UNDERSTANDING AND RESPONDING TO RELIGIOUS MATERIAL IN THE THERAPY OF MULTIPLE PERSONALITY DISORDER

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ABSTRACT

A review of the literature on religion and MPD shows numerous associations between MPD and a fundamentalist religious upbringing and demonstrates that primary and secondary personalities differ greatly in God images and religious practices. The suffering and abuse experiences of MPD patients raise religious and existential questions in psychotherapy. Religious questions fall into three areas: God and the existence of evil, anger at God or institutional religion, and spiritual growth questions that accompany psychological growth. The dynamic significance of religious ideation and of five components of God images are explained. Suggestions are offered for eliciting and interpreting religious background and ideation. Pitfalls originating in positive and negative countertransference are identified and a neutral approach to religion is suggested. Examples are given for dealing with religious material that functions as resistance and suggestions are offered for collaborating with clergy in the treatment of religious MPD patients.

INTRODUCTION

Surveys have shown that at least 90 percent of the American public, but only 40 to 70 percent of psychiatrists and 43 percent of psychologists believe in God (Gallup, 1981; American Psychiatric Association, 1975; Ragan, Maloney, & Beit-Hallahmi, 1980). Kroll and Sheehan (1989) found that religion is no less important to psychiatric patients, 95 percent of whom believe in God. When faced with emotional difficulties, over 40 percent of Americans turn to a local religious leader for help before they seek help from the mental health care system (Beitman, 1982).

In light of these statistics, it is likely that the therapist of a multiple personality disorder (MPD) patient will be faced with religious issues in therapy. This is particularly true since hardship in life, a universal phenomenon for MPD patients, raises religious and existential questions. In trying to make sense of their suffering, patients may frame their questions in religious terms. Since therapists, as a group, are less religiously oriented, they may misunderstand religious material. The goal of this paper is to help therapists deal constructively with religious material in the therapy of MPD by examining three areas: the literature on conventional religious experiences among MPD patients, the content and psychological meaning of religious issues commonly voiced by MPD patients, and practical ways to approach religious issues in psychotherapy. This paper will deal with conventional religious experiences and will not address cult experiences.

Review of the Literature

Most of the literature on the religious lives of MPD patients consists of brief references to religious backgrounds or to the association between MPD and a strict or hypocritical religious upbringing. No large studies of the religious experiences of MPD patients are available but the patients who have been studied come from a variety of backgrounds. Stern found that six of eight MPD patients had had significant contact with religion and four had lived in strict religious homes (Stern, 1984). Kemp, Gilbertson and Torem found that religion was important to 50 percent of ten MPD patients (Kemp, Gilbertson, & Torem, 1988). In their study of seven MPD patients Bowman, Coons, Jones, and Oldstrom (1987) found their religious upbringings evenly divided among Roman Catholic, mainline Protestant, and fundamentalist Protestant.

Other authors note that MPD patients often come from a fundamentalist Christian family with strict religious practices, severe punishments, and emotionally or sexually stifling atmospheres (Gottleib, 1977; Saltman & Solomon, 1982). Coons noted that the patients who found religion important often had a parent or grandparent who adhered to a fundamentalist religion. Among these patients one personality frequently identified strongly with the fundamentalist religion while another personality engaged in quite different practices (Coons, 1980). Boor observed that a childhood environment with pronounced authoritarian, religious, or perfectionistic standards was noted from Prince's 1920 report through cases in the 1980s (Boor, 1982). Schreiber repeatedly noted the hypocritical religious stance of Sybil's family and the role of religion as a resistance in her analysis (Schreiber, 1973).

Noting two logical fallacies which are institutionalized in fundamentalist thinking and practices, Higdon (1984, 1986) suggested that fundamentalism was an overlooked factor in the etiology of MPD. The category fallacy equates

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"bad" actions with being a "bad" person. In the thought magic fallacy, "bad" thoughts are defined as equivalent to "bad" actions. Higdon notes that a literal interpretation of scripture (Matthew 5:28) contributes to the second fallacy. When thoughts and feelings are confused with actions, negative feelings are banned from consciousness, or engender guilt. If expressed, they merit severe punishment which is rationalized as appropriate for "bad" children. Higdon suggests that such a system of thinking encourages the introjection of the severely punitive superego seen in the personalities of some multiples and enables parents to rationalize abuse.

Two articles describe the religious beliefs of MPD patients. Shepperson (1985) described a conservative Christian woman whose presenting personality was superficially religious and whose alters expressed a mixture of belief and disbelief. During treatment, an alter experienced a religious conversion, but the religiously intrusive technique of the therapist clouded understanding of the psychodynamic significance of the conversion.

Bowman, Coons, Jones, and Oldstrom (1987) provide the only detailed study of religious lives and God images of MPD patients. In their study of seven women they found that the God images, religious experiences, prayer practices, and current religious practices of primary and secondary (alter) personalities were quite different. Among the primary personalities their views of God reflected low self-esteem and ambivalence toward their parents. All primary personalities confidently believed God existed but five of seven exhibited profound ambivalence toward God. They experienced God as a very personal being with whom they had intense interactions and whose presence they could not escape. Their God images reflected their experiences with their parents: they clung to a God who they intellectually believed was loving but who they actually experienced as angry, demanding, and never pleased with them. They continually tried to please God and receive love, but felt like inadequate children who deserved bad treatment. Two primary personalities had benevolent God images which reflected positive childhood religious experiences with persons outside the immediate family.

Secondary personalities were characterized by adamant beliefs about God, less tendency to believe in God, less intense interaction with God and no ambivalence about God's character. God images were clear-cut and revealed a split between an all-bad/non-existent God and a good but distant one. Three angry personalities who rejected God either believed God was a cosmic sadist who was responsible for their abuse or they flatly rejected the idea that there could be a God. All personalities who rejected God were carriers of assertive or angry feelings, were angry at their parents, and were derisive of the religion of parents or of the primary personality. Secondary personalities who believed in God found God less personal and less willing to help them. God images correlated with the object relations of personalities and with their functions within the personality system. The conclusion of this study was that God images in MPD reflect the dynamics of parental object relations, with secondary personalities reflecting the splitting of the primary

personalities' ambivalence.

This study also found that prayer and religious experiences differed markedly between primary and secondary personalities. Six of seven primary personalities prayed and found prayer meaningful. Only one of the secondary personalities ever prayed and most scoffed at the idea that God would respond. While six primary personalities endorsed a conversion experience as a child or adult, the only secondary personality who had such an experience later doubted its validity. The higher rates of belief and religious participation among primary personalities was partly explained by the finding that they received considerably greater childhood exposure to religious training and worship than did secondary personalities.

A final finding of this study was the greater adulthood religious involvement of the primary personalities. Six of seven frequently attended church and three had very positive or intensely supportive relationships with their pastors. Among the secondary personalities, only one of six ever attended church, and then only occasionally. None had relationships with their pastors. In short, the current religious practices of the personalities reflected both their background experiences and their current religious dynamics.

COMMON RELIGIOUS CONCERNS OF MPD PATIENTS

Since all large studies of MPD patients have found that MPD arises in a context of severe abuse, MPD patients are faced with formidable existential questions as they recover memories of pain and humiliation perpetrated by other humans and as they begin to take stock of what their lives might have been if abuse and dissociation had not robbed them of years of more fulfilling life experiences (Putnam, Guroff, Silberman, Barban, & Post, 1986; Coons & Milstein, 1986; Coons, Bowman, & Milstein, 1988). Religious and existential questions begin to arise in therapy during the stage in which patients begin to recover memories of abuse. The details of the MPD patient's religious concerns will be shaped by her religious background and current stage of spiritual development, but the content generally falls into three categories: the existence of evil, anger at institutional religions, and spiritual growth issues that accompany personal growth during therapy.

God and the Existence of Evil

Patients who have been abused tend to enter therapy with agonizing questions about the existence of evil and its implications for their view of God and of reality in general. Questions about evil tend to arise in the middle portion of therapy when patients recover memories and try to come to terms with feelings toward their abusers.

MPD patients usually raise the questions of classical theodicy: How can God be good and have allowed me to suffer so much? Why didn't God stop the abuse? Could God have stopped the abuse? Was my abuse a punishment from God? Will God punish my abuser or send him/her to hell? Patients often hate God and blame God for the abuse. At

other times, anger at God may be projected and they feel God hates or ignores them. Primary personalities may cling to a belief in God, trying to obtain a feeling of love and acceptance, but will complain that God despises them.

Anger at Organized Religion

Patients who were raised in homes where religion was used to rationalize abusive discipline often express rage at institutional religion. Anger at religion generally arises in the stage of therapy where memories of abuse are uncovered. Patients may be directly angry at the religion of the abusers or they may make religion the target of displaced anger at the abusers. Anger at the hypocrisy of publicly devout but privately abusive parents is a common theme among the children of highly religious parents. These patients may then reject their parents' religion as part of a reaction formation against becoming like their abusers. During this time the patient may cease religious involvement since it brings painful reminders of parental religious practices. Displaced anger tends to diminish as patients work through their rage at their abusers and are able to separate religious teachings from parental practices. At this point they express anger at the selective use of religion, not at the religion itself. MPD patients often express anger at how abusers used scripture to justify abuse while ignoring passages that teach parents to love and protect their children.

Patients who were not believed when they tried to reveal their abuse to clergy or other congregants are often angry because the congregation ignored abuse or quoted biblical passages to justify physical abuse or to support the authority of parents. Patients who were sexually abused by clergy are frequently the most angry at religion. Patients may also feel anger over abusive treatment by their spouses. At times patients express anger at churches who presented God as perfectionistic, demanding, and vindictive. Primary personalities frequently want a less severe deity and are angry because they cannot easily shed the God of their childhood religion. Less commonly patients report solely positive experiences with childhood religious practices and express sadness that their parents were not like the kind and caring church or synagogue members or clergy who acted as positive role models.

Other patients are angry at the hierarchical authority structure advocated by fundamentalist religions that teach that authority is passed from God through men to women and then finally to children, who possess the least power or authority. Patients echo the findings of Swiss analyst Alice Miller that this Western European system of thought enables the wielding of power by fathers and restricts the ability of mothers to intervene. Children find their objections dismissed as a sinful willfulness that needs eradication (Miller, 1980). Anger at the power structure of religion is particularly prominent when abusers quoted biblical references to justify physical abuse or used the Fourth Commandment ("Honor your father and mother") or the epistles ("Children obey your parents in the Lord, for this is right") to squelch objections to incest (*Holy Bible*, 1978: Proverbs 23:13-14; Deuteronomy 5:16; Ephesians 6:1-3).

Spiritual Growth Issues In Therapy

During therapy, religious and spiritual issues arise as patients confront changes within themselves. These issues fall into two general categories: genuine religious/existential concern and religious issues which serve as a focus for working on underlying psychodynamic issues. In a religiously devout patient, dynamic issues are often presented in religious terms, causing therapy to revolve around interpreting the psychological meaning of the overtly religious material.

As primary personalities proceed through therapy they usually discover that alter personalities do not share their religious beliefs. They may be horrified to discover that alters are atheistic or derisive of religion, especially the religion of the primary personality. This raises considerable anxiety about the fate of the religious personality's faith after integration. This anxiety is usually a mixture of genuine religious concern about salvation and psychological resistance to fusion. A religious personality may raise religious objections to sharing consciousness with alters who swear, express anger, or engage in practices such as sexual activity outside of marriage, all of which the religious personality finds offensive. By invoking religious tenets which she considers too sacred to be challenged, the religious personality unconsciously tries to thwart the therapist's attempts to dismantle her resistance to accepting the feelings of alters. Conversely, alter personalities may attack the religious personality's beliefs during times of internal warfare or during times when the religious personality cites religious prohibitions against being angry at abusers.

Religious issues which are the focus for underlying dynamics do not always function as resistances. As alter personalities make progress in working through their negative feelings toward their parents (if their parents were abusive), they may begin to desire the positive aspects of a relationship with a loving parental figure such as God. By observing religious personalities, non-religious alters may see that such a relationship is possible. Religious issues may become the focus for cooperation among personalities as co-consciousness develops, as demonstrated in the following case: The primary personality of Ms. A was a conservative Protestant with long-standing faith in God and a history of regular church attendance. Initially few alters expressed a belief in God. As therapy progressed, alters progressively began to listen during worship and expressed curiosity and profound ignorance about religious teachings. Because the primary personality found religious questions from alters more tolerable than their memories and affects, she engaged them in dialogue on religious issues and arranged for alters to meet with the pastor to discuss their religious questions. This resulted in the religious conversion of several alters. Although the primary personality found converted alters more acceptable, she was still reluctant to accept the reality of her MPD and did not want to share her worship experience with them. As more co-consciousness developed, the thoughts and participation of the alters disrupted the primary personality's worship, forcing her to acknowledge them. The first significant cooperation began when a musically ignorant alter decided to help the primary

personality sing in the choir. The embarrassing result forced the primary personality to actively interact with the alter by teaching her musical skills. Since the purpose of the interaction was to better worship God, the primary personality was less resistant to the interaction.

MPD patients may raise religious questions which are not screens for deeper psychological issues. A religious personality may raise genuine theological questions about the nature of the soul or salvation in a person whose consciousness and capability for belief are fragmented. As they realize the full impact of their suffering, patients may reach out for a belief system to help them find meaning in their suffering. At these times, religious beliefs may function as an invaluable asset. Case example: Ms. A was struggling in therapy with anger at having MPD and anger at God for having allowed her to be born into an abusive family. As she began to realize that her dissociation had protected her from intolerable childhood pain she utilized her belief in divine sovereignty to see the MPD as a divinely bestowed gift that enabled her to survive. This lessened her hostility toward her illness. When the pain of therapy became severe she would remind herself of her belief that God had directed her to a therapist who was able to diagnose her MPD. This enabled her to modulate her negative transference when she blamed the therapist for her illness. She also resisted the desire to quit therapy by seeing the goal as restoration to a state of wholeness — the way God intended her to be. Her suicide attempts occurred when she felt separated from God or could not believe God had a reason for her existence.

DEALING WITH RELIGIOUS MATERIAL IN THERAPY

When patients discuss religious issues in therapy, difficulties can arise if the therapist is inexperienced in dealing with religious issues, is ignorant of the patient's religious tradition, or has unexamined countertransference regarding religion. This section of this paper aims to reduce the likelihood of such difficulties by describing ways to elicit, evaluate, and work with religious material in the therapy of MPD patients.

Taking and Understanding a Religious History

The first step in understanding any patient is taking a history. As therapists, we would not attempt to engage a patient in therapy on any topic without first obtaining background information about the patient's experiences in that area. Accordingly, one should not attempt to deal with religious issues without first getting a religious history. Commonly, therapists either fail to ask about religion during initial evaluations or limit their questions to asking patients what faith they come from. Dynamically, this material is all but worthless since even patients in a single denomination may have beliefs that vary greatly. To determine how the patient *really* functions religiously, a therapist must obtain a more detailed history. Unfortunately, clinical training seldom prepares therapists to do this.

A few key questions from a previously published religious ideation interview can quickly provide historical and dynamically revealing material (Bowman, Coons, Jones, &

Oldstrom, 1987). The religious background of the patient and the attitudes and practices of her parents will yield information about the emotional tone of her childhood religious experiences and any connection between religion and abuse. It is helpful to ask childhood denominational affiliations, changes in affiliation, frequency of worship attendance by the child and by parents, the amount of religious training, the reasons for beginning or discontinuing religious practices at various ages, how the patient viewed her parents' religious practices and how she viewed the sincerity of parental beliefs. The question "How is God meaningful to your mother and father?" yields information about what kind of religious role models the parents really were. Asking about both practices and beliefs helps uncover inconsistencies in the religious atmosphere of the family.

After reviewing religious background, a dynamically useful picture of the patient's current religious situation can be obtained by asking questions about current religious affiliation, the patient's view of God and of prayer. If religious affiliation has changed since childhood, asking the reason for the change will provide information about the nature of the patient's religious growth and her view of her religious upbringing. The frequency of attendance at religious services is an obvious marker of the importance of religion, but it is also useful to directly ask what religion means to the patient and how God, prayer, and religion function in her life. These direct questions open up discussion with patients who continue frequent religious attendance but are struggling with doubt about the reality of their faith.

Questions about the patient's relationship with God are the most revealing of her current psychodynamic situation. A useful opening question is: "If you believe in the existence of a God, how would you describe God?" When religiously sophisticated patients provide an intellectual answer that sounds more like a theological statement than a real relationship, dynamically useful material may be obtained by asking how the patient *feels* about God, how God *feels* about the patient, and how God *treats* the patient. Since God is a kind of archetypal parent, questions about God are revealing of parent-child dynamics, an emotionally loaded subject for most MPD patients. The patient's God image can help the therapist predict the kind of parental transference that will develop in therapy.

This author has found that each of the five dimensions of a God image postulated by Pattison can reveal clinically useful material (Pattison,E.M., personal communication, June 13, 1986). First, belief in the existence of a deity reveals if God images are formed in alignment or opposition to parental introjects (Rizzuto, 1979). Personalities who cannot believe in God are often those who experienced abuse and have connected God with hated parental images. Second, the level of surety of belief may reveal the intensity of parental cathexis. Primary personalities report an intense cathexis of God which betrays their longing for the close parental relationships they missed during childhood. Third, the feelings of a person toward God reveal feelings toward one or both parents. Frequently the intellectual component of the primary personality's view of God reflects her fantasied ideal parent. Among secondary personalities, feelings

toward God reveal parental transferences based on feelings which the primary personality has dissociated. Fourth, the perceived feelings of God toward the patient are an important indicator of how these patients felt in their relationships with their parents. Among primary personalities, the third and fourth parts of the God image are often contradictory. Commonly, primary personalities claim they love a God who is described as benevolent and caring, but they feel God is critical of their inadequacies. The fourth part of the God image is often formed in alignment with a person's self-representation and gives a clue to self-image. The fifth part of the God image, the sense of personalization of God, is indicative of the emotional attachment to parents. Secondary personalities who are less attached to their parents tend to experience God as distant and uninvolved.

In studying MPD patients, this author found that the most useful question to pursue is how God treats the patient. This question cuts through intellectual descriptions of God and elicits material about the actual relationship with God and, indirectly, with parents. How the patient believes God *feels* about her and how God *treats* her may be quite different. If questions about how God feels about the patient elicit intellectually defensive answers, asking how God treats the patient will often bring forth affectively-laden material that is more clinically useful.

At times religiously conservative patients cannot bring themselves to admit, much less express, that they are angry at God. Such a direct admission is in conflict with their belief that it is wrong to be angry with God or say "bad" things about God. This resistance can be skirted by asking questions about prayer, since such questions indirectly provide a picture of how the patient really interacts with God. In this author's experience with MPD patients, questions about prayer provided the shortest route to the dynamically rich God image. Patients were the least defended when asked about prayer, since they perceived the question to be more about themselves than about God.

The following questions about prayer provide the most useful material: "What does prayer mean to you? If you pray, what do you pray for and what do you think happens when you pray?" If an intellectual answer is offered, ask patients what happens when they pray for others and what happens when they pray for themselves. This is nearly identical dynamically to asking how God theoretically acts and how God really treats them. The latter is a clue to self-image: God treats us as we feel we deserve to be treated. One patient demonstrated this graphically when she wrote that God answered her prayers when she prayed for others, but when she prayed for herself, God was not listening.

Pitfalls for Therapists

Before ever exploring the patient's religious history and current beliefs, therapists would do well to take stock of their own history and feelings about religion. Therapeutic misadventures with religious material generally arise from two sources — ignorance and unexamined countertransference. Ignorance about the patient's religious tradition is easily remedied. If the therapist assumes a neutral approach and asks to be informed about the patient's religious tradi-

tion, the result is an inevitable strengthening of the therapeutic relationship as the patient sees the therapist's willingness to understand her world view. Even religiously sophisticated therapists should ask questions. Religious experience tends to be personally idiosyncratic; a patient and therapist from the same religious background may experience their tradition very differently. Unspoken assumptions can easily lead to misunderstandings.

Countertransference about religion is, by far, the most common source of therapist error. Unduly positive or negative views of religion are equally likely to cause difficulty. Therapists who have not resolved negative feelings about their own religious upbringings may be unable to be neutral enough to help the patient modulate her anger against religion and come to a final realistic assessment of what religious beliefs have to offer. Such therapists run the risk of using therapy as a vehicle for acting out hostile impulses toward their parents and religious traditions.

Therapists may become anxious about discussions of religious material because religion deals with the most difficult questions faced by humanity — questions of evil, death, suffering, and the ultimate meaning of human existence. Wishing to avoid facing these issues in their own lives, therapists may try to avoid them in therapy. They may defend against their anxiety by devaluing all religion as immature (in the manner of Sigmund Freud) or dismissing religious issues as irrelevant. Devaluation or deflection of religious issues is not helpful to the patient and results in the therapist missing a golden opportunity to use religious material to understand the patient's psychodynamics.

The positive countertransference of religiously identified therapists can be equally problematic. These therapists may become so interested in the theological content of the patient's beliefs that they fail to recognize its dynamic significance. A propensity for literal interpretation of religious material makes this error particularly likely for fundamentalist therapists. Fundamentalist therapists can avoid this trap and not abrogate their own value system if they can view religious material as simultaneously literally true and dynamically symbolic. Religiously devout therapists may share a patient's view that religious material is sacred and thus not subject to the same critical examination that other topics receive in therapy. This results in an inability to recognize the wolf of resistance beneath the sheep's clothing of religious ideation.

The most destructive effect of countertransference occurs when zealous therapists use therapy as a setting for converting the patient to their own religious position. It is unethical to use therapy to promote the therapist's value system. Such a violation of interpersonal boundaries in the therapist-patient relationship may be experienced by the patient as a repetition of past coercive religious experiences or interpersonally intrusive abuse and should be avoided at all costs. Therapists who are concerned for the fate of their patient's souls should remember that a religious conversion that takes place at the urging of the therapist may really be a move by the patient to please a powerful parental figure and may not represent any real internal change. MPD patients have spent years engaging in overtly pleasing behav-

ior while harboring rage at their abusers. Urging a patient toward religious conversion is likely to result in an explosion of rage immediately from an alter or later on as the patient realizes the similarity between intrusive parental behavior and the therapist's behavior.

Religiously identified therapists may also make the mistake of using their own religious terminology in discussions of religious material, forgetting that these terms may not have the same connotation for the patient. An example of this is the use of "Lord" or "Father" to refer to God. A patient who was abused by her father may not wish to think of God in male terms. Because alters often lack basic cultural information about religion and because they use trance logic, they are especially vulnerable to literal interpretations of religious symbols and are more likely than other patients to misunderstand them.

Case example: One of Ms. A's personalities who had experienced sexual abuse by her father was initially very contemptuous of Ms. A's religion. As this personality began to explore her desire for a warm and tender relationship with her father, she concurrently became desirous of knowing God the way Ms. A did. In church the alter heard God referred to as a "loving father." In therapy she expressed a desire to know God as a loving father but was fearful to take this step because she feared God would exploit her and ask her for sex. After her pastor and I separately explained that Christians believed God was not literally male, did not have a penis and had never been reported to have sex with humans, she gradually was able to approach a relationship with God.

Practical Tips For Dealing With Religious Material

The most useful approach to religious material in psychotherapy is a neutral but respectful approach that deals with religious questions as one would deal with any other topic in therapy. When dealing with religious material, always try to understand the material in the context of the current psychodynamic issues in therapy. Above all, keep in mind that God, the church, and clergy are just as much the target of transference as is the therapist. In fact, God is probably more of a target because of God's analyst-like blankness.

When speaking of God, use neutral terms such as God or God's self and avoid gender-related terms or pronouns. If the therapist follows the patient's lead in calling God "Father," the patient may see this as a confirmation that God is literally male. Analogies and references to the variety of beliefs in the patient's religion are particularly useful when discussing God.

The following is an example of a neutral approach to questions about God: When Ms. A, in a personality who was struggling with approaching God, asked me directly what I thought God was like, I replied that my specific view of God came out of different life circumstances and might not be helpful to her. I felt that I might unduly influence her decision about God if I told her my personal opinion. I reminded her that because I was her therapist she saw my opinions as authoritative, but my view of God carried no real authority. If my personal view persuaded her to approach God and she was upset about the results, she would have

every right to feel I had violated her autonomy, something her father had already done. I then added, "Throughout history, most Christians have described God as being *like* a loving parent. Some have thought of God as *like* a mother, a father, or neither mother nor father. Christians have not described God as intrusive or cruel to those who approach God for love." I then asked her to discuss the question with her pastor who would provide personal opinions about God. Her subsequent talks with her pastor led to a religious conversion experience that was accompanied by a decrease in alienation from other religious alters.

A neutral approach to religious material should not be confused with an unwillingness to challenge illogical beliefs or unrealistic assumptions. Challenges to God images should take the form of gentle proddings and thoughtful musings about the contradictions involved. This approach helps the patient think about her beliefs without feeling the need to defend them from attack and it models an ability to think critically about religious matters without rejecting religion. Anger at parents, God, or the church is frequently difficult for devout Christian patients and religious therapists who have been taught that anger is sinful. It is critically important to allow the patient to experience the anger so she can truly be free to choose her final religious stance. It is helpful to remember that the anger of certain personalities is only part of the entire patient's faith. When patients need permission to be angry at God, they are often relieved to be reminded that Jesus openly displayed anger in the temple court, that Moses broke the tablets in anger, that Hebrew prophets made a career of expressing anger over injustice toward helpless persons, and that apostolic writings (Ephesians 4:26-7) assume the normalcy of anger but admonish that it is to be dealt with promptly and not allowed to simmer. Some patients are helped by the observation that God has weathered millenia of human rage and is great enough that the patient's anger is not likely to damage God's being.

Devout personalities often worry that they will lose their faith or salvation if they fuse with an irreligious personality. When this occurs I remind them that integration cannot be forced on them and requires resolution of differences beforehand. Resistance usually decreases when patients are told that as progress is made in therapy, the capacity of the total person for religious belief usually increases. This increase occurs as resolution of painful feelings toward abusers is accompanied by diminished anger at God. As dissociative barriers erode during treatment, religious personalities who are horrified by the feelings of alters are helped by reminders that diminished amnesia also allows the alters to learn about the faith of the religious personality. This concept lends existential and religious meaning to the treatment and can help the religious personality continue to tolerate the alters until she learns to accept their feelings. Alters do exhibit religious conversions during the course of treatment, especially when they work on religious issues with pastors while in psychotherapy with the therapist. Religious conversions generally accompany de-repression of a positive cathexis of parental objects and help pave the way for fusion with religious personalities.

A religious problem which is unique to MPD patients is

the frequency with which church members mistake their illness for demon possession. This is not surprising in view of the appearance of patients when angry alters emerge briefly and glare at others. Attempts to exorcise the patients are psychologically disastrous since they are experienced by alters as a denial of their feelings and existence as well as a repetition of the intrusive behavior of abusers. When clergy or parishioners insist that the patient is possessed, it may be helpful to get written permission to meet with the pastor and educate him or her about MPD. This is less successful with fundamentalist or charismatic ministers who have strong beliefs in demon possession, but some subsequently modify their approach to the patient.

Some patients endorse religious ideation systems that are less than psychologically healthy. Such systems, described more fully elsewhere, may teach that emotional difficulties are due to sin or spiritual weakness (Bowman, 1989). When patients are members of such groups, the therapist may be tempted to suggest the patient cease such religious involvement. Regardless of the relative health of the religious system, patients who need the external ego strength provided by a very structured and dogmatic religious approach should not be dissuaded from such involvement. Sometimes such a system is the patient's only social support system and provides superego strength that curtails dangerous acting out of impulses.

Since few therapists are theologically trained, it is likely that questions will arise that are beyond the therapist's expertise. In this situation it is useful to request help from a chaplain or minister. Religious primary personalities are often in counseling with their ministers before and during therapy, so they can easily take questions to their pastors. Inpatients can talk to hospital chaplains who are trained in clinical pastoral care. It is very important to know the religious ideation system of the clergy to whom patients are referred. Get to know the hospital chaplain and at least one clergy person in the community. Referrals are most successful when the clergy's religious approach is similar to that of the patient but is flexible enough to encourage free expression of feelings and avoid inculcation of guilt.

During the stage of therapy when patients are angry about abuse, the ecclesial authority of the clergy is infinitely more powerful than that of the therapist when giving permission to be angry at God or religion. Permission from clergy tends to diminish religious resistance much more rapidly. Clergy who are sin-oriented or guilt-inducing should be avoided for a patient who is trying to express long-overdue anger at God and parental figures. Such clergy only reinforce old patterns of denial, isolation and repression of unacceptable feelings. Clergy are also helpful when patients become stuck in anger and are unwilling to try to move forward toward resolution. Again, ecclesial authority helps patients hear the need to accept and sometimes even forgive the wrongs of the past.

Occasionally, a special session with both clergy and therapist is needed to address the persistent use of religion as resistance or splitting of the transference between the minister and the therapist. Psychological resistance can be addressed by the therapist and religious resistance by the minister as aesculapian and ecclesial authority are respectively called into use. A dual session is a powerful way of preventing the patient from pitting religious and therapeutic systems against each other in an attempt to avoid dealing with feelings. The therapist and minister or rabbi should discuss their plan ahead of time to avoid unproductive conflict in the session.

By approaching religious material with respect and psychodynamic sophistication, therapists can open up rich dynamics and further the healing of badly damaged human beings. By teaming up with clergy a therapist can hasten examination of religious material in therapy and can even more effectively help patients through spiritually difficult times. ∎

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