PRIMUM NON-NOCERE – A REASON FOR RESTRAINT: DR. BOWMAN'S REPLY TO DRS. CRABTREE, ROSIK, AND NOLL

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Primum non nocere. (The Hippocratic Oath.)

In replying to the lively discussion generated by my paper on exorcism of MPD patients, I will answer specific questions by my colleague commenters and then explain why I now recommend that therapists currently refrain from performing exorcism of MPD patients.

Dr. Crabtree questioned two of my viewpoints on exorcists and therapists. First, my conclusion that exorcism may serve the exorcist's narcissistic needs comes from comments by subjects who described their exorcists bragging about conquering their (the patients') demons. Narcissistic gratification doesn't motivate all exorcists, but it played a role in some exorcisms and in the subject's rejection by exorcists who blamed them for its failure. Second, my concern that therapists who consider exorcism may not be aware of the extent and subjective reality of dissociative/hypnotic sensations and hallucinations arises from observations during consultations with therapists who treat MPD. Not all therapists are aware of these phenomena or of transference-influenced symptom production. The mental health workers involved in the exorcisms of my subjects appeared to act on the basis of their religious convictions rather than on the basis of clinical knowledge.

I agree with Dr. Rosik that religious affiliation is a poor measure of religiousness, but space constraints limited further descriptions of the rich religious lives of these subjects. The relationship between their beliefs and their contact with exorcists deserves study.

Dr. Rosik raises a valid question about the occurrence of positive reactions in the hosts and alters of the same subjects. None of my subjects reported this. Only one alter group of the two patients with a positive host response to exorcism reported a positive response to exorcism. No subject reported a mostly positive experience.

I agree with Dr. Rosik that lack of standardization of the exorcism procedure is a methodologic problem. Each exorcism was unique. The technical variations which did occur hint that gentler approaches and no subsequent rejection of the subject result in fewer negative sequelae. I have seen persons without dissociative disorders who have undergone coercive and/or chaotic exorcisms and were not as damaged as were persons with MPD. I believe diagnosis may also influence outcome.

Dr. Noll's viewpoint seems largely determined by his preoccupation with perceived turf wars. He believes data (and percentages) are being used to bolster an adversarial relationship between science and religion. I disagree and I advocate cooperation between therapists and clergy. I believe exorcism is a spiritual treatment best performed by clergy, not by therapists. If patients seek it, I feel discussion between the therapists and clergy can help avoid harm, but I cannot see how the stance of a therapist performing an exorcism is compatible with the neutrality necessary for resolving the intense transferences of MPD patients. I also disagree that abreaction is another term for exorcism. An abreaction requires patients to accept and transform affect; exorcism handles affect by disowning it as alien. Unlike exorcism, abreaction does not require the therapist to agree with the patient's beliefs in order to be effective.

Dr. Noll accuses psychiatry of hubris for having "no place for spirits." My subjects' exorcists had no place for angry affect, preferring to eject it ceremonially. Error has occurred on *both* sides of the science/religion gulf. Perhaps Dr. Noll's rage at hubris should also be directed at those whose belief that they could distinguish personalities from demons led to such suffering.

I agree with Dr. Noll that there is selection bias in the subject pool of my study, but the bias was not treatment by a psychiatrist. Of the fifteen treating therapists, only three were psychiatrists. I agree that persons with positive views of exorcism may be less likely to participate in such research, resulting in a narrower subject group. The only successfully treated patient who was referred to me was also the only subject who declined to participate.

My sample was biased, but it was gathered in as systematic a manner as possible. Advertising for persons with a specific outcome, i.e., a positive one, would have produced an intentionally biased and truly pseudo-scientific study. If therapists who use exorcism avoid MPD study groups or research, their outcomes cannot be included in systematic ascertainment of subjects. If these therapists want me to withhold conclusions about exorcism, they need to have enough confidence in their technique to allow it to be studied.

The answer to the methodologic "uncleanness" of initial clinical research is not to nullify the validity of all results but to use them to guide further studies. This study was a first attempt to explore exorcism in MPD patients. Hopefully

it will open up discussion with clergy about the need to rule out alter ego states as symptom sources before performing an exorcism. My data point to the need for further studies of persons with MPD who felt helped by exorcism and of therapists who operate more prudently with exorcism than did my subjects' exorcists. Studies of homogeneous samples of persons with positive outcomes should be done to determine the roles of the exorcism technique, the therapeutic relationship, and the world views of the therapist exorcist, clergy exorcist, and patient in influencing the outcome. Like Dr. Noll, I suspect that gentle exorcisms that do not try to extrude alter personalities may have different outcomes, but this must be *demonstrated* before exorcism can be responsibly recommended. Strong trusting relationships with exorcists did not prevent damage to my subjects, so more data are needed to determine if results will be better with exorcisms by currently treating therapists (as opposed to the nontreating therapist-exorcists of some subjects).

The lack of research about exorcisms done by currently treating therapists conversant with MPD is the basis for my recommendation that, at the present time, therapists never exorcise a person with MPD. My colleague reviewers have taken issue with my stance, but at the present time, what limited knowledge we have about exorcism outcome is overwhelmingly negative. No study has yet been done to show that exorcism of MPD patients within therapy is helpful. Until such a study demonstrates helpful results and delineates what factors avoid harm, it would be irresponsible to recommend exorcism for MPD patients. Patients are not toys for our experimentation. For two reasons, it is better to err on the side of safety until we have better studies of exorcism within the therapy of MPD. First, primum non nocere (above all, do no harm) is a basic principle of the Hippocratic Oath which guides my profession. Exorcism is known to harm but not yet known to help. Second, if faith teaches us anything, it is to view human beings as so valuable to the Divine Spirit, that we take extreme care in how we treat them. Until I see data on the clinical helpfulness of exorcism for MPD patients, I cannot ethically recommend it. ■