ISSMP&D NEWS

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LETTER TO THE EDITOR

Exorcism

I thank the Critical Issues Committee for addressing the sensitive topic of exorcism (*ISSMP&D News*, April 1993). As MPD/DD receives increasing attention from popular media—and particularly from conservative Christians due to the wider distribution of Friesen's work (1991, 1992)—an informed, nondefensive stance is needed from clinical practitioners.

Of patients reporting having received some form of "exorcism," many report benefits to be short term and transitory, usually lasting from 3 to 6 months. The dynamic tends to parallel that of hypnotic suggestion.

Of patients 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 (Rizzuto, 1979), introjection (Bryant, Kessler, & Shirar, 1992) and cultural artifact (Ross, 1989).

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 nonsupport 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.

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. While not advocating "exorcism" as popularly understood, I make the following suggestions:

There are healing rites less melodramatic and sensational than exorcism available in most Christian faith traditions and several New Age modalities. Clinically speaking, these carry the positive effects of the power of suggestion (Durkheim, 1915), cognitive reorganization (Van der Hart, 1988), and ego enhancement (Erikson, 1972) induced through the altered consciousness inherent in classical forms of prayer. These rites speak of cleansing, absolution, 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's religious system; all while avoiding the risks of labeling certain parts of a person as evil and encouraging further pandemonic understanding.

Vesper (1991) 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 and colleagues (1992) described 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..." (p. 84). Such exploration and participation by the therapist and personality system before any separation ritual minimizes the risk of alienating angry or persecuting alters by judging them as evil, alien, or introjects of an abuser. Additionally, such protocol promotes responsibility and communication within the system, and empowers 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 therapy has been found helpful in MPD/DD treatment (Bilich, 1992; Bowman, 1992;) and would seem critical when approaching the issue of possession and exorcism. As Ross (1993) points out, "demons are both a clinical and theological problem." Stated differently, there are two disciplines and languages involved in han-

continued on page 10

LETTER TO THE EDITOR

continued from page 2

dling the same reality. 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 countertransference and stress-related symptoms noted in therapists treating MPD and ritually abused patients. 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 ritual abuse.

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