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# Return to work: A case of PTSD, dissociative identity disorder, and satanic ritual abuse

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**Abstract**. This case study investigated an intervention that enabled an individual with Posttraumatic Stress Disorder (PTSD), Dissociative Identity Disorder (DID), and satanic ritual abuse to return to work after discharge from psychiatric inpatient treatment. The Occupational Questionnaire [88] revealed past difficulties in organization, awareness of time, communication, cooperation, frustration tolerance, competition, stress management, goal setting, and amnesia resulting in incomplete tasks and sporadic attendance at work. The Role Checklist [72] identified alters valuing work and employed in the past. The Modified Interest Checklist [70] identified running as an interest that 24 alters shared. Based on the initial evaluations, three times a week treadmill running was used as an intervention that built work skills (as measured by the Clerical Work Sample of the Valpar Component Work Sample Series [97]) necessary to sustain gainful employment upon discharge. After intervention, this individual improved in awareness of time, stress management, and goal setting abilities and was less amnestic as per the Occupational Questionnaire [88] and four additional alters expressed an interest in work according to the Modified Interest Checklist [70].

Keywords: Employment, occupational therapy, running, trauma

## 1. Introduction

### *1.1. Posttraumatic stress disorder (PTSD) and work*

People with PTSD often have difficulty returning to work (after the trauma if the trauma was a singular event) [9,47] or sustaining gainful employment in general (if the trauma occurred over a prolonged period). Burton, Polatin, and Gatchel's study [12] explored the effects of mental health factors on employment outcome over time on individuals who completed a multidisciplinary functional restoration program for the treatment of symptoms induced by trauma reported subjects with anxiety disorders were significantly less likely than individuals without to return to employment after the first-year follow-up. Jaquet et al.'s study [49] on time off work and return to work after trauma reported the average time off work was 34.7 weeks and 45.2% (out of 50) of the subjects did not return to work within the year following the trauma. Studies by Michaels et al. [64–67] found clients' work status one year post trauma was dependent on mental health outcome secondary to PTSD symptoms (including substance misuse). Yet, if people did not return to work after a traumatic event, psychosocial symptoms increased [58].

Various interventions have been utilized in the treatment of people with PTSD to help them return to work. Critical incident stress debriefing was initially developed for emergency personnel with PTSD and has been described by various authors [3,15,18,68,69]. This intervention has been reported to have decreased long-term destructive behavior [4] and has been implemented for sufferers of PTSD in over 25 major disasters [45]. Ochberg [73] and Mayou and Farmer [61] described vocational rehabilitation programs for people with PTSD. Additional interventions effective in return to work in this population were cognitive be-

havior [16,63,91], prolonged exposure [94], exposure therapy [30], imagery rescripting [39], debriefing [37, 98], early intervention [59], eye movement desensitization [75,104], stress inoculation techniques [62], group treatment [76], home programs [103], and complementary and alternative medicine [42] including acupuncture, chiropractic and herbal medicines, and holistic treatments.

### *1.2. Dissociative identity disorder*

According to the DSM-IV-TR [1] and summarized below, Dissociative Identity Disorder (DID) is a dissociative disorder in which an individual has at least two separate identities/personalities each with its own characteristic defenses, ego structure, and way of relating to the world. These identities or alters, alternate to dominate control of the individual's behavior. Because some alters may be unaware of each other, the individual loses the ability to recall certain daily events and personal information that cannot be attributed to normal forgetfulness. Because of this sporadic amnesia, individuals with DID tend to have difficulty keeping track of time and often report losing hours, days, or weeks of time. Each alter may have its own name, identity, consciousness, personal history, and self-image. They may be different genders and ages, and therefore, have different sets of knowledge and levels of functioning. Different alters have been reported to have different physiological functioning as well. Specific alters may emerge under certain circumstances. There is often internal conflict and competition regarding which alter will take control of the body at any given time. Associated features include a diagnosis or symptoms of PTSD and severe sexual and physical childhood abuse. Individuals with DID tend to have unusual abilities to control pain. Repeated abuse reinforces the defense of dissociation [23]. This allows abusive memories to be stored in different memory banks that eventually split off from one another to form alters with different personalities to handle the abuse [82]. This way, no one individual has to remember all of the abuse. Instead, it is dispersed through many, some being amnesic as protection against anxiety.

A multidisciplinary intervention approach is usually taken with individuals with DID during an inpatient psychiatric hospitalization. Occupational therapy (OT) rehabilitation services were recommended most often [2,8,10,25,26,34,35,46,52,53,84,86,87]. Recommendations were frequently made for art therapy [8, 17,36,37,52,53] and also vocational counseling [8,20, 83]. Others have reported the use of music and movement therapy [51–53]. Intervention for DID usually begins with forming a good rapport so trust can occur and the individual will allow different alters to meet the OT, and contract for a therapeutic alliance. Assessment by observation happens over time for determination of each alter's individual level of function and function within the system [84,35,74,79,87,102]. This assessment would include each alter's performance skills and patterns, client factors, and areas of occupation. A map is then usually made of the different alters and includes some of their identifying information. Further intervention involves encouraging all of the alters to share their memories of abuse in order to reduce the need for separateness and so integration can take place with the knowledge that none of the alters will be eliminated, but integrated into the whole [35,74,79,84, 85,102]. This process can be arduous and take many years because of denial, lack of trust, guilt, damaged self-esteem, and a tendency to split off and dissociate painful feelings brought about by extreme abuse [53]. People with DID who have not integrated are usually not group tolerant and have difficulty participating in group projects [74]. Instead, they require one-to-one attention with an OT [79,102]. Intervention goals have included developing a trusting rapport, increasing internal cooperation, facilitating memory recall [35,74, 79,84,87,102], and vocational counseling [8,83]. Problem solving has been used to promote cooperation in the sharing of time during daily activities [74].

Different modalities have been used to treat DID. Fike [31] utilized a national survey to discover the types of modalities used most often by OTs. They were: developmental techniques for child alters, leisure and recreational activities, self-awareness and projective techniques, training in activities of daily living, and role management. Journal writing [20], psychoeducation [20], and talent groups [83] have also been used. Others have used tasks [35,79,84,87,102]. Given the different identified modalities, the second most frequently selected by OTs in the treatment of DID was physical activity (secondary to expressive arts) [79].

If a physical activity is used, the physical activity chosen should be congruent with as many alters' level of function as possible to allow for the greatest amount of participation in the activity [79] because when external information was processed by many alters, internal communication increased [102]. Once many alters are involved, the activity should enhance cooperation, communication, and later, integration among alters [25, 26,79,86]; serve as an ongoing evaluation tool [87];

foster goal setting [79], reduce stress [102], provide empowerment through task completion mastery [102], increase frustration tolerance [102], and physically express emotions [102].

Waid [102] emphasized the importance of using an activity to create a repetitive consistent routine to provide a sense of security, boundaries, and structure to contain anger, fear, and overwhelming feelings. A routine used in this way helps provide external organization that facilitates internal organization and stability [102]. By directing the individual to a task, organization occurs unconsciously as well as consciously. Increased organization through attention to task facilitates a concrete bond to the present instead of dissociation. Waid also pointed out that abuse often begins at a young age before language and a personality develop and can be an assault to any or all of the child's sensory channels from which there is no escape. Under these conditions, the child's nervous system is set for fight or flight, but motor action is inhibited because the infant cannot move [92]. In intervening with an adult individual who suffered early abuse, talk therapies may not be fully effective because there are no words for the early abuse and resultant emotions suffered. Thus, a physical activity that utilizes kinesthetic-proprioceptive, tactile, auditory, visual, gustatory, and olfactory input can help the individual release pent up motor energy that may have been stored since the time of abuse. Engaging in selected, controlled, sensory-based tasks can change helplessness into personal empowerment. Waid stated that activities in the treatment of DID should be appropriately chosen to provide a stable base on which a person with DID can construct an internal bridge between alters to foster the communication of events, emotions, thoughts, and mobility throughout the system as a whole. While activities have been used to develop organization and a more integrated self, the vocational rehabilitation of people with DID remains a challenge [21,79,81].

### *1.3. Satanic ritual abuse*

Although very controversial [29,77] and in most cases unproven by substantial evidence [55,56,78,101], a phenomena referred to as satanic ritual abuse [101] arose in the years between 1980 and approximately 1995 [14,50] in the United States and later in Norway and New Zealand [71] although its existence can be traced throughout history [32]. Satanic ritual abuse referred to the physical, emotional, and sexual abuse of children through underground satanic rituals for adult sexual gratification, the propagation of pornography, and/or the selling of drugs [28]. A satanic blood cult was a closed community of blood relatives that used satanic worship to install fear in their members while selling and engaging in child pornography and drugs [11]. Leaders were professional people [43], well connected in their community [22], but whose secret remained unknown to their colleagues and unreported by governmental agents [11]. Yet, testimony of children [28,41, 101], controversial confessions [28], documentation of therapists [5,19,22,41,55,77,96,98] and adult recall of childhood events [28,41] related horrible acts of abuse that resulted in symptoms of dissociation, drug abuse, self mutilation, depression, anxiety, and sleep disorders, among others [39]. A survey of 12,000 cases of satanic ritual abuse revealed most of these individuals were diagnosed with PTSD and DID [7]. Symptoms of co-occurring satanic ritual abuse and DID included PTSD, dissociation, survival guilt, bizarre self-abuse, indoctrinated beliefs, and substance abuse [100]. Because of skepticism [29,77], by 2003, satanic ritual abuse was thought by many to have been an episode of moral panic [101]. Some believed reports of abuse were due to improper interviewing of children [13] and/or false memories [41,89]. Currently, people refer to satanic ritual abuse as sadistic abuse [85], organized abuse [5], ritual or ritualistic abuse [48], or child sex rings [56]. The word "satanic" has been removed because the satanic rituals in satanic ritual abuse were thought to be used to control and frighten members and for sexual gratification [55,57] instead of devil worship as may be the case in other types of satanic cults. Some believed the aspect of Satan was introduced as a cover for conventional child abuse [93].

Whether or not the actual abusive events took place as reported may remain uncertain at this time. At one point in his career, Freud [33] stated whether or not an adult's childhood memories of sexual abuse accurately reflected reality was not as important as the memories themselves because they were part of the individual's psyche, and therefore affected their conscious and unconscious processes. Many clients sought psychosocial treatment for the relief of symptoms that, in many cases, greatly impaired their ability to work and function in society due to what they believed was abuse. Treatment for people with satanic ritual abuse is similar to PTSD and DID; however, there is an absence of substantial literature on return to work and satanic ritual abuse.

### *1.4. Running as a therapeutic intervention*

Ochberg [73] in his return to work intervention model used physical exercise as a coping skill for people with PTSD. Exercise has been used as a treatment modality with individuals diagnosed with other psychiatric disorders [90]. The activity of running satisfies all of Waid's suggested requirements of a task activity for people with DID [102]. Yet, an extensive literature review revealed a lack of publications to date documenting the use of running to improve work skills in individuals with PTSD, DID, or satanic ritual abuse. The purpose of this study was to investigate the use of treadmill running with an individual with PTSD, DID, and satanic cult involvement to develop work skills sufficient enough to sustain gainful employment after discharge from a psychiatric inpatient unit.

## 2. Case history

O. was approximately 26 years old when first treated on an inpatient psychiatric unit of mixed age and diagnoses. This was her first psychiatric hospitalization. At the time of admission, she was a single Caucasian and street-homeless with no friends. She had a two-year inconsistent relationship with an outpatient therapist who referred her to inpatient treatment. Upon arrival, O. was emaciated, disheveled, and had sustained cuts and burns on her forearms, legs, and back. O. explained she had been in some bad places. Her chief complaint was she had lost track of time, did not know what was happening, and could not function anymore. She appeared overwhelmed, fearful, anxious, exhausted, fragile, and depressed.

During her eight month inpatient stay, she disclosed the following history. O. was born into a satanic blood cult and chosen to be a leader. Being groomed to be a leader in the cult meant she underwent various methods from birth to purposefully split her psyche into multiple self-states or alters. Some alters were trained to be cult involved and others to survive in the real world. Most of her alters had amnesia with respect to each other, meaning they did not know the others existed and did not remember things they did. One of the methods the cult used to develop a split psyche in O. was to constantly create inconsistent experiences for her. This type of training penetrated every aspect of her life including actions, emotions, and relationships and became an internalized process. One time it was good to defecate in the toilet; the next time she was severely beaten for it. She was never given the same food or the same amount of food at any particular time. She never slept in the same place or had things of her own. Most of the time she was discouraged from forming bonds with people, yet, when she was allowed to make a friend at age five she was instructed to cut off her friend's thumb and ingest it. Other methods of splitting O.'s psyche consisted of starvation, isolation, drugging, and subjecting to extreme temperatures, deception, and sexual, physical, and emotional abuse executed at the whim of her elders without cause and effect or predictability. She never knew who her parents were, but this was not an issue for her. She felt lucky and special to be chosen to be a leader.

O. suffered severe chronic repetitive trauma [44] beginning at an early age and continuing through adulthood through an abusive satanic cult, resulting in the development of a complex defensive structure of distinct personality states rendering the diagnosis of DID. O. also developed symptoms of PTSD. She became distressed after finding drawings of traumatic events that one of her alters frequently drew at night from past memories and hid under her bed. It seemed as if O.'s traumatic memories had been distributed between alters so no one particular alter would be incapacitated by the totality of her abuse, so the realization of another's otherwise amnesic memories led O. to re-experience the event. O. suffered from flashbacks and nightmares (resulting in difficulty sleeping), keeping her in a state of hyper-vigilance. She avoided painful feelings that resulted from her trauma through dissociating or switching alters and detaching from others outside herself. Because of her inability to form secure attachments to people, O. experienced difficulty bonding with and loving others.

O. received four months of inpatient psychiatric treatment from a multidisciplinary perspective in order to stabilize her so she did not harm herself and so she could begin to function more effectively on the unit through transferring her way of being with authority figures in the cult to a healthier environment of the unit. This initial part of her inpatient treatment consisted of encouraging the different personality states/alters to emerge and tell their stories, while keeping peace with the body. Over 55 distinct alters became apparent. Some were supportive of each other, but some were not. Some fought violently (hurting the body) with each other because they disagreed or fought to take dominance of the body so they could be heard and produce motor action. As O. developed more conscious awareness of the others, their opinions, and the stories

they contained, more and more alters were created in defense, resulting in further disintegration of O.'s ego. At this point, O. needed the staff to contain, hold, and manage all of her split off alters. The staff did this through creating an echogram map of the names of O.'s alters and their relationships to each other. At the end of her fourth month of treatment, O. was stable enough to receive an OT assessment.

O.'s OT initial assessment included four evaluations the: Occupational Questionnaire (OQ) [88], Valpar Clerical Work Sample (CWS) [97], Role Checklist (RC) [24,27,72], and the Modified Interest Checklist (MIC) [59,70,80]. The latter two evaluations were administered to all of O.'s alters that were willing to participate (10 and 31 respectively). The OQ, because of its length, and the CWS were only administered to O. The OQ revealed that O. had a two year work history as an administrative assistant with the same company up until a few weeks prior to her psychiatric inpatient admission. O.'s strength at work was her intelligence and her overall endearing nature, yet she had difficulties in organization, awareness of time, communication, cooperation, frustration tolerance, competition, stress management, goal setting, and memory that resulted in several incomplete tasks and sporadic attendance at work. The RC identified which alters currently valued work, which wanted to work in the future, and which had participated in O.'s administrative job in the past. O. was able to type 25 words per minute with 11 errors according to the CWS. The MIC identified running as an interest that 24 alters shared.

Based on these initial evaluations and after a physical stress test performed by the hospital's physician, a three-time-a-week treadmill running intervention was implemented by the OT to develop O.'s problematic work skills. The intervention took place on the hospital's client treadmill during a fixed time when no one else besides O. and her OT were in the room, creating a consistently safe space for O. over a four month period. O. had run races and had treadmill experience; therefore, instruction by the therapist on how to stretch and run was not necessary. O. had 24 alters interested in running/walking who performed well on the stress test, and she reported running without tiring in the past. She and the therapist set a pattern of running. Each alter was asked to run for five minutes in a predetermined order and to remain conscious throughout the two hour run. After O. became used to running in this fashion, some of her alters were able and willing to converse with the OT during their five minutes of running. These conversations built rapport and gave the OT a better understanding of each alter's construct and purpose to O. as a whole person. Not all of O.'s past running attempts had been successful. She often did not complete races secondary to her internal disorganization and competition among alters for the body. After each treatment run and stretch, a period of processing the run occurred between O. and her OT during which problems were identified and worked through for the runs to follow. On most days, O. looked forward to each run and she even tried several times to sneak into the treadmill room during the middle of the night. This running intervention was repeated three times per week for four months until her discharge from the unit after her eight month treatment ended.

Prior to discharge and post intervention, O. was reassessed using the same evaluations. The post-OQ revealed improvements in awareness of time, stress management, goal setting, and amnesia. The RC showed that four additional alters became interested in work. O.'s typing scores improved from 25 words per minute with 11 errors (pre-intervention) to 40 words per minute with 3 errors (post-intervention) on the CWS. Upon discharge, O. was able to return to community living and her job.

## 3. Discussion

O.'s deficits in organization, awareness of time, frustration tolerance, memory, stress management, and goal setting (identification, initiation, and completion of a task or goal) are typical as reported in the literature for individuals diagnosed with PTSD and DID, as was her work performance (incomplete tasks and sporadic attendance) prior to the treadmill running intervention. O. was unable to utilize more standard pre-vocational interventions such as practicing/engaging in occupational work hardening tasks that resembled her duties on the job because her amnesia and internal conflicts precluded the organization and follow through necessary to engage in and complete these tasks. Repetitive practice alone was ineffective. Instead, she required a reorganization of her internal structure that allowed for cooperation, communication, awareness, and tolerance amongst her alters.

This reorganization of her internal structure may have been enhanced through the task of running. As O. ran, her running alters had to be aware of the passage of time, since each alter could only run for five minutes. Because five minutes is a relatively short interval of time, each of the 24 alters had to be constantly vigilant

of time in order not to miss his or her turn. If someone did miss a turn, another had to remind him or her, thereby fostering communication and cooperation and decreasing amnesia. When an alter finished running, he or she had to set the treadmill's speed and incline to the appropriate setting for the next alter. This required the running alters to communicate with each other in order to obtain knowledge regarding each other's running pattern. It also entailed cooperation and decreased competitiveness between alters who preferred to keep running rather than to switch when the time was up. Running seemed to increase organization and conscious awareness (as apposed to dissociative amnesia) amongst the alters, and therefore, of the overall functioning of O. because each alter had to be aware of the order of runners and where each fit into the order. Because the alters enjoyed running and wanted to compete with each other, they were motivated to pay attention to time and order. A certain level of tolerance was achieved by alters who had an overall goal for O. to complete a certain number of miles within the two hour time frame and alters who ran slowly or walked instead of ran. Alters that did not know how to use the treadmill had to be taught by another alter, enhancing collaboration. Running in this fashion became a stress management technique for O. because her body did not seem to physically tire, but did seem to benefit from the usual documented physical and emotional gains of exercise, such as overall stress reduction, cardiovascular and respiratory benefits, and elevated mood/decreased depression as noted by her medical doctor [95]. Running presented a way for O. to physically express emotions too difficult to discuss or experience directly. After the first week of running when the alters were familiar with the task, the OT would talk to each alter while he or she was on the treadmill to increase rapport and build trust. The more trust existed between O. and the OT, the more alters came out to the OT and to themselves because they felt more comfortable and less threatened that therapy would extinguish them. Instead, they felt they were encouraged to participate in the occupation of running and life in general. Each time the two hour run was completed, and after stretching, the OT processed the experience to help O. work out any problems that arose. All alters were expected to be present during this process, which usually lasted for an hour. Problems were discussed and solved and goals were set to improve future performance. Working in this way taught O. the skills necessary for her to master a lengthy task until completion and to show up at the gymnasium consistently. It encouraged her to take better care of her body: to stretch before and after running, to shower, and to become more aware of nutritional needs. She was better able to work with different alters (resembling teamwork) in order to accomplish her goal of running for two hours.

The skills that O. used for running were necessary for successful, consistent, completion of administrative work tasks. Many of O.'s alters were capable of typing quickly and accurately and were computer literate. Many had the necessary skills to form good relations with co-workers and authority figures. Yet, O. could not consistently use the strengths that many of her alters possessed because she had so many alters and they did not cooperate with each other but competed for time in her body and they had different ideas of what to do. Her overall work functioning was marked by disorganization and an inability to complete assignments. The running helped O. organize around a work task through fostering cooperation amongst alters, frustration tolerance, and awareness of time and of one another. Running helped her gain control of the switching of alters, so she could better utilize the strengths of a particular alter during a specific situation. For example, an alter who was very good at mathematics may be called upon to help with an accounting spreadsheet, or an alter who could present his or her self well at a board of director's meeting may be summoned to take minutes. Running helped her to focus on a goal until completion. She developed a certain amount of meta-cognition that enabled awareness of problems as they occurred and the ability to problem solve in the moment instead of becoming overwhelmed and impulsively switching alters to deal with stress. Her time management and stress management skills improved.

O.'s administrative work task performance improved as noted by her score on the clerical assessment of the Valpar Component Work Sample Series [97] after running was used as an intervention to help O. properly organize and follow through with tasks. This administrative competence is in keeping with Richert and Bergland's [79] finding that most of their 20 patients with DID were able to develop competent executive work skills. The combination of creating a plan for running, actualizing the plan, then immediately processing its execution may have been factors that enabled O. to return to work.

While this is only one case, this finding lends support for the clinical use of the MIC [70], RC [72], and OQ [88] to identify an appropriate intervention for developing work skills in individuals who have sustained traumatic experiences. O.'s case provides implications

to increase the evidence base for knowledge of traumatic symptoms and the deleterious effects on the ability to work. This case provides evidence for the ability of a very structurally (neurological brain organization) and functionally impaired individual to be able to return to work after a lengthy psychiatric hospitalization. This intervention need not take place solely in an inpatient unit or with severely impaired individuals. Intervention may more easily be administered in an outpatient setting or with the use of a community gymnasium because its effectiveness may have been, in part, related to the amount of time spent in the activity (four months). Running may be a viable technique to help other individuals with difficulties in dissociation, organization, awareness of time, stress management, and goal setting increase skills and engagement in the occupation of work if it falls within an individual's physical ability, interest, and value system.

## 4. Summary

This case study investigated the use of running to enhance work skills in an individual with PTSD, DID, and satanic ritual abuse. This individual's job was at risk because of a lengthy absence secondary to an inpatient hospital stay and a prior inability to complete administrative work assignments and attend work on a regular basis. A treadmill running protocol designed specifically to meet the client's interests, values, and goal to return to work was administered by an OT in an inpatient psychiatric unit. This client was able to increase her organization and attention enough to sustain administrative work tasks independently with consistency after an OT intervention of treadmill running three times per week for two hours at a time over a period of four months coordinated with one-to-one OT to help facilitate and process the planned task. The use of treadmill running as a therapeutic activity for OT intervention may have been associated with the ability of this individual to return to work.

## References


[1] American Psychological Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.), Author, Washington, DC, 2000.

[2] S.L. Angel, Case report: On becoming oneself, *American Journal of Occupational Therapy* **44** (1990), 1037–1043.

[3] T. Barnett-Queen and L. Bergmann, Post-trauma response programs, *Fire Engineering* (1988) 52–58.

[4] R. Beck and C. Fogarty, Vocational rehabilitation in post-traumatic stress disorders, in: *Proceedings of Rehabilitation and Stress Disorders Conference*, Southern Illinois University, eds, Southern Illinois University, Carbondale, Illinois, April 19 and 20, 1995.

[5] P.A. Bibby, *Organized Abuse: The Current Debate*, Arena, Aldershot, England, 1996.

[6] H. Boecker, T. Sprenger, M.E. Spilker, G. Henriksen, M. Koppenhoefer, K.J. Wagner, M. Valet, A. Berthele and T.R. Tolle, The runner's high: Opioidergic mechanisms in the human brain, *Cerebral Cortex* **18**(11) (2008), 2523–2531.

[7] B.L. Bottoms, P.R. Shaver and G.S. Goodman, An analysis of ritualistic and religion-related child abuse allegations, *Law and Human Behavior* **20**(1) (1996), 1–34.

[8] B.G. Braun, Issues in the psychotherapy of multiple personality disorder, in: *Treatment of Multiple Personality Disorder*, B.G. Braun, ed., American Psychiatric Press, Washington, DC, 1986, pp. 3–28.

[9] F.D. Brenneman, D.A. Redelmeier, B.R. Boulanger, B.A. McLellan and J.P. Culhane, Long-term outcomes in blunt trauma: Who goes back to work? *Journal of Trauma* **42** (1997), 778.

[10] E.J. Brown, Multiple personality patients learn to befriend themselves, *Advance for Occupational Therapists* (8 January 1990), 1–2.

[11] V. Bugliosi and C. Gentry, *Helter Skelter: The True Story of the Mansion Murders*, W.W. Norton & Company, Inc., New York, 1974/2001.

[12] K. Burton, P.B. Polatin and R.J. Gatchel, Psychosocial factors and the rehabilitation of patients with chronic work-related upper extremity disorders, *Journal of Occupational Rehabilitation* **7**(3) (1997), 139–153.

[13] CBC News, Satanic sex scandal, February 12, 2003. Retrieved on 8/26/09 from http://www.cbc.ca/fifth/martin/scandal.html. Retrieved 2007-10-31.

[14] G. Clapton, *Satanic Abuse Controversy: Social Workers and the Social work Press: Essential Issues in the 1990s*, University of North London Press, North London, 1993.

[15] D. Clark, Debriefing to defuse stress, *Fire Command* (1988), 33–35.

[16] D.J. Clauw, C.C. Engel, Jr., R. Aronowitz and E. Jones, CME Unexplained symptoms after terrorism and war: An expert consensus statement, *Journal of Occupational and Environmental Medicine* **45**(10) (2003), 1040–1048.

[17] B.M. Cohen and C.T. Cox, Breaking the code. Identification of multiplicity through art reproductions, *Dissociation* **2** (1989), 132–137.

[18] L. Comfort, Managing disaster, Duke University Press, Durham, North Carolina, 1988.

[19] J.R. Conte, *Critical Issues in Child Sexual Abuse: Historical, Legal, and Psychological Perspectives*, Sage Publications, Thousand Oaks, 2002.

[20] P. Coons, Treatment progress in 20 patients with multiple personality disorder, *Journal of Nervous and Mental Disease* **174** (1986), 715–721.

[21] P. Coons and K. Bradley, Group psychotherapy with multiple personality patients, *Journal of Nervous and Mental Disease* **173**(9) (1985), 515–576.

[22] L. Cozolino, The ritual abuse of children: Implications for clinical practice and research, *The Journal of Sex Research* **26**(1) (1989), 131–138.

[23] J.C. Curtis, Exposing multiple personality disorder, *The Canadian Journal of Diagnosis* **5**(2) (1988), 85–95.

[24] S. Cynkin and A. Robinson, *Occupational therapy and activ-*

*ities health*, Little Brown & Company, Boston, 1990.
[25] P. Dawson, *The value of occupational therapy in the treatment of multiple personality disorder*, Paper presented at the Second International Conference on Multiple Personality/Dissociative States, Chicago (1985, October).
[26] P. Dawson, Understanding and cooperation among alter and host personalities, *American Journal of Occupational Therapy* **44** (1990), 994–997.
[27] A.E. Dickerson, The Role Checklist, in: *Assessment in occupational therapy mental health*, B.J. Hemphill-Pearson, ed., SLACK, Inc., Thorofare, New Jersey, 1999.
[28] P.W. Edge, *Legal responses to religious difference*, Springer, Berlin, 2001.
[29] K.C. Faller, *Understanding and assessing child sexual maltreatment*, Sage Publications, Thousand Oaks, 2003.
[30] N.C. Feeny, E.A. Hembree and L.A. Zoellner, Myths regarding exposure therapy for PTSD, *Cognitive and Behavioral Practice* **10**(1) (2003), 85–90.
[31] M.L. Fike, Clinical manifestations in persons with multiple personality disorder, *American Journal of Occupational Therapy* **44** (1990), 984–990.
[32] D. Frankfurter, *Evil incarnate: Rumors of demonic conspiracy and ritual abuse in history*, Princeton University Press, Princeton, NJ, 2006.
[33] S. Freud, *The psychopathology of everyday life*, W.W. Norton & Company, Inc., New York, 1901.
[34] B. Frye, *Art and the multiple: Do I D.A.R.E.? A developmental framework*, Paper presented at the Fifth International Conference on Multiple Personality/Dissociative States, Chicago (3 October 1988).
[35] B. Frye, Art and multiple personality disorder: An expressive framework for occupational therapy, *American Journal of Occupational Therapy* **44** (1990), 1013–1021.
[36] B. Frye and L. Gannon, The use, misuse and abuse of art with dissociative/multiple personality disorders, *Occupational Therapy Forum* **5** (18 June 1990), 1, 3–5, 8.
[37] N.L. Fuhrman, Art interpretation, and multiple personality disorder, *Dissociation* **1** (1988), 331–340.
[38] C.S. Fullerton, R.J. Ursano, K. Vance and L. Wang, Debriefing following trauma, *Psychiatric Quarterly* **7**(3) (2000), 259–276.
[39] C. Gould, Satanic ritual abuse: child victims, adult survivors, system response, *California Psychologist* **22**(3) (1987), 9–14.
[40] B.K. Grunert, J.M. Weis, M.R. Smucker and H.F. Christianson, Imagery rescripting and reprocessing therapy after failed prolonged exposure for post-traumatic stress disorder following industrial injury, *Journal of Behavior Therapy and Experimental Psychiatry* **38**(4) (2007), 317–328.
[41] D.C. Hammond, D.P. Brown and A.W. Scheflin, *Memory, trauma treatment, and the law*, W.W. Norton, New York, 1998.
[42] A. Hankey, CAM and post-traumatic stress disorder, *Evidence-based Complementary and Alternative Medicine* **4**(1) (2007), 131–132.
[43] D. Hechler, *The battle and the backlash: The child sexual abuse war*, Macmillan Publishing Company, New York, 1989.
[44] J. Herman, *Trauma and recovery: The aftermath of violence–from domestic abuse to political terror*, Basic Books, New York, 1997.
[45] R. Herman, *Disaster planning for local government*, Universe Books, New York, 1982.
[46] J.F. Higdon, Expressive therapy in conjunction with psychotherapy in the treatment of persons with multiple personality disorder, *American Journal of Occupational Therapy* **44** (1990), 991-993.
[47] T.L. Holbrook, D.B. Hoyt, M.B. Stein and an W.J. Sieber, Perceived threat to life predicts posttraumatic stress disorder after major trauma: Risk factors and functional outcome, *The Journal of Trauma: Injury, Infection, and Critical Care* **51**(2) (2001), 287–293.
[48] P.S. Hudson, *Ritual child abuse: Discovery, diagnosis, and treatment*, R&E Publishers, Saratoga, California, 1991.
[49] J. Jaquet, I. van der Jagt, P. Kuypers, T. Schreuders, A. Kalminjn and S. Hovius, Spaghetti wrist trauma: Functional recovery, return to work, and psycholoical effects, *Plastic and Reconstructive Surgery* **115**(6) (2005), 1609–1617.
[50] P. Jenkins, Satanism and ritual abuse, in: *The Oxford Handbook of New Religious Movements*, J.R. Lewis, ed., Oxford University Press, Oxford, 2004, pp. 221–242.
[51] E.S. Kluft, J. Poteat and R.P. Kluft, Movement observation in multiple personality disorder: A preliminary report, *American Journal of Dance Therapy* **9** (1986), 31–46.
[52] R.P. Kluft, Aspects of the treatment of multiple personality disorder, *Psychiatric Annals* **14** (1984), 51–55.
[53] R.P. Kluft and R.P. Kluft, Personality unification in multiple personality disorder. A follow yp study, in: *Treatment of multiple personality disorder*, B.G. Braun, ed., American Psychiatric Press, Washington, DC, 1986, pp. 31–60.
[54] R.P. Kluft, The post-unification treatment of multiple personality disorder, *American Journal of Psychotherapy* **42** (1987), 293–298.
[55] J.S. LaFontaine, *Speak of the devil: Allegations of satanic abuse in Britain*, Cambridge University Press, Cambridge, UK, 1998.
[56] K.V. Lanning, *Investigator's guide to allegations of "ritual" childhood abuse*, 1992. Retrieved on 8/23/09 from http://web.archive.org/web/20031025012607/http://www.pointnet.calmedia/igtaorca.pdf.
[57] K. Lanning, D. Bender and B. Leone, *Satanic ritual abuse of children Is not widespread*, Opposing Viewpoints Series, Greenhaven Press, Inc., Farmington Hills, Mississippi, 1994.
[58] S. Mason, J. Wardrope, G. Turpin and A. Rowlands, Outcomes after injury: A comparison of workplace and non-workplace injury, *Journal of Trauma-Injury Infection & Critical Care* **53**(1) (2002), 98–103.
[59] J. Matsutsuyu, The Interest Checklist, *American Journal of Occupational Therapy* **11** (1967), 179–181.
[60] L.R. Matthews, Work potential of road accident survivors with post-traumatic stress disorder, *Behavior Research and Therapy* **43**(4) (2005), 475–483.
[61] R.A. Mayou and A. Farmer, ABC of psychological medicine. Trauma, *British Journal of Psychiatry* **325** (2002), 426–429.
[62] D. Meichenbaum, *Stress inoculation training*, Pergamon Press, New York, 1985.
[63] T.M. Meyer, Psychological aspects of mutilating hand injuries, *Hand Clinics* **19**(1) (2003), 41–49.
[64] A.J. Michaels, C.E. Michaels, C.H. Moon et al., Psychosocial factors limit outcomes after trauma, *Journal of Trauma* **44** (1998), 644–648.
[65] A.J. Michaels, C.E. Michaels, C.H. Moon et al., Posttraumatic stress disorder after injury: impact on general health outcome and early risk assessment, *Journal of Trauma* **47** (1999), 460–467.
[66] A.J. Michaels, C.H. Moon, C.E. Michaels et al., General health outcome following injury is most contingent on mental

health, *Surgery Forum* XLIX (1998), 534–536.
[67] A.J. Michaels, C.E. Michaels, J.S. Smith, C.H. Moon, C. Peterson and W.B. Long, Outcome form injury: General health, work status, and satisfaction 12 months after trauma, *The Journal of Trauma: Injury, Infection, and Critical Care* **48**(5) (2000), 841–850.
[68] J. Mitchell, When disaster strikes. . . The critical incident stress debriefing process, *Journal of Emergency Medical Services* **8**(1) (1983), 34–36.
[69] J. Mitchell and G. Bray, *Emergency Services Stress: Guidelines for Preserving the Health and Careers of Emergency Services Personnel*, Brady Books, Englewood Cliffs, NJ, 1990.
[70] Model of Human Occupation (MOHO) Clearinghouse, *Modified Interest Checklist*, Retrieved on 8/23/09 from http://www.moho.uic.edu/mohorelatedrsrcs.html#OtherInstruments BasedonMOHO.
[71] D. Nathan and M. Snedeker, *Satan's Silence: Ritual Abuse and the Making of a Modern American Witch Hunt*, Basic Books, New York, 1995.
[72] F. Oakley, G. Kielhofner, R. Barris and R.K. Reichler, The Role Checklist: Development and empirical assessment of reliability, *Occupational Therapy Journal of Research* **6**(3) (1986), 157–170.
[73] F. Ochberg, Posttraumatic therapy, in: *International Handbook of Traumatic Stress Syndromes*, J. Wilson and B. Raphael, eds, Plenum, New York, 1993.
[74] S. Oke and E. Kanigsberg, Occupational therapy in the treatment of individuals with multiple personality disorder, *Canadian Journal of Occupational Therapy* **58**(5) (1991), 234–240.
[75] A.C. Page and R.D. Crino, Eye-movement desensitisation: A simple treatment for post-traumatic stress disorder? *Australian an New Zealand Journal of Psychiatry* **27**(20) (1993), 288–293.
[76] L.A. Pearlman, Treatment of persons with complex PTSD and other trauma-related disruptions of the self, in: *Treating Psychological Trauma in PTSD*, J.P. Wilson, M.J. Friedman and J.D. Lindy, Eds., The Guilford Press, New York, 2001, pp. 205–236.
[77] R.D. Perrin and C.L. Miller-Perrin, *Child Maltreatment: An Introduction*, Sage Publications, Thousand Oaks, 2006.
[78] F.W. Putnam, The satanic ritual abuse controversy, Child abuse and neglect, *The International Journal* **15**(3) (1991), 175–179.
[79] G.Z. Richert and C. Bergland, Treatment Choices: Rehabilitation services used by patients with multiple personality disorder, *The American Journal of Occupational Therapy* **46**(7) (1992), 634–638.
[80] J. Rogers, J. Weinstein and J. Firone, The Interest Checklist: An empirical assessment, *American Journal of Occupational Therapy* **32** (1978), 628–630.
[81] C.A. Ross, Dissociative Identity Disorder, *Current Psychosis and Therapeutics Reports* **4**(3) (2006), 112–116.
[82] C. Ross and G. Fraser, Recognizing multiple personality disorder, *Annals of the Royal College of Physicians and Surgeons of Canada* **20** (1987), 357–360.
[83] R.G. Sachs, The adjunctive role of social support system in the treatment of multiple personality disorder, in: *Treatment of Multiple Personality Disorder*, B.G. Braun, ed., American Psychiatric Press, Washington, DC, 1986, pp. 159–174.
[84] J.M. Sepiol and J. Froehlich, Use of the role checklist with the patient with multiple personality disorder, *American Journal of Occupational Therapy* **44** (1990), 1008–1012.
[85] V. Sinason, *Treating Survivors of Satanist Bbuse*, Routledge, New York, 1994.
[86] S.T. Skinner, Multiple ersoality disorder: Occupational therapy intervention in acute care psychiatry, *Occupational Therapy in Mental Health* **7** (1987), 93–108.
[87] S.T. Skinner, Occupational therapy with patients with multiple personality disorder: Personal reflections, *American Journal of Occupational Therapy* **44** (1990), 1024–1027.
[88] H.R. Smith, G. Kielhofner and J.H. Watts, Occupational Questionnaire, *American Journal of Occupational Therapy* **40** (1986), 278–283.
[89] N.P. Spanos, *Multiple Identities & False Memories: A Sociocognitive Perspective*, American Psychological Association, Washington, D.C., 1996.
[90] G.A. Tkachuk and G.L. Martin, Exercise therapy for patients with psychiatric disorders: Research and clinical implications, *Professional Psychology: Research and Practice* **30**(33) (1999), 275–282.
[91] S. Taylor, J. Wald and G.J.G. Asmundson, Current status and future directions in the cognitive-behavioral treatment of PTSD, in: *Trends in Posttraumatic Stress Disorder Research*, T.A. Corales, ed., Nova Science Publishers, Inc., Hauppauge, New York, 2005, pp. 263–284.
[92] L. Terr, *Too Scared to Cry*, Harper & Row, New York, 1990.
[93] W. Thorpe, J.B. Gwatkin, W.P. Glenn and M.F. Gregory, Revised joint enquiry report, Nottinghamshire Social Services, 1990. Retrieved on 8/25/09 from http://www.users.globalnet.co.uk/∼dlheb/jetrepor.htm.
[94] D.F. Tolin and E.B. Foa, Treatment of a police officer with PTSD using prolonged exposure, *Behavior Therapy* **30**(3) (1999), 527–538.
[95] R. Tucker, J. Dugas and M. Fitzgerald, *Runner's World the Runner's Body: How the Latest Exercise Science can help you Run Stronger, Longer, and Faster*, Rodel, Inc., New York, 2009.
[96] R.C. Underwager and H. Wakefield, *Return of the Furies: An Investigation into Recovered Memory Therapy*, Open Court, La Salle, Illinois, 1995 Utah Governor's Commission for Women and Families, Report of Utah State Task Force on ritual abuse, 1992. Retrieved on 8/25/09 from http://www.saferchildren. net/print/utahrataskforce.pdf.
[97] Valpar Corporation, *Component Work Sample Series* (1994). Retrieved on 8/23/09 from http://www.valparint.com.
[98] S.C. Van Benschoten, Multiple personality disorder and satanic ritual abuse: The issue of credibility, *Dissociation* **1**(3) (1990), 13–20.
[99] J.J.L. Van der Klink, R.W.B. Blonk, A.H. Schene and F.J.H. van Dijk, Reducing long term sickness absence by an activating intervention in adjustment disorders: A cluster randomized controlled design, *British Medical Journal* **60** (2003), 429–437.
[100] J. Victor, Construction of satanic ritual abuse and the creation of false memories, in: *Believed-in-Imaginings: The Narrative Construction of Reality*, J. DeRivera and T. Sarbin, eds, American Psychological Association, Washington, D.C., 1998, p. 203.
[101] J.S. Victor, *Satanic Panic: The Creation of a Contemporary Legend*, Open Court Publishing Company, Chicago, Illinois, 1993.
[102] K.M. Waid, An occupational therapy perspective in the treatment of multiple personality disorder, *The American Journal of Occupational Therapy* **47**(10) (1993), 872–876.
[103] D.L. Warden, A.M. Salazar, E.M. Martin, K.A. Schwab, M. Coyle, J. Walter and the DVHIP Study Group, A home pro-

gram of rehabilitation for moderately severe traumatic brain injury patients, *The Journal of Head Trauma Rehabilitation* **15**(5) (2000), 1092–1102.
[104] J. Wolpe and J Abrams, Post-traumatic stress disorder overcome by eye movement desensitization: A case report, *Journal of Behavior Therapy and Experimental Psychiatry* **22**(1) (1991), 39–43.