UTILIZING CLERGY IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER

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ABSTRACT

Religious/existential issues arise frequently in the treatment of MPD, but therapists often feel reluctant or inadequate to address them. Collaboration with clergy can resolve specific religious questions efficiently while preventing ethical and boundary violations, and safeguarding against the inherent disturbance of therapeutic neutrality which accompanies disclosure of the therapist's personal religious views. This article outlines types of counseling training and services by clergy and provides suggestions for locating appropriate clergy and initiating referrals. Four areas of clerical involvement in the treatment of MPD are discussed: 1) Traditional pastoral care (supportive listening, access to congregational support, transition from hospital to community). 2) Educating care givers about religious material. 3) Consultant for the treatment team (assessment of religious history, personal support of therapists). 4) Treatment interventions (long-term spiritual growth counseling, brief problem-focused religious counseling, performing rituals to celebrate resolution of abuse). Clinical examples of clergy-therapist collaboration are offered.

REVIEW OF THE LITERATURE

Despite the existence of a sizeable literature on religious aspects of psychiatric treatment, mental health practitioners have given relatively little attention to collaboration between clergy and therapists. The multiple personality disorder (MPD) literature contains few articles specifically on religious aspects of treatment (Shepperson, 1985; Bowman, Coons, Jones & Oldstrom, 1987; Bowman 1989; Friesen, 1991). The first conference presentations to address collaboration with clergy in the treatment of MPD occurred in November 1992 (Bilich & Carlson, 1992; Bowman, 1992). Rosik (1992b) recently provided helpful guidelines for religious therapists who wish to encourage support of patients by introducing parish clergy and congregants to MPD. He suggested education of supportive clergy and congregants, emphasis on provision of steady reliable support without over involvement, clergy assessment of the emotional stability of supportive congregants, and teamwork between therapists and parish clergy. While the pastoral counseling literature is just beginning to introduce clergy to MPD (Rosik, 1992a; Rogers, 1992), the psychiatric literature has not addressed collaboration of clergy and secularly identified therapists who treat MPD patients.

Presley (1992) observed that mental health practitioners approach patients' religious experiences with avoidance, eradication or integration. Avoidance discourages or postpones dealing with religious issues. Eradication likely violates professional ethical codes (American Psychiatric Association, 1990; American Psychological Association, 1992). Presley favored integration of religious values into therapy. Bergin (1980) agreed, but warned "secular humanistic" therapists that informed consent about the values which underlie therapy is necessary, especially for patients with theistic values. Some therapists who feel unable or unwilling to work at integrating religious values into therapy turn to clergy for assistance, but collaboration is still relatively rare. Larson et al. (1988) note that despite encouragement from two presidential commissions, a gap still exists in linkages between clergy and mental health providers.

The purpose of this article is to help non-clergy therapists successfully collaborate with clergy in the treatment of MPD patients. The treatment approach assumed in this paper is inpatient and outpatient individual psychodynamic psychotherapy by a secular therapist (one not advertised as a religiously-based therapist) with clergy adjunctively providing spiritual and religious support. Clinical vignettes have been disguised to protect patient confidentiality.

DEFINITION OF THE PROBLEM

The religious and existential issues which arises while treating severely abused persons often involve deep and difficult questions about evil, abusive uses of religion, and the nature of deity (Bowman, 1989). In addition, because some alter personalities have experienced so little religious involvement, their questions often require very basic religious education.

When such religious questions are raised in therapy, several difficulties may arise. As a group, therapists are less reli-

giously oriented than their patients (Gallup, 1981; American Psychiatric Association, 1975; Ragan, Maloney & Beit-Hallahmi, 1980). We may lack the religious knowledge or experience needed for answering questions about norms of religious beliefs and practices. We may correctly perceive that questions of a theological nature are outside our area of expertise, making it unethical for us to try to address them. If we are of a different faith than our patient, we may feel it is inappropriate for us to comment on the beliefs of another faith group. In addition, the training of secular therapists rarely addresses dealing with religious issues.

A second difficulty with religious questions is the disturbance of the therapeutic neutrality which underlies the formation of a transference and the examination of emotionally charged material. While recalling and abreacting trauma is certainly important to the resolution of MPD, treatment also requires the identification of maladaptive character defenses and transference distortions in relationships with the therapist and other people. A degree of anonymity and neutrality on the part of the therapist is necessary for the development of the transference and the maintenance of the secure therapeutic boundaries needed during the treatment of MPD (Fine, 1989). While completely value-neutral therapy cannot exist (Bergin, 1980), a certain amount of neutrality is necessary to avoid unduly influencing patients' religious beliefs—a stance considered explicitly unethical by some professional groups (American Psychiatric Association, 1990; American Psychological Association, 1992).

Some religious issues, such as the nature of God's interactions with people, are difficult to discuss without the interjection of personal opinion. It is particularly difficult for patients to resolve some of these issues without direct input from another person who is free to state a theological position. If therapists offer their personal opinions, they break therapeutic neutrality. Strongly offered personal beliefs risk violating professional ethics which forbid proselytizing. In the long and intense treatment of MPD, the therapist is in a powerfully influential position. Our personal opinions, while no more authoritative than that of any other human being, can carry phenomenal weight with our patients because of dependent and idealized transferences or simply because patients usually respect their therapists' opinions. In light of these difficulties in dealing with the religious questions of MPD patients, the utilization of a third party such as clergy has considerable advantages.

A CLINICIAN'S GUIDE TO CLERGY

The training and skills of clergy, like those of therapists, vary greatly. Some have virtually no psychological education while others may have several years of supervised counseling experience. When patients have no parish pastor or rabbi and when the therapist is without ties to the religious community, identifying clergy with the skills *and* willingness to help MPD patients may require some effort. Therapists needing assistance with locating appropriately trained chaplains, pastoral counselors, and clergy could contact the national training and accrediting groups listed in the Appendix.

Young and Griffith (1989) have divided counseling provided by clergy into three groups. Religious counseling is usually provided by parish clergy and focuses on spiritual-emotional crisis. Generally the pastor has had little or no formal training in counseling. Pastoral mental health work is provided by parish or religious agency personnel who have had some course work in counseling. It focuses on difficulties in psychological and religious growth. Pastoral psychotherapy is directed at *DSM-III-R* mental illness, is fee based, and conducted by clergy with formal counseling training and supervised experience, i.e., those accredited by the American Association of Pastoral Counselors (AAPC). Chaplains assigned to inpatient psychiatric services may be certified by the College of Chaplains, have training from the Association of Clinical Pastoral Education (ACPE) or may have little counseling training.

CLERGY-THERAPIST COMMUNICATION

With serial or long-term clergy-patient contact it is extremely helpful to obtain mutual releases of information that allow clergy-therapist communication. Although such communication tends to occur infrequently, it usually takes place when the clergy or patient perceive a crisis. One function of clergy-therapist communication is education. Clergy who begin pastoral support of an MPD patient usually need education about MPD. This is particularly critical in congregations where demon possession is considered as an explanation for coconscious phenomena or switching behaviors. Clergy benefit greatly from the gift of a packet of basic articles on MPD, followed up by a phone conversation for answering questions. Sending literature to the clergy communicates respect for them as helping professionals and helps break down clergy misconceptions about MPD or about the therapist's attitude toward the clergy.

Support of the clergy is a second function of pastor-therapist communication. Clergy who are unfamiliar with MPD may become anxious the first time an obvious switch of personalities occurs in their presence or when an angry or anti-religious personality emerges. Often this first encounter occasions a call to the therapist to process the handling of the situation. This is a good time to suggest basic approaches to dealing with alters and to provide reassurance. Clergy tend to feel more secure in proceeding with pastoral care once they know the therapist will be supportive of them and not abandon them to deal alone with a disorder which they may find unnerving.

A third function of clergy-therapist communication is prevention of therapeutic misadventures. Such communication is essential with patients who tend toward transferential splitting, avoidance of relationships with non-professionals, or with overly dependent patients. Triangulation, transference splits or acting out of the transference can be curtailed by a discussion of these phenomena with the pastor and a mutual agreement to consistently point the patient back toward direct communication with the involved party. If the patient cannot curtail the tendency to use clergy contact as a way of avoiding more "risky" relationships, the therapist can alert the clergy about this trend. The clergy can then set better limits on the amount of time given to the

patient and can actively insist the patient establish relationships in the congregation.

FOUR AREAS OF CLERICAL INVOLVEMENT

The adjunctive involvement of clergy in the treatment of MPD patients can be divided into four areas listed below. Within each area, the function of clergy is explained and clinical examples are offered. This list is not a comprehensive catalogue of the help clergy can offer but it reviews the most common interactions between therapists and clergy in the treatment of MPD.

1. Traditional Pastoral Care

The provision of personal emotional support to suffering souls is a function of the clergy that predates psychodynamic psychotherapy by at least two millennia. Secular therapists who lack much contact with institutional religion may feel that the transfer of this function to secular psychotherapists is a fait accompli. Religiously committed patients, however, frequently feel otherwise; 40% of them seek out clergy before turning to mental health practitioners (Beitman, 1982).

While most psychiatric patients can turn to families for support, the treatment of MPD patients often leads to the severance of ties to abusive families of origin. This understandable and sometimes necessary separation can lead to painful isolation and loneliness. Within Christianity, the church is portrayed as the family of God, a place where acceptance is "guaranteed" on the basis of a shared faith. The church, synagogue and clergy, serving as transferential family and parental objects and as socially supportive relationships, are the logical place for religiously committed patients to turn for support. Thus, a faith community may serve to replace the family of origin with a less pathological "family."

Likewise, parish clergy can provide supportive pastoral care to the patient's extended family and especially to spouses and children who are often in great need of support. Clergy have almost automatic access to families in ways that other professionals do not. While it may be somewhat easier for clergy to relate to family members who are involved with the patient, those who are estranged from the patient may need pastoral support as well. The unique role of clergy can often provide the only connection between and within families who are responding to someone with MPD.

Clergy can provide pastoral support in the form of the empathetic listening ear. The therapy of MPD is a long difficult process full of periods of exquisite emotional pain. Patients often seek out clergy after new memories of abuse have emerged or when they are actively revising cathexes to abusive parents. The experience of having one's pain heard by a powerful parental figure who has moral authority to validate the evil of abuse can be a powerfully healing experience.

Clinical example: A woman with MPD who was geographically separated from her family experienced progressive inability to tolerate contact with them as memories of abuse at the hands of numerous family members emerged in therapy. Initially her pastor provided emotional support, but encouraged her to establish relationships in the congregation. When particularly disturbing memories emerged, meeting with her pastor for up to an hour soon thereafter lessened her sense of isolation. Over time, congregants became her "family" for holiday celebrations. This context provided previously unavailable models of normal family life and healthy behavioral interactions. When she eventually integrated her pastor was the first to hear and celebrate this good news.

Clergy can be helpful when the stigma of the MPD diagnosis interferes with the patient establishing confiding relationships with fellow congregants. Therapists who deal daily with mental illness can become inured to the stigma that such illnesses can carry. Regardless of the official denominational stance on mental illness, individual congregants may hold condemning or skewed views of MPD. In these situations, the pastor can help patients establish an appropriate support system in the congregation by marshaling congregational resources to ensure contact with more parishioners. The result should be a widening of the patient's often shaky support system.

Marshaling congregational support helps avoid the pitfall of patients' making clergy their sole source of psychosocial support. Such a relationship threatens to exhaust the pastor's personal care giving strength and is a form of therapeutic resistance that needs direct confrontation and exploration. This pattern of exclusively seeking relationships with helping professionals is likely indicative of the avoidant and dependent personality traits commonly seen in severely abused persons. Conversely, avoidant personality traits combined with compulsively based independence can lead MPD patients to avoid appropriate pastoral contact while asking the therapist to serve as therapist, pastor and sole social support. The problem of overdependence on clergy can be avoided if therapists communicate this possibility to clergy and remind their patients that contact with clergy is, among other things, a stepping-stone to establishing supportive relationships within the community of faith.

Clinical example: A devoutly religious woman moved to a new city and joined a church. Members of her former church had shunned her after becoming convinced that her MPD was demon possession which rendered her unsafe around them or their families. Deeply hurt, she felt unable to trust the parishioners of her new church. In addition, considerable anger at religiously based familial abuse led alter personalities to disrupt public worship, bringing her plight to the attention of the pastor. He quickly formed a support committee of parishioners who met with her individually and as a group to learn about her MPD, support continued church involvement and become her friends. Over several years this group enabled her to experience acceptance and love and enabled the pastor to focus his interactions with her on specific religious questions rather than on general support.

Supportive pastoral care can be invaluable in easing a patient's transition back into the religious community after a hospitalization. The experience of being unable to handle one's problems as an outpatient can engender a sense of shame. In addition, MPD patients are often hospitalized

with suicidal ideation or attempts—acts viewed by some faith communities as a serious sin. Other parishioners may think that MPD implies demonic influence or is a sign of spiritual weakness. In such situations, MPD patients may feel social shame when returning to the congregation. The pastor can begin to ease their transition during the hospitalization by suggesting they invite supportive parishioners to visit and listen if they choose to explain their MPD or psychiatric difficulties. Hospital visits from parishioners can reduce the perceived discontinuity between hospitalization and life in the congregation. Clergy who understand MPD can also work behind the scenes to reduce the stigma of MPD by countering misperceptions with accurate information about the illness and by using theological approaches to minimize congregational gossip about the patient. Sensitive invitations to participate in congregational life following discharge can greatly enhance a patient's feeling of acceptance.

2. Educator of Caregivers

Therapeutic disasters can arise when the therapist or the inpatient treatment team do not understand the patient's religious beliefs or when the local clergy do not understand the philosophical approach of the inpatient team. In these situations, a hospital chaplain or pastoral counselor can serve as a go-between and educator of either party.

Like any special purpose group, religious groups can have unique terminology and practices with which mental health professionals are completely unfamiliar. Asking patients to explain their beliefs is helpful but does not help the team assess whether these beliefs are normative for the religious group or represent personally based distortions. For example, a Pentecostal patient who expresses emotional experiences in terms of "having the demon of" depression or fear, or speaks of being "slain in" or "filled with" the spirit is using normative charismatic terminology. If the treatment team is unfamiliar with the meaning of these terms, the patient's experiences may be confused with psychotic or dissociative phenomena. Clergy may be of help in clarifying the situation, especially one who has an established alliance with the treatment team as hospital chaplains/pastoral counselors often do.

Inviting the inpatient chaplain/pastoral counselor to treatment planning helps educate the whole team about the patient's beliefs and belief distortions. The team may feel more free to express doubts about the health of these beliefs to "insider" clergy with which they are familiar. Hospital clergy can then suggest approaches to religious resistance that are least likely to violate the patient's basic values. If the patient's parish pastor is suspicious about mental health professionals, the chaplain may be the best person to approach the pastor with the team's inquiries about normative congregational beliefs. The ecclesial identification of the chaplain minimizes the chance of alienating the parish clergy and enhances the likelihood of the team's viewpoint being understood and accepted.

Utilizing a chaplain for communication with local clergy is most essential when the difference between the patient's beliefs and the treatment team's viewpoint are considerable. Since hostile clashes with clergy are rarely productive, a team who feels unable to communicate productively with the local clergy should utilize a trusted chaplain. Pastor-chaplain contact can be used to educate the MPD, especially about commonly misunderstood symptoms. Such communication may avoid unfortunate incidents such as inpatient "exorcisms" of alters or poorly-timed hands-on healing ceremonies which frighten young alters.

Clinical examples: A Protestant woman with MPD belonged to a congregation which doubted the efficacy of mental health treatment. She wished for a marital separation but her pastor strongly advocated her submission to her physically abusive husband as God's will. Conflicted, she attempted suicide. While hospitalized, her pastor visited and held her hand as he prayed with her. This evoked fears of abuse in younger alters and aroused the rage of an anti-religious alter who drove the pastor away with colorful language. The patient did not wish a repeat of this behavior but felt too guilty to request that the pastor not visit. The therapist and chaplain met with the pastor to explain the temporary restriction of visits. When the patient wished to discuss religious aspects of her desire for safety from spouse abuse (a position the treatment team felt was essential to further progress), she was offered sessions with a chaplain who allowed her to explore her questions in a neutral atmosphere. This example illustrates the essential role of the chaplain when theological constructs are intrinsic to disagreements between the religious group and the treatment team.

3. Treatment Team Consultant

The long and often difficult treatment of MPD means prolonged contact with severely abused persons who can be personally needy and who are prone to splitting inpatient teams. Treating persons with MPD can exact a personal toll on the therapist. Working with persons who report repeated reprehensible abuse can raise serious religious and existential questions in the caregivers. Chaplains and pastoral counselors can provide personal support for therapists.

A chaplain who is regularly assigned to an inpatient unit can be a valuable resource for ward personnel who need a neutral listening ear when events on the unit become unusually stressful. Chaplains often have enough distance from the team to spot pathological team dynamics developing and to detect staff on the road to burnout. A skilled, well trained chaplain can provide preventive assistance when a staff split is developing around issues related to an MPD patient's treatment.

Chaplains and pastoral counselors can be invaluable in helping outpatient and inpatient caregivers assess a patient's religious history. An in-depth spiritual and religious history is not ordinarily obtained by therapists, but it can contain critically important information when the patient is highly religious, reports religious types of abuse, or has a complicated religious history that is relevant to treatment. Although sample lists of questions about religious history and ideation are available (Bowman et al., 1987), therapists may lack the necessary background knowledge for interpreting the patient's responses. Interpretation of the relative health of a religious ideation system is best done by one with formal theological training and some knowledge of psychodynam-

ics. Chaplains (trained by the Association of Clinical Pastoral Education) or pastoral counselors (trained by the American Association of Pastoral Counselors) are ideal for this task.

4. Treatment Interventions

Nearly all MPD patients report repeated abuse or trauma, events which inevitably raise existential and religious questions. I encourage therapists to actively suggest referral to clergy for work on specific religious issues. The most common issues which prompt referral to clergy are: 1. *Theodicy.* This is the sticky question about how a God who did not stop the patient's abuse can be perfectly good and omnipotent. Secular therapists who doubt the need for pastoral consultation should imagine seriously addressing that question with their most religiously sophisticated MPD patient. 2. *Anger.* Is it religiously acceptable to hate for abusers or sincerely wish their death and eternal punishment? 3. *Guilt.* Will/can I be forgiven for the sexual indiscretions of sexualized alters? Can I be forgiven for my perpetration of abuse? 4. *God.* Is God like my abusive father/mother? 5. *Salvation.* If some alters do not believe, is the whole person condemned?

For some patients, particularly conservative Christians, these questions can be life and death theological issues which encompass the very philosophical foundation of life. They cannot be trivialized or ignored. A referral to clergy to address such questions can be invaluable, especially when examination of these questions is necessary for resolution of abuse experiences.

We recommend that therapists discuss the need for clergy consultation with the patient and assist her or him in choosing a pastoral consultant. If patients sense that their own minister will be unable to tolerate their religious questions, the therapist might suggest a chaplain, pastoral counselor or other clergy whose beliefs are generally compatible with the patient's. Therapists who work with religious patients may need to initiate contacts in the clergy community in order to become acquainted with clergy who are appropriate for referral.

When referring to clergy, we strongly suggest arranging a time-limited counseling agreement between the patient and clergy. Limiting the length and duration of clergy contact is essential for extremely dependent patients who could use religious counseling to set up a de facto second therapy. Clergy are more accustomed to free access by parishioners—a situation which is not necessarily desirable for all MPD patients. Most specific religious problems respond to six to eight one hour sessions without causing dependent regression. Time limits are equally necessary for inpatient and outpatient referrals. Many patients do well with repeated clusters of sessions with clergy over a long period of time. Spiritual growth, like that in psychotherapy, does not occur overnight and can involve a series of spiritual crises. Repeated clergy involvement can be helpful as long as it remains problem focused and does not function to replace other relationships.

Referral is not synonymous with a desire to avoid religious issues in therapy, but is undertaken for specific reasons. First, it avoids dual roles in therapy. Many of the religious questions posed by MPD patients call for the active input of theological ideas. It is the role of clergy to discuss their personal theology. When they do so they do not enter a dual role with the patient, nor do they violate professional ethical standards. The same *cannot* be said of the secular therapist who contaminates the transference and violates therapeutic boundaries and neutrality by engaging in discussions that call for interjection of personal opinion. This is an especially critical issue since the long treatment of MPD fosters an intense transference, often of a dependent or idealizing nature. In such situations, the therapist's opinion carries extreme weight with the patient. This is appropriate for therapeutic matters but not for religious beliefs. As a group, MPD patients are well known for pushing the boundaries of therapy. Asking therapists to discuss their religious beliefs is no different than asking for disclosure about other personal matters.

Second, referral avoids problems with ethics and countertransference. Therapists tend to be more religiously liberal than their patients, so personal disclosures run a risk of violating the patient's beliefs, a stance generally considered unethical. Conversely, highly committed conservative Christian therapists can risk ethical violations by urging salvation experiences as necessary for psychological healing. How free can we be in suggesting our personal stances without crossing the line into unethical territory? Religious material tends to elicit either positive or negative countertransferences, often leaving therapists unable to address these issues without introjection of their own hostility or enthusiastic commitment (Pruyser, 1971).

The third reason for referral of specific religious questions is utilization of the ecclesial authority and knowledge of clergy. Many of the religious questions of abused patients are simply too complicated for competent management by someone without theological training. We owe our MPD patients more competent spiritual help than most of us can offer. Equally important, the authority of clergy sets up a transference that allows them to effectively give permission for patients to be freely angry with God, to question God, and to experiment with various views of God with less guilt and, hopefully, a wider variety of possible answers. On religious issues, clergy are simply more believable than secular therapists.

As with any referral, initial communication with the consultant is an important move. It communicates respect, clarifies roles so that transferential splitting is less likely, and prevents duplication of effort. Written communication from the therapist at the beginning and conclusion of the referral tends to keep boundary issues clear for all concerned.

Clinical example: An MPD patient with a strongly dependent and avoidant personality structure formed close relationships only with helping professionals. As treatment progressed, religiously ignorant alters began observing the host and pious alters worshipping a loving "heavenly father." Desiring such a relationship, they pressed their therapist for personal opinions about salvation, the nature of God, and the identity of Jesus Christ. The therapist declined to reveal her views, but explained several common Christian viewpoints. Basic religious education was clearly needed, evidenced by the sexualized alter who asked if conversion meant God would

demand sex from her as her father had done. In addition, the religious issues with her "heavenly father" were of great importance since they paralleled work on resolving abuse by her father.

Consultation with clergy occurred in two ways. During a stage of therapy when she was unable to tolerate much contact with any males (including her pastor), a series of eight sessions was arranged with a female chaplain who the patient knew from inpatient treatment. These sessions resolved theodicy issues that had caused suicidality. Intermittent pastoral support was provided by her male pastor until a female pastor was available. Her pastors provided basic religious education that addressed serious abuse-related distortions about God, resulting in her alters progressively coming to a vital faith that was congruent with the host's beliefs. In psychotherapy, reflection on talks with the pastor allowed integration of spiritual and psychological growth. Her therapist remained encouraging but theologically neutral. The eventual outcome was integration of alters and emergence of a vital faith.

Clergy can be helpful when religiously-framed resistance blocks treatment. An example is a patient who feels anger is unchristian-a combination of inaccurate religious teaching and resistance to experiencing affect. It may not be possible for the therapist to reeducate the patient about the religious acceptability of anger. When patients are suspicious of secular therapists, challenges to religiously based resistance require clergy involvement. By allowing clergy to address the resistance, the therapist escapes being viewed as the secular attacker of faith. On rare occasions, religious resistance is so extreme that "double teaming" is necessary. This consists of the therapist and clergy meeting together with the patient to confront persistent religious distortions that block progress. Meeting together minimizes transference splitting, enhances communication among the three parties, and allows each professional to learn from observing the other.

Finally, clergy can participate in rituals which bring all the power and symbolism of a religious rite to the healing process. Vesper (1991) has reported on the use of a healing ceremony with a patient who wished closure on abuse by a "druidic cult". We have observed patients benefit from the writing and experiencing of ceremonies designed to renounce the power of abusers. In participating in these rituals, clergy bring the symbolic presence of the household of faith to the healing process. In addition to personalized healing rituals, clergy can participate in traditional religious rituals which symbolize change. An example is the re-baptism of a patient to celebrate the acceptance of God's love by alters who previously felt bound to Satan.

Therapist participation in these rituals has both positive and negative aspects. Religious rituals can be powerful healing experiences for MPD patients, but therapists who participate should be careful to avoid quasi-ministerial roles such as reading scripture or liturgy, or participating in rituals in a way that places the therapist in a dual role. Some therapists have successfully participated in healing rituals that took place outside of the usual time and place of therapy (Bilich & Carlson, 1992). We recommend therapists handle such requests by seeking the consultation of colleagues about whether participation would constitute boundary and neutrality violations. With patients who tend to push therapeutic boundaries, therapists can encourage them toward appropriate timing of ceremonies during the course of therapy and can offer participation by reviewing a recording of the ceremony during a therapy session.

In summary, by inviting clergy to participate in the treatment of MPD, therapists can assure that the patient's spiritual needs are met, that therapeutic neutrality is maintained, and in most cases, that therapeutic tasks are dealt with more rapidly and competently than either therapist or clergy could accomplish alone. ■

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APPENDIX

Professional groups who train or accredit clergy counselors and chaplains:

American Association of Pastoral Counselors
9504A Lee Highway
Fairfax, VA 22031

Association of Clinical Pastoral Educators
1549 Clairmont Road, Suite 103
Decatur, GA 30033

Association of Mental Health Clergy
12320 River Oaks Point
Knoxville, TN 37922

College of Chaplains
1701 E. Woodfield Road, Suite 311
Schaumberg, IL 60173