

Dissociative Identity Disorder: The Mystery Surrounding its Etiology and its Connection to
Satanic Ritual Abuse

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Abstract

The purpose of this project is to inform its readers of the often overlooked and sometimes avoided diagnosis of dissociative identity disorder along with its possible connections to extreme abuse such as satanic ritual abuse as well as intentional mind control. This project gives a complete description of the present definitions of dissociation including dissociative identity disorder as defined in the *Diagnostic and Statistical Manual Fourth Edition Text Revised* (American Psychiatric Association, 2000). By including the history of dissociative identity disorder, addressing the controversies that surround this disorder, as well as reviewing relevant research the mystery of this diagnosis begins to gain clarity. In light of this clarity this project proposes a more holistic, effective approach to treatment including that of a spiritual nature.

In the Adlerian theory of psychology there is an assessment technique used by many therapists referred to as “a typical day”. This technique consists of the therapist asking the client what their typical day would look like. This technique proves to be effective as a skilled therapist gains insight through the plethora of information gathered from the response of this simple answer. For many here in America a typical day could consist of arising in the morning, preparing oneself or one’s family for the activities of the day, eating three meals during the day, going to work or school, returning home for the evening, and going to bed to sleep for the night. The variations of how individuals engage in these activities differ immensely thus exposing possible clues as to why the client is seeking therapy at this time (Dinkmeyer & Sperry, 2000).

When asked this question in therapy, a couple may reveal a pattern of arguing late at night thus clueing the therapist into the possible need to teach conflict resolution skills. A teenager may share with the therapist his/her newly found desire to get high just to make it through the school day. A school-aged child may tell the therapist how much he/she likes school because then he/she gets to eat. All of these answers aid the therapist in recognizing the various forms of discouragement each individual is experiencing and the areas where encouragement is needed.

When a client answers this assessment question with comments such as; “I have no idea what a typical day even looks like along with, I have many blank spots in my day, or sometimes I find myself in an unfamiliar place and I do not know how I got there” this could clue the therapist into the possibility that this individual may be experiencing some form of dissociation. Keep in mind that other possible explanations such as delirium, dementia, malnutrition or dehydration have already been ruled out.

Definitions of Dissociation

Dissociation can be described as “a state that includes feelings of unreality and depersonalization, sometimes accompanied by a loss of self-identity” (Sarason & Sarason, 2005, p. 589). For those who experience any form of dissociation on a regular basis living life on a day to day basis can become very chaotic and often scary.

To begin to understand dissociative identity disorder more fully it is important to take a look at what is presently understood regarding this diagnosis. The following gives a thorough description of the definitions of dissociation and how this diagnosis develops within an individual by including relevant research that supports the proposed connection to satanic ritual abuse as well as offering hope through a more holistic treatment plan approach.

Dissociation to the extreme can typically be a key that this individual has experienced some type of trauma. Dissociation is a coping mechanism or a way to safeguard while enduring a traumatic experience and can become one’s preferred safeguarding tool in nearly every uncomfortable situation. The individual is able to detach from reality and enter into an altered state of consciousness as a means to reduce the conflict or trauma at hand (Sarason & Sarason, 2005).

Dissociation is the key factor in the diagnosis of Dissociative Identity Disorder and like any other mental health diagnoses dissociation can be experienced by an individual on a continuum. Mild dissociation could be experienced by individuals without the individual recognizing that some form of dissociation has occurred. Think, for example, of a time when you as an individual were driving home from work and before you knew it you were home. It was as if the car had a mind of its own and it just seemed to steer itself toward home. This is a mild form of dissociation. On the other end of the continuum is an individual who has figured

out how to survive by hiding within him/her self and has created another part of him/her self to do life, so to speak. These other parts are actually a newly created identity often referred to as “alters” (Sarason & Sarason, 2005).

Along this continuum of dissociation various forms of dissociation or disconnecting from one’s thoughts, emotions, body, or identity can be found. On the high end of the dissociation continuum is the complex disorder called dissociative identity disorder. The American Psychiatric Association (2000) describes dissociative identity disorder as an individual who has

The presence of two or more distinct identities or personality states that recurrently take control of the individual’s behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. 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). It is a disorder characterized by identity fragmentation rather than a proliferation of separate personalities (p. 519).

An individual diagnosed with dissociative identity disorder most often experiences dissociative amnesia, dissociative fugue, depersonalization, as well as the fragmentation in one’s identity to the point of creating two or more self-identities or “alters” generally as a means for survival during an extreme traumatic event such as ongoing childhood physical abuse, incest, or ritual abuse (Sarason & Sarason, 2005).

On the low end of the continuum we see dissociative amnesia, which is characterized by “an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness” (American Psychiatric Association, 2000, p. 519). Often times the effect after experiencing a natural disaster such as

earthquakes or tsunamis can cause people to enter into a state of shock for a period of time.

When an individual continues to remain in an altered state of consciousness while experiencing gaps in one's memory along with one's ability to function normally remains impaired and one is experiencing distress over an extended period of time this can lead to a dissociative disorder such as dissociative amnesia. Dissociative amnesia, like any form of dissociation, can be used as a means to cope with the traumatic experience (Sarason & Sarason, 2005).

Dissociative fugue also lies on the dissociation continuum. Dissociative fugue is characterized by "sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity" (American Psychiatric Association, 2000, p. 519). Dissociative fugue, like dissociative amnesia, is often preceded by some form of intolerable stress such as combat of war, extreme personal rejection, or natural disasters. When an individual experiences dissociative fugue he/she often times creates an entire new life involving new friendships, a new job, and sometimes a new family and does so with a newly created identity. The fugue state usually ends when the individual suddenly "wakes up" confused and distraught as to how this new life was created (Sarason & Sarason, 2005).

Depersonalization is another form of dissociation; however, it could be argued that depersonalization is not truly a form of dissociation as it does not include any loss of memory. Depersonalization includes an individual experiencing a change in self-perception and one's sense of reality is greatly altered. An individual experiencing depersonalization may say "I feel like I am living in a dream", or "I feel like my body is just a machine". When an individual continues to experience depersonalization for a prolonged period of time along with a distortion of one's bodily perception combined with the impairment of one's ability to function,

depersonalization becomes depersonalization disorder. For example, an individual may believe his/her arm is detached from his/her body or that his/her foot has somehow become distorted to an unreal size and the individual begins to obsess over this distorted body part. According to the American Psychiatric Association 2000 depersonalization disorder can be characterized by a “persistent or recurrent feeling of being detached from one’s mental processes or body that is accompanied by intact reality testing” (p. 519).

There are those individuals who may experience a combination or bits and pieces of the previous forms of dissociation; however, there may not be enough evidence for a specific diagnosis. In this situation the American Psychiatric Association 2000 will use the diagnosis of dissociative disorder not otherwise specified (NOS) which is defined as “an inclusion for coding disorders in which the predominant feature is a dissociative symptom, but that do not meet the criteria for any specific dissociative disorder” (p. 519). These individuals may have experienced brief episodes of dissociation related to a traumatic event; however, the dissociation experienced has not completely affected one’s ability to function.

Brief History of Dissociative Identity Disorder

Dissociative identity disorder is among one of the most fascinating psychological disorders. It seems that throughout history and across many cultures generations have been confronted with individuals who have claimed to have many parts or multiple personalities or as now referred to as dissociative identities (Pica, 1999). For some it seemed it could be explained as a spiritual condition of demonic spirit possession as well as in some ancient forms of shamanism (Braude, 1995). For those in the mental health field it was not enough to explain this condition as a spiritual condition alone. In the late 1800’s Pierre Janet began studying philosophy, psychology and medicine and through this he began to make the connection of an

individual's childhood trauma experiences to one's present day ability to function. As a result of his studies, Pierre Janet successfully communicated the connection of dissociative behaviors to traumatic childhood memories. Pierre Janet is the one given credit for the term "dissociation" to describe the split in consciousness that resulted when individuals had been exposed to traumatic events (Putnam, 1989).

Pierre Janet's study of psychology emerged just before the time of Sigmund Freud's study of psychology. Ross, Norton, and Fraser (1989) argue that due to Freud's "repudiation of the incestuous seduction theory" only a handful of cases involving dissociative disorders would be reported in literature in the first half of the twentieth century (p. 62).

In the early 1970's the release of films such as "Eve" and "Sybil" aided in creating a new social awareness of dissociative disorders. Some would argue that it was this social awareness that brought about the rise of clinical awareness resulting in approximately 6,000 reportable cases of dissociative nature to the surface as compared to a mere 79 reported cases in the United States of America before the 1970's (Elzinga, Van Dyck, & Spinhoven, 1998). As soldiers returning from the Vietnam War began to display behaviors that we now know as post traumatic stress the psychological study of trauma once again became of interest to many in the mental health field. It was through psychophysiological research led by Ludwig, Brandsman, Wilbur, Bendfeldt, and Jameson (1972) and Larmore, Ludwig, and Cain (1977) that the Diagnostic and Statistical Manual of Mental Disorders-3rd ed. recognized multiple personality disorder as a diagnosable condition (American Psychiatric Association, 1981). With the release of the most recent Diagnostic and Statistical Manual of Mental Disorders TR-IV in 2000 multiple personality disorder has more accurately been renamed as dissociative identity disorder.

Kluft (1984) attributes the rise of reportable cases of dissociative identity disorder to the increasing interest in psychological research pertaining to dissociative behavior resulting in the development of more accurate assessment instruments, coherent diagnostic criteria, and an increased awareness of dissociative psychopathology.

More recently there seems to be a slight rise in the social awareness of dissociation especially as dissociation is so vividly displayed through films such as *Precious* created from the novel *Push* by Sapphire. Showtime's 2009 Emmy award winning series, *The United States of Tara*, is a series also attempting to demonstrate what life could be like for someone diagnosed with dissociative identity disorder.

In the late 1980's there were those who believed that dissociative identity disorder truly remained a very rare occurrence and that it has been "grossly over diagnosed" (Aldridge-Morris, 1989, p. 109). Then there are those who believe that dissociative identity disorder continues to remain under diagnosed leaving many who are still suffering (Behrs, 1982; Putnam, 1989; Ross, 1991). In all areas pertaining to dissociative identity disorder there is much controversy. Questions surrounding the legitimacy of dissociation itself, the creation of alters, the psychodynamics leading to the psychopathology of the diagnosis, as well as the rarity of the disorder leave much room for further ongoing research.

Controversy Surrounding the Diagnosis of Dissociative Identity Disorder

A great deal of controversy surrounds several areas of the diagnosis of dissociative identity disorder including the legitimacy of the disorder, the function of its symptoms, and the role of the environment in its origins. There are those within the mental health community who are skeptical about the legitimacy of the diagnosis of dissociative identity disorder (North, Ryall, Ricci, & Wetzel, 1993). It has been suggested by some that the disorder is an "iatrogenic

phenomenon” wherein highly influential individuals such as therapists are able to suggest the dissociative symptoms to vulnerable individuals resulting in individuals experiencing some form of a dissociative state (Merskey, 1992; Spanos, 1994, 1996). Then there are those within the mental health community who maintain that the diagnosis of dissociative identity disorder has developed as a means to survive or protect oneself while enduring ongoing extreme childhood abuse. Extensive, large-scale epidemiological research does indeed suggest the linkage of extreme childhood abuse to the diagnosis of dissociative identity disorder (Putnam, Guroff, Silberman, Barban, & Post, 1986; Schultz, Braun, & Kluft, 1989). It is almost as if the opposing views are arguing one of the age old battles within psychology: nature versus nurture.

Dissociative Identity Disorder and the Sociocognitive Model

The sociocognitive model effectively backs up the controversial claims of those in the mental health field who argue the diagnosis of dissociative identity disorder as an iatrogenic phenomenon (Ganaway, 1995; Merskey, 1992; Spanos, 1994, 1996). The sociocognitive model proposes “dissociative identity disorder is a syndrome that consists of rule-governed and goal-directed experiences” (Lilienfeld et al., 1999, p. 507-508). Within these goal-directed experiences an individual will create many parts or actors and then shift into playing a different role much like one who performs different parts of a play in order to handle or cope with the present situation. The sociocognitive model suggests that this individual is not experiencing amnesia while acting in one of these roles; however, the individual continues to shift into the differing characters because the individual is supported by his/her environment (Lilienfeld et al., 1999).

The sociocognitive model argues one diagnosed with dissociative identity disorder does not experience varying states of consciousness or a split in one’s identity due to traumatic

childhood abuse; rather it suggests individuals diagnosed with dissociative identity disorder are predisposed to obtaining dissociative identity disorder due to a higher vulnerability to “fantasy proneness” (Lilienfeld et.al., 1999, p. 509). The sociocognitive model argues that it is due to this fantasy proneness that an individual could have a higher vulnerability to several psychopathological conditions. Spanos (1996) argues that “dissociative identity disorder overlaps substantially with several psychopathological conditions, including borderline personality disorder and somatization disorder” (p.22).

According to Lynn, Rhue, and Green (1988) this model does not dispute “the possibility that childhood trauma might produce predisposition toward certain psychological traits that in turn increase individuals’ receptivity to therapist cues nor does this model posit that the creation of alters is a defensive reaction to trauma” (p. 508). This model does suggest that an individual has learned how to adopt or enact certain social roles geared to one’s aspirations and displays varying characteristics due to the demands placed upon an individual in varying social contexts (Sarbin & Coe, 1972). The sociocognitive model explains the creation of alters within an individual diagnosed with dissociative identity disorder as “a consequence of therapist influences, media portrayals, and socio-cultural expectations” (Lilienfeld et. al., 1999, p. 508). In other words, it could be argued, that an individual diagnosed with dissociative identity disorder very well may have endured extreme childhood abuse such as incest, physical, or ritual abuse and as a result of this individual’s biological predisposition this individual could become much more vulnerable to other negative influences experienced within his/her environment. It is this type of individual, the sociocognitive model argues, that may be more prone to fantasy and is more likely to engage in fantasy or role enactment possibly as a way to get attention or as a cry for help (Lilienfeld et. al., 1999).

Dissociative Identity Disorder due to Extreme Childhood Abuse

Although the sociocognitive perspective posits that the diagnosis of dissociative identity disorder is iatrogenic in nature (Ganaway, 1995; Merskey, 1992; Spanos, 1994, 1996). It has also been argued that dissociative identity disorder is a “chronic, posttraumatic dissociative disorder characterized by recurrent disturbances of identity and memory” (Kluft, 1988, p. 212). Dissociative identity disorder is a complex disorder that generally finds its roots in an individual’s childhood. “The severe, sustained, and repetitive trauma that occurs during the early to middle stages of childhood (ages 2 and a half to 8) for most victims is thought to promote the development of Multiple Personality Disorder” now known as dissociative identity disorder (Wilbur, 1984, p. 5). Research suggests that “the most important task the infant faces in the first six months of life is the development of a core self. This development of a core self provides the basic context from which to integrate and make sense of further life experiences” (Stern, 1985, p.100). Stern (1985) goes on to suggest that the development of the core self creates a sense of security as being a unified and integrated person who exhibits control over one’s individual actions. The core self also aids the infant in experiencing the self as a “single and bounded entity” that is able to recognize and successfully own one’s experiences as coming from the core self over a lifetime (p.101).

When an infant experiences extreme trauma such as physical abuse, incest, or ritual abuse the infant’s core self is affected and the ability to remain as a “single and bounded entity” becomes less and less plausible. Tollefson (2009) argues when an individual experiences trauma such as heart trauma or head trauma, the physical trauma can affect one specific system where as emotional/psychological trauma can affect many systems at the same time. Several studies (Friedman, 1998; Petit, 1991; & Pitman, Van der Kilk 1990) show physical trauma episodes

create biochemical alterations in the brain and nervous systems that trigger signs and symptoms of posttraumatic stress producing shock and emotional numbness. Research has also shown that “psychiatric trauma creates substantial and lasting damage to the psychological development of an individual” (Tollefson, 2009, p. 3). With this understanding that trauma of any kind does indeed affect an individual physically, mentally, emotionally, and spiritually; imagine the affects ongoing trauma has on the many developing systems of a child.

It has been acknowledged that abused or neglected children are at risk for a number of differing mental health problems and that significant dissociative psychopathology has more recently been linked with extreme abuse and neglect. This type of dissociation has been described as “the disruption of the normal integrative processes of consciousness, perception, memory, and identity that define selfhood” (Waseem et al., 2010, p. 2). Putnam (1989) argues that the most extreme response to such psychological trauma results with individuals receiving the diagnosis of dissociative identity disorder.

In a survey conducted by the National Institute of Mental Health of 100 individuals diagnosed with dissociative identity disorder it was found that 97% reported experiencing significant childhood trauma (Putnam et al., 1986). The type of childhood trauma recognized in the etiology of dissociative identity disorder was the presence of extreme childhood abuse more specifically sexual abuse such as; “sadism, bondage, torture, prostitution” (Putnam, 1989). Extreme physical abuse such as; “burnings, torture, purification by bleeding, satanic rituals, and even live burial” has also been recognized in the etiological formation of dissociative identity disorder (Wilbur, 1984, p. 5). Other forms of abuse such as, “extreme forms of neglect, emotional abuse, and witnessing violent deaths” have also been linked with the etiological formation of dissociative identity disorder (Putnam et al., 1986, p. 287). When children are

exposed to such extreme forms of abuse over and over again it seems that the primal need to survive is what has taken over in these individuals. Some way, somehow, these children learned that in order to endure the torture they must escape from reality thus possibly enabling the ability to dissociate and for some to dissociate to the point of creating a new part of themselves to endure the torture for them.

Dissociative Identity Disorder due to Nature and Nurture

The sociocognitive model helps us understand that the diagnosis of dissociative identity disorder can form because of the environment one is exposed to or the way in which one is nurtured to behave by society when young (Ganaway, 1995; Lilienfeld et al., 1999; Merskey, 1992; Spanos, 1994, 1996). Others attribute the formation of the diagnosis of dissociative identity disorder as a result of ongoing extreme childhood abuse (Friedman, 1988; Kluft, 1988; Putnam et al., 1986; Stern, 1985; Waseem et al., 2010; Wilbur, 1984). Adlerian theory approaches any psychopathological condition from a holistic perspective including the diagnosis of dissociative identity disorder. Alfred Adler viewed individuals as holistic beings including the influences of one's biological makeup as well as the influences of one's environment. Adler refused to examine an isolated human being because he suggested that one's mental health is affected by one's social embeddedness. In other words, Adlerian psychology believes that most mental health disorders are the manifestation of discouragement, inferiority feelings, fear, and the lack of knowledge about how to be successful in one or more of the life tasks as well as understanding one's "heredity and physical determinants" (Ansbacher & Ansbacher, 1956 p. 204). Ansbacher and Ansbacher (1956) continue to explain Adlerian psychology in recognizing that by placing "these two aspects together meant that the various psychological processes of an individual must be understood with the framework of his individuality" (p.126). I concur with

the beliefs within Adlerian psychology that all psychological disorders are the result of one's physiological make up as well as the experiences in one's environment. When discussing Dissociative Identity Disorder, the field of psychology continues to do detriment to its research by splitting the two and researching Dissociative Identity Disorder as either an iatrogenic phenomenon or as a result of extreme childhood trauma. I believe that Dissociative Identity Disorder forms within an individual by one's level of vulnerability as well as one's extreme traumatic experiences. Could it be that mental disorders, specifically Dissociative Identity Disorder, are formed through both nature and nurture?

If this is true that both nature and nurture are influential in one developing the use of dissociation to the point of developing the diagnosis of dissociative identity disorder this would suggest that an individual would have to be highly vulnerable and experience some form of extreme trauma at the same time.

Research suggests that there seems to be a window of vulnerability for the development of dissociative identity disorder during childhood, specifically "between the ages of 18 months and 4 to 5 years of age" (Marmer, 1991, p. 685). Putnam (1995) researched this further only to discover that several clinicians believe that this "window of vulnerability" could actually extend up to age 8 (Bliss, 1980; Coons, Bowman, & Milstein, 1988; Greaves, 1980; Putnam et. al., 1986). Further research reveals that "children traumatized before age 6 displayed greater disorganization and a larger number of personalities, while children traumatized after 8 years of age tended to exhibit fewer personalities and greater ego strength" (Allison & Schwartz, 1980, p. 15). In other words, there seems to be a specific time frame in which individuals are more vulnerable to using dissociation as a means to safeguard oneself while experiencing trauma.

Jean Piaget described the ages of two to age eight in healthy childhood development as the preoperational and concrete operational stages of development. During the preoperational to concrete operational stage one's imagination flourishes and symbolic thinking begins. One's reasoning ability is often rigid, concrete, and very often black and white when interpreting his/her environment and the experiences therein (Berger, 2005). It has been found that individuals diagnosed with dissociative identity disorder display this similar type of thinking as that of children in the preoperational and concrete operational stages of development (Beere & Pica, 1995; Beere, Pica, & Maurer 1996; Fine, 1988). This suggests those diagnosed with dissociative identity disorder could possibly be stuck in the preoperational and concrete operational stage of thinking. Individuals exhibiting this way of thinking could be due to the emotional maturity level of an individual who has suffered extreme abuse and trauma or it could be due to one who truly has a part of his/her self living life as though he/she were actually still in that stage of development.

Validity of Autobiographical Memories within Dissociative Identity Disorder

The question of the validity of one's cognitive ability to accurately retrieve one's memories diagnosed with dissociative identity disorder has been an ongoing question within the mental health field. Questions such as: are the client's memories retrieved only by suggestion or are the memories validly related to the truth of the nature of the horrendous abuse these individuals have suffered. Bryant (1995) conducted research on an individual with the diagnosis of dissociative identity disorder for the purpose of investigating autobiographical memories in a patient before the diagnosis of dissociative identity disorder and after the diagnosis of dissociative disorder as a means for some answers to these very questions.

Bryant (1995) chose to conduct research as a quantitative descriptive study including one participant with a diagnosis of dissociative identity disorder and an examination of autobiographical memories within a range of two years. The first autobiographical memories were collected when this client first sought therapeutic treatment and the second set of autobiographical memories were collected two years later during which time she received the diagnosis of dissociative identity disorder. In order to compare the pattern of this client's autobiographical memories two types of control measures were obtained. A quasi-control methodology of using the same form of obtaining the autobiographical memories from a control group of fifteen female undergraduate university students was used to make comparisons of the results. The members in the control group were given education of dissociative identity disorder and then given instructions to respond to the questioning in a way that they believed would be concurrent with someone with the diagnosis of dissociative identity disorder.

The results were interesting. It was suggested that each time the client with dissociative identity disorder was cued to recall a memory from under the age of twelve years she would shift to a child alter and give the memory as if it happened yesterday. When asked to report on memories at random the host personality was able to stay forward and generally reported memories of a positive nature. It was also found that there was indeed some type of amnesia between the alter personalities when reporting autobiographical memories. The control group presented differently in that they gave both positive and negative autobiographical memories when acting in the "host personality" and the same for when acting in the "child personality".

The findings suggest "that a patient with dissociative identity disorder reports different autobiographical memories across personalities" (Bryant, 1995, p. 629). It also suggests what researchers have suggested all along regarding the nature of dissociation in individuals with

extreme abusive backgrounds. Which is the idea that “dissociative identity disorder patients protect themselves from traumatic memories by dissociating themselves from awareness of those memories” (Putnam, 1989 & Ross, 1989). The findings go on to suggest that individuals with dissociative identity disorder may experience amnesia with selective traumatic memories rather than global amnesia over a specific time frame of life. The memories retrieved from the “child alters” also exhibited cognitive reasoning congruent with one in the preoperational to concrete operational stages of development also suggesting that these memories are connected to very real alters and not fantasy characters made up by the client (Bryant, 1995).

Children during the preoperational and concrete operational stage are not only concrete thinkers it has been suggested that children during this same stage are also highly hypnotizable (Pica, 1999). Pica (1999) conducted extensive research and discovered that “children are more hypnotizable than adults and that their hypnotic capacity peaks at about age 10 before declining during adolescence and stabilizing in adulthood” (Ambrose, 1961; Gardner, 1974; 1977; Gardner & Olness, 1981; London, 1965; London & Cooper, 1969; Place, 1984; Williams, 1981). Pica, (1999) concludes from his research “that children use this natural hypnotic capacity to dissociate in response to psychosocial stressors and that given equal circumstances, children who display the highest hypnotic capacity will find it easier to dissociate” (p. 407).

Everyone is unique, not all children are born with this natural vulnerability to fantasy proneness. Research conducted by Lynn, Rhue, and Green (1988) revealed that “approximately 4% of the population tend to have a more fantasy proneness, are more easily hypnotizable, hallucinate vividly, and have trouble distinguishing between fantasy and reality” (p. 140). I speculate it is these individuals who also endure extreme trauma quickly learn to dissociate. It is interesting to note that research has also found that individuals lacking the capability to engage

in dissociation when under the age of eight years while also experiencing ongoing extreme physical, incestuous, or satanic ritualistic forms of abuse that these individuals generally receive the diagnosis of borderline personality disorder (Kemp, Gilbertson, & Torem, 1988).

I believe that children, due to their ever growing and developing cognitive abilities, are by nature more vulnerable or more susceptible to the iatrogenic phenomenon. Add to that natural vulnerability ongoing physical, sexual, or ritualistic abuse and the child becomes even more vulnerable. This child is nurtured through these horrendous experiences of continual abuse therefore rendering him/her even more vulnerable. One's natural ability to use fantasy at this age could actually aid him/her to figure out how to survive the ongoing traumatic abuse and he/she dissociates. As the cycle continues, the child eventually figures out how to dissociate to the point of creating another part of him/her self to be the vulnerable and abused one. It appears that dissociative identity disorder has many contributing psychodynamic features. Kluft (1984) agrees with this potential cycle as he recognizes one's "innate potential to dissociate" and that early childhood traumatic experiences "may disturb personality development, leading to greater potential for psychodynamic dividedness" (p. 20). Dissociative identity disorder is indeed a highly complex and multi-faceted disorder wherein both nature and nurture have impaired one's ability to function.

The Connection of Dissociative Identity Disorder and Satanic Ritual Abuse

There is a rising belief among therapists working with those diagnosed with dissociative identity disorder that there has been a missing piece to the puzzle to better understand and work with these clients. That missing clue being that a high percentage rate of individuals diagnosed with dissociative identity disorder are also victims of satanic ritual abuse. Friesen (1991) believes that some "50%-60% of those diagnosed are victims of satanic ritual abuse" (p. 209).

Friesen (1991) goes on to say that “we are not talking about spanking children too hard, or about the use of excessive forms of punishment. We are talking about children reporting that they were drugged, terrorized, and subjected to horrifying abuse, and that they witnessed the murder of animals and of other children during ceremonies of Satan worship” (p. 208).

Over the past few decades the field of psychology has improved its effectiveness in society as it has willingly accepted the awful truths that research was revealing regarding issues of abuse. For example, in the 1960’s there was rampant denial that any form of child abuse even existed. There seemed to be a belief that maybe “one in one hundred children were abused” (Friesen, 1991, p. 206). In the 1970’s incest finally came into focus of a possibility of being more widespread than previously thought and in the 1980’s victims of abuse and incest were finally beginning to be believed as telling the truth. As a result of these individuals finally being believed diagnoses such as multiple personality disorder, now known as dissociative identity disorder, began to rise (Friesen, 1991). Friesen (1991) proposes that the next wave of awareness that will take place in our society, especially in the world of psychology, is information surrounding Satanic ritual abuse as connected to dissociative identity disorder and hopes that an understanding of the spiritual nature of this form of extreme abuse will begin to be more widely understood.

As the field of psychology and more importantly society embraced the ugly truth of rampant child abuse and the reality of wide spread incest America improved. America improved in its ability to rescue, protect, and bring some restoration to these abused individuals by lifting the widespread cloak of shame surrounding abuse. As society and the field of psychology slowly embrace and believe what individuals diagnosed with dissociative identity disorder are sharing as

truth then the cloak of shame for them can be lifted as well. The American society is faced again with a truth that is becoming harder and harder to ignore and that is the possibility that some 100,000 or more individuals in our society have been victims to heinous evil acts through Satanic ritual abuse as children (Friesen, 1991).

One of the mainstays of working with individuals with dissociative identity disorder is to aid the client in breaking down the amnesiac, dissociative walls which have been constructed as a means of self-protection. One way to help break down these walls is to aid the individual in remembering the abuse he/she endured. As these walls begin to weaken more and more memories of trauma begin to rise. According to the research conducted by Bryant (1995) these memories are not delusions, hallucinations, or made up fantasy, in fact as research is revealing they are indeed memories of actual events that have taken place. The content of these memories is what is proving to be almost unbelievable for the client and therapist alike. They are memories including not only incestuous acts, but also themes of torture, memories of children even babies being sacrificed, memories containing murders being witnessed, the individuals are remembering others forcing him/her to drink blood, to drink urine, or consume feces. Individuals are also sharing memories containing wedding ceremonies to Satan vowing him/her self to be the bride of Satan. Many memories shared also contain unrealistic vows and oaths made to the loyalty of the occult and its members. The perpetrators of these despicable acts often are remembered as wearing either all black or all white robes. Other common themes in these memories include torture and programming through the use of electricity, specific tones, and even certain children's books all for the purpose to either access these individuals later or to protect themselves from the individual ever revealing the perpetrators true identities (Friesen,

1991; Rutz, Becker, Overkamp, & Karriker, 2008; Ryder, 1992 Vought, 2010). These are all signs of satanic ritual abuse for the purpose of mind control.

According to the *Report of the Ritual Abuse Task Force* from the Los Angeles County Commission for Women (September 15, 1989):

Mind control is the cornerstone of ritual abuse, the key element in the subjugation and silencing of its victims. Victims of ritual abuse are subjected to a rigorously applied system of mind control designed to rob them of their sense of free will and to impose upon them the will of the cult and its leaders. Most often, these ritually abusive cults are motivated by a satanic belief system. The mind control is achieved through an elaborate system of brainwashing, programming, indoctrination, hypnosis, and the use of various mind-altering drugs. The purpose of the mind control is to compel ritual abuse victims to keep secret of their abuse, to conform to the beliefs and behaviors of the cult, and to become functioning members who serve the cult by carrying out the directives of its leaders without being detected within society at large (p.1).

As Edmund Burke said “Evil prevails when good men do nothing”. I propose that the field of psychology embrace what these individuals are sharing as truth and conduct further ongoing research in this area of Satanic Ritualistic Abuse. I also propose that due to the spiritual nature of the abuse endured by these individuals that the therapies these individuals receive include truths from the field of psychology as well as truths of a spiritual nature.

Relevant Research of Adult Survivors of Extreme Abuse

In conducting the literature review for the topic of satanic ritual abuse as it is connected to individuals diagnosed with dissociative identity disorder it was very difficult to find much relevant, scientific research that has been conducted on this subject. With that being said, it can

still be deemed of utmost importance that accepting what is being shared by these individuals as truth, stories of extreme abuse such as satanic ritual abuse, could be the missing clue in genuinely understanding and subsequently effectively helping these individuals walk the road of true healing to their very core. A phenomenal international online survey that was conducted by Rutz, Becker, Overkamp, and Karriker (2008) with its intention “to explore commonalities reported by survivors of extreme abuse including, but not limited to, Ritual Abuse and Mind Control” appears to be the beginning of the necessary cutting edge research that sheds light into the actual experiences of those diagnosed with dissociative identity disorder (p.67). The full spectrum of this research including the purpose, the controversies, the methodology, as well as the results are found in the book titled, *Ritual Abuse in the Twenty-First Century*, edited by Noblitt and Noblitt in the chapter entitled, *Exploring Commonalities Reported by Adult Survivors of Extreme Abuse: Preliminary Empirical Findings* (pp. 31-84).

The purpose of this research was “to gather preliminary descriptive data to obtain indications of the nature and extent of extreme abuse like that suffered by ritual abuse/mind control survivors and to use our findings to give survivors voice, validation, and visibility” (Rutz et. al., 2008, p. 37). The conductors of this research were faced with issues of working with individuals reporting memories of trauma as described by the International Society for the Study of Dissociation (2005) as “seemingly bizarre abuse experiences such as involvement in organized occultist ‘ritual’ abuse and covert government-sponsored mind control experiments” (p. 2). Those working with individuals diagnosed with dissociative identity disorder are offered guidelines by the International Society for the Study of Dissociation. To address the controversy surrounding the existence of ritual abuse, the guidelines specify three opinions held by therapists including “clinicians who believe patients’ reports of organized abuse, other types of sadistic

events are misremembered as ‘ritual’ abuse and mind control, and can be explained as contagion, unconscious defensive elaborations, false memory, delusion, or deliberate confabulation”

(International Society for the Study of Dissociation, 2005, p.3).

In an effort to bring clarity to the clinicians working with these individuals and to “bring the existence of extreme abuse like that suffered by ritual abuse/mind control victims to the attention not only of mental health professionals, but also to the media and to individuals and organizations from around the world who are in positions to expose the hidden holocaust” the authors collaboratively brought to the table their skills, knowledge, and experiences to begin to conduct research on the very survivors reporting these memories (Rutz et al., 2008, p. 34).

The method of research used for this study was an extensive online survey titled, *Extreme Abuse Survey*, consisting of sections containing closed-response questions as well as one section using a Likert-type scale. The online survey used for this research was similar to the type of web based research used with the bisexual, gay, lesbian and transgender population as it has been found that research conducted in this fashion is more effective in reaching “subpopulations that are not easily identifiable, are decentralized, or are rare in the general population” (Rutz et. al, 2008, p. 37). The survey was offered in English and German including the following six sections: demographics, memories, possible aftereffects, personal experiences, healing methods, and categories of abuse (Rutz et. al., 2008).

Letters inviting survivors to go online and take the survey as well as asking the survivors to extend an invitation to others that they knew to go online as well to take the survey were sent out. “The target population for our study is defined as all adult survivors of extreme abuse including, but not limited to, ritual abuse and mind control who saw or heard about the announcement on December 31, 2006” (Rutz et. al, 2008, p. 39).

The method was scrutinized and criticized as to the validity of the potential results especially due to the nature of the survey being conducted online. Concerns expressing “the risk that clients might incorporate events that didn’t happen to them into their memory systems as well as fear that the mere exposure to the items might provoke intense anxiety in fragile, unhealed clients causing them to decompensate” were acknowledged (Rutz et. al, 2008, p. 44). Many therapists and clients offered support in response to these criticisms with the general consensus being that this survey is nothing compared to what these individuals have been through as well as a general desire to gain a better understanding of the atrocities that these individuals have been through in order to begin to fill the gap in the therapeutic process (Noblitt & Noblitt, 2008, p. 45).

Rutz et al. (2008) acknowledge:

Limitations on the external validity of the results drawn from online surveys are unavoidable and go on to say that however, we believe that the participants have provided valuable information that is consistent with what we have heard personally and professionally from persons who identify themselves as survivors of extreme abuse. For its limited purpose, we assert that our approach is consistent with acceptable descriptive social science research. It is a starting point from which other researchers can decide if further investigation is warranted (p. 48).

In other words, this is cutting edge research that through its enormous amount of collected data reveals a great deal of validity to the skeptics of ritual abuse with its connection to dissociative identity disorder. It also provided a safe way for survivors to begin to be heard, believed and to learn that they are not alone which in and of itself is healing.

The results were overwhelming in revealing a connection of satanic ritualistic abuse to the diagnosis of dissociative identity disorder as well as opening shedding light into other ritualistic forms of abuse such as mind control used through the occult rituals as well as government-sponsored mind control experiments. This research reveals the two are very often connected with one another. For example this data shows that “64% of 985 respondents reported memories of incest and 48% of 977 respondents reported memories of ritual abuse before they sought therapy and 69% of 257 respondents who reported secret mind control experiments used on them as children also reported having been abused in a satanic cult” (Rutz et al., 2008, p. 50). This research also reveals that these unspeakable acts are being perpetrated upon victims in other countries and not just here in America, in fact survivors report in this survey that often memories of trauma include individuals being transported internationally with the specific intention of being ritualistically abused in one form or another (Rutz et. al, 2008).

One thousand four hundred and seventy-one (1471) individuals from more than thirty countries participated in the Extreme Abuse Survey and the results were astonishing. The results, according to Rutz et al. (2008) in the categories of memories, possible aftereffects, personal experiences, and healing methods reveal the top five most frequently answered as “yes” in the survey. The top five memories reported by individuals in the Extreme Abuse Survey included, “receiving physical from perpetrators, sexual abuse by multiple perpetrators, other abuses, being threatened with death if I ever talked about the abuse, and witnessing physical abuse by perpetrators on other victims” (p. 49). No wonder these same individuals report the top five possible aftereffects of the extreme abuse to include, “sleep problems, painful body memories, posttraumatic stress disorder, unusual fears, and beliefs indoctrinated by perpetrators” (p. 50). The same individuals report the top five results of personal experiences to include, “I

have a spiritual belief system, I was subjected to ritual abuse/mind control at ages 3-6, I was subjected to ritual abuse/mind control at ages 7-13, I have been diagnosed with dissociative identity disorder/formerly multiple personality disorder, and I had memories of incest before I sought therapy/counseling” (p. 50). In understanding what these individuals have endured as well as how one’s internal belief system could be affected because of the extreme abuse it makes perfect sense that the five most frequently reported healing methods that were checked either “much help” or “great help” were “individual psychotherapy/counseling, supportive friends, creative writing, personal prayer/meditation, and journaling” (p. 50).

Other astonishing results were the high percentage of respondents containing memories involving murder. The results reveal 46%-54% answering “yes” to questions such as; “forced participation in murder by perpetrators, forced to murder (or made to think I had murdered) a baby, forced to participate in animal mutilations/killings, and witnessing murder by perpetrators” (Rutz et al., 2008 p. 57).

Any individual involved in any type of murder whether having witnessed or having participated somehow experiences many traits of posttraumatic stress, yet pile on top of that the many other forms of abuse these same individuals are reporting to have experienced as well. These same respondents’ results reveal that some 44%-79% answer “yes” to the following categories of abuse as well: “sexual abuse by multiple perpetrators, being caged, starvation, forced cannibalism, bestiality, buried alive, electroshock, sensory deprivation, sleep deprivation, incest, child pornography, and child prostitution” (Rutz et al., 2008, p. 58).

As Rutz et al. (2008) plainly puts it, “Now imagine that no one believes you. This is what it feels like to be an extreme abuse survivor” (p. 58). This information can be overwhelming and hopefully challenging for the present way in which the field of psychology

approaches those diagnosed with dissociative identity disorder and its connection to satanic ritual abuse. This information sheds a whole new light on what these individuals have endured, survived, and the way in which these individuals need to be helped.

Often there is no better way to describe what these individuals have suffered at the hands of intentional human beings for selfish power and control over others and what they continue to experience today except by hearing their own words. The following is a portion of an excerpt shared by a highly-respected researcher and clinical psychologist, who is also a survivor of ritual abuse and mind control. She writes this as a response to her involvement with the *Extreme Abuse Survey* and its research:

Tortured by the silence and self-hatred and trying to find some redeeming value in your own life after having your life threatened every moment creates an indefinable terror. Being buried alive with bugs or dead animals and later being rescued by the same torturer who is now your savior. Being brainwashed that you are one of them because you have had to kill an animal to save yourself or a sibling. Wrapped in paper and buried alive to later be thrown in a pond so that you can demonstrate how much you want to live. And, being raped and then forced to deliver and bury your own child when you are but a child is impossible to process. Repeated medical tests and intrusive treatments that the professionals can document but not explain contribute to a complete and utter hopelessness. This, the world needs to know (Rutz et al., 2008, p. 63-64).

What this research reveals is a strong connection of the diagnosis of dissociative identity disorder and satanic ritual abuse. When working with individuals diagnosed with dissociative identity disorder it is important to not lose hope. The field of psychology has encountered the diagnosis of dissociative identity disorder in its many forms for centuries and has worked to the

best of its ability to help improve the lives of these individuals. Once again, when someone is discouraged it is amazing what encouragement can do. This research does just that it gives encouragement for those suffering that they are not alone; answers to many of the questions that therapists have wondered when working with those diagnosed with dissociative identity disorder, and hope that as the field of psychology embraces this new found truth that both clinician and client will benefit from this new knowledge.

The field of psychology has an opportunity to grow and expand its ability to help those diagnosed with dissociative identity disorder by embracing what these individuals are sharing as truth. In order to grow it is important to take a look at what forms of treatment have been effective up to this point and then begin the integrative process that these individuals are seeking.

Traditional Forms of Treatment for Dissociative Identity Disorder

Once an individual has been properly diagnosed with dissociative identity disorder helpful therapeutic treatment can begin. There are many varying therapeutic theories and techniques that have proven to be somewhat effective (Klein & Landreth, 1993, MacGregor, 1996; Pais, 2009). The first being that the individual receive Carl Roger's approach of unconditional positive regard along with a therapist who is truly willing to walk the journey of healing with these individuals expressing encouragement along the way. An individual who has experienced any form of abuse silently suffers; however, when that same suffering individual musters up the courage to tell someone of the abuse only to find what they are sharing discarded, minimized, or entirely not believed well that just perpetuates the suffering. Adlerian therapists strive to join their clients by walking alongside others offering consistent encouragement and hope. For those diagnosed with dissociative identity disorder the journey can prove to be long. Dr. Vought (2010) agrees that the road to recovery for these individuals often takes years for one

to truly recover and remains confident that recovery is possible for many of these individuals. Approaches such as brief therapy or cognitive behavior therapy alone would not be enough. Ample research suggests effective and positive results for individuals diagnosed with dissociative identity disorder include a multi-model, integration approach including a psychodynamic approach as well as a cognitive behavioral approach using techniques such as those found in play therapy or internal family systems (Klein & Landreth, 1993, MacGregor, 1996; Pais, 2009).

The psychodynamic approach to working with individuals diagnosed with dissociative identity disorder holds the viewpoint that the etiology of this disorder includes the presence of extreme childhood abuse more specifically sexual abuse such as; “sadism, bondage, torture, prostitution” (Putnam, 1989). Extreme physical abuse such as; “burnings, torture, purification by bleeding, satanic rituals, and even live burial” (Wilbur, 1984, p. 5). The psychodynamic approach also holds the viewpoint that differing identities or alters manifest such as; child personalities, protector personalities, persecutor personalities, personalities of the opposite sex, nurturing personalities all of which serve a purpose to protect the core self (MacGregor, 1996).

There is an understanding among those who choose to use the psychodynamic approach when working with individuals diagnosed with dissociative identity disorder that “all psychodynamic treatments basically involve the same processes” (MacGregor, 1996, p. 401). According to Sakheim et al. (1988) this process can be considered a seven-step process including: 1) establishing the diagnosis, 2) developing awareness of multiplicity, 3) developing awareness of past history and the purpose of alters, 4) working through the dissociative defenses, 5) integration and fusion, 6) post-integration, and 7) termination.

Within each of the seven steps multiple techniques such as “mapping of the personality system, abreaction, hypnosis, repression-revivification, and fusion-integration” are generally used and proven effective (MacGregor, 1996, p. 391).

Coons (1986) points out that one very important factor to keep in mind is that the alter personalities are not people and that the personality system is driven by pain and conflict implying that dissociative identity disorder could be most effectively treated with a psychodynamic approach with the understanding that behavior is influenced by the interaction of emotional and motivational forces and mental states especially on a subconscious level. Coons (1986) further explains that he believes that “no other therapy can match the success of the psychodynamic approach” (p. 402).

It is important to remember that the goal of integration when working with individuals diagnosed with dissociative identity disorder remains one critical part in the overall process. When working through the various stages therapy must include providing a safe, trustworthy and comfortable place for the individual to begin to share the memories of trauma. This begins again with a therapist/client relationship built on trust and the client perceiving that the therapist believes the individual as well as the therapist supportively providing space for each alter to begin to share his/her story.

Establishing the diagnosis can often be the most difficult and frustrating stage for the individual as well as those working with these individuals. Many individuals that do finally receive the proper diagnosis of dissociative identity disorder have spent an average of “6.7 to 6.8 years in the mental health system and have been misdiagnosed three to four times” (Ross et al., 1989, p. 63). This once again reiterates the importance of building a trusting relationship with the individual. As the alters begin to present themselves the therapist is given the opportunity to

continuously join with each part building a sense of trust and safety. Putnam (1989) emphasizes “it is important to listen to all of the alters and not ignore or favor one over the others because cooperation is needed from all personalities” (p. 55). Joining and collaborative techniques become very useful during this first stage of therapy especially because this first stage of therapy is visited often when working with those diagnosed with dissociative identity disorder.

For those diagnosed with dissociative identity disorder it may take some time before the level of trust is built strong enough for the therapist to help the individual gain awareness of multiplicity. It is during this second stage of therapy that the therapist must be sensitive to what the individual can handle and use accurate clinical judgment as to how and when disclosure should occur. If sensitivity is not used the individual could engage in strong avoidant defenses to the point of quitting therapy resulting in the individual’s continued suffering without any kind of support (Sakheim et al., 1988). In preparation for the third stage of therapy using techniques to help maintain stabilization and developing new coping skills becomes necessary during the second stage of therapy. It has been suggested that use of suicide contracts, hospitalizations, hypnosis, and sometimes video feedback become necessary during the second stage of therapy to aid the individual in acceptance of the diagnosis as well as continual stabilization (Ross, 1989; Putnam, 1989; Sakheim et al., 1989). Another form of therapy that has proven successful in aiding in stabilization for those diagnosed with dissociative identity disorder and can easily be integrated into the psychoanalytic approach to therapy is the development of Dialectic Behavior Therapy (DBT) (Linehan, 1993). The individual can receive individual therapy alongside DBT group therapy as a means of developing effective daily coping skills in hopes of more effectively proceeding through stage three of therapy and even throughout life in general.

Stage three of therapy from the psychodynamic approach includes the individual understanding the diagnosis of dissociative identity disorder with the understanding of the presence of two or more alters. As Alfred Adler stated “all behavior serves a purpose”, this stage includes the individual coming to an understanding as to the purpose for the creation of the alter identities and then in turn finding a more useful behavior to manage present day life. This stage of therapy consists of the individual becoming aware of his/her early traumatic experiences and how each alter was developed as a means to protect the core self in order to endure the ongoing trauma. “The goal of this phase is to lessen and then eliminate the need for dissociative barriers” (MacGregor, 1996 p. 393). Due to the nature of the content of the memories that each alter shares during this stage of therapy it requires a therapist continually filled with unconditional positive regard along with a non-judgmental open mind. It is important that each alter perceive that the therapist believes what is being shared in order for each part to receive the necessary healing to prepare for integration. Sakheim et al. (1988) explains that “this is a period in treatment when traumatic experiences are brought to light and child personalities often emerge for the first time” (p. 120). With the understanding that it is estimated that 95% to 98% of individuals diagnosed with dissociative identity disorder have a history of child abuse it should be of no surprise that the majority of the traumatic memories are held by child alters (Klein & Landreth, 1993, p. 4).

Stage three in the psychodynamic approach with dissociative identity disorder is often where the therapist and individual spend the majority of time. It is during this stage of therapy that the therapist has an opportunity to be creative by integrating many therapeutic techniques into the ongoing therapy. The use of play therapy with the child alters during stage three of therapy aids the child alters in expressing varying emotions such as anger, pain, or terror as well

as giving the child alters an avenue to reenact the trauma he/she has endured non-verbally (Klein & Landreth, 1993). Research shows that internal family systems is another form of therapy that has proven effective with individuals diagnosed with dissociative identity disorder during stage three of the psychodynamic approach of therapy by aiding the individual to look at the system he/she has created internally as a family and introducing more of a systemic approach to his/her internal world (Pais, 2009).

Stage four of the psychodynamic approach includes working through the dissociative defenses. Often stage three and stage four overlap as the individual and therapist collaboratively work together to piece together the memories of trauma including events, emotions, and sometimes the people involved with the trauma. As the individual gains a clearer picture of what actually happened it can become easier for the individual to accept the other alters inside as an actual part of him/her self and the goal of this stage of therapy is for increasing internal communication amongst the alters. As this internal communication develops over time quite often the individual begins to experience overwhelming anxiety and often relies on previous defense mechanisms of dissociation to manage the anxiety. It is also of utmost importance that the individual have learned alternative effective life coping skills as opposed to dissociation to successfully endure this stage of therapy. Which is why it cannot be emphasized enough the importance of an ongoing therapeutic relationship including trust and strong healthy boundaries. The therapeutic relationship in this stage of therapy serves as the foundation for those working through the diagnosis of dissociative identity disorder and as this relationship remains stable other relationships for the individual will also begin to experience healthy changes (MacGregor, 1996).

Stage five of the psychodynamic approach to therapy begins the process of fusion and integration of alters. Putnam (1989) describes fusion “to be the process of removing the dissociative barriers that segregate specific alters and this is to be understood as the initial compacting process that lays the groundwork for integration” (p. 60). The process of fusion is basically two alter identities fusing together as one; however, not necessarily with the core part of the individual which is when integration takes place. “Integration is the complete and pervasive restructuring of the personality. It involves the combination of the separate alters and elements of alters into a unified personality” (Putnam, 1989, p. 61). Often throughout the various stages of therapy fusion and integration can take place with the understanding that stage five of the psychodynamic approach to therapy includes the ongoing process of developing the awareness of past history and the purpose of alter identities as well as continuing to work through the dissociative defenses (MacGregor, 1996).

Stage six of the psychodynamic approach to therapy is the post integration stage. “The purpose of this stage of therapy is to continue working with the multiple personality disorder patient to consolidate the new integrated self. The patient must also actively develop and use non-dissociative defense mechanisms within the context of a fully integrated personality” (MacGregor, 1996, p. 394). The individual diagnosed with dissociative identity disorder would have successfully worked through many intense memories of trauma along with the emotions, thoughts, and often behaviors associated with those memories and have been willing to integrate those memories into one whole identity. This is not to negate the idea that the individual could still be experiencing memories of trauma and all that goes along with those types of memories; however, at this stage the individual is successfully working as one whole identity and actively using more effective coping skills other than dissociation to do life so to speak.

The final stage of therapy would be termination. Once the individual has successfully integrated all of the identities and is successfully managing life with newly developed effective coping skills other than dissociation without disruption to the core self then theoretically the individual would be ready for termination (MacGregor, 1996). Often when working with individuals diagnosed with dissociative identity disorder the therapeutic road has been a long journey consisting of years of work by both the individual as well as the therapist. Even though integration is often viewed as the main therapeutic goal when working with those diagnosed with dissociative identity disorder, the termination stage remains a very vital part in the therapeutic process. It is at this stage that it is much like raising a child with the intention of preparing the child for the adult world to be an active, contributing member of society, who maintains healthy relationships, and experiences a full life filled with hope.

Building on the Psychodynamic Treatment for those Diagnosed with Dissociative Identity Disorder

According to studies conducted in the 1980's most therapists when working with those diagnosed with dissociative identity disorder work from a psychodynamic based eclectic approach that includes cognitive reforming and reports that the success rates for psychodynamic therapy to be about 66% (Kluft, 1984 & Ross, 1989). The psychodynamic approach to therapy has proven to be and continues to be an excellent foundation for therapists to work from when working with those diagnosed with dissociative identity disorder. It is also reported that "there is a certain group of multiple personality disorder patients who are presently unhelped by psychodynamic psychotherapy" (Coons, 1986, p. 718). Could this be the group of individuals diagnosed with dissociative identity disorder who have also been victimized through satanic ritual abuse? It has been suggested that with this knowledge that "the search for alternative

treatments and ways to improve on the success of existing psychodynamic treatments must continue” (MacGregor, 1996, p. 400). As recent research has revealed there is a connection of the diagnosis of dissociative identity disorder to satanic ritual abuse and well, this opens the door to a deeper understanding of the type of alternative treatments that could prove even more effective for those diagnosed with dissociative identity disorder hopefully resulting in higher treatment outcomes and people living whole lives filled with hope (Rutz et. al., 2008).

Keep in mind that there are a percentage of individuals diagnosed with dissociative identity disorder who do not respond well to the traditional psychodynamic psychotherapy approach alone and this it could be proposed that it is those individuals who have also been victim to satanic ritual abuse as well. These individuals have truly experienced both the nature and nurture contributing factors in the development of dissociative identity disorder. Little children, often babies have suffered at the hands of intentional cult leaders disguising themselves as prominent members in society. These individuals clearly understand the iatrogenic phenomenon, an infant’s vulnerability, as well as the effects of continued extreme abuse on an individual; all for the purpose of selfish ambition, personal power, and to fulfill the lusts of the flesh.

Miller (2008) reports that organized cults will typically intentionally create in infants:

An original group of ‘foundational’ alters which are split off between the ages of 6 weeks and 6 months by means of loud noises, bright lights, small electric shocks, and other noxious and shocking stimuli, so that by the age of 6 months the child has at minimum 18-20 alters. Each alter will come out in response to the trigger that created it. These infant alters are trained to recognize their names, special colors, magical symbols, and location in the structure, which is simulated in the outside world so that the child will

internalize this image of who all the alters are and where they 'live' on the inside (p. 445).

These little babies have completely had all personal power stripped of them and a very confusing, scary, and tortuous lifestyle was given to them instead. Ryder (1992) describes this intentionality on the part of the cult leaders as a "cult split" (p. 153). It has been reported that members of the cult will intentionally create alters in a victim. Members of the cult will use scare tactics including torture, some type of sensory deprivation, and/or starvation to induce a dissociative state in an individual. Once this dissociative state has been achieved, a cult member will actually "call forth a new alter, name it, and tell him/her which demon they belong to" (Ryder, 1992, p. 153). These alters serve a purpose for the individual as well as for the cult. The individual has gained the ability to dissociate from some of the heinous assignments differing alters are given by the cult. For example some alters are asked to commit crimes involving murder, torture, or extreme sexual acts. Other alters may be assigned to bring a person back to the cult later in life. While another alter may "be designated to commit suicide if the system starts to get close to the memories" (Ryder, 1992, p. 153). No wonder some individuals diagnosed with dissociative identity disorder present with what the International Society for the Study of Dissociation (2005) describes as "seemingly bizarre abuse experiences" (p. 3).

In order to know how to effectively work with those diagnosed with dissociative identity disorder and satanic ritual abuse therapists first need to know what signs or clues to look for in these individuals. Holly Hector, a psychotherapist who has worked with individuals diagnosed with dissociative identity disorder and satanic ritual abuse since the late 1980's has put together several lists of symptoms and indicators including behavior, psychological, obsession/compulsions, and possible fears and phobias that could help clue the therapist in on

when there has been satanic ritual abuse (Ryder, 1992). The symptoms generally include symptomatology from a variety of diagnoses such as Post Traumatic Stress Disorder, Obsessive Compulsive Disorder, Schizophrenia, Borderline Personality Disorder, Anxiety, and Depression all within the same individual. According to Ryder (1992) additional symptoms or indicators to look for could include individuals with missing digits (fingers), a noticeable aversion to drinking water (prefers tea, pop, juice), speaking in unknown languages, speaking in different voices—extreme intonation changes, draws or doodles satanic or occult symbols, strong reactions to circles even discomfort when sitting in a group formed in a circle, heightened phobias of items such as coffins, trunks, boxes, cages, raw meat, and particular colors (red, black, white). These are greatly discouraged individuals reporting horrendous memories of ritualistic abuse who all too often get “diagnosed” rather than encouraged. Because of the evil spiritual nature of abuse these individuals have endured it seems to be necessary for the treatment these individuals receive to also consist of a more holy and pure spiritual nature filled with hope.

Integrating Spiritual Truths

Understanding that individuals diagnosed with dissociative identity disorder and satanic ritual abuse have undergone vial attacks against one’s psyche, physical body, and soul leaving prominent residual damage to every aspect of one’s life would suggest that one’s therapy be holistic, all inclusive and meet the needs of these individual’s body, mind, and spirit as well. Friesen (1991) agrees that “it is becoming evident that satanic ritual abuse survivors need their therapy to include spiritual as well as psychological interventions” (p. 210). It could be implied that due to the spiritual nature that seems to be connected with extreme abuse like that of satanic ritual abuse offering an individual an exception to the rule experience so to speak in regards to a spiritual experience could bring about further restoration in one diagnosed with dissociative

identity disorder. If the therapy could intertwine effective techniques such as those that hold truths of psychology and truths of a spiritual nature, it could be suggested that one with the diagnosis of dissociative identity disorder and satanic ritual abuse could experience deeper restoration. Ball (2008) contends “that along with pharmacology, sound psychotherapy, nutrition, exercise, dependable support structures, and a number of other good things, God does make available to believers the special ministries of prayer for inner healing of memories” (p. 414).

Friesen (1991) believes that showing the interconnectedness between psychological and spiritual restoration and its effectiveness when working with individuals with the diagnosis of dissociative identity disorder and satanic ritual abuse is a beginning to healing the spiritual part of the holistic individual. He uses stories from the Bible that express thoughts of how there is a “love that is great enough and a power that is strong enough” in stories such as the one of the prodigal son from Luke 15: 11-22 to express how much love a father can have for his children no matter what has happened and compares that to how God has that same love for people. He uses another story from the book of Judges that speaks of the power of God given to Gideon and his men to enter into the “promised land” that had been taken from them by the Midianites. Gideon and his men won that battle without any bloodshed. He emphasizes this point that there is a power strong enough to do battle for us and it does not require any more human blood being shed. He goes on to express how when one feels weak and hopeless at times, especially while undergoing therapy, there is a power that one can draw upon that is far greater than any human being.

Ryder (1992) emphasizes his agreement that there is indeed a spiritual aspect to working with individuals diagnosed with dissociative identity disorder and satanic ritual abuse that cannot continue to go on being overlooked.

Therapists can't gloss over the spiritual aspects of the abuse and recovery when it is commonly being reported to hear ritually abused children say things like: 'I can't go in the bedroom—the devil is there,' or 'I know the god below wants me to...' He goes on to say that "It is ineffective to simply ignore the underlying references to evil and deal only with behavior modification. Since much of the abuse revolved around 'dark side' spiritual abuse and programming, children continually need to be reassured that there is another, 'good' spiritual power that is stronger and can protect them (p. 43).

Those diagnosed with dissociative identity disorder and satanic ritual abuse generally have a deep spiritual faith as part of his/her internal system as well as a dark space, badlands, or dark forest as some call it where the cult loyal alters generally dwell. They also report an understanding or belief that there truly is a supernatural realm involving "a rival force of evil, such as Satan and demons" (Lacter and Lehman, 2008, p.112). Others agree that more often than not when working with individuals diagnosed with dissociative identity disorder and satanic ritual abuse these individuals believe that they commonly experience harassment both internally and externally by evil spirits. There is a belief that evil spirits have attached themselves to differing parts or alters and often express feeling controlled by these evil spirits or demons (Lacter & Lehman, 2008; Rutz et. al., 2008; Vought, 2010). Individuals who have experienced extreme abuse involving that of a spiritual nature report a deep personal belief in the existence of God as well. In this belief it has been shared by many survivors that a source of divine guidance and support comes from one's "personal relationship with God with this relationship often

beginning with a profound spiritual experience while being tortured as a child” (Lacter and Lehman, 2008, p. 112).

It is important that children and adults alike who have been victim to continual atrocities including ones of an evil spiritual nature that these individuals be assured over and over again that “they are inherently good and that what was done to them or what they did to others could not be helped” (Ryder, 1992, p. 44). It is also extremely important for those therapists choosing to work with individuals diagnosed with dissociative identity disorder and satanic ritual abuse who hold such strong internal spiritual belief systems that he/she firmly know and are confident in their own beliefs around the spiritual dynamics of good and evil.

The survivors themselves are reporting that in addition to the traditional forms of therapy such as talk therapy, exercise, supportive friends, journaling, art therapy, increased self care just how incredibly effective alternative techniques such as personal prayer/meditation, spiritual guidance/counseling, theophostic prayer, and even deliverance has deepened their overall healing journey (Rutz et al., 2008).

It is by hearing from the survivors themselves that true clarity surrounding the diagnosis of dissociative identity disorder begins. Relevant research addressing pertinent and applicable data surrounding what could be the missing piece to the puzzle in understanding a majority of those diagnosed with dissociative identity disorder has just begun. If the field of psychology continues to build upon the plethora of knowledge that already exists by gleaning new insight from this significant research the ability to holistically improve another’s life could deepen. Making it essential that further, ongoing research surrounding the subject of dissociative identity disorder and its connection to satanic ritual abuse and mind control continue. These individuals are seeking others who believe what they are saying is truth and others who contain the

willingness to gain the wisdom and knowledge as to what it takes to help bring freedom and hope into their lives.

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