PRACTICE

PROBLEMS OF BELIEF IN APPROACHING PATIENTS' ACCOUNTS OF RITUAL ABUSE

—by Jean Goodwin

"How do you tell if what I say is real?" asked a patient.

"I more or less assume that everything is real," I said. "It has to be unwrapped, of course, whether it's a dream, or a sudden wave of fear, or your boss's evaluation of your work. Then it has to be integrated into everything else you know about yourself."

Then she told me about some memories she thought were not real, memories of being 10 and taking part in some kind of ritual. She thought her parents were present, that there were robes and blood, and that sexual things were done to her.

How do I evaluate the veracity of her report? Should I believe it or not?

Would a physical exam help? Perhaps there still some physical signs of the abuse she describes. Should she be separated from family members with whom she remains in contact? Does she need to be persuaded to contact police or other law enforcement?

As I try to evaluate her report, I ask myself dozens of questions: How disjointed is her account? Could it be an account of a daydream that took place while she was being traumatized or in a trance state? Could it be a posttraumatic nightmare that uses symbolism, displacement and condensation to depict an actual traumatic event? Or an hallucination of hysterical psychosis constructed on the same principles? Are there now or were there at the time of the abuse organic factors that could have produced hallucinations? Such factors could include sleep deprivation, head trauma, malnutrition, electrolyte imbalance, extreme pain, administered substances, infections, mania, depression, and many more—all conditions that are more likely to occur in abused children.

Does the account fit in with what we already know about the family? In this case, for example, we have documented the parents' joint alcoholism, and the sadistic physical and sexual abuse of all children in the family, half of whom have already acquired dissociative disorder diagnoses (the other half are diagnosed as borderline plus substance abuse). Is the patient still trying to absolve the parents from personal responsibility for their actions? Is that part of the appeal of the notion of cult involvement? Could it represent a later paranoid pseudoexplanation for years of pain, an explanation that covers a still more humiliating and destructive reality that remains to be unwrapped?

How does this account mesh with the patient's symptoms? Does it connect to her sadistic sexual fantasies? Her fascination with blood? Her genital self-mutilation? Is there a psychotic process that I've missed? Is there more projection, suspiciousness, and grandiosity in this patient than I recognized previously?

All of these questions offer themselves for exploration when a patient begins recounting an experience with ritual abuse. Sorting them out is invariably a lengthy task, fraught with long periods of uncertainty when many different conflicting versions remain simultaneously possible.

While I listen to the patient, I am also listening to myself and asking a different set of questions: Am I approaching this disclosure any differently from the way I approach other accounts of violence? What if the patient were describing the same scenes but said she had participated as an adult? What if she described the same scenes but with pleasure instead of fear? What if she'd described the same feelings and actions and sensations, but without the ritual details? The same ritual details but with no violence?

As I try to evaluate my patient's startling disclosures, I have to remain aware of my own biases. I know that one of my core biases is that people do dreadful things to each other with great regularity: I am predisposed to believe her. I have to make an effort to keep in focus some optimism about as-yet-undiscovered positives in these childhoods. I remind myself that, even with a parent who is antisocial, sadistic, and occasionally psychotic, there are moments of tenderness, even if only of anticipated tenderness; there may be scores of those moments, hundreds, and hundreds of hundreds.

But I have colleagues whose bias is to believe the world to be a much safer place than I do, colleagues who must remind themselves to ask routinely about arrests, alcohol and substance abuse, about weapons, violence history, pornography, suicidality. Colleagues who know they would prefer to believe child abuse to be an occasional and solitary affair, but must remind themselves of the reality by reading the personal ads in the pornography magazines or by watching the passengers in a bus or the shoppers in a grocery store tacitly approve as a parent emotionally or physically abuses a child.

As we try to deal with our tendency not to believe some of the shocking disclosures we hear, we can use statistics as a good centering device. In a survey of college students, 5.4% said they'd been kicked by parents, 12.1% said parental discipline had caused injuries (bruising or beyond), 1.2% had been locked in closets by parents; 8.8% said parents abused each other. Yet only 2.9% of these respondents felt they were abused. The optimist will look at these data and see children surviving significant quantities of violence even without intervenion. The pessimist will wonder if all this worry about patients' overreporting abuse is not just a vain hope: patients, like college students, may be willing to put up with almost any level of violence as long as they don't have to call it violence.

I remember Hippocrates's dictum: "First, do no harm." This remains my responsibility whether I'm acting as a consultant or as a therapist.

If this patient has not yet dealt with her parents' alcoholism as a reality, will shifting the focus to their possible practice of ritual group sex simply prolong her successful use of derealization to keep in limbo her childhood pain?

Therapeutic aims should always take precedence over our attempt to disprove or prove a patient's description of a prior traumatic experience. Posttrauma syndromes consist of both reliving and suppressing. Recovery also consists of reliving and suppressing, each hopefully practiced with ever-greater autonomy and mastery. Keeping the two in balance is the key to increasing function and decreasing disability.

Patients need our help in finally re-

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NEWS

FREE MEMBERSHIP!

The key to APSAC's success is a dynamic, vocal, and **large** membership! The McMartin case has dramatized, among other things, our need for interdisciplinary support—one of the needs APSAC was founded to address. To meet program and budget goals, we need to sign up 1,000 new members this year: twice the number we signed up last year! Enthusiasm for APSAC's mission is growing across the country, however, so we think we can meet this ambitious goal. To ensure APSAC's success, a membership drive begins today.

Every member who signs up 10 new members by June 1, 1990, receives one year's free membership.

Here's how it works:

* Call the Chicago office for a supply of brochures, if you need them. Or xerox the membership application from the back of this newsletter.

* Tell your colleagues about APSAC. Urge them to join. If several of you work together, you may be able to take advantage of the new institutional memberships for 5 or more people—see "Board" article, page 3.

* Have everyone you recruit write your name clearly at the top of his or her application. Remember: *until April 1*, new members can choose to sign up at the old rates or at the new rates. After April 1, new rates kick in for everyone.

We'll keep tabs on the number of people who sign up under your name, and award you free membership for one year when that number hits 10. In the Spring and Summer newsletters, we will publish a list of names of people who have recruited new members, and the number they've recruited. Every member you sign up gives the field and APSAC an important boost.

Please feel free to call the office if you have any questions. We look forward to hearing from you. Good luck!

APSAC MEMBERSHIP BY STATE

CA	179	ME	15
IL	83	LA	13
NY	68	MO	12
MA	64	DC	11
NC	59	KS	11
TX	41	MS	11
FL	38	CT	10
CO	28	IA	10
WA	31	IN	10
WI	27	HI	9
PA	25	NH	9
MD	24	NM	8
NJ	23	UT	8
OK	23	SC	7
OH	22	RI	6
VA	22	CN	6
AL	21	AK	5
AZ	20	KY	5
GA	20	NE	4
MN	20	AR	3
MI	19	ND	3
TN	19	VT	2
NV	18	DE	1
OR	17	WV	1
ID	15		

States with no members: Montana and South Dakota
Members with no states: 3 (England), 1 (Australia), 1 (Guam), 1 (Israel).
TOTAL: 1,114

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viewing, exploring, unwrapping these experiences in all the ways they've alredy learned to process other mental contents that were not freighted with secrecy prohibitions, trance distortions, or organic distortions. Given encouragement, dialogue, and latitude to explore, the patient can submit emerging memories to the same critical processing that has shaped the other impressions and memories that make up her sense of self. This emerging reality is the one that truly belongs to the patient and, to my mind, the one that is most "real."

Regarding the role of the therapists's credulity in this process, I can think of no better advice than that an old Tibetan teacher of meditation gave his students: "Incredulity comes sometimes. Indeed it is one of the ultimate objects. But if the disciple reaches this state of mind before the proper time, he misses something which these exercises are designed to develop: fearlessness."

Jean Goodwin, MD, MPH, is a faculty member of the Medical College of Wisconsin, Department of Psychiatry, and a member of APSAC's Board of Directors.

ONGOING APSAC TASK FORCES

Assessment and Treatment of Perpetrators of Child Sexual Abuse
Judith Becker, Ph.D., Chair
New York State Psychiatric Institute,
722 W. 168th St.,
NY, NY 10032

Evaluation of Suspected Sexual Abuse in Young Children
Lucy Berliner, MSW, Chair
Harborview Medical Center,
325 9th Av., Seattle, WA 98104

Medical Evaluation of Suspected Child Abuse
David Chadwick, MD, Chair
Center for Child Protection,
Children's Hospital,
8001 Frost St.,
San Diego, CA 92123

JOB BOARD

POSITION AVAILABLE

EXECUTIVE DIRECTOR for growing national child abuse prevention organization. Three years' non-profit management experience required, including Board and program development. Sensitivity to self-help philosophy and knowledge of resource development required. Master's degree; travel required.

Send resume and salary requirements to Parents Anonymous, Inc. 6733 S. Sepulveda, Suite 270, Los Angeles CA 90045. *Deadline: February 28, 1990, or until filled.*