memories in MPD Patients." Paper presented to the Seventh International Conference on Multiple Personality/Dissociative States, Chicago, IL, 1992 and "Alternative Hypothesis Regarding Satanic Ritual Abuse Memories," paper presented to the Ninety-ninth Annual Convention of the American Psychological Association, San Francisco, CA, 1991.

[189]J. Goodwin, "Credibility problems in Multiple Personality Disorder Patients and Abused Children," in R.P. Kluft(ed.), *Childhood Antecedents, ibid,* p. 7-8.

as "Satan" or "his demons." These alters, of course, cannot be seen, but they do protest and respond to anointing, holy water, religious objects and "exorcism."

It is precisely *for* these reasons I believe these "entities" to be more of the flesh and blood variety than spirit. Save exploiting the emotional vulnerability of others, they can perform no feats of magic or miracle. While creating the emotional illusion of the presence of another person, these "entities" cannot really be in relationship.[190] They present with much bravado, but when pressed, revert to very cowardly action. They shame, blame and accuse. Their only real power is to scare people, including developmentally arrested children, naive therapists and well meaning Christians. Except for terminology, there is nothing spiritual or biblical about these characterizations. Like medieval caricature from a Milton pageant, they can best be described as *traditional*, parodies of our own worst fears about incarnate evil. They are scripted actors, reading lines from our religious and cultural worldview.

Perhaps a more biblical reflection on the role of Satan might be helpful. Generally, Hebrew scripture speaks of *hassatan*-- literally "the satan"-- as a role rather than a proper name.[191] According to Hebrew etymology, the label connotes *adversary, opponent, accuser* or *prosecutor.* The verbal root *stn* does not refer to an action that is necessarily evil but to the behavior of one who challenges another party.[192] The role of the satan is to expose where others are vulnerable. Cynical, sarcastic and cunning, Satan seems not deliberately hostile to God, but is skeptical about God's success in creating humanity. Satan knows well how to detect and expose human weakness. This perhaps explains the angry reaction of Jesus to Peter when the later suggests an easier, more glorious way than death to bring about the Reign of God: "Get behind me Satan!" (Matthew 16:23, Mark 8:33)[193] MPD/DID patient/clients easily understand about

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[190]Ross, *Multiple Personality Disorder, ibid*, p. 117, on relationships with two-dimensional characters.

[191]*e.g.*, Job 1:6ff, 2 Samuel 19:23; 1 Kings 5:18, 11:14ff; Psalm 109:6.

[192]*e.g.*, Numbers 22:22, 32; 1 Samuel 29:4, 1 Kings 11:14. In the court context of Zechariah 3:1-2, the satan seems to hold the office of a prosecutor intent on exposing the darker side of human nature.

[193]Should one doubt Satan's efficacy in this role of exploiting vulnerability, a reading of the interaction between God and the satan from the prologue of Job depicts a

the vulnerability to be tempted, taunted, enticed, enchanted or frightened into actions they would not normally undertake.

If we were to look for manifestations of demonic activity in MPD/DID we might have to include the economic pressures involved in diagnosis and treatment, or the human vulnerabilities involved in otherwise competent clinician finding professional excuses to "dabble in the occult."

C.S. Lewis cautioned us to keep the devil out of red tights and horns. SRA stories tend to put Satan back in costume. Like putting God in heaven, ensconcing Satan in SRA stories, rock lyrics and shadow cultures is an attempt to turn an ominous spiritual reality into an object that we can manipulate by prayer, incantation or exorcism. Frankly, I expect Satan to be a more formitable enemy.

Popular demonology has always used the idea of Satan to externalize--literally dissociate from--our motives: "the Devil made me do it." The notion that as a society we might blame satanic cults for turning women and children into morally impaired zombies is suspect.

***Pastoral Care*.** Pastorally, I worry because "SRA" uses religion to speak to our worst fears. Bertrand Russell observed that people seem not to need a god so much as a devil. Our own evil is banal. But when we can create monsters, we can again become intrigued with evil and summon religious values in terms of what we are afraid of. Some conservative Christians have grasped the notion of SRA with the same sensationalized, witch-hunt fervor with which they embraced Peck[194] and Peretti[195] in the early 1980's. Both authors were clear enough that they were speaking of generalized human weakness in the face of evil. But scores of Christians began calling each other names and imagining leather-winged, sulfur-breathing creatures in their midst. I find very little intrinsically Christian in denouncing those who make us afraid as being evil and demonic.

Many dissociative persons already refer to themselves as evil and as "monsters." If they were, in fact, initiated into cults, and have participated in actions as they remember them, over-focusing on the

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tempter that can seduce even God, by way of holy pride, into afflicting-- in wager!--one of God's own.

[194]M. Scott Peck, *People of the Lie*, New York: Simon and Schuster, 1983.

[195]Frank E. Peretti, *This Present Darkness*, Westchester, IL: Crossway Books, 1988; *Piercing the Darkness*, 1989.

cultic aspects reinforces cognitive and perceptual distortions about themselves, keeps them in the victim's position and would seem to perpetuate the ritual aspects of the abuse.

If dissociative persons are generating highly stylized or allegorical screen memories, it is unclear how over-focusing on cultic elements can empower the patient to move into life giving interpretations of their experience. In either case, there can be nothing pastoral about labeling a part of another human being as evil, satanic or demonic. This is particularly true given the high suggestibility of many dissociative persons in early treatment.

Empirical possibility. These activities could not have happened in the magnitude that clinicians hear them reported. Children are abused, sometimes with a brutal and sadistic quality that is in every way incarnate evil. Children do disappear. Cults do operate-- one need only remember Charles Manson, the Branch Davidians and Jonestown. Some cults do, in fact, engage in the traditional worship of Satan. But there has never been anywhere near the physical evidence needed to corroborate the mass of incidents that are reported. There would have to be Satanic covens equal in presence to a mainstream Christian denomination in order to support the reported activity. The numbers simply do not add up.[196]

This does not mean there are no satanic cults, that innocent victims are not abused or that a patient is not telling a factual narrative. Most MPD/DID patients will themselves say they are not certain about what happened. The pastoral task remains to calmly listen, reflect, and help the patient interpret what her experience, including her uncertainty, means for her spiritual life and how her healthy spirituality can be supported. Considerations of veracity, happily, belong to another discipline.

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[196]The victims of human sacrifices and murders are alleged to be abducted and missing children, runaway and throwaway children, derelicts and the babies of breeder women. Bodies and other physical evidence are non-existent. "...the number of children kidnapped and murdered by non-family members is between 52 and 58 a year and that adolescents fourteen to seventeen years old account for nearly two-thirds of these victims... we live in a very violent society, and yet we have 'only' 23,000 murders a year, Those who accept the stories of human sacrifice would have us believe that the satanists and other occult practitioners are murdering more than twice as many people every year in this country as all the other murders combined. " Lanning, *ibid,* p. 130-131, citing National incident reports from the US Department of Justice.

A WORD ABOUT DEMON POSSESSION AND "EXORCISM"

In the professional literature, exorcism was treated recently in the newsletter of ISSMP&D.[197] Generally, positions range from Fraser--reporting very negative effects; to Young--preferring psychological terms rather than theological ones, such as "evil;" to Ross, who suggests that demons are both a clinical and theological problem, and suggests an outline for forming a therapeutic alliance.

Ritualization of a separation experience may be appropriate, for instance, in the cases of the introject of an abuser or of a dead, problematic relative. Ross postulates that demon alters occur because of

> a fundamental dissociation at the root of Christian religion, a dissociation of religious consciousness from the physical body. In Christian culture the spontaneous, pagan sources of physical vitality, including, but not limited to sexuality, are dissociated and disavowed. They are then identified as evil and undesirable, needing to be fought and contained. It is culturally normal for MPD patients to create demon alters to embody irreverent, hostile, and "bad" aspects of themselves, and for the "badness" to be linked to sexuality... Exorcism may simply have functioned as a culturally sanctioned integration ritual for a purely psychological entity. Demons I have meet are secular in nature, except that they claim to be demons[198]

MPD/DID receiving increasing attention from popular media, and particularly from evangelical Christians. Friesen[199] suggests a protocol based on spiritual warfare, deliverance, and exorcism after

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[197]G.A. Faser, C.A. Ross, and W.C. Young, "Critical Issues Committee report: Exorcism in the Treatment of Patients with MPD," *ISSMP&D News,* 11.2 p.3, April 1993; and the response of H.W. Whitaker, "Letter to the Editor," *ISSMP&D News,* 11.5, p.2, October, 1993.

[198]*Multiple Personality Disorder, ibid,* p. 118. Ross' *Satanic Ritual Abuse: Principles of Treatment* should be out in 1995. As he generally includes quite thorough historical and philosophical review in his work, this should be an important book in the field.

[199]James G. Friesen, ibid.

discernment. Criteria for spiritual discernment between an alter and a demon are suggested. Along with others, I believe Dr. Friesen has underestimated the complexity of discernment of spirits.

There is much to mitigate against using exorcism with dissociative persons. The first issue would be whether a demon really possesses the patient, or whether the presentations are that of a belligerent alter. The language of dissociation understands the self (soul) to be split or fragmented. The language of possession understands the body to be shared. The next issue is whether separation of the "demonized" part is consistent with the goal of treatment: association and wholeness. These issues aside, a patient obsessed with the idea of exorcism will likely find someone to oblige them. I offer the following observations.

Of dissociative persons reporting having received some form of "exorcism," many report benefits to be short term and transitory, usually 3-6 months, up to a year in less intensive therapies. The dynamic tends to parallel that of hypnotic suggestion. Of dissociative persons reporting concern about possession and exorcism, either they, or a positive or negative relationship in their history, present strong dualistic religious ideologies. Such is consistent with theories of object relations,[200] introjection[201] and cultural artifact.[202]

Those who report positive effects from exorcism usually have received and integrated the experience with their therapy, with some level of support from their treatment team. The benefit seems to correlate positively with the patient's ownership of the experience and active participation in it. Those reporting less benefit describe their participation in terms suggesting an object being acted upon. They frequently sought the experience outside the process of therapy, feeling or fearing negative reaction or non-support from their therapist. *This did not prevent the patient from seeking exorcism.* Dualistic spirituality and demonology--as well as assuming the role of object during religious ritual--may be integral to the patient's experience or culture.

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[200]Rizzuto, *ibid*.

[201]D.J. Bryant, Kessler and L. Shirar, *The Family Inside: Working with the Multiple,* W.W. Norton, New York, NY.

[202]Colin Ross, *Multiple Personality Disorder: Diagnosis, clinical features and treatment,* (Irvington Publishers, New York, NY, 1992)

The issue seems not to be whether to use the patient's religious ideation, but how to reframe it in such a way as to be supportive to therapy. The therapeutic effects of helpful ritual have been discussed above. There is no reason to assume that introjects of abusers; dead, problematic relatives; or criminally active alters; cannot be "exorcised."[203] The difference between a sexually abusive grandparent, and a demon, is subjective. As Ross points out, "demons are both a clinical and theological problem."[204] Stated differently, there are two disciplines and languages involved in handling the same reality.

Vesper[205] presents a framework for developing healing rituals with MPD patients. Its obvious strengths lie in the active participation of the patient's personality system in the exploration, design and celebration of the rite. Working out of a family systems model, Bryant, *et. al.* describes a process whereby, after months or years of opportunity to transform, be loved, and belong, negative introject personalities "were asked to leave by the inner family...this process was not seen as an 'exorcism,' but rather as the removal of foreign objects..."[206] Such exploration and participation by the therapist and personality system before any separation ritual will minimize the risk of alienating angry or persecuting alters by judging them as evil, alien, or introjects of an abuser. Additionally, such protocol promotes responsibility, reconciliation and communication within the system, empowering the patient toward wholeness. These are indicators of good pastoral theology, good liturgy and good therapy.

Exorcism, as religious issues generally, seems to evoke great reactivity in secular therapists. Pastoral consultation and adjunctive

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[203]*Ibid,* p. 120; *also,* A. Crabtree, *Multiple man: Explanations in possession and Multiple Personality,* cited in Goodwin, Hill and Attias, "Historical and Folk Techniques of Exorcism: Applications to the treatment of Dissociative Disorders, *Dissociation, III.2,* p. 97.

[204]C. Ross, "Response to Critical Issues Committee Report: Exorcism." *ISSMP&D News,* 11(2), 4.

[205]J.H. Vesper, "The Use of Healing Ceremonies in the Treatment of Multiple Personality Disorder," *Dissociation,* 4(2), 109-114.

[206]*ibid,* p84.

therapy have been found helpful in MPD/DID treatment[207] and would seem critical when approaching the issue of possession and exorcism. Christian scripture tells of inappropriate practitioners attempting to exorcise demons *(Acts 19:13-16).* Such stories need not be understood literally to be taken seriously, in light of counter-transference and stress related symptoms noted in therapists treating MPD and ritually abused dissociative persons. Clinically trained chaplains and pastoral therapists can give a treatment team the liminality, language, and balance needed to preserve its clinical neutrality, while preventing validating ceremony and symbolic intervention from developing into another form of dis-empowering, ritual abuse.

A PASTORAL POSITION

Dissociative persons and treatment teams seek out pastoral clinicians to help them process SRA issues, presumably because pastors can approach the narratives with some spiritual discernment and theological wisdom. We are to listen with the ear of a clinician, with the heart of a pastor and the mind of theologian. We can validate evil when we hear of its presence. We can listen for signs of God's presence in people's narratives and celebrate with them as they own those signs for themselves. We can listen to the narratives, interpret and reflect on what is eternal, and reframe what can be helpful. This is the same way a theologian reads scripture.

In chapter three, I attempted to outline the ways biblical theology might interpret and reconcile the differing perspectives of Israel's experience of God. It seems to be important to read for *geschichte*-- significance, rather than *historie*-- historical account. Legends, sagas and myths are not the opposite of truth. Because they transmit the emotionality of an event and record how participants were changed as a result, such stories are truer than true. It is these stories that have been interpreted to give meaning, purpose and identity to God's people.

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[207]M. Bilich, *Collaboration with Clergy in the Treatment of MPD.* ibid; also, E.S. Bowman, *Utilizing Clergy in the Treatment of MPD: A non-clergy therapist guide,* ibid.

The Creation and Fall of Humanity, the Resurrection of Jesus and the great battle and triumph described in biblical *Revelation*, are all important pieces of Sacred Story. However, few theologians outside of Christian fundamentalist denominations are out looking for remnants of the Garden of Eden in Ethiopia, idolizing the Shroud of Turin or preparing for the Apocalypse.

Nor do most people expect such activity from their pastoral leaders. People do expect pastors to be faithful interpreters of their narratives and to help make the Sacred Story relevant to their experience. While pastors know the nuances of biblical criticism, to side track pastoral care in its pursuit might well be an abdication of their proper role. People grow and come to more mature understandings of sacred myth on their own. Pastors can validate those deeper understandings at the appropriate time.

As a chaplain in a psychiatric hospital, I do not need to read the *Revelation* literally in order to see the staff, patients and families battle daily against the Beast. Nor do I need to hear the stories of dissociative persons relating SRA literally in order to be a faithful interpreter of their narratives and help make the Sacred Story relevant to their experience.

As a clinician, I am aware of the nuances of recovered memory. However, to side track pastoral care in establishing or discrediting the veracity of SRA accounts would be to abdicate my role as pastor. Survivors may come to different understandings of their memories over time.[208] As transferential moral authority, pastors can validate those developmental understandings appropriately.

WHOLE AND HUMAN PERSONS

Persons presenting to clinical pastors are, in Boisen's words, living human documents of salvation history-- incarnate pieces of the sacred story. Like scripture, some pieces are narrative, some history, some poetry, some song. There are parables and allegories and dreams. There are legends, sagas and myths. No pieces of the story are more true or false than others. They must all be read as a whole. I have been blessed to sit with such living human documents as they study their sacred story. I have listened to the "Wisdom of Hazel the Jesuit" and the "Revelation to Anthony the Soldier" as these living

[208]Power, *Managing, ibid,* p. 62. Excellent Chapter on dealing with changing truth.

human documents witness to their changing understanding of experience.

Our ability to listen to such reports as skilled observers of the human condition, thoughtful theologians and stewards of divine mystery, sets us apart from others on the treatment team. Persons reporting SRA have something to tell us about evil. Their witness reveals the beast as clearly as the book *Revelation.* Some of what we hear will be horrificly accurate. Some will be distorted recall of a terrorized and traumatized child. Some will be culturally based religious drama written by the fragmented mind of a child of God desperately trying to make sense of what has happened to her. The pastoral task remains to listen and interpret, as God continues to write and work out our *Heilsgeschichte.* Investigation of, much less exploitive facination with, SRA reports is not pastoral and not therapeutic.

Not by might, not by power, but by my Spirit says the LORD of hosts.
Zechariah 4:6 (NRSV)

Chapter 8
AFTER THE SMOKE HAS CLEARED
Some second thoughts

Some of the material in this monograph was written for a variety of purposes as long as three years before publication. Much has happened since then. I have had some second thoughts. It has been tempting to go back into the manuscript and revise. Wiser heads instead advise me to let those pieces stand as developing, in process thinking.

Nevertheless, in the Winter of 1994 there are some things that must be added.

NEW DD MATERIAL

Much has happened in the field of dissociative disorders in the last few months. *DSM-IV* has been published, heralding the conceptualization and name change from "Multiple Personality Disorder" to "Dissociative Identity Disorder." To me, for reasons discussed previously, it seems like a better idea all the time.

The International Society for the Study of Dissociation has also undergone its name change and has published standard treatment guidelines for DID in adults.[209]

A belated issue of the journal *Dissociation* was finally released containing the "Amsterdam Papers" presented at the 1992 ISSMP&D Spring Conference in the Netherlands.[210] Included are

[209]Available from *ISSD*, 5700 Old Orchard Road, First Floor, Skokie, IL 60077.

[210]Vol.VI.2/3: June/September 1993.

recent articles by Putnam, Goodwin, Fraser and family physician Marlene Hunter. Most notable for me in this collection were two articles by Richard Kluft.[211]

The first Kluft piece gives an overview of discoveries, successes and failures in the field over the last decade. I thought it an excellent summary and confirmation of what has been commonly found good, efficacious and safe delivery of care.

The second was Kluft's article describing an approach to initial stages of treatment urging the focus on ego strengthening rather than recovery of repressed trauma material. Kluft found that patients who were properly supported and paced over their care frequently *never* required hospitalization or disability action. Pastors, by virtue of being the initial contact points for persons in crisis, and as providers of relational oversight in community can benefit by awareness of Kluft's model and arguments. I would also, again, submit that pastoral care plays a more appropriate role in ego support than in trauma recovery.

ADDENDUM ON POSSESSION AND EXORCISM

As this monograph goes to press, a belated issue of the Journal *Dissociation* has been released dealing exclusively with possession and exorcism.[212] As I have come to expect, there are excellent presentations, particularly by Begelman, Bowman, Frasier and Rosik. My reaction to the articles was not disagreement--as a whole they support my position urging extreme caution and provide the preliminary empirical data I have lacked for illustration.

I was appalled nevertheless because every attempt to address the issue by these clinicians was done from a stance that considered ritual action merely individualized magic rather than *sacramental action undertaken in support of an individual by a gathered, loving community of faith. Sacramental action is a common celebration of experience.* If clinicians wish to investigate the efficacy of

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[211]In reading over the drafts, I became aware that I may have slighted Kluft in mention of research and writing. I am not sure how that happened, but along with many in the DD field, I have come to regard him as one of the wisest teachers alive. Kluft is Director of the Dissociative Disorders Program at The Institute of Pennsylvania Hospital, Philadelphia, PA.

[212]Vol.VI.4: December 1993.

superstitiously understood religious practice, better perhaps we should study long term effects of... say, magically understood marriage rites among mental health professionals.

SOME REFLECTIONS ON RECENT EXPERIENCE

I now find myself working less in hospitals and more in community and private practice settings. The populations I work with are less the insured, individual middle-class patients and more the working-class families referred by churches, child-protection and social service agencies.

Mental health insurance coverage, specialized hospital treatment, competent intensive psychotherapy, all show a predisposition for a shrinking privileged class in the United States. I submit most dissociative persons are now being seen in community mental health centers, social service agencies, law enforcement and justice centers, and pastor's studies.

To my utter amazement, I see more persons with dissociative symptoms now than I ever did in a hospital. And while I am very grateful for the highly structured, intense work that goes on in the research and teaching institutions, I am becoming convinced that DD treatment as it has been developed in the last decade will not translate well out of the institutions of care for the privileged.

I find helpful a more normalized expectation for dissociation as developmental adaptation rather than pathology. This sort of approach may develop as the disciplines of social work, pastoral care, education, law, family therapy, as well as others, begin to critique the good work that has been largely done up until now by psychiatry.

I have been surprised to find that outside the hospital, the therapeutic stance I take as a family therapist or pastoral counselor frequently comes not from a DD orientation, but from skills I learned from inpatient HMO teams about managing dissociative patients from their strengths rather than their pathology. As much as possible, persons need to be supported in their vocations as professionals, students, workers, spouses and parents. It is not in every dissociative person's best interest to do intensive trauma recovery work.

This is *not* to say we should go around ignoring or denying the existence of dissociative disorders. It *is* to say that we do not always have to inflict the cutting edge of our rapidly changing understandings on people who are already overwhelmed by their changing reality and

environment. This is *not* to say that buried trauma memory and affect does not need to be uncovered. It *is* to say that such recovery needs to be paced carefully, and cannot be helpfully done at all if people cannot be supported in some skill mastery in their daily living.

Persons who are given support with their daily struggle for living simply heal better and faster than those given support for their pathology and primary identity as victims. To paraphrase Paul's admonition to the Corinthians, just because we know something is true, does not mean such knowledge is always good for others in community.

There are dissociative persons who need to do intensive, debilitating, work which may result in frequent life-threatening periods and require multiple hospitalizations. I still enjoy doing this type of work with people in an inter-disciplinary atmosphere. But if I am properly understanding my own experience--as reflected in Kluft's conclusions cited above--the invasive and paternal modality of treatment currently practiced in many large teaching centers and invasive technique currently taught at conferences may need to become the exception rather than the standard of care.

MODELS, TECHNIQUE AND DATA

I frequently have to remind myself that both "Multiple Personality" and "Dissociative Identity" are conceptual models that have no substantive reality of their own. Perhaps, like pious practice and worldview, they are helpful superstitions. The conceptual models and techniques I have been taught serve the essential function of managing my own anxiety in the face of bizarre, dissociated behavior so that I may be a healing presence. But for those in my care who are not aware of the language or experience of the MPD/DID culture, I see no reason to further overwhelm them.

People are real, and relationships within and among people will always be the real venue of healing. God's concern is with people, not models, skill or technique. Reductionism, whether in psychiatry or fundamentalist religion, represents the same phenomena. Like its source and creator, Life is a lot more ambiguous than we are comfortable with. Structure, technique and data are the professional's analgesic for anxiety. If we are looking for "demons" in the world of dissociative persons, we might look for the one that seduces professionals into focusing on the wrong data, obsessing over

technique, perpetually imbibing excess information and being snookered into behaving as society's defense mechanism against scary people with painful stories.

Most of us have more information than we can handle already. It is by relationship we have been broken, and by relationship we will be healed.

ANOTHER WORD ABOUT THE PASTORAL RELATIONSHIP

Much has been written about the nature of the therapeutic relationship with dissociative persons. I have neither read nor cited in this work any cautions against extraordinary extension of personal and professional boundaries that should not be embraced by pastoral care. While not wishing to create an exception, I do want to reiterate two paths of reflection for pastors.

While the constant testing of boundaries is a feature of victims of abuse, they did not ask to be abused, nor did they design their personality's adaptation. Pastors can best model responsibility by assuming appropriate responsibility *for themselves* in the relationship. In supervision, I find it more helpful to reframe this issue in terms of the vulnerability and dependency needs of the pastor, rather than the personality deficits of the client. Empathy is important, but not as important as consistency, safety, self-definition, honesty and longevity in relationship. If the pastor's management of the relationship ultimately compromises or "burns out" the pastor, the pastoral relationship has failed.

At the same time, the rigidity of many writings on this issue seem problematic to me. The pastoral task is by nature more shamelessly human than its more clinical counterparts. While the soft and hard roles inherent in interdisciplinary team approaches is helpful, such a defense is never a substitute for a clear sense of pastoral identity that transcends external rules about personal boundaries. Particularly for pastors who have roles in the larger community, issues about availability, dual relationship, and even reasonably appropriate physical contact are more difficult to resolve than they would be for secular clinicians. Pastors routinely visit in homes, hug people at the Eucharist, have differing roles with several people in families, give didactic counsel and preside over life-stage events in ways that secular clinicians would never consider. Representative of both the divine and the flesh, the pastor has to be faithful to the religious object

represented, while retaining the ability to step from behind the object at strategic points in order to represent humanity.

Directly addressing relational boundary questions with the client, parishioner or patient is necessary, as is open, honest communication with the primary therapist or treatment team contact. Because of my background, I continue to believe that consultation or ongoing supervision is important.

Most importantly, however, will be the Christian pastor's understanding of the informative relationship between identity and rule. The New Testament most clearly articulates this understanding of gospel and law. The empowering love of God mediated through human relationship can never be reduced to objective precepts and prohibitions that can then be transferred from the page into flesh. The gospel ethic is "written upon the heart." This grounding of the pastoral identity in the agape of God is what can make the relationship both dependable and flexible. Without this grounding, there will be no pastoral relationship, no incarnation of the healing love of God.

IN CONVERTENDO

When our God restored the fortunes of Zion,
then were we like those who dream.

Then was our mouth filled with laughter,
and our tongue with shouts of joy.

Then they said among the nations,
"God has done great things for them."

God has done great things for us,
and we are glad indeed.

Restore our fortunes, O God,
like the watercourses of the Negev.

Those who sowed with tears
will reap with songs of joy.

Those who go out weeping, carrying the seed,
will come again with joy, shouldering their sheaves.

Psalm 126

SÆPE EXPUGNAVERUNT

"Greatly have they oppressed me since my youth,"
let Israel now say;

"Greatly have they oppressed me since my youth,
but they have not prevailed against me."

The plowmen plowed upon my back
and made their furrows long.

Our God, the Righteous One,
has cut the cords of the wicked.

Let them be put to shame and thrown back,
all those who are enemies of Zion.

Let them be like grass upon the housetops,
which withers before it can be plucked;

Which does not fill the hand of the reaper,
nor bosom of him that binds the sheaves;

So that those who go by say not so much as,
"The Lord prosper you. We wish you well in the name of the Lord."

Psalm 129

Appendix I.

The chart "Understanding Faith Development" by Mary Marks Wilcox and used in Chapter four is reproduced by agreement with Living the Good News, Denver, CO, publishers of Christian Education material. It can be obtained in a single wall chart from the publisher by calling (800) 824-1813.

The major resources used in the preparation of the chart are as follows:

James W. Fowler and Sam Keen, edited by Jerome W. Berryman. *Life-Maps: Conversations on the Journey of Faith*. Waco, Texas: Word, 1978, 1985.

James W. Fowler. *Stages of Faith: The Psychology of Human Development and the Quest for Meaning.* San Francisco: Harper and Row, 1981.

Robert Kegan. *The Evolving Self: Problem and Process in Human Development*. Cambridge: Harvard University Press, 1982.

Lawrence Kohlberg. *Essays on Moral Development. Volume One: The Philosophy of Moral Development.* San Francisco: Harper and Row, 1981. *Volume Two: The Psychology of Moral Development*. 1984.

Donna Newendorp. "Images of God." Unpublished class project, Iliff School of Theology, 1985.

William G. Perry, Jr. *Forms of Intellectual and Ethical Development in the College Years: A Scheme*. New York et al.: Holt, Rinehart, and Winston, Inc., 1968, 1970.

Mary Marks Wilcox. *Developmental Journey: A Guide to the Development of Logical and Moral Reasoning and Social Perspective*. Nashville: Abingdon, 1979.

Mary Marks Wilcox. *Spiritual Growth in Later Life*. Atlanta: Presbyterian Office on Aging, 1985. Address: 341 Ponce de Leon Ave. NE, Atlanta, GA 30365. Cost: $2.00

Journey With Me: Managing Your Church School. Karen C. Nelson, Ed. Denver: Living the Good News, 1986.

A significant amount of the content of the chart has come from unpublished results of an ongoing research project at the Iliff School of Theology in Denver, Colorado, 2201 S. University Blvd., Denver 80210. Directing this project is Mary M. Wilcox, with Clarence H. Snelling Jr. and H. Edward Everding Jr.

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