INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
Multiple personality disorder in conjunction with satanic ritual abuse, an educational training film: A survey of need

Brockman, Pamela Faye, M.A.

The University of Arizona, 1992
MULTIPLE PERSONALITY DISORDER IN CONJUNCTION WITH SATANIC RITUAL ABUSE, AN EDUCATIONAL TRAINING FILM: A SURVEY OF NEED

by

Pamela Faye Brockman

A A Thesis Submitted to the Faculty of the SCHOOL OF FAMILY AND CONSUMER RESOURCES In Partial Fulfillment of the Requirements For the Degree of MASTER OF ARTS WITH A MAJOR IN COUNSELING AND GUIDANCE In the Graduate College THE UNIVERSITY OF ARIZONA 1992
STATEMENT BY THE AUTHOR

This thesis has been submitted in partial fulfillment of requirements for an advanced degree at the University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the library.

Brief quotations from this thesis are allowable without special permission, provided that accurate acknowledgement of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his or her judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: [Signature]

APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

[Signature]  Nov. 18, 1992
Dr. Betty Newlon  Date
Professor of Family & Consumer Resources
ACKNOWLEDGEMENTS

I extend my deepest appreciation to each of those people who have given their time and interest to this project over the past two years.

To my committee chair, Dr. Tom Schramski for his limitless supply of patience, support, and encouragement; especially for his editing suggestions. To my other committee members, Dr. Betty Newlon, and Dr. Norma Gray, my thanks for their support throughout the project.

To my husband, Scott, and my children — Luke and Sam. They have put up with so much, especially at those times nearing deadlines. Without their support and loving understanding at home, I could not have completed this project. Also to my great friend Jeff Wright.
TABLE OF CONTENTS

ABSTRACT .................................................................................................................. 6

CHAPTER 1 — INTRODUCTION .............................................................................. 7

Purpose of the Study ................................................................................................. 8
Hypotheses .................................................................................................................. 9
Significance of The Study ......................................................................................... 9
Assumptions .............................................................................................................. 10
Limitations ............................................................................................................... 10
Definition of Terms .................................................................................................. 10
Credibility Issue of SRA: .......................................................................................... 32
Summary .................................................................................................................. 35

CHAPTER 2 — REVIEW OF LITERATURE ............................................................... 36

Introduction ............................................................................................................. 36
Historical Perspective of MPD ................................................................................. 36
MPD Treatment, a Controversial Area ..................................................................... 40
Diagnosis, Another Aspect of The Controversy ....................................................... 43
Current State of Clinical Knowledge ....................................................................... 45
MPD/SRA, Diagnosis and Treatment ...................................................................... 46
Historical View of Mental Health Video Training Films ............................................ 48
Video Applications in Mental Health Professional Training ................................. 51
Modeling .................................................................................................................. 51
Summary .................................................................................................................. 53

CHAPTER 3 — METHODOLOGY ............................................................................. 54

Survey Method ......................................................................................................... 54
Subjects ..................................................................................................................... 55
Materials ................................................................................................................... 56
Procedure .................................................................................................................. 56
Summary .................................................................................................................. 57

CHAPTER 4 — RESULTS .......................................................................................... 58

Introduction ............................................................................................................. 58
Description of the Sample ....................................................................................... 58
ABSTRACT

The issue of satanic ritual abuse has gained widespread public and professional attention in the past ten years. During therapy, many adult Multiple Personality Disorder (MPD) clients describe memories of Satanic Ritual Abuse (SRA) beginning in childhood. Basically, the only information circulating in the mental health professional community about MPD/SRA issues is derived from workshops and lectures at trainings and professional meetings.

The intent of this project was to determine the need for an in-depth educational training film for mental health professionals to assess, diagnose and treat satanic ritual abuse survivors in conjunction with multiple personality disorder. A questionnaire was used to determine whether a video educational training film would be beneficial. The conclusion was reached that an educational training film would be useful in helping mental health professionals. It was also concluded that educational training films in the behavioral sciences is an effective training tool.
CHAPTER 1
INTRODUCTION

Reports of Multiple Personality Disorder (MPD) in conjunction with Satanic Ritual Abuse (SRA) began emerging publicly in the early 1980's (Smith, M. & Pazder, L., 1980). Accounts continue to come from the television and news media, law enforcement sources, psychotherapists, clergy working with mental health professions, and both child and adult survivors. While professional literature on the topic of SRA is nearly non-existent, MPD literature acknowledges that clients are reporting SRA beginning in childhood (Braun & Gray, 1986). Many professional groups and the public are becoming concerned about the issue. Therapists who treat MPD clients suggest a link between MPD and SRA accounts (Kaye & Klein, 1987).

Organized lay groups are providing concerned citizens with some educational material and linking MPD/SRA survivors with professional resources. Adult SRA survivors have begun networking and forming support groups (Benschoten, 1990). Published accounts alleging and describing satanic ritual abuse are beginning to come forward (Antonelli, 1988; Marron, 1989; Smith & Pazder, 1980; Spencer, 1989). The topic of SRA is being addressed at conferences sponsored by numerous psychiatric
and psychological organizations, including the International Society for the Study of Multiple Personality and Dissociation, the National Coalition Against Sexual Assault, the National Conference on the Sexual Victimization of Children, the U.C. Berkeley Rape Prevention Education Program, and several regional groups in the United States studying and treating MPD (Braun & Sachs, 1988). In 1989, a few papers and workshops on satanic ritual abuse were presented in Arizona, California, Colorado, Georgia, Illinois, North Carolina, Ohio, and Virginia (Benschoten, 1990).

Programs have been developed in the last ten years to diagnose and treat MPD which have been described in either journal article texts and seen in a few video films (Braun, 1986). However, there is virtually no professional treatment programs developed specifically for MPD/SRA clients. This study suggests video educational training films in the mental health profession is an effective tool in teaching therapeutic skills and increases involvement in training (Benschoten, 1965).

Purpose of the Study

The major purpose of this study was to ascertain if a video educational training film which deals with specific diagnosis and treatment suggestions for persons experiencing multiple personality disorder (MPD) in conjunction with satanic ritual abuse (SRA) would be beneficial as a teaching tool for professionals in the mental health field.
Hypotheses

The general hypotheses for the study were:

1. The majority of mental health professionals involved with MPD/SRA clients believe that a video education training film would assist them to understand and learn treatment and diagnostic tools specific for their clients.

2. The information received from mental health professionals on the questionnaire would lead to a prospectus for an educational training film.

Significance of The Study

Review of pertinent literature indicates that there has apparently been an increase in sexually abused clients who have been diagnosed as having MPD, with allegations of SRA abuse (Brown, 1986; Kluft, 1989; Putman, 1989; Benschoten, 1990; Young, Sachs, Braun & Watkins, 1991). However, there is still very limited information in any media form that instructs mental health professionals on treatment, diagnoses or defines multiple personality disorder in conjunction with SRA.
Assumptions

The following are the assumptions upon which this study was based:

1. The sample mental health professionals are representative of the population for which the results of this study would most benefit.

2. The response from the sample of mental health professionals will be useful information that would lead to an educational training film.

3. The sample of mental health professionals were somewhat familiar with the issues surrounding MPD and SRA.

Limitations

The limitations of the study were:

1. Questionnaires of this type are often accompanied by a low response rate.

2. There is limited control for individual bias.

3. There is the possibility that the questions are too vague and open-ended, which could limit validity of the results of the study.

Definition of Terms

Due to their use throughout the study, the following terms need clarification:

Multiple Personality Disorder: The official definition in The Diagnostic and Statistical Manual of Mental Disorders Revised (DSM III R, 1987), the
manual that classifies mental disorders which is accepted by mental health professionals and is used in all research and settings, states:

1. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

2. At least two of these personalities or personality states recurrently take full control of the person's behavior (p. 272).

Brown and Braun (1979) unite classic and contemporary descriptions:

One human being demonstrating two or more personalities with identifiable, distinctive, and consistently ongoing characteristics, each of which has a relatively separate memory of its life history. . . . There must also be a demonstration of the transfer of executive control of the body from one personality to another (switching). However, the total individual is never out of touch with reality. The host personality (the one who has executive control of the body the greatest percentage of the time) often experiences periods of amnesias, time loss, or blackouts (other personalities may or may not experience this) (Brown & Braun, 1979, p. 179).

Personality is the characteristic way in which a person thinks, feels, and behaves, the ingrained pattern of behavior that each person evolves, both consciously and unconsciously, as the style or way of being in adapting to the environment (Talbott, Hales, & Yodofsky, 1988, p. 1261).
In MPD, Personality is defined as a relatively enduring pattern of perceiving and relating to one's self that is exhibited in a wide range of important social and personal contexts. According to the American Psychiatric Association (1987), personality states differ only in that the pattern is not exhibited in as wide a range of contexts.

Alter personalities are psychological structures, not separate people. Most cases in older literature had relatively few personalities. Forty-eight of the 76 clients reviewed by Taylor and Martin (1944) had two, 12 had three. However, among cases before 1979, “Sybil” had 16 personalities, “Eve” 22, and Billy Mulligan had 24. Kluft (1979) reported a “model range” of 8 to 13 personalities. In 1991, reports were coming forward with clients having as many as 2500 personality states (Kluft, 1991).

Clinically, the personalities’ overt differences and disparate self-conception prove puzzling and striking. They may experience themselves as of different genders, ages (older and/or younger), and sexual orientations. They may have separate wardrobes, possessions, pursuits, and interpersonal styles. Their values and beliefs may be different and they may manifest problems that diverge. Some may have symptoms which others in the system do not experience (Braun, 1983). Their behavior reflects their inner senses of difference. An important issue is that they may have received completely different diagnoses before the MPD was discovered.
Psychophysiological variations are documented (Braun, 1983). Different handwritings and different handedness are seen. Voices, vocabularies, speech patterns, accents, and even languages may vary. The facial expressions of several personalities, both when “neutral” and affectively engaged, may show dramatic and consistent differences, as may their movement characteristics. When personalities have acquired separate wardrobes, followed different interests and chosen different avenues of creative expression, their distinctive personalities can definitely be marked (Kluft, 1985).

The different personalities usually come into existence to serve defensive purposes. Many acquire a high degree of secondary autonomy and narcissistic investment in separateness. While not psychotic, personalities may behave with the conviction that the actions they take against other personalities will not affect “themselves” or “their bodies.” They may try to kill one another, refusing to concede that the death of the body dooms all, or mutilate the body and say that the personality that the body belongs to is now ugly, while they are untouched (Kluft, 1984).

The classic “host personality” is the alter or separate identity that is in executive control most of the time, over a given period of time. They often seek treatment, are depressed, anxious, suffering from exhaustion, compulsively good, masochistic, conscience-stricken, constricted hedonically, and suffer both psychophysiological symptoms and time
loss/distortion (Braun, 1986). Personalities can be fearful, recalling traumas, or love-seeking. Some personalities are protectors, helpers/advisors, inner self helpers, guardians of memories and family secrets. They are also memory traces, inner persecutors (often based on identification with the aggressor), expressors or forbidden impulses (pleasurable and otherwise, such as defiant, aggressive, or antisocial). They can be avengers (which express anger over abuses done and may wish to redress the wrongs), defenders or apologists for the abusers. Some personalities are based on lost love objects or identifications, specialized encapsulators or traumatic experiences and affects, which preserve the idealized potential for happiness, growth and the healthy expressions of feelings distorted (by trauma) in others.

Personalities may or may not be aware of one another. Some may have alliances, inner relationships, or ongoing civil wars. Some are protected and/or suppressed by others, such as a child guarded by a protector, or an avenger or expressor of some feeling perceived as dangerous controlled by those who fear the consequences of such actions or expressions. Inner persecutors, a common type, often are responsible for resistance, self-harm, and suicide attempts. They may "punish" others for cooperating in therapy. They may be based on actual abusers or culturally-accepted representations of evil intent which were created during SRA.
Diagnosis of Multiple Personality Disorder (MPD): The diagnosis of MPD, which has been the subject of several studies (Coons, 1984; Kluft, 1987b, 1988a; Solomon & Solomon, 1982; Putman, 1989; Ross, Heber, & Norton, 1989, and Coons, Bowman, & Milstein, 1988) found that a series of MPD clients averaged 6.8, 7.1, and 7.0 years between their entry into the mental health system and their receiving the MPD diagnosis.

MPD or Dissociative Disorder Not Otherwise Specified (Zuckerman, 1990) with the structure of MPD, should be suspected whenever both alternating separate identities and episodes of amnesia or time distortion are present. This condition is often covert and unobtrusive for long periods of time, that the client may resist sharing data relevant to the diagnosis. Also, because there are so many symptoms associated with MPD, the mental health professional can become confused. According to Kluft (1987b), there are manifestations that would warrant scrutiny for MPD: 1) prior treatment failure, 2) three or more prior diagnoses, 3) concurrent psychiatric and somatic symptoms, 4) fluctuation in symptoms and levels of functioning, 5) severe headaches and/or other pain syndromes, 6) time distortion, time lapses, or frank amnesia, 7) being told of disremembered behaviors, 8) others noting observable changes, 9) the discovery of objects, productions, or handwriting in one’s possession that one cannot account for or recognize, 10) the hearing of voices (80% experienced as within the head) that are experienced as separate, urging the client toward some
activity. 11) the client's use of "we" in a collective sense and making self-referential statements in the third person, 12) the eliciting of other entities through hypnosis or a drug facilitated interview, 13) a history of child abuse, and 14) an inability to recall childhood events from the age of 6 to 11. Although the inability to recall childhood events is universal, for the MPD client, there are periods of amnesia with regard to grade school and preadolescent years.

Lowenstein et al. (1988) stated that if a client exhibits: 1) differences in behavior, linguistic indications or language accents, switching, 2) signs of high potential for hypnosis, 3) amnesia, 4) somatoform symptoms, 5) PTSD symptoms and 6) affective symptoms, the client is highly likely to have MPD.

Overt manifestations of MPD may not be readily distinguished in the first or second diagnostic encounter. On occasion, a tentative diagnosis can be obtained with history, data and clinical judgment. Some mental health professionals ask their clients to keep journals for at least 30 minutes a day because other personalities might make themselves known. Also, longer initial sessions of approximately three hour can be helpful for spontaneous dissociation to be witnessed (Kluft, 1987b, 1987d).

Three structured interviews for the diagnosis of MPD have been devised. The Dissociative Disorders Interview Schedule (DDIS) of Colin Ross, M.D. (Ross, 1989a) is a 131-question instrument, has demonstrated
a 90% sensitivity and a specificity of 100%. It allows the client to endorse, or not to endorse, a series of symptoms keyed to various DSM-III-R diagnostic criteria (Kluft, 1991). The Structured Clinical Interview for Dissociative Disorders (SCID-D) (Steinberg, Rounsaville & Cicchetti, 1990) is a more elaborate interview currently undergoing field trials. It is extremely comprehensive and sensitive and has shown the capacity to support the diagnosis of previously unsuspected cases of dissociative disorders. The Dissociative Experiences Scale of Bernstein and Putman (1986) has proved a useful screening instrument which focuses on epidemiologic questions.

**Treatment of Multiple Personality Disorder:** The terms “unification,” “integration,” and “fusion” are often used synonymously and are understood to connote the spontaneous or facilitated coming together of personalities after adequate therapy has helped the client to see, abreact, and work through the reasons for being of each separate alter. But in the MPD field integration refers to the ongoing process of undoing the separateness of personalities before there is any reduction of alters. This persists through fusion, which is the coming together or unifying the person. It becomes apparent when fusion has truly happened if after three months the client has 1) continuity of present memories without any time lapses, 2) an absence of overt behavioral signs of MPD, 3) a subjective sense of unity, 4) absence of alters re-exploration, 5) modification of transference
with bringing the personalities together, 6) and clinical evidence that unification is acknowledged by the client through awareness and attitudes (Kluft, 1982, 1987).

Professionals differ as to whether integration should be pursued. Putman (1989) observed that it is the client’s right to remain multiple. Nonetheless, the vast majority of experienced therapists value integration and find that clients who continue to stay multiple tend to dissociate to the point that it is ego-weakening.

Braun (1986) and Putman (1989) outlined what they believe to be the phases an MPD client must work through for treatment to be successful.

1. Establishing psychotherapeutic alliance: involves the creation of trust and an atmosphere of safety. When the client begins to understand the concept of the treatment alliance and the nature of the treatment is explained, the hope is to establish a confidence in the process.

2. Preliminary interventions: involves gaining access to the more readily reached personalities, establishing agreement or contracts with the alters against harming the client, or stopping therapy without telephoning, supporting communication and cooperation among the alters, expanding the treatment to include alters who will share the diagnosis and treatment modalities, and helping the client gain relief from symptoms.
3. In establishing communication with the alters, there will be alters who will spontaneously emerge in therapy and cannot leave or really know how to. Hypnosis or hypnotic techniques without hypnosis, may be helpful.

4. History gathering and mapping refers to learning more about the personalities; why, how, when, and where they originated, and what their relationship is among them. Also, what are their names, how old they are, and what is their function to the system.

5. Begin to work with the problems of each individual personality. It is important for the therapist to support the client to remain with each personality as they work through their personal issues. MPD clients, out of fear, can move through many personalities in a very rapid pace. This is also where the personalities can begin to work with each other in a group therapy session.

6. Moving toward integration-resolution involves the working through the reclaimed memories. As communication increases among the alters, internal conflicts come to the forefront and can be worked through. During this phase, clients begin to blur some of the personalities. When integration is established, this then brings on unification.

7. Learning new coping skills is quite important at this stage. The client begins to learn and practice new behaviors in a safe environment.
New perspectives of their lives begin to emerge and the therapist must support the client in not running away via dissociation. Networking and social support groups are very useful as a therapy adjunct. These groups can provide a safe environment and helps the client to return to the community.

8. Follow-up is essential for several different reasons. It is important that the stability of the client is assessed and to assess whether other layered personalities have or have not emerged.

Working with the MPD population requires a prolonged, arduous and painful experience for the client, who may be dealing with difficult material for years on end. Ideally, a minimum of two session a week is desirable, with an opportunity to double the session time. Putman (1989) advocates 90 minute sessions. Being available to clients via telephone is also advantageous because those who begin to become aware of memories are in a constant state of crisis.

**Satanic Ritual Abuse (SRA):** Ritual abuse may or may have satanic overtones. However, many of the allegations of ritual abuse which have surfaced over the last twelve years specifically implicate allegiance to or worship of Satan as the bases for accomplishing or justifying the ceremonial activities performed. For semantic reasons it is important for mental health professionals to be aware of the fact that “satanism” has been used
as an umbrella term to refer to religious practices which may be similar to but not synonymous with Orthodox Satanism (e.g. Santeria, Voodoo). It is also essential for the professional to differentiate between varying degrees of involvement in Satanism (e.g. dabblers, self-styled, public Satanic churches, and orthodox churches). Beginning assessment of degree of involvement may be based on apparent level of secrecy, with the orthodox aspect being at one end of the continuum as the most secret and apparently the most widely networked, organized and ritualized (Snowden, 1990).

Survivors of Orthodox Satanism all over North America have similar reports of a religious network characterized by a belief system which includes sacrificing humans and routine torture of children in worship of Satan as the primary deity. Survivors further report that Orthodox Satanists continuously seek new “recruits” (children, adolescents and adults) to be used by the cult. However, inner circle positions involving knowledge of the larger hierarchical network will generally be held only by those into the cult indoctrinated at a young age (Snowden, 1990).

There are commonalities in the descriptions from children (Jonker & Jonker-Bakke, 1991) and from adults recalling their childhood experiences (Young, Sachs, Braun & Watkins, 1991). Both sources have described perverse sexuality with sadistic elements such as the inserting of sticks or objects into the vagina, anus, or penis. Children have reported being silenced by extreme physical violence and threats accompanying the sexual
violence. Subsequently, the children have become terrified to tell anyone because of guilt, shame, and secrecy. Very often the children were young when first initiated into these activities. Later on, sex between children was encouraged by the abuser, which seems to have had the effect of deepening the children's guilt and restricting opportunities for disclosure. Children described the sexualization of defecation and urination and allege that they were given drugs and/or alcohol before and during such activities. Some children have described that either they or their abusers dress up with masks, robes, and other unusual clothes. If the abuse involved more than one child, parties and group games may have been used to initiate new recruits, lowering the resistance to becoming involved in worse activities. Sometimes pornography was a prominent feature, seemingly both for its own sake, and to lower the children's resistance by normalizing the activities. Finally, in some instances, all these elements are sometimes coordinated into satanic ritual and a belief system in which the children participate and are misused sexually and physically as an integral part of the religion. (Satan is the proper name for the supreme evil spirit and satanism describes the principles as well as the rites and practices of those who believe in and worship Satan.) Descriptions given by children include being tortured or witnessing the sacrifice of animals and humans, the consumption of bodily parts and fluids, and burial ceremonies (Jones, 1991).
MPD with SRA: Adult MPD clients in psychotherapy are reporting memories of explicit satanic ritual abuse beginning in childhood. The authors of two limited surveys, conducted with a select group of MPD therapists, suggest the percentage of reported satanic abuse in the MPD population to be 20% (Braun & Gray, 1986), and 28% (Braun & Gray, 1987). A survey by Kaye and Klein (1987) reveals that 20 of the 42 MPD clients in treatment with seven Ohio therapists describe a history of satanic ritual abuse. Hopponen (1987) states that 38 of the more than 70 MPD clients she has treated report memories of satanic-type ritualized abuse. Two impatient facilities specializing in the treatment of MPD report that approximately 50% of their clients disclose memories of satanic ritual abuse (Braun, 1989a; Ganaway, 1989).

Similar accounts of satanic ritual abuse are being reported by personally unrelated MPD clients from across the United States (Braun, 1989a; Braun & Sachs, 1988; Kahaner, 1988; Braun & Sachs, 1987). In addition, according to Braun (1989b) and Jones (1991), the reports of clients in this country are similar to data collected from adult survivors in England, Holland, Germany, France, Canada, and Mexico.

Brown (1986) notes many similar allegations in child and adult survivors of SRA. This suggests that reports are not only comparable across geographic and personal boundaries but across generations as well.
According to Snowden (1990), it would be impossible for a survivor of orthodox Satanism not to develop some form of dissociative disorder. The more extensive the cult involvement and the earlier the age of initial exposure, the more entrenched the dissociative disorder or multiplicity will be. Due to cult injunctions regarding secrecy, internal splitting, fragments, or personalities may show quite subtle presentations and are difficult to diagnose. The cult's very survival as a clandestine organization depends upon maintaining the dissociative splits of those members destined to survive and function in the non-cult world. When high level cult leaders assume total responsibility for their positions (usually age 41), they become consciously aware of their cult role.

The form of MPD found among survivors differs from non-SRA MPD in that the perpetrators traumatize children to consciously induce amnestic barriers and different personalities to handle different tasks in service of the cult. Normally, it is believed that MPD develops as a self generating defense against overwhelming trauma to the person. Conscious awareness of traumatic events is altered to some degree as the trauma is split off or internally compartmentalized, thus forming personalities, fragments or memory traces. MPD/SRA develops: 1) as a self-generated defense system, and 2) as prescribed and induced by cult rituals and brainwashing (Snowden, 1990). Examples relevant to cult induced MPD, are as follows: The survivor child may be paired with a disposable child to promote
bonding. Then the disposable child is sacrificed and the survivor is called by the dead child's name, given "staged transfusions/grafts" from body parts of the dead child. This can also be done with siblings. The survivor child may contribute to incorporating the identity of the dead child to decrease survivor guilt and recurring aloneness (Braun, 1986).

Other cult names will be associated with certain programmed tasks and their related trigger cues. Some personalities will refuse to be called by names (in therapy), perceiving names as giving others control over them. It is routine for cult children to be called by distinctly different names at different times. Some names are purely symbolic; the form of the name is a verbal cue, which can signify a demon or ritual. Certain named alters may have been subjected to more precise programming and are most susceptible to cult control later in life. In therapy these alters are essential to uncover because of the self-inflicted pain they could produce.

One of the processes clinically believed to contribute to internal spitting is inconsistent environmental response to the same behavior. The confusion the cult and the inconsistencies perpetrated on the children, supports the child having no self perceived impact at all upon relationship interaction (Benschoten, 1990). An example of this is if the cult member would dress the child in nice clothes, telling the child he/she were going to a special party where he/she would be the guest of honor, through hypnotic suggestion and or drug induction. The child then participates in
death rituals victimizing others while suffering rape, bizarre tortures, death rituals involving torture, incest, perverted sex, animal and human sacrifice, cannibalism, and necrophilia. The next time the child would receive pretty clothes and truly become the "little darling of the party."

The trauma experienced by survivors is so extreme that the memory of one event may be split between numerous personalities or fragments. The cult also programs various alters to be mute, deaf, blind, etc., so as to fragment the memory of ritual participation and therefore fragment the possible future integrated recall and disclosure of cult activities (Braun, 1986).

Those cult children who fail to adequately dissociate and who become psychotic are generally killed. Psychotic children could not perform ritual tasks correctly and might risk exposure of the cult by calling attention to themselves outside the cult. Young children in the cult could be perceived as psychotic by a therapist unaware of ritual abuse. Even an older child or adolescent may be diagnosed as having a psychotic break as a new alter reveals and communicates classic cult behavior and reasoning. Misdiagnosis of ritual abuse symptoms, of course, is helpful to maintaining the success of the cult (Friensen, 1991).

According to Dr. Friensen (1991), the more a survivor in therapy integrates various alters and splitting decreases, the greater the threat to the cult because the cult will have decreased ability to control the survivor
simply by activating various personalities. If the survivor is particularly important to the cult, this is the point in the survivor's recovery process when blatant cult retaliation against the survivor may occur.

Initially, most adult survivors exhibit a high level of amnesic barriers between personalities. It would be possible for some alters to be involved in therapy, with the police, and with conversion to Christianity, while other alters unknown to the therapist or to those alters seeking help are easily cult activated and involved in ongoing ritual participation (Snowden, 1990).

**Diagnosis and Treatment for MPD/SRA:** As with other MPD clients, the crucial issue in diagnosis becomes whether the MPD/SRA client manifests alternating separate identities and episodes of amnesia or time distortion, as fulfills the *DSM-III-R* criteria. As the client becomes aware of their multiplicity, and the treatment alliance is contracted, the MPD/SRA client begins to reveal the heinous crimes that were perpetrated against them. MPD clients' satanic abuse material is often revealed during hypnotic states, for example, in the context of formal hypnotic inquiry, spontaneous abreaction, and journal writing or drawing while in trance (Friensen, 1991).

MPD/SRA clients may compulsively and repetitively enact ritual movements or chanting, either in overt behavior or in fantasy. Repetitive drawings of trauma related events may contain satanic symbols, parapher-
nalia or structural diagrams. External stimuli may trigger spontaneous abreactive reenactment of trauma with explicitly satanic features. Exposures to objects or symbolism can be associatively linked to the attempts of contact to alleged satanic group members around satanic holidays or a birthday (Benschoten, 1990).

Eating disorders may occur when hallucinations or illusions cause food to be mispercieved as substances reportedly consumed in satanic rituals. Bizarre forms of self-mutilation, including cutting or painting the body with satanic symbols, and burning or cutting the genitals may be seen. Self-destructive behaviors, including suicide attempts, are not uncommon following verbal disclosure of ritual abuse. The reenactment of the heinous crimes may express a great deal about the actual nature of the traumas which engendered them (Friesen, 1991).

The clinical syndrome presented by Young, Sachs, Braun, and Watkins (1991) offers a set of symptoms or “psychiatric sequela” exhibited by the majority of the study population. These include unusual fears, survivor guilt, indoctrinated beliefs, substance abuse, severe post-traumatic disorder, bizarre self-abuse, sexualization of sadistic impulses, and dissociative states with satanic overtones. PTSD symptoms were prominent, with high levels of anxiety and panic, flashbacks, nightmares and intrusive images. These symptoms alternated with states of withdrawal, feelings of numbness, or shifts into dissociated functional states or alter
personalities. Other symptoms common to the MPD/SRA population include hearing internal voices or conversations, experiencing a sense of being controlled by inner forces, and periods of amnesia.

The MPD/SRA client is clearly a severely abused individual. Many times they are thoroughly cult-indoctrinated and carry a lot of emotional pain. The pain may be showing through whatever presenting symptoms they may manifest. MPD/SRA are unique people with unique needs such as: 1) Having memories of things very bizarre, scary and painful that happened to them. They are afraid to tell because they might bring harm to themselves or others. They think nobody cares enough to want to know. Therefore, sometimes they have a need to let the world know they have been hurt badly by a phenomena unknown to the rest of society; 2) Because the stories they tell are so bizarre and hard to believe, these clients want to be believed that they are not trying to get attention by making up these stories; 3) These clients need support emotionally through the recognition and acknowledgement of the legitimacy of their pain, regardless of their distorted perceptions of what actually happened (Mungadze, 1992).

The goals for treatment of MPD/SRA clients are the same as for non-SRA(see Treatment for MPD section), with the awareness of the complexity of MPD/SRA client. According to Braun (1986), these treatment goals are:
1. Trust-therapeutic alliance

2. Diagnosis (patient and therapist)

3. Communication with personalities

4. Contracting: therapy, suicide/homicide, other

5. Individual and system history gathering

6. Working the issues of each personality

7. Special procedures: mapping, sand worlds, hypnosis

8. Interpersonality communications

9. Resolution - integration

10. New coping skills

11. Social networking

12. Solidifying skills

13. Follow-up

Mungadze (1992) suggests an eight step model which this author believes is the only therapy model designed specifically for MPD/SRA clients. The process is as follows:

1. Contacting alters (separate identities) and crisis stabilization. This can be done either through hypnosis, journaling, or having the clients draw to contact the alters. At times the therapist may decide to contact the alters by talking to them through a hypnotic induction. Crisis stabilization is supporting the client to find out who,
why, where and when about the alters. This empowers the host or presenter to resolve the situation and is preferable in most situations.

2. Discovering the structural map of the alter system. A structural map is considered very important because the map shows the way into the client's psyche. Once the map is discovered, the therapist follows the map very closely unless the system directs a change.

3. Identifying crucial alters. These are alters most significant in the system, such as helpers, protectors, narrators, controllers, destructive ones.

4. Begin teaching coping skills.

5. Begin to deal with the memories such as body memories and flashbacks. A client does not need to re-live the memory to allow closure around that particular memory, but abreaction (which does not re-enact the total pain) can support the alter to let go.

6. Diffusing violent alters. This is probably the hardest part of working with multiples with SRA. They have violent alters who could be programmed to be violent. To diffuse these alters:
   a. Ask who is causing the violence and why.
   b. Ask for the place, position and function of this alter.
   c. If an introject is involved in the violence, empower the system alters to separate from the introject.
d. Be assertive with the violent alters but do not be aggressive with them.

e. Realize that underneath the violence could be a sea of pain, therefore attend to the pain.

f. You need a safe environment to able to deal with violent alters.

g. Facilitate the host or presenter and other alters to accept the violent alters but not the violence.

h. Win the violent alters to the supportive side.

7. Fusing and integrating alters.

8. Post-integration therapy.

**Credibility Issue of SRA:** The increasing controversy challenging the credibility of allegation of satanic ritual abuse is beginning to reach proportions which may detract from the focus on treating clients with SRA allegations. Kluft (1989), reflecting on allegations of ritual abuse, said:

> ... to accept the inevitability of controversy and disagreement in the matter of allegations of ritual abuse and look forward to the time when this matter will be clarified and resolved. In the meantime, we must do our best for the patients who present with allegations of ritual abuse and must do so in the midst of great uncertainty (p. 192).
Goodwin (1985) addressing therapist incredulity toward MPD and satanic ritual abuse, discusses disbelief of client's reported experiences as a countertransference issue "rooted in personal defenses against fear, guilt, and anger" (Goodwin, 1985, p. 7), suggesting that clients' most extreme allegations are those most likely to be defensively denied. Goodwin states that:

Physicians can be counted on to routinely disbelieve SRA accounts that are simply too horrible to be accepted without threatening their emotional homeostasis. Stories that will be disbelieved include those involving genital mutilation, the placing of objects into the vagina, anal, or urethral openings, incest with multiple family members, incest pregnancies and the protracted tying down or locking up of children (1985, pp. 7-8).

The other side of denial is over-determination; there are obvious dangers inherent in both points of view. Denial will support the abuse continuing and going unchecked and people will continue to be abused, whereas over-determination involves the absolute acceptance of survivors' accounts as completely and literally accurate, and involves exaggerating the prevalence of the problem. It is important to be aware that taking sides on the issue creates fuel to the other's fire. One extreme invites a reactive
opposite response. Denial fosters over-determination, and over-determination invites denial (Benschoten, 1990).

Despite the uncertainty of the allegations of SRA (Ganaway, 1989), there are a few things that are certain about the MPD clients who present with SRA allegations. First, the number of MPD clients presenting with SRA is growing (Benschoten, 1990). Secondly, similarities of all the accounts of SRA allegations across the country and Western Europe are consistently establishing a definite pattern (Kluft, 1989). Thirdly, the intensity of the psychological pain that accompanies most of SRA allegations is very evident in this population. Lastly, the majority of SRA clients seriously believe in their memories of SRA suggesting that something traumatic happened to them and that they need help.

The essential task facing professionals is to sustain an attitude of critical judgment. Critical judgment requires one to remain open to the possibility that SRA does occur, while considering the enormous credibility problems involved. The attempt to examine this difficult issue critically expresses an essential value based on high regard for truth. To realize the danger in not taking clients' accounts of SRA seriously, one only has to consider instances in the past where atrocities were initially denied and found to be true.
Summary

The advent of MPD in conjunction with SRA gaining attention in the last ten years has shown that there is a need for in-depth training to assess, diagnose and treat MPD/SRA clients. The introductory chapter has presented a review of the prevalence of MPD in conjunction with SRA. Definitions of MPD with treatment and diagnosis ideas were addressed. A definition of SRA was presented along with MPD/SRA and its treatment and diagnosis concepts. The issue of credibility of SRA was addressed.

The following chapter represents a review of the literature pertinent to this study. The third chapter presents the methodology and procedures used in this study. The fourth chapter offers an analysis of the results of the study. Finally, the fifth chapter gives a summary of any conclusions from this study and offers implications for future studies.
CHAPTER 2
REVIEW OF LITERATURE

Introduction

Chapter Two provides a review of literature addressing various aspects of assessment, diagnosis and treatment for those persons exhibiting multiple personality disorder and multiple personality disorder in conjunction with Satanic ritual abuse. It begins with reviews of literature addressing a historical perspective of the treating of MPD. This is followed by a discussion of the controversial area of MPD treatment and diagnosis. Next comes a review of literature regarding the current state of clinical knowledge. This is followed by a review of literature pertaining to the MPD/SRA clients and their critical needs. This chapter also provides a review of literature addressing the use of videotape in training and instructing mental health professionals.

Historical Perspective of MPD

Multiple personality disorder (MPD), as a distinct clinical entity, can be traced back to the 17th century (Bliss, 1980). The history of the disorder shows a cyclic waxing in the numbers of clinical case reports (Ellenberger, 1970; Sutcliffe & Jones, 1962). The reasons for the changes in the apparent numbers of recognized cases are complex and have been ascribed to several factors: 1) The decline in the use of hypnosis in psychi-
atry (Braun, 1984a); 2) reaction to charges that the clinicians who diagnosed MPD were duped by their clients or were charlatans colluding with their clients in deceiving others (Ellenberger, 1970; Rosenbaum, 1980); and 3) the increasing popularity of the diagnosis of schizophrenia over the last 60 years (Rosenbaum, 1980). Currently there is an influx in the numbers of clients receiving the diagnoses of MPD (Boor, 1982; Braun, 1984b; Greaves, 1980; Kluft, 1984c).

Bliss (1980), in his article on 14 cases of MPD, credited Paracelsus with the first report of a case in 1538. By the 19th century, case reports became common and included some excellent descriptions of treatment, the most notable being Despene’s work with “Estelle” in 1836 (Ellenberger, 1970; Kluft, 1984). During the early part of the 19th century, Benjamin Rush and others investigated and described cases of dissociation and multiple personality (Carlson, 1981, 1984). At the turn of the century, Morton Prince (1960, 1975), and William James (Ellenberger, 1970; Taylor, 1983) were among the notable researchers who devoted considerable attention to the phenomena of dissociation and multiplicity.

For a number of reasons well reviewed by Ellenberger (1970) and Rosenbaum (1980), the diagnosis of MPD fell into disrepute shortly after the turn of the century and the number of reports plunged (Rosenbaum, 1980). In an analysis of the historical context in which decline occurred, Rosenbaum suggested that the replacement of “dementia praecox” with the
term "schizophrenia", introduced by Blueler in 1910, contributed to the misdiagnosis and consequent mistreatment of MPD clients. He noted that Blueler encouraged this trend when he stated that "all cases so diagnosed [hysterical psychoses] by others differed in no ways from other schizophrenia" (Rosenbaum, 1980, p. 1385). Multiple personality disorder clients are still trying to escape from what Rosenbaum termed the "schizophrenia net," as numerous case reports, reviews, and case series document (Bliss, 1980; Boor, 1982; Greaves, 1980; Kluft, 1984c; Putman, 1985b).

"The Three Faces of Eve" (Thigpen, 1954) was an important case report which served to redirect attention to the syndrome, after a long absence from clinical literature. The media representation of Eve presented a stereotype of MPD clients that made recognition of actual cases more difficult for many professionals without other sources of information about MPD. The case of "Sybil" (Schreiber, 1973), with its clear description of phenomenology and treatment, facilitated recognition of MPD clients and began the current dramatic increase in the numbers of diagnosed cases. It is a statement about the feelings of the times that the description of Cornelia Wilbur's successful treatment of Sybil, presented in a professional symposium, was deliberately excluded from publication in the proceedings of the symposium and had to be reported in the lay press by Schreiber (1973). In the face of professional indifference or outright hostility to diagnosis of MPD and the near impossibility of getting articles on MPD
published in professional journals, clinicians interested in these clients were forced to create other forums for the presentation and exchange of ideas on diagnosis and treatment. Kluft (1985) described the development of an "oral literature" on MPD, which occurred in conjunction with the organization of courses, workshops, and newsletters by the modern pioneers in the treatment of this disorder. As is the case with all oral literature, the authorship of individual contributions to the body of knowledge becomes blurred with time. Braun formalized the oral tradition in 1984, by instituting the annual International Conference on Multiple Personality/Dissociative States, sponsored by Rush-Presbyterian-St. Lukes Medical Center.

The inclusion of dissociative disorders category and the formal recognition of MPD as a discrete clinical entity in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition), DSM-III, American Psychiatric Association (1980), had redressed the prior denial of the diagnosis. In response to this formal legitimization, clinical literature on MPD and other forms of dissociation has grown rapidly. During 1983 and 1984, four journals devoted special issues to the disorder (Braun, 1983a, 1984a; Kluft, 1984; Orne, 1984). Kluft's edition on childhood MPD, and others who will be mentioned in this chapter, shows the efforts of the pioneers and experts to share their knowledge of MPD with others in the mental health and medical professions.
MPD Treatment, a Controversial Area

Throughout the history of medicine, suffering individuals have presented themselves for help long before their conditions could be understood definitively and comprehensively by those who try to alleviate their discomfort and their stress (Orne, 1984).

When present mental health professional attempts to learn about the treatment of MPD, they will find both articles that advocate and articles that question virtually every major therapeutic approach (Kluft, 1985a). Close inspection of a number of articles in which certain treatment principles are illustrated and/or advocated, reveals that the authors either do not specify their data base nor offer their advice on the bases of experience with a single case that did not enjoy a successful outcome (Braun and Sachs, 1988; Summit, R. 1988).

The growing literature on MPD was catalogued by Boor and Coons (1988). A number of the authors described psychoanalytic approaches to MPD (Lasky, 1978; Marmer, 1980; Lampl-de-Groot, 1981). Multiple personality disorder clients whose personalities are accessible and cooperative without hypnosis and are otherwise analyzable, may profit from analysis, but cases are known in which one personality was analyzed and others were never discovered (Kluft, 1985a). The behavioral literature is sparse (Caddy, 1985; Kohlenberg, 1973; Price & Hess, 1979). In an unpublished presentation (Association for the Advancement of Behavioral
Therapy, 1984), Drs. Klonoss and Janata described a behavioral paradigm. The authors found they could suppress overt manifestations of MPD, but that in the absence of abreaction, or in other words, the releasing of pent-up emotions by reliving the experiences associated with the emotions, their clients relapsed readily. Pending reports of several successful treatments with adequate follow-up, the behavioral treatment of MPD must be regarded as experimental (Kluft, 1985a). Braun (1989a) argues that abreaction requires a pre-existing cognitive structure adequate for understanding and interpreting the abreacted experience if lasting effect is to occur. This is similar to emotional congruencies being required if behavioral change is to be lasting.

A number of authors in the literature catalogued by Boor and Coons described family intervention approaches to treating MPD (Davis & Osherson, 1977; Beale, 1978; Levenson & Berry, 1983; Kluft, 1984). Family therapy has not proved to be a viable primary treatment modality, but it may have excellent ancillary uses. It can be used with a traumatizing family of origin. However, if associated with high incidence of crisis, it may not be useful. Family therapy can be helpful to other genuinely concerned persons in the client's life space and therefore may be of great support to the client (Braun, 1986).

The syndrome generally has not proved to be responsive to medication, but may co-exist with other conditions that are drug responsive
 Clients may manifest target symptoms that require palliative treatment (Kluft, 1984b).

The use of videotaped hypnotic sessions was described by Caul (1984). Caul also described the creation of an internal group therapy among the personalities (1984). MPD clients have not proved to be good candidates for inclusion in heterogeneous group therapies unless they share a common bond with the others in the group, such as being incest survivors. Homogeneous groups of MPD clients are difficult to control but can be a valuable ancillary tool (Coons & Bradley, 1985). Such clients may do well in structured occupational art, movement, and music therapy groups used as adjuncts to impatient treatment (Kluft, 1984b).

Abundant literature is available on the use of hypnosis in treating MPD. In recent studies, applicable techniques were catalogued (Braun, 1983, 1984c; Kluft, 1982). Fears that hypnosis can create or worsen MPD prevail, but several reviews have shown that such concerns are highly overstated (Braun, 1984b; Gruenwald, 1984; Kluft, 1982; Sutcliffe & Jones, 1962). Unpublished research by Braun and Sachs indicates that the collaboration of several therapists using several modalities can be productive (Braun, 1986).

The majority of successful treatments of MPD has been accomplished by clinicians who provide a supportive psychodynamic psychotherapy that
is facilitated when necessary by hypnotic interventions (Bowers et al., 1971; and Wilbur, 1984).

**Diagnosis, Another Aspect of The Controversy**

Multiple personality disorder is a severe chronic dissociative disorder characterized by a disturbance of memory and identity (Nemiah, 1985). Putman (1984) observed that "the existence of multiple amnestic episodes, together with the presence of alternating separate and distinct identities, distinguishes multiple personality disorder from all other psychiatric syndromes" (p. 172). Clearly since publication of the *Diagnostic and Statistical Manual of Mental Disorders. (Third Edition)*, *DSM-III*: American Psychiatric Association, 1980, it is difficult for clinicians of today to retrospectively assess reports from a time when medical science could not reliably distinguish individuals afflicted by luetic, epileptic, schizophrenic, affective, schizophrenic borderline, or post-traumatic stress pathologies from persons suffering from a dissociative disorder. Moreover, the evaluation of reports from a time before investigators became sophisticated about the impact of their suggestions and inquiries on the phenomena they observed is problematic (Braun, 1986).

Since 1974, there has been a rising awareness in the MPD condition. By 1980, the literature contained more than 200 cases. The reasons for the abrupt rise in the recognition and reporting of MPD cases are varied and
have occasion to create compelling debates. The reclassification of MPD in the DSM-III as a freestanding entity among the dissociative disorders also brought this condition to the attention of mental health professionals. Many have become aware of the compelling parallels and similarities between MPD and post-traumatic stress disorder (Spiegel, 1984). Excitement has been generated by neuropsychophysiological research findings that suggest that the study of MPD may offer insights into psychosomatics and brain functions and also may constitute a paradigm for the exploration of the structures and processes of the human mind (Braun, 1983; Brende, 1984; Coons et al., 1988; Putman, 1989; Putman, 1984a, 1985b).

The growing accord that MPD has long been seriously under-diagnosed and misdiagnosed is far from a consensus. Victor (1975) wondered if the diagnosis and treatment of MPD can constitute "disorder of the day" (P.8) syndrome. And Kline expressed concern whether clients with severe ego fragmentation are being erroneously labeled as having MPD (1984).

Although clinicians are now beginning to be able to reliably identify MPD, they still do not clearly understand what causes and maintains the symptoms of the disorder. However, in the last ten years, a number of investigating practitioners have systematized their observations on a large number of MPD cases (Bliss, 1980; Braun, 1983, 1984c, 1986; Fagan & McMahon, 1984; Kluft, 1984, 1984b; Putman, 1984a).
Current State of Clinical Knowledge

The published information on the diagnosis and treatment of MPD lags behind. Cursory examination of the recent literature reveals a wide range of different treatment modalities advocated as primary therapeutic interventions of MPD. In just the last ten years, articles have appeared describing the use of psychoanalysis (Lampl-de-Groot, 1981; Lasky, 1978; Marmer, 1980), hypnosis (Braun, 1984d, 1990; Horevitz, 1983; Howland, 1975; Kluft, 1982, 1984), behavior modification (Caddy, 1985; Price & Hess, 1979), family therapy (Beale 1978; Davis & Osherson, 1977; Kluft, 1985; Levenson & Berry, 1983), group therapy (Caul, 1984; Coons & Bradley, 1985), amobarbital-facilitated psychotherapy (Hall, 1975), and anticonvulsant medication (Mesulam, 1981; Schenk & Bear, 1981). A closer look at the literature reveals that most of these treatment recommendations are complementary or adjunctive rather than mutually exclusive interventions. Clinical descriptions and recommendations indicate that most MPD clients share a constellation of symptoms. The variety of therapeutic interventions advocated by therapists reflects the diversity of theoretical orientations and professional training being applied to treatment of MPD.

A considerable body of clinical knowledge has formed, which is based on experience with relatively large numbers of MPD clients (Braun, 1986).
MPD/SRA, Diagnosis and Treatment

Professional literature on diagnosis and treatment is nearly non-existent on the topic of Satanic ritual abuse with multiple personality disorder. However, because of concern with the issue, organized lay groups are providing educational material and linking survivors with professional resources. Published accounts are beginning to emerge (Antonelli, 1988; Marron, 1989; Spencer, 1989). The topic of satanic ritual abuse is being addressed at conferences by numerous psychiatric, and psychological organizations, including the International Society for the Study of Multiple Personality and Dissociation, the National Conference on the Sexual Victimization of Children, the U. C. Berkeley Rape Prevention Education Program, and several regional groups in the United States studying and treating MPD, such as the Arizona Group Psychotherapy Society's 12th Annual Conference "In the Wake of Trauma: PTSD, Multiple Personality, Ritual Abuse and Dissociative Disorders" presented April, 1992, in Tucson, Arizona.

Mental health professionals do not know just how widely spread satanic ritual abuse is, its involvement in a variety of contexts and diverse belief systems has been reported. There are highly secretive and rigidly structured groups that are multigenerational to self-styled adolescent involvement (Brown, 1986; Gallant, 1986; Gould, 1986; Kahaner, 1988; Young, 1989; Benschoten, 1990).
Whether satanic ritual abuse is described as spiritual, philosophical, political, social, or as personally motivated, the atrocities being reported are profoundly similar among survivors groups: adult survivors describing experiences of SRA beginning in childhood (Braun, 1986; Braun & Gray, 1986, 1987; Braun & Sachs, 1988; Kahaner, 1988; Olson, Marron, & Kowal-Ellis, 1987; Young, 1989), and preschool children reporting present incidents in day care settings (Believe the Children, 1989; Gould, 1986; Hudson, 1988; Kagy, 1986; Kahaner, 1988).

A large number of MPD clients are reporting satanic ritual abuse. Braun and Gray (1986) reported 20% of MPD clients are also SRA. A survey by Kaye and Klein (1987) reveals 20 of the 42 MPD clients describe a history of satanic ritual abuse. Hopponen (1987) reports that 38 of her 70 MPD clients have SRA related memories. Also, Braun (1989a) and Ganaway (1989), have stated that two different inpatient treatment centers specializing in the treatment of MPD have reported that 50% of their clients have SRA memories.

Because SRA allegations are still very controversial, some therapists may dismiss SRA accounts entirely. Hill and Goodwin (1989) suggest that some therapists may not have a conceptual scheme to work with SRA, and consider SRA reports as delusional. The MPD literature does, acknowledge that some alters in an MPD system could be psychotic (Bliss, Larson, & Nakashima, 1983; Coons, 1984; Solomon & Solomon, 1982) and express
delusions. However, Hill and Goodwin (1989) supports that there are differences in the content, form and quality of schizophrenic clients accounts of witchcraft and satanic ritual abuse reports of MPD clients. The MPD narrative, though often fragmented, focuses on human behaviors and upsetting interpersonal interactions, in contrast to the schizophrenics narratives, which express bizarre content, disintegrated form, and emphasis on mysterious external forces.

As of January 1992, this author's research for specific treatment and diagnosis material for MPD/SRA has lead to only two articles that at this point, and are both unpublished (Mungadze, 1992; Snowden, 1990). Putman (1984) states that it takes on average of 6.8 years after first entry into the mental health system before an MPD client is correctly diagnosed. With MPD/SRA client, diagnosis can take a much longer time because of the complexity of the alters’ system. The use of diagnostic tools such as the DES (Bernstein & Putman, 1986), the DDIS (Ross, Heber, & Norton, 1989, and the SCID-D (Steinberg, Rounsaville, & Cicchetti, 1990), can help clinicians make the diagnosis of MPD/SRA somewhat more expeditious.

Historical View of Mental Health Video Training Films

The application of videotape recording in training mental health professionals has increased in the last twenty years (Dowrick, 1991). This development is rooted in the early 1940's when audiotape recording was
first used (Rogers, 1942; Bloom, 1954; Gaier, 1952). At the time, training considerations were as unsophisticated as the equipment being used. The equipment was incredibly bulky and inadequate, technologically.

As the medium of television developed, a few educators experimented with new ways to train mental health professionals. In the late 1950's closed circuit television was used in teaching psychotherapy (Fleishmann, 1955; Moore, Hanes, & Harrison, 1961) and clinical psychiatry (Holmes, 1961; Kornfeld & Kolb, 1964).

As videotape technology began to advance, teaching basic courses on video in clinical psychology and psychiatry was being tried (Suess, 1975; Ryan, 1966). Widespread application of video in psychotherapy, however, was somewhat slower to develop. Historically, psychotherapy supervision has focused on discussing what was done or what to do, with little direct observation (Schmidt & Messner, 1977). Personal psychotherapy was sometimes used to augment the student’s understanding of the therapeutic process. Teaching psychotherapeutic techniques, however, is relatively a new field in the last twenty years. As of 1966, there was essentially no research regarding effective and efficient teaching of psychotherapy (Matarazzo, Wiens, & Saslow, 1966). Besides, many instructors did not use video because it was so alien to their own education process.
The explosion of video in the mental health profession as a training tool is attributed to three factors according to Dr. Fryrear (Fryrear & Fleshman, 1981).


2. Teachable therapeutic skills have been identified and empirically validated (Carkhuff, 1969; Kagan & Krathwohl, 1967) as have the importance of therapist characteristics and variables in therapist-client interaction (Strupp, 1960; Strupp, 1962; Strupp, Wallak, & Wogan, 1964).

3. There has been an increased recognition of the need for counseling skills among a wider range of mental health professionals (Fryrear & Fleshman, 1981).

Video is used widely in psychotherapy training at universities, medical schools, mental health clinics, and professional conventions and workshops. It has been used to teach psychiatric fundamental and family therapy to family practitioners (Lurie, 1978). Schmidt and Messner (1977) used video for interviewing and diagnostic techniques to teach with medical students (Hunt, MacKennon, & Michels, 1975), and fundamental skills to nurses, pastoral counselors, and paraprofessionals. Video is also increasingly used in advanced training for clinical psychologists, psychiatrists, and social workers. In 1979 the American Association of Sex
Educators, Counselors and Therapists introduced video in training programs for sex therapy supervisors. Video has been a prominent aspect of the annual convention of the American Group Psychotherapy Association for many years (Fryrear & Fleshman, 1981).

**Video Applications in Mental Health Professional Training**

As a teaching tool, video reinforces what is typically only heard or read and what is seen (Heilveil, 1983). The varieties of video applications for training are substantial. Video is used in training psychologists, psychiatrists, social workers, marriage and family counselors (Hector, 1970); music and art therapist (Greenfield, 1978; Alley, 1980; Hanser & Furman, 1980), and crisis intervention workers (Folsom & Grant, 1978).

Information storage and dissemination are two advantages of video in training mental health providers. Video libraries preserve case material for future use. Prerecorded video can illustrate client defense mechanisms, unconscious processes and security operations, verbal and nonverbal communications, psychopathology, or specific interviewing techniques (Fryrear & Fleshman, 1981).

**Modeling**

A considerable amount of human learning takes place vicariously. That is, we learn a lot simply by watching others. Observation provides
information about what we potentially could learn; when it occurs under the right circumstances, the observation results in immediate personal change (Bandura, 1977, 1986; Thelen, Fry, Fehrenbach, & Frautschi, 1979). A modeling procedure focuses on the skill to be learned, its context, and its consequences. Albert Bandura (1986, 1977), the foremost proponent of modeling strategies, identifies components that mediate observational learning: attention to modeled events, retention of what is observed, ability to replicate modeled behaviors, and motivation to reproduce those behaviors.

Video modeling is frequently used in training professional skills in the mental health professions (e.g., Clark, 1988). An informative example is provided by Schoonover, Bassuk, Smith, and Gaskill (1983) in their videotape series for training health care providers to handle psychiatric emergencies.

Video modeling is frequently used in various types of counselor training (e.g., Hargle, 1988). In a well-designed investigation of the relative effects of role-playing, videotape feedback and modeling, Baily, Deardorff, and May (1977) found modeling to be consistently associated with the largest behavioral gain in specific counseling skills.
Summary

This chapter provided a review of literature addressing various assessments, diagnosis, and treatment ideas for MPD clients and for person exhibiting MPD/SRA symptoms, the historical perspective of the disorder, and a section on the latest clinical knowledge of MPD. There has been more written about multiple personality disorder dealing with diagnosis and treatment in the last ten years. However, literature on MPD/SRA treatment and diagnosis is nearly non-existent.

Also this chapter discusses the use of video by mental health professionals. In therapy, unlike film, video could be fed back almost immediately, while in research, training and modeling, video presented the opportunity for repeated exposures of identical events.
CHAPTER 3

METHODOLOGY

The purpose of the study was to determine the need for a video educational training film for mental health professionals in assessing, diagnosing and treating MPD/SRA clients. The methodology will include a brief description of the survey method and why it was chosen as the methodology, a subject section, material section, and a procedure section.

Survey Method

The survey method of acquiring data, as described by Conrad and Maul (1981) was used to collect data for this study. The method was chosen because of the relatively inexpensive nature of the method. The survey method relies on people's observations of their own behaviors and attitudes by asking them for written self-reports. Surveys are most often used to investigate phenomena that are not researchable through direct observation (Conrad & Maul, 1981).

According to Conrad and Maul (1981), the degree of control over research conditions using the survey method ranks in the moderate level. The survey method of research allows greater control than the archival method, naturalistic observation, and natural observation with intervention. However, the survey method ranks below clinical descriptive research and the true experimental method (Conrad & Maul, 1981).
The survey method gives the researcher control through content, phrasing and order of questions asked. The primary advantage of the survey is that it is one of the least expensive ways to reach a large amount of people. The second advantage is that the survey has an impersonal nature. People have more anonymity in this research and this can set the state for gaining information that is not usually obtained (Conrad & Maul, 1981).

Subjects

The respondents were all members of the International Society for the Study of Multiple Personality and Dissociation (ISSMP & D). ISSMP & D is "not-for-profit professional association organized to promote research and training in the identification and treatment of Multiple Personality Disorder (MPD) and other dissociative states" (ISSMP & D Membership Directory, 1991). In 1991, the association consisted of 2,000 members.

The nationwide survey was conducted January 17, 1992 to March 10, 1992 and included sending out approximately 150 surveys (see Appendices A and B). Participants were 30 members (15% response rate) of the ISSMP & D who responded to a mailing originally sent to 150. A random sample was selected because of the nature of the study. The 150 random participants were selected because it was impossible to survey the entire ISSMP&D association of 2,000 members. It is impossible to assess
the extent of bias introduced into the study by the non-respondents; however, it is believed that the present sample is highly representative of both ISSMP & D members and mental health practitioners nationally who have contact with MPD and MPD/SRA clients.

Materials

The survey was based on questions related to assessment, diagnosis and treatment of MPD/SRA clients. Enclosed in the envelope with the survey was a cover letter stating the intentions of the study (see Appendix A). Also enclosed with the survey and cover letter was a self-addressed stamped envelope in order to gain a larger response. In addition, there were questions concerning the respondents such as: professional title, length of treating MPD/SRA clients, percentages of men and women who are MPD/SRA clients. Eleven questions were presented in a forced-choice Likert type format. Eighteen items were open-ended questions which allowed the respondents to write in an answer concerning a specific example with which they were familiar (see Appendix B).

Procedure

The respondents for the survey were selected because of their professional affiliation and because they were mental health practitioners that had MPD and MPD/SRA clients. The survey, which was designed to
evaluate what mental health practitioners consider to be important issues for therapists working with MPD/SRA clients, was mailed to respondents along with a self-addressed stamped envelope and a cover letter stating the intentions of the research. The questions were selected because the literature review reflected commonalities in issues. The respondents were asked to complete the questionnaire and return it in the self-addressed stamped envelope.

After the survey was competed and returned, the raw data was charted by tabulating each response.

Summary

This chapter considered the methods and procedures used in conducting this study. The first section presented an explanation of the survey method and why it was chosen as the methodology. A subject section was presented in depth. This chapter concluded with a discussion about materials used in the survey and the procedure the subjects used to answer the survey.

In Chapter 4 there is a presentation of the results of the study according to the guidelines provided by the hypotheses and the methods of analysis in Chapter 3.
CHAPTER 4

RESULTS

Introduction

The purpose of this study was to determine the need for an in-depth educational training film for mental health professionals to assess, diagnose and treat satanic ritual abuse survivors in conjunction with multiple personality disorder. A questionnaire was sent to mental health professionals to determine whether a video educational training film would be beneficial.

In this section, results of the survey will be presented. Throughout this chapter, all percentages are rounded, and thus may not equal 100% when totalled.

Description of the Sample

Participants of this study were mental health professionals who are members of the International Society for the study of Multiple Personality and Dissociation. One hundred and fifty surveys were sent, 40 were returned; 30 were completed and ten were not. Factors involved in the uncompleted surveys include:

1. not applicable
2. do not work with SRA clients
3. do not like the format (two respondents indicated they would not respond due to this reason).

Table 1 details the frequency of responses to relevant demographic characteristics and the professional background of the sample respondents. Of those who did complete the survey, 3% were doctorate level, 57% were clinical psychologists and 6% were doctorate level in education. Thirty-seven percent of the respondents were master level counselors and social workers.

When asked what type of practice they had, 80% indicated they were in private practice, 10% worked in a hospital setting, 7% with an agency, and 3% were other (one director).

Twenty-seven percent of the mental health professionals said that they had been treating MPD/SRA clients for 13-15 years. Twenty percent said they had been treating MPD/SRA for less than two years, 20% reported two years, and 20% said five years. Thirteen percent stated they had treated MPD/SRA clients for more than five years.

Among the 30 respondents, 50% said that >50% of their clients have been ritually abused. Fifty percent also stated that >50% of their MPD/SRA clients were women. Sixteen percent of their MPD/SRA clients were men.

When asked if their clients had been misdiagnosed, 67% of their clients had been misdiagnosed for depression, 56% for anxiety disorders, 50% for personality disorders, 43% for schizophrenia, 43% for bipolardis-
order, 30% for unipolar affective disorders, 24% for alcoholism, and 13% for temporal lobe epilepsy.

Seventy-three percent of the survey respondents said that their MPD/SRA clients had been misdiagnosed for more than five years. Twenty-seven percent stated that their MPD/SRA had been misdiagnosed for more than five years.

Table 2 details the distributions of the items comprising of questions dealing with assessment and treatment for MPD/SRA clients. Question thirteen was eliminated from the table due to the incompatibility with the statistical procedure employed.

When the respondents were asked what assessment tools were most helpful in the diagnoses of MPD/SRA, 23% said the DES (Dissociative Experiences Scale) was effective, 23% said journaling, 23% said art tools, 26% indicated that clinical interviews worked and 10% said the Minnesota Multiphasic Personality Inventory (MMPI) was a good assessment tool. On the other hand, when asked what assessment tools do not work, 15% stated that MMPI was not effective, 3% said the DES could not tap into SRA clients, and 3% stated that straight clinical testing did not work. When asked about drug therapy and drug side effects, 83% indicated their MPD/SRA clients were taking antidepressants or lithium. Sixty-seven percent said side effects of drugs affected people differently. Therefore, they could not answer the question.
Table 1. Percentage distributions of demographics/professional background of respondents.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Breakdown of answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Educational background</td>
<td>BA/BS = 0</td>
</tr>
<tr>
<td></td>
<td>MA/MSW = 37</td>
</tr>
<tr>
<td></td>
<td>PhD = 63</td>
</tr>
<tr>
<td>2. Type of practice</td>
<td>Private = 80</td>
</tr>
<tr>
<td></td>
<td>Agency = 7</td>
</tr>
<tr>
<td></td>
<td>Hospital = 10</td>
</tr>
<tr>
<td></td>
<td>Other = 3</td>
</tr>
<tr>
<td>3. Years treating MPD/SRA</td>
<td>&gt; 2 = 20</td>
</tr>
<tr>
<td></td>
<td>2 = 20</td>
</tr>
<tr>
<td></td>
<td>5 = 20</td>
</tr>
<tr>
<td></td>
<td>&lt; 5 = 13</td>
</tr>
<tr>
<td></td>
<td>13-15 = 27</td>
</tr>
<tr>
<td>4. % of client MPD/SRA</td>
<td>&gt; 5 = 36</td>
</tr>
<tr>
<td></td>
<td>20 = 6</td>
</tr>
<tr>
<td></td>
<td>&gt; 50 = 50</td>
</tr>
<tr>
<td>5. % of MPD/SRA women:</td>
<td>&lt; 5 = 30</td>
</tr>
<tr>
<td></td>
<td>20 = 7</td>
</tr>
<tr>
<td></td>
<td>&gt; 50 = 50</td>
</tr>
<tr>
<td>6. % of MPD/SRA men</td>
<td>&lt; 5 = 7</td>
</tr>
<tr>
<td></td>
<td>20 = 0</td>
</tr>
<tr>
<td></td>
<td>&gt; 50 = 16</td>
</tr>
<tr>
<td>7. Misdiagnosed as</td>
<td>Schizophrenic = 43</td>
</tr>
<tr>
<td></td>
<td>Bipolar = 43</td>
</tr>
<tr>
<td></td>
<td>Affective = 30</td>
</tr>
<tr>
<td></td>
<td>Personality disorder = 50</td>
</tr>
<tr>
<td></td>
<td>Anxiety = 57</td>
</tr>
<tr>
<td></td>
<td>Temporal Lobe epilepsy = 13</td>
</tr>
<tr>
<td></td>
<td>Depression = 67</td>
</tr>
<tr>
<td></td>
<td>Alcoholic = 23</td>
</tr>
<tr>
<td>8. Years of misdiagnosis</td>
<td>&lt; 2 = 20</td>
</tr>
<tr>
<td></td>
<td>2 = 13</td>
</tr>
<tr>
<td></td>
<td>&gt; 5 = 37</td>
</tr>
<tr>
<td></td>
<td>7-40 = 37</td>
</tr>
</tbody>
</table>
When asked about appropriate treatment techniques, 60% indicated that hypnosis was a viable way to treat MPD/SRA clients. Other treatment techniques were rated such as: 53% chose art therapy, 36% used sand trays, 33% worked with play therapy and gestalt therapy; also experiential psychotherapy with a psychoanalytical emphasis was used by 73%. Respondents also listed twelve other treatments in the “other” slot on question fourteen. Treatment techniques that work the best were answered by the respondents as a combination of the above at 15%. Thirty-three percent said hypnosis was a good technique, 15% said mapping the personality system, 28% said expressive therapy and 10% said art therapy. Treatments that did not work were rigid adherence to one particular modality at 40%, and 60% said failure to make the correct diagnosis. Average treatment for MPD/SRA was stated at more than five years by 63% of the respondents; 36% said more than two years, and 7% said less than one year.

Table 3 presents the distribution of items pertaining to alters, memories, integration and issues involving MPD/SRA clients. When respondents were asked what were the average number of alters within an MPD/SRA client, 50% stated that an average for them was between 10 to 20 alters, 30% said 50 to 160 alters, and 15% said between 20 to 50 alters.

When asked what constitutes a successful therapeutic experience, 30% said reliving memories, 20% said functioning and not just surviving,
Table 2. Percentage distributions of items dealing with assessment and treatment.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Breakdown of answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Helpful assessment tools</td>
<td>DES = 23%</td>
</tr>
<tr>
<td></td>
<td>MMPI = 10</td>
</tr>
<tr>
<td></td>
<td>Clinical interview = 26</td>
</tr>
<tr>
<td></td>
<td>Journaling = 23</td>
</tr>
<tr>
<td></td>
<td>Art tools = 23</td>
</tr>
<tr>
<td>10. Assessment tools not helpful</td>
<td>DES = 3</td>
</tr>
<tr>
<td></td>
<td>MMPI = 15</td>
</tr>
<tr>
<td></td>
<td>Clinical testing = 3</td>
</tr>
<tr>
<td>11. Drug therapy</td>
<td>Anxiolytics = 30</td>
</tr>
<tr>
<td></td>
<td>Sedatives = 33</td>
</tr>
<tr>
<td></td>
<td>Neuroleptic drugs = 20</td>
</tr>
<tr>
<td></td>
<td>Antidepressants = 50</td>
</tr>
<tr>
<td></td>
<td>Lithium = 33</td>
</tr>
<tr>
<td>12. Side effects</td>
<td>Different for different people = 67</td>
</tr>
<tr>
<td></td>
<td>More anxiety = 15</td>
</tr>
<tr>
<td></td>
<td>Weight gain = 6</td>
</tr>
<tr>
<td></td>
<td>Dry mouth = 6</td>
</tr>
<tr>
<td>14. Appropriate treatment techniques</td>
<td>Hypnosis = 60</td>
</tr>
<tr>
<td></td>
<td>Art therapy = 53</td>
</tr>
<tr>
<td></td>
<td>Play therapy = 33</td>
</tr>
<tr>
<td></td>
<td>Sand trays = 36</td>
</tr>
<tr>
<td></td>
<td>Gestalt = 13</td>
</tr>
<tr>
<td></td>
<td>Experiential = 30</td>
</tr>
<tr>
<td></td>
<td>Psychoanalytical = 30</td>
</tr>
<tr>
<td>15. Treatment most helpful</td>
<td>Combination = 15</td>
</tr>
<tr>
<td></td>
<td>Hypnosis = 33</td>
</tr>
<tr>
<td></td>
<td>Mapping = 15</td>
</tr>
<tr>
<td></td>
<td>Expressive psychotherapy = 28</td>
</tr>
<tr>
<td></td>
<td>Art therapy = 10</td>
</tr>
<tr>
<td>16. Techniques not helpful</td>
<td>Rigid adherence to modalities = 40</td>
</tr>
<tr>
<td></td>
<td>Failure to make correct diagnoses = 60</td>
</tr>
<tr>
<td>17. Average length of treatment</td>
<td>&lt;2 = 7</td>
</tr>
<tr>
<td></td>
<td>&gt;2 = 36</td>
</tr>
<tr>
<td></td>
<td>&gt;5 = 63</td>
</tr>
</tbody>
</table>
and 15% indicated that improving personal comfort would be helpful.

Sixty percent of the respondents stated that regaining all memories was not necessary. Thirty-seven percent said that regaining memories was essential to a successful therapeutic experience.

On the question of integration, 77% of the respondents believed integration was necessary for successful therapy. Also, 90% had experienced integration with their MPD/SRA clients.

Table 4 details the issue involving film or video as a training tool. When respondents were asked if they ever used video or film to train, 53% said they did. When asked if a training film that demonstrated treatment and assessment techniques of persons experiencing MPD in conjunction with satanic ritual abuse would be beneficial, 83% stated they would be supported by such a film.

**Hypotheses**

Hypothesis 1: It was hypothesized that mental health professionals involved with MPD/SRA clients believe that a video education training film would assist them to understand and learn treatment and diagnostic tools specific for their clients. Results of the 28th question indicates that 83% of the respondents would benefit from a training film. Therefore, hypothesis 1 is accepted.
<table>
<thead>
<tr>
<th>Questions</th>
<th>Breakdown of answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Average amount of alters</td>
<td>10-20 = 50</td>
</tr>
<tr>
<td></td>
<td>20-50 = 15</td>
</tr>
<tr>
<td></td>
<td>50-160 = 30</td>
</tr>
<tr>
<td>19. Most amount of alters</td>
<td>&gt;20 = 15</td>
</tr>
<tr>
<td></td>
<td>&gt;50 = 15</td>
</tr>
<tr>
<td></td>
<td>&gt;100 = 70</td>
</tr>
<tr>
<td>20. Least alters experienced</td>
<td>&lt;3 = 15</td>
</tr>
<tr>
<td></td>
<td>6 = 60</td>
</tr>
<tr>
<td></td>
<td>10-15 = 15</td>
</tr>
<tr>
<td>21. Successful therapy</td>
<td>Reliving memories = 30</td>
</tr>
<tr>
<td></td>
<td>Functioning = 20</td>
</tr>
<tr>
<td></td>
<td>Improving personal comfort = 15</td>
</tr>
<tr>
<td>22. Regaining all memories</td>
<td>Yes = 37</td>
</tr>
<tr>
<td></td>
<td>No = 60</td>
</tr>
<tr>
<td>23. Integration necessary</td>
<td>Yes = 16</td>
</tr>
<tr>
<td></td>
<td>No = 77</td>
</tr>
<tr>
<td>24. Has the therapist seen integration</td>
<td>Yes = 90</td>
</tr>
<tr>
<td></td>
<td>No = 10</td>
</tr>
</tbody>
</table>
Hypothesis 2: It was hypothesized that the information received from mental health professionals on the questionnaire would lead to a prospectus for an educational film. Results from the questionnaire could lead to a prospectus, which is an in-depth database that answers all the questions pertaining to funding for the production of an educational film. It is indicated by the questionnaire that there are many different modalities and techniques to treat MPD/SRA clients. Therefore, hypothesis 2 is partially accepted.

Summary

The analysis of the data did substantiate hypothesis 1. Mental health professionals would benefit from an educational training film about specific treatment and diagnosis idea for MPD/SRA clients.

Hypothesis 2, however, was only partially supported. Information received from mental health professionals about persons dealing with MPD/SRA would help in making a prospectus for an educational film, but the prospectus still needs to be written for funding.

In Chapter 5 there follows a review of the findings, limitations of the study, and recommendations for further study.
Table 4. Percentage distributions of issues involving video training films.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Breakdown of answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Ever used film or video as</td>
<td>Yes = 53</td>
</tr>
<tr>
<td>training tool?</td>
<td>No = 46</td>
</tr>
<tr>
<td>28. Would a film on MPD/SRA</td>
<td>Yes = 83</td>
</tr>
<tr>
<td>be helpful?</td>
<td>No = 16</td>
</tr>
</tbody>
</table>
CHAPTER 5

DISCUSSION, SUMMARY, AND RECOMMENDATIONS

In this chapter a brief review of the study is presented first. It is followed by a summary and discussion of the findings of the study. Conclusions are drawn from these results and suggestions are made for further research.

Purpose of the Study

Reports of Multiple Personality Disorder (MPD) in conjunction with Satanic Ritual Abuse (SRA) began to emerge publicly in the early 1980's (Smith & Pazder, 1980). To this date, professional literature on the topic of SRA is nearly non-existent. Meanwhile, mental health professionals who treat persons with MPD are acknowledging that their adult clients are beginning to report SRA that began in their childhoods (Braun & Gray, 1986). Because there is so little information available for mental health professionals to learn specific assessment, diagnosis and treatment tools for MPD/SRA clients, professional communities have begun to provide workshops, seminars and lectures to deliver training.

The purpose of this study was to determine the need for an in-depth educational training film for mental health professionals to assess, diagnose, and treat SRA survivors in conjunction with MPD.
Population and Sample

A total of 30 mental health professionals participated in a study to determine if an educational training film was needed. Nineteen professionals from this sample were doctorate level psychologists (17 clinical psychologists, and two doctors of education). Eleven participants were masters’ level counselors or social workers.

Sample characteristics were fairly consistent in the areas of education and type of practice.

Measurement

The instrument used for this study was a paper and pencil questionnaire, or the survey method. This survey was mailed to mental health professionals who were all members of the International Society for the Study of Multiple Personality and Dissociation.

Hypothesis I

It was hypothesized that mental health professionals involved with MPD/SRA clients believe that a video education training film would assist them to understand and learn treatment and diagnostic tools specific for their clients. Results of the survey indicated that 83% of those responding would benefit from a training film.
Hypothesis II

It was hypothesized that the information received from mental health professionals on the questionnaire would lead to a prospectus for an educational film. This hypothesis was weakly substantiated because the mental health professionals stated the need for a film. However, even though the information provided by the professionals is valuable for the writing of the prospectus, it still needs to be written.

A prospectus for a training film contains all the pertinent information about the film including title, statement of purpose, budget, financial overview, distribution markets, release schedules, income projection, festival and resumes (Brockman, 1989).

Summary of the Findings

There is a need for a well-presented video educational training film for mental health professionals to assess, diagnose and treat satanic ritual abuse survivors in conjunction with multiple personality disorder. There was weak support from the data of this study for the purpose of a completed prospectus to support making a film.

Discussion of the Findings

The findings of this study supported the hypothesis that a video training film would help mental health professionals in treating MPD/SRA
clients. Question number 28 received a response of 83%, indicating that these 30 respondents would benefit from a training film. However, there seems to be an issue of what theoretical models were used in treatment of MPD/SRA clients.

It was interesting to note that the survey received 23 different theoretical models to use with ritual abuse survivors. These are the answers received:

1. Braun and Putman's textbooks
2. psychodynamic
3. self-psychology
4. post-trauma
5. developmental theory
6. transactional analysis
7. Jungian
8. short-term therapy
9. feminist
10. abreactive
11. psychoanalytical
12. BASK
13. cognitive
14. object relations base
15. existential
16. Watkins and Watkins ego state
17. mind control theory
18. Rogerian
19. hypnosis
20. psychodrama
21. Neo Reichian
22. inner child
23. reality base theory

This study implies that there are many ways to help MPD/SRA clients, or that each mental health professional had been trained in different theory modalities. The importance of these findings in respect to an educational video training film would be to decide how to develop a training film that could incorporate the theoretical model responses. It is this author’s intention to emphasize particular theories such as transactional analysis, hypnosis, psychodrama and inner child. The other theoretical models would be defined briefly.

The use of an educational video training film is a very effective teaching tool. The attention-gaining power of a video program is widely evident, particularly in contrast to audiotape or print media. Part of the reason is the ability of video to produce a close approximation to human presence (Dorwrick, 1991).
Limitations of the Survey

Several limitations may be a threat to the validity of a survey. General limitations of a survey include the issue of who chooses to respond to the mail survey. Although the surveys were mailed to 150 potential respondents, it is impossible for the researcher to account for the portion of people who chose not to respond.

Secondly, because the questions are presented and responded to in writing, the researcher cannot determine the subject’s understanding of a question. Although control over the content and phrasing of survey question is accounted for, there is no control over such variables as to which order the respondent answers questions.

Although there are limitations to any research study, I have general confidence, given the high rate of return (27%), in the validity of the study.

The training film would first define MPD, SRA/MPD. The film would use actors to model persons with SRA/MPD as well as the therapists (see page 51). This allows therapists to view procedures focused on assessment, diagnosis and treatment.

Conclusions and Suggestions for Future Research

Certain findings of this study were statistically significant. It was found that 83% of the respondents would like a video educational training film to assist them in assessing, diagnosing, and treating MPD/SRA
clients. The findings offer a basis for writing a prospectus to gain funding to produce the film.

Perhaps a means of sample selection and data gathering other than by mailed questionnaires (e.g., personal interviews) would allow for a more controlled study of what mental health professionals would like to see in a film, although an improved questionnaire would ask different and more specific questions related to SRA.

In summary, an educational film to help mental health professionals to assist their MPD/SRA client is needed in the mental health field. There is no doubt that progress has been made in the last year in the understanding of therapy with MPD/SRA clients, but so much more needs to be addressed in terms of education. It is important mental professionals continue forward with open minds and continue to educate themselves on satanic ritual abuse in order to treat MPD/SRA clients as individuals with very real concerns. An educational training film is one way to further that education.
APPENDIX A

LETTER OF PARTICIPATION
Pamela Brockman  
University of Arizona  
Education Building 218  
Tucson, Arizona 85721

This questionnaire will help me decide if making an educational film for mental health professionals who treat Multiple Personality Disorder in conjunction with ritual abuse is feasible or needed. The intent of this film (video) would educate professionals about specific diagnostic assessments and treatment techniques for ritual abuse survivors with MPD. In order for me to make this decision, I require your assistance.

The enclosed questionnaire, with a self-addressed stamped envelope, will take approximately one-half hour to complete. Please feel free to express an opinion, ask any questions, or add any additional information in length on the back of the questionnaire.

I will be happy to share any findings and information with you upon your request.

Thank you very much for your participation.

Pamela Brockman
APPENDIX B

SURVEY FOR MENTAL HEALTH PROFESSIONALS
What is your educational background?

- B.A. or B.S. in ________________________________
- M.A. or M.S. in ________________________________
- Ph.D. in ________________________________
- M.D. specializing in ________________________________

What type of practice do you have?

- private practice
- agency
- hospital
- other ________________________________

How long have you been treating the ritually abused with MPD?

- less than two years
- two years
- 5 years
- more than 5 years. How long? ________________________________

What percentage of your clients have been ritually abused who are also MPD?

- less than 5%
- 20%
- 50%
- Other ________________________________

What percentage of your clients, who have been ritually abused with MPD, are women?

- less than 5%
- 20%
- 50%
- Other ________________________________

What percentage are men?

- 20%
- 50%
- Other ________________________________
Have your clients experienced treatment for other diagnosis?

- schizophrenia
- bipolar
- unipolar affective disorders
- personality disorders, which were
- anxiety disorders
- temporal lobe epilepsy
- depression
- other

How many years have your clients been misdiagnosed before the diagnosis of MPD with ritual abuse experience?

- less than 2 years
- more than 2 years
- more than 5 years
- other (please specify)

What type of assessment tools are the most helpful, if any, in diagnosing MPD with ritual abuse experience?

What assessment tools have not worked?

What types of drug therapies, if any, are your clients using or have used in the past?

- anxiolytics
- sedatives / hypnotics
- neuroleptic drugs
- antidepressants
- lithium
- other

White side effects, if any, have your clients experienced?
What theoretical models do you use in treatment for MPD with ritual abuse experience?

What appropriate treatment techniques for this population do you use?

- [ ] experiential
- [ ] gestalt
- [ ] hypnosis
- [ ] art therapy
- [ ] sand trays
- [ ] play therapy
- [ ] psychoanalytical
- [ ] others (please be specific)

What treatment techniques have worked the best?

What treatment techniques have not worked?

Average length of treatment?

- [ ] less than one year
- [ ] more than two years
- [ ] more than five years
- [ ] other (please specify) ______________________________

What is the average number of alters within a client?
The most alters you have experienced in a client?

The least you have experienced in a client?

What constitutes a successful therapeutic experience?

Does a client have to regain all memories to have a successful therapeutic experience?

Is integration necessary for successful therapy?

Have you experienced integration of alters with your client? If so, how?

How do you deal with countertransference issues with ritual abuse.

How do you deal with the legal issues involved with MPD in conjunction with ritual abuse experience?
Have you ever used film or video as a training tool?

Would it be supportive to your education and to other mental health professionals to view actual demonstrations of treatment and assessment techniques of person experiencing MPD in conjunction with ritual abuse?
APPENDIX C

TABLES
Table 1. Percentage distribution demographics/professional background of respondents.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Breakdown of answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Educational background</td>
<td>BA/BS = 0</td>
</tr>
<tr>
<td></td>
<td>MA/MSW = 37</td>
</tr>
<tr>
<td></td>
<td>PhD = 63</td>
</tr>
<tr>
<td>2. Type of practice</td>
<td>Private = 80</td>
</tr>
<tr>
<td></td>
<td>Agency = 7</td>
</tr>
<tr>
<td></td>
<td>Hospital = 10</td>
</tr>
<tr>
<td></td>
<td>Other = 3</td>
</tr>
<tr>
<td>3. Years treating MPD/SRA</td>
<td>&gt; 2 = 20</td>
</tr>
<tr>
<td></td>
<td>2 = 20</td>
</tr>
<tr>
<td></td>
<td>5 = 20</td>
</tr>
<tr>
<td></td>
<td>&lt; 5 = 13</td>
</tr>
<tr>
<td></td>
<td>13-15 = 27</td>
</tr>
<tr>
<td>4. % of client MPD/SRA</td>
<td>&gt;5 = 36</td>
</tr>
<tr>
<td></td>
<td>20 = 6</td>
</tr>
<tr>
<td></td>
<td>&gt;50 = 50</td>
</tr>
<tr>
<td>5. % of MPD/SRA women:</td>
<td>&lt;5 = 30</td>
</tr>
<tr>
<td></td>
<td>20 = 7</td>
</tr>
<tr>
<td></td>
<td>&gt;50 = 50</td>
</tr>
<tr>
<td>6. % of MPD/SRA men</td>
<td>&lt;5 = 7</td>
</tr>
<tr>
<td></td>
<td>20 = 0</td>
</tr>
<tr>
<td></td>
<td>&gt;50 = 16</td>
</tr>
<tr>
<td>7. Misdiagnosed as</td>
<td>Schizophrenic = 43</td>
</tr>
<tr>
<td></td>
<td>Bipolar = 43</td>
</tr>
<tr>
<td></td>
<td>Affective = 30</td>
</tr>
<tr>
<td></td>
<td>Personality disorder = 50</td>
</tr>
<tr>
<td></td>
<td>Anxiety = 57</td>
</tr>
<tr>
<td></td>
<td>Temporal Lobe epilepsy = 13</td>
</tr>
<tr>
<td></td>
<td>Depression = 67</td>
</tr>
<tr>
<td></td>
<td>Alcoholic = 23</td>
</tr>
<tr>
<td>8. Years of misdiagnosis</td>
<td>&lt;2 = 20</td>
</tr>
<tr>
<td></td>
<td>2 = 13</td>
</tr>
<tr>
<td></td>
<td>&gt;5 = 37</td>
</tr>
<tr>
<td></td>
<td>7-40 = 37</td>
</tr>
</tbody>
</table>
Table 2. Percentage distributions of items dealing with assessment and treatment.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Breakdown of answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Helpful assessment tools</td>
<td>DES = 23%</td>
</tr>
<tr>
<td></td>
<td>MMPI = 10</td>
</tr>
<tr>
<td></td>
<td>Clinical interview = 26</td>
</tr>
<tr>
<td></td>
<td>Journaling = 23</td>
</tr>
<tr>
<td></td>
<td>Art tools = 23</td>
</tr>
<tr>
<td>10. Assessment tools not helpful</td>
<td>DES = 3</td>
</tr>
<tr>
<td></td>
<td>MMPI = 15</td>
</tr>
<tr>
<td></td>
<td>Clinical testing = 3</td>
</tr>
<tr>
<td>11. Drug therapy</td>
<td>Anxiolytics = 30</td>
</tr>
<tr>
<td></td>
<td>Sedatives = 33</td>
</tr>
<tr>
<td></td>
<td>Neuroleptic drugs = 20</td>
</tr>
<tr>
<td></td>
<td>Antidepressants = 50</td>
</tr>
<tr>
<td></td>
<td>Lithium = 33</td>
</tr>
<tr>
<td>12. Side effects</td>
<td>Different for different people = 67</td>
</tr>
<tr>
<td></td>
<td>More anxiety = 15</td>
</tr>
<tr>
<td></td>
<td>Weight gain = 6</td>
</tr>
<tr>
<td></td>
<td>Dry mouth = 6</td>
</tr>
<tr>
<td>14. Appropriate treatment techniques</td>
<td>Hypnosis = 60</td>
</tr>
<tr>
<td></td>
<td>Art therapy = 53</td>
</tr>
<tr>
<td></td>
<td>Play therapy = 33</td>
</tr>
<tr>
<td></td>
<td>Sand trays = 36</td>
</tr>
<tr>
<td></td>
<td>Gestalt = 13</td>
</tr>
<tr>
<td></td>
<td>Experiential = 30</td>
</tr>
<tr>
<td></td>
<td>Psychoanalytical = 30</td>
</tr>
<tr>
<td>15. Treatment most helpful</td>
<td>Combination = 15</td>
</tr>
<tr>
<td></td>
<td>Hypnosis = 33</td>
</tr>
<tr>
<td></td>
<td>Mapping = 15</td>
</tr>
<tr>
<td></td>
<td>Expressive psychotherapy = 28</td>
</tr>
<tr>
<td></td>
<td>Art therapy = 10</td>
</tr>
<tr>
<td>16. Techniques not helpful</td>
<td>Rigid adherence to modalities = 40</td>
</tr>
<tr>
<td></td>
<td>Failure to make correct diagnoses = 60</td>
</tr>
<tr>
<td>17. Average length of treatment</td>
<td>&lt;2 = 7</td>
</tr>
<tr>
<td></td>
<td>&gt;2 = 36</td>
</tr>
<tr>
<td></td>
<td>&gt;5 = 63</td>
</tr>
</tbody>
</table>
Table 3. Percentage distributions of items on alters, memories, integration.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Breakdown of answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Average amount of alters</td>
<td>10-20 = 50</td>
</tr>
<tr>
<td></td>
<td>20-50 = 15</td>
</tr>
<tr>
<td></td>
<td>50-160 = 30</td>
</tr>
<tr>
<td>19. Most amount of alters</td>
<td>&gt;20 = 15</td>
</tr>
<tr>
<td></td>
<td>&gt;50 = 15</td>
</tr>
<tr>
<td></td>
<td>&gt;100 = 70</td>
</tr>
<tr>
<td>20. Least alters experienced</td>
<td>&lt;3 = 15</td>
</tr>
<tr>
<td></td>
<td>6 = 60</td>
</tr>
<tr>
<td></td>
<td>10-15 = 15</td>
</tr>
<tr>
<td>21. Successful therapy</td>
<td>Reliving memories = 30</td>
</tr>
<tr>
<td></td>
<td>Functioning = 20</td>
</tr>
<tr>
<td></td>
<td>Improving personal comfort = 15</td>
</tr>
<tr>
<td>22. Regaining all memories</td>
<td>Yes = 37</td>
</tr>
<tr>
<td></td>
<td>No = 60</td>
</tr>
<tr>
<td>23. Integration necessary</td>
<td>Yes = 16</td>
</tr>
<tr>
<td></td>
<td>No = 77</td>
</tr>
<tr>
<td>24. As a therapist seen integration</td>
<td>Yes = 90</td>
</tr>
<tr>
<td></td>
<td>No = 10</td>
</tr>
</tbody>
</table>
Table 4. Percentage distributions of issues involving video training films.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Breakdown of answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Ever used film or video as training tool?</td>
<td>Yes = 53  No = 46</td>
</tr>
<tr>
<td>28. Would a film on MPD/SRA be helpful?</td>
<td>Yes = 83  No = 16</td>
</tr>
</tbody>
</table>
REFERENCES


article from Mungadze Association at the Center for the Treatment of Dissociative Disorders and Ritualistic Abuse, Bedford Texas.


