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An Analysis of Ritualistic and Religion-Related Child Abuse Allegations

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A stratified random sample survey of clinical members of the American Psychological Association was conducted to determine the number and nature of cases involving alleged ritualistic and religion-related child abuse, whether reported directly by children or retrospectively by adults. Results indicated that only a minority of clinical psychologists have encountered ritual cases, but of those, the vast majority believe their clients' claims. Even so, the purported evidence for the allegations, especially in cases reported by adults claiming to have suffered the abuse during childhood, is questionable. Most clients who allege ritual abuse are diagnosed as having multiple personality disorder or post-traumatic stress disorder, two increasingly popular, but controversial, psychological diagnoses. Clinical and legal implications are discussed and a future research agenda is urged.

One of the most shocking and baffling claims to emerge from American society's recent confrontation with child abuse is that satanic or ritualistic abuse has been occurring for decades and is still widespread. Hundreds of children and adults have reported abuse involving multiple perpetrators; intergenerational cults; and quasireligious rituals complete with grotesque sexual assaults, human sacrifice, cannibalism, and consumption of blood, urine, and excrement (Gould, 1987; Kahaner, 1988; Raschke, 1990; Ryder, 1992; Sakheim & Devine, 1992; Sinason, 1994). Law enforcement professionals have responded with seminars in which satanic crime "experts" recount classic cases, summarize the history of the occult, and explain how to identify satanic activity. State legislatures have even passed special laws targeting this kind of crime,[4] and mental health professionals have held countless con-

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[4]For example, in 1992, Illinois enacted the following law, which is a point by point response to allegations of satanic ritual abuse involving torture and human sacrifice: "A person is guilty of ritualized abuse of a child when he or she commits any of the following acts with, upon, or in the presence of a child as part of a ceremony, rite or any similar observance: (1) actually or in simulation, tortures, mutilates, or sacrifices any warm-blooded animal or human being; (2) forces ingestion, injection or other application

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ferences and workshops in which supposed experts discuss how to recognize and treat "ritual abuse." Books by psychotherapists, from *Michelle Remembers* (Smith & Pazder, 1980) to *Lessons in Evil, Lessons from the Light* (Feldman, 1993) have stirred the interest of psychologists, attorneys, journalists, and the general public. Dramatic court cases involving ritualistic allegations (e.g., the McMartin daycare case in Manhattan Beach, CA) have cost millions of dollars and received extensive media attention.

Of special significance to psychologists, and to legal professionals who rely on their evaluations, interviews, and testimony, is the claim that many cases of alleged ritual abuse emerge in the context of psychotherapy. This has caused courts to question the credibility of child witnesses whose reports arise in therapy (e.g., *Felix and Ontiveros v. Nevada*, 1993) and has led skeptical social scientists (e.g., Richardson, Best, & Bromley, 1991) to doubt the competence and wisdom of psychotherapists and the advisability of using certain therapeutic methods, such as hypnosis, and diagnostic categories such as multiple personality disorder (MPD).

Surprisingly, given the multifaceted impact on American society of ritual abuse claims, few scientific studies of these allegations have been conducted. Existing studies documenting severe psychological effects of alleged ritual abuse generally rest on the assumption that reports of ritual abuse can be taken literally (e.g., Jonker & Jonker-Bakker, 1991; Kelley, 1988, 1989, 1992; Young, Sachs, Braun, & Watkins, 1991). Research dealing with multiple personality disorder (MPD), an increasingly diagnosed form of psychopathology thought to result from severe childhood trauma (Kluft, 1985; Putnam, 1989), has also seemed to support the claim that ritualistic abuse has extremely damaging psychological effects (e.g., Hopponen, 1987; Kaye & Klein, 1987; Lawson, 1987; Sachs & Braun, 1987). Indeed, if such abuse is occurring, one would expect its psychological sequelae to be devastating.

In contrast, skeptics claim that ritual abuse, especially so-called satanic cult abuse, either does not exist at all or occurs very infrequently, perhaps only at the behest of a deranged individual and never in connection with an organized network of satanic cults (e.g., Ofshe & Watters, 1994; Richardson et al., 1991). Most skeptical analyses include the claim that the vast majority of cases of supposed ritual abuse are created by irresponsible, overzealous therapists (e.g., Mulhern, 1991; Victor, 1993). For example, at a professional conference attended by clinicians, Ofshe (1993), a sociologist and expert on cult phenomena, asserted that a clinician's having dealt with several cases of ritualistic or satanic child abuse is "prima facie evidence of malpractice."

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of any narcotic, drug, hallucinogen or anesthetic for the purpose of dulling sensitivity, cognition, recollection of, or resistance to any criminal activity; (3) involves the child in a mock, unauthorized or unlawful marriage ceremony with another person or representation of any force or deity, followed by sexual contact with the child; (4) threatens death or serious harm to a child, his or her parents, family, pets or friends that instills a well-founded fear in the child that the threat will be carried out; or (5) unlawfully dissects, mutilates, or incinerates a human corpse . . . The provisions of this Section shall not be construed to apply to: (1) lawful agricultural, animal husbandry, food preparation, or wild game hunting and fishing practices and specifically the branding or identification of livestock; (2) the lawful medical practice of circumcision or any ceremony related to circumcision; or (3) any state or federally approved, licensed, or funded research project; or (4) the ingestion of animal flesh or blood in the performance of a religious service or ceremony." [Public Act #87-1167.]

If ritual abuse is really occurring with any frequency and is due to a large network of sadistic cults, it is obviously a grave problem for American society. If it is not really occurring, or occurring only rarely, the creation of stories about it by some combination of troubled clients, well-intentioned therapists and prosecuting attorneys, religious groups, and journalists is a problem of considerable magnitude in its own right, one that may already have done considerable damage to children, families, and the reputation of scientific psychology and its therapeutic applications. An article in *Christianity Today* (Kam, 1988) accurately characterized societal and professional tension concerning allegations of ritual abuse: "Ritualistic child abuse has become an emotionally charged issue that has rocked communities and divided parents, social workers, therapists, and law enforcers—some who charge a growing conspiracy of satanic worship, others who cry witch-hunt" (p. 51).

From a scientific standpoint, what is most troubling about the debate is that many professionals on both sides use similarly unsatisfying modes of argument, basing their claims on newspaper articles, a few well-chosen examples, and personal philosophy, and often arguing in an emotional or ad hominem way. Researchers have not previously assessed the prevalence of claims of satanic or ritualistic abuse among clients of American clinical psychologists or determined the range of cases and the nature of the typical case. What exactly are psychologists encountering in the course of their clinical work and how compelling are their clients' claims of ritual abuse? What are the psychological and legal outcomes of these cases?

To address these questions, we conducted a stratified random sample survey of clinical members of the American Psychological Association (APA). The purpose of the present article is to describe major results of the survey, indicate how differently they can be interpreted by ritual abuse believers and skeptics, and propose an agenda for future research.

Whereas other researchers who have investigated the characteristics and psychological outcome of ritual abuse have used more common types of child sexual abuse cases as a comparison group (e.g., Kelley, 1992), we chose a more conceptually interesting comparison group. Specifically, we chose to examine equally troubling abuse cases that, like satanic ritual cases, included a religion-related element, but a religion-related element of a more traditional nature; for example, sexual molestation perpetrated by societally recognized religious authorities such as Catholic priests and Methodist ministers, medical neglect motivated by the standard ideology of groups such as Jehova's Witnesses and Christian Scientists, and severe physical abuse inflicted in an attempt to rid children of imagined evil. We will call abuse characterized by these kinds of features "religion-related." We chose this comparison group for several reasons. First, like satanic ritual abuse cases, these more traditional religion-related cases could include sexual abuse, murder, and physical abuse; intra- or extrafamilial abuse; supernatural beliefs, etc. Second, virtually no research had or has addressed this kind of abuse. Third, early in our project we sought the opinions of local social service and law enforcement officials about ritualistic abuse cases. It was their impression that religion-related kinds of abuse might be more common and better documented than satanic ritual abuse. Fourth, because part of the emotion generated by claims of ritual abuse stems from the idea, common among certain religious writers, that America is mortally threat-

ened by satanists—cult members in league with a literal Satan—it seemed important to look more broadly at the ways in which beliefs concerning supernatural forces promote both child abuse (Berry, 1992; Capps, 1992; Greven, 1991; Straus, 1994) and claims of child abuse encountered in therapeutic settings. And finally, organized mainstream and fundamentalist religions played a significant role in instigating the early rise in public concern over satanic ritual abuse in the 1980s (Victor, 1993); therefore, it made sense to examine not only the satanic claims, but also abuse related to the practices and beliefs of the religions that so vigorously called attention to ritual abuse. (For a more detailed discussion of the religion-related abuse cases reported in the present study, see Bottoms, Shaver, Goodman, & Qin, in press; and Goodman, Bottoms, Redlich, Shaver, & Beety, in press).

Our goal was to sample clinical members of the APA who might work with ritual and religion-related abuse cases and to ask them a wide variety of questions about such cases. The study consisted of two phases: a postcard survey to identify clinicians who had encountered relevant cases in their clinical practice, and a detailed survey to obtain more complete information about the cases.[5]

PRELIMINARY POSTCARD SURVEY

Sampling

To increase the probability of finding appropriate cases, we oversampled certain groups of clinicians. We randomly selected 3,278 clinical psychologists from those whose primary specialties, according to APA membership records, were clinical, counseling, school, or child psychology and 2,720 from all other clinical specialties.

Each clinician received a cover letter in 1990 or 1991 explaining that we were interested in child abuse allegations involving ritualistic, ceremonial, supernatural, religious, or mystical practices; examples included abuse in which the perpetrator was a member of a cult (e.g., a satanic or other religious cult) or in which someone tried to rid a child of the devil or evil spirits. We also included a brief postcard reply form on which respondents could indicate the number of cases of ritualistic or religion-related child abuse they had encountered between January 1, 1980, and January 1, 1990. We were interested in cases reported by children and/or adult survivors (i.e., adults 18 or older who claim to have been abused as children). We restricted their reports to the decade of the 1980s, during which the reporting of ritual abuse became increasingly common, to assure a common time frame among respondents.

Because there was no widely agreed-upon definition of either ritualistic or religion-related abuse, we gave respondents both a general characterization of the kinds of abuse we were interested in (as paraphrased in the previous paragraph) and a set of features mentioned in the professional and popular literatures that

[5]Respondents were given the option of providing identifying information or of withholding this information, but they could not be fully anonymous because we had to correspond with them multiple times and thus gave each questionnaire a (noticeable) code number. They received no payment for participating but were offered feedback at the end of the study. A copy of the postcard response form and questionnaire can be obtained from the first author.

Table I. Features Used to Define Ritualistic and Religion-Related Abuse Categories

F1:	Abuse by a member or members of any cult-like group in which members feel compelled to follow the orders of a leader or leaders
F2:	Abuse related to any practice or behavior repeated in a prescribed manner (including prayers, chants, incantations, wearing of special costumes)
F3:	Abuse related to symbols (for example, 666, inverted pentagrams, inverted or broken crosses), invocations, costumes, beliefs, etc. associated with the devil
F4:	Abuse related to belief in supernatural, paranormal, occult, or special powers (for example, magical surgery, calling on spirits, magical flying)
F5:	Abuse associated with threats or activities involving graveyards, crypts, bones, the dead, ghosts, etc.
F6:	Abuse involving rituals using human or animal excrement or blood
F7:	Abuse involving rituals that include special knives, candles, altars, etc.
F8:	Abuse involving actual or staged sacrifice or killing of humans
F9:	Abuse involving actual or staged torture of humans
F10:	Abuse involving actual or staged cannibalism (eating human flesh)*
F11:	Abuse involving actual or staged sacrifice, killing, or torture of animals
F12:	Ritualistic abuse involving forced participation in or observation of sexual practices*
F13:	Ritualistic abuse involving child pornography
F14:	Ritualistic abuse involving drugs
F15:	Abuse involving the withholding of medical care for religious reasons, resulting in harm to a child
F16:	Abuse related to attempts to rid a child of the devil or evil spirits
F17:	Abuse by religious professionals such as priests, rabbis, or ministers
F18:	Abuse committed in a religious setting, a religious school, or a religious daycare center
F19:	Abuse related to the "breeding" of infants for ritual sacrifice
F20:	Ritualistic abuse resulting in amnesic periods or preoccupation with dates*
F21:	Abuse disclosed by an individual with a dissociative or multiple personality disorder traceable to earlier ritualistic or religious abuse

Note. Features marked by asterisks were added in the second phase of the study. The designations F1, F2, etc. are used in the text.

could be used, in combination, to describe particular cases. These features are listed in Table I, along with three (marked with asterisks) added during the second phase of the project based on phase-one respondents' comments. In the postcard survey, respondents were asked to report the number of cases they had encountered that included one or more of the features in Table I.

Returns

There were 2,722 valid respondents (a 46% return rate), of whom 803 had encountered one or more ritual *or* religion-related cases.[6] Four kinds of cases were defined on the basis of two binary distinctions: *child cases* (in which the victim was

[6]There were 2,722 valid respondents after we eliminated 26 "invalid" respondents (e.g., those who turned out to be retired or deceased). The actual response rate of people who *received* the questionnaire was undoubtedly higher than 46%. We used bulk mailing procedures and thus do not know how many postcard surveys failed to reach target individuals. Also, because our statistics were highly affected by one psychologist claiming to have encountered approximately 1000 child and 1000 adult cases during the 1980s—a total far greater than the next highest number, 285—we computed the statistics with his data excluded, leaving 802 psychologists who had encountered one or more cases.

under 18 years of age when seen by the respondent) versus *adult survivor cases* (in which the victim was 18 years of age or older at the time of report, but was under age 18 when the abuse allegedly occurred), and *ritual cases* versus *religion-related cases*. The adult versus child distinction was made on all postcards; the ritual versus religion-related distinction was made only in a second wave of postcard survey mailings. (Sample members who failed to return the first postcard within three months received a second-wave postcard survey.)[7]

Of the 802 psychologists with cases, 43% saw at least one child/ritual case (13% of all 2,722 respondents); 36% saw at least one child/religion case (11% of all respondents); 38% saw at least one adult/ritual case (11% of all respondents); and 41% saw at least one adult/religion case (12% of all respondents). In all, 6,821 cases were reported, of which 22% were child/ritual cases, 31% were child/religion cases, 18% were adult/ritual cases, and 29% were adult/religion cases. A majority of those who had encountered any kind of ritual case had encountered only one or two, yet a few clinicians (2% of those reporting any cases) said they had encountered more than a hundred apiece. As explained below, these numbers may be slightly inflated, because a few of the cases evaporated upon closer scrutiny in the second phase of the study (when we or the respondent determined that the cases did not fit a more precise definition of ritual or religion-related abuse). Still, the initial numbers provide a good first approximation of the proportion of clinicians who have seen various kinds of cases. It is important to keep in mind that the vast majority of clinicians saw neither a child nor an adult case of ritual abuse during the 1980s.

Incidence as a Function of Geographical Location

Because publicity about ritual abuse seems to come more from some regions of the country (e.g., the West Coast) than from others, and because law enforcement and social service professionals in western New York had no documented cases when we asked about them, we compared the rates for the eight standard geographic and cultural regions used by the Bureau of the Census.[8] Ritual and religion-related cases were encountered by clinical psychologists throughout the United States, but there was a higher rate of encountering *ritual* cases in the East South Central (23% of clinicians), West South Central (20%), Mountain (21%), and Pacific regions (22%), and a lower rate in the New England (6%), South Atlantic (17%), East North Cen-

[7]Because the percentages of <u>respondents</u> who reported encountering child and adult cases were very similar in waves one and two (65% versus 62% for child cases; 66% versus 66% for adult cases), and the percentages of all <u>cases</u> of each kind encountered were similar in the two waves (60% versus 53% for child cases; 40% versus 47% for adult cases), we are fairly confident that the proportions of ritual and religion-related cases obtained in the second wave can be generalized to the unmeasured proportions in the first wave. Among clinicians who encountered any cases, the mean (7), median (2), and mode (1) of reported cases were the same in both groups.

[8]The states within each region are as follows. *New England*: ME, NH, VT, NY, MA, RI, CT, NJ, PA. *South Atlantic*: DE, MD, DC, WV, VA, NC, SC, GA, FL. *East South Central*: KY, TN, MS, AL. *East North Central*: Ohio, IN, IL, MI, WI. *West North Central*: ND, SD, MN, IA, MO, NE, KS. *West South Central*: OK, AR, TX, LA. *Mountain*: MT, ID, WY, CO, UT, NV, AZ, NM. *Pacific*: WA, OR, CA, AK, HI. The differences reported in the text were highly significant by chi-square test, but we have chosen not to present the details here. These particular patterns are not the focus of the present article, and the detailed findings require complex tabular presentation for which there is insufficient space.

tral (14%), and West North Central (12%) regions. In other words, the northern and eastern states had relatively low rates of reported ritual abuse, while the southern and western states had relatively high rates. The picture for *religion-related* cases was different: Two regions, West South Central (35%) and East South Central (35%), had particularly high rates of religion-related abuse, while the remaining regions had almost equally low rates (ranging from 10% to 15%).

Thus, although the rate of reporting ritual abuse did not differ greatly by region, there were proportionally more cases in the region that includes the West Coast. Rates of religion-related abuse were more clearly differentiated by region: As perhaps might have been expected, many reports came from parts of the country popularly known as the "Bible Belt."

DETAILED SURVEY

All 803 psychologists reporting one or more cases in the postcard survey were sent a detailed second-phase questionnaire designed to gather specific information about their cases. We again indicated our interest in ritualistic and religion-related abuse and included the set of descriptive features listed in Table I. Following this features list, we defined ritualistic abuse as "cases involving nontraditional beliefs and practices; for example, cases with features such as satanism, inverted pentagrams, or animal sacrifice" and religion-related abuse as "cases in which more traditional religious beliefs are involved; for example, withholding medical treatment for religious reasons or beating a child to rid him or her of the devil." The questionnaire covered a wide range of issues: number of cases encountered, case features, characteristics of victims and perpetrators, abuse setting (including its possible relation to parental custody disputes or daycare settings), victims' symptoms and diagnoses, legal pursuit and outcome of each case, disclosure circumstances, evidence for victims' claims, respondents' degree of belief in the claims, and their experiences with ritual abuse workshops and seminars.[9]

Returns

Of the 803 targeted clinicians, 338 (42%) received and returned our detailed survey questionnaire. Forty-one of these respondents were eliminated from subsequent analyses, either because they decided that they had not actually encountered any relevant cases or because we decided that their cases were inappropriate (e.g., the alleged victim was an adult when the assault occurred). The 297 respondents on whose data subsequent sections of the present article are based had personally encountered 287 adult ritual cases, 217 adult religion-related cases, 457 child ritual cases, and 274 child religion-related cases. Of these, 643 were described by

[9]We included as many questionnaires as possible in our data analyses, but some of them were incomplete. The questionnaire was four pages long and asked about many details that some respondents said they could not take the time to provide. This resulted in variable *N*'s in our data analyses, reflected in the degrees of freedom reported in some tables.

respondents. (Not all encountered cases were described, because each respondent was asked to describe no more than eight cases, as explained next.)

Case Definition and Allegation Prototypes

Case Definition

We asked respondents to describe up to eight cases—all they had personally encountered if that number was less than nine; eight representative cases if more than eight had been encountered. We categorized the cases as ritualistic or religion-related based on our a priori distinction between ritual and religion-related abuses.[10] Specifically, religion-related cases were those that included one or more of the following features: abuse involving withholding of medical care for religious reasons, resulting in harm to a child; abuse related to attempts to rid a child of the devil or evil spirits; abuse by religious professionals such as priests, rabbis, or ministers; and abuse committed in a religious setting. In addition, for a case to be classified as religion-related, the respondent could not have indicated features F2–F11 or F19 or F21 in Table I (see below for exceptions).

Ritual cases were defined in two ways. First, cases were classified as ritualistic if they exhibited ten or more of the following features that are prominent in the literature on ritual abuse: F1–F11 and F19–F21, regardless of any other indicated features. We allowed religion-related features F15–F18 to be included because some respondents reported extreme cases that included every feature on the list. Second, cases were classified as ritualistic if none of features F15–F18 (the religion-related features) were indicated but at least one of features F1–F14 or F19–F21 (the ritualistic features) was indicated. This left 54 cases that exhibited a mixture of typical religion-related and ritualistic features (for example, a case with features F1, F7, F11, F13, and F16, or a case having features F9, F12, F15, and F21). We examined each of these cases individually and classified them, taking into account other information provided by respondents (e.g., the respondent calling the case ritualistic or religion-related when answering other questions, mentioning in response to open-ended questions that a satanic cult was involved). The vast majority of cases were easily categorized based on respondents' comments. Features F12–F14 were considered compatible with any of the ritual or religion-related categories, because re-

[10]Our conceptually based case definition was empirically supported by subjecting the indicated case features (from the list in Table I) to a principal components analysis followed by varimax rotation. This factor analysis revealed three feature groups (with eigenvalues of 9.19, 1.75, and 1.31, respectively) corresponding to the following case types: (a) ritual abuse, on which features F1–F14 and F19–F21 all loaded above .48; (b) religion-related abuse by clergy, on which features F17 and F18 loaded above .68; and (c) religion-related abuse perpetrated primarily by parents or other lay persons, on which features F15 and F16 loaded above .77. The clear ritual abuse factor supported our a priori distinction between ritualistic and religion-related abuse. The second two factors both concerned religion-related abuses that we considered more conceptually related to each other than to ritual abuse. Thus, for present purposes, we combined the two religion-related groups, because we are interested here only in our theoretical distinction of ritualistic versus religion-related abuses. The combination of the two groups also ensured adequate cell sizes for most analyses. (For a more detailed breakdown of correlates of the different kinds of religion-related abuse, see Bottoms et al., in press, and Goodman et al., in press.)

spondents sometimes seemed to ignore the word "ritualistic" in these features—for example, saying that F14 (drug use) was involved in a case in which a Catholic priest had sex with a child, with no apparent ritual involvement.

In 36 additional cases, respondents failed to complete the feature-designation section of the questionnaire but did answer subsequent questions. We examined each of these cases individually and classified them as ritualistic or religion-related based on answers to relevant open-ended questions. Finally, we excluded 56 cases in which a respondent's client was not an abuse victim (e.g., the client was a perpetrator or a victim's relative). In all, there were 386 ritualistic cases and 191 religion-related cases, according to these classification decisions. Ten cases were unclassifiable because the respondent answered no questions.

Allegation Prototypes

From the most frequently checked case features, we constructed prototypes of ritualistic and religion-related cases. As can be seen in Table II, the most common feature of ritual cases was "forced sex." The next most common was "repeated practices." Notice that neither of these features necessarily entails participation by

Table II. Proportion of Cases of Each Type Exhibiting Particular Features

		Allegation type						
		Ritual		Religion-related		*F* ratios (*df* = 1, 526)		
	Case features	Child	Adult	Child	Adult	VT	AT	INT
F1	Cult member	.35	.65	.12	.10	26.32***	98.33***	17.25***
F2	Repeated practices	.46	.61	.03	.05	7.82**	162.22***	2.52
F3	Devil symbols	.41	.53	.01	.02	5.33*	146.01***	2.07
F4	Supernatural	.25	.42	.00	.02	13.42***	85.28***	4.64*
F5	Graveyards, etc.	.24	.41	.00	.00	11.45***	89.81***	5.89*
F6	Excrement, blood	.30	.55	.00	.04	26.89***	120.98***	7.90**
F7	Knives, candles	.27	.55	.01	.03	32.39***	117.37***	13.15***
F8	Human sacrifice	.27	.53	.00	.01	28.59***	123.25***	12.96***
F9	Human torture	.16	.53	.00	.11	69.84***	69.12***	15.04***
F10	Cannibalism	.10	.29	.00	.01	24.27***	43.25***	10.53***
F11	Animal sacrifice	.31	.57	.01	.04	27.73***	123.04***	9.64**
F12	Forced sex	.51	.75	.08	.14	24.59***	179.23***	5.31*
F13	Child pornography	.28	.24	.06	.03	.86	38.61***	.03
F14	Drugs	.19	.44	.04	.03	22.99***	62.54***	13.67***
F15	Withheld medical care	.01	.05	.15	.14	1.06	26.24***	.71
F16	Beating devil out	.05	.12	.38	.29	.20	61.74***	6.69**
F17	Abuse by clergy	.01	.10	.45	.70	25.63***	284.83***	6.86**
F18	Religious setting	.04	.12	.33	.32	2.88	59.61***	1.92
F19	Baby breeding	.06	.24	.00	.00	22.33***	33.76***	11.49***
F20	Amnesia	.10	.49	.01	.11	88.26***	49.82***	20.08***
F21	Dissociation, MPD	.15	.62	.01	.18	124.78***	69.57***	19.88***

Note. VT = victim type effect; AT = allegation type effect; INT = interaction effect.
*$p < .05$.
**$p < .01$.
***$p < .001$.

satanists or cultists of any kind. Also common, however, were abuse by a member of a cultlike group; abuse related to symbols associated with the devil; abuse involving sacrifice or torture of animals; abuse involving excrement or blood; and abuse involving knives, altars, and candles. These are the kinds of features that have created a stir in American society. Aside from purely religion-related features, which were uncommon in ritual cases, the least common features of ritualistic cases were abuse related to the breeding of infants for ritual sacrifice, abuse involving cannibalism, child pornography, and amnesic periods or preoccupation with dates. Nevertheless, even these features were mentioned in a substantial number of cases (15%, 19%, 26%, and 29% of ritual cases, respectively).

The most common feature of religion-related cases was "abuse by religious professionals." The next most common features were "ridding a child of evil spirits" and "abuse committed in a religious setting." Relatively uncommon was "withholding of medical care." When a religion-related case contained features that were not specifically religious, they tended to be "abuse by member(s) of cult-like group," and/or "forced sex." Pornography and drug involvement were infrequent.

ALLEGATIONS REPORTED BY CHILDREN AND ADULTS

The presence versus absence of each feature was entered as a dependent variable into a series of 2 (victim type: child vs. adult) × 2 (allegation type: ritual vs. religion-related) analyses of variance performed on all cases.[11] Significant main effects of allegation type were expected, of course, because certain features were used to distinguish ritual from religion-related cases. However, significant main effects of victim type and significant victim type × allegation type interactions are informative.

One of our major goals was to compare the features of child and adult-survivor cases. If one assumes, as many writers have, that these different kinds of cases provide two perspectives on the *same* phenomenon, the features obtained from the two sources should be similar. If, instead, adult-survivor allegations are dramatic fabrications based on therapists' suggestions, client suggestibility, or sensational media models (such as *Michelle Remembers*), we might expect these allegations to be especially bizarre or extreme, thereby producing statistical interactions between victim type (adult/child) and allegation type (ritual/religion-related), with elevated means in the adult/ritual cells.

In fact, main effects of victim type and interactions between victim type and allegation type were statistically significant for most features (see Table II). Adult-survivor cases more often included the most florid features and were more likely than child cases to exhibit certain extreme clinical features: amnesia, dissociation,

[11]Throughout the results section, some caution is appropriate in interpreting particular effects. We have necessarily conducted analyses of variance on a wide range of dependent variables. We provide F values and probability levels for each individual analysis; however, we are mainly concerned with the overall pattern of results, realizing that a proportion of our "significant" effects may be attributable to chance. An additional caveat is that our methodology produced retrospective self-report data, from a partly self-selected sample. Nonetheless, our response rate is high for a mail survey and is high enough to reduce self-selection bias to an acceptable level.

and MPD. This clinical extremity can be attributed in part to the greater general frequency of diagnosing certain symptoms in adults as compared to children, but that would not explain the severity of the adult survivors' *experiences* as indicated by other features. Ritual abuse features were associated most prominently with allegations made by adults, whereas religion-related features were associated more or less equally with allegations made by adults and children. There were two exceptions to this pattern: Abuse involving beating the devil out of a child was most commonly reported in child religion-related cases, and clergy abuse was most commonly reported in adult religion-related cases. The latter was the only religion-related feature to be more prevalent in adult than in child cases. Perhaps abuse by clergy remains hidden in many cases because children fail to disclose it, whereas untreated medical conditions or severe beatings are more likely to receive public attention soon after they occur, while the victims are still in childhood.

As mentioned, if adult survivors of ritual abuse are reporting the same type of abuse as are child victims, adults' allegations should be similar to children's (or perhaps less detailed, because memory generally fades with the passage of time; e.g., Baddeley, 1976; Ebbinghaus, 1885/1913; Rubin, 1986). In contrast, the results in Table II indicate that reports made by adult survivors of ritual abuse contained more extreme details than reports of child victims. There are at least two interpretations of this finding. On the one hand, survivors' reports might be false or exaggerated, perhaps because they are modeled on dramatic media examples and are either adopted unwittingly by suggestible clients or adopted deliberately to garner attention and sympathy. On the other hand, adult survivors might produce the most lurid reports because they are precisely the people who experienced the most extreme abuse during childhood and later sought therapy as adults to cope with its consequences. Interestingly, this same argument should apply to adult survivors of religion-related abuse, but in fact such survivors did not report more extreme experiences than child victims of religion-related abuse. In every respect, then, cases involving adult survivors of ritual abuse stand out as extreme.

CLIENTS' SYMPTOMS AND DIAGNOSES

Are adult survivors of ritual abuse particularly disturbed psychologically, as the above results suggest? To find out, we examined therapists' reports of their clients' original presenting symptoms and current DSM-III-R diagnoses.

Presenting Symptoms

Therapists were asked to indicate which of a list of common symptoms (shown in Table III) were displayed by their clients. When dichotomous yes–no scores for each symptom category were entered into a series of 2 (victim type) × 2 (allegation type) analyses of variance, a number of significant main effects of victim type emerged. Adults were more likely than children to evidence depression, insomnia, suicidal ideation, and substance abuse; children were more likely than adults to

exhibit sexual acting out, inappropriate toilet behavior, and inappropriate aggression. (Some of these differences are due simply to the fact that certain disorders are diagnosed more frequently at one age level than another.) When there were differences between ritualistic and religion-related cases, the more extreme symptoms were associated with ritual abuse. Although no interactions were significant, the combination of main effects for victim and allegation type generally resulted in higher means for the adult ritual group.

DSM-III-R Diagnoses

Respondents provided up to five DSM-III-R codes to describe each of their clients. For ease of analysis, we grouped the codes into the categories shown in the lower half of Table III. MPD was isolated from other dissociative disorders,

Table III. Proportion of Cases Involving Particular Presenting Symptoms and DSM Diagnoses

	Allegation type						
	Ritual		Religion-related		*F* ratios		
Case features	Child	Adult	Child	Adult	VT	AT	INT
Presenting symptoms (df = 1, 477)							
Depression	.29	.67	.32	.61	66.28***	.18	1.08
Insomnia	.09	.16	.01	.07	6.92**	8.59**	.17
Somatic complaints	.16	.20	.14	.15	.64	1.12	.15
Excessive fears, phobias	.27	.29	.14	.22	1.01	5.42*	.46
Sexual acting out	.30	.15	.15	.14	9.13**	4.02*	3.15
Obsessive compulsiveness	.07	.11	.03	.08	2.61	1.80	.13
Suicidal ideation	.11	.40	.04	.22	51.51***	11.75***	2.37
Substance abuse	.05	.12	.10	.11	4.06*	.56	.94
Inappropriate toilet behavior	.12	.04	.01	.00	6.56*	10.41***	1.71
Social withdrawal	.19	.15	.21	.14	2.08	.01	.23
Inappropriate aggression	.32	.13	.25	.11	23.01***	.85	.46
DSM-III-R diagnoses (df = 1, 367)							
Alcohol/drug problems	.02	.06	.13	.03	.01	.67	8.50**
Affective disorders	.13	.13	.16	.28	.61	6.15*	2.07
MPD	.11	.49	.08	.06	44.60***	42.49***	20.42***
Other dissociative disorders	.05	.04	.03	.10	.20	1.00	2.45
PTSD	.37	.28	.21	.28	.84	1.47	2.05
Anxiety disorders	.02	.02	.00	.10	2.45	4.42*	5.25*
Personality disorders	.11	.11	.13	.18	.32	1.79	.26
Childhood disorders	.21	.01	.16	.00	48.38***	.67	.60
Adjustment disorders/life problems	.14	.05	.16	.13	5.83*	2.56	.74
Impulse control problems	.07	.01	.05	.00	11.71***	.33	.08

Note. More than one symptom or diagnosis could have been mentioned per case. Some disorders were omitted because of infrequent use. VT = victim type effect; AT = allegation type effect; INT = interaction effect.
*p < .05.
**p < .01.
***p < .001.

and post-traumatic stress disorder (PTSD) was distinguished from other anxiety and panic disorders, because these two diagnoses are associated in the literature with alleged ritual abuse. Indeed, they were among the most frequently mentioned diagnoses in our study: Fully 49% of the adult survivors of ritual abuse were diagnosed as suffering from MPD and 28% from PTSD.

Two-way analyses of variance revealed that MPD was more likely for clients alleging ritual abuse than religion-related abuse, whereas the opposite was true for affective and anxiety disorders. Adjustment and general life problems were more common in child than adult-survivor cases, and more children than adults were diagnosed with impulse control disorders and, not surprisingly, with disorders associated with childhood. Significant interactions indicated that adults alleging ritual abuse were especially likely to receive diagnoses of MPD, that adults alleging religion-related abuse were likely to have an anxiety disorder, and that alcohol and drug problems were more common in child religion cases than in other kinds of cases.

It is particularly striking that nearly half of alleged adult survivors of ritual abuse received a diagnosis, MPD, that was rare before 1980. This is compatible with skeptics' claim that therapists who encourage allegations of ritual abuse are also likely to overdiagnose, and perhaps create, MPD symptoms (e.g., Ofshe & Watters, 1994). It is also consistent with the alternate analysis that MPD itself is a real psychological phenomenon, but that its sufferers are highly suggestible (from any number of sources, including media, support groups, and therapists) and prone to incorporate stories of ritual abuse into their own life histories (e.g., Ganaway, 1989). A third interpretation is that genuine ritual abuse is a major cause of MPD (e.g., Kluft, 1985; Ross, 1994). This interpretation seems to imply that ritual abuse drastically increased in frequency a decade or two ago and subsequently caused the recent explosion of adult MPD cases. To the best of our knowledge, no one has made that historical claim about ritual abuse. In fact, believers assert that ritualistic abuse has existed for centuries as an intergenerational activity (Feldman, 1993; Hill & Goodwin, 1989). One of our respondents suggested a fourth possibility: "This patient was a child MPD before the school/ritualistic cult abuse. Her dissociation made her a vulnerable victim."[12] The same respondent noted the power of MPD to sustain cult involvement: "At time of treatment, the client reported having no religion, but it was later discovered that some alters [i.e., alter personalities] were continuing to practice Satanism, though the host personality was unaware of the continued involvement." Finally, a fifth possibility is that the rates of ritual abuse and MPD have always been about the same, but until recently psychologists were poorly trained to detect MPD and probe for repressed memories of ritual abuse. To date, advocates of particular interpretations have relied mainly on ideology. Arguments concerning these different interpretations need to be addressed by future research, especially research that documents actual clinical practices in particular cases involving clients diagnosed with MPD.

[12]Quotations have been edited slightly throughout this article to remove details that might identify respondents and well-known cases. They have also been shortened if possible.

CASE CHARACTERISTICS

We asked respondents for details about each of their cases, including the type of abuse reported by clients; the number, gender, and age of the child victims; the number and gender of the perpetrators; setting of the abuse; and the legal response to each case.

Forms of Maltreatment

Respondents reported that ritual abuse cases involved claims of particularly severe abuse. As can be seen from Table IV, every kind of maltreatment except

Table IV. Forms of Maltreatment and Victim Characteristics

	Allegation type				*F* ratios		
	Ritual		Religion-related				
Case features	Child	Adult	Child	Adult	VT	AT	INT
Form of maltreatment (proportions)[a] (*df* = 1, 497)							
Sexual	.81	.94	.59	.78	19.08***	27.78***	.92
Physical	.42	.76	.36	.31	25.50***	35.05***	20.05***
Psychological	.63	.84	.46	.42	10.34***	48.37***	8.59**
Murder	.13	.39	.02	.02	29.54***	52.50***	15.38***
Neglect	.19	.38	.16	.18	12.45***	7.73**	4.46*
Victim age in years[b]							
Age when abuse began (*df* = 1, 433)	5.65	4.78	8.67	8.72	1.67	58.56***	1.03
Age when abuse ended (*df* = 1, 396)	8.35	14.58	10.20	14.12	101.64**	1.33	3.96*
Age abuse was discovered (*df* = 1, 407)	9.08	30.79	10.89	28.15	603.36***	.16	6.52*
(*df* = 1, 405)	9.08	30.79	10.89	26.77	691.47***	1.54	13.34***
Number child victims[b]							
Both genders (*df* = 1, 380)	4.20	17.83	4.63	1.84	6.88**	6.86**	9.07**
(*df* = 1, 372)	4.20	4.50	1.90	1.84	.04	10.83***	.06
Males (*df* = 1, 350)	1.58	8.94	3.72	.82	2.04	1.37	5.61*
(*df* = 1, 345)	1.58	1.19	.80	.82	.66	4.86*	.56
Female (*df* = 1, 353)	1.18	2.35	.54	1.44	21.25***	10.95***	.33

Note. Because some respondents provided only the total number of victims, undifferentiated by gender, "both genders" is not a simple total of males and females. VT = victim type effect; AT = allegation type effect; INT = interaction effect.
[a]More than one type of maltreatment could have been indicated per case.
[b]For each measure, where data included outliers, means are provided both with (first row) and without (second row) outliers.
*$p < .05$.
**$p < .01$.
***$p < .001$.

sexual abuse was more common in cases involving adult survivors of ritual abuse. The frequency of murders reported by ritual victims is particularly striking given the absence of legal evidence for them (Lanning, 1991, 1992).

Characteristics of Victims

Age

Child and adult victims of ritual abuse reported earlier ages of abuse onset than victims of religion-related abuse (see Table IV). Child victims of ritual abuse were also younger when their abuse ended than victims of religion-related abuse, but there was little difference in the ages when the abuse ended for adult victims of religion-related and ritual abuse. A significant interaction indicated that in adult cases, ritual victims disclosed at somewhat older ages than religion-related victims; whereas in child cases, religion-related victims disclosed at somewhat older ages than ritual victims. One possible interpretation of this interaction is that younger children are easier than older children to influence with suggestions of ritual abuse. Alternatively, some writers have indicated that children are purposely indoctrinated into satanic cults at very early ages. Another supposed hallmark of ritual abuse, however, is life-long clandestine involvement, which seems incompatible with the many reports made by children and with earlier disclosure in child ritual cases.

The years that elapsed between victims' alleged abuse and the onset of therapy did not differ significantly for ritual cases (11 years) and religion-related cases (9 years). Children generally entered therapy about 2 years after being abused, and adults about 16 years after.

Number and Gender of Victims

Compared with sexual abuse cases in general, ritual abuse is often described as involving multiple perpetrators and victims, and relatively high numbers of female perpetrators and male victims. Ritual cases in our sample did allegedly involve significantly more victims than did religion-related cases, and adult cases involved more victims than child cases (Table IV). A significant interaction revealed that adult ritual cases were largely responsible for these effects, involving four times as many victims as child ritual or child religion cases, and about ten times as many victims as adult religion cases. When outliers were excluded, however, only the main effect of allegation type (ritual vs. religion-related) remained significant, $F(1, 372) = 10.83$, $p < .01$, suggesting that only a few respondents reported extremely high numbers for adult ritual cases.[13]

Ritual cases involved significantly more female victims than religion-related cases, and adult cases involved more female victims than child cases. A significant

[13]Outliers were defined as scores that fell three standard deviations above the mean and were set apart from the next highest values by a substantial gap. In most cases, this criterion resulted in the removal of 1–8 values.

interaction for number of male victims indicated that the number was especially high in adult ritual cases. Again, however, when outliers were excluded, only the effect of allegation type was significant; ritual cases involved more male victims than religion-related cases, $F(1, 345) = 4.86, p < .05$.

Thus, there were many more alleged victims, including male victims, in ritual cases than in religion-related cases (especially if outliers were included in the analyses), suggesting either that there are thousands of survivors (including thousands of male survivors) of ritual abuse committed in the 1950s and 1960s, or that false claims of ritual abuse include an inflated number of victims of both sexes. The purported number of male victims is especially interesting given that most reported sexual abuse involves female victims (e.g., Finkelhor, 1984). Moreover, media accounts of the adult-survivor phenomenon certainly suggest that most of the purported survivors are female. (For example, 90% of the accusations reported by accused parents to the False Memory Syndrome Foundation are made by females; Wakefield & Underwager, 1992.) Thus, either the number of male victims is exaggerated in clients' reports of ritual abuse (which would be consistent with the exaggeration of other features as well), or there are thousands of male survivors who remain silent about their abuse—even more so than with other forms of sexual abuse.

Characteristics of Perpetrators

Number and Gender

The extreme nature of ritual abuse cases was also evident in the large number of perpetrators, both male and female, alleged to have been involved. The number of perpetrators was particularly high in cases reported by adult survivors of ritual abuse. The large number of female perpetrators in ritual cases is particularly noteworthy, because reports of female involvement are relatively uncommon in the perpetration of other forms of sexual abuse (Finkelhor, 1984; Haugaard & Reppucci, 1988).

Relationship to Victim

Consistent with other research on sexual abuse, victims generally knew their abusers, who were often their parents. Stranger and acquaintance abuse was infrequent. Allegations against parents or step-parents were more common in ritual than in religion-related cases; specifically, an interaction revealed that parents were implicated most often by adult survivors of ritual abuse, but least often by adult survivors of religion-related abuse. Allegations against a person in a position of trust were more common in religion-related than in ritual cases, reflecting the fact that many of the religion-related cases involved abuse perpetrated by persons with religious authority. The finding that only a small minority of ritual cases involved strangers and acquaintances seems inconsistent with the common claim that most

ritual abuse occurs during organized ceremonies performed by large numbers of cult-member perpetrators.

Settings of Abuse: Home, Daycare, and Custody Disputes

Highly publicized child sexual abuse cases, such as the McMartin Preschool case in California (Waterman, Kelly, Oliveri, & McCord, 1993), the Wee Care case in New Jersey (Rabinowitz, 1990), the Little Rascals daycare case in North Carolina (Victor, 1993), and many local cases involving child custody disputes between divorced or divorcing parents have led the public to believe that daycare settings and

Table V. Perpetrator Characteristics and Abuse Settings

	Allegation type				F ratios		
	Ritual		Religion-related				
Case features	Child	Adult	Child	Adult	VT	AT	INT
Number of perpetrators[a]							
Both genders							
(df = 1, 363)	5.46	11.94	1.51	2.38	3.72	9.37**	1.51
(df = 1, 358)	2.83	6.90	1.51	2.38	27.17***	30.54***	8.45**
Males							
(df = 1, 340)	4.46	10.87	1.00	1.80	3.26	7.33**	1.38
(df = 1, 336)	2.56	5.25	1.00	1.80	12.24***	20.56***	2.78
Females							
(df = 1, 331)	3.27	8.51	0.41	.89	1.95	4.89*	.96
(df = 1, 327)	1.36	2.26	0.41	.89	5.12*	12.63***	.41
Relationship of perpetrators to victims (proportions)[b] (df = 1, 475)							
Parent or step-parent	.60	.73	.54	.31	.03	30.18***	15.34***
Person in position of trust (e.g., teacher, relative)	.28	.34	.50	.69	5.86*	40.85***	2.05
Acquaintance	.20	.17	.07	.06	.66	13.72***	.16
Stranger	.06	.12	.01	.02	3.80	10.00**	1.18
Settings (proportions)[c] (df = 1, 467)							
Daycare or schools	.12	.03	.17	.08	10.37***	2.77	.01
Parents'/relatives' homes	.66	.55	.47	.40	4.46*	12.36***	.09
Religious setting	.02	.05	.15	.36	11.49***	64.20***	10.10**
Cult location	.04	.11	.04	.00	2.10	6.69**	5.64*
Other	.16	.25	.17	.14	2.19	1.76	2.28

Note. Because some respondents provided only the total number of perpetrators, undifferentiated by gender, "both genders" is not a simple total of males and females. VT = victim type effect; AT = allegation type effect; INT = interaction effect.

[a]Means are provided both with (first row) and without (second row) outliers.

[b]Each case may have included more than one type of perpetrator.

[c]More than one setting could have been noted for each case. A foster/group home category, mentioned in less than 1% of any category of case, was omitted.

*$p < .05$.

**$p < .01$.

***$p < .001$.

custody disputes are closely related to claims of sexual abuse, and particularly to claims of ritual abuse (Finkelhor, Williams, & Burns, 1988). Our results fail to support these stereotypes.

Specifically, there was no difference between the proportion of ritual and religion-related cases involving divorcing parents ($M = .13$ and $M = .12$, respectively). Divorce was involved more frequently in cases reported by children ($M = .17$) than by adult survivors ($M = .08$); $F(1, 415) = 7.69, p < .01$, possibly because the divorce rate was lower during the period when the adult survivors were children (the 1950s and 1960s).

As can be seen in Table V, ritual abuse was not more likely than religion-related abuse to occur in daycare or school settings. Child cases were more likely than adult cases to involve daycare or school settings, probably because daycare centers and preschools were less common when the adults were growing up.

As expected, given our findings concerning familial perpetrators, the most common setting of abuse in both ritualistic and religion-related cases was parents' or relatives' homes. In addition, not surprisingly, there were some subsidiary differences between the two kinds of cases: Adult ritual abuse survivors were more likely to name cult locations as abuse sites; adult survivors of religion-related abuse were more likely to name religious locations.

Legal Responses to Cases

Are ritual abuse cases aggressively pursued by social service and criminal justice professionals? How representative are vigorous prosecution efforts of the kind witnessed in the McMartin daycare case (Waterman et al., 1993) and the Ingram case in Washington (Wright, 1994)? In our sample, child cases were frequently reported to authorities, as is now mandated by child abuse reporting laws, but few adult cases were ever reported (Table VI). Furthermore, police and social service agencies were significantly less likely to have investigated any aspect (including the sexual abuse claims) of religion-related cases than of ritual abuse cases.

There are many reasons why abuse reported by an adult might not have been pursued when he or she was a child. The now-adult might have been severely warned about the dire consequences of disclosing child abuse (disclosures were generally not encouraged decades ago), or he or she might have "repressed" the memories of abuse.[14] These are all common claims among adult survivors. Of course, if the allegations are false, there was nothing to disclose during childhood.

Children's reports of religion-related abuse were particularly likely to be neglected. This is attributable in part to some states' legal protection of parents who withhold medical care from children for religious reasons. It may also be due to the secrecy with which many valid claims of abuse by clergy have, until recently, been treated by church officials (Berry, 1992).

We also examined the legal processing of cases (see Table VI). Most child cases, but few adult-survivor cases, were reported to authorities, and child cases

[14]For a full discussion of the cases in our sample which arose as recovered, formerly repressed memories, see Qin, Goodman, Bottoms, & Shaver (in press).

Table VI. Proportion of Cases Involving Various Types of Investigation and Case Outcomes

	Allegation type						
	Ritual		Religion-related		*F* ratios		
Case features	Child	Adult	Child	Adult	VT	AT	INT
Type of investigation ($df = 1, 464$)							
No investigation	.15	.83	.35	.91	344.48***	14.00***	2.89
Social service	.72	.13	.47	.03	219.92***	21.41***	4.37*
Police	.53	.06	.32	.02	132.72***	10.75***	5.10*
District attorney	.23	.04	.17	.02	34.39***	1.34	.31
Case outcome[a] ($df = 1, 448$)							
Never reported	.12	.83	.33	.92	378.95***	18.04***	2.93
Social service unfounded	.10	.08	.03	.00	1.00	10.48***	.02
Social service substantiated	.44	.01	.32	.00	135.61***	3.44	2.21
Arrest	.28	.03	.36	.03	72.62***	1.31	1.02
Dismissal	.05	.01	.03	.02	1.92	.10	.74
Plea bargain	.09	.00	.07	.02	13.72***	.02	1.13
Trial	.19	.01	.28	.01	56.04***	2.68	2.37
Conviction	.16	.01	.20	.01	40.16***	.66	.46
Reversal	.02	.00	.05	.00	7.60**	1.81	1.93

Note. More than one type of investigation or outcome could have been mentioned per case. VT = victim type effect; AT = allegation type effect; INT = interaction effect.
[a]Twelve percent of the ritual cases and 4% of the religion-related cases were still open at the time of the survey.
*$p < .05$.
**$p < .01$.
***$p < .001$.

were legally verified (via plea bargains and convictions) more often than cases reported by adult survivors. An arrest and/or social service substantiation was the highest level of action taken in most of the ritual cases whose outcomes were known by our respondents. Religion-related cases were less likely than ritual cases to have been reported, but once reported there were few differences between the outcomes of the two kinds of cases. The only exception was that more social services "unsubstantiated" determinations were given in ritual than in religion-related cases.

Even when ritual cases were investigated or prosecuted, the validity of their satanic or ritualistic aspects was often unknown. One of our respondents said, for example: "Physical and sexual abuse were disclosed during a social services investigation, but the satanic (ritualistic) abuse was disclosed in treatment." Thus, numbers in Table VI that seem to imply substantiation or court convictions do not necessarily support claims of ritual abuse, which may have been suppressed by prosecutors or brought to light only later, in therapy.

Overall, there was little legal confirmation of ritual or religion-related claims in most cases. This could occur either because no allegations were made in a manner or at a time that would have led to legal proceedings or because

the evidence was not sufficiently convincing. Actually, most child abuse is not reported to authorities, and child sexual abuse in particular is difficult to prosecute or prove. In at least some cases there may have been no legal action because there were no real transgressions to pursue. Although a sizable proportion of child ritual abuse cases (44%) were "substantiated" by social services, social services were also significantly more likely to deem ritual as compared with religion-related claims unfounded. And, as noted, even where "substantiation" occurred, the focus may have been on the abuse or harm, not on the alleged ritualistic nature of the abuse.

HOW BELIEVABLE ARE THE ABUSE CLAIMS?

Circumstances of Disclosure

One of the most controversial issues related to ritual abuse allegations is the role psychotherapists play in uncovering or helping to co-create the alleged experiences (e.g., Dawes, 1994). (This is also in question with regard to allegations of repressed memories of nonritualistic child sexual abuse and the diagnosis of MPD; e.g., Loftus, 1992; Spanos, 1994.) Is it possible that therapists encourage clients to "recover" false memories of ritual abuse (Lindsay & Read, 1994)? To gain insight into this issue, we asked respondents about the circumstances under which disclosures of ritualistic or religion-related harm were first made. Responses were coded into the following categories: (a) disclosed to professionals or authorities such as police, teachers, doctors, or priests; (b) disclosed in combination with some form of corroboration, such as a perpetrator's confession, physical evidence, publicly discovered withholding of medical treatment, death of a child; (c) disclosed in therapy; (d) disclosed to family members, neighbors, or friends; and (e) miscellaneous (see Table VII).

Consistent with skeptics' claims, adults' reports of ritual abuse were likely to have emerged in the course of therapy; but this was also true of adults' reports of religion-related abuse. The situation was different for children. They were more likely than adults to have disclosed to authorities, family members, neighbors, or other nontherapist professionals. Their disclosures were also more likely than adults' to be linked to corroborative evidence.

It is difficult to interpret these findings as supporting either a skeptical or a credulous approach to purported ritual abuse. For example, if adult survivors failed to report abuse during childhood, therapy would provide an appropriate forum for adult disclosures. But it is also reasonable to wonder about the validity of extensive, dramatic reports that first emerge only after months or years of possibly suggestive therapy (Lindsay & Read, 1994; Loftus, 1992; Yapko, 1994). Despite the increasingly heated arguments about such matters at professional conferences, there is surprisingly little hard evidence concerning what exactly happens in ritual-related therapy sessions.

Table VII. Disclosure of and Evidence for Allegations

	Allegation type						
	Ritual		Religion-related		*F* ratios		
Case features	Child	Adult	Child	Adult	VT	AT	INT
Circumstances of disclosure (df = 1, 474)							
Disclosed to authorities or professionals	.28	.01	.26	.05	65.79***	.04	.79
Disclosure linked to corroborative evidence	.05	.00	.08	.01	13.41***	1.17	.17
Revealed in therapy	.38	.95	.41	.89	233.95***	.32	1.18
Disclosed to family, neighbors, etc.	.40	.06	.35	.15	62.70***	.30	3.18
Miscellaneous	.03	.05	.04	.01	.00	.51	1.54
Evidence of ritual or religion-related case elements (df = 1, 352)							
Convincing report	.27	.39	.02	.07	5.53*	42.05***	.58
Client's claims	.50	.60	.17	.45	10.35***	20.57***	2.88
Corroborative evidence[a]	.37	.14	.71	.46	25.49***	46.85***	.03
Eyewitness	.16	.02	.07	.01	17.26***	2.84	2.64
Physical[b]	.08	.05	.00	.00			
Medical[b]	.00	.00	.04	.01			
Confession	.04	.01	.15	.01	10.98***	6.17*	5.43*
Skepticism	.07	.05	.14	.06	1.80	1.42	1.21
Miscellaneous	.07	.05	.02	.04	.06	1.16	1.11
Evidence of abuse/harm (df = 1, 372)							
Client's claims	.26	.40	.20	.42	11.47***	.09	.62
Clinician opinion/ psychological symptoms	.29	.33	.17	.35	3.45	.90	2.08
Corroborative evidence[a]	.39	.34	.59	.26	8.31**	1.31	7.26**
Eyewitness	.15	.09	.10	.05	3.10	1.55	0.00
Physical	.12	.05	.15	.00	12.54***	.10	1.73
Medical	.22	.23	.22	.13	.25	1.40	1.33
Confession	.06	.02	.22	.03	13.43***	10.75***	7.25**
Miscellaneous	.18	.08	.15	.13	4.23*	.12	.91
Perceived validity judgments							
Believed some aspects were staged (df = 1, 397)	.80	.91	.26	.24	.77	59.10***	.70
Believed there was abuse/harm (df = 1, 476)	1.77	1.93	1.91	2.00	12.97***	6.28*	.69
Believed the ritual/religious aspects (df = 1, 486)	1.75	1.87	1.86	1.88	3.66	1.65	.29

Note: More than one kind of circumstance or evidence could have been mentioned per case. Evidence and circumstance variables were scored dichotomously (0 = *no*, 1 = *yes*). "Staged" was scored on a 3-point scale (0 = *no*, 1 = *maybe*, 2 = *yes*); harm and ritualistic/religion validity questions were scored on a 3-point scale (0 = *false*, 1 = *maybe*, and 2 = *true*). VT = victim type effect; AT = allegation type effect; INT = interaction effect.

[a]Because the subordinate coding categories (eyewitness, physical, medical, confession) are more restrictive than the superordinate category "corroborative evidence," the four subcategories do not add to the total of the corroborative evidence category.

[b]Too few data per cells for valid analyses.

*$p < .05$.

**$p < .01$.

***$p < .001$.

Evidence for Claims

We asked respondents to describe what they accepted as evidence for or against the genuineness of the ritualistic or religion-related elements of their cases. Responses fell into four categories: (a) client reports seemed convincing based on clinical indicators such as flashbacks, post-traumatic play, reactions to "trigger" stimuli, and dramatic expressions of emotion; (b) client's claims; (c) physical or other corroborative evidence reported by the client but not necessarily seen by the therapist (e.g., tattoos on a child, letters and diaries, photographs, videotapes, satanic books and artifacts, perpetrator confessions); (d) skepticism expressed by the respondent regarding the validity of the claims; and (e) miscellaneous. As can be seen from Table VII, ritual abuse allegations, especially those made by adults, were likely to be supported only by clients' words and dramatic emotional symptoms; and this was more often the case for ritual than for religion-related cases. Somewhat stronger corroborative evidence was noted in religion-related than ritual cases, and more so in child than adult cases (some form of corroboration was noted in 71% of child religion-related cases). Corroborative evidence was least often associated with allegations made by adult survivors of ritual abuse.

To examine the corroborative evidence more specifically, we further coded evidence in this broad category into four more stringent sub-categories commonly employed by the legal system: (a) testimony by a witness or another victim; (b) physical evidence such as satanic paraphernalia; (c) medical evidence such as venereal disease; (d) confession or admission by the accused (see Table VII). (Again, the evidence was not necessarily seen by the respondent.) Analyses revealed that there was significantly more eyewitness testimony and more perpetrator confessions in child than adult cases. There was too little physical and medical evidence for valid analyses.

We also asked whether, aside from ritualistic or religion-related claims, there was evidence of the alleged abuse itself. It is certainly possible that in some cases there was genuine abuse even if its ritual overlay was false (Ganaway, 1989). Responses to this question were categorized as follows: (a) client's claims; (b) clinician opinion/psychological symptoms (including the client having psychological or physical symptoms of abuse, special knowledge relevant to the abuse, or seemingly convincing memories); (c) corroborative evidence (similar to category "b" in the previous paragraph); and (d) miscellaneous (see Table VII). Corroborative evidence of abuse or harm was more likely in child than adult cases, and especially in religion-related cases involving children. In cases reported by adults, "clients' reports" was likely to be the only evidence of harm cited by our respondents. Examining the more restrictive coding of corroborative evidence, one can see that there was more physical evidence of abuse in child than adult cases, and confessions were particularly likely in child religion-related cases.

Thus, overall there was more evidence in religion-related than ritual cases, especially in religion-related child cases. Moreover, something that cannot be seen from the tables, but is apparent from careful examination of clinicians' responses, is that the quality of the evidence was more compelling in the religion-related than in the ritual cases, with respondents providing particularly vivid examples of evidence for religion-related abuse of children. The following quotations (each from

a different respondent) convey graphically what it means for there to be concrete evidence of religion-related child abuse:

> My client was a 14-year-old boy whose eyeball had been plucked out of his head in an exorcism ceremony. The abuse was disclosed when, shortly after the incident, the child was admitted to the hospital emergency room. The fundamentalist minister acknowledged religious intent, and he was convicted.
>
> The father performed an exorcism on his children by dismembering and then boiling them. Evidence? The children were dead.
>
> I saw the daughter of a woman who had thought her 12-year-old boy was possessed by the devil. The woman had had an incestuous relationship with the boy. . . . She decapitated him and had the daughter help her move the body—the daughter took the head and the mother took the body. Parts of the story were published in the local newspaper.

In contrast to these publicly documented examples of religion-related abuse, there was little concrete evidence offered for ritual claims, whether made by children or adults. Most respondents cited their patient's reports or behaviors; for example, "only patient's disclosure via hypnotherapy," and "play behavior, drawings, fear of satanic symbols." One respondent cited as evidence the Ritual Abuse Behavior Checklist, a dubious diagnostic checklist which includes many behaviors common to childhood (Gould, 1986; see Hicks, 1991). In only a few cases was physical evidence mentioned, usually "scars." For example, one respondent wrote, "scars on right hand—a very small pentagram on her wrist and very faint double cross on back of her hand." Another respondent wrote of a case in which victims were allegedly branded with a symbol associated with the devil. However, a third respondent's comments illustrate problems with accepting clients' untested claims of scarring: "Three adult siblings described patterned marks burned on genitals, but medical examination revealed no scars."

Some respondents cited evidence of ritualistic or satanic elements that was suggestive but not conclusive: "black clothing, devil symbols written everywhere," "there was a strange altar in the house." A few described cases of abuse motivated by pornography, mentioning "pictures" as evidence of the ritual aspects, but failed to describe whether the pictures depicted ritual or religious elements. According to the FBI, no pornography illustrating child abuse involving satanic rituals has ever been confiscated by federal authorities in the United States (Farley, 1993; Lanning, 1991, 1992). In one case involving the documented death of an infant, the respondent noted that the police "investigated" Satanic cult involvement, but the outcome was not mentioned.

Lack of skepticism on the part of some respondents, combined with the absence of solid evidence, made us wary about simply accepting what they offered as evidence; for example: "One client, an adult woman, became aware in therapy with someone else that her problems might be cult-related. She started seeing me. Many memories started coming up. In the course of my therapy with her, she became aware that she herself was still a high priestess in a cult and was trying to get out." The respondent assigned this woman an MPD diagnosis, and took the MPD as evidence of prior child abuse. For evidence of the ritual aspects of her abuse, the respondent wrote: "She knew of many details of the cult's codes." Another believer in ritual abuse, who had reportedly worked on cases involving hundreds of victims

and perpetrators, wrote that "for all patients, dissociated memories of abuse, previously unknown, came to light during therapy. The specific details of the abuse are difficult to list, because recollections by patients are partial and increase with duration of therapy. Much abuse is denied. Cult perpetrators are excellent at hiding/destroying evidence and doing 'unbelievable' acts." Some clinicians suspected ritual abuse on the basis of little more than intuition. Of one case, a clinician wrote: "Child has disclosed only sexual abuse to me, but her play behavior suggests ritual abuse." About a separate case the same clinician wrote: "Symptoms suggested ritual abuse, symptoms improved with treatment for ritual abuse, and child later reported specific memories [of ritual abuse] to therapist." Given the ritual abuse presupposition, it seems possible that the later memories were iatrogenic.

Even so, it is important to note that a few of the cases for which there was evidence might qualify as actual ritual abuse cases. For example, one respondent reported a documented case in which a male and a female perpetrator were convicted of sexually abusing two victims. The case was classified as ritualistic because the perpetrators took the victims to a desert and frightened them with an exhibition of animal bones. In other cases, there was apparently good evidence for ritually tinged brutality, but not in the context of an organized cult; for example:

> Over the last 8 years I have evaluated 700+ and supervised 500+ cases of alleged sexual abuse for forensic purposes. I've provided therapy to 150+ victims and 300+ sex offenders. Out of all these cases, only one sex offender was engaged in satanic activities, but his offenses seemed to be independent brutal assaults.

In general, the ritual cases with the most convincing evidence were unlike the satanic ritual abuse stereotype, except perhaps for one:

> Chuck, aged 16, was admitted to a psychiatric hospital following an attempted homicide. He was living in a group home and stabbed the male house parent in the chest with a knife. Chuck was born to active members of a satanic cult. He had sexual intercourse with his mother as well as other female cultists from his earliest memory. He was bred for the cult. His parents divorced and Chuck went with his father who left the cult. His father remarried a woman with two daughters from a previous marriage. Chuck was placed in a group home when the daughters disclosed that he had been sexually molesting them for a couple of years. He spoke freely of the rituals, animal sacrifices, and sexual abuse as victim and perpetrator. He reported that his mother appeared in a TV documentary as a high priestess. . . . He pled guilty to the attempted homicide (the victim barely survived) and was ordered into long-term psychiatric treatment at an adolescent facility. His father confirmed the life in a satanic cult for Chuck's first 10 years of life, and his mother's continuing leadership role in the cult.

Although this example is disturbing and apparently involved a violent assault on an adult, the satanic cult activities were alleged mainly through eyewitness reports; there was no hard evidence for an intergenerational child-abusing satanic cult. Even if this case is accepted at face value, it is unique in our data set.

Respondents' Acceptance of Clients' Claims

Do clinical psychologists generally believe their clients' claims of abuse? In principle, it should be possible for a therapist to sympathize with a client's psychological pain while remaining skeptical about the validity of the client's bizarre

memories. To explore this issue, we asked respondents if they personally believed their clients' allegations of harm, and, separately, whether they believed the ritualistic or religion-related aspects of the allegations. We also asked whether or not the respondents thought that any of the alleged ritual or religious elements of the abuse acts had been faked or staged by perpetrators (e.g., staged human sacrifice to intimidate the victim).

Overwhelmingly, our respondents believed their clients' claims, even in the absence of corroborative evidence (see Table VII). However, they were more likely to think that certain acts had been faked in ritual than in religion-related cases. In a few cases, the fakery was actually documented. One respondent wrote, for example, "I obtained a portion of a videotaped confession of the adolescent perpetrator in which he confirmed his use of staged sacrifices." But in most cases, evidence of fakery was less convincing: "Victims were abused in a training camp for intergenerational satanic cult members, which included elaborate equipment that could have created some illusions, e.g., demons flying into people." This respondent mentioned no evidence for the existence of this camp. Interpreting clients' claims as mistaken perceptions of staged acts may be a way for some clinicians to accept their clients' perceived experiences as potentially real, without having to believe either (a) that gruesome tortures, sacrifices, and acts of cannibalism actually occurred, or (b) that clients can misremember traumatic events.

Respondents were more likely to believe reports of harm made by adults than by children, and in religion-related rather than ritual cases. They were no more likely to believe in the religious than in the ritual elements of the case, but were somewhat more likely to believe in the ritual or religious aspects when an adult rather than a child reported them. It is noteworthy that respondents found adults more credible than children, even though the data in Table 7 indicate that children's abuse claims are more often corroborated than similar claims made by adults. Overall, though, what seems most striking is the high degree of clinicians' belief in their clients' reports.

CHARACTERISTICS OF RESPONDENTS

Workshop Attendance

It has been suggested that clinicians learn at workshops and seminars to identify cases of ritual abuse and then begin to encounter, or create, such cases in their own practice (Mulhern, 1991). In our survey, respondents indicated whether they had attended "a lecture, seminar, or workshop concerned with ritualistic child abuse." Overall, 60% of the respondents who reported one or more cases of ritual abuse had attended such training events, compared with only 27% of those who reported no ritual abuse cases, $\chi^2(1, N = 265) = 22.81, p < .001$. There was no such association between attending ritual abuse workshops and reporting religion-related cases. Overall, 46% of the respondents who reported one or more cases of religion-related abuse had attended such training events, compared with 55% of those who reported no religion-related cases, $\chi^2(1, N = 265) = 2.36$, n.s.

Further, even with outliers omitted, those who had attended ritualistic child abuse workshops ($N = 133$) reported more than twice as many cases ($M = 2.29$) as those who had not attended ($N = 131$; $M = 1.03$), a statistically significant difference, $t(262) = 3.49, p < .001$. There was no such difference in reports of religion-related cases. Psychologists who attended or did not attend ritual child abuse lectures or workshops reported an average of one religion-related case ($M = 1.00$ and $M = .99$, respectively). Thus, there is a connection between encountering ritual cases and having attended a relevant workshop; but the causal direction of the association is unclear. If a psychologist encounters a client who claims to have been ritually abused, it is not surprising if he or she seeks relevant information through workshops and seminars. It is also possible, as Mulhern (1991) argues, that once therapists learn about the supposed sequelae of ritual abuse, they (and, in turn, their clients) are more likely to search for relevant memories, and inadvertently encourage false reports in the process.

Kinds of Areas Served

Twenty-five percent of our sample reported serving a rural area, 56% an urban area, and 42% a suburban area (respondents were allowed to indicate more than one type of area). Folklorists (e.g., Stevens, 1991; Victor, 1993) have suggested that claims and rumors of satanic activity are most likely to arise in rural communities, many of which have been threatened in recent years by cultural change and economic hard times. Although respondents who serve rural areas reported slightly more ritual ($M = 2.04$) and religion-related cases ($M = 1.07$) than those who do not serve rural areas ($M = 1.57$ and $M = .92$, respectively), the differences were not statistically significant: $t(270) = 1.15$ and $t(269) = .65$, respectively. Similarly, there were no significant differences between the mean number of ritual ($M = 1.78$) or religion-related cases ($M = 1.02$) reported by psychologists who practice in urban areas versus those who do not ($M = 1.56$ and $M = .88$, respectively); or in the number of ritual ($M = 1.82$) or religion-related ($M = 1.18$) cases reported by those who serve suburban areas versus those who do not ($M = 1.59$ and $M = .80$, respectively; all t's $(\geq 269) \leq 1.82$). Thus we found little evidence that reports of ritual abuse are more a rural than an urban phenomenon.

DISCUSSION

Relatively few clinicians encountered cases of ritualistic or religion-related child abuse (as defined here) during the decade of the 1980s, whether reported by children or adult survivors. Only 13% encountered adult-survivor cases of ritual abuse and only 11% encountered child cases. A very small proportion of clinicians (around 2%), each claiming to have treated scores of cases, accounted for many of the reports of ritualistic child abuse.

Across most of our data analyses, what stood out was the extremity of the adult-survivor cases of ritual abuse. These cases more often included exceptionally

florid features: cult members, supernatural forces, graveyards, excrement and blood, knives and candles, human torture and sacrifice, cannibalism, animal sacrifice, forced sex, drugs, baby breeding, amnesia, and dissociative states. Forty-nine percent of adult survivors of ritual abuse were diagnosed with MPD and 28% with PTSD. Adult ritual survivors alleged more severe abuse, including witnessing and participating in murders, and an earlier average age of abuse onset. They claimed that many victims (including males) and many perpetrators (including females) were involved. Parents and relatives were often alleged to be among the perpetrators, meaning that clients' parents were claimed to be members of cults. Adult survivor cases were unlikely to have been reported to authorities or pursued legally, and there was not much evidence other than psychological manifestations for the claims of abuse or ritual involvement. In most cases, ritual abuse was first disclosed in the course of psychotherapy, and most of the therapists involved seemed to believe their clients' claims, largely on the basis of dramatic symptoms and powerful emotions. When therapists were skeptical, they tended to believe their clients' experiences but to suspect that the alleged abusers had faked certain actions, such as sacrificing babies; and indeed, there was evidence of fakery in some cases. Finally, there was a strong association between attending ritual abuse workshops and encountering ritual abuse cases.

Believers in ritual abuse assert that it has been occurring in the same fashion for generations. If the intergenerational view is valid, current reports by child and adult survivors should be quite similar because they are simply two views of the same phenomenon. Our data challenge that premise. Child ritual cases shared some features with adult cases, but they also differed in important ways. In general, child ritual cases were not as extreme as adult ritual cases. There was more social service and legal investigation of child cases and more corroborative evidence of abuse. The evidence for ritualistic elements of the abuse was generally weak, however, even in the child cases. Children were less likely than adults to have disclosed their alleged abuse in the context of psychotherapy. Contrary to popular perceptions, reports of ritual abuse were not statistically associated (any more so than reports of religion-related abuse) with custody disputes or daycare centers.

There are several interpretations of the differences between child and adult-survivor cases. A nonskeptical interpretation is that children are particularly unable or unwilling to report the full extent of the horrors they have undergone. In contrast, it is possible that children's less extreme claims are more often valid than adult's claims. Indeed, our respondents reported more evidence in child ritual cases than in adult cases, although most of it was still open to multiple interpretations. A final possibility is that both child- and adult-reported cases are largely false but that children have not adopted the suggested stories as completely or as coherently as adults. Children may not have the knowledge base to understand the satanic-cult prototype (Quas et al., 1995), and may not have been as self-selected as the adults to adopt it. Ironically, clinicians in our sample tended to believe their adult clients more readily than their child clients.

When ritual abuse cases were compared with cases of religion-related abuse, the evidence for the child religion-related cases seemed particularly convincing. More of the religion-related abuse perpetrators confessed their role in the abuse,

and therapists' accounts of religion-related cases more often referred to specific investigatory evidence of the abuse. As illustrated in previous quotations, evidence for the religious aspects of religion-related murders was often conclusive and publicly documented. This was not the case for alleged cult-related murders. Even so, police and social service agencies were less likely to pursue cases involving claims of religion-related abuse than claims of ritual abuse, although social services more often found the ritual abuse cases "unsubstantiated."

Alleged Ritual Abuse: What Explains It?

There is a continuum of interpretations for the evidence we have presented—the same continuum evident in American courtrooms, at professional conferences, in research journals, and in media accounts. At one extreme, there are people who believe that society is threatened by an organized, intergenerational, international network of satanic cults, and that one of the main activities of these cults is sadistic child abuse. Some of our clinical-psychologist respondents belong to this contingent, as illustrated by the following quotations:

> I have very little hope that any of this [study] will be useful and am confident that the results will be used by cult members. That is sad. I am not very hopeful about our country being able to deal with this problem. I think satanic cults are controlled and used by the drug and porno 'kings!' [This was written by a therapist who offered no evidence for the ritualistic elements of any of the eight extreme cases he reported.]

> What is so horrifying is that people in high places—doctors, lawyers, teachers—are part of the horrendous abuse and walk around as innocents.

At the other extreme are vocal skeptics who come close to maintaining that there has never been a single genuine case of ritualistic child abuse and there are no child-abusing satanic cults (Ofshe, 1992; Ofshe & Watters, 1994; Richardson et al., 1991; Victor, 1993). Some of our respondents displayed a degree of such skepticism:

> All of this is *alleged*. I found it hard to believe because patient's affect was so *bland* in describing her ritual murder of a child she gave birth to (allegedly) at age 11 (allegedly).

> Do you find that borderline personalities unconsciously produce memories, or MPD-like symptoms? I can tell what diagnosis my borderline will qualify for by the book she is reading the week before.

> I sometimes suspect that the things my patient tells me are part of a general 'sensationalizing' of ritualistic abuse. How come bodies are never found? Fundamentalist Christians are part of this sensationalizing process. . . . I always want to believe my patients, but I also want to stay objective. I know also that therapists suggest things to patients—e.g., that the patient has MPD. I therefore avoid leading questions.

In between the believers and skeptics in our sample, one finds a variety of positions. Some clinicians believe that ritual abuse claims, including allegations of satanic abuse, stem from actual abuse, but that the ritualistic or satanic elements are fabricated or based on cultural or clinical suggestions. Others believe that a few deranged individuals or families engage in ritualistic or satanic abuse, but that there is no organized network of satanic cults and that the few genuine cases are

being swamped by an avalanche of false ones. Others believe that many of the cases are genuine but that some of the victims' claims are false:

> I have no doubt that my patients were abused. My doubt is about some of the specific details.
>
> I tend to believe the patient's claims, but I'm not 100% sure. Patient has history of delusions and hallucinations.
>
> A male infant was poisoned by street drugs at the hands of the infant's parents. CPS became involved; the father told a social worker about the cult. Both parents speak of the satanic cult as playing a role in the abuse. . . . It's true abuse, but I'm not sure of satanic influence in an organized way.

Our results point to the possibility that some acts of child abuse qualify as "ritualistic," but not that highly organized, intergenerational, international child-abusing satanic cults exist. Few people would deny the existence of pedophiles, sadistic killers, authoritarian religious cultists, or even practicing satanists. It would be surprising if these categories were *not* occasionally conjoined in a quasi-satanic mixture with serious consequences. As discussed earlier, several examples provided by our respondents contained realistic elements of brutality, some perhaps influenced by satanic themes, along with other seemingly unrealistic elements. Weir and Wheatcroft (1995) have recently reported results of a clinical evaluation of 20 cases in which British children alleged to have suffered satanic ritual abuse. Their conclusions were similar to our own: specifically, that most cases of ritual abuse were probably false, but not all, including one case in which incriminating photographs and documented confessions of multiple perpetrators substantiated the claims of multiple child victims. Thus, some true cases are likely to exist that meet the heinous criteria for the label ritualistic abuse, but many, and perhaps most, other cases are unsubstantiated.

In any case, further research is needed before we can fully understand the phenomenon of ritual abuse claims. Many of the cases of ritual abuse in our study were reported by a small minority of therapists. We need to learn more about those therapists. Are they known in their locality as experts on ritual abuse, which causes large numbers of cases to be referred to them, or are they somehow helping to create cases? What goes on in their therapy sessions? Do they use hypnosis, which can contribute to misinformation effects in recall (Bowers & Hilgard, 1988; Orne, Whitehouse, Dinges, & Orne, 1988), perhaps in conjunction with "past life regression" (Feldman, 1993)? Do they make ritual-related suggestions to clients, perhaps unwittingly (Lindsay & Read, 1994)? Do they probe for ritual-related memories and evidence? Are clinicians with large numbers of satanic abuse cases religious in ways that encourage belief in satanic forces or satanic cults? We are now conducting research investigating these important issues (Bottoms, Beety, Goodman, Tyda, & Shaver, 1995).

In terms of psychological characteristics, who are the patients who allege ritual abuse? Do their disorders predispose them to the suggestibility necessary for adoption of false ritualistic abuse narratives from any number of sources, including the media, and support groups for "survivors"? Because so many of the ritual abuse clients in our study were diagnosed with MPD or PTSD, we need to learn more about the assignment of those diagnoses. Do clients arrive at therapists' offices with

obvious symptoms of MPD, or are these symptoms gradually discovered, or created, in the course of therapy? How reliable are such diagnoses? How well qualified are the leaders of professional workshops on these topics? Because it remains possible that there are *no* organized child-abusing satanic cults, it is difficult to imagine where "experts" on such cults could have gotten legitimate information and training. In ritual cases involving children, where do the children get their knowledge of satanic and ritualistic practices? Are they questioned along these lines by parents, religious professionals, or law enforcement officers before they reach a therapist's office? How, and how often, are ritualistic possibilities first broached by therapists?

These are researchable questions that scientists should seek to answer. The task will be difficult, however, as long as therapy sessions remain hidden from empirical study. In our experience, a thorough investigative approach is often discouraged by therapists and victims, with such protestations as (a) all of the evidence was hidden or destroyed by an exceptionally well-organized and secretive cult, (b) therapy sessions must remain confidential, or (c) an investigation of the past would pose a danger to the victim, the therapist, or ourselves because of retribution from cult members. Although confidentiality is obviously an important consideration, it is not ethically insurmountable. Therapy research has been conducted for other reasons (e.g., Horowitz et al., 1984; Luborsky, 1984; Weiss & Sampson, 1986); surely it could be conducted to study possible iatrogenic processes as well.

Influences on Ritual Reports

If reports of ritual abuse are, at least in some cases, fabricated, where do they come from? In the child cases determined to be false, Weir and Wheatcroft (1995) noted sources of contamination such as a paranoid schizophrenic mother with delusions about cults, therapists and caretakers who had special interests in and knowledge about ritualistic abuse, and even religious groups that provided adolescents with information about satanic practices and actively encouraged disclosure of ritual abuse.

Some claims of ritual abuse clearly reflect exposure to mass media (Coons, 1994). Religious publishers and radio and television talk-show hosts devote huge amounts of page space and air time to the topic of ritual abuse. Some of our respondents mentioned the effects: (a) "Grandmother/guardian questioned the children [2 and 4 years old] after seeing a Geraldo show." (b) "I was struck by the fact that the patient first 'realized' she was a 'multiple' while attending a talk show where multiples were interviewed. She now attends group meetings of ritual abuse survivors." Regarding "true accounts" of ritual abuse that have been published, investigative journalists (Passantino, Passantino, & Trott, 1990) checked the validity of satanic abuse claims made by authors of two popular religious books, *Satan's Underground* (Stratford, 1991) and *The Satan Seller* (Warnke, 1972), and found them totally without merit (involving, for example, false allegations about baby breeding, drug use, and cult-inflicted wounds).

Aside from media influences, some adults may pressure children to "recall" ritualistic events, although not always successfully. One of our respondents wrote: "Parent remembered. Child denies." We, like Weir and Wheatcroft (1995), also saw

evidence of influences from clinicians' own ideologies, training experiences, and personal struggles: (a) "[These claims of satanic abuse] would all have sounded very bizarre, but I had recently been to a workshop on MPD and ritualistic abuse." (b) "Therapy went okay during the time I made no inquiry into satanic worship. After a workshop, I wanted to get information and she switched therapists." (c) "When your questionnaire arrived, I was confused and somewhat apprehensive about working with ritually abused clients. Since then, I have put to rest subconscious fears that there may be some supernatural evil power . . . When the questionnaire arrived, I was in the middle of this struggle/growth."

Finally, as previously noted, another influence on ritual abuse reporting may be clients' mental condition. We have shown that many of respondents' clients who reported ritual abuse were diagnosed with some form of dissociative disorder, which may be connected with increased suggestibility. In addition, clients' real, nonritualistic abuse may also be a contributing factor. As indicated by previous quotations, several of our respondents indicated greater confidence in their clients' abuse than in the ritualistic claims surrounding it. In many of the child cases at least, there was good evidence for some kind of abuse, even when its ritualistic trappings were questionable. The resulting psychological disturbance might predispose victims to fabricate false memories regarding the circumstances of the abuse (Ganaway, 1989).

The Problem of Definition

For future work on this topic, whether forensic or psychological, it will be important to clarify the definition of ritualistic abuse. Our respondents' definitions varied widely. The two most common features—(1) forced participation in sexual activities and (2) abuse repeated in a prescribed manner—have no necessary connection with satanism, the issue that makes ritual abuse such a volatile topic. Nevertheless, many of the cases viewed as ritualistic *did* include symbols or objects associated with the devil.

The term "ritualistic" was originally a vehicle for talking about "satanic" abuse without mentioning Satan, a move that seemed reasonable at the time but has contributed to conceptual fuzziness. If one wishes to talk about particularly brutal, bizarre, or horrifying abuse, it would be wise to say so directly. If one wishes to talk about repeated abuse, perhaps with compulsive elements, it would be useful to create a special term for it. If one wishes to talk about abuse perpetrated by members of a satanic cult, the preferred term should be satanic cult abuse, not ritualistic abuse. If the issue is abuse by some other kind of cult (Jim Jones's People's Temple, David Koresh's Branch Davidians) it should be called cult abuse or given a name that distinguishes it from both compulsive repetition and satanism.

Replies to our questionnaire indicate that many kinds of abuse now classified as ritualistic have nothing to do with supernatural beliefs, satanists, or organized cults. It has proven socially dangerous to combine such different phenomena as abuse by a compulsive, demented individual and ideologically motivated abuse inflicted by religious or satanic cult members. The term "ritualistic" is too broad and loose to serve as a useful professional category.

DOES THE TRUTH MATTER?

In describing to us her discomfort in working with the case of an alleged ritual abuse survivor, a respondent wrote, "I often find myself doubting that it happened or that this patient is a multiple. However, I choose to accept her and her descriptions at face value and work with her as if these are the facts." While working on this project we were told by many highly trained clinical psychologists that it "doesn't matter" whether their clients' reports of satanic or ritualistic abuse are accurate or inaccurate. Therapists can and should, they said, help their clients get better, no matter what actually happened in the past. They contended, understandably, that they are not detectives, that often it is impossible to find out what actually happened to a client, and that accurate knowledge of the past is not essential to good treatment. These arguments have merit, but when thousands of ritual abuse reports ignite widespread public and professional fears about a national or international satanic cult conspiracy, resulting in specific accusations of sexual abuse against preschool operators, teachers, parents, and other family members, as well as changes in state laws, it definitely *does* matter whether the cults actually exist. To the extent that such claims are false, they undermine the believability of actual victims of child abuse and create a backlash against child protection, prosecution of actual child abusers, and psychological treatment—a backlash from which these endeavors cannot easily recover.

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