12. Core, Diane, *Chasing Satan*, p.82.
13. In an October 1988 Los Angeles Times article the medical examiners of the original 13 children scheduled to testify in the McMartin Pre-school trial reported finding "scars, tears, enlarged body openings or other evidence indicating blunt force trauma consistent with repeated sodomy and rape." One of the children bled from the anus. Some had contracted venereal disease. Civia Tamarkin, a former journalist from Time and People Magazine gave a detailed account of the McMartin case and others in a recorded talk given at the 1993 Eastern Regional ISSMPD Conference. She will be publishing a book about her findings soon.
14. Vargo, Beth, "Ritual Abuse in Europe," *Believe the Children Newsletter*, Vol IX, 1992, p. 1, 6-9.
15. Personal communication and compilation by Dale McCulley, Cavalcade Productions, Ukiah, CA.
16. Vargo, Beth, "Ritual Child Abuse in Europe," *Believe the Children Newsletter* Summer 1993, vol X, issue II, p 6, and Gamino, Denise and Ward, Pamela, "Garden of horror: Parents shudder over tales of abuse at Texas day-care center," Fort Worth Star-Telegram, Sunday December 20, 1992, Section A, pp. 8-9.
17. Anastasi, Paul, "Greek Satanist Group Accused of Killing 2," New York Times Service, *International Herald Tribune*, Thursday, December 30, 1993.
18. Civia Tamarkin, an award winning journalist spoke at the 1993 Eastern Regional ISSMPD giving details of the evidence and the problems in bringing the reports of murder into the court. Tape available.
19. See Neswald, David, "Common 'Programs' Observed in Survivors of Satanic Ritual Abuse," The California Therapist, Sept/Oct. 1991, pp. 47-50. also Gould, Catherine and Cozolino, Louis, "Ritual, Abuse, Multiplicity and Mind Control," Journal of Psychology and Theology, vol 20, No. 3, 1992, pp 194-196.
20. See Scheflin, Alan and Opton, Edward M., *The Mind Manipulators*, Paddington Press, 1978. Scheflin, Alan, *Freedom of the Mind as an International Human Rights Issue*, **Human Rights Law Journal** vol. 3, No. 1-4 see particularly pp.49-64. Marks, John, *The Search for the "Manchurian Candidate,"* W.W. Norton & Co., NY, 1979., see also Budiansky, Stephen, et al, "The Cold War Guinea Pigs: The Government's Secret Experiments Using Radiation, Mind Control, Chemicals and Drugs on its Citizens," *U.S. News and World Report*, January 24, 1994 pp.33-38.
21. See Witkin, Gordon and Cary, Peter, "Through a glass, very darkly," *U.S. News and World Report*, Dec. 27, '93 - Jan 3, '94, p. 30. also Civia Tamarkin's reports on this cover up in her talk .
22. DeCamp, John, *The Franklin Cover—Up*, AWT, Inc., Lincoln, Nebraska, 1992.
23. See Henderson, Joseph, et al, *Shadow and Self*, Chiron Publications, 1990.
24. See Howard, Michael, *The Occult Conspiracy*, Destiny Books, Rochester, VT, 1989. This is an interesting book tracing occult influences in potitics and government from the time of ancient Egypt to the present.
25. Howard, p 29.
26. These positions were derived from personal discussions with Murray Stein, a Jungian analyst and author in Chicago, IL, Nathan Schwartz-Salant, an author and Jungian analyst in Princeton, NJ and Jeffrey Satinover, an author and Jungian analyst in Westport, CT.

SANDRA L. BLOOM

Hearing the Survivor's Voice: Sundering the Wall of Denial

"The need to deny death, or at least to blunt consciousness of it is shared by everyone. We could not live with a persistent awareness of death ... Denial of death may be a stabilizer of action for life's sake, but seduced by it, we may also be brought closer to the death we wish to evade." —Martin Wangh, *The Evolution of Psychoanalytic Thought on Negation and Denial*

In "Schindler's List," Spielberg's monumental film about the Holocaust, a remarkable scene takes place in the female prisoners' barracks of a forced labor camp. The characters who are speaking are all Jewish women. They have just experienced being forced into leaving their homes and moving into the Krakow ghetto and have then survived the liquidation of that ghetto, only to be imprisoned in the unspeakable conditions of the camp, a place in which random murders, arbitrary torture, and routine humiliation are part of daily life. As observers, we know what has happened to them, and we know what their future is to be. But they represent the voice of the unknowing present. Crowded together, three and four to a narrow bunk, the women are deep in conversation. One of the women is telling a story she has heard about what is happening to other Jews in places like Auschwitz. She gives what we now know to be an accurate account of the gassings and the crematoria. But her listeners actively deny that her story could be true, arguing how illogical, how incomprehensible, it would be to do such things, finally telling her to keep quiet and stop trying to scare them.

The horrors of the present are only truly known to the victims and to those who perpetrate the horror. The rest of us, the bystanders,

spend most of our lives denying the reality of the irrational all around us, despite the many lessons history has to teach us. Only when confronted with massive evidence and/or personal experience do we lower our protective shield of belief in the fundamental and controlling rationality of human existence and even then, often the shattering of our comfortable belief systems are only temporary. Denial is a potent and universal defense, protecting us from being overwhelmed by an unacceptable internal or external reality. Rafael Moses has described the functioning of denial in the political process, using examples taken not from satanic cult experiences but from the Holocaust and modern Israel. He describes an adult form of denial different from the more primitive forms of denial seen in childhood or in psychotic patients, a denial that is set in motion by relatively healthy persons, is unconscious, and is directed mainly at an external reality that represents a threat to physical or psychological existence. This form of denial can be used by the individual, by a group, by a community, or by a nation and becomes visible in the political process and is, he believes, ubiquitous. Like any defense, denial can be life-saving in the presence of acute threat, but Moses raises the question of what price we pay for this type of denial and asserts, "Bluntly stated, I believe that such denial brings about an impediment in the ability to face and therefore deal with the danger that is being partially denied. By not facing danger, the society, just as the person, is able to deal less efficiently than possible with the approaching threat." (Moses, 1989).

THE RITUAL ABUSE CONTROVERSY

In the last ten years there have been increasing numbers of reports of ritual cult abuse in children and in adults, remarkably similar in detail, from all over the United States and in other parts of the world (Cozolino, 1989; Jonker & Jonker-Bakker, 1991; Nurcombe & Unutzer, 1991; Sackheim & Devine, 1992; Sinason, in press;Young et al, 1991). Because of the sensational nature of the material and its pornographic content, it has aroused great interest and great controversy. Theories abound ranging from attention-seeking on the part of hysterical patients to theories that involve ex-Nazis and CIA-directed mind-control experiments. Unfortunately there is still a dearth of both scientifically controlled studies or good investigative journalism (Jones, 1991; Kluft, 1989; Putnam, 1991; Van Berschoten, 1990).

The entire subject of ritual abuse is so inflammatory and controversial that most discussions about the subject flare up into bitter and

divisive arguments between different camps of believers. These groups generally constellate into those who believe that there is no such thing as cult abuse, alleging that the present phenomenon is the twentieth century version of the medieval witch hysteria (Lotto, 1994) and those who believe that there is a widespread network of sadistic abusers who have been and are still in the business of abusing children for a number of scurrilous motives, not the least of which is financial gain. There are also those religious fundamentalists who believe in the literal existence of Satan as an active oppositional force to God (Richardson et al, 1991; Sackheim & Devine, 1992; Victor, 1993).

In the process of focusing on the issue of "belief" what is frequently overlooked is the very real, devastatingly destructive, and prolonged suffering of the patient. Certainly, questions can and should be raised about the nature of widespread and organized abuse. There can be no question, however, that a significant proportion of the psychiatric population suffers from syndromes that are trauma-related. Initially recognized through work with Vietnam veterans, it is now generally accepted that there is a universal reaction to overwhelming stress that has come to be called posttraumatic stress disorder. Stress that overwhelms our capacity to cope consistently produces serious biological, psychological, social and moral consequences. Many survivor groups have now been studied including disaster victims, Holocaust survivors and their children, victims of torture, prisoners of war, refugees, burn victims, and others (Wilson & Raphael, 1993). Although there are some distinguishing features about patients who report ritual abuse, in the main their symptoms differ little in nature or severity from patients with similar long-term and devastating psychological damage like concentration camp survivors, prisoners of war, and torture victims—all of whom have experienced prolonged periods of coercive control (Herman, 1992) and numerous encounters with the threat or reality of death—the death imprint (Lifton, 1993). We cannot claim direct knowledge about the exact details of the traumatic childhood experiences of our patients who report ritual abuse, many of whom suffer from multiple personality disorder, but we can say with a high degree of certainty that their symptom picture is consistent only with trauma of monumental proportions.

By now there are many accounts of the experiences that patients report, some examples of which can be found within other articles in this issue. The experienced clinician becomes readily caught on the horns of a dilemma when listening to these stories. On the one hand, the cult

survivor's account is often difficult to credit due to the frequent flamboyant nature of the story, the extremes of recounted behavior, and the ongoing elaboration of more and more detail. For any reasonable person, the inevitable questions present themselves: Where are all the dead bodies? How could this many children have been kidnapped, abused, and murdered? Could there actually exist a large group of modern men and women sane enough to pursue normal lives by day and insane enough to engage in satanic rituals by night? Why would groups of people revel in death, blood, eating excrement, fornicating with dead bodies? Is it possible for any group of humans to keep this big a secret for this long? Where is the evidence? And what could it mean to our vision of the world if, in fact, these activities are going on in a relatively widespread fashion? Who could blame any rational person for preferring an explanation that focuses on the somewhat mystical concept of hysteria that firmly bases the explanation within the imaginative pathology of the patient—usually the female patient.

A psychohistorical perspective implicitly demands a willingness to look at the other half of reality, the part we would just as soon not see, the threatening but obvious irrationality of historical and political events, of individuals and groups. Nothing illustrates the irrational as much as the alleged beliefs and practices of satanist cults. For many therapists and laypeople, the willingness to believe in the real existence of such people and practices comes gradually, a process of incremental acceptance of human cruelty and sadism, more than the sudden conversion to a belief in the unbelievable. This gradual process of exposure makes the unbelievable more believable because the shield of denial that surrounds us in our daily life is gradually reduced rather than being suddenly shattered or threatened. Much of the entire difficulty in making any sense of the present "dialogue" between those who advocate that patients' memories of abuse are false and those who assert that they are all or partially true hinges on the issues of credibility and experience.

As I have stated in another work, "Ten years ago, had a patient come to me and told me that they had been sexually and physically abused in a satanic cult, that they had been forced to engage in the most degrading of acts, that they had participated in the sacrifice and cannibalism of infants and adults, I would have diagnosed them as suffering from some form of paranoid disorder and I would have tried antipsychotic medications to treat their delusions. I would have labeled their dissociative experiences psychotic. I would have found any excuse to get them out of my practice and out of my life. I could not bear to believe that such things are possible. Now I recognize that there is a very long continuum of human pain and human possibility" (Bloom, 1994).

SPEAKING FROM PERSONAL EXPERIENCE

My comments must be understood within the context of my own experience. I have been running an inpatient psychiatric unit since 1980. Around 1986, we began recognizing that we had been denying the impact of childhood abuse on many of our patients, even though, in many cases, we had that information available to us. Our patients did not suddenly begin telling us about their abuse as a result of influence from us, the media, or anyone else. They had been telling us all along, we had just been refusing to listen (Jacobson & Richardson, 1987). When we reviewed old charts of patients who had been readmitted to our unit we discovered that they often had told us about information that only now began to make sense. We had a particularly interesting situation since, being in a relatively stable community with a stable practice, many of our patients were people we treated before and after we had begun to recognize abuse as a major treatment issue and we were therefore able to see our own "before and after" results. As we expressed a willingness to take this information more seriously and include it in our treatment recommendations, our patients began to respond rather dramatically to the change in us, in our willingness to see them as credible informants about their own histories, as suffering human beings who deserved our respect rather than our disdain. When we began validating the horror and injustice of their experiences and in return offered a comprehensive cognitive framework within which they could understand and begin to restructure their symptoms, treatment became much more effective and patients previously considered virtually hopeless began to show improvement which has been sustained. Many of these patients entered treatment with clear memories of their childhood physical, sexual, or emotional abuse. Others had fragments of memories but had begun having flashback experiences that were vivid and terrifying. Still others, with symptoms similar to the first two groups, remembered little until after they had entered treatment. For the first several years, we had few preconceptions about the nature of the entire recovery process. This was all new material to us. Little that we had been taught in our various training programs prepared us for what we were inadvertently uncovering.

I can say quite unequivocally that we had no previous agenda, no ax to grind, no crusade to launch. We simply were willing to admit that

up until that point our methods of treatment and the extent of our understanding of psychiatric disorder was quite limited and we were, therefore, still open to new learning. What we learned was not from textbooks, was not anything we wanted to know about, was not conveyed easily or comfortably to us by our patients. The reality of child abuse was hard to digest, internally conflictual for us all, made us feel contaminated, deskilled, angry, resentful, disgusted, frightened, and sad. Only our respect for these survivors of traumatic experience kept us able and willing to listen. As we began to recognize their courage instead of seeing only their failures, they inadvertently rewarded our "efforts" by improving, and like any other scientific discovery, we suspected that we were on to something quite important, something with major implications for the culture.

But not everyone improved. Gradually we began to notice a subgroup of patients whose symptoms were similar to those of our most traumatized survivors, symptoms also consistent with those of other survivor groups who had suffered severe, prolonged, dehumanizing experiences—Holocaust survivors, victims of torture, prisoners of war. Many of them also were diagnosed as suffering from multiple personality disorder known to be etiologically linked to severe, repetitive, and inescapable trauma in childhood. But there were also differences in their clinical presentation, differences that though hard to quantify were easily identifiable by the entire clinical team. Their symptoms were, somehow, worse, more severe, more disabling, more encompassing. Their general level of terror was higher, more paralyzing, more persistent. They would be "triggered" by an unusual number of everyday articles like knives, articles of clothing, jewelry, by specific dates, by symbols, particularly religious symbols although they were not necessarily religious. And when any of these objects or events triggered a flashback experience similar to many other trauma survivors, their fear and symptoms of physiological hyperarousal were markedly greater and far more difficult to soothe. Their ability to connect with other human beings was significantly more impaired than others, and they had a clearer tendency to test the boundaries and reliability of relationships than other patients with the more typical intrafamilial abuse. They showed more difficulty tolerating group therapy and appeared to be particularly disturbed by the physical layout of the group in a circle, especially if music was in any way involved in the group setting. They had a pronounced heightened tendency to dissociate in the group setting as well, and tended to be more dissociative than even

other multiple personality patients. In their art work , they consistently limited themselves to using only reds, blacks, and grays and the same representations would appear over and over among people who had no contact with each other and had not even begun to talk about ritual abuse—bloody bodies on altars, tombstones, upside-down crosses, hooded and robed figures, crowds of watching figures, pentacles, blood, excrement. dismemberment, aborted fetuses, animals being killed. When asked about these drawings, the patient would often deny that they had any meaning, apparently oblivious of the actual content.

These patients had other characteristics that began to differentiate them from others on the unit once we became clinically sophisticated enough to notice. Victims of early childhood trauma often are quite self-destructive and victims of sexual abuse, particularly, commonly self-mutilate, often repeatedly inflicting cuts to their arms and legs. But these patients cut more and cut more bizarrely. Not infrequently they made wounds not just to their arms and legs but to their abdomens, their faces, their genitals. And we noticed that this behavior seemed to be provoked by much lower levels of distress than other patients. Additionally, their general level of rage, hostility, aggression, detachment from others, lack of trust, and impairment in the capacity to attach to others seemed much greater than patients, who for instance, were incest victims or victims of other kinds of sexual assault and more similar to reports of concentration camp survivors and other victims of prolonged imprisonment and torture (Lifton, 1993). When they did spontaneously form tight interpersonal bonds, it was usually to patients with a similar constellation of symptoms, and the two or three of them would quite rapidly form a "minicult" that became quite exclusive of other members of the community and an air of secrecy permeated these bonds, an attitude that only the other could truly understand their experience.

Despite the clinical evidence that these patients had been severely traumatized in unusual ways that were somehow quite different from the abuse suffered by other patients we were treating, we resisted the information that started to appear in the literature and conferences that pointed to the possibility of organized ritual abuse. It was too bizarre to contemplate, too irrational, too horrible, too frightening. And this comes from clinicians who had been hearing bizarre tales of cruel and irrational behavior for years—children savagely beaten, deliberately burnt, tied to doghouses and starved, passed from family member to family member for sexual pleasure, and many of these ac-

counts had corroborating evidence. We had spent years, by this time, bearing witness to human cruelty to children, and yet we still resisted the possibility that such cruelty could spring from organized groups of family members and other adults who were presumably motivated by power, money, sadistic pleasure, and bizarre "religious" beliefs, despite the obvious existence of child pornography—which somebody must be filming—and the well-established practice of child prostitution documented in many areas of the world (Simons, 1993; Nash, 1993). To be perfectly frank, many of us still have a great deal of difficulty accepting the reality of satanic cults, and yet when faced with the clinical material, the actual presence and witness of the suffering patient, one cannot help but become convinced that the greatest danger is not that well-meaning clinicians will be found gullible in the face of histrionic patients. The greater danger is that as we colluded for the last century in denying the reality of child abuse, so too will we deny the more flagrant examples of human evil, despite the manifest twentieth century examples of the Nazis, the Cosa Nostra, the torturers in South America and Southeast Asia, or closer to home, Dresden, Hiroshima, Nagasaki, Iraq.

Many of the questions raised by skeptics are valid and need to be answered, but answers need to be sought from a perspective of open-minded investigation, not from the point of view of absolute belief or non-belief, and too frequently the critics are as strident, sarcastic, self-assured, and condescending about their criticism as the true believers are in their certainty. As the matter stands now, we cannot be sure about the extent of ritual abuse. Although there have not been many convictions, there have been some, and even in the most widely known cases there has been a great deal of information that leads one to question not so much the innocence of the alleged perpetrators as the faulty investigative procedures or legal procedures of the criminal investigative and judicial branches of various levels of government (Kahaner, 1988; Sinason, 1994; Summit, 1987; Tate, 1991; Timarkin, 1993). It certainly is possible that there are other explanations that could explain the similarities between the symptoms of these patients and those of other victims of prolonged coercive control, including explanations that focus on fantasized elaborations of actual family pathology (Lotto, 1994), but such explanations do not apply consistently to all the cases. No one has investigated the possibility that some of these patients may have experienced very early infant or childhood traumatic experiences like premature birth and the use of incubators, surgical experiences, accidents, prolonged illnesses to see if there may be a correlation, experiences that to a young, nonverbal child could feel persecutory, life-threatening, and tortuous.

But for us to believe that satanic, organized, ritual abuse does not occur, someone is going to have to offer us an explanation that is at least as credible as the eyewitness accounts of our adult patients and the child patients of our colleagues. This is not to say that every person who says that they were ritually abused was, or that the country is actually being run by a bunch of satanists. Incompetent therapists do exist, memory is at times fallible, people are at times open to the influence of others, and there are cases in which people would presumably rather believe they were victimized by an anonymous cult rather than by their beloved father, but nonetheless it is impossible to rule out the existence of organized, motivated criminal behavior by a group of adult sadists who require an ever-increasing level of sadistic behaviors in order to have their perverted urges sated. We would much prefer to believe that Jeffrey Dahmer is the only human being sitting around enjoying eating people, but after our exposure of the last several years we are fully aware that human aberration is more common than any of us would like to admit. We would like to forget that the roots of human social experience go back to human sacrifice in virtually all parts of the globe and power has always been gained by killing others (Tierney,1989). Although we do not want to believe in the existence of satanist cults, and despite the fact that we have no evidence other than the walking evidence of our damaged patients, we do find it possible now to believe that they *could* exist. And to properly investigate this phenomenon we have to get it out of the realm of belief and into the realm of possibility while looking for proof.

THE "FALSE MEMORY SYNDROME" CONTROVERSY

Given the inflammatory nature of the abuse material in general, and the cult material specifically, and given the enormous social implications of any meaningful attempt to correct the situations in which abuse flourishes, it should come as no surprise that a backlash phenomenon would occur, not entirely unlike the "denial of the Holocaust" movement (Lipstadt, 1993).

The False Memory Syndrome Foundation originated in Philadelphia in 1992. It was founded by Dr. Pamela Freyd, a professor at the University of Pennsylvania, who is not clinically trained. Dr.Freyd serves as the executive director of the Foundation. The Foundation was

formed to "aid the victims of what is being called false memory syndrome." The FMSF quickly founded a board of directors upon which sat some prominent clinicians, including Dr. Harold Lief, a psychiatrist who had treated Dr. Freyd and her husband in the early ë80's. Ralph Underwager, another prominent board member of the FMSF resigned last year after giving an interview to a Dutch journal of pedophilia in which he described sex with children as a "responsible choice for the individual" (Fried, 1994). According to a newspaper article, Dr. Freyd "started the foundation because she has had 'personal experience' with a child conjuring up false memories" (Every, 1992). Recently it has been made public that the personal experience referred to by Dr. Freyd is quite personal, since her daughter, a professor of psychology at the University of Oregon, accused her father of having molested her as a child (Freyd, 1993).

The members of this group are predominantly parents and family members who have been accused of abusing—usually sexually abusing—their children. It is of note that the need for such an organization is at least temporally related to lawsuits filed against parents as a result of changes in the statutes of limitation for many states. The annual budget of the foundation now is over $600,000 (Fried, 1994).

The Problem, as stated in the False Memory Syndrome Foundation statement of mission and purpose, is this:

> Increasingly throughout the country, grown children while undergoing "therapeutic" programs have come to believe that they suffer from "repressed memories" of incest and sexual abuse. While some reports of incest and sexual abuse are surely true, these "decade-delayed memories" are too often the result of False Memory Syndrome caused by a disastrous "therapeutic" program. False Memory Syndrome has a devastating effect on the victim and typically produces a continuing dependency on the very program that creates the syndrome. False Memory Syndrome proceeds to destroy the psychological well-being of not only the primary victim but—through false accusations of incest and sexual abuse—of other members of the primary victim's family. (FMS Foundation)

The use of the medical term "syndrome" is interesting since it lends credibility to something that has not yet been shown to exist, for which there have been no clinical trials, no scientifically controlled comparison groups, no research to document or quantify the alleged phenomenon. It is also of interest that the word "false" suggesting an

element of lying and deception, was chosen instead of possibly more accurate words like distorted, layered, complex, confused, or altered (Olio, 1993).

The Foundation appears to be composed of a variety of people with different issues as complaints. Some appear to dislike survivor groups and the self-help movement, leveling rather vicious attacks at books like "The Courage To Heal," a self-help book for incest survivors. Others report on the unreliability of hypnotic or drug-induced recovery of memory, others deny the reality of the possibility of repressed memory claiming there is no such thing, others base their incredulity on the reports of ritual abuse, still others question the epidemiological findings (Loftus, 1992, 1993; Ofshe & Watters, 1993; Olio, 1993). Some of the criticism that is lodged against the field is correct and warranted. But there is a notable lack of substantiation for their claims and a degree of overgeneralization that is definitely "unscientific." Yet they have received a great deal of publicity nationally and internationally for their claims. The Freyd family has been called "the most influentially dysfunctional family in America" (Fried, 1994). Little attention has been paid to the notable fact that there has been an identifiable "false memory syndrome" known for centuries—perpetrators of many crimes are well known to deny charges brought against them. As David Calof has pointed out, "Advocates of false memory often paint a picture of an idyllic family victimized by overzealous or unethical therapists and lying clients. They avoid discussing the possibility of lying, sociopathy, amnesia, dissociation, alcohol blackout, and other "false memories" of the families themselves" (Calof, 1993). Even FMSF board members have admitted privately that they assume that at least some of the members of their organization are guilty as accused (Fried, 1994).

The premise is basically that through a variety of methods—suggestion, hypnosis, drugs—therapists are implanting pseudomemories of abuse into thousands of unwitting patients' heads. Memory is fallible and certain memory research studies are used as support for this claim. The implication is that a great deal of the motivation for all this is greed on the part of therapists, and lawsuits against therapists are encouraged. This "flood" of cases is being created by therapists because it makes them money, not because there are so many people who have been abused. Patients are just trying to blame someone else for their problems that can be explained in other ways. Interestingly, it is never stated what all those other explanations actually are. There is a pre-

sumption that, somehow, accusing your closest relatives of the highest act of betrayal creates a simple solution to one's problems, presumably only for women. Naive and suggestible, hysterical women—there are few complaints related to male victims—are being led falsely astray by greedy or ignorant therapists who use Svengalian methods to dredge up false memories and then direct the patients to terminate all ties with their innocent, but beleaguered parents. Interestingly also is that the focus of attention is on sexual abuse, not physical abuse, neglect, or emotional abuse, despite the fact that many of the presenting symptoms are similar..

It must be kept in mind that there have not yet been any documented, controlled studies that support any of these claims. Scientific terminology is used to describe anecdotal events, studies done on normal people are applied to traumatic situations, most members of the professional board have relatively little clinical experience in dealing with many of the abuse-related syndromes, no other substantial explanation for these syndromes has been offered that positively influences the course of treatment. Nor is there any explanation for how perfectly normal, supposedly healthy human beings could be influenced, sometimes within a session or two, by a perfect stranger, to suddenly and spuriously believe that someone in their family had molested them as a child. This goes against everything we know about attachment behavior. If people are so astonishingly susceptible to suggestion then we would like to know why patients have been so reluctant to respond to our oft-repeated suggestions that they trade in their symptomatic behavior for healthier actions. This simply defies not just clinical experience, but common sense. Go up to a friend, relative, or stranger on the street and say something insulting about a member of their family and they are much more likely to react violently against you then they are to agree with your negative judgment. Children tend to be extremely protective of family members even as adults and although they may say negative things about their parents, they are likely to defend those same parents against the criticism of others.

Let us focus for a minute on the epidemiologic argument that basically alleges that the rates of sexual abuse are grossly overestimated. By now, there have been many studies that support the incidence of child abuse in this country and throughout the world, the best being a study done by sociologist Diana Russell, indicating that one girl in three is sexually abused by age 18 (Russell, 1986). To claim that these numbers are highly controversial is just nonsense. Nothing in science

can be considered to be absolutely "proven," but there is considerable support for the hypothesis that a significant proportion of the female and male population are sexually abused in childhood.

The memory question also must be addressed. Dr. Elizabeth Loftus has been an active member of the FMSF Board. Her area of interest is in the mechanism of memory. She has been able to create false memories in the minds of volunteers (Loftus, 1992). However, neither she nor anyone else have in any way recreated the traumatic situations which characterize our patients' experience. It is clearly injudicious, and scientifically invalid, to generalize from research findings on normal subjects and apply these findings to traumatic memory. There is a growing body of research evidence, based on human and animal data, that the mechanism of memory that is functioning during states of terror and hyperarousal is quite different from that of normal memory encoding (Herman, 1993; Van der Kolk, 1993), so different in fact, that they are not really comparable.

Judith Herman and Mary Harvey have put the memory research problem quite cogently:

> To generalize from these findings [laboratory findings of normal memory and the acquisition of false memory] to the real situation of adult survivors, it is necessary to make four assumptions. 1) The patient is as suggestible as a motivated student volunteer, and trusts her therapist as much as that volunteer trusts a brother or sister [the experimental situation]. 2) The therapist, unassisted by the patient's family, is capable of planting a wholly inaccurate, scripted scenario in the patient's mind. 3) An adult patient who has not been abused would find the idea of sexual abuse by a trusted caretaker or devoted parent as plausible as a moderately upsetting event that might occur even in the happiest childhood, such as being temporarily lost in a store, and finally 4) False memories inspired by therapists are not only theoretically possible, but also probable enough to warrant an especially high degree of skepticism. No evidence supports any one of these assumptions; to string all four of them together violates the rule of parsimony. Such speculations fail to meet minimal standards of serious social research (Herman and Harvey, 1993).

It is also worthy of note that, in all the studies used to discredit patient's memories, what is not recalled, or recalled falsely, are relatively insignificant details of events. People falsely remembered where they

were when the Challenger disaster occurred, but no one falsely remembered that it happened and people died. In fact, more recent evidence on the San Francisco earthquake by the same people who did the Challenger study indicates that "memories of the circumstances surrounding the earthquake for those subjects who actually experienced the earthquake were essentially perfect" (Olio, 1993).

Among the proponents of the "false memory syndrome," there are frequent claims that repressed memory does not exist, although apparently the concept of "normal forgetting" or "motivation driven memory failure" are not so open to question, even among the memory researchers critical of repression, although no one has satisfactorily demonstrated to us the differences between these terms (Olio, 1993; Watters, 1993). Yet, in a study done by Herman and Schatzow in 1987, most of the study group of sexually abused women reported delayed recall after a period of either partial or complete amnesia and 75% of them obtained independent corroborating evidence for the abuse. Another 9% found strongly suggestive but not conclusive evidence. Another 11% did not attempt to find confirmation. Only 6% could not find any supporting evidence (Herman and Schatzow, 1987).

In another recent study, Linda Williams of the Family Violence Research Laboratory at the University of New Hampshire found that of 200 children who had been part of an NIMH study on sexual abuse in the early 1970's, one in three did not remember the experiences that had been documented in their hospital records twenty years before (Herman and Harvey, 1993; Williams, 1992).

The False Memory Syndrome Foundation has raised legitimate concerns, particularly about poorly trained therapists. Adults who have been abused as children often present with a complex array of symptoms that have been unresponsive to other interventions.To the extent that the "false memory" debate encourages the mental health field to be more rigorous in its scientific and ethical methodologies, it serves a highly constructive purpose. To the extent that the debate encourages a resurgence of social denial of abuse and protects the perpetrators, it serves a highly destructive purpose. Although there is no good documentation for the consistent presence of false memory on the part of victims, there is a great deal of documentation for the presence of false memory on the part of perpetrators. The organized and motivated torture of other human beings for political, financial, religious, and idealogical purposes can be found throughout history. If an entire movement can be founded denying the reality of the Holocaust as an "other

side" of history (Lipstadt, 1993), then it is entirely conceivable that large portions of a society can deny the more covert forms of abuse that originate within the family structure. As has been well- documented, there is a long history of denial and false memory on the part of the mental health profession and the society it represents (DeMause, 1990, 1991; Greaves, 1992; Herman, 1992; Masson, 1984; Rush, 1980; Summit, 1987,1988,1989,1992; Van der Kolk, 1990). But, when we are able to stop denying the reality of the cruelty that human beings inflict upon each other, then we are able to look at the role that trauma has played in the creation of many of the world's problems including many psychiatric disorders.

The author would like to thank J. Foderaro, R. Ryan, J. Vogel, M. DeArment, and E. Mayro for their assistance in the preparation of this paper.

Sandra L. Bloom, M.D. Medical Director, Sanctuary at Northwestern, Fort Washington, Pa, USA. and President, The Allliance for Creative Development.

REFERENCES

Bloom, SL (in press). Creating sanctuary: ritual abuse and complex post-traumatic stress disorder. In V. Sinason: Treating Survivors of Satanist Abuse. London: Routledge.

Calof, D (1993). Facing the truth about false memory. The Family Therapy Networker, September/October.

Cozolino, LJ (1989). The ritual abuse of children: implications for clinical practice and research. The Journal of Sex Research 26:131-138.

DeMause, L (1982). Foundations of Psychohistory. New York: Creative Roots.

DeMause, L. (1990). The history of child assault. The Journal of Psychohistory, 18(1), Summer.

DeMause, L. (1991). The universality of incest. The Journal of Psychohistory. Vol. 19, No. 2.

Every, Mary (1992). Memories: true or false? Santa Barbara News-Press, October 18, 1992.

FMS Foundation Mission and Purpose Statement

Fried, S (1994). War of Remembrance. Philadelphia Magazine, January, p 66.

Freyd, J (1993). Personal perspectives on the delayed memory debate. Family Violence and Sexual Assault Bulletin, Volume 9, Number 3. .

Greaves, GB. (1992). Alternative hypotheses regarding claims of satanic cult activity: a critical analysis. In DK Sackheim & SE Devine. Out of Darkness: Exploring Satanism and Ritual Abuse. New York: Lexington Books.

Herman, JL. (1981). Father-Daughter Incest. Cambridge, Mass: Harvard University Press.

Herman, JL. (1992). Trauma and Recovery. New York: Basic Books.

Herman, JL. (1993). Adult memories of childhood trauma: current controversies. Paper presented at the Annual Meeting of the American Psychiatric Association, May 26, 1993.

Herman, JL. & Harvey, M. (1993). The false memory debate: Social science or social backlash? In the Harvard Medical School Mental Health Letter.

Herman, JL. & Schatzow, E. (1987). Recovery and verification of memories of childhood sexual trauma. Psychoanalytic Psychology, Vol.4, No.1.

Jacobson, A. and Richardson, B. (1987). Assault experiences of 100 psychiatric inpatients: evidence of the need for routine inquiry. Am J Psychiatry 144:7, July 1987.

Jonker, F. & Jonker-Bakker, P. (1991). Experiences with ritualistic child sexual abuse: A case study from the Netherlands. Child Abuse and Neglect 15: 191-196.

Jones, DPH (1991). Ritualism and child sexual abuse. Child Abuse and Neglect 15: 163-170.

Jung, CG (1953). Psychological Reflections: A Jung Anthology. As quoted in Bartlett, J. Bartlett's Familiar Quotations. New York: Little, Brown and Company.

Kahaner, L (1988). Cults That Kill: Probing the Underworld of Occult Crime. New York: Warner Books.

Kluft, RP (1989). Reflections of allegations of ritual abuse. Dissociation II, 4:191-193.

Kuhn, TS (1970). The Structure of Scientific Revolutions. Chicago: University of Chicago Press.

Lifton, RJ (1993). From Hiroshima to the Nazi doctors: The evolution of psychoformative approaches to understanding traumatic stress syndromes. In Wilson JP & Raphael B (Eds): International Handbook of Traumatic Stress Syndromes. New ork: Plenum Press.

Lipstadt, Deborah (1993). Denying the Holocaust: The Growing Assault on Truth and Memory. New York: The Free Press.

Loftus, EF. (1992). When a lie becomes memory's truth: memory distortion after exposure to misinformation. Current Directions in Psychological Science, Vol.1, No.4.

Loftus, EF (1993). The reality of repressed memories. American Psychologist 48:5, 518-537.

Lotto, D (1994). On witches and witch hunts: ritual and satanic cult abuse. Journal of Psychohistory, Volume 21, Number 4.

Masson, JM. (1984). The Assault on Truth: Freud's Suppression of the Seduction Theory. New York: Farrar, Strauss and Giroux.

Moses, R (1989). Denial in political process. In EL Edelstein, DL Nathanson, AM Stone (eds): Denial: A Clarification of Concepts and Research. New York: Plenum Press.

Nash, NC (1993). Argentines say a sex cult enslaved 268 children. The New York Times, Friday, September 3.

Nurcombe, B & Unutzer, J (1991). The ritual abuse of children: clinical features and diagnostic reasoning. J Am Acad Child Adolesc Psychiatry 30:2; 272-276.

Ofshe, R & Watters, E. (1993). Making monsters. Society, March/April, 4-16.

Olio, KA. (1993). The truth behind the false memory syndrome. (unpublished paper).

Putnam, FW. (1991). The satanic ritual abuse controversy. Child Abuse and Neglect 15: 175-179.

Richardson, JT; Best J, & Bromley DG (1991). The Satanism Scare. New York: Aldine de Gruyter.

Rush, F. (1980). The Best Kept Secret: Sexual Abuse of Children. New York: McGraw-Hill.

Russell, DEH. (1986). The Secret Trauma: Incest in the Lives of Girls and Women. New York: Basic Books.

Sackheim, DK & Devine SE (1992). Out of Darkness: Exploring Satanism and Ritual Abuse. New York: Lexington Books.

Schwartz, J. (1992). The Creative Moment: How Science Made Itself Alien to Modern Culture. London: Jonathan Cape.

Simons, M (1993). The sex market: scourge on the world's chidren. New York Times, April 9, 1993.

Sinason, V (in press). Treating Survivors of Satanist Abuse. London: Routledge.

Summit, RC. (1987). Too terrible to hear: Barriers to perception of child sexual assault. Paper written in support of testimony before the U.S. Attorney General's Commission on Pornography, Miami, Fla, November 20, 1985.

Summit, RC. (1988). Hidden victims, hidden pain: Societal avoidance of child sexual abuse. In GE Wyatt & GJ Powell, Lasting Effects of Child Sexual Abuse. Newbury Park: Sage Publications.

Summit, RC. (1989). The centrality of victimization: Regaining the focal point of recovery for survivors of child sexual abuse. Psychiatric Clinics of North America, Vol. 12, No.2.

Summit, RC. (1992). Misplaced attention to delayed memory.

The American Professional Society on the Abuse of Children Advisor. Summer, 1992.

Tate, T (1991). Children For the Devil: Ritual Abuse and Satanic Crime. London: Methuen,.

Tierney, P (1989). The Highest Altar: Unveiling the Mystery of Human Sacrifice. New York: Penguin Books.

Timarkin, S (1993). Professional Forum: Investigative issues in ritual abuse cases. Presented at Eastern Regional Conference on Multiple Personality and Dissociation, Alexandria, Virginia, June 3-8. Tape 50A&B.

Van Benschoten, SC (1990). Multiple personality disorder and satanic ritual abuse: the issue of credibility. Dissociation III,1;22-30.

Van der Kolk, BA. (1987). Psychological Trauma. Washington, D.C.: American Psychiatric Press.

Van der Kolk, BA (1993) Trauma, affects, and the brain. In Ablon SL, Brown D, Khantzian EJ, & Mack JE (Eds.) Human Feelings: Explorations in Affect Development and Meaning. Hillsdale, NJ: The Analytic Press..

Van der Kolk, BA., Brown, P., & Van der Hart, O. (1990). Pierre Janet on Post-Traumatic Stress. Journal of Traumatic Stress, Vol.2, No.4.

Victor, JS. (1993). Satanic Panic: The Creation of a Contemporary Legend. Chicago: Open Court.

Wangh, N. (1989). The evolution of psychoanalytic thought on negation and denial. In Edelstein EL, Nathanson DL and Stone AM (Eds). Denial: A Clarification of Concepts and Research. New York: Plenum Press.

Watters, E. (1993). Doors of memory. Mother Jones, Jan/Feb.

Williams, LM. (1992). Adult memories of childhood abuse: Preliminary findings from a longitudinal study. The American Professional Society on the Abuse of Children Advisor. Summer, 1992.

Wilson, JP & Raphael, B (Eds) (1993). International Handbook of Traumatic Stress Syndromes. New ork: Plenum Press.