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THE USE OF SOCIAL CONSTRUCTIONIST THEORY TO INFORM TREATMENT DECISIONS: A COMPARISON OF DISSOCIATIVE IDENTITY DISORDER AND DEMONIC POSSESSION.

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Psy.D. Dissertation submitted to the
Graduate Institute of Professional Psychology
Doctoral Program in Clinical Psychology
University of Hartford
in partial fulfillment of the
requirements for the degree of
Doctor of Psychology
1996

Abstract

THE USE OF SOCIAL CONSTRUCTIONIST THEORY TO INFORM TREATMENT DECISIONS: A COMPARISON OF DISSOCIATIVE IDENTITY DISORDER AND DEMONIC POSSESSION.

Gregg A. Januszewski, Doctor of Psychology, 1997

Psy.D. Dissertation Chaired by David Singer, Ph.D., Director, Graduate Institute of Professional Psychology

This dissertation employs the lens of social constructionist theory to examine two disorders, Dissociative Identity Disorder and demonic possession, which appear to have similar clinical presentations. These diagnostic labels are viewed as metaphors which provide meaning and a sense of "truth" to an obscure set of behaviors characterized by an individual's speaking in a "second voice". The function of diagnostic labeling and the roles of healer and client are discussed from a position of exploring their social value within specific cultures. Some recent trends toward incorporating demon possession into the diagnostic framework of Dissociative Identity Disorder are outlined as an example of contemporary efforts at re-authoring the past.

Following a comprehensive description of the internally consistent, yet entirely different, metaphors created by both the Catholic culture and the contemporary Western mental health culture, the dissertation shifts focus toward employing a social constructionist lens in the treatment of these conditions. Examples of demonstrated treatment strategies from a social constructionist lens are provided and implications for utilizing social constructionist theory in treatment in general is discussed.

DEDICATION

This work is dedicated to my wife,

Helen Januszewski

ACKNOWLEDGMENTS

This work is the product of many years of thought and dialogue. I thank everybody who participated in its creation:

Dr. David Singer, not only for chairing the dissertation committee, but also for his direction, encouragement, organization, and support.

Dr. David Klein and Dr. Len Goldstein, for their willingness to give their time as dissertation committee members and their words of encouragement and advice along the way.

Alfred Januszewski, my father, for a lifetime of Christian values and for being my friend.

Joan Richardson, my mother, for the kindness and support only a mother can give.

Fred Gerhard, my study partner and friend, for listening, for pushing me to keep working, and for sharing his world.

Robert D'Angelo, my friend, for helping to smooth out the difficult times.

Lollipop and Baby, for keeping me entertained as I sat for hours in front of a keyboard.

Helen, for nudging me gently.

For all friends and family members who have been kind, patient, and inspirational.

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Chapter One

Introduction

For the past 2 millenia much of the world has been influenced by Christianity and Western philosophy. Today these pursuits are often separated, as in the division of church and state. However, much of Christian ideology emerged within the context of Western civilization. Likewise, Western civilization has been inextricably tied to Christianity. People have used both of these frames of reference, or lenses, to help make sense of the world. The human pursuit of meaning-making has been greatly influenced by prevailing beliefs seen through both of these lenses.

It may be difficult at times to think of the secular Western world as sharing a history with Christianity, yet many of the people who created the ideology of one lens have also participated in the other. And while the progressive scientific outlook of the modern Western world does not always coincide with Christian beliefs they do share some fundamental elements. Perhaps the most poignant similarity among Christian and Western traditions is adherence to a single-truth approach to making meaning.

For Christian cultures there is the Bible to guide all meaning making efforts. People within Christian cultures rely on faith and doctrine to explain their experiences in the world. These cultures accept that God has a divine plan for the universe which can only be understood through faith.

Western civilization employs positivist ideology to make sense of the world. Positivists believe that there are "facts" inherent in nature, which when discovered help to advance mankind's understanding of the world. (Woolfolk, 1992). The Western world has rapidly advanced in technology, medicine, and other pursuits by using scientific investigation to "discover" information about the world.

Both faith in God and positivism are single-truth approaches to meaning making efforts. What is taken as truth in either culture is construed as reality and held on to with vehement conviction. Such reality provides a sense of assurance that what one knows about the world is the answer to providing meaning. A faith based belief and an empirically proven belief each share the quality of providing one's best efforts at giving meaning to something.

Within the past few decades there has been a shift in the meaning making style prevalent among

people across many different cultures. The rapid expansion of telecommunications, international travel, and other means of exposing different cultures to one another has led to a position whereby people are not so confident in the traditional approaches to meaning making. People are now repeatedly exposed to a multitude of perspectives on everything from art to food to clothing styles to religions; there is perhaps no area in which one does not routinely get their own view challenged by some competing perspective. Kenneth Gergen calls this phenomenon social saturation (Gergen, 1991) and he identifies the current epoch of social saturation as the postmodern period.

One consequence of social saturation has been the challenging of traditional ways of giving meaning to things. The single-truth approaches to meaning making, such as faith in God and scientific positivism, are now suspect as people consider expanding their understanding of the world by incorporating various other perspectives. Social constructionism has emerged as a metatheory which provides an alternative to the single-truth approaches.

The most basic tenet of the social constructionist metatheory is that people create their own truths

and reality by social consensus (Woolfolk, 1992). Through this lens reality is not something to be discovered, as if it were already present in the world. Instead, reality is viewed as constituting all the social arrangements among a group of people. From this lens, beliefs which are held with faith in God are true only insofar as people accept them as adequate explanations. There is no ultimate truth; rather, there is truth that helps groups of people make sense of their experiences. Likewise, any so called discovery of science is true only to the extent that people accept it as providing meaning to something. If the people don't accept it, then it is not true. Science, then, is not discovering things, but it is creating explanations. Social constructionism breaks free of the single-truth approaches to meaning making by reframing the meaning of truth. From this lens there are as many versions of truth as there are social arrangements.

If one can suspend judgment on what is "real" and what is not, then the possibility of considering alternatives is established. Social constructionism looks at those alternative "truths", or differing perspectives on "reality", as metaphors. People create words and groups of ideas to denote a common

understanding of something. The words and ideas are not considered representative of any pre-existing reality, yet they do help people to represent a shared belief system, and therefore they can be called metaphors.

As an example, many people might accept the term 'common cold' as an explanation for their runny nose, watery eyes, headache, and sneezing. Common cold, however, is a metaphor, a term with implied meaning used in place of other terms. If, in a hundred years, people attribute different meaning to the sneezing, runny nose, watery eyes, and headache, then the term 'common cold' may have no meaning, as it is replaced by some other metaphor. Since social constructionism does not seek the single best explanation for anything, the words we use to denote various ideas are, in a sense, all metaphors.

This dissertation outlines how social constructionism can be applied to the work of the helping professional. It is believed by some that healers among all cultures play an important role in defining and creating the disorders of their clients (Fabrega, 1989; Caldwell, 1994). Educating clients about the metaphors which explain their subjective experiences is part of the social exchange between

healer and client. By examining two metaphors of human disorders with seemingly similar presentation, this author demonstrates their social creation, despite their being viewed as "real" conditions. Using these metaphors as an example, an alternative to single-truth thinking is provided by outlining a social constructionist approach to treatment.

Chapter two provides a detailed description and explanation of social constructionism. It is the lens used throughout the remaining chapters to look at the meaning making efforts of people across various time periods and cultures. Social constructionism, itself a metaphor, is described as a product of postmodern discontent with traditional ways of knowing.

Chapter three explains in detail the metaphor of Dissociative Identity Disorder (DID), a creation of Western mental health professionals steeped in positivist ideology. The history of dissociation and various historical manifestations of DID are presented to illustrate the changing nature of the metaphor over time. The modern psychiatric definition of DID is included, with a section explaining how social consensus is used in the establishment of all modern psychiatric diagnoses. The goal in presenting DID is to illustrate the internally consistent meaning

making used by Western mental health practitioners who operate from a positivist lens.

Chapter four examines Demonic Possession, as a metaphor, from the perspective of the Catholic church. While possession states, construed as both positive and negative, occur in a wide variety of cultures, the Christian, and particularly Catholic, manifestations of possession have been most extensively documented. Unlike DID, however, people do not use empiricism or positivist ideology to understand demonic possession. It is entirely based on faith and models provided in the Bible. The system of beliefs which support demonic possession are an internally consistent way of making meaning within the Catholic and other Christian cultures.

Chapter five makes a comparison between DID and demonic possession. While chapters three and four outline two distinctly different metaphors and approaches to meaning making, this chapter reveals similarities in the presentation of people identified as having DID or demon possession. In both metaphors the affected individual speaks with a so called second voice which seems to have personality characteristics different from those of the affected person. As the DID metaphor has gained credibility in recent years

there has been an upsurge of people claiming that the diagnosis of DID offers a better explanation of this behavior than does demon possession. The drive for single truth approaches to meaning making is emphasized in chapter five as proponents of different views argue their positions.

Chapter six explains the evolution of social constructionism from its history in cognitive psychology. This chapter shows how early efforts to find new ways of making meaning within psychology led to the emergence of cognitive lenses. Those lenses afforded more importance to the subjective experience of the individual and less importance on external "reality". Cognitive psychology, however, maintained the positivist stance of discovering the best explanation for things. It was not until cognitive psychology and social saturation mixed that social constructionism became a viable way of looking at the ways people give meaning to their experiences. Chapter six ends with some examples of treatment approaches which employ social constructionist ideas.

The final chapter ties together the use of social constructionist ideas in treatment and the metaphors of DID and demon possession. It illustrates how one can think about various maladies as metaphors and

skillfully utilize treatment which does not rely on single truth beliefs. This chapter also explains why one can not successfully mix metaphors in treatment and expect to get good results. The example is made of using psychotherapy to treat demon possession and using exorcism to treat DID. The chapter ends with a discussion of when social constructionist ideas can be useful in treatment and what limitations one can expect.

Chapter Two

Social Constructionism

Technology and the progress of knowledge are expanding more rapidly than ever before. Changes in the ways we think about, interact with, and influence our environment are making human beings increasingly conscious of ourselves and the methods we use to understand our experiences. We are in an age where people do not necessarily accept the long held ideas of truth and reality. We have, in a sense, progressed from the logical positivist movement, which maintained the conviction that an objective external reality exists, to a more subjective, interactive way of viewing so called "facts".

Logical positivism is a belief that there is an objective reality to the world which exists independent of the observer. Science, by applying empirical observation, seeks to discover the "realities" or "facts" inherently present in the world. The acquisition of knowledge appears limited only by the speed which data can be collected, and such knowledge has been considered cumulative, building

upon previous observations (Woolfolk, 1992).

The prevailing approach to science, following positivist ideology, has become known as the standard view of science. According to Manicas and Secord (1983), there are five tenets to this standard view of science. They are: 1- all hypotheses are tested by comparing them to data or facts, 2- theories involve terms which derive meaning through their relationship to the theory as a whole, via operational definitions, 3- research is atheoretical, deriving its meaning from its ability to predict, 4- causal relationships between independent and dependent variables are assumed, even if only to describe probable relationships, and 5- explanation and prediction are equivalent, so that if an experiment proves to explain something then it also will predict its recurrence if repeated. This standard view of science has been and continues to prevail as the primary tool used in giving meaning to our observations. Application of this approach to making meaning in the world has solidified most Westerners' beliefs about objective reality. The standard view of science supports the positivist ideology.

This positivist, empirical approach not only has strong historical support, but it continues to

be perpetuated as the way to make sense of one's experiences. Even though many universities and colleges currently espouse alternatives to positivist thinking, they perpetuate the study and mastery of the traditional scientific method by requiring students to learn statistics and methodologies to be applied toward original research projects (see Osbeck, 1993). While many people are willing to challenge positivist ideology, it appears to be difficult to make use of alternatives to the traditional empirical methodologies.

During the nineteen-sixties positivist ideology came under the scrutiny of researchers in many fields. "They demonstrated convincingly that scientific meanings could not be found in observations alone, as the logical empiricists had maintained" (Manicas and Secord, 1983). At that time alternatives to the standard view of science were not practical and adherence to traditional methods continued, despite a belief that researchers were operating within a false view of science (see Manicas and Secord, 1983).

Many writers (Lazarus, 1993; Woolfolk, 1992; Gergen, 1991, 1985; Fabrega, 1989; Manicas and Secord, 1983) now argue that it is no longer viable to accept "facts" based on observations which do not include

consideration of the person doing the observing. It is now widely believed that there are no absolute truths "out there" in the world, rather, all realities are believed to involve an interaction between the observer and the observed. In addition, all observers bring their own biases to their observations in the form of preconceived ideas, cultural frames of reference, and a general inability to remain truly neutral and objective in considering anything. It is said that, "...all our perceptions, categories, and frames of meaning are mediated and are culturally and historically loaded" (Manicas and Secord, 1983). This perspective is at odds with the positivist assumptions about the "real" world. Since all people have distinct historical and social influences, there are, potentially, as many "realities" as there are observers.

In both the natural sciences, such as physics and biology, as well as the social sciences, such as sociology and psychology, accounting for the subjectivity of the observer has become increasingly important. The positivist ideology is much less secure, now, as scientists of all disciplines come to view what had previously been factual images of the universe as increasingly uncertain and unstable

(see Osbeck, 1993; Manicas and Secord, 1983). While the very essence of science is being re-examined people are becoming increasingly receptive to the idea of alternate explanations for making sense of the world.

Physicists in the present, who study quantum mechanics, relativity, and chaos theories, have adopted a new philosophy which considers "reality" to be largely subjective (see Lazarus, 1993). "The Newtonian physics on which our scientific model is based has been replaced by a physics in which the universe is characterized by uncertainty at its most elemental level" (Osbeck, 1993). The scientific community is increasingly receptive to the idea that the "facts" of the positivist ideology are not as stable as previously believed.

The social sciences, which have sought validity by copying the scientific approaches of the natural sciences (Woolfolk, 1992), are now also moving toward a more subjective and relative perspective of knowledge. There is increasing attention being paid to the idea that human behavior can never be studied in isolation from its social context (Osbeck, 1993). As such, the use of a scientific approach, which seeks to isolate a measured variable from other confounding variables, is no longer the best or only way of

studying human behavior.

As people debate the merits of classical empiricism versus a more interactive approach in the acquisition of knowledge, there exists a difficult theoretical conundrum. The majority of Western culture is based on the old concepts of science. According to Fabrega, "...science is a product and key component of the Western cultural tradition" (Fabrega, 1989, p. 416). It becomes difficult to view "reality" through non-scientific lenses when Western civilization has grown up around positivist conceptions of what is real. Our ability to look outside of empirically derived "knowledge" remains uncertain.

How can one explain the validity of a counterpoint to empirical science when the only tool we have to validate our ideas is empirical investigation? It's a circular argument which requires one to suspend judgment and consider alternative viewpoints. As Gergen points out, "We cannot turn to empirical evidence to prove (or to falsify) the belief that the world exists independent of mind, that concepts can map reality, that propositions can be corrected by facts, and so on. To do so would be using the paradigm to justify itself, thus ruling out the possibility of falsification. (One cannot falsify

falsification without entering a paradox). Thus, empiricism itself is not empirically based" (Gergen, 1985, p. 481). Clearly, there is no simple explanation for discovering how we best learn to make sense of our perceptions. Tolerance for different viewpoints might be a prudent alternative to rigid adherence to objective scientific empiricism. The very notion that present day thinkers are capable of contemplating alternatives to positivism suggests that Western civilization is, in a sense, outgrowing its traditional ideology.

Examination of some recent ideological shifts may help to put the present state of scientific discontent into context. Over the past few centuries people have evolved through three distinct, but overlapping, conceptions of self. Each of these self views has, in turn, affected the ways people construe and value their environments. These views of the self and world are described by Gergen, "...the vocabulary of moral feeling, loyalty, and inner joy is largely derived from a Romanticist conception of the self. Although it reached its zenith in the nineteenth century, this view remains very much alive in the present world. It is a perspective that lays central stress on unseen, even sacred forces that

dwell deep within the person, forces that give life and relationships their significance. Yet this conception of the person has fallen into disrepair in the present century, largely replaced by a Modernist view of personality, in which reason and observation are the central ingredients of human functioning. This latter view pervades the sciences, government, and business, and has made inroads into the sphere of informal relations" (Gergen, 1991, p. 19).

As Gergen points out, Romanticism was a period when people focused on ideals and passions. Romantic endeavors favored freedom of content over structure. This can be seen in the literature and music of the Romantic period, which is marked by freedom of expression and experimentation.

The shift toward Modernism occurred during the twentieth century and it involved a deliberate divergence from Romantic ideology. Gergen describes the essence of Modernism as fulfilling a grand narrative, "...of continuous upward movement - improvement, conquest, achievement - toward some goal. Science furnishes the guiding metaphor" (Gergen, 1991, p. 30). Modernism seeks to find the pure and most elemental properties in things. It is exemplified by the mentality of 'form follows function'.

Modernism has reached its pinnacle, as it has proved tremendously successful in advancing technology, medicine, and other endeavors. Some of the very practical Modernist successes include advanced telecommunications, disease control, and space exploration. Scientific exploration has changed society by leaps and bounds. As science and technology have eliminated the communication barriers of time and distance, people of the late twentieth century are now immersed with data, people, opinions, and information from around the world. Cellular telephones, televisions, personal computers, and other technologies have all but erased the cultural lines between various people and groups. Ongoing daily exposure to such a wide array of information Gergen refers to as social saturation, and he describes the ways which it contributes to a diminished trust in traditional ways of knowing.

"Social saturation does more than bring us face to face with disagreements about the nature of things. As we begin to incorporate the dispositions of the varied others to whom we are exposed, we become capable of taking their positions, adopting their attitudes, talking their language, playing their roles. In effect, one's self becomes populated with others.

The result is a steadily accumulating sense of doubt in the objectivity of any position one holds. For as opinions are expressed, one becomes aware of the alternative voices lurking under the eaves of consciousness, like Herman Hesse's subterranean Steppenwolf, howling its mocking disapproval. In the face of continuous point and counterpoint - both in the public and private spheres - one slowly approaches the awareness that perhaps the monument to objectivity is hollow" (Gergen, 1991, p. 85).

Social saturation, exposure to increasingly diverse perspectives, has led to a new consciousness which is referred to as the Postmodern. We are now, on a daily basis, exposed to differing world views and "realities" which challenge our own. Rather than seeking the truest or most logical information, as was the case with Modernist thinkers, people are now increasingly willing to consider alternative perspectives. The Postmodern thinker assesses value based on what sounds reasonable, interesting, and possible. It is an attitude of curious acceptance of differing perspectives. Since there is increasing exposure to a multiplicity of perspectives it is no longer viable to strive for the most correct or purest form. Rather, the Postmodern movement understands

"reality" to be largely a product of the observer, inclusive of his social, historical, and linguistic contexts. It is within this Postmodern era that the metatheory of social constructionism came to be.

Social constructionism is a relatively new way to help us understand how we make sense of our world and our experiences. It lies in sharp contrast to logical positivism in that social constructionism views truth as nothing more than social consensus (Woolfolk, 1992). "Thus, our understanding of reality is a representation, that is, a 're-presentation,' not a replica of what is 'out there.' Representations of reality are shared meanings that derive from language, history, and culture" (Hare-Mustin and Marecek, 1988). In essence, nothing has any meaning until people come together to create it.

There have been numerous writers who have shared these ideas, yet Kenneth Gergen appears to be the most influential writer of our time to clearly define and describe social constructionism. In The Social Constructionist Movement in Modern Psychology, an article from 1985 (Gergen, 1985), Gergen outlined the four primary tenets of the social constructionist orientation. Subsequent writers frequently refer back to Gergen's article to elaborate or comment on

the topic. The following paragraphs outline and describe social constructionism based on Gergen's writings.

The first tenet of the social constructionist orientation is that, "What we take to be experience of the world does not in itself dictate the terms by which the world is understood" (Gergen, 1985, p. 266) The empirical "truths" which have been acquired via the logical positivist orientation are challenged. Rather than blindly accepting "scientific findings" as indicative of underlying "reality", there is a suspending of the conventional ways of understanding, a freedom to withhold from accepting "facts" based solely on empirical data, in fact, a willingness to accept that the meanings we provide to our observations are independent of any "reality". "Constructionism asks one to suspend belief that commonly accepted categories or understandings receive their warrant through observation" (Gergen, 1985, p. 267). Knowledge based on objective observation is suspect. This brings us to the second tenet of the social constructionist orientation.

"The terms in which the world is understood are social artifacts, products of historically situated interchanges among people" (Gergen, 1985, p. 267).

Human interaction with the environment and with each other is essential to giving meaning to our world. The form of any object is meaningless, independent of the interaction such an object has with another object or person (Maturana and Varela, 1987). There is no meaning or reality independent of the people who experience such understanding. "We do not see what we do not see, and what we do not see does not exist. Only when some interaction dislodges us - such as being suddenly relocated to a different cultural environment - and we reflect upon it, do we bring forth new constellations of relation that we explain by saying that we were not aware of them, or that we took them for granted" (Maturana and Varela, 1987, p. 242). The process of interaction is essential in giving meaning to anything. Knowledge and "...the process of understanding is not automatically driven by the forces of nature, but is the result of active, cooperative enterprise of persons in relationship" (Gergen, 1985, p. 267). This is the social aspect of social constructionism. All reality, all understanding, all facts are socially agreed upon and subject to refutation, re-examination, and change. "The world everyone sees is not the world but a world which we bring forth with others" (Maturana and Varela,

1987, p. 245).

The third tenet of the social constructionist orientation deals with the instability of ideas across time. "The degree to which a given form of understanding prevails or is sustained across time is not fundamentally dependent on the empirical validity of the perspective in question, but on the vicissitudes of social processes (e.g., communication, negotiation, conflict, rhetoric)" (Gergen, 1985, p. 268.) Ideas which prevail in one era can all but disappear in another time period. This will be explored in further detail in later chapters.

The consensual validity of even the most "scientific" ideas has a way of shifting meaning and evolving over time. As stated previously, we are blind to the things we do not know, therefore what we believe to be true is often held onto as if it constituted the truth. As such, "...many Anglo-American psychiatric illness entities as currently formulated are themselves (Western) culture-bound and are being inappropriately exported as though they were universal" (Fabrega, 1989, p. 423). Imposing one perspective of "reality" onto others ignores the fundamental recognition that people in different places and times have differing

arrangements for what they understand as their own "reality". Furthermore, if we accept that peoples' realities can differ, one is left to question the basis for believing in any fundamental truths.

The fourth tenet of the social constructionist orientation states, "Forms of negotiated understanding are of critical significance in social life, as they are integrally connected with many other activities in which people engage" (Gergen, 1985, p. 268). People do not merely come together to agree on ideas then act independently of one another. The ideas and concepts which we use to make sense of our experiences lead us to certain behaviors, typically in support of our shared beliefs. Our actions are evidence of our belief systems, and such beliefs vary among different cultures and time periods. Fabrega states, "...culture influences basic characteristics of humans, such as beliefs, emotions, the idea of self, and presumably the illnesses to which humans are susceptible" (Fabrega, 1989, p. 415). Since culture is an evolving interchange of ideas among a given population, it follows that the behaviors of the people within a culture are directly related to their shared ideologies. We provide meaning to our world by agreeing to certain ideas and by acting within the

framework of our shared beliefs.

In describing social constructionism Gergen points out, "...one might prefer to speak of a shared consciousness rather than a movement" (Gergen, 1985, p. 266). A counterpoint was written by Lisa Osbeck in her critique of the usefulness of social constructionism: "...social constructionism is better described as a movement than as a single theoretical position" (Osbeck, 1993). Like all ideas, social constructionism exists within a certain context. The present technologically advanced societies of the Western world create the setting in which social constructionism flourishes.

Social constructionism provides a different lens for viewing the ways we make meaning in our world. It is not, however, sweeping all conventions into obsolescence. Ideological drift progresses slowly. For some, who chose to participate in the discourse of social constructionism, there is a liberating freedom from adherence to a singular way of knowing.

The metatheory provided by social constructionism is, itself, not exempt from evolution and social shaping. Since its creation social constructionism has developed at least two camps, which make some profound theoretical distinctions. Social

constructionism as described by Gergen is considered the more radical camp, in which, "cultural or linguistic context allows the only basis by which action can be considered either ethical or useful. Social utility in this sense must be viewed as only a communal and arbitrary construction" (Osbeck, 1993). In this view no idea or possibility is more valid or superior to any other. All things are merely artifacts of the constructions of social groups.

The second camp, the more moderate view of social constructionism, "...identifies something as constituent of reality. This something is persons in conversation" (Osbeck, 1993). For this camp, people and their interactions are real things prior to the meanings ascribed to them via social agreements. This distinction between camps can be elusive, though it is profound. By recognizing the reality of conversations, independent of their social value, this moderate social constructionism does give priority to certain things over others. "Reality" continues to be a product of social arrangements, yet the basic materials used in the production of reality, people and their discourse, are valid and real to begin with. The social effects of language use are considered a second moral order (Osbeck, 1993), thereby any

meaning or value given to discourse is truly a social construction, without independent validity.

There is no proof that social constructionism, in any form, is more valid than logical positivism. Seeking to validate the merits of social constructionism would require the use of the types of empirical investigation which are in question (see Gergen, 1986). Rather than challenging the merits of social constructionism, a position of curiosity and inquiry can help move our ways of thinking in new, and hopefully positive, directions.

There is also no clear way of making sense of our current views on social constructionism. Since one cannot be an objective observer of his subjective participation in the dialogue of social constructionism the whole phenomenon can be considered one of many aspects of the social and cultural drift of modern society. "Social history and science transmogrify over time, but we have no Archimedean vantage point from which to evaluate that movement as progress or regression. We simply, as a general society or as circumscribed learned societies, find various beliefs or capacities more or less useful, appealing, acceptable - or we have some ideology imposed upon us" (Woolfolk, 1992, p. 218). In our present

Postmodern world there is increasing usefulness, appeal, and acceptability of the ideas of social constructionism.

Postmodernism and social constructionism will inevitably pass, as have all cultural movements in Western civilization. From the Middle Ages to the nineteenth century Western civilization has been dominated by cultural beliefs from the Renaissance, Baroque, Enlightenment, and Romantic periods (see Ellenberger, 1977). More recently, Modernism and now Postmodernism influence our beliefs (see Gergen, 1991). This dissertation seeks to offer a new way of understanding the treatment of so called "mental health issues" in the present Postmodern world. Within this dissertation, many of the topics and their underlying assumptions, as well as the method used to examine those topics are all a part of the current "zietgiest" of Postmodern Western civilization. The purpose and meaning of this dissertation exist only to the extent that people find value in its language and ideas. The concepts presented herein do not constitute the truth or the reality, rather this dissertation exemplifies a socially constructed truth and reality for our time and culture.

Using the lens of social constructionism, the

following two chapters examine some metaphors used to explain a certain cluster of deviant behaviors in two different cultures. The modern psychiatric concept of dissociative identity disorder is explored in chapter three. Chapter four details the Christian tradition of understanding demonic spirit possession. These metaphors are explored in depth to illustrate their place within their respective cultures. Particular attention is paid to the internally consistent belief systems and shared social values which allow these metaphors to survive.

In chapter five these metaphors are compared and contrasted to illustrate the power socially constructed ideas have within different cultures. There exists a body of literature which points out similarities in the presenting symptoms of people labeled as having demonic spirit possession or dissociative identity disorder. This literature is reviewed and then discussed as a way of giving meaning to these phenomena. The social constructionist lens is used to give meaning not only to the metaphors themselves, but also to the more recent attempts at integration of these two phenomena.

Chapter six demonstrates how social constructionism can be helpful in various

client/helper relationships. Treatment interventions from a social constructionist lens are outlined as an alternative to single-truth approaches to treatment.

The final chapter is a discussion of applications of social constructionism to various treatment paradigms. DID and demon possession are used to illustrate the social nature of the creation and treatment of disease and disorder. The use of social constructionism as an alternative to traditional psychotherapy and exorcism is proposed. Finally, strategies are explored for incorporating a social constructionist orientation into the work of all helping professionals.

Chapter Three

Dissociative Identity Disorder

Diagnostic nosology

In present day American culture, the prevailing diagnostic nomenclature of the psychiatric, psychological, and other mental health communities is contained within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). This text outlines conceptual distinctions and empirical findings concerning the recognized mental health diagnoses in the United States. Since 1952, when the American Psychiatric Association published the first edition of the DSM, mental health communities have relied on this lexicon of mental health diagnoses for making sense of their clients' signs and symptoms. Now in its fifth version [DSM, DSM-II, DSM-III, DSM-III-R, DSM-IV], this series of manuals is a testament to the evolving nature of knowledge in mental health circles.

Traditionally, scientists and researchers have viewed diagnostic categories as "...empirically derived, reflecting what is 'real' and 'in' nature;

that is, as objective, neutral, culture free, and value free (scientific objectivism)" (Fabrega, 1989, p. 416). Viewing diagnostic categories as "real" entities which can be understood via scientific exploration is consistent with the logical positivist frame of reference. Historically, psychiatric diagnoses have been conceived of and supported in this context.

Over the years attempts have been made to reduce the subjectivity of diagnostic labeling. The first DSM, published in 1952, was heavily influenced by Adolf Meyer's psychobiologic view of personality. In 1968 DSM-II was published, relying less heavily on Meyer's ideas, but still favoring certain theoretical frameworks, including the concept of neurosis. By 1974, with the publication of DSM-III, specific diagnostic criteria were established for the various diagnoses, helping to improve the reliability of diagnoses. Early attempts were made with DSM-III to reduce etiological assumptions and to increase reliance on statistical information and research (American Psychiatric Association, 1987).

When the DSM-III-R was published, in 1987, it reflected an evolving trend to diagnose based on descriptions of behavior, rather than basing diagnoses

on etiological factors (First, 1992). The latest update to this diagnostic library, DSM-IV, places great emphasis on the use of empirical data to support each diagnosis. In fact, the introduction to DSM-IV states, "More than any other nomenclature of mental disorders, DSM-IV is grounded in empirical evidence" (American Psychiatric Association, 1994, p. xvi). International communication, literature reviews, data analyses, and field trials were all considered to be important aspects in the creation of the updated diagnostic lexicon (see Francis, 1991; Spitzer, 1991).

Consensus regarding the final form of the DSM-IV was not easily reached. There were many suggestions for change in the way DSM-IV would approach diagnosis. Suggestions were made to have cultural factors included in diagnoses (Fabrega, 1992); religious categories listed separately (Lukoff, Lu, Turner, 1992); defense mechanisms listed on a separate axis (Skodol, 1993); and suggestions for altogether new diagnostic categories such as Trance and Possession Disorder (Cardena, 1992) and Brief Reactive Dissociative Disorder (Speigel, 1991).

While many changes were taken into consideration, those that survived are said to be the diagnostic entities which held up under stringent empirical review

(American Psychiatric Association, 1994). Theoretically, such empirical scrutiny might appear to provide the highest degree of safeguard against erroneous or biased beliefs, yet the very process of studying a phenomenon is known to alter the way in which it is perceived [more will be said about this later] (see Maturana & Varela, 1987). Just as the authors of the original DSM sought to document and unify their understanding of mental disorders, so too the authors of DSM-IV sought to use the prevailing knowledge of the time to document what has been empirically learned about mental disorders. An important point to be made, however, is that the diagnosticians operate within social and political spheres which contribute to their constructions of diagnoses, despite their best efforts to remain purely empirical.

One of the leaders in the development of DSM-III and DSM-III-R, Robert Spitzer, suggests that decisions regarding diagnostic categories are ultimately made by expert consensus, not empirical support (Spitzer, 1991). From the social constructionist perspective there is no standardization or empiricism in any psychological construct, since the very nature of psychological inquiry is a phenomenon of modern Western

ideology (Cushman, 1995). Given these views, the DSM-IV may be considered the Western mental health community's best efforts at constructing diagnoses at the end of the twentieth century, though it is not a factual account of "real" diagnostic entities inherently present in our shared world.

According to Roberto Lewis-Fernandez, "Current psychiatric nosology categorizes experience as normal or pathological based mainly on the presence of descriptive indicators ("symptoms") and only secondarily on contextual characteristics, such as the appropriateness of the setting, the human circumstances, the provocation and the personal or social timing of the experience" (Lewis-Fernandez, 1992, p. 303). Such decontextualized diagnostic entities do not seem suitable for making sense of the differences among people who share a diagnosis. By de-emphasizing social and situational factors, however, diagnosticians may believe that they are working with diagnostic categories that are empirically sound. Basing diagnostic entities on empirically verifiable data is a goal held by the majority of Western diagnosticians, who tend to operate within a positivist scientific orientation.

The professional workgroups who created DSM-IV

were made up of clinicians and others recognized as experts in specific fields of mental health. They were directed to "...participate as consensus scholars...reflect[ing] the breadth of available evidence and opinion and not just the views of the specific members" (American Psychiatric Association, 1994, p. xv). While it is clear that social consensus dictated the existence and form of this nomenclature, the authors maintain that this text is empirically based. They would likely consider themselves remiss if it was thought that they had written a socially constructed document, with its attendant separation from empirically derived information. Despite their empirical efforts and the logical positivist roots of their work, this author contends that Western diagnosticians are producing diagnostic labels which appear to be serving functions other than identifying and learning about "real" diseases in the world.

The mission of the DSM-IV diagnosticians, to maintain the highest scientific standards, eludes them as they participate in numerous political and social settings. Can a researcher be truly unbiased when funding for a research project only allows for certain lines of inquiry? Can a psychotherapist treat a client for an adjustment disorder if the insurance

company refuses payment? These types of questions help to shape the socio-political stage upon which diagnoses like DID are sustained.

The social intertwining of clients, helping professionals, administrators, and third party payers creates an intricate dance of diverse interests. Those who identify [i.e. create] diagnostic entities lead the dance by weighting certain interests more heavily over others. Currently, "The motivation for developing [a diagnosis]... reflects the economic realities of North American research funding and third-party reimbursement for clinical services" (Kirmayer, 1992, p. 285). The culture of American health care is caught between incompatible interests. Fidelity to scientific empiricism may not be profitable, while fidelity to the demands of third party payers is not necessarily conducive to good science. One might call this dilemma a conflict of split loyalties. Add to this the interests of the clients, stock holders, insurance companies, and other parties and the scientific empiricism of creating diagnostic nosologies becomes unintelligible. As with all psychological concepts and theories, the often unacknowledged focus on social ideologies and value structures prevents them from being objective

(see Cushman, 1995).

In addition to financial pressures, there are significant political forces which affect whether a society views particular behaviors as outside of the norm, or deviant. For example, in the earlier versions of DSM homosexuality was viewed as a pathological behavior warranting treatment. Over the past three decades the advent of the sexual revolution and gay liberation movement have shifted people's thinking toward more openness about homosexuality (Gibson, 1989). By 1975 both the American Psychiatric Association and the American Psychological Association had adopted resolutions eliminating homosexuality from their diagnostic nomenclatures (William and Mary GALA, pamphlet). The DSM-IV does not even include homosexuality in its index. While the prevalence of homosexuals is unlikely to have changed very much, their acceptance within society increased, thereby eroding beliefs that homosexuality is outside of the norm among Western civilizations. One can see how social, financial, political, and other pressures contribute to the shaping of what becomes viewed as pathological within a particular context.

This is the current state of affairs for mental

health and other professionals as they attempt to make sense of their diagnostic categories. The utility of any diagnosis is now less certain as social consensus among the users of diagnoses is dramatically waning. In the remainder of this chapter attention will be paid to the evolution of the ideology of Dissociative Identity Disorder (DID), a diagnosis present in the DSM-IV. The language used to make sense of DID, the metaphor, will be outlined throughout the chapter.

Defining DID

In 1994, when the DSM-IV was published, Multiple Personality Disorder was renamed Dissociative Identity Disorder. As clinicians had spent more time trying to make sense of this thing called Multiple Personality Disorder they shifted their perceptions from observing more than one personality [multiple] in such clients to observing less than one whole personality [dissociated], or a fragmented sense of self in these clients (Ganaway, 1994). The name change to DID was intended to more accurately reflect the symptomatology of clients affected by this condition. Throughout this dissertation MPD and DID are used to denote a single clinical phenomenon which, admittedly, has not maintained a stable definition over the years.

Those said to be affected by DID are now viewed as having a self identity which is disrupted by the process of dissociation, therefore they lack a coherent sense of self. Over time, the study of DID has moved away from the concept of fully formed personality states, and now people with DID are recognized as having any combination of dissociated personalities and fragments of experience - such as knowledge or emotions - split off from consciousness (Braun, 1990).

The following definitions of the terms "personality" and "fragment" help to illustrate the different levels of complexity and sophistication which dissociated experiences are assumed to take.

> Personality - an entity that has the following: a) a consistent and ongoing set of response patterns to given stimuli; b) a significant confluent history; c) a range of emotions available (anger, sadness, joy, and so on); and d) a range of intensity of affect for each emotion (for example, anger ranging from neutrality to frustration and irritation to anger and rage)" (Braun, 1986, p. xii).
>
> "Fragment - an entity that is less than a personality. Fragments have a consistent and ongoing set of response patterns to given stimuli and either a significant history or a range of emotions/affect, but usually not both to the same degree (Braun, 1986, P. xii).

Along with the modified ways clinicians presently view DID, there is increased support for the concept of dissociation, as seen in the name DID. However, dissociation has itself waxed and waned in popularity over the years. During the years of Freud's greatest influence, dissociation was dismissed as a concept in favor of mechanisms of repression. However, "The dissociative disorders are currently enjoying a resurgence of popularity in American psychiatry after almost a century of relative neglect" (Kirmayer, 1992, p. 283). Such waxing and waning of belief systems adds credence to the notion that the mental health

field, like other fields, creates and supports their "realities" in partial response to their collective needs. Though professional skepticism about DID remains strong (see Herman, 1992; Dawson, 1990; Dell, 1988), the metaphor is growing in acceptance throughout mental health communities. The following definition of DID, from the DSM-IV, represents the shared beliefs of many modern American diagnosticians.

Diagnostic criteria for 300.14 Dissociative Identity Disorder.

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play. (American Psychiatric Association, 1994).

History

Beliefs about the etiology and treatment of DID have changed considerably over the years, and as people continue to use the metaphor it evolves to suit the common dialogue of its constituents. Paracelsus is credited as the first person to document a case resembling DID. Although in 1646 he did not have a diagnostic label to apply to his observations, he described a woman who was amnesic of an alter personality who had stolen her money (Stafford, 1993). Over one hundred years later, beginning in 1789, Eberhardt Gmelin, began treating a 20 year old woman for a condition described as exchanged personality. In 1791 Gmelin published an 87 page report of his treatment of this case. He, too, has been credited as the first person to write about this phenomenon (Greaves in Kluft & Fine, 1993). Later still, from 1815, is the case of Mary Reynolds which received widespread public attention. Her case was described by S.W. Mitchell in the Medical Repository in the year 1817. Mitchell called the Mary Reynolds case, "A Double Consciousness, or a Duality of Person in the Same Individual". This also has been termed by some authors as the first published example of an individual experiencing multiple personalities (Taylor

& Martin, 1944).

There may be other cases of apparent Dissociative Identity Disorder from before the seventeenth century which were poorly documented or perhaps never documented at all. It may be that before the seventeenth century people had a different means of intcorporating this condition into their way of understanding human nature and the world. The conceptual framework of DID has not been a long-standing piece of history.

The seeming novelty attributed to each of the cases described above attests to the fact that people of the seventeenth and eighteenth centuries did not have within their nomenclature a means of identifying this condition which modern clinicians label as DID. Only in retrospect can we review these cases and suggest that they might fit the current diagnostic category of DID. However, such retrospective sense-making of historical information always serves the interests of present day narratives better than explaining what was "real" for the people of the past (Gergen, 1991). Because Paracelsus, Gmelin, and Mitchell did not share a vocabulary or conceptual framework for understanding their cases the "reality" of their ideas was questionable.

During the 1800s reports of new cases became more common, including a case involving an adolescent. By 1840 the first case of childhood multiple personality was documented (Baldwin, 1990). In 1860, Harper's New Monthly Magazine published the 1815 case of Mary Reynolds and brought the concept of multiple personality into the public eye (Stafford, 1993). Twenty-six years later, in 1886, Robert Louis Stevenson published "The Strange Case of Dr. Jekyll and Mr. Hyde" (Stevenson, 1952). This book reflected in classical literature the public's acceptance of people exhibiting more than one personality state. The concept of multiple personality became more real to people as they were increasingly exposed to it and used the concept in their own conversations.

Despite growing interest in this phenomenon, clinicians and scientists of the mid eighteen hundreds had limited means for making sense of this "new" pathology. They did not have a consistent label with which they might categorize such cases. "Exchanged personality", "double consciousness", "dual consciousness", "alternating personality", "multiple personality", and "split personality" were some of the terms being used to describe cases which appear to have had similar symptoms (Greaves in Kluft & Fine,

1993).

It was not until 1889 that Pierre Janet first introduced the concept of dissociation. He defined it as, "The separation of an idea or thought process from the main stream of consciousness" (Braun, 1990). The following year William James published what has been called his psychological masterwork, "Principles of Psychology". In this text James clearly outlined the phenomena of altered and divided states of consciousness, including the possibility of multiple personality (Ross, 1989; Greaves in Kluft & Fine, 1993).

With the availability of a framework called dissociation, reported cases of multiple personality became more frequent in the literature. In the early nineteen hundreds Morton Prince published several cases of multiple personality and he formed the Journal of Abnormal Psychology which became the standard journal for publication in this area (Greaves in Kluft & Fine, 1993). "Multiple personality" as a label to identify this phenomenon was first used by Sidis and Godhard in 1905 (Ross, 1989). At the beginning of the twentieth century William James, Pierre Janet, and Morton Prince were at the forefront of psychology, writing and lecturing on dissociation and their

clinical work with clients identified as having multiple personalities. In professional circles, and among laymen, multiple personality had become a reality, a topic to be learned about through empirical investigation.

Around the year 1910, dissociation ceased to be a topic of serious study. Flaws in earlier studies diminished its credibility and the interest people had in dissociation (Ross, 1989). By the nineteen-twenties Sigmund Freud's theory of repression had taken over the field of psychiatry and dissociation was no longer in vogue. Bleuler's introduction of the term schizophrenia in 1911 contributed to the diminished interest in dissociation, and many cases that might have previously been considered multiple personality were subsequently diagnosed as schizophrenia (Stafford, 1993; Whitman & Munkel, 1991).

By the middle of the twentieth century German psychiatric thought dominated Western civilization. Jewish psychiatrists and psychoanalysts escaping persecution in Germany fled to English-speaking countries where they spread their German-influenced ideas of psychiatry. Freud, Bleuler, and Kraepelin became the new forefront of psychiatry (Greaves in

Kluft & Fine, 1993). Publication of cases of multiple personality decreased dramatically during the middle of the twentieth century.

Some modern proponents of DID believe that during the middle of the twentieth century many cases of DID were misdiagnosed as schizophrenia (see Spiegel in Kluft and Fine, 1993; Nakdimen, 1990). They use their modern metaphor of DID to make sense of historical metaphors with seemingly similar clinical presentations. Despite the historical rise and fall in the belief and interest in multiple personality, some present advocates of DID attempt to re-write history by explaining certain historical clinical cases using the modern metaphor of DID (for example, Putnam, 1989; Greaves in Kluft and Fine, 1993). Such transcendence of modern beliefs is inevitable as people attempt to re-create and give meaning to the past using their own frame of reference (see Gergen, 1991).

Although reports of multiple personality were few and far between during the mid nineteen hundreds, the concept had not become extinct. Taylor and Martin published an extensive review in 1944 in which they reported that there were 76 known cases of multiple personality (Taylor & Martin, 1944). Their article has been cited frequently by subsequent authors,

primarily to prove that multiple personality exists and that it is a rare occurrence (Greaves in Kluft & Fine, 1993).

Ten years later, in 1954, C. Thigpen and H. Cleckley published data about Chris Costner Sizemore's case in the Journal of Abnormal and Social Psychology (Thigpen & Cleckley, 1954). Another three years passed before they published the detailed account of Ms. Sizemore's story in "The Three Faces of Eve" (Thigpen & Cleckley, 1957). Once again, public consciousness of multiple personality was building and this metaphor became an increasingly viable concept, presumably "in" certain people.

Although curiosity about multiple personality was on the rise, it was not yet firmly established again as a "true" or "real" phenomenon in the public's view. In 1971 Margareta Bowers et al published a detailed article titled "Therapy of Multiple Personality" (Bowers et al, 1971). It provided many of the insights now considered accurate in the understanding of DID. Despite its clinical promise, the article was not very influential and has been described as, "too early for its time" (Greaves in Kluft & Fine, 1993). The leading edge of knowledge at the time was unacceptable to a community which

was still in its infancy with regard to making sense of multiple personality. The concepts presented by Bowers et al did not easily fit in with the social dialogue of the time, and as such, those ideas were not a part of the "reality" people created in their 1971 metaphor of MPD.

An English Professor named Flora Rheta Schreiber offered a seemingly more objective outsider's perspective on a case of multiple personality when she published the book "Sybil" in 1973 (Schreiber, 1973). This popular book appears to have created a turning point from which the public was able to make multiple personality a normal part of their vocabulary. At that point in time people came to accept the metaphor about multiple personality as a real entity which describes a viable piece of the human experience.

Nineteen-eighty is considered the year when multiple personality flourished as a credible concept in psychiatric and psychological circles. A flurry of scholarly activity brought back dissociation and multiple personality as useful concepts to the mental health profession. George Greaves has outlined the following factors which made 1980 the most pivotal year in the history of MPD/DID:

1980 - Ralph Allison and Ted Schwartz published the book "Minds in Many Pieces" in which they assertively hold that MPD exists.

1980 - Milton Rosenbaum published his assertion that psychiatrists may have been inadvertently misdiagnosing cases of multiple personality as schizophrenia.

1980 - George Greaves published a comprehensive analysis of the known literature on multiple personality in the Journal of Nervous and Mental Disease.

1980 - Eugene Bliss announced his famous hypothesis that people with multiple personality had an autohypnotic illness not induced by therapists.

1980 - DSM-III listed multiple personality as an entity separate from hysteria or schizophrenia (Greaves in Kluft & Fine, 1993).

Since 1980 the scholarly activity surrounding MPD/DID has been tremendous. Not coincidentally, DID has also become a more frequently diagnosed disorder (Kluft, 1987). Despite increased incidence of reported cases of DID there is a belief that the prevalence of cases has not increased (see Greaves in Kluft & Fine, 1993). Many clinicians believe that increased awareness of the "reality" of DID has led to more frequent and accurate diagnoses. With a basic acceptance that DID exists, the mental health communities purport to advance their understanding about dissociation and DID, which leads to more consensual agreement regarding diagnosis,

and ultimately to a greater frequency with which cases of DID are "identified". Richard Kluft suggested the following influences which might contribute to increasing use of the diagnosis of DID:

> * DSM-III grouped MPD [and now DSM-IV groups DID] with dissociative disorders.
>
> * DSM-III tightened definitions of schizophrenia and affective disorders.
>
> * Closer scrutiny of pharmacological treatment failures and greater precision in diagnosing.
>
> * Increased awareness of abuse and incest and their sequalae in adult psychopathology.
>
> * Media sensationalism.
>
> * Historical fact that as interest in hypnosis is high interest in MPD [DID] increases (Kluft 1987).

While all of the events Kluft describes may have occurred, they do not necessarily explain the observation that DID is being increasingly diagnosed. An alternative viewpoint is that people are making DID more real in their minds by talking about it, studying it, and building upon the social milieu which supports it. In effect, people are more likely to make diagnoses of DID as they increasingly come to believe in the shared construction of the diagnosis. Whether or not there is increased prevalence of DID becomes a somewhat different question once one arrives

at the view that DID is a socially constructed metaphor suitable for use in modern, Western, mental health circles.

Building a Metaphor (Etiology)

From a social constructionist point of view, DID is a metaphor, a word used to capture a wide range of concepts. DID does not represent an actual thing, but a man made distinction of certain ideas. The modern metaphor of DID is entwined with numerous concepts which are characteristic of Western civilization. Belief in a "real" thing called DID also incorporates belief in dissociation, defense mechanisms, empiricism, and psychotherapy. These concepts build upon one another to form an internally consistent dialogue with which people come to understand DID. The entire bedrock of this belief system is a basic acceptance of the logical positivist ideology. Proponents of social constructionism view distinctions such as DID as powerful metaphors, while they do not embrace the positivist agenda. In the following section social constructionism is used to outline the modern Western construct of DID, as it is understood by people identified as specialists in the field of dissociative disorders.

DID, as a metaphor, is viewed as the most extreme form of posttraumatic pathology. It is considered, "...a failure of self-integration in which individuals isolate one component of memory from another, usually

for defensive purposes" (Spiegel in Kluft and Fine, 1993, p. 89). When exposed to severe trauma people do not have identical reactions. Research studies suggest that those with the highest tolerance for extreme stress share certain characteristics including, "high sociability, a thoughtful and active coping style, and a strong perception of their ability to control their destiny" (Herman, 1992, p. 58). Those who are most vulnerable to developing DID are believed to share the characteristic of excessively using dissociation during childhood as a means of compartmentalizing their traumatic experiences (see Ross et al., 1991; Kluft, 1987). "The dissociation [associated with DID] is best understood as a defense mechanism out of control: dissociative inward flight by a child overwhelmed by abuse becomes, over time, chronic posttraumatic psychopathology" (Braun, 1990, p. 971).

Belief in dissociation is elementary to the theoretical framework used in the construction of DID. All who study DID seem to accept dissociation as the key to understanding people who experience this condition.

Dissociation is the idea that various parts of the self, such as feelings, ideas, or memories, can

become separated or split off in ways that make them inaccessible to other parts of the self. Inherent in this notion is the belief that unity of the self is an illusory concept. All people have a sense of self - the I - which is not a singular thing, but rather it is made up of various subsystems (see Erdelyi in Spiegel, 1994). An example of such polypsychism is Freud's division of the personality into id, ego, and superego. Although people do not necessarily experience their "self" as a conglomerate of systems, Western thought has embraced polypsychism for many years. What makes dissociation so intriguing is the idea that various subsystems within a single "self" appear to function independently of the others. The whole is not always comprised of the sum of its parts.

The concept of dissociation has evolved since its introduction. The following definitions represent the two main perspectives on dissociation, as understood by Pierre Janet and Sigmund Freud.

> Janetian dissociationism is a deficit phenomenon. Insufficiency of binding energy, caused by hereditary factors, life stresses, or traumas, or an interaction among them, results in a splitting off of personality clusters from the ego, the core personality. The split-off clusters or fragments constitute minipersonalities or, if they cohere, an alternate personality.
>
> Freudian dissociation is an active defense phenomenon. Subsystems of ideas/wishes/thoughts/ memories that threaten the integrity of the

> overall system (as judged by a judging system, Freud's ego) are forcibly suppressed/repressed/ inhibited/dissociated/split off, and so on (Erdelyi in Spiegel, 1994).

Today, many researchers seem to blend these ideas so that a modern understanding of dissociation includes notions of defensive activity, reaction to trauma or stress, fragments, alter personalities, and threatened integrity of the whole system - the self. Elaborating on the metaphor of DID, one can hypothesize that dissociation is not limited to a pathological condition, rather it can be thought of as extending along a spectrum on which all people lie (Price, 1987). At one end, this spectrum is believed to have a hypothetical "single personality disorder", followed by normal dissociation, depersonalization, psychogenic amnesia, psychogenic fugue, multiple personality disorder (DID), and at the most pathological end of the spectrum - poly-fragmented MPD (DID) (Bunk, 1993).

The spectrum of dissociation makes real this concept by identifying it as a regular part of the human condition. It is no longer considered pathological to dissociate, since researchers and clinicians find "evidence" that many "normal" people identify themselves as experiencing some dissociative phenomena (Putnam, 1989). Examples of the more

"normal" forms of dissociation include "tuning out" and "highway hypnosis". It has been suggested that the human capacity to dissociate serves some survival value as it facilitates, "...(1) the automatization of certain behaviors, (2) the efficiency and economy of effort, (3) the resolution of irreconcilable conflicts, (4) escape from the constraints of reality, (5) the isolation of catastrophic experiences, (6) the cathartic discharge of certain feelings, and (7) the enhancement of herd sense (e.g. the submersion of the individual ego for the group identity, greater suggestibility, etc.)" (Ludwig, 1983). The question has shifted from whether dissociation exists to what degree of dissociation do each of us employ.

Used in moderation, dissociation is considered adaptive, but like most things, when it is used in excess it becomes problematic. Some researchers have found that while ongoing dissociation can provide relief from overwhelming affects, it also leads to a subjective sense of deadness, disconnection from others, and it is highly correlated with self abusive cutting behaviors (van der Kolk, Perry, & Lewis Herman, 1991).

If all people are now believed to use dissociation, then what constitutes excess and what

specifically is believed to generate Dissociative Identity Disorder? The prevailing belief is that the development of DID is most often associated with childhood use of dissociation to cope with abuse and trauma. Such children are said to deal with intolerable realities by relegating the traumatic experience to some dissociative state. Over time, if the trauma is repeated, the dissociated states begin to develop a sense of separate identity, which become manifest as fragments or alter personalities (Ross, et al., 1991).

There are several modern theories regarding what is considered necessary for a person to develop DID. One of these theories is the 3-P model developed by Braun (Braun, 1990). This model views DID as a posttraumatic dissociative disorder which has 3 prerequisite conditions. The 3-Ps which are considered necessary in the development of DID are predisposing, precipitating, and perpetuating factors. According to Braun,

> Two predisposing factors are requisite: (a) a biopsychological capacity to dissociate... ...and (b) repeated exposure to an inconsistently stressful environment... ...The precipitating event is almost always a specific, overwhelming, traumatic episode to which the victim responds by dissociating... ...The final necessary 3-P condition is that of perpetuating phenomena that

> link the dissociative episode with a common affective theme. The perpetuating phenomena are interactive behaviors, usually between the abuser and the abused, that result in separate memories for each dissociative episode (Braun, 1990).

It is believed that these 3-P factors are not individually sufficient to produce DID, but in combination they set the stage for developing DID.

If one maintains the position that all people fall on a continuum of dissociation, it is likely that very few people fail to meet Braun's first predisposing factor, capacity to dissociate. The second predisposing factor, repeated exposure to an inconsistently stressful environment, might hold significantly more weight in determining who may or may not develop DID. According to Terr (1991), a very large number of psychiatric diagnoses can be linked to childhood traumas, such as conduct disorders, borderline personality disorders, attention deficit hyperactivity disorders, phobic disorders, Obsessive compulsive disorders, adjustment disorders, panic disorders, etc.. What is believed to separate DID from most of these other diagnoses is the repetition of the traumas, so that the affected children come to expect that they have to find ways of coping with such extreme stress. The metaphor maintains that

it is not just dealing with a single trauma, but the inconsistency of repeated traumas which predisposes a child to developing DID.

The second of the 3-P factors, precipitating events, has been well documented in the DID research. As stated above, most all cases of DID are directly traceable to childhood trauma (Sanders, & Giolas, 1991). Each of the traumatic experiences is considered a separate precipitating event, which the child may defend against by dissociating.

The final 3-P factor, perpetuating phenomena, is believed to link the individual dissociative episodes into fragments or alter personalities, which begin to develop a separate existence from the original "self" (Ross, et al, 1991). By perpetuating the circumstances which led the child to dissociate, there appears to be some constancy, albeit pathological, to the existence of dissociative states.

Another modern theory regarding the etiology of DID is the four-factor theory developed by Richard Kluft, possibly the leading authority on DID in this century. Kluft's description of the four-factor theory is quoted below:

> "According to the four-factor theory, multiple personality disorder [DID] occurs when a child with the capacity to dissociate (factor 1) is exposed to overwhelming stimuli (factor 2) that

> cannot be managed with less drastic defenses. Hence the capacity to dissociate is enlisted in the service of defense. Dissociated contents become linked with one of many possible substrates and shaping influences for personality organization (factor 3). If there are inadequate stimulus barriers and restorative experiences, or an excess of double-binding messages that inhibits the child's capacity to process his experience (factor 4), multiple personality disorder [DID] can result" (Kluft, 1987).

Although framed somewhat differently, the four-factor theory and the 3-P model each contain the same basic elements. They both recognize the following elements which contribute to the development of DID: a) capacity to dissociate, b) exposure to traumatic stimuli, which is defended against by dissociating, and c) some way of associating dissociative episodes into themes, which may become organized into fragments or personalities.

Kluft's factor four, inability to process the experience, is not paralleled in Braun's 3-P model. Braun's second predisposing factor, repeated exposure to an inconsistently stressful environment, does not appear in the four-factor theory. While these theories vary slightly, they share the culturally sanctioned constructions of DID. Their similarities allow for their survival, while their differences suggest that the "truth" is present in one's own beliefs.

Researchers suggest that 95% to 98% of subjects

with DID report a history of child abuse (Braun, 1990; Putnam, 1989; Kluft, 1987). This constitutes the prevailing and most fundamental belief about the etiology of DID (Spiegel, 1994; Kluft and Fine, 1993; Herman, 1992; Terr, 1991; Ross et al., 1991; Baldwin, 1990; Chu and Dill, 1990). Traumata other than child abuse have been considered as precipitants to DID (see Braun, 1990, 1986), though these are seldom written about in professional literature.

While trauma is an important piece of the story people construct around DID, there is no definitive cause and effect relationship between trauma and DID. The cornerstone of all modern conceptions of DID involves a theory that connects trauma and DID. It is not possible to have hard evidence about a "real" or "true" origin of this condition. Rather, there is a shared consciousness and agreement among many professionals regarding how to make sense of the confusing clinical picture certain clients present. Mental health professionals construct the reality of DID by sharing a sensible dialogue to help explain their clinical experiences. DID is "real" in the late twentieth century Western world because many people in this time period embrace this metaphor as an important and useful part of their world view.

Clinical Presentation

Recognizing a client with DID is said to be a formidable task. It is claimed that clients never initially present themselves to clinicians with a complaint of having multiple personalities (Schafer, 1986). To the contrary, the vast majority of clients identified with DID are initially unaware of their diagnosis. Rather than dramatizing their condition, it is reported that 94 percent of DID clients minimize and deny their symptoms (Kluft, 1987). Those who treat people with DID inevitably have to "educate" their clients about the condition; in a sense, invite them to share the metaphor.

Recognition of DID is not all that successful among clinicians. On average it takes 6.8 years from the time a client initially presents himself for treatment to the time he or she is diagnosed with DID. Within that 6.8 years the client will receive an average of 3.6 erroneous diagnoses (Kluft, 1987). The signs and symptoms which the DID client presents with are typically suggestive of other disorders, such as depression, anxiety, borderline personality disorder, schizophrenia, and post traumatic stress disorder (Braun, 1990). It has been suggested that when a particular personality becomes dominant the

characteristics of that personality, such as depression, can be mistaken as characteristics of the whole person (see Schafer, 1986). While these other diagnoses might co-exist with DID they are considered secondary to the diagnosis of DID.

How, then, does one recognize and accurately diagnose DID? Schafer described three cardinal attributes of multiple personality disorder (DID) from which clinicians should seriously suspect the presence of DID, "(1) Amnesic periods, subjectively and/or objectively observed; (2) abuse in childhood; (3) a stormy psychiatric history, especially with borderline and/or hysterical features" (Schafer, 1986). In this outline, stormy psychiatric history refers to the DID client's failure to respond to the standard treatment of previously made diagnoses (Putnam, 1989). While the verifiable presence of alter personalities is not part of this outline, the three attributes presented are believed to warrant sufficient suspicion for the diagnosis of DID.

More recently, Bennett Braun offered the following indicators which are said to be characteristic signs and symptoms of DID:

* A history of several psychiatric or medical diagnoses.

* Inconsistencies in physical behavior, for

example, voice changes, changes in facial expression, switching in right or left handedness, substantial differences in clothing worn on the first and subsequent visits, differences in hair style and facial makeup on different visits.

* Inconsistencies in accounts of elapsed time.

* Psychophysiologic manifestations, such as headache, anxiety, chest pain, fluctuations in pain threshold, or unpredictable responses to medication (e.g., sudden alterations in insulin requirement).

* The experiencing of voices inside the head talking to one another or to the patient; the schizophrenic patient, by contrast, usually experiences voices originating outside the head.

* Multiple personality disorder or other dissociative disorders, or history of abuse in the patient's family; evidence exists for a transgenerational component in multiple personality disorder (Braun, 1990).

The clinician who understands and accepts these signs and symptoms as pathognomonic for DID is expected to be able to diagnose this condition by following the diagnostic criteria in the DSM-IV. Given the turbulent history of diagnosing MPD, many clinicians now consider a false positive diagnosis of DID the more conservative of diagnostic errors (Kluft, 1987), particularly since there is an increase in the successful treatment of DID with appropriate psychotherapy. As a serious psychiatric condition which is said to respond well to psychotherapy (Spiegel in Kluft & Fine, 1993), many consider it an egregious error not to diagnose accurately when presented with

the diagnostic "evidence".

The client's presentation of more than one distinct personality state, called "alter" personalities, in a therapy session can greatly increase a therapist's confidence of diagnosis. However, switching between alter personalities is not always so frequent or noticeable. "Approximately 80 percent [of DID clients] experience substantial periods of time in which the various personalities do not emerge overtly but instead are in relative harmony or influence one another without assuming complete executive control" (Kluft, 1987). Clients are also said to present fragments, which do not have a full range of response patterns or emotions, as do alter personalities (Braun, 1986). Failure to witness switching personalities or non-dramatic switches are not considered valid reasons to give up believing in one's diagnosis if other indicators have been present. Faith in the metaphor is encouraged as a contribution to successful treatment. Such adherence to the metaphor clearly illustrates the social forces which contribute to its survival.

Different personalities in DID are said to manifest in a variety of forms. M. Lauretta Fike outlined many of the common alter personalities in

her article, "Clinical Manifestations in Persons With Multiple Personality Disorder" (Fike, 1990). Some of the personalities she wrote about include, child and adolescent alters, protective or rescuer alters, negative or hostile alters, perpetrator alters, avenger alters, self-destroyer alters, internal self helper alters, opposite sex alters, nonhuman alters, animal alters, and demonic alters. While most people have a normal capacity to segment different life activities and stages, the DID client is said to take segmentation to its extreme. Each alter personality is believed to be responsible for certain roles, which are not necessarily shared by the whole person. Amnesic barriers keep some alters from experiencing all the vagaries of the person's total life (Fike, 1990).

While the initial use of dissociation is believed to protect a child from stress and trauma, the development of independent personalities is said not to stop in childhood. The defensive pattern is repeatedly employed to deal with life stressors and even normal developmental issues. What began as a defense against intolerable stress can later be used to cope with mundane daily situations (Kluft, 1987). As such, adolescents and young adults with DID are

considered likely to be proliferating their personality systems as they attempt to cope with the many stressors of early adulthood. It is not uncommon for therapists to report cases with over 50 alter personalities in a single client. While there is no consensus regarding the average number or alter personalities in DID clients, modern researchers' reports have ranged from an average of 3.5 alter personalities up to an average of 15 alter personalities (Putnam, 1989).

The majority of DID cases which are considered accurately diagnosed occur when the client is in early adulthood (Braun, 1990). More women than men are diagnosed with DID, yet this is not necessarily reflective of the set of all people believed to have DID. It has been suggested that many men with DID act out violently and end up in prison, rather than in treatment (Putnam, 1989; Fike, 1990). DID is also highly correlated with intelligence. Most DID clients have an IQ over 130, which is suggested might account for the use of dissociation over more primitive defenses (see Schafer, 1986).

Taken together, the information in this section can provide a "textbook" example of the "typical" DID client: A young adult woman with high intelligence, who was abused in childhood, had been diagnosed and

unsuccessfully treated for a variety of disorders, and who experiences amnesic periods and confusion regarding elapsed time. Clearly this example does not cover all cases, yet it provides a concise statement about the beliefs held about DID.

Treatment

The metaphor of DID, as presented thus far, coincides with the production of its own treatment paradigm. As with any diagnostic entity, the construction of etiology overlaps with and contributes significantly to the construction of treatment. Successful treatments which coincide with ideas of etiology help to create a sense of confidence in the entire metaphor. As noted in the history section of this chapter, the modern approach to treatment of DID was not accepted by most people when Bowers et al. published "Therapy of Multiple Personality" in 1971. It was not until other aspects of the metaphor were more firmly in place that people came to accept a treatment paradigm. The entire belief system, as it is understood today, has been and will continue to be a work in progress, evolving to suit the culture which supports it. Culture serves as a frame for its members to outline their perceptions of reality (see Martinez-Taboas, 1991).

Individual psychotherapy combined with hypnosis is the most widely endorsed treatment approach for alleviating the symptoms of DID (Putnam and Loewenstein, 1993). This treatment approach supports and builds upon the accepted metaphor used in making

sense of DID. It has already been established that the distinction, DID, is a product of modern Western culture, and now its treatment, psychotherapy, is also considered a product of the same tradition. Psychotherapy as a form of treatment reflects and shapes the central themes of the middle class, twentieth century American people (Cushman, 1995). In particular, American culture focuses on a self that is individualistic, thus establishing the backdrop for disorders and treatments dealing with unique and distinct perceptions of the self (Martinez-Taboas, 1991). To treat DID by a non-Western method would fail to maintain the integrity of the modern Western psychotherapy enterprise, and in turn would impede acceptance of the present metaphor. The use of psychotherapy is a temporal treatment approach for a temporal construction of a disorder; neither makes sense outside of its present place in culture and history.

People identified with DID do not enter therapy with a conceptual framework for understanding their difficulties. They do not ask for treatment because they know they have dissociated personalities. What they generally seek is treatment of one or more of the many corollary conditions or symptoms which are

often treated as the primary diagnosis. As noted earlier, it typically takes over 6 years from the time a DID client enters the mental health system until they are "accurately" diagnosed. The clinician who eventually makes the diagnosis of DID usually has worked with the client over 6 months before identifying the symptoms as indicators of DID (Putnam, 1989).

Once the clinician is clear about the diagnosis there is a standard and accepted approach to the treatment of DID. Based on an understanding of DID as a defensive use of dissociation to deal with trauma and chaos, treatment generally seeks to reassociate the fragmented states and personalities in a safe and consistent setting, thereby overcoming the disordered use of dissociation. An approach offered by Braun outlines 13 progressive points in treatment: (1) trust, (2) diagnosis, (3) communication with personalities, (4) contracting [for safety], (5) individual and system history gathering, (6) working the issues of each personality, (7) special procedures [ie: mapping], (8) interpersonality communication, (9) resolution and integration, (10) new coping skills, (11) social networking, (12) solidifying skills, and (13) follow up (Braun, 1990) Braun's approach is

typical of modern treatment paradigms, all of which tend to progress through three basic stages, (1) establishing trust, (2) increasing awareness and cooperation among alters, and (3) integration of alters and fragments (Erxleben and Cates, 1991). Basic to all modern treatments is belief that the client truly has definitive, separate personalities or fragments which, taken collectively, constitute the self of the client.

The treatment of DID is not believed to be particularly suited to any of the many traditional psychological or therapeutic orientations (e.g. psychoanalysis; behavior therapy; humanistic therapy). Good rapport, honesty, and trust seem to be the most important elements of the helping relationship, regardless of the psychological orientation of the therapist (Fike, 1990). Provision of these conditions is considered necessary in establishing an environment conducive to change for the DID client. This type of therapy can be a long drawn out process, as certain personalities are said to take longer to emerge and trust the therapeutic relationship. In this approach each of the personalities must individually be convinced of the efficacy of treatment. Each personality is dealt with as if real in its own right.

Over the past two decades the prevailing thinking about DID treatment has shifted dramatically. Early interventions sought to eliminate undesirable personalities, presumably leaving the client with a stronger, more desirable self identity. This idea shifted, however, when it was found that suppressing, banishing, or otherwise separating certain alter-personalities from the primary personality resulted in the client feeling depleted rather than relieved (Kluft in Braun, 1986). While clients often request that the therapist eliminate certain aggressive or evil alters (Ross and Gahan, 1988), such dismantling of the person is now believed to perpetuate the sense of dividedness.

Unification of all alters, regardless of their personality characteristics, became the new hallmark of successful treatment. Regarding each alter as responsible for certain necessary survival functions is now a valued belief. Each personality or fragment is considered an important aspect of the whole person. According to Ross and Gahan, "Treatment involves explicitly defining the behavior as positive in intent for all alters, which changes the primary personality's cognitions about her hostile alters" (Ross and Gahan, 1988). If every alter and fragment exists to help

the whole person then it no longer is sensible to cordon them off, no matter how undesirable their characteristics may initially appear.

Two terms have often been used to describe a goal of treatment for DID. They are "integration" and "fusion". These terms have been used synonymously in the past to describe the reassociation of dissociated parts. As the metaphor evolves, these terms have acquired slightly different meanings in the treatment of DID. According to Braun, "...integration means the process by which thought and physiological processes are mixed and solidified. Fusion is defined as the bringing together of separate personalities. Integration starts before fusion and continues after it" (Braun, 1986).

Integration of alters, a concept with a brief history, has already shifted from the goal of therapy (Kluft, 1987) to a possible goal (Erxleben and Cates, 1991; Fike, 1990). Primary goals of treatment currently include, "(a) reduction of the amnesiac barriers for precipitating trauma; (b) reduction of cognitive, perceptual, and emotional dissonance resulting from the amnesia; (c) resolution of emotional conflicts surrounding the traumatic events; (d) understanding of the effect of the trauma and amnesia

on current life and behavior; (e) establishment of internal cooperation; and (f) resumption of a socially acceptable and personally satisfying life-style" (Fike, 1990, pp. 999-1000). As clinicians increasingly accept and use DID in their dialogues, the metaphor is taking hold as a piece of reality which may be studied and incorporated into the pool of "knowledge" acquired through empirical investigation.

In a recent survey of clinicians treating DID, psychotherapy and hypnosis were endorsed most frequently as the treatment of choice. Other less endorsed treatments included medication, art therapy, family therapy, group therapy, and behavior modification (Putnam and Loewenstein, 1993). It was acknowledged in this study that endorsement of certain techniques might be more a function of the prevailing recommended approach and not necessarily an empirical investigation into the "best" treatment approach. Regardless of the intended research interests, this survey clearly shows that the metaphor of DID is firmly established and accepted among mental health professionals. DID has become real in the logical positivist world of Western civilization.

Chapter Four

Demonic Spirit Possession

Background

In this paper, Catholicism is used as an example of a specific Cristian culture which sustains belief in demonic possession. It has been suggested that the Catholic church is the leader among Cristian people in perpetuating belief in demon possession (see Oesterreich, 1974). The Catholic church also has a well documented doctrine, which helps reduce the amount of inferences which are made in studying its ideology. For these reasons, Catholicism is used as a representative culture in comparing demon possession with DID. It is understood that many other cultures, Christian and others, sustain beliefs in demon possession.

Throughout history it has been common to believe that spirits can possess a human being. It has been observed that societies which clearly oppress certain of its members, such as slaves, are more likely to witness possession among the oppressed groups. For example, women and low status individuals in male dominated societies, are most likely to believe in

and experience possession. It seems that dominant, non-oppressed people are less likely to believe in concepts such as spirit possession, which are highly organized around faith. Conversely, the more oppressed people are more likely to depend on religion and faith to make sense of their phenomenal experiences (Kemp & Williams, 1987).

As a culture of its own, the Roman Catholic church depends on the faith of its members to maintain its integrity. Although faith is experienced to varying degrees among members of the Catholic church, there is an expectation that all Catholic people evidence faith in the church doctrines and structure. As such, followers of Catholicism are subject to the power of the leaders in the church hierarchy. Deference to that authority encourages the Catholic people to trust in faith, just as oppressed groups turn to faith to make sense of their plight. In fact, for centuries followers of Catholicism were preached to by members of the church hierarchy without having direct access to written doctrine by which they might form their own opinions (Boorstin, 1983).

It logically follows that many Catholics, who are subordinate in the church structure, will hold many beliefs based on their faith, such as belief

in the reality of spirit possession. It is this group, or culture, which is of interest to this dissertation.

The Catholic culture, which is one among many Christian cultures, is comprised of people from all socioeconomic groups, races, ethnicities, ages, both genders, and people across the globe. As a cultural group, the people of the Catholic church are as diverse as one can imagine. It is their shared traditions, mores, beliefs, and faith which unite such a diverse group of people into a culture we call Catholicism. Members of this culture, however, also belong to other cultures, such as nationalities, which are sometimes at odds with the values of Catholicism. Belief in spirit possession varies greatly among Catholics, as each person attempts to balance the attitudes and beliefs of the numerous cultures to which they belong.

In modern Western societies belief in spirit possession is declining, although there do exist pockets of people who continue to carry the idea within their subcultures (see Goff, Brotman, Kindlon, Waites, & Amico, 1991). According to Oesterreich, "Only where a high degree of [Western] civilization prevails does it [possession] disappear or retreat

into the shadows" (Oesterreich, 1974). Many modern Westerners appear to have replaced the world view held by their ancestors with a modern Westernized world view that seeks to explain phenomena via the scientific method.

Phenomena such as spirit possession, which were traditionally explained by faith in the teachings of the Bible, are now frequently examined through a secular, scientific, Western frame of reference which has little respect for ideas that do not hold up to empirical scrutiny. For example, some writers try to make sense of demon possession through psychodynamic theory, suggesting that possession affords the individual with, "...direct escape from a conflict situation and diminution of guilt by projecting blame onto the intruding spirit" (Ward and Beaubrun, 1980). Some Westerners believe that possession is "in reality" a form of dissociation (see Kenny, 1981). Still others want to medicalize possession, by including it in the DSM as a type of dissociative disorder (Cardena, 1992; Lewis-Fernandez, 1992). It has been observed that, "...in 90% of the countries of the world, dissociative states are mostly evident as trance and possession states (Martinez-Taboas, 1991). This type of re-authoring

of what is "real" does not recognize the past and present drive to make meaning through social consensus. What makes sense to empirical researchers is not easily applied to phenomena which lie outside of the purview of positivism. Such attempts to impose positivist ideology onto other cultures ignores the social, political, historical, and interpersonal forces that create and give meaning to those cultures.

Not all of the globe, however, participates in the highly scientific perspective of Western societies. It is estimated that three fourths of all known societies continue to hold some level of belief in possession (Kemp & Williams, 1987). The scientific lens for sense-making in this world has a relatively brief history when compared with the Christian lens, which has endured two thousand years, since the time of Jesus.

Demon Possession in Catholicism

Among the numerous religions subsumed under Christianity, it has been suggested that Catholicism holds the most weight in sustaining belief in demon possession (see Oesterreich, 1974). Most basic to this lens is belief that God is the creator of all things. Although God could have created perfection, he instead allowed humans and angels to have their own will to choose a righteous way of life or to choose evil. Therefore, God permits evil to survive (United States Catholic Conference, Inc., 1994).

Evil itself is not easily defined, though it is believed to embody anything that interferes with God's will. Some qualities of evil evident in human beings include destructive and scapegoating behavior, intolerance to criticism, pretentiousness and excessive concern with self-image, and intellectual deviousness (Peck, 1983). All of these qualities tend to focus attention on the self instead of on God. While evil is not necessarily a tangible thing it becomes manifest in the self-directed activities which separate individuals from God.

The evil spirits which are said to possess human beings are called demons. According to the recently published Catechism of the Catholic Church, "Satan

or the devil and other demons are fallen angels who have freely refused to serve God and his plan. Their choice against God is definitive. They try to associate man in their revolt against God" (United States Catholic Conference, Inc., 1994). Possession of human beings by one or more demons is one of many ways Catholics believe evil to be present in the world.

Possessions are believed to occur by individual demons, groups of demons, and sometimes by Satan himself, the leader of all evil. "Although intangible and immaterial, [Satan] has a personality, a true being... Satan's personality cannot be characterized simply by an absence, a nothingness. It is true that there is an absence of love in its personality. It is also true, however, that pervading this personality is an active presence of hate" (Peck, 1983). Regardless of the name or number of demons involved in the possession of a human being, the intent is believed to always be the invocation of evil. Hereafter, references to spirit possession are referred to as demon possession.

History

Public acceptance of any kind of spirit possession has waxed and waned throughout history, and appears to depend largely on the cultural "zeitgeist" operating in each society. Although belief in spirit possession existed prior to Jesus' time on earth, this dissertation does not focus on earlier beliefs as they are seldom cited in relation to Christian traditions. It is acknowledged that forms of possession occur in a variety of cultures [for instance, Pentecostal trance states, voodoo possession, Shamanism, and mediumship channeling (see Coons, 1993)], yet this dissertation maintains focus on the social construction of demonic possession as understood by Christian cultures, particularly that of the Roman Catholic church.

According to Berends (1975), the New Testament offers the only authoritative accounts of demon possession from that era. Two books from Biblical times, the book of "Tobit" and Josephus' "Antiquities", offer proof that belief in demon possession did occur prior to Jesus' time, yet Berends (1975) suggests that those accounts are too fanciful and unlikely to reflect actual cases. Thus, this chapter focuses on the Catholic tradition of demon possession from

the time of Jesus onward.

In first century Palestine, science, medicine, and magic were not clearly defined and separable pursuits. Sincere religious healers and medical practitioners competed with charlatans and tricksters in offering aid to the ill (Hankoff, 1992). In this culture the diagnosis of spirit and demonic possession was common (Kemp & Williams, 1987), as was belief in spiritual healing and miracles (Hankoff, 1992). It was in this setting that Jesus lived and performed various acts of healing.

Some believe that, as a human being, Jesus' participation in society was bound by first century Jewish knowledge. The Reverend Michael Wilson has commented, "I have little doubt that Jesus also believed that the earth was flat" (Wilson, 1975). This comment suggests that Jesus, like all the people of his era, made meaning of his world through the creation and acceptance of the prevailing social beliefs. The Bible, however, suggests that Jesus was not limited to human knowledge, but also had direct knowledge and information from God. In a prayer to God, Jesus said, "...Father, Righteous One, the world has not known you, but I have known you, and these [people] have known that you have sent me. I have

made your name known to them and will continue to make it known, so that the love with which you loved me may be in them, and so that I may be in them" [John 17: 25-26] (Jones, 1968). Certain passages from the Bible, such as the one quoted above, suggest that Jesus did not construct meaning solely from human interaction. He is believed to have been privy to divine knowledge, which allowed him to function on earth in ways which were outside of the scope of first century understanding.

According to Hankoff (1992), the spiritual healings of Jesus, as described in the Bible, took three forms: (1) Healing by prayer, which involved Jesus' declaring ailments be gone from peoples' bodies: the faith of the sick is viewed as the primary healing agent; (2) Healing involving magical acts, included instances such as when Jesus touched lepers and blind men curing them of their ailments or when he made concoctions with his saliva to cure blindness; and (3) Healing by exorcism, which involved Jesus' rebuking demons and declaring the afflicted individual healed of their ailments. It is Jesus' use of exorcism which is of most concern in this study.

It is said that during Jesus' time demons were conceptually equivalent to germs, believed to enter

the body and cause diseases (Wilson, 1975). The Bible's Gospels and the Book of Acts contain over 50 references to demon possession (Berends, 1975). Among these references are seven detailed accounts of possession and the exorcisms used to rid the demons from the sufferers' bodies (Page, 1989).

Despite the frequent description of demon possession, there are no Biblical criteria for discerning who might be possessed (Shuster, 1991). There are cases in the Bible of people having identical problems yet they are treated differently, sometimes with exorcism, sometimes without. As an example, in Matthew 12:22-28 Jesus casts out demons to restore a blind man's vision, then again he restores a blind man's vision in Mark 10:46-52, but this time Jesus attributes the cure to the man's faith (Jones, 1968). While one might argue that these two cases of blindness had different causes, there is no Biblical support for this view, other than the difference in treatment. Such lack of detail and lack of consistency among cases from the Bible makes it difficult use the Bible as a guide to understanding how attributions of demon possession are made.

Nevertheless, people did, and continue to, attribute certain human conditions to demonic

possession. In the years following Jesus' life on earth there was great success among his disciples in expelling demons from afflicted people. Their fervor and enthusiasm are believed to have aided in their success rate for exorcisms, which in part contributed to the growth of Christianity (Oesterreich, 1974).

Classical Antiquity, up until about 500 a.d., experienced widespread belief in an active spiritual world, including frequent demonic possessions. The Middle Ages (6th through 13th centureis), too, saw extensive writings about cases of demonic possession, as did the Renaissance (14th through 17th centuries) and more modern times (18th century through the present).

According to Oesterreich (1974), writings on possession over the past 20 centuries have consistently been comparable to the Biblical accounts. In his book, Possession and Exorcism, Oesterreich documents numerous cases of possession from nearly every century. Despite his references being written centuries apart, the descriptions of demonic possession become monotonous, as case after case is described in the same fashion, coincident with Biblical accounts.

Over the past three centuries people have been

increasingly skeptical about the devil, demons, and possession (Beck and Lewis, 1989). Belief in demon possession experienced a dramatic decline in the seventeenth century, following widespread public exorcisms which became associated with hucksters and charlatans (Belegman, 1993). In reaction to their decreasing credibility, the Catholic hierarchy established guidelines for exorcists, requiring all exorcisms to be sanctioned by the church. Since that time, each diocese of the church is assigned an exorcist, appointed by a bishop. In the event that an exorcism is to be performed, the appointed priest is responsible for fulfilling this duty. Due to a decline in reports of possession over the past century, some dioceses do not presently maintain an appointed exorcist (Martin, 1976).

Cases of demonic possession continue to be documented in the twentieth century. David VanGelder wrote of his participation in an exorcism in the article A Case of Demon Possession (VanGelder, 1987) Two other respected authors, M. Scott Peck, a psychiatrist, and Malachi Martin, a former Jesuit professor, have published recent books in which they both claim to have witnessed numerous cases of demonic possession (Peck, 1983; Martin, 1976). These authors

identify demonic possession as a rare occurrence and a private event in the lives of the affected people. In this way demonic possession has changed, since it once was considered more common and public.

Despite the apparent decline in frequency of demonic possession, belief in this phenomena remains central to the meaning many Catholics attribute to their overall faith. Demonic possessions need not occur frequently, but the construct continues to occupy a significant place in the meaning-making of the Catholic faith.

Presentation

There does not exist a document that unequivocally describes the presentation of a person possessed by demons. Since the New Testament of the Bible discusses accounts of Jesus' use of exorcism it is the starting point from which people attempt to make sense of understanding demonic possession. Virkler and Virkler (1977) identified the following categories of symptoms of possession found in the Bible.

> 1) The demon may speak using the voice of the possessed person, sometimes conveying knowledge of supernatural realities (Luke 4:33-35, 8:26-29; Acts 16:16-18).
>
> 2) The person may manifest supernormal strength (Matthew 8:28-34; Acts 19:16).
>
> 3) The person may go about naked (Mark 6:1-20; Luke 8:27).
>
> 4) The person may be unable to speak or hear (Mark 9:25; Luke 11:14).
>
> 5) The person may suffer from self-destructive, epileptic-like seizures with convulsions and other attendant symptoms such as rigidity, foaming at the mouth, and bruxism (Matthew 17:14-21; Mark 9:17; Luke 9:37).
>
> 6) Blindness may result (Matthew 12:22). (Virkler and Virkler, 1977)

Although the Bible offers no definitive means of assessing who is possessed and who is not, certain themes from the Biblical accounts have been elucidated. Berends (1975) offers the following Biblical criteria

for demon possession.

1. that demon possession was limited to a certain era in history;

2. that demon possession was limited to a certain class of people;

3. that demoniacs were readily diagnosed;

4. that psychosomatic symptoms always accompanied demon-possession;

5. that the demons possessing demoniacs had distinct personalities;

6. that demoniacs had some supernatural knowledge by virtue of their demons;

7. that the demoniacs were compelled to acclaim the authority of Jesus when confronted by him or by one of his representatives;

8. that demoniacs never came out of themselves to be cured.

9. that an authoritative word, spoken in faith, is the only biblical way of exorcising a demon.

This list of nine criteria of demon possession is descriptive of the Biblical accounts, yet it does not provide diagnostic clarity for assessing whether an individual in subsequent cultures or societies might be possessed. There are no conclusive reviews of the Bible's accounts of possession which adequately differentiate demon possession from other disorders. Even the Catechism of the Catholic Church (United States Catholic Conference, Inc., 1994), which defines the belief system of Catholic people, fails to mention demon possession.

A frequently cited author, T.K. Oesterreich, believes that the Biblical accounts of demon possession created a model by which all subsequent Western cultures have understood possession. In his book, Possession and Exorcism (Oesterreich, 1974), Oesterreich outlines some basic similarities of cases identified as demon possession over the past 20 centuries. The three main external features of all such cases are outlined below.

1. The possessed individual takes on a new physiognomy (eg. facial changes).

2. The possessed individual takes on a new voice, in most cases a male voice.

3. The possessed individual's new voice speaks not according to the normal personality, rather it has a separate ego and character (Oesterreich, 1974).

While Oesterreich considers the Bible a reference point which contributes to an enduring cultural acceptance of the phenomena of demon possession, others contend that Biblical references to possession are not intended to be models. Virkler and Virkler succinctly defend this latter point, "...we have no guarantee that the relatively brief descriptions of demonically-caused symptomatology found in Scripture were meant to be considered normative examples of possession across time and cultures. All that the narrative accounts of demonization found in the Gospels

and Acts claim is that they are accurate descriptions of demonization of that time, not normative descriptions of demonization that can be used for all succeeding generations" (Virkler & Virkler, 1977).

Perhaps the question of whether the Bible provides a model of possession can not be answered. To do so would be suspect, giving meaning to a historical document which was not present at the time of its authorship. Numerous positions have been posited: demonic activity in Biblical times was unusually intense (Beck and Lewis, 1989), first century Jews associated possession with insanity (Page, 1989b), Biblical accounts of possession influenced all subsequent Christian thinking (Kemp and Williams, 1987) and New Testament records dramatized some isolated events (Hankoff, 1992). None of these positions can be proved in an empirical sense. This type of speculation likely contributes to the difficulty people have encountered in trying to define criteria which might add credence to the "reality" of demon possession.

Until the seventeenth century there was little concern over specific criteria for demon possession. However, as charlatans increasingly misused exorcisms for personal and political gains, the seventeenth

century Catholic church became increasingly involved in establishing criteria for identifying "real" cases of possession and controlling who could perform exorcisms. The criteria they formulated for demonic possession included: 1) revulsion to sacred objects; 2) paranormal knowledge; 3) paranormal strength; and 4) paranormal linguistic ability such as speaking a language previously unknown to the possessed person (Belegman,1993). These features continue to be evident in reports of possession from the twentieth century (see Martin, 1976).

As noted previously, accounts of demon possession consistently maintain similarity to Biblical accounts. There is, however, a belief that possessing demons are always in tune with contemporary interests, therefore a twentieth century possession might appear entirely different from a Biblical possession (see Martin, 1976). It has been observed that possession in this century tends to involve spirits of the dead, rather than demons, which is consistent with declining belief in demonology (Oesterreich, 1974). As a result of the seemingly changing presentation of possessions, the average observer would be hard pressed to recognize demonic possession among the variety of other disorders of a given time and culture. As the metaphor would

have it, however, average people are not expected to be able to identify demons. Such a task is relegated to those who have the gift of spiritual discernment. This gift will be explained in more detail later in the chapter.

A unique aspect of demonic possession which distinguishes it from many other disorders is the impact a possessed person may have on others in his vicinity. It has been reported that those near the possessed person may feel suffocation while praying, smell an acrid stench, and experience dramatically cold temperatures in proximity to the possessed person. They also are said to witness objects moving about the room and feel an alien presence in the room (Isaacs, 1987). Shared belief in the "reality" of possessing demons appears to manifest itself in people other than just the identified target of the demons. This type of shared involvement in the disorder is unparalleled in Western medicine.

While the presentation of a possessed individual remains elusive, certain themes, particularly the supernatural criteria, seem to endure over the centuries. It has been suggested that these supernatural criteria survive precisely because of their resistance to naturalistic explanation (Belegman,

1993). In the empirical perspective of Western civilization there is no explanation for poltergeist activity, paranormal linguistic ability, or paranormal knowledge. It is precisely this incompatibility of world views which lends credence to the constructions of the Catholic church. The shared faith and beliefs of Catholic people uphold an internally consistent dialogue for sense-making of demon possession.

Faith

As noted previously, DID emerged in a culture with a logical positivist ideology which encourages scientific empiricism. Demonic spirit possession, however, is not easily explainable through a scientific lens because the culture of possession is not empirical. For nearly 2000 years theologists and many Christian cultures have come to understand reality and truth by their faith in God and the teachings of the Bible.

According to Saint Paul's letter to the Hebrews, "Only faith can guarantee the blessings that we hope for, or prove the existence of the realities that at present remain unseen. It was for faith that our ancestors were commended. It is by faith that we understand that the world was created by one word from God, so that no apparent cause can account for the things that we can see" (Hebrews 11:1-3, Jones, 1968). This faith Saint Paul spoke of has endured for many centuries. The people of the Catholic culture do not depend on hypotheses, control groups, and data because their faith affords them belief in a divine order to the universe. What they know and believe to be reality is not limited to tangible and worldly things. Therefore, constructions such as

demon possession are entirely logical and fit well with the lens the Catholic community uses to make sense of the world.

Within Catholicism, faith in God is acknowledged as a social action, an interchange among people for the sharing of ideas. As described by the Catholic church, "Faith is not an isolated act. No one can believe alone, just as no one can live alone. You have not given yourself faith as you have not given yourself life. The believer has received faith from others and should hand it on to others. Our love for Jesus and for our neighbor impels us to speak to others about our faith. Each believer is thus a link in the great chain of believers. I cannot believe without being carried by the faith of others, and by my faith I help support others in the faith" (United States Catholic Conference, Inc., 1994). Clearly, social exchange plays a significant role in providing meaning for the Catholic church. While most Catholics would be unlikely to accept the idea that they construct "reality" by social give and take, they do recognize the role of the people in carrying on their perceptions of "reality" from generation to generation.

In the twentieth century, Catholics are often

faced with a clash of world views. Western empiricism and Catholicism do not always meld easily, despite the fact that many people identify themselves as part of both cultures. Some suggest that belief in the dualism of good versus evil, God versus Satan, is no longer essential to the integrity of Catholicism (see Belegman, 1993). The Catholic church does not give up on faith, however, despite scientific attempts to give meaning to the world. According to the Catholic church, "methodical research in all branches of knowledge, provided it is carried out in a truly scientific manner and does not override moral laws, can never conflict with the faith, because the things of the world and the things of faith derive from the same God" (United States Catholic Conference, Inc., 1994). Based on this position, some of the more dualistic arguments, such as "creation versus evolution" do not need to be thought of as intrinsically incompatible. The human capacity for scientific study is presumably a God given ability, as is the capacity for faith. The positivist position of empirically discovering "reality" is not inherently opposed to the "truths" evident in the faith-based Catholic culture, even though they at times appear in conflict.

Etiology

To speak of etiology in any individual case of demon possession is an act of translocution. The history and culture that support the construct of demonic spirit possession do not include a conception of etiology. Simply put, evil causes possession to occur. There is no sense-making in attributing a logical cause to this phenomena. Those with strong faith do not trust or depend on "man-made" explanations for occurrances which are believed to be within the realm of a divine plan. Any efforts to make sense of the etiology of demon possession are, by nature, impositions of a world view other than that of the Catholic community which has no definitive cause and effect relationship to make sense of who becomes possessed.

In the scientific world there are certain "facts" about the etiology of disorders: smoking leads to lung cancer, and high fat diets lead to arteriosclerosis. In the Catholic culture such "facts" are not always so obvious. Faith permits certain observations about the world to be made, yet spiritual and divine intervention can take the logic out of any efforts at prediction. Rather than predicting who will become posessed, Catholic people are more

likely to identify conditions which make one vulnerable to posession, leaving the deciding factors to forces outside of their control.

Many Catholic people in faith believe that the way to avoid demonic possession, and other evils, is to remain true to God in one's thoughts and actions. While humans are believed to have no control over the mystical world of spirits, their faith in God is believed to make them less easy targets for evil. Subsequently, those who have weak faith or ignore what they have learned about God are believed to become more vulnerable to demonic influence. "Possession appears to be a gradual process in which the possessed person repeatedly sells out [to evil] for one reason or another" (Peck, 1983). Rather than being an instantaneous occurrence, possession seems to slowly take hold of a person, eroding their capacity to uphold their free will.

While God is believed to be able to provide people with certain gifts, such as grace, evil spirits are said to work only with the attributes already present in a person (Martin, 1976). Based on this line of reasoning, if a person does not actively practice devotion to God then he leaves himself vulnerable to the will of evil spirits. While it appears that

losing faith may constitute an etiology, documentation of such loss of faith is seldom found in reports of demon possession. Furthermore, there is no obvious pattern evident among people who experience possession. Well documented cases of demonic possession have included nuns, priests, children, and adults, including people with strong faith in God. Attempts at discovering a cause and effect relationship for demon possession have been unfruitful. And ultimately, the victim of possession is believed to be determined by the will of the demons themselves.

It has been suggested that lack of faith in God may increase the likelihood of demonic possession, however this assumption does not constitue an etiology. When specific cases of possession are investgated, faith in God has not appeared to be etiologically related to who became affected. While people of faith may describe their devotion to God as a form of protection from evil forces, there is no apparent connection between one's faith and demon possession.

Exorcism

Exorcism is the name of a ritual employed by Catholic priests to expel a demon from a person or place (see Martin, 1976). To perform an exorcism one must be certain that it is one or more demons which causes another's curious behaviors. As described in the next chapter, it is often quite difficult to discriminate demon possession from so called naturalistic causes of maladies. The Catholic metaphor, however, provides certain individuals with the ability to know, without doubt, whether a spirit, or demon, is responsible for an occurrence. This knowledge is provided to certain individuals as the gift of spiritual discernment.

According to the apostle Paul's first letter to the church at Corinth, the Holy Spirit gives different gifts to people to facilitate the spread of God's word. He wrote, "One may have the gift of preaching with wisdom given him by the Spirit; another may have the gift of preaching instruction given him by the same Spirit; and another the gift of faith given by the same Spirit; another again the gift of healing, through this one Spirit, one, the power of miracles; another prophecy; another the gift of recognizing spirits; another the gift of tongues and

another the ability to interpret them. All these are the work of one and the same Spirit, who distributes different gifts to different people just as he chooses" [Corinthians 12:8-11] (Jones, 1968). Though the Holy Spirit remains mysterious, even to Catholics, the explanation of how demons are recognized is not an un-accounted-for mystery. Through their faith, as described previously, The Catholic people accept as "reality" that certain people are capable of knowing when there is a spiritual presence. Once a person with this gift has identified a demonic presence in a human being, consideration can be given to expelling the demon.

The only recognized treatment for demonic spirit possession is exorcism. It is viewed as a duel with evil in which a priest, appointed by a Bishop, confronts the possessing demon(s) in a win or lose spiritual battle. The goal of this treatment is to expell any and all demons from the body of the affected person (Martin, 1976).

The exorcist, the priest performing the exorcism, while engaged in spiritual battle, operates from a position of love and fairness rather than as a powerful opponent to the invading demon(s) (Peck, 1983). The underlying rationale behind exorcism is the belief

that faith in God will overcome any evil. It has been suggested that just as demonic possession involves an individual's acceptance or belief in demonology, so too is belief and faith in God the curative agent (Oesterreich, 1974). The exorcist, therefore, must be prepared to demonstrate unyielding faith in God when confronting the demons, and perhaps Satan himself.

The exorcism itself, as modeled by Jesus, is simply the act of commanding the demon(s) to leave the body of the possessed individual (Martin, 1976). Jesus' exorcisms, as written in the Bible, were often just a few words. After Classical Antiquity, when followers of Jesus could no longer recall the man himself, exorcisms took on additional social meanings. Performing exorcisms was, at times, a show for public consumption. During the Middle Ages, as Christians and others became enamored with the public performance of exorcisms, audiences of up to 7000 people were recorded. In 1614, at the request of Paul V, the Rituale Romanum was published, establishing, through the Catholic church, a ritual for exorcism, and ending public demonstrations for large audiences (Oesterreich, 1974).

From the 17th century to the present, the Roman ritual of exorcism has remained the standard to which

most all exorcisms have subscribed. However, since exorcism is not a sacrament* in the Catholic church, it is not bound by adherence to a rigid formula (Martin, 1974). The Rituale Romanum provides recommendations and a model of actions to follow, though it is accepted that each individual exorcism may have unique characteristics, as determined by the exorcist.

The following outline of the Rituale Romanum is taken from Martin's (1976) English translation of the Latin document. Although the original document is not broken into three chapters, Martin did so to present the information more clearly. Chapter one is instructions for exorcising those possessed by an evil spirit. It includes recommendations, such as placing a crucifix on the chest of the possessed, and avoiding conversations with the demon. Chapter two is the actual ritual for exorcising demons from a person, while chapter three deals with exorcising demons from places.

* There are seven sacraments in the Catholic church: baptism, confirmation, eucharist, penance, anointing of the sick, holy orders, and matrimony. Sacraments are considered vehicles by which the Holy Spirit spreads the grace of Christ through the church. While exorcism is condoned by the Catholic church, it is not considered a means of spreading the grace of Christ through the church. Exorcism is not a sacrament (see United States Catholic Conference, Inc., 1994)

Chapter One: Instructions for Exorcising Those Possessed by Evil Spirit.
[paragraph form]

Chapter Two: Ritual for Exorcising Those Possessed by Evil Spirit.
1. Preliminary Instructions
2. Invocations
3. Summoning of Evil Spirit
4. Gospel Readings
5. Laying of Hands on Possessed
6. Exorcism Addresses to Evil Spirit
 (1) Serving Notice on Evil Spirit
 (2) Enjoining of Evil Spirit
 (3) Second Enjoining of Evil Spirit
7. Further Instructions and Prayers
8. Profession of Faith
9. Psalm Readings
10. Concluding Prayer of Thanks

Chapter Three: Exorcism of Satan and Apostate Angels.
1. Instructions
2. Invocation of Michael the Archangel
3. Announcement of Exorcism
4. Prayer
5. Exorcism Address to Satan and to Apostate Angels
6. Prayer
7. Invocations
8. Blessing of Place of Exorcism

As with any form of treatment, the paradigm is coordinated with beliefs about where the disorder originates. In the case of possession and exorcism, the affected individual is treated, through expulsion of the demon(s), by an emphatic demonstration of faith in God and love. The meaning making of demonic possession is something few people need to think about, yet its very existence provides a sort of safety net for making sense of the most unusual and otherwise

unexplainable human behavior found in the Catholic community. As a metaphor, demonic possession provides the Catholic culture with a means of understanding some of the most extreme forms of deviant human behaviors.

Chapter Five

Comparison of Dissociative Identity Disorder and Demonic Possession

It has been well established that a particular disorder can be present in a specified cultural milieu while not appearing in other cultures. For example, "amok" is considered a culture specific explosive behavioral disorder first described in Malaysia. It consists of, "homicidal frenzy preceded by a state of brooding and ending with a somnolence and amnesia" (Gaw and Bernstein, 1992). Amok does not have a recognized counterpart in American culture.

Other disorders which appear to be culture specific might be conceptualized differently across cultures while having similar clinical manifestations. Taijinkyofusho is a disorder primarily affecting young Japanese males in which they experience phobic reactions to interpersonal situations (Russell, 1989). These symptoms are not unusual in Western ideology and might be accounted for by agoraphobia or panic attacks. Differentiating between culture bound disorders, such as amok, and the popular labeling of a disorder within a culture, such as taijinkyofusho,

can be very useful in determining how to best conceptualize and treat such illnesses. Research of different culture-bound syndromes suggests that language and culture are key variables in determining the manifestation of such conditions (Fabrega, 1989). This chapter, by way of comparison, shows how DID and demon possession are subject to the shaping and constraining forces of their own cultures, languages, and traditions.

The preceding two chapters explained in detail the metaphors of DID and demonic possession. In those chapters it was explained how each metaphor involves a complex, internally consistent story of how people make sense of certain individualistic behaviors found infrequently within their cultures. In their explanatory functions, each of the metaphors is sensible, practical, and condoned by its culture. Neither is superior to the other, since each metaphor serves its purpose within a designated social setting. Although both DID and demonic possession are considered anomalies, their places within their respective cultures are firmly established. Modern Western civilization has a need for the construct of DID; likewise, the Catholic culture has a need for the construct of demon possession. Both of these metaphors

serve an important social function by giving meaning to certain behaviors which lie at the periphery of "normal" experience in each of the respective cultures.

Since people can participate in both cultures to varying degrees, there is some ideological overlap. A person belonging to both the Western positivist culture and the Catholic culture may be equally susceptible to DID and demon possession. Identification of the "diagnosis" may be determined as much by the person sought for help (eg., doctor or priest) as any "real" etiological factors. The social exchanges relevant to the afflicted person's condition serve to shape and create their condition in a manner that is understandable to the people in the dialogue. As such, a person ignorant of the diagnosis of DID could not "recognize" such a condition in another and, therefore, would likely find alternative means for explaining the behaviors. Furthermore, one may understand a particular diagnosis and choose to reject it, resulting, again, in the framing of one's condition in a manner acceptable to the participants in the dialogue.

While DID and demonic possession each have strong historical support in the Catholic and positivist traditions and writings respectively, there has been

some recent speculation that these two phenomena are "really" one and the same. Particular emphasis has been given to the position that demonic possession may be more accurately subsumed under the criteria for DID. There is a body of literature that argues for this position (Hankoff, 1992; Ross, 1989; Kenny, 1981) by outlining how the similarities of clinical presentation in each phenomenon are labeled differently by their respective cultures. Advocates of this position usually operate from a positivist frame of reference, as they seek the truth about these phenomena. They do not consider DID and demonic possession to be metaphors, used for making meaning amongst social groups. Rather, they view DID and demonic possession as two differing perceptions of one "reality", of which the latter might be false and disprovable. To this end they write what they believe to be factual information about the inaccuracies they discover in other people's constructions of meaning.

The primary and most impressive similarity between the DID and demon possession metaphors is the presence of a second voice within an individual. This second voice is one that comes from the affected individual, though it is different than the person's recognized

and familiar voice. The existence of the second voice is the hallmark of identification of both metaphorical conditions. Advocates of the metaphors attribute qualities to the second voice, such as describing its "personality" or labeling it as "evil". Such qualities, attributed to the second voice, help to build confidence in the metaphors themselves, creating context in which the second voice becomes defined.

The construction of each metaphor serves the dual purpose of explaining a seemingly unusual human phenomenon, while maintaining the larger social values and belief systems. The metaphors fit in with other belief systems present in each culture and, therefore, help to perpetuate the social meaning making which facilitates cultural stability and a sense of understanding about the environment. Ironically, these metaphors both led to a talk treatment to facilitate "curing" the person with the second voice. The collective social forces contributing to the establishment of these metaphors may have, quite possibly, led to some basic structural similarities between DID and demonic possession.

There are clearly some aspects of DID and demon possession which appear to overlap. These similarities have compelled writers to make comparisons, whether

in support of the positivist agenda or not. Some of the perspectives taken among such comparisons include: qualifying the two phenomena as one "reality"; creating new criteria to "medicalize" a diagnosis pertaining to demonic possession; maintaining separate positions and advocating cooperation among clergy and mental health practitioners; and illustrating conceptual differences which over-ride attempts to unite the phenomena.

The history of comparing demonic possession and DID is as young as the relatively recent construction of DID itself. There were some early attempts to compare demon possession to other Western diagnostic metaphors, though these writings tended to be more haphazard. For example, in 1979, in an attempt to distinguish between psychosis and possession the following explanation was offered, "Psychosis has a genetic or interpersonal etiology, while possession has a moral etiology. The two can be expressed in a fashion which is confusingly intertwined, but can nonetheless be held conceptually distinct" (Bach, 1979). This type of comparison appears to have had minimal support in professional circles, since writings of this sort were few and far between prior to 1980.

However, since 1980, when MPD was identified

as a dissociative disorder and given stricter diagnostic criteria, numerous researchers have attempted to make comparisons between possession and MPD [DID] (see for example, Kemp and Williams, 1987; Sperry, 1990). The writing in this area has become prolific, suggesting a potential for some conceptual shifts in the meanings constructed about both the DID metaphor and the demonic possession metaphor.

Such comparative writing about DID and possession is one means of exposing new ideas for social consumption. As social groups consider the many alternative viewpoints, certain positions are likely to be favored, elaborated upon, and incorporated into the metaphorical "reality" constructed around these phenomena. Since no position in the comparison of DID and possession has yet emerged as predominant, the struggle for exposure among alternative positions can be observed as it occurs. In a sense, one can observe the evolution of metaphors by stepping outside of the dialogue to watch ideas rise or fall in popularity. Some of these alternative viewpoints are outlined below.

Most of the current leading authorities on DID have included the topic of possession in their writings. A popular belief among many of these writers

is the notion that DID scientifically explains what some people have misconstrued as demonic possession. It has been said that DID is the secularization of what were once considered possession syndromes (see Greaves in Kluft and Fine, 1993). The recent increase in interest and acceptance of DID has been attributed to a decline in belief in demonic possession (Putnam, 1989); the assumption being that the so called disordered behavior has remained constant, while the way of labeling it has shifted from religious perspectives to a scientific viewpoint. These positivist, empirical writers suggest that these two views, the metaphors of DID and demonic possession, explain one phenomenon.

In 1987 Simon Kemp and Kevin Williams published "Demonic Possession and Mental Disorder in Medieval and Early Modern Europe" in the journal Psychological Medicine. This article provides a detailed historical account of beliefs in possession across many evolving and different cultures. Kemp and Williams discuss various peoples' belief in possession from a Westernized perspective which differs from the cultures they studied. They point out medical conditions to aid in an elusive argument that beliefs in possession merely served to explain what certain people

lacked in medical information. The following quotes from their article illustrate the implicit lens used by Kemp and Williams. "Overall, the twelfth century cases reveal a fair degree of willingness to blame the devil for a variety of mental disorders..." and "Finally, it should be remarked that the demonic tradition survives not only in language. Within some pentecostal and fundamentalist sects, the Christian tradition of ascribing mental disorder to diabolical influence is still important" (Kemp and Williams, 1987). Their writing is replete with references to medicine, apparently used to shed light on some historic demonic beliefs.

According to Fabrega, "In all types of societies hidden things (e.g., spirits, viruses, genes, sorcery) play a role in accounting for illnesses, and culture stipulates their reality" (Fabrega, 1989). Kemp and Williams fail to consider how culture influences their own perspective of explaining illness. Without actually stating that all historical cases of possession are attributable to medical causes, Kemp and Williams write from such a lens. They acknowledge cultural support for historical belief systems, yet Kemp and Williams do not recognize their own position as culturally relative. Their implied "reality" is

that demonic possession is explainable by scientific knowledge, a poignant example of the positivist ideology.

The following research study illustrates an effort to medicalize demon possession by including it as a diagnosis in Western medicine. In 1987 T. Craig Isaacs published the results of a research study which suggests that there should be a distinct diagnostic category for the Possessive States Disorders. Using five diagnosticians, including four psychologists and a psychiatrist, and fourteen case examples, Isaacs discovered a unique cluster of symptoms which he described as the Possessive States Disorder. The outline of the diagnostic criteria for the Possessive States Disorder, found on the following page, is taken from Isaacs' work.

Isaacs' diagnostic criteria for Possessive States Disorder shares many features with other diagnoses in the DSM-IV, yet it also includes some unique phenomena not pathognomonic to any recognized disorders. The most similar diagnoses to Possessive States Disorder are the dissociative disorders, particularly DID; yet these do not fully overlap.

In describing Possessive States Disorder, Isaacs clarified how it is different from a host of other

Diagnostic criteria for the Possessive States Disorder. A, B, and C must be present.

A. The experience of being controlled by someone, or something, other than oneself, with a subsequent loss of self-control in one of four areas: thinking; anger or profanity; impulsivity; or physical functioning.

B. A sense of self which fluctuates between periods of emptiness and periods of inflation, though one period may predominate. This fluctuation is not due to external circumstances, but corresponds to whether the person is feeling in control of him or herself, or is feeling out-of-control.

C. At least one of the following is present:

1) The person experiences visions of dark figures or apparitions and/or the person hears coherent voices which have a real, and not dream-like quality.

2) Trances, or the presence of more than one personality. If only during a trance, or if present in normal consciousness, the person is able to maintain an independent sense of reality respective to the other personality. Also there may be variations in voice or the ability to speak or understand a previously unknown language.

3) Revulsive religious reactions, such as extreme negative reactions to prayer, or to religious objects. The inability to articulate the name Jesus, or the destruction of religious objects.

4) Some form of paranormal phenomena, such as poltergeist-type phenomena, telepathy, levitation, or strength out of proportion to age or situation.

5) There is an impact on others: Paranormal phenomena, stench, coldness or the feeling of an alien presence or that the patient has lost a human quality, is experienced by someone other than the patient.

(Isaacs, 1987)

psychiatric conditions. His differential diagnostic criteria to rule out Multiple Personality Disorder (DID) involved the focus of the client's sense of reality. Isaacs claims that in Multiple Personality Disorder (DID) only one sense of reality is present in any moment of time, whereas in the Possessive States Disorder many states of reality may be present (Isaacs, 1987). This idea is not supported by the literature on MPD/DID which suggests that various alter personalities can be co-conscious, thereby having several states of consciousness existing simultaneously (Braun, 1986).

Adopting the positivist frame of reference, paranormal phenomena, criterion C, of Possessive States Disorder is the only area which clearly could be used to rule out a dissociative disorder. Examples of paranormal phenomena included telepathy, levitation, poltergeist-type phenomena, or strength out of proportion to age or situation. Since these paranormal phenomena are not among the necessary components in the diagnosis of the Possessive States Disorder they can not be considered essential in differentiating this from DID.

Using research methodology of the positivist ideology, Isaacs attempted to bring the metaphor of

demon possession into the context of medicine. By uprooting demon possession and attempting to introduce it to a new context, Isaacs failed to honor the traditions and beliefs which contribute to the construction of the metaphor's very essence. This failure to acknowledge the socially embedded meaning inherent in demon possession resulted in research which could not bridge the gap between positivist and Christian ideologies. Isaacs did not demonstrate any utility of turning demon possession into a Western diagnosis.

More recently, James G. Friesen (1992) suggested the addition of Oppressive Supernatural States Disorder to the realm of Western diagnoses. Friesen seems to be well versed in the language of DID, and he contends that a distinction can be made between the ego-dystonic personalities in DID and the ego-alien entities which are present when demons inhabit one's body. In his own clinical work, Friesen claims that he has found this distinction helpful in discerning just what type of pathology he is facing, demon or alter personality. As a Western positivist thinker, however, Freisen does not mention the gift of spiritual discernment, which is an integral part of Catholic faith. He attempts to "identify" demons by applying

an empirical construct which he labels "ego-alien" entities. Like Isaacs, his effort to include demon possession in the lexicon of Western diagnoses ignores the values and meaning making efforts of the culture and societies that have built the demon possesion metaphor. The outline below was presented by Friesen for further study.

Oppressive Supernatural States Disorder

When these two questions are answered affirmatively, Oppressive Supernatural States Disorder should be considered:

1) Does the client consistently perceive the oppressive state to be ego-alien--an external intruder?

2) Has schizophrenia been ruled out?
Aside from the symptoms which suggest schizophrenia, it is often helpful to ask about the entity's "voice". Schizophrenic-induced voices are typically external, dissociated personalities' voices are internal, and demonic voices have no personality.

If both are affirmative, and at least one of the following is present, Oppressive Supernatural States Disorder is suggested:

1) Marked revulsion to Christian symbols and/or to the name of Jesus (see Hart, 1991; Isaacs, 1985).

2) Evidences of supernatural occurrences, such as telepathy, levitations, objects moving by themselves, or strength out of proportion to age or size (see Isaacs, 1985; Koch, 1972).

3) An "evil presence" is perceived by persons other than the oppressed person (see Hart, 1991; Isaacs, 1985; White, 1990). (Friesen, 1992)

Other writers are more tolerant of the notion that their own ideology is a construction born of a circumscribed set of social arrangements. In his comparison of MPD and demonic possession, Michael Kenny allows for the ambiguity of accepting a social constructionist perspective while maintaining a modern Western psychological orientation. He wrote, "The boundary between self and other, or I and It, is a product of experience; it is also a linguistic fact which is socially embedded. But since the self is a social creation, it need not be any more stable than the situations which created it; the mode of apprehension which we call the ego must often deal with manifest contradiction and paradox, and in this fact lies the unstable foundation of the divided self, the 'sick soul' of multiple personality, and certain of the varieties of religious experience. The specific forms into which such misfortunes fall are often culturally bound. Multiple personality, like spirit possession, has roots of its own through the distinctive psychological theories of those who interpret and shape it and through the equivalent theories and surrounding ambience of those who become its reported victims" (Kenny, 1981, p.354).

In Kenny's argument it is a "fact" that the ego

deals with contradiction and paradox. It is also a "fact" that language produces a boundary between self and other. These "facts" help Kenny to write within a context, to provide clarity and meaning to an ongoing set of ideas.

Interestingly, however, Kenny does not use his psychological acumen to advocate for MPD (DID). Instead, Kenny uses a psychological lens to illustrate that neither DID nor demonic possession are "real", rather they are viewed as social constructions. In his words, "I will show how both demons and multiple personality were once considered theoretically plausible - and how both obligingly provided evidence for their existence" (Kenny, 1981). Kenny taps some of the ideas of the social constructionist lens to apply to others' theories without submersing his own ideology into the same depths of understanding. He exempted himself from the type of linguistic, cultural, constructionistic arguments to which he subjected others' views. Like Kemp and Williams, Kenny's attempts to be objective left him trapped within the positivist frame of reference.

A different approach was taken by Sydney Page, as well as by some of his critics. Page suggests that DID and demon possession might be concurrently

viable paradigms. DID, in this view, may be understood from a psychological point of view with the understanding that evil, or the demonic, works in different ways within different cultural periods. In this case there is overlap of both metaphors. The social constructions of demonic possession and DID are allowed to co-mingle, largely due to Page's dissatisfaction with efforts at separating the two metaphors. "It is often taken for granted that possession must be distinguished from mental illness and that it only exists in cases where psychological explanations are lacking. When this approach is taken demonic involvement is restricted to that residue of cases that remains after all other types of explanation have been exhausted. The result is a 'demon of the gaps' which shrinks with the advance of knowledge" (Page, 1989a). Consideration of DID as demonically mediated allows for the survival of the theological tradition in an increasingly scientifically driven world.

Beck and Lewis, critics of Page, point out that demon possession may account for certain cases of DID, but, "...it does not also follow that therefore the demonic is involved in all psychopathology" (Beck and Lewis, 1989). They, like page, allow for the

co-existence of both the DID and demonic possession metaphors, viewing them both as "realities" in the twentieth century world. Beck and Lewis, however, do not assume that all disorders, psychiatric or otherwise, are necessarily linked to evil or sin.

They go on to question the integrity of intermingling the DID and demon possession belief systems: "What are the ethics involved in leading a client to believe that an intervention is actually the exorcism of a demon when it is not?" (Beck and Lewis, 1989). This type of ideological questioning illustrates increased tolerance for paradigms and beliefs which do not easily co-exist. This is the essence of postmodern thinking; increased exposure to a wider variety of ideologies forces one to reconsider the basis of his beliefs.

Beck and Lewis do not seek to discredit the merits of either DID or demon possession, rather, they seek understanding of ideas which have primarily been constructed independently of one another and are now included in the same dialogue. In their concluding remarks, Beck and Lewis seek criteria to help healers in discerning when demon possession is present in a human malady. Like the other writers cited above, the pull for positivist, and logical, solutions is

difficult to disembrace. The postmodern ideology is now in the infancy of its evolution.

In general, the writers cited above attempted to maintain an objective, empirical stance in support of their various positions. To varying degrees they all write from the positivist lens. The Catholic community, however, is not dependent upon empiricism to validate its beliefs. While many Catholics are also Westerners, the history of some of their conceptual differences with Western positivism is distinct: Demon possession is based on faith, and DID is based on empiricism. The very backbone of each metaphor is an established and distinct network of social arrangements. The two do not easily overlap, yet the increasing blurring of cultural boundaries is making it increasingly difficult to keep the metaphors distinct.

According to Fabrega, "Pschiatric illnesses are abstract 'objects' or constructions that are constituted of the scientific knowledge base of the Western tradition of medicine" (Fabrega, 1989). Psychologists and psychiatrists are biased by the prevailing "knowledge" of the Western world. This same principle can be applied to Catholics and other Christians. Their belief in demon possession can

be construed as an object or construction based on Biblical and religious faith. Both Western knowledge and Christian faith offer a guiding lens for giving meaning to available information. Both DID and demonic possession are social constructions. Both have meaning in their own context. And the two are increasingly colliding in the postmodern world of social saturation.

Culturally distinct ideas which were once held apart from each other are becomming common within individual dialogues. It is now fathomable for a person with the "second voice" experience to be viewed as sufferring from DID, demon possession, or both. Social saturation has both increased the scope of peoples' perceptions as well as diminished their confidence in their beliefs. Postmodern helping professionals now have more evaluation and treatment options, yet they may also experience some diminished cenfidence in their efficacy.

Chapter Six

Treatment Considerations

From Biblical times up to the present Westerners have operated from a single-truth frame of reference. Beginning with the early Christianized Roman Empire, there has been a drive among Westerners to convert all people to Christianity. In the process, dualistic thinking became the norm, creating in-groups and out-groups. There has historically been very little tolerance for people having alternative viewpoints from the Western norms. Every Western influenced group, including the Catholic church and modern empiricists, has adopted this belief that there is a singular explanation for just about everything (see Ebel, 1986). This single-truth frame of reference has permeated all Western ideologies, even in matters both related to and unassociated with Christianity. This is evident in both metaphors under consideration in this paper.

The construct of DID is the product of years of empirical research and professional social

consensus among mental health practitioners and researchers. As outlined previously, it entails a system of ideas, including ideas about treatment, which are captured as a "reality" in the term DID. Likewise, demon possession is a product of years of observation and meaning making efforts. It, too, is a "reality" which embodies a certain system of interrelated ideas. Both of these metaphors grew out of the same Christian influenced, Westernized consensus that single-truth explanations are favorable.

The comparisons between DID and demon possession, outlined in the previous chapter, highlight the sort of battle of wills which takes place among groups who believe that their own metaphors explain the reality, while other views are potential challenges to that "reality". Such single-truth points of view set the stage for dualistic, either-or mentalities which tend not to allow for incorporation or accomodation of seemingly disparate views.

Social constructionism, and the entire postmodern movement, stems from dissatisfaction with the single-truth mentality. While postmoderism now flourishes in this age of social

saturation, humanity has a long history of dissatisfaction with the single-truth mentality. Even in Biblical times people were challenging the dogma and seeking alternative ways of understanding their experiences. It has been said that, "self-scrutiny is therefore as much a part of the traditional Western outlook as the critique of alien, non-Christian societies" (Ebel, 1986). While self-scrutiny has been a part of Western societies, social saturation is unique to the 20th century. It will be explained below how these forces, in combination, led to the ideology of social constructionism.

Within the past few decades, coincident with the emergence of postmodern thinking, cognitive psychology has grown extremely popular. It lies in contrast with the objective focus seen in most other so-called scientific orientations. "Cognitive psychology recognizes a disparity between what is 'out there' and its internal representation and argues that behavior is a function of the subjective world as transformed and represented internally. People respond to how they define stimulus situations, not to the objective properties of those stimulus

situations" (Sampson, 1981). Early writers in cognitive psychology laid a groundwork for ideologies which focus beyond the empirical boundaries of an object.

Some of the ideas contained within the cognitive movement have roots in early writings from Descartes and Kant. It has been suggested that Descates' model of "I think..." represented an early focus on the individual knower over the validity afforded to objective reality (see Sampson, 1981). Reducing reality to subjective or individualistic perceptions has resulted in a cognitive lens which seems to turn positivism around so that subjectivity becomes the primary reality, rather than the product of objective "truths". According to Sampson, "It is the order of human thinking and reasoning that grants an order and meaning to the world of reality. Clear and distinct forms of the mind produce clear, distinct, and true understanding of reality" (Sampson, 1981). The cognitive lens has grown out of the basic premise that the subjective precedes the objective in making "reality".

George Kelly's psychology of personal constructs (1963) offers a good example of how

cognitive psychology focuses on the individual's phenomenal experience. This theory states that people understand their world via personal constructs which are constantly in a process of change. The individual creates their own constructs, therefore objective "reality" is less important than the individual's way of sense making. Kelly's work is one among a large group of cognitive theorists' attempts to give primary meaning to subjective phenomenal experience.

However, cognitive psychology, like most other approaches in psychology, has tended to maintain a single truth approach common to positivist thinkers. The single truth of cognitive psychology places emphasis on the subjective rather than the objective, yet it has generally not moved beyond providing another single truth option. While cognitive psychology itself has not provided an alternative to the positivist ideology, it did shift attention away from the objective world. It made personal experience and interpretation primary, focusing on the "reality" of the individual.

While such a subjective view may, at first, appear to run counter to the Western empirical

tradition, it has developed into a unique branch of empiricism focused on the study of how people make meaning: "...cognitive science represents an empirically based effort to answer long-standing epistemological questions... concerned with the nature of knowledge, its components, its sources, its development, and its deployment" (Mahoney, 1988). The early writers in cognitive psychology, for the most part, remained entrenched in the single-truth approach, focusing on the prevailing methods of scientific inquiry to make sense of what they viewed as subjective experience. Even though their focus tended to be different, their methods remained the same; the only methods readily available at the time for making sense of "data", scientific methods. It was not until after cognitive ideologies percolated through an increasingly globally conscious world that social constructionism began to take hold.

Social constructionism goes one step further than cognitive psychology by removing reality from the equation altogether, and replacing it with the idea of shared consciousness. Reality, in the social constructionist lens,

is not something to be sought as it is in positivist ideologies. Reality is no more than shared ideas created by groups of people. Rather than emphasizing objective "reality" or an individual's subjective experience, social constructionism focuses on shared beliefs which provide meaning for groups of people. The evolution, from purely positivist objectivity to the cognitive focus on the subjective within the positivist framework, and now to the social constructionist focus on subjective meaning in social groups, all illustrates the basic social constructionist premise that meaning making is a process of ideological shift among groups. It was not until large masses of people were exposed to increasingly diverse social arrangements that social constructionism began to take hold.

For this report the point of exploring social constructionsim is to consider new approaches for helping people. Those who seek professional help for conditions or ailments which bother them may find that social constructionsim offers a unique alternative to traditional, positivist, treatment approaches. Helping professionals

operating from a social constructionist lens can treat in unique ways because they are not confined by the limits of implied "reality" and the logic of logical positivism. They can question reality without having to find a single most correct answer to problems.

As outlined earlier, concepts of disease and disorder are defined by social constructions. People come together to unify their beliefs about certain conditions (ailments) and create a metaphor for explaining the circumstances. The helping professional, who is generally more well versed in certain metaphors, plays an important role in affecting the client's beliefs and understanding of their condition (see Fabrega, 1989; Caldwell, 1994). As such, the helping professional's role has traditionally been more than simply providing treatment; it also included educating the client about the metaphor, and coming to some agreement as to an explanation for the client's specific condition.

The client and professional work together to construct a belief about the client's condition. Both people operate in the service of the client. The professional brings experience

and some level of expertise to the endeavor, while clients bring the subjective experience of their conditions. Together, the client and professional create a shared understanding of the condition and the proposed treatment.

According to Raymond H. Prince, "fundamental healing factors are universal and have to do with the special relationship between the healer and the patient; the shared world view; the expectant hope of the patient; naming of the illness, attribution of cause, and prescription of treatment by the healer; and the central role of suggestion" (Prince, 1976). Prince's perspective supports the belief that "diseases" or "conditions" are socially created metaphors. The "reality" of such metaphors lies solely in eyes of those who participate in the dialogue. While the healer generally has held stronger preconceived ideas about certain metaphors, it has always required people in conversation, interacting to make the metaphors "real".

This is not to imply that all concepts of disease are to be viewed as psychosomatic, or merely in the minds of the people in dialogue. There are currently Western metaphors for such

diseases, such as somatoform disorders and factitious disorders, which appear to have etiologies in the minds of their victims. [Note that the concept of the psychosomatic disease is itself part of the Western positivist ideology.] Social constructionism does not necessarily imply that there is no pain, sensation, or experience; rather, it suggests that the meaning attributed to such things is socially constructed. The meaning itself is not a "reality", while the symptoms can be occurring independently of any defined meaning. The helping professional operating from a social constructionist lens attempts to extricate himself from the confines of single-truth labels or explanations for various conditions in order to help make sense of the social meanings a particular condition has for a particular individual.

Professionals operating from a social constructionist perspective have a particularly acute understanding of their role in affecting their clients' belief systems. Rather than operating from an assumption that they can identify and treat "real" conditions, the social

constructionist oriented professional can avoid positivist assumptions, thereby helping their clients to define and redefine their condition in ways which are more useful. The "social constructionist places emphasis on social interpretation and the intersubjective influences of language, family, and culture" (Atwood and Ruiz, 1993).

As a result, treatment from a social constructionist frame of reference acknowledges and makes use of the client's belief system and patterns of social interaction. Interventions do not attempt to impose a preconceived belief or metaphor, as in positivist treatment models. Instead, the helping professional who operates from a social constructionist lens makes use of their knowledge of social meaning-making to facilitate shifts in the existing interpretations by which clients view their condition. There are numerous strategies which the helping professional can utilize in applying social constructionistic ideas in their treatment.

The following example illustrates a fairly overt use of social constructionism in family treatment. Joan Atwood and Joan Ruiz of Hofstra

University outlined a six stage family based model of conducting therapy from a social constructionist perspective. The stages in their model are: 1) Joining the family meaning system; 2) Proposing the notion of a socially constructed family meaning system; 3) Learning the family's meaning system; 4) Challenging the family's meaning system; 5) Amplifying the new meaning system; and 6) Stabilizing the new meaning system (Atwood and Ruiz, 1993). Because family therapy relies heavily on a systemic approach to problems, the social constructionist lens is easily employed in such treatment. The family is one example of a social group in which people establish specific belief systems and patterns of interaction.

While the outline presented by Atwood and Ruiz is intended for use by family therapists, it is used here to illustrate the broader concept of applying social constructionist ideas in any relationship between helping professional and client. Each of the stages in the Atwood and Ruiz model is explained below.

The first stage of the Atwood and Ruiz approach to treatment is joining the family

meaning system. Through this joining, the helping professional acquires a preliminary sense of who the client is and how they and their family think about their world and experiences. This is part of the initial building of rapport with a client where the helping professional (therapist, clergy, etc...) tries to get acquainted with the client. It is a period of attentive listening in which the helping professional gathers both overt and covert messages through verbal and nonverbal information (see Beier and Young, 1984).

Joining the client at this first stage involves eliciting information and accepting it as representative of the client's frame of reference. There is no judgment or challenge to the client's opinions at this stage, rather there is an effort to become thoroughly acquainted with the perspective of the client. According to George Kelly, "...each man contemplates in his own personal way the stream of events upon which he finds himself so swiftly borne" (Kelly, 1963). It is the job of the helping professional to become familiar with the ways each client interprets their life. While social

constructionism does not maintain that people interpret their worlds in isolation, the helping professional must first join with the client where the client is at before the idea of socially constructed meaning can be introduced.

The second stage of conducting therapy from a social constructionist lens, as presented by Atwood and Ruiz, is proposing the notion of a family meaning system. Their work deals specifically with family therapy, though the principles can be applied to helping professionals of any orientation. Atwood and Ruiz encourage families to divide issues into three different stories, "[1] the family's story about their families of origin (whether there are old skeletons or not), [2] their story about their present relationship (how the problems they are experiencing are maintained), and [3] their story about what they see for their future (how their family meanings and resultant scripts can change)" (Atwood and Ruiz, 1993). At this stage clients are introduced to the idea of socially constructed meaning systems. "The family problem is seen as emanating from various forms of action or practice within the family life" (Atwood and

Ruiz, 1993).

In their work, Atwood and Ruiz illustrate how families maintain meaning systems through mutual consent among family members. It is, however, important to emphasize that family meaning systems are only one among many forces shaping the beliefs of any single individual. In family therapy, acknowledgment of unique family meaning systems can be helpful in the initiation of change and movement among family members. There may be some propensity for families to accept the systemic nature of their meaning-making more readily than other groups. Groups other than families, such as professional guilds, may find it difficult to understand their own ideology as metaphor or socially created, since they are usually entrenched in the positivist frame of "fact finding". Family therapy provides easy access to a ready made group with an often identifiable pre-existing style of meaning-making.

Whether considering family beliefs or other socially constructed meaning systems, it is important to provide the client with some preliminary understanding of the social nature of information. Symbols and metaphors specific

to the client's life may help to illustrate how meaning is made through social interactions. For example, a business executive can be encouraged to ponder the personal, familial, professional, community, and cultural meanings of his driving a B.M.W. automobile. In each social sphere there are values, beliefs, and meanings attached to the executive's choice of a motor vehicle. Consideration of numerous social groups can help a client, like the executive, to see the social nature of their individual way of thinking. Furthermore, the client's "internalization" of these meanings and dialogues contributes to certain of his/her behaviors in the absence of other people.

Thus, although Atwood and Ruiz suggest proposing the notion of a family meaning system, this author suggests proposing the general concept of socially constructed meaning to clients. While it may be easier to grasp the concept of social constructionism when applied to a concrete situation, such as a family problem, the usefulness of this approach extends to many situations outside of a family group. Some means of generalizing social constructionist principles

beyond the family is suggested.

Returning to the example, once the notion of a systemic understanding of families is introduced, the helping professional endeavors to join the family in its own meaning system. Family members have often been accustomed to viewing themselves as individuals more than as social beings. In this stage of treatment the helping professional seeks to learn how the family members give meaning to their familial patterns and beliefs. The purpose of this phase of treatment is to learn about and become familiar with the entire family's way of understanding themselves. Initially, the helping professional does not become involved in the process of meaning-making, but rather they seek to create an atmosphere in which the family feels safe expressing their perceptions of their own way of being.

As described above, learning the present family meaning system is the third stage in the Atwood and Ruiz model. This is the point at which the family can offer their perspectives on the problems which brought them in for help. Up to this point the helping professional has

done little more than describe how ideas can be social creations and to gather information. This part of treatment needs to be thorough because after this stage ends the helping professional becomes more involved in producing change from which there is no way of accurately looking back. Once change occurs it becomes the new "reality". And the social exchanges of the helping professional and clients, or any other social exchanges for that matter, result in a process of change for the participants (see Maturana and Varela, 1987).

Sometimes, with the introduction of the concept of family meaning systems, there comes a new perspective in which problems formerly ascribed to an identified patient [single family member] are now seen as systemic problems. When the individual's problems are reframed as systemic problems the system as a whole is encouraged to give meaning to their patterns of interaction which contribute to creating and sustaining the problems. It is at this stage of treatment that an identified patient is liberated from the burden of being viewed as the person with the problems or being viewed

as the problem. Salvador Minuchin identifies this shift of focus from individual problems to family problems as structural family therapy because it results in changes to the organization, or structure, of the family, which, in turn, leads to changed behavior (Minuchin, 1974).

This leads to the fourth stage of the Atwood and Ruiz model, challenging the family's meaning system. At this stage the therapist becomes active in proposing alternative possibilities for meaning-making within the family. "Complementary questions [two or more possible descriptions of the problem] are derived and introduced to challenge or help to deconstruct the dominant explanation and to assist families in achieving a relational or double description of the problem" (Atwood and Ruiz, 1993). This approach makes use of the belief that once an idea [social exchange] is introduced the participants are unable to avoid reacting to it in some way (Maturana and Varela, 1987; Gergen, 1991). This is the point at which treatment from a social constructionist perspective can differ from other more traditional treatment approaches. The "reality" as originally presented

by the family is deflated of its power to affect the family members once it is reframed as a group construct which, at this point in treatment, begins to compete with other complementary constructs. The "reality" ascribed to the family's original views is here undermined.

The focus of treatment is not to replace the family's constructs with "better" explanations. To do so would be reminiscent of the positivist single-truth approaches, replacing one "truth" with another "truth". What can occur differently in a social constructionist approach to treatment is a shift in the grasp which a "reality" holds for the people troubled by it. By focusing attention on alternative constructions the helping professional offers new opportunity for problem solving, without advocating any particular construction as most correct. Social constructionism allows for "both - and" thinking rather than employing "either - or" thinking.

Amplifying the new meaning system is the fifth stage in the Atwood and Ruiz approach. Having already introduced competing constructions, the helping professional is in a position to

help build new metaphors around them. Amplification of new ways of viewing the presenting problem can focus on positive reframing. "When the problem is not there, how is your relationship? If you were to enjoy your relationship more frequently, how would you notice? What would be different? What else would be different? How would that be for you? By helping the family to deepen the experience of the relationship without the problem, the therapist is facilitating a new construction, that of a more positive relationship. This new construction holds new meaning for the family. Thus, the therapist creates an environment that amplifies the family's strengths, resources, and solutions" (Atwood and Ruiz, 1993). At this important stage of treatment the old constructions of the problem are actively put aside as new constructions begin to gain meaning and strength.

The content of the new construction is less important than the process of coming together as a social group to create a more adaptive system of meaning. Even though the new meaning system is amplified it ought not be touted as the solution, as if it were always there waiting

to be discovered. The amplified meaning system is a new way of viewing circumstances. The new meaning is created, not discovered, by the participants. What they come to view as a solution to the original problem is a product of their own efforts. It is not a new "reality" that offers help, but rather a new construction, a re-authoring of information to produce more satisfactory meaning.

The final stage presented by Atwood and Ruiz is stabilizing the new meaning system. Their recommendation for stabilization involves focused questions which address the future without the problem. Getting people to have conversations around new constructions helps to deconstruct the old ideas. The alternative meaning system comes to replace the old meaning which contained the problem. When the new constructions become an active part of the group's dialogue they will inevitably be changed by them (see Gergen, 1991).

By this point in treatment the helping professional has effectively shifted focus from a meaning system which involves some problem to an alternative meaning system in which the former problem is no longer disturbing. Dialogue

and social exchanges within the new meaning system will continually build and change the system, with the exception of not including the original meaning attributed to the problem. The overt use of social constructionism can facilitate change by opening peoples' awareness to more numerous possibilities for change and growth.

An alternative to the Atwood and Ruiz approach of overtly explaining and employing social constructionism in treatment is to engage in covert strategies to make shifts in a client's meaning-making efforts. Michael Caldwell (1994) wrote about the use of social constructionism to treat aggressive clients. Due to their non-compliance with other more traditional forms of treatment, aggressive clients may need unique treatment approaches. Caldwell explained how the use of social constructionist principles has been effective in producing positive changes in clients' aggressive behavior. His example is more covert in that it does not inform the client of the use of social constructionist principles.

By altering the client's role within an institution, Caldwell (1994) demonstrated how

social consensus and social norms help to maintain certain "negative behaviors" which lead patients to be institutionalized. He cites an example of a 30 year old man with a lifelong history of institutionalization for uncontrollable and aggressive behaviors. Through the creation of a treatment paradigm which did not allow the staff to de-escalate his behaviors or talk in any way therapeutically to him, Caldwell was able to create a view of the man in which there was no aggression whatsoever. The staff ignored any acts of aggression and the client's privileges on the unit were based on the daily roll of dice, rather than by acknowledging any specific behavior as deserving of reward or punishment (Caldwell, 1994). By successfully controlling all of the social value and meaning attached to the label of "aggressive client" Caldwell was able to change that "reality".

The covert alteration of social expectations led the man to a new way of interacting with those in his environment. When he was no longer viewed and treated as an uncontrollable patient he no longer behaved as such. The change, however, was not only intended for the man.

The staff, too, had to change. The role of the staff was understood beforehand, while the patient was unaware of the reasoning behind the change in interactional patterns. In this way the social construction of being an "aggressive and uncontrollable patient" was covertly altered. The main issue at hand is the creation of certain behaviors, labels, and roles by means of social arrangements. The value of any event is only as great as the meaning attributed to it by those it affects.

There may be any number of applications of social constructionism to the work of helping professionals. The above examples offer only a few ways by which helping professionals have endeavored to make use of this postmodern idiom. The prospect of expanding beyond an existing belief system is where applications of social constructionism can be of help in a client/helper relationship. As Gergen states, "Each cultural form - each language of understanding - offers only a limited range of solutions to the problems confronting a culture. To break the bonds of any 'given' - in government, business, education, and so on - is to open the way to new solutions"

(Gergen, 1991). By helping a client, or family, or group, to break the bonds which limit their problem solving ability the helping professional who uses social constructionism offers fresh perspectives from which growth and change can occur.

Chapter Seven

Social Constructionism, Dissociative Identity Disorder & Demon Possession

The previous chapter outlined the rise of circumstances leading to the creation of social constructionism, and some alternatives to traditional single-truth approaches to treatment. In the contemporary world, influenced by postmodernism, there is opportunity for helping professionals of different cultures to make use of the ideas of social construcionism. This chapter uses DID and demon possession as examples of metaphors of psychological distress whose narrative might be challenged and whose symptoms treated by employing methods of social constructionism. The chapter also discusses some of the utility and limitations of using social constructionism in the work of helping professionals.

As illustrated in previous chapters, the constructs identified as DID and demon possession are powerful metaphors. They are words with symbolic meaning, supposedly representing "real" conditions experienced by some human beings.

From a social constructionist viewpoint they are no more than interpretations of observations by social groups to make sense of certain clusters of behavior. In both metaphors the helping professional plays an imprtant role in the creation of the condition by identifying and validating the diagnosis. The professional's role in the creation of these conditions is particularly emphasized with DID and demon possession, since they are viewed as extremes on the continuum of disorders experienced by members of their respective cultures. They are described separately below to demonstrate this point.

The distinction "DID", formerly "MPD", has not been easily accepted, even among the mental health communities of the past few centuries. It is now a more popular diagnosis, yet it continues to be skeptically applied, usually after a client has gone years with other diagnoses. Clients never identify themselves as having DID, since self diagnosis would imply awareness of the dissociation, which would diminish credibility in the application of the diagnosis (Spiegel, 1994). This situation leaves

diagnosis almost entirely up to the helping professional. Certainly the client presents a cluster of symptomatic behaviors, but it is the helping professional who works with the client to mold these behaviors into an identifiable metaphor, DID, for which an established treatment is available within the Western psychiatric discourse.

Likewise with "demon possession", within the Christian discourse the helping professional, through the power of spiritual discernment, validates presuppositions pertaining to the diagnosis. The "demon possessed" client does not typically approach a healer asking for treatment (Peck, 1983). To do so would imply that the possessing demon seeks to be exorcised, which runs counter to beliefs about the condition. The healer of demon possession is generally summoned by acquaintances of the client to identify the condition as demonic and to initiate a healing ritual.

There are strong social mores and beliefs which contribute to the creation of metaphors of disordered behavior. While the client is always a participant to some degree in the

creation of his/her diagnosis, in some of the more extreme forms of disordered behavior, as DID and demon possession are considered, the individual's role in creating the label is often not very overt. Cultural forces beyond the control of any individual play an important role in sustaining the powerful metaphors which give meaning to what, in that culture, are held to be extreme forms of individual behavior.

Cultures have an investment in being able to provide meaning and labels for the exceptions to "normality" which they encounter. The name given to a condition and the approach to treatment are not independent realities in and of themselves; they derive their legitimacy through the functions they serve to provide meaning to the participants involved. Any diagnosis and related treatment is viable only if the people creating it agree to it. The Reverend Michael Wilson made this point clear:

> "However we may look at it, and in whatever language we wish to talk about it, 'possession' is some kind of bondage which is cramping a person's full sense of human autonomy. He needs to be helped to 'come to himself', to 'find himself', to 'affirm himself', to 'love himself'. Whether this is achieved by some authoritative command [as in exorcism], or by patient counseling [as in psychotherapy], my feeling is that

> recovery takes place only when the particular help is undergirded by a strong group or congregational life which is founded upon life's normality. 'Possession' or 'Identity Confusion' is some piece of life experience which has evaded synthesis, and obtained a power of its own to influence and destroy the person. The person must be helped to assume responsibility for it, and this he can only do if other people also are willing to assume responsibility for it and to share it: 'A man is a man by reason of other people'." (Wilson, 1975).

Wilson speaks of defining one's self in relation to other people. The helping professional is paramount among those who contribute to defining an individual. And that definition of others, provided in part by the helping professional, builds upon the social fabric of a culture, contributing to the definition of the helper himself. The metaphors for disorders within a culture, as well as their treatment protocols, are in a constant process of being redefined by the ideological drift of the community at large.

In both DID and demon possession the clients do not typically seek help for the conditions which end up being treated. The explanations of their symptom clusters can be viewed as metaphors created by cultures over time with a resulting strong investment in the acceptance

of the "reality" of such conditions. The typical healers in each culture apply their preconceived expectations onto the clients whom they treat. Their single-truth frames of reference convince them that what they see in their clients is real. Traditionally, most healers of most cultures have not tended to think of diagnoses as socially constructed metaphors. Instead, to the extent that they embrace single-truth orientations, they operate with a degree of certainty that their treatment approach offers the known cure for the known condition, whether that condition is labeled DID, demon possession, or any other label which provides suitable meaning.

As illustrated in chapter six, social constructionism offers healers an alternative to single-truth approaches. As such, a priest who observes a client appearing to manifest demon possession may question what purpose the metaphor of demon possession serves in the immediate community and culture at large. Rather than perpetuating the metaphor with the client the priest may choose to challenge the construct and offer new perspectives on the client's behavior if doing so is deemed productive in

any given case. The priest may opt to ignore the demonic presentation and treat the client as a healthy peer, an approach Caldwell (1994) successfully demonstrated with aggressive clients. Applying a social constructionist orientation allows the priest to avoid framing his client's behavior as attributable to demonic intervention.

An advantage of a priest's having a social constructionist orientation is his increased capacity to recognize his own role in the identification of demonic possession in another person. By recognizing the demon possession label as a way of providing meaning for an individual's behavior, the social constructionist oriented priest may select from a variety of helping interventions. Helping approaches need not adhere to the single-truth frame of meaning making provided by the demon possession label. The social constructionist informed priest becomes free to choose whether to apply the traditional label and treatment approach or to ignore the demon possession metaphor altogether. Having a social constructionist framework allows the priest to refuse to make demon possession a "reality" by not incorporating it into his

definition of the situation or his helping endeavors.

And what of the DID-labeled client? Perhaps a therapist who is sought to conduct treatment could reframe the client's symptoms in a way which does not involve DID. After all, the construct of DID is generally presented to the client more so than the client presents DID. If the therapist never offers the DID metaphor as an option, how else might the client make sense of their symptoms? The possibilities are endless: perhaps bad manners, inadequate social skills, mind control by aliens. Any description is worthwhile if the participants can make sense of it and establish some social arrangement by which the metaphor proves useful.

The advantage, again, of having a social constructionist orientation is largely in the recognition of the role the healer plays in creating "pathology" in people by "identifying" and thereby defining it. Once the therapist understands this he/she can operate from a position of open mindedness in trying to more fully understand a client without the bounds of preconceived labels.

One of the points to consider with both DID and demon possession is that people ancillary to the client/helper relationship are often involved in establishing those roles. The clients end up in a position whereby they require, through a social arrangement, to be treated by the healer. The healer, presumably chosen by some combination of forces including the client and social expectations, inherently biases the options for constructing a metaphor to explain the symptoms. It is no coincidence that Christian cultures seek out priests as their healers, while more secular, medically minded people seek out doctors as their healers. The social expectations and preconceived beliefs about disorders are present before the healer even becomes involved with a client. The initial meeting of healer and client in most cases serves to affirm and solidify pre-existing ideas about the nature of a presupposed condition.

Cultures expect their healers to operate within a frame that supports the predominant beliefs about disorders and treatments. While a range of treatment approaches is tolerated in any culture, those that deviate too far from

the norm will be rejected. This was evident when Bowers et al. (1971) presented their ideas on multiple personality. In 1971 the mental health community was not ready to accept ideas which subsequently became the standard in the field. Bowers et al. were rejected because they strayed too far from the cultural beliefs of the time. It was not that their ideas were implausible, but they just didn't coordinate well with the existing expectations of the culture.

People choose healers whose beliefs are reasonably consistent with their own beliefs, generally with the expectation that the healer will build positively upon the shared baseline beliefs. Because of this self confirming tendency it is highly unlikely that people operating from a traditional single-truth lens would seek a healer who represents a different ideology. As outlined previously, people do not consider things to be "real" until they are made aware of them by incorporating them into their own individual experience (See Maturana and Varela, 1987). Going outside of one's own cultural and social frame of reference has traditionally been

difficult. With the advent of postmodernism, however, this is changing.

Members of traditional, single-truth cultures, such as the Catholic community or the Western positivist community, have not historically been prepared to challenge their own ideology too vehemently, since the available options were for the most part invisible to them. Other constructions of reality have always existed, but access to those other perspectives has historically been restricted by natural obstacles such as physical distance. As a result individual cultures were able to build complex systems of metaphorical beliefs among fairly homogeneous groups of people. People sharing the same frame of reference could communicate ideas easily and build high levels of confidence in their non-challenged ideologies.

In such traditional, single-truth cultures treatment for recognized disorders was part of the culture's ideology. Exorcism for demon possession was culturally sanctioned. Psychotherapy for DID was also socially constructed and supported. As long as the cultures remained fairly closed systems there

was no reason to question such treatment approaches. Questioning the "reality" of disorders would be unlikely in such closed cultures.

Traditionally, it would not make sense to attempt to treat demon possession with psychotherapy, or to treat DID by exorcism. Doing so would entail mixing metaphors in a way which would not be tolerated by single-truth cultures. The healer who attempts to go outside of the accepted ideology of the social group is rejected by it [recall Bowers et al]. As members of various cultures have traditionally viewed their disease and disorder concepts as "realities" they have restricted their range of treatment options. With the creation of social constructionist ideology and the evolution of postmodernism there is now a possibility of helping people to look beyond the traditional bounds of their conceptions of disease and disorder.

Healers in Catholic and Western positivist cultures presently live in postmodern times. The limited access to information, which contributed to the establishment of certain

constructions of "reality", are no longer present. Healers, as well as their clients, have increasing levels of exposure to alternative viewpoints. As such, the current "reality" of any conception of disease or disorder is not so certain. While people continue to affiliate with certain cultural groups, there is an ever present realization that their own system of beliefs is but one among many. The days of totally unchallenged beliefs within closed cultural groups are gone. Now conceptions of disease and disorder are options rather than "realities".

Today's healers must balance adherence to their own training with the proposition that alternate constructions might provide equally useful treatment alternatives. This is not to say that present day healers must abandon their traditional approaches. Cultures continue to create differing metaphors to provide meaning. The postmodern period is changing the way many people adhere to single-truth perspectives, but it is not weeding out various "realities" in order to find some grand "reality". In the midst of the postmodern period cultures continue to operate as they always have, giving meaning to

phenomena in a manner consistent with existing social mores. The difference now, in the postmodern era, is an increased level of social consciousness which allows people to view their own meaning making efforts as more relative to a particular group of people.

Treatment for DID and demon possession is not necessarily different just because we live in postmodern times. The respective cultures continue to find meaning in their single-truth approaches and clients today are engaged in both exorcisms and psychotherapy. Present day exorcists and psychotherapists can continue to honor their traditions in spite of the postmodern backdrop of society. They might be wise to view their treatment as culturally relative, yet the approach need not change if it continues to be useful to their clients.

Many helping professionals are aware of postmodern ideas without having knowledge of social constructionism. For those who do know about social constructionism there may need to be some decision making process in order to decide when the application of social constructionist principles is most beneficial. The traditional

disease and disorder concept metaphors are powerful beliefs in most cultures. Helping clients to view such conditions as metaphors ought to be considered judiciously and cautiously.

At the same time, exposing labels such as DID and demon possession as powerful metaphors can be a useful alternative to traditional single-truth approaches. People who might otherwise be identified with DID or demon possession can now look at the relativity of such constructions. The healer can help by making public the dialogues which a client carries in his or her mind. Whether or not a healer teaches a client about social constructionism, they can demonstrate it's principles in the manner by which they invite clients to clarify and explain "reality" as they see it. Illustrating the relativity of the client's socially constructed beliefs, the healer offers opportunities to re-frame the "reality" of a client in less problematic ways.

As people become increasingly socially saturated they may on their own start to question the traditional labels of disorders thereby creating a need for a new breed of helping

professionals. Healers who eschew single-truth constructs may become increasingly in demand as postmodernism flourishes.

Such healers can come from any of the traditional cultural groups. One might think of them as postmodern healers who have training in both the traditional methods of their disciplines and social constructionist alternatives. In practice this might be a priest who can perform exorcisms yet maintains awareness of the strong social forces which make his work "real" for his clients. The psychotherapist, too, might choose to treat a client for DID in therapy while recognizing that the approach is but one of many frames for understanding the client. As a healer with awareness of social constructionism one can decide to what degree it is useful to share the metaphorical aspect of a disorder with the clients.

For some clients it may be wise to maintain the illusion of "reality" in their disorder. Some clients need to know for sure what their condition is and that it has a proven treatment. For them traditional healing mechanisms may work best. Other clients, however, may not be so

invested in finding a specific label for their condition. Clients who show receptivity to exploring perspectives outside of single-truth lenses may do well with a healer who encourages alternative options to traditional metaphors.

Part of the initial assessment a helping professional makes with a client may need to be an assessment of the client's receptivity to social constructionism. Determining the client's acceptance or rejection of social constructionism can be a benchmark from which treatment progresses. Some clients may fare better with traditional treatment regimens, while others may venture into unknown avenues of deconstructionsim and re-creating definitions of their "conditions" which they find more helpful.

A brief example can clarify a possible application of social constructionism in treatment. Suppose a client is presented to a healer with the symptom of experiencing a "second-voice", traditionally characteristic of DID or demon possession. After initial assessment that the client may respond well to a social constructionist approach to treatment,

the healer may decide to use an overt treatment strategy. Whether the healer is a priest or psychotherapist obviously plays a role in the expectations for treatment, but it need not interfere with the social constructionist approach. The healer, priest or psychotherapist, can begin by engaging the client in a discussion of the problem. The failure of the helping professional to direct the conversation toward a traditional metaphor, DID or demon possession, may hold significant weight in deflating preconceived expectations. With the goal of helping the client to provide meaning to their symptoms the healer may explain the social nature of disease and disorder metaphors. Assisting the client in reconceptualizing their "condition" as a metaphor rather than a "real" problem can begin a process of understanding and healing. Such labeling of traditional disorders as metaphors can apply to the work of healers from any variety of cultures.

The execution of social constructionist principles in helping professions is not a clear cut task. Social constructionism is not a religion or psychological orientation, rather

it is a broader means of conceptualizing human meaning making efforts. Since many people are increasingly conscious of social differences in meaning making it makes sense to create treatment approaches which coincide with people's level of awareness. Social constructionism offers a possible lens for aiding the treatment of "clients" in the postmodern world.

Social constructionist principles are not the best form of treatment for all people. Those who are deeply entrenched in their single-truth culture and resistant to challenges may find social constructionist ideas offensive. To use a social constructionist approach with such clients would likely turn them away and be counterproductive. Social constructionism may also not be well suited for people who rely heavily on the role of a healer as the provider of answers. Such people are likely to be comforted by the sense of security which single-truth beliefs maintain. The most likely people to find social constructionism helpful are those who are directly exposed to the effects of social saturation. People who, on a daily basis, are exposed to divergent opinions, through

international travel, fax machines, etc., are the most likely candidates for social constructionist approaches to healing endeavors. It is the socially saturated crowd which has the most immediate need for a new way of making meaning in their complex worlds. Social constructionism offers the level of understanding which socially saturated people desire. It is, after all, the creation of the postmodern people.

References

American Psychiatric Association (1980). Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, D.C.: American Psychiatric Association.

American Psychiatric Association (1987). Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised. Washington, D.C.: American Psychiatric Association.

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, D.C.: American Psychiatric Association.

Atwood, Joan D., and Ruiz Joan (1993). Social Constructionist Therapy with the Elderly. Journal of Family Psychotherapy, 4(1), 1-30.

Bach, Paul J. (1979). Demon Possession and Psychopathology: A Theological Relationship. Journal of Psychology and Theology, 7, 22-26.

Baldwin, Lynda C. (1990). Child Abuse as an Antecedent of Multiple Personality Disorder. The American Journal of Occupational Therapy, 44 (11), 978-983.

Beck, James R., and Lewis, Gordon R. (1989). Counseling and the Demonic: A Reaction to Page. Journal of Psychology and Theology, 17 (2), 132-134.

Beier, Ernst G., and Young, David M. (1984). The Silent Language of Psychotherapy. New York: Aldine De Gruyter.

Belegman, D. A. (1993). Possession: Interdisciplinary Roots. Dissociation: Progress in the Dissociative Disorders, VI (4), 201-212.

Berends, Willem (1975). Biblical Criteria for Demon-Possession. The Westminster Theological Journal, 37, 342-365.

Boorstin, Daniel J. (1983). The Discoverers. New York: Random House.

Bowers, Margaretta K., Brecher-Marer, Sylvia., Newton, Bernauer W., Piotrowski, Zygmunt, Spyer, Thea C., Taylor, William S., & Watkins, John G. (1971). Therapy of Multiple Personality. The International Journal of Clinical Experimental Hypnosis, 19 (2), 57-65.

Braun, Bennett G. (Ed.). (1986). Treatment of Multiple Personality Disorder. Washington, D.C.: American Psychiatric Press, Inc.

Braun, Bennett G. (1990). Multiple Personality Disorder: An Overview. The American Journal of Occupational Therapy, 44 (11), 971-977.

Bunk, Barbara (1993). Multiple Personality Disorder as an Attachment Disorder (presentation). Connecticut Psychological Association Convention, 5/1/93.

Caldwell, Michael F. (1994). Applying Social Constructionism in the Treatment of Patients Who Are Intractably Aggressive. Hospital and Community Psychiatry, 45 (6), 597-601.

Cardena, Etzel (1992). Trance and Possession as Dissociative Disorders. Transcultural Psychiatric Research Review, XXIX (4), 287-300.

Chu, James A., and Dill, Diana L. (1990). Dissociative Symptoms in Relation to Childhood Physical and Sexual Abuse. American Journal of Psychiatry, 147, 887-892.

Coons, Philip M. (1993). The Differential Diagnosis of Possession States. Dissociation: Progress in the Dissociative Disorders, VI (4), 213-221.

Cushman, Philip (1995). Constructing the Self, Constructing America. Reading, Massachusetts: Addison-Wesley Publishing Co..

Dawson, Peggy L. (1990). Understanding and Cooperation Among Alter and Host Personalities. The American Journal of Occupational Therapy, 44 (11), 994-997.

Dell, Paul F. (1988). Professional Skepticism about Multiple Personality. The Journal of Nervous and Mental Disease, 176 (9), 528-531.

Ebel, Henry (1986). The Strange History of Cultural Relativism. The Journal of Psychoanalytic Anthropology, 9 (2), 177-183.

Ellenberger, H.F. (1977). The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry. New York: Basic Books.

Erxleben, Jan, and Cates, Jim A. (1991). Systematic Treatment of Multiple Personality: Response to a Chronic Disorder. American Journal of Psychotherapy, XLV (2), 269-278.

Fabrega, Horacio (1992). The Role of Culture in a Theory of Psychiatric Illness. Social Science Medicine, 35 (1), 91-103.

Fabrega, Horacio (1989). Cultural Relativism and Psychiatric Illness. The Journal of Nervous and Mental Disease, 177 (7), 415-425.

Fike, M. Laurita (1990). Considerations and Techniques in the Treatment of Persons With Multiple Personality Disorder. The American Journal of Occupational Therapy, 44 (11), 999-1007.

First, Michael B. (1992). Trends in Psychiatric Classification: DSM-III-R to DSM-IV. Psychiatria Hungarica, 7 (6), 539-546.

Francis, A., Davis, W. Wakefield, Kline, M., and Pincus, H. (1991). The DSM-IV Field Trials: Moving Toward an Empirically Derived Classification. European Psychiatry, 6 (6), 307-314.

Friesen, James G. (1992). Ego-Dystonic or Ego-Alien: Alternate Personality or Evil Spirit? Journal of Psychology and Theology, 20 (3), 197-200.

Ganaway, George K. (1994). MPD Dropped in DSM-IV. Inside Ridgeview, Spring, 2.

Gaw, Albert C., and Bernstein, Ruth L. (1992). Classification of Amok in DSM-IV. Hospital and Community Psychiatry, 43 (8), 789-793.

Gergen, Kenneth J. (1991). The Saturated Self. New York: Basic Books, Harper Collins Publishers.

Gergen, Kenneth J. (1985). The Social Constructionist Movement in Modern Psychology. American Psychologist, 40 (3), 266-275.

Gibson, Keith (1989). Psychiatry Training and Research. Canadian Journal of Psychiatry, 34 (3), 182-185.

Goff, Donald C., Brotman, Andrew W., Kindlon, Daniel, Waites, Meredith, & Amico, Edward (1991). The Delusion of Possession in Chronically Psychotic Patients. Journal of Nervous and Mental Disease, 179 (9), 567-571.

Greaves, George B. (1980). Multiple Personality: 165 Years after Mary Reynolds. The Journal of Nervous and Mental Disease, 168 (10), 577-596.

Hankoff, L.D. (1992). Religious Healing in First-Century Christianity. Journal of Psychohistory, 19 (4), 387-407.

Hare-Mustin, Rachel T., and Marecek, Jeanne (1988). The Meaning of Difference: Gender Theory, Postmodernism, and Psychology. American Psychologist, 43 (6), 455-464.

Henderson, James (1982). Exorcism and Possession in Psychotherapy Practice. Canadian Journal of Psychiatry, 27 (Mar), 129-134.

Herman, Judith Lewis (1992). Trauma and Recovery. New York: Basic Books, Harper Collins Publishers.

Isaacs, T. Craig (1987). The Possessive States Disorder: The Diagnosis of Demonic Possession. Pastoral Psychology, 35 (4), 263-273.

Jones, Alexander (1968). The Jerusalem Bible, Reader's Edition. New York: Doubleday & Company, Inc.

Kelly, George A. (1963). A Theory of Personality, The Psychology of Personal Constructs. New York: W. W. Norton & Company.

Kemp, Simon, and Williams, Kevin (1987). Demonic Possession and Mental Disorder in Medieval and Early Modern Europe. Psychological Medicine, 17, 21-29.

Kenny, Michael G. (1981). Multiple Personality and Spirit Possession. Psychiatry, 44, 337-358.

Kirmayer, Laurence J. (1992). Social Constructions of Hypnosis. International Journal of Clinical and Experimental Hypnosis, 40 (4), 276-300.

Kluft, Richard P. & Fine, Catherine G. (Eds.). (1993). Clinical Perspectives on Multiple Personality Disorder. Washington, DC: American Psychiatric Press, Inc.

Kluft, Richard P. (1987). An Update on Multiple Personality Disorder. Hospital and Community Psychiatry, 38 (4), 363-373.

Lazarus, Arnold A. (1993). Theory, Subjectivity and Bias: Can There be a Future? Psychotherapy, 30 (4), 674-677.

Lewis-Fernandez, Roberto (1992). The Proposed DSM-IV Trance and Possession Disorder Category: Potential Benefits and Risks. Transcultural Psychiatric Research Review, XXIX (4), 301-318.

Ludwig, A. M. (1983). The Psychobiological Functions of Dissociation. American Journal of Clinical Hypnosis, 26, 93-99.

Lukoff, David; Lu, Francis; and Turner, Robert (1992). Toward a More Culturally Sensitive DSM-IV: Psychoreligious and Psychospiritual Problems. Journal of Nervous and Mental Disease, 180 (11), 673-682.

Mahoney, Michael J., and Lyddon, William J. (1988). Recent Developments in Cognitive Approaches to Counseling and Psychotherapy. The Counseling Psychologist, 16 (2), 190-234.

Manicas, Peter T. and Secord, Paul F. (1983). Implications for Psychology of the New Philosophy of Science. American Psychologist, April, 399-413.

Martin, Malachi (1976). Hostage to the Devil. New York: Harper and Row, Publishers.

Martinez-Taboas, Alfonso (1991). Multiple Personality Disorder as Seen From a Social Constructionist Viewpoint. Dissociation: Progress in the Dissociative Disorders, IV (3), 129-133.

Maturana, Humberto R. & Varela, Francisco J. (1987). The Tree Of Knowledge, The Biological Roots of Human Understanding. Boston: Shambhala Publications, Inc.

Minuchin, Salvador (1974). Families and Family Therapy. Cambridge, Massachusetts: Harvard University Press.

Nakdimen, Kenneth A. (1990). Differential Diagnosis of Multiple Personality Disorder. American Journal of Psychiatry, 147 (9), 1259-1260.

Oesterreich, T.K. (1974). Possession, Demoniacal & Other Among Primitive Races, In Antiquity, The Middle Ages, and Modern Times. New York: University Books.

Osbeck, Lisa M. (1993). Social Constructionism and the Pragmatic Standard. Theory and Psychology, 3 (3), 337-349.

Page, Sydney H.T. (1989a). The Role of Exorcism in Clinical Practice and Pastoral Care. Journal of Psychology and Theology, 17 (2), 121-131.

Page, Sydney H.T. (1989b). Exorcism Revisited: A Response to Beck and Lewis and to Wilson. Journal of Psychology and Theology, 17 (2), 140-143.

Peck, M. Scott (1983). People of the Lie: The Hope for Healing Human Evil. New York: Simon and Schuster.

Price, Reese (1987). Dissociative Disorders of the Self: A Continuum Extending Into Multiple Personality. Psychotherapy, 24 (3), 387-391.

Prince, Raymond H. (1976). Psychotherapy as the Manipulation of Endogenous Healing Mechanisms: A Transcultural Survey. Transcultural Psychiatric Research Review, 13, 115-133.

Putnam, Frank W. (1989). Diagnosis and Treatment of Multiple Personality Disorder. New York: The Guilford Press.

Putnam, Frank W., Loewenstein, Richard J. (1993). Treatment of Multiple Personality Disorder: A Survey of Current Practices. American Journal of Psychiatry, 150 (7), 1048-1052.

Ross, Colin A. (1989). Multiple Personality Disorder, Diagnosis, Clinical Features, and Treatment. New York: John Wiley & Sons, Inc.

Ross, Colin A. and Gahan, Pam (1988). Techniques in the Treatment of Multiple Personality Disorder. American Journal of Psychotherapy, 42 (1), 40-52.

Ross, Colin A., Miller, Scott D., Bjornson, Lynda, Reagor, Pamela, Fraser, George A., & Anderson, Geri (1991). Abuse Histories in 102 Cases of Multiple Personality Disorder. Canadian Journal of Psychiatry, 36, 97-101.

Russell, John G. (1989). Anxiety Disorders in Japan: A Review of the Japanese Literature on Shinkeishitso and Taijinkyofusho. Culture, Medicine, and Psychiatry, 13 (4), 391-403.

Sampson, Edward E. (1981). Cognitive Psychology as Ideology. American Psychologist, 36 (7), 730-743.

Sanders, Barbara, and Giolas, Marina H. (1991). Dissociation and Childhood Trauma in Psychologically Disturbed Adolescents. American Journal of Psychiatry, 148 (1), 50-54.

Schafer, Donald W. (1986). Recognizing Multiple Personality Patients. American Journal of Psychotherapy, XL (4), 500-510.

Schreiber, F. (1973). Sybil. Chicago, IL: Regnery.

Shuster, Marguerite (1991). Giving the Devil More Than His Due, Sometimes Exorcism Causes Damage not Deliverance. Leadership, Summer, 64-67.

Skodol, Andrew E., and Perry, Christopher J. (1993). Should an Axis for Defense Mechanisms be Included in DSM-IV? Comprehensive Psychiatry, 34 (2), 108-119.

Sperry, Len (1990). Dissociation, Multiple Personality, and the Phenomenon of Evil. The Journal of Pastoral Counseling, 25, 90-100.

Spiegel, David (Ed.). (1994). Dissociation: Culture, Mind, and Body. Washington, DC: American Psychiatric Press, Inc.

Spiegel, David, and Cardena, Etzel (1991). Disintegrated Experience: The Dissociative Disorders Revisited. Journal of Abnormal Psychology, 100 (3), 366-378.

Spitzer, Robert L. (1991). An Outsider-Insider's Views About Revisiting the DSMs. Journal of Abnormal Psychology, 100 (3), 294-296.

Stafford, Linda L. (1993). Dissociation & Multiple Personality Disorder, A Challenge for Psychosocial Nurses. Journal of Psychosocial Nursing, 31 (1), 15-20.

Stein, Howard F. (1986). Cultural Relativism as the Central Organizing Resistance in Cultural Anthropology. The Journal of Psychoanalytic Anthropology, 9 (2), 157-175.

Stevenson, Robert Louis (1952). Strange Case of Dr. Jekyll and Mr. Hyde. New York: The Heritage Press.

Taylor, W. & Martin, M. (1944). Multiple Personality. The Journal of Abnormal and Social Psychology, 39, 281-300.

Terr, Lenore C. (1991). Childhood Traumas: An Outline and Overview. American Journal of Psychiatry, 148 (1), 10-20.

Thigpen, C. & Cleckley, H. (1954). A Case of Multiple Personality. The Journal of Abnormal and Social Psychology, 49, 135-151.

Thigpen, C. & Cleckley, H. (1957). The Three Faces of Eve. New York: McGraw-Hill.

United States Catholic Conference, Inc. (1994). Catechism of the Catholic Church. Citta del Vaticano: St. Paul Books and Media.

van der Kolk, Bessel A., Perry, Christopher, and Lewis Herman, Judith, (1991). Childhood Origins of Self Destructive Behavior. AMerican Journal of Psychiatry, 148, 1655-1671.

VanGelder, David W. (1987). A Case of Demon Possession. The Journal of Pastoral Care, XLI (2), 151-161.

Virkler Henry A. & Virkler Mary B. (1977). Demonic Involvement in Human Life and Illness. Journal of Psychology and Theology, 5, 95-102.

Ward, Colleen A., and Beaubrun, Michael H. (1980). The Psychodynamics of Demon Possession. Journal for the Scientific Study of Religion, 19 (2), 201-207.

Watts, Roderick J. (1992). Elements of a Psychology of Human Diversity. Journal of Community Psychology, 20, 116-131.

Whitman, Barbara Y. & Munkel, Wayne (1991). Multiple Personality Disorder: A Risk Indicator, Diagnostic Marker and Psychiatric Outcome for Severe Child Abuse. Clinical Pediatrics, 30 (7), 422-428.

William and MAry GALA, Inc. Some Straight Talk About Homosexuality. Washington, D.C.: William And Mary.

Wilson, Michael (1975). Exorcism, A Clinical/Pastoral Practice Which Raises Serious Questions. The Expository Times, 86, 292-296.

Woolfolk, Robert L. (1992). Hermeneutics, Social Constructionism and other Items of Intellectual Fashion: Intimations for Clinical Science. Behavior Therapy, 23, 213-223.

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