- # Mirrored:Forensic Considerations in Ritual Trauma Cases (Svali Blog Post)

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- If you are a survivor of ritual abuse, please exercise caution since this article deals with ritual abuse in detail.

Occasionally, a person writes an article that is outstanding, clear, and definitive. Ms. Gillotte has done this in this article, and her work shows the effects of ritual trauma on small children, and explains why it is often difficult for them to disclose their abuse. Because the formatting here at Suite 101 limits article lengths, I am publishing this in three parts, so that it may be presented in its entirety. If you work with ritual abuse survivors, if you are a social worker, and law enforcement officer, or a caseworker, please read this and share it with your coworkers. This is invaluable information for all. Svali

Part One -

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• FORENSIC CONSIDERATIONS IN RITUAL TRAUMA CASES

• ABSTRACT:

Cases involving child sexual abuse, as well as other types of abuse, sometimes involve allegations that are unusually bizarre, or even incredible in nature. Such cases may actually be indicative of a far more complex and sinister form of abuse referred to as ritual trauma or ritual child abuse. While much is known about the dynamics of ritual trauma, very few professionals have the training necessary to effectively recognize and assess such cases. As a consequence, the bizarre nature of a child's behaviors and/or disclosures often leads professionals to discount the child's allegations of abuse altogether.

This material is designed to assist and educate virtually every level of professional in the system dealing with child abuse in recognizing ritual trauma and understanding its basic dynamics. In addition to providing a workable definition for ritual trauma and describing its common elements, professionals are provided a comprehensive checklist of signs and symptoms in children that will assist them in making cases assessments. The significance of these signs and symptoms to ritual trauma will also be discussed.

Beyond initial assessment, the investigation and prosecution of cases involving ritual trauma can be exceedingly difficult and most often requires specialized assistance. Inasmuch as expert assistance is not always readily affordable or available, this material provides specific recommendations and guidance to professionals in the major fields of specialty likely to encounter such cases, including prosecutors, attorneys, law enforcement officers, physicians, psychologists, therapists, social service workers, and Guardian ad Litem/CASA representatives. Readers are provided with a list of references, publications, and resources for further study and assistance.

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FORENSIC CONSIDERATIONS IN RITUAL TRAUMA CASES

"Cases of ritualistic abuse may come to light when a child is being evaluated or treated for sexual abuse. Unfortunately, investigators and therapists, lacking knowledge of the clinical

indicators of cult-based ritualistic abuse, often fail to recognize that the sexual abuse being described has occurred within the context of satanic cult worship."

- Susan J. Kelley, R.N., Ph.D.

• I. INTRODUCTION

Ritual trauma is a highly sadistic form of abuse that is perpetrated upon individuals of all ages, but which most commonly originates in infancy and early childhood in an intrafamilial and intergenerational setting. It is a unique form of child abuse, where children are sexually exploited and systematically traumatized in a deliberate effort to induce dissociative mental states for purposes of indoctrination and programming. As a sub-category of ritual crime, it often includes the use of symbols and other paraphernalia designed to have specific psychological impact on its victims.

The dynamics of ritual trauma are significantly different from those of other forms of child abuse. Ritual trauma is neither commonly understood, nor easily recognized, and usually requires specialized training and handling in order to be successfully assessed, investigated, and prosecuted. Due to the nature of the abuse and the manner in which it is perpetrated, supportive medical and physical evidence is difficult, if not impossible, to obtain. Therefore, an investigative paradigm that is designed to assist professionals in overcoming these and other obstacles must be created and incorporated into any existing multidisciplinary framework addressing the sexual abuse of children.

Children who have been sexually abused in conjunction with ritual trauma do not readily disclose the ritual aspects of their abuse. In fact, disclosure of this aspect of their abuse is usually extremely delayed due to a variety of psychological factors that often accompany this type of trauma. In cases involving child sexual abuse, it is both common and appropriate for professionals to assess veracity by looking for consistency in a child's disclosure. However, in a genuine case of ritual trauma, a child's disclosures involving abuse will naturally be both inconsistent and "incredible" in nature. This is primarily due to the manner in which the child has been victimized, as well as the frequent use of drugs in conjunction with this type of abuse. These dynamics are covered in this material in an effort to assist professionals in recognizing, assessing, and properly handling these cases.

• II. UNDERSTANDING RITUAL TRAUMA

• A. DEFINITION

There have been many attempts to label and define ritual trauma in a context that can be understood and universally referenced by various professionals, clinicians, and researchers. However, given the nature of the abuse, the diversity of the perpetrators, and the many manifestations which ritual crime can take, this task has not been easy or without controversy. Undaunted by this challenge, some states have managed to pass specific legislation prohibiting and/or providing for increased penalties for certain criminal acts of a ritualized nature.

Although accounts of ritual trauma as an extremely sadistic form of child abuse and neglect date back several centuries, it is a phenomenon which has only been recently recognized, studied, and publicized. Modern revelations concerning ritual trauma have coincided with an increased awareness of child abuse in general, and the recognition of multiple personality and dissociative disorders by the medical, psychiatric, and psychological communities.

In 1988, the Los Angeles County Commission for Women organized a Task Force of professionals from the fields of law, medicine, mental health, education, law enforcement, religion, and social work to study and develop a report concerning the existence and problem of ritual abuse. Working with adult survivors and parents of child victims, the Task Force published a definitive report on the nature of ritual trauma and described it as "…a brutal form of abuse of children, adolescents, and adults, consisting of physical, sexual, and psychological abuse, and involving the use of rituals."

In its Report, the Task Force further clarified that although "ritual" does not necessarily mean "satanic," a majority of survivors report repeated abuse over an extended period of time in rituals involving either satanic symbology or satanic worship apparently designed to indoctrinate them into related beliefs or practices. It is important to note that - as with all other spiritual belief systems in this country - the worship of Satan is constitutionally protected. There are many Satanic churches and organizations in America which are legally incorporated and formally recognized, and these groups claim no involvement in the underground criminal activity and child abuse which is characteristic of ritual trauma.

• B. COMMON ELEMENTS

It is clear from the work of this Task Force, as well as the work of numerous other prominent researchers and professionals who have examined this topic, that regardless of definition, ritual child abuse almost always includes certain basic elements:

- 1) Multiple victims
- 2) Multiple perpetrators
- 3) The use of ritual in connection with:
    - a) severe physical abuse and deprivation, and
    - b) sadistic and painful sexual abuse4)The use of drugs and/or mind control techniques for the purposes of indoctrination, domination, and as a deterrent to disclosure.

Because ritual child abuse involves both multiple victims and multiple perpetrators, such activity necessarily involves a level of organization and planning which is not found in more commonly investigated cases of abuse and neglect. This impedes and complicates the investigation and prosecution of ritual child abuse. Often referred to as "organized cults," these perpetrator groups are highly secretive and go to extraordinary lengths to hide their criminal activity.

• C. STRUCTURE OF CULTS

A successful cult can be compared to a successful pedophile, since both are known to function and operate out of any group structure that a) is convenient, b) provides private, easy, and regular access to victims and an environment for their activities, c) which can be safely infiltrated and/or logistically controlled, and d) naturally instills a false sense of trust in the perpetrator(s). For example, since Masons belong to a fraternal society which practices secret rituals and which extends membership by invitation only, many cults have successfully used local lodges as a cover for their activity. Any structure or organization which is practical or convenient can be used; e.g., a volunteer fireman's group, a local church or synagogue, an elementary school, etc.

It is important to point out that while these structures and organizations may be secretly used by cults, their criminal activities are usually kept hidden from the unsuspecting membership of the larger and legitimate group under whose "umbrella" the cult may be hiding. It is interesting to note that a majority of adult survivors of ritual abuse report victimization by cults that were operated out of well-established or "mainstream" churches in their community. Naturally, activities and rituals of this nature were successfully conducted without the knowledge and approval of the larger congregation.

Since most - though not all - ritual trauma is intergenerational in nature, it is important to remember that the majority of cult victims and participants are either born into a group or recruited at a very young age. Programming and brainwashing through sexual and other trauma begins very early and is systematic and brutal. Children who demonstrate particular intelligence or talent are carefully primed and subsequently groomed to enter certain professions and infiltrate specific organizations that are deemed critical to the successful operation, networking, and protection of the cult.

The use of credible organizations and structures also has additional benefits. Cults, adult sex rings, and pedophiles alike are extremely aware that allegations of sexual and ritual abuse are easily discounted when they involve any perpetrator having professional trust and standing in the community. Since successful cults operate as a mutually protective group, the greater the number of "professional" participants involved, the less likely it is that their activities will be investigated or prosecuted. In a study of five cases of ritualistic abuse, Barbara Snow and Teena Sorenson describe this "duplicitous" component as follows:

"The overwhelming majority of known offenders were active members of the predominant religion in the neighborhood. Several held high profile church and community leadership positions. There were typically in marital relationships that non-offending partners described as stable and low in conflict. Most were respected parents with positive family images. Many were recognized in their various areas of employment, including the legal and child-care professions. Women were identified as perpetrators in all five of the neighborhoods…most often mothers and grandmothers who were involved in church, community, and extracurricular activities of children. These women were often reported as working cooperatively with their husbands in the ring. Participants in the adult ritual sex ring included

extended family (i.e., grandparents, aunts, uncles, and cousins) who cooperated with neighbors and other adults."

In order to understand this contradictory presentation by perpetrators, one must first recognize that cults use severe trauma to create dissociation in victims; and repeated trauma and extreme dissociation can result in level of psychological fragmentation that permits both victims and perpetrators to live a "Jekyll and Hyde" existence - often appearing quite normal, trustworthy, and stable to the outside world. This little understood phenomenon, further discussed in Section II (D) below, often prevents disclosures and allegations of ritual trauma from being seriously investigated. Naturally, many people would have a great deal of difficulty imagining and accepting the fact that a teacher, parent, professional, or otherwise respected member of the community could be capable of such horrific activity.

This is not to say that all perpetrators of ritual abuse fit a similar profile. Perpetrators of this type of abuse come in all shapes, sizes, and colors, and may just as easily come from a clearly dysfunctional family setting with a history of various psychological or drug-related problems. Some families appear to be more capable – genetically, psychologically, emotionally, or otherwise – of handling certain aspects of trauma more effectively than others. Capacity to dissociate as a coping mechanism to trauma may play a critical role. Furthermore, the level of sophistication in mind control techniques used by a particular cult may also be an important factor.

Similarly, the size and location of perpetrator groups may vary considerably, ranging from a few members in one general location, to hundreds of members located in different parts of the world. By necessity, the larger the group, the more organized and dangerous the cult. Furthermore, it is important to understand that many organized cults engage in a variety of money-making endeavors which are criminal in nature. The sexual abuse of children in conjunction with sadistic physical abuse and/or torture is often coupled with the use of these victims for child pornography and child prostitution. Cults may also engage in other money-making activity of a criminal nature including, e.g., the trafficking of children, drugs, and weapons; blackmail; insurance and computer fraud; etc.

As a result of these secretive and sinister activities, cults have been compared with the Mafia. It is interesting to note that in spite of overwhelming evidence to the contrary, former FBI director J. Edgar Hoover "publicly denied the existence of organized crime" for nearly forty years. Similarly, in spite of unequivocal evidence of convictions involving ritualistic mutilation, murder, and sacrifice in this country over the last three decades, the FBI has continued to deny the existence of ritual abuse by organized cults. Fortunately, there are state and local law enforcement officials who have disagreed with this untenable perspective and pursued investigations which have resulted in successful prosecutions and convictions of these criminals.

- ## D. DIFFERENTIATING BETWEEN SEXUAL AND PHYSICALABUSE & RITUAL TRAUMA

For reasons discussed throughout this material, protecting a child who is the victim of ritual trauma can be extremely difficult and demands specialized assistance. Therefore, it may be necessary to assess the nature of a child's allegations, disclosures, and behaviors to determine whether or not the abuse falls within the parameters of ritual trauma. Section III below provides a list of disclosures and symptoms that are consistent with ritual child abuse. The presence of a cluster of any of these signs and symptoms warrants further professional assessment and investigation of the case as possibly involving ritual trauma.

Ritual trauma not only involves multiple victims and perpetrators, but the psychological, physical, and sexual abuse that is perpetrated upon its victims is extremely intense, frequent, and sadistic in nature, thereby distinguishing it from other forms of child abuse. Furthermore, most groups use highly sophisticated mind control techniques to dominate, manipulate, program, and indoctrinate their victims to ensure loyalty, guarantee access for future exploitation, and prevent disclosure. This use of mind control techniques and programming is perhaps the most distinguishing characteristic of ritual trauma, and serves as the single most significant impediment to the successful assessment, investigation, and prosecution of such cases.

While the focus of this material deals with the sexual abuse of children, it is impossible to properly assess a case involving ritual trauma without also looking at accompanying physical and psychological symptoms and allegations consistent with this type of abuse. A genuine case involving ritual trauma would likely include a wide range of abuse and/or torture. As best described by the Ritual Abuse Task Force:

"The physical abuse is severe, sometimes including torture and killing. The sexual abuse is usually painful, sadistic, and humiliating, intended as a means of gaining dominance over the victim. The psychological abuse is devastating and involves the use of ritual/indoctrination, which includes mind control techniques and mind altering drugs, and ritual/intimidation which conveys to the victim a profound terror of the cult members and of the evil spirits they believe cult members can command.Both during and after the abuse, most victims are in a state of terror, mind control, and dissociation in which disclosure is exceedingly difficult."

In most ritual abuse cases, the intensity and severity of the trauma is intended to create a dissociative mental state in its victims, and the use of drugs to facilitate this process is very common. While dissociation is a natural phenomenon in which everyone engages to some degree or another, it is also a common psychological response to trauma that can spontaneously occur with any form of abuse. In ritual trauma, however, dissociation is the desired result because it ensures that the victim will not only survive the experience, but have great difficulty remembering the details of the trauma - thereby limiting subsequent disclosure of the abuse by the victim.

Furthermore, sophisticated cults deliberately exploit the dissociative process in victims. As a result of experiencing repeated trauma designed to fragment their psyches, victims often develop a number of psychological conditions, including Dissociative Identity Disorder (DID). Formerly characterized as "Multiple Personality Disorder" in the Diagnostic and

Statistical Manual of Mental Disorders published by the American Psychiatric Association (and, thereby, referenced as such in many articles and publications included in this material), DID is the presence of two or more "personality states" in an individual that recurrently take control of his or her behavior.

These personality states are commonly referred to as "personalities," "sub-personalities," "alters," "components," or "parts," and they can operate independently of one another in the consciousness of the victim. The degree of dissociation in DID creates amnesic barriers between these parts, representing an extreme on what might be considered a "continuum of dissociation." In ritual trauma - through a systematic and traumatic conditioning process - these distinctly created alters can be programmed, triggered, and subsequently accessed by controlling cult members. In this manner, separate "sub-personalities" within a victim can be formed and developed by the cult, then trained and conditioned to serve special functions or take on specific roles. Consequently, ritual abuse is sometimes referred to as a form of "trauma-based mind control."

• III. SIGNS AND SYMPTOMS OF RITUAL TRAUMA IN CHILDREN

There are numerous behavioral and psychological indicators in children that are consistent with ritual trauma. For professionals assessing cases of child sexual abuse, as well as other cases of abuse, these indicators should be considered to be "red flags" warranting expert assistance and special handling. Sexual abuse is a universal component of ritual trauma. Therefore, a child who has been ritually traumatized may have any number of the physical and behavioral signs and symptoms that might ordinarily be observed in cases involving sexual abuse. However, the manner in which sexual and other abuse is perpetrated on children who are victims of ritual child abuse usually leads to additional symptoms and disclosures which are relatively unique to ritual trauma.

Dr. Catherine Gould is a member of the Ritual Abuse Task Force, and is one of the most highly respected and recognized clinicians treating ritual child abuse victims in this country. She has compiled a comprehensive list of signs and symptoms of ritualistic abuse in children that many professionals have found extremely useful. A slightly modified version of this list is provided below. It is broken down into thematic categories, the significance of which will be further discussed in Sections V and VI of this material:

• A. PROBLEMS ASSOCIATED WITH SEXUAL BEHAVIOR OR BELIEFS

- Child masturbates compulsively, and attempts to insert objects into the vagina or rectum
- Child behaves in a highly seductive or sexually provocative manner, particularly when being photographed or videotaped
- Child refers to sexual activity between other children, or between him/herself and another child, and/or adults

- Child states that sharp objects were inserted into his/her private parts, including pins, needles, rods, screwdrivers, wands, sticks, knives, etc., or relates that he/she was asked or forced to stick sharp objects into someone else
- Child states that he or she witnessed sexual acts between adults; between adults and children; between adults or children and animals, etc.

On professional examination, child relaxes rather than tenses rectum when touched; or there is evidence of a relaxed anal sphincter, enlargement of the vaginal opening; or anal/rectal or vaginal laceration or scarring; or sore penis

- Child exhibits chronic vaginitis, constipation, and/or painful urination or defecation
- Child exhibits outbreaks of oral and genital herpes; or on exam, is diagnosed with an STD or HIV/AIDS

There is evidence of multiple pregnancies or “abortion” in adolescence

- Child refers to being married; or states that she is married or going to have a baby; or child states that she will never be able to have a baby

B. PROBLEMS ASSOCIATED WITH TOILETING AND THE BATHROOM

- Child avoids the bathroom and is highly fearful or agitated when in or around a bathroom
- Child avoids or is fearful of using the toilet; has toileting accidents because he or she puts off going; develops constipation; is unnecessarily fearful or resistant to being toilet trained
- Child avoids wiping self; or child’s underwear is soiled because he or she will not wipe, or due to relaxed sphincter muscle
- Child fears or avoids the bathtub, panics when being bathed, or resists being washed in the genital area
- Child seems preoccupied with urine and/or feces, or spontaneously urinates or defecates at inappropriate times or places
- Child either handles urine and feces, urinates on others, or smears feces on self, others, and/or objects
- Child attempts to ingest urine or feces, or compulsively discusses it at meal times
- Child draws nude pictures of self and/or family members urinating or defecating
- Child talks about any of the above scenarios involving urine and feces; or having been urinated or defecated upon; or witnessing these things having happened to someone else

C. PROBLEMS ASSOCIATED WITH THE SUPERNATURAL,RITUALS, OCCULT SYMBOLS, RELIGION, ETC.

- Child fears ghosts, monsters, witches, devils, dracula, vampires, evil spirits, dinosaurs, etc.

- Child fears Halloween, or themes associated with the celebration of Halloween, Easter, etc; regresses or gets highly agitated at Halloween, Easter, or other ritual holidays
- Child believes evil spirits inhabit his/her closet, enter the house, peer at the child through windows, accompany the child, torment or abuse him/her or watch to make sure he/she keeps secrets, inhabit the child's body, and/or direct the child's thoughts and behavior
- Child is afraid of or preoccupied with wands, sticks, swords, spirits, magic potions, curses, supernatural powers, crucifixions; or makes potions, attempts magic, throws curses, calls on spirits, prays to the devil, etc.
- Child sings odd, ritualistic songs or chants, sometimes in an incomprehensible language
- Child sings songs with a sexual, bizarre, or "you better not tell" theme
- Child does odd, ritualistic dances which may involve a circle or other symbols; child may costume him/herself in red or black, take off his/her clothes, or wear a mask for such dances
- Child is preoccupied with what might be considered occult symbols, such as the circle, inverted pentagram, hexagram, the number 6, horns, goats, inverted cross, etc.
- Child writes backwards or inverts all the letters and/or writing from right to left
- Child compulsively writes or draws esoteric symbols, such as those related to ancient civilizations and/or esoteric teachings such as the Kabbalah, etc.
- Child fears such symbols, or becomes highly agitated or upset in their presence
- Child fears attending church, becomes agitated or upset in church, fears religious objects or people, or refuses to worship God
- Child claims to see spirits, or hear voices talking to him/her and/or telling him/her what to do
- Child states that he/she or someone else prayed to the devil, threw curses, made potions, performed ritualized songs or dances, called upon spirits, did magic, etc.

Child states that he/she or someone else unexplainably wore ghost, devil, dracula, witch, etc. costumes; used ceremonial wands, knives, or swords; or had their body painted (usually black)

- ## D. PROBLEMS ASSOCIATED WITH SMALL SPACES; BEING CONFINED OR TIED UP

  - Child fears closet or being locked in a closet or coffin
  - Child fears other small spaces, e.g., elevators, boxes, cages, etc., and becomes agitated if forced to enter one
  - Child closes pets or other children in closets, or otherwise attempts to entrap or confine them
  - Child states that he/she or someone else was confined in a closet, box, coffin, cage, or other confined space

- Child fears being tied up and/or hung upside down, or states that he/she or someone else was tied up and/or hung upside down
- Child attempts to tie up other children, pets, adults, etc.

Rope burns or marks are evident on the child

• E.PROBLEMS ASSOCIATED WITH DEATH

- Child is afraid of dying; states that he/she is dying, or fears the he/she will die on a particular day or birthday (usually his/her sixth birthday, but can be any increment of 6, or a cult holiday of special significance)
- Child states that he/she is "practicing" to be dead, or is dead
- Child is afraid that parents, siblings, other family members, friends, will die or be killed
- Child talks frequently of death, asks many questions about illness, accidents, and other means by which people die. These questions may have an overly anxious, compulsive or even bizarre quality

E. PROBLEMS ASSOCIATED WITH THE DOCTOR'S OFFICE

- Child has a fear of pins and needles
- Child fears, avoids visits to the doctor and/or becomes highly agitated in or on the way to the doctor's office or medical facility; refers to "bad doctors" or otherwise expresses unusual mistrust of the doctor's motives
- Child is excessively fearful of shots and/or blood tests and procedures; may ask if he/she will die from the shot or blood tests, or whether someone will drink the blood
- Child appears to dissociate or mentally "check out" when subjected to shots, blood work, or other medical examination or procedure
- Child excessively fears taking clothes off in the doctor's office or asks whether he/she will have to walk around naked in front of others
- Child behaves in a sexually seductive way on the examining table or appears to expect or "invite" sexual contact
- Child states that he/she or someone else received "bad" shots, pills, or medicine

F. PROBLEMS ASSOCIATED WITH CERTAIN COLORS

- Child fears or strongly dislikes certain colors (usually red or black, but can be any other color significant in a particular ritual); refuses to wear clothes or eat foods of these colors, or becomes agitated in the presence of them
- Child states that red or black is a favorite color, for peculiar reasons
- Child refers to ritualistic uses of red or black that are inconsistent with what he/she has experienced in a spiritual setting
- Child obsessively draws using certain colors, particularly red or black, and/or associates certain colors with bizarre themes

G. PROBLEMS ASSOCIATED WITH EATING

- Child refuses to ingest certain foods or drinks because they are red or brown, and becomes highly agitated at meal times
- Child expresses fears that his/her food or drink is poisoned, or has been poisoned in the past, contains drugs, etc.
- Child binges, gorges, vomits, or refuses to eat when unrelated to an identifiable illness
- Child states that he/she or someone else was forced to ingest blood, urine, feces, human or animal body parts

H. EMOTIONAL PROBLEMS (INCLUDING SPEECH, SLEEP, AND LEARNING PROBLEMS)

- Child has rapid mood swings, is easily angered or upset, has tantrums, acts out, and then acts normal, passive, etc.
- Child is agitated, hyperactive, wild, and/or resists authority
- Child displays marked anxiety, e.g., rocking, nail, biting, teeth grinding
- Child feels he/she is bad, ugly, stupid, "damned," or deserving of punishment
- Child hurts self or others frequently, and/or is accident prone
- Child is fearful, withdrawn, clingy, regressed, babyish
- Child's speech is delayed or regressed, speech production drops, and/or speech disorder develops
- Child's handwriting and/or knowledge of various school subjects erratically changes or switches
- Child has "flat" affect, or fails to respond in emotionally appropriate ways, especially when viewing violence or cruelty
- Child has poor attention span, learning problems
- Child has frequent or intense nightmares; fears going to bed, cannot sleep, or has disturbed sleep such as night terrors, bedwetting, or sleepwalking
- Child has suicidal or homicidal ideation
- Child compulsively self-mutilates
- Child cries continuously and/or is inconsolable

I. PROBLEMS ASSOCIATED WITH FAMILY RELATIONSHIPS

- Child fears the parent(s) will die, be killed, or abandon him/her; or states that someone has threatened similar action
- Child fears that he/she will be kidnapped and forced to live with someone else
- Child is afraid to be separated from caretaker, cannot be alone at all, clings
- Child fears the parent(s) no longer love him/her, are angry and wish to punish him/her, or want to kill him/her
- Child "screens out" what parent(s), other caretaker, teacher, etc., says and/or fails to retain information they give
- Child becomes excessively angry or upset when told what to do or not to do
- Child frequently reacts to correction and guidance with "I hate you," "I want to kill you," physically attacks others, or otherwise threatens them with bodily harm

- Child talks about my “other” mommy or daddy or family (i.e., in the cult)
- Child expresses fear that a sibling, friend, or pet will be killed, hurt, kidnapped, or molested

J. PROBLEMS ASSOCIATED WITH PLAY OR PEER RELATIONS

- Child destroys toys; acts out death, mutilation, cannibalism, and burial themes; pretends to kill play figures, taking out eyes, pulling off heads or limbs; pretends to eat the figures or drink their blood and/or bury them
- Child’s play involves themes of drugging, threats, humiliation, hanging, torture, bondage, magic, weddings and other ceremonies
- Child, e.g., in play therapy setting, obsessively chooses toys such as dinosaurs, monsters, or hooded figures, and engages them in frightening, aggressive and/or destructive scenarios; or child seems unnaturally fearful of such figures
- Child is unable to engage in age-appropriate fantasy play, or can do so for only brief periods
- Child hurts other children, sexually and/or physically
- Child’s drawings or other creative productions show bizarre, occult, sexual, excretory, sadistic, death or mutilation themes
- Child is extremely controlling with other children and/or siblings, and constantly plays “chase” games
- Child talks to an “imaginary friend” who he/she will not discuss, or who he/she states is a “spirit” friend
- Child gets on the floor and pretends to be an animal, or believes that he/she is an animal at any given moment

K. OTHER FEARS, REFERENCES, DISCLOSURES AND STRANGE BELIEFS OR BEHAVIORS

- Child fears the police will come and put him/her in jail, or states that “bad” policeman hurt or threatened him/her
- Child is excessively afraid of spiders, insects, and/or aggressive animals; e.g., crocodiles, sharks, large dogs, lions, tigers, dinosaurs, etc.; states that he/she was hurt or threatened with such spiders, insects, or animals
- Child is terrified of being in or around water, swimming, drowning, etc., especially if an activity involves putting their head under water
- Child fears that the house will be broken into, robbed, or burned down, or states that someone has threatened that this will happen
- Child fears “bad people,” “robbers,” “strangers,” “spirit entities,” etc.; states that “they” will come after him/her or someone he/she cares about; watches out the window for “bad people”
- Child discusses unusual places such as cemeteries, mortuaries, tunnels, church basements, underground rooms, etc., or states that he/she and/or others were taken to such places; displays irrational fears of these and/or other places

- Child alludes to pictures or films of nude people, sometimes with references to sexual acts, unusual costuming, animal involvement, etc.; states that he/she was a victim of pornography, fears having picture taken, or strikes provocative poses
- Child discusses drugs, pills, bad candy, alcohol, mushrooms, "bad medicine," or injections in an age-inappropriate manner or context; may refer to drug or laxative effects, or state that he/she was given a substance that made them sick or drowsy; has general lethargy and black circles around the eyes
- Child fears his/her own blood, becomes hysterical, and/or thinks he/she is dying
- Child excessively fears violent movies
- Child believes or fears that there is something foreign inside his/her chest or stomach; e.g., a bomb, a demon, a monster, poison, etc.
- Child talks about animals, babies, and humans being hung, confined, hurt, killed, mutilated, eaten, etc.
- Child experiences constant illness, severe fatigue, allergies, and somatic complaints; e.g., stomach or leg pains
- Child fears or reacts poorly to certain stimuli; e.g., certain sounds, music, or high-pitched frequencies
- Child has a fear of certain professions; e.g., doctors, policemen, firemen, judges, ministers, etc.
- Child engages in fire-setting or pyromania
- Child responds inexplicably to certain words, phrases, music, dates, etc., which could be consistent with triggering and programming

Confinement or restraint marks

- Unusual marks, tattoos, burns, and/or bruises are noted on the child's body, sometimes in patterns
- Evidence of ashes, wax, or cuts on the child's clothing or body
- Evidence of dried blood in the child's hair, scalp, fingernails, toenails, etc.

L. RELATED DISSOCIATIVE SYMPTOMS

- Repressed memory; inability to recall an important event
- Psychogenic amnesia resulting in the inability to recall important personal information concerning self and other family members, etc.
- Sudden loss of knowledge in an area of prior competence; sudden inability to perform tasks (involving, e.g., a certain school subject, the playing of an instrument, knowing the route from one location to another, etc.)
- Evidence of splitting or disowning certain behaviors or experiences and attributing them to someone else
- Voluntary and involuntary detachment from reality, which may include dropping into trance-like states or "spacing out"
- Emotional detachment, remoteness, and depersonalization both to self and others
- Use of another name or reference to self as "we"

- Belief by self, or awareness by others, that more than one "identity" is present; drawing self as more than one person in artwork
- Losing time inexplicably
- Presence of auditory and/or visual hallucinations
- Sudden changes in handwriting, speech, mannerism, dress, or vision

M. RELATED HEALTH PROBLEMS

- General lethargy and black circles around the eyes
- Severe or chronic fatigue, especially in or around ritual holidays
- Evidence of loss of enamel of his/her teeth; blood chemistry imbalances and/or liver/adrenal problems
- Constant illness, allergies, and somatic complaints; e.g., stomach or leg pains
- Recurrent migraine headaches
- History of eating disorders
- Sleep disorders, including nightmares, night terrors, sleepwalking, etc.
- Missing digits or toes

IV. INCIDENCE AND FREQUENCY

There is no current national system in place to track the reporting or incidence of ritual trauma as opposed to other forms of child abuse. Skeptics claim that ritual abuse allegations are the result of children's delusional fantasies or suggestive techniques on the part of adults and treating professionals. Unfortunately, the hideous and unbelievable nature of ritual child abuse offends our sensibilities and is so repugnant that there is a tendency to either sweep it under the carpet or find reasons why it does not exist. The biggest problem, however, is that the vast majority of professionals who work directly or indirectly with victims of child abuse are unable to recognize critical indicators for such abuse. Consequently, most cases of ritual trauma go unidentified as such in the child protective system, with tragic and long-term consequences for both the victims and society. Many experts agree that, for these reasons, the ritual abuse of children is under-reported, under-investigated, and under-prosecuted.

While obtaining truly accurate figures on the prevalence of ritual trauma would be difficult given the secrecy and criminality surrounding the phenomenon, there is nonetheless growing evidence that the problem of ritual trauma is considerably greater than ever imagined. Out of 2,709 members of the American Psychological Association responding to a poll, 30% responded that they had seen cases of ritual or religious-related abuse. Of these, 93% responded that they believed the reported harm and/or alleged ritualism had actually occurred. In a similar survey involving therapists treating clients with dissociative disorders, 85% of 1185 respondents reported a parallel belief in ritual trauma, including the existence of related mind control and programming.

In a 1995 article entitled "Cultural and Economic Barriers to Protecting Children from Ritual Abuse and Mind Control," Dr. Catherine Gould states that "(I)n 1992 alone, Childhelp USA logged 1,741 calls pertaining to ritual abuse, Monarch Resources of Los Angeles logged

approximately 5,000, Real Active Survivors tallied nearly 3,600, Justus Unlimited of Colorado received almost 7,000, and Looking Up of Maine handled around 6,000." This constitutes an alarming number of helpline inquiries, even discounting the numbers or allowing for duplication.

Dr. Kathleen Faller has conducted a review of the empirical research on ritual abuse. She notes that there is great similarity in claims of abuse which are individually made by both children and adults, and that studies demonstrate some independent corroboration for such allegations. Given that historical accounts of ritual abuse date back several centuries, and that children as young as two and adults as old as ninety from across the globe continue to describe accounts of abuse consistent with ritual trauma, it should be considerably alarming that so little has been done to increase professional awareness of the problem.

While we may never be able to fix or eradicate the problem, we must move beyond denial and begin to understand the dynamics of this abuse so that our investigative paradigms can shift accordingly. Unless we directly address the problem, we can rest assured that future generations will reap a harvest that has geometrically increased proportionate to our own ignorance and negligence.

• V. THE "HOW" AND "WHY" OF RITUAL TRAUMA

Inasmuch as there are numerous reports consistent with ritual trauma that cross both centuries and cultures, it is difficult to pinpoint the exact origins of ritual trauma either as a form of child abuse or a technique of mind control. The North American continent has been populated by such a diverse number of cultures that ritualistic child abuse in America likely originates from many sources. However, it would appear that the vast majority of victims seeking assistance in this country today are of European heritage, so it is likely that many ritualistic practices date back to early pagan belief systems on that continent which continue to be secretly practiced through generations of adherents.

In a predominately Judeo-Christian society, satanic symbols can convey an archetypal and powerful message to victims, particularly when used in conjunction with severe trauma and torture. Therefore, it is not necessary that organized perpetrators have any spiritual belief system behind their practices or activities. Suffice it to say that whether motivated by religious belief, sexual desire, power, or mind control of the victim, cults use a ritualized setting to abuse, exploit, and manipulate children and other victims. As a group, therefore, their internal and external structure functions to provide access to children and protect members from criminal prosecution.

• A. SIGNIFICANCE OF THE PSYCHOLOGICAL COMPONENT

As mentioned earlier, the development of dissociation and DID are an intended result of ritual trauma. Virtually every individual who survives cult victimization and indoctrination necessarily develops an ability to dissociate. Dissociation is a psychological process that permits a person to separate him/herself from his/her thoughts, feelings, and actions, particularly during an overwhelmingly traumatic or life-threatening event or experience. This

process can produce changes in memory and allow the individual to function as if the trauma had not occurred. In effect, it is the psyche's way of surviving an otherwise impossible situation while preserving some area of healthy functioning.

Dissociation, and more specifically DID, are psychological conditions which also permit perpetrators of ritual trauma and abuse to function in a contradictory "Jekyll and Hyde" manner - exhibiting more "normal" personalities by day, and "ritual" personalities by night. It is impossible to understand ritual abuse without comprehending the roles that dissociation and DID play in the process. For example, females are often programmed to be "amnesic" about their cult involvement during their child-bearing years, ensuring the cult regular access to any offspring for early indoctrination.

Since dissociation can be a natural consequence of abuse and trauma and is so prevalent in cases involving ritual trauma, professionals should pay particular attention to any dissociative symptom in a child who is alleged to have been abused - sexually or otherwise. Many of the signs and symptoms listed in Section III of this material directly relate to dissociation that may have ensued as a result of ritual trauma. Furthermore, once dissociation and DID are understood and accepted as a sad reality of this type of abuse, no professional assessing or investigating a case should be surprised or offended if an alleged perpetrator neither looks nor acts “capable” of engaging in behavior as heinous and offensive as ritual trauma. To use a well-known maxim: it is, unfortunately, the “nature of the beast.”

• B. TECHNIQUES AND METHODOLOGY USED BY PERPETRATORS

Perpetrators of ritual trauma desire total and complete control over their victims. Effectively, this means robbing a victim of his or her “will,” including the will to live or die. To a victim, the “choice” is often presented as "allegiance to the cult" or "death to self or others," which serves as a powerful deterrent to disclosure. Breaking the child psychologically through fear, intimidation, and severe trauma is one of the first steps. The use of drugs to further the dissociative process is common, and in sophisticated or “orthodox” cults, this may actually occur while the child is still in utero.

Drugs, many of which are specially designed and concocted by individual cults, serve a variety of functions:

1) They make a child more compliant and manageable2) They function as pain control and permit a child to experience the trauma without losing consciousness3) They facilitate manipulation of the ritual itself by altering the child’s cognitive awareness4) They facilitate removal of psychological barriers5) They make it more difficult for the child to maintain defenses and a strong connection to reality6) They promote dissociation7) They impact the child’s memory and perception of the experience

Even prior to being abused in a ritualistic setting, young children and infants are “assaulted” by perpetrators in a variety of ways that are intended to induce dissociation and condition the victim to more severe trauma. These include tactile, auditory, visual, olfactory, and gustatory

deprivation and/or overload, as well as manipulation and exploitation of the infant/child's maturing nerve and physiological reflex system. Techniques that are commonly associated with "prisoner interrogation," such as lengthy isolation and confinement, as well as sleep and sensory deprivation, are also used with great success.

When a child is repeatedly held underwater to the point of panic, he or she will naturally learn to dissociate from the experience. If the child reacts poorly during a ritual or programming, he or she may be "punished" through the use of electroshock or a cattle prod until there is total compliance via an "internal" retreat via dissociation. If the child is confined in a small dark space (e.g., a small closet or a coffin-like box) along with various spiders, insects, and other creepy crawlers of which the child is terrified, it will not be long before dissociation is seen as the only means of "escape." It is important to note that none of these terrorizing and dissociation-inducing techniques produce any external signs of abuse – only long term emotional and psychological damage.

Cult leaders are usually extremely intelligent. They are also very knowledgeable about methods of inducing pain and torture that do not leave marks or physical evidence (e.g., the use of pins, needles, electroshock, etc.), and typically have hundreds of years of practiced trauma technique "under their belts." Furthermore, they understand the legal and judicial process and carefully design their rituals so that children who might disclose will be discredited. Finally, cults know that the activity in which they are engaged is so outrageous as to be "unbelievable" to the average person. Given the experience of victims of the Holocaust, such thinking is not without merit.

Clearly, the most distressing aspect of ritual trauma relates to accounts of child mutilation and sacrifice, cannibalism, and the use of blood, feces, and urine in ritual ceremonies. In spite of historical documentation of such activity, it is extremely difficult to imagine such behavior in a modern setting. Of course, it was likewise impossible for most people to imagine the crimes of Hitler, Stalin, Idi Amin, Manson, Dahmer, etc. Therefore, if we are to address this problem with any success, we must move beyond our own limited perceptions and experiences – no matter how uncomfortable the process may make us.

To understand and confront this phenomenon, we must accept the fact that most survivors of ritual trauma not only report severe sexual abuse and torture, they also report exposure to these other most heinous acts. A study of ritual trauma (conducted in conjunction with a research project at the University of Colorado at Boulder) reports results which appear to be consistent with survivor accounts across this country and elsewhere. Of survivors responding:

- 100% were subjected to sexual molestation and intercourse
- 97% were tortured
- 97% were forced to participate in group sex with adults
- 97% witnessed or were forced to participate in animal sacrifice
- 94% were sodomized
- 88% were drugged
- 88% witnessed or were forced to participate in human sacrifice

- 82% witnessed or were forced to participate in cannibalism
- 76% were forced to torture others
- 70% were used in child pornography
- 58% were used in child prostitution
- 33% were forced to breed children for later sacrifice

These figures were reported by adult survivors, and are consistent with everything that we have heard about the ritual abuse of children. In addition to the above figures, many of these survivors disclosed that they had developed MPD/DID as a result of their abuse. Most reported their father or mother as their primary perpetrator. Additional perpetrators mentioned included other family members, as well as physicians (30%), priests (18%), and teachers (15%). All survivors noted that the abuse began at a very early age.

In the case of children, organized perpetrator groups go to great lengths to create ritual scenarios that will create “unbelievable” disclosures in which discrepancies are rampant. Once again, drugs are used in the process to tremendous advantage. For example:

1) Since confinement and isolation is an effective method of psychological conditioning, children often report having been put in a closet or cage with a lion. In reality, these children might have been placed with a large lion-like dog - or perhaps a human dressed in a lion costume. When this experience is combined with the use of sound effects and hallucinogens, the experience seems very real to a child. This deceptive method ensures absolute terror and compliance, while at the same time, serves to discredit the child should there be subsequent disclosure.

2) Children frequently report having been taken by train, boat, submarine or airplane to a specific location to participate in ritual activity. Often they are blindfolded and only told the name of the location after they have arrived.

In reality, such transportation may have only been simulated, and a false location given. Or the child may, in fact, have been in a plane that simply flew in a circle for 20 minutes or so, with the ultimate destination falsified. In either case, facts are distorted to discredit later disclosures.

3)The use of cartoon characters and hero figures in costume is frequently reported, and is especially effective with very young victims. Children who disclose abuse in these settings are assumed to be dealing with nightmares at a fantasy level.

4) Intergenerational cults have additional protective techniques. For example, some of the perpetrators attending a given ritual may, in fact, be prominent members of their community. To deliberately confuse child victims, cult members may introduce other adults who are falsely identified as other well-known public figures.

If and when a subsequent disclosure occurs, the innocent “perpetrators" who are named come forward with concrete alibis and are unwittingly used by the cult to discredit any investigation.

While children who are used by organized cults are victimized with regularity throughout the year, it is important to be aware that certain calendar dates have special ritual significance to perpetrators whose activities are also based on satanic and/or pagan belief systems. Such holidays may be fixed (i.e., celebrated on the same day every year) such as All Hallows Eve/Halloween; or vary slightly based upon astrological considerations (e.g., Easter, which even for Christians falls on the first Sunday after the full moon following the Spring Equinox.) Full moons, eclipses, solstices, and equinoxes are frequently celebrated dates among cults, as are individual birthdays – especially for months and/or calendar years which are a multiple of the number "6". In addition to these readily identifiable dates, most individual cults will also celebrate on dates which have unique significance to them..

Although the subject is too complex to be adequately covered in this material, it is ultimately important for professionals to understand that, just as repeated dissociation through severe trauma can ultimately lead to full-blown DID, so too does initial psychological "conditioning" of victims naturally move toward more systematic "programming;" and ultimately, total mind control. Once the psyche of an adult or child victim is dissociated and fragmented to the degree necessary to create DID, cult perpetrators use sophisticated mind control techniques to create various alters within the consciousness of the victim. Through the use of a repeated "conditioned stimulus-response sequence," a victim will develop separate and distinct alters or personalities that can be called into action by a pre-programmed "triggers." These "triggers" can be internal (e.g., a ritual holiday) or external (e.g., a phone call or hand signal).

Some perpetrator groups with access to highly advanced programming techniques and equipment are able to create extremely complex and layered systems of programming in victims that can take years to therapeutically neutralize and unravel. All survivors of ritual trauma who have been systematically programmed, however, seem to exhibit common categories of basic programming that are designed to ensure compliance with certain directives. These programs are usually "backed-up" by secondary programs and fall into such categories as self-injury, suicide, reporting, screen, and flooding programs which operate in the following manner:

"If I remember my abuse, I must cut or hurt myself so that I will no longer remember" "If I disclose my abuse to the authorities, I will kill myself" "If I am taken into protective custody, I must get to a phoneto report my location back to the cult" "If I notice that I have lost time (during which I was ritually abused and programmed), I will suddenly "remember" that I was actually at the grocery store" "If my therapist gets too close to a particular memory of abuse, my mind will flood forth with painful memories so that therapy cannot continue and I will see my therapist as the cause

- ## C. IMPACT OF ABUSE ON DISCLOSURE, ASSESSMENT,INVESTIGATION & PROSECUTION

Dr. Catherine Gould has stated that "...you can abuse a hundred children ritualistically, with all the overlay of terror...and pretty much a hundred children will keep the secret of their

abuse until there is some kind of intervention." And yet, when children do disclose, the extreme delay in their disclosure, coupled with perceived "discrepancies" from original accounts, often results in system disbelief and a failure to further investigate and prosecute additional allegations. Without a proper understanding of the dynamics of this abuse and how victims are impacted, it is easy to summarily dismiss legitimate claims of ritual trauma.

Even when a report is seriously heeded and investigated, professionals need to be aware that medical and physical evidence substantiating ritual child abuse is difficult to obtain, especially in view of the extreme delay in disclosure. While it may be prudent to request that toxicology tests and a sexual abuse examination be conducted on a child, receipt of negative or non-conclusive results in a case involving ritual trauma does not negate the child's allegations. Nor does the fact that some of the specifics of a child's allegations can, in fact, be disproved. Cults are known to use sophisticated techniques to simulate ritual scenarios that appear extremely real to a child victim. When combined with the use of drugs, children's perceptions of an event are effectively manipulated for the purpose of discrediting a potential disclosure.

These factors may be particularly frustrating to law enforcement officers who wish to put a stop to this activity. It is important to recognize, however, that the very nature and structure of organized cults prohibit their infiltration. In order for a law enforcement officer or investigator to penetrate a cult, he or she would have to earn the trust of the group. This would necessarily involve engaging in illegal and offensive activities, including the drinking of blood and urine, the eating of feces, and participation in animal sacrifice at a minimum. Only after these repeated tests and trials would any individual be permitted to participate in more intimate and heinous rites involving child sexual abuse, mutilation, and sacrifice. Consequently, it would be unrealistic to consider this avenue of pursuit.

Physical and electronic surveillance of these groups can likewise be difficult or impossible, even when ritual holiday dates are known and understood. Cult ceremonies are usually conducted late at night in remote wooded areas, or in buildings which are under the total control of perpetrators. These sites are highly guarded both before, during, and after an event. In fact, children who have not yet been terrorized and programmed into total secrecy are more likely than adults who are actively involved to relate where such activity has taken place. Unfortunately, unlike adults, children are not given location information in advance of a ceremony. This is not the least bit helpful to law enforcement.

Even more problematic is the fact that law enforcement agencies are often infiltrated by cults at virtually every operational level. This should come as no surprise to anyone since members are groomed to pursue these positions and there are economic and other interests to protect. Cult members who are strategically placed in the system are usually one step ahead of any investigation so that they can run interference and effectively derail investigative and prosecutorial efforts. In sophisticated cult networks, these connections in the system can run very high and very deep, so professionals working with ritual trauma victims should not be surprised to run across evidence that they, themselves, are "under surveillance."

Inasmuch as all of these factors create unique challenges and obstacles for professionals to overcome, it may be helpful to break the problem down into several general components:

1)PHYSICAL EVIDENCE

First of all, there will rarely be physical evidence to substantiate allegations of abuse involving organized cults. Unlike criminal investigations involving dabblers and self-styled cultists that might produce ritual paraphernalia or even mutilated victims, intergenerational cults are highly organized and extremely secretive concerning their activities. Ritual sites and ceremonial implements are carefully guarded before, during, and after ritual ceremonies. Since the successful operation of the cult is dependent upon absolute secrecy, thorough and systematic disposal of any and all evidence is routine.

Allegations of ritual sacrifice are particularly difficult to substantiate. Even where cults require their members to demonstrate ultimate allegiance by offering up their first-born child for sacrifice, the young female is usually in early adolescence. Having been earlier impregnated by a cult member(s) during a ritual, early labor is reportedly induced by saline injection (e.g., at 6 months gestation) and the fetus is then offered up and sacrificed in a dedication ceremony. Because of the age of the mother and size of the fetus at delivery, pregnancy is rarely suspected by the outside world.

More commonly, infant victims that are to be used in sacrificial rites are provided by "breeders" within cults themselves. As with the first-born babies of cult members, there is never any record of these children's existence, much less their deaths. Furthermore, organized cults have their own unique methods and systems for disposing of bodies and/or body parts. Many cults either own or have access to a crematorium, and are assisted by cult physicians and/or coroners who cover up the cause of death of their victims. However, less sophisticated methods for body disposal such as acid or lime pits and tree shredders have also been used quite effectively.

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2) MEDICAL EVIDENCE

It is very difficult to obtain conclusive medical evidence supportive of a child's allegations of ritual and sexual abuse. Since cults often use electroshock, pins and needles which are inserted under the fingernails or into sexual and other orifices of the body, knife cuts or burns into the scalp, onto the soles of the feet, or in the creases of the skin, and other methods that make injuries difficult to detect or are otherwise explainable, professionals are faced with explaining in court “why” such evidence is not present.

While evidence of sexual abuse may be more apparent with the use of a colposcope (e.g., repeated multiple perpetrator abuse is more likely to leave scarring in the vaginal and anal areas in children), many cults have physicians who treat and effectively cover up evidence of abuse. In addition, it is important to understand that cults often prime infants early on for sexual penetration using special instruments designed to stretch the vagina and anus in a gradual, non-traumatic manner. Delayed disclosure by children further reduces the likelihood

of obtaining conclusive medical and physical evidence, either through examination or drug screen.

3) PSYCHOLOGICAL AND BEHAVIORAL EVIDENCE

Children who have been sexually abused exhibit numerous debilitating effects of their trauma. However, studies show that children who have been ritually abused suffer greater problems and consequences which can diminish their level of recovery, even with treatment. This evidence contradicts theories that accounts of ritual abuse are the mere fantasy of children, or a bizarre substitution, replacement, and/or "screen" memory for an incestuous childhood. "If children claiming to be ritually abused were in fact sexually abused only, then clearly their symptomatology should be similar to and no more serious than that of sexually abused children." Consequently, psychological and behavioral indicators in sexual abuse cases should be carefully assessed to rule out ritual trauma.

In ritual trauma, the terror and intimidation used by perpetrators is designed to be so severe that children involved will not only dissociate during the trauma, but also have trouble remembering and disclosing their victimization to anyone following the abuse. The use of drugs during rituals further complicates matters because it can affect the child's ability to subsequently relate the event in clear detail. While children may exhibit a wide range of behavioral indicators for ritual trauma, until and unless they have been removed from their abusive environment for an extensive period of time, verbal disclosure of their abuse is unlikely. Since lengthy removal from perpetrators is usually necessary for disclosure of ritual trauma, extreme delay in disclosure should never be used to discredit a child's allegations.

Children who have been ritually traumatized since birth, or over an extensive period of time, may also be suffering the effects of psychological conditioning and programming, as well as DID. Removing them from the environment which reinforces such conditioning and programming is extremely important. Once removed from various "reinforcements" that an abusive environment provides, conditioning and programming often begin to fall apart. The end result is that a child's behavior (e.g., after being in foster care for a year or so without any significant problems) may rapidly deteriorate without apparent explanation. In reality, the structure underlying the child's conditioning or programming is collapsing, thereby allowing the child to begin remembering and processing his or her former trauma. While system protocol may direct that the child be removed from this alternative placement, a knowledgeable professional will recognize that this may not necessarily be in the child's best interest. In the Snow and Sorenson study cited above, the authors note:

"Disclosure became a process, not an event. As the process of disclosure brought children closer to their psychological pain and terror, behavioral and emotional problems emerged. Indeed, it appeared that children got worse before they got better. Depression with an unusual impending sense of death at their own or another's hand, extreme hyperactivity, aggressive acting out, obsessive fears and compulsions, reenactment of abusive rituals, and intense sibling conflict characterized the children's behavior as the disclosure process progressed."

• VI. “BEST PRACTICE” GUIDELINES FOR PROFESSIONALS

• A. PROSECUTORS, ATTORNEYS, AND LAW ENFORCEMENT

[Note: Law enforcement officers and prosecutors are encouraged to carefully read Section V above, as well as a two-part article by journalist Civia Tamarkin entitled “Investigative Issues in Ritual Abuse Cases”]

Investigations related to ritual abuse allegations should center around any and all evidence corroborating the victim’s statements that can be subsequently used in court. Naturally, this would include interviews with any witnesses that might have knowledge about the case: the child and other children whom the child relates may have been involved; the alleged perpetrator(s); the family and other siblings; individuals from the neighborhood, day care, or other setting where the abuse was alleged to have taken place; teachers and counselors; medical doctors and mental health professionals evaluating or treating the child; social workers, foster parents, and CASA/GAL advocates who may have had contact with the child; and any other individual having possible information which would further the investigation. Keep in mind that once the interviewing process moves beyond the victim in a case, it may be impossible to protect information related to your investigation.

Any forensic interview of the child should be conducted by a professional who is properly trained in interviewing techniques and knowledgeable about the dynamics of ritual trauma. If necessary, this can be handled by a team approach, where two or more professionals with complementary expertise work together during the process. A professional who is familiar with the nature of allegations in ritual trauma cases is more likely to understand the subtle nuances and hidden meanings which accompany such disclosures. This knowledge is critical in directing the questioning process. As with any case involving child abuse, the use of leading questions in ritual trauma cases should be avoided. Whenever possible, it may be extremely useful and advantageous to videotape the interview process.

When multiple victims have been identified (e.g., a day care center is involved) a modified approach may be necessary. In such cases, it is best to compartmentalize the investigative process by using separate professionals with each child. These professionals should have no contact with one another during the initial stages of the investigation, but should report their independent findings to an individual who is selected to oversee and coordinate the overall investigation. The purpose of this is to limit cross-contamination between victims. At the same time, other individuals having contact with the children – parents, caseworkers, Guardians, etc. - should be instructed not to question any child, and to share and relay any information or spontaneous disclosures directly with the managing coordinator.In assessing a child’s disclosure, it is important to consider all aspects of the child’s story. As mentioned herein, allegations concerning ritual trauma often involve bizarre elements and scenarios which an untrained professional might easily discount – particularly if some portion of the child’s statement is highly unlikely or impossible. [See Section V, supra]. In order to substantiate any allegation or uncover supportive physical evidence, one must first attempt to

identify the exact location(s) where abuse may have been perpetrated, as well as any items, paraphernalia, etc., which may have been used during the abuse.

One of the greatest errors made by professionals investigating such cases is the failure to use and issue search warrants in a timely fashion. Search warrants should be requested as early as possible - before alleged perpetrators have a chance to move or dispose of evidence. If a child's disclosures include the use of such things as robes, hoods, masks, knives, candles, ritual paraphernalia, cages, "coffins," secret rooms, tunnels, photographs, cameras, computers, books, ashes, bones, drugs, needles, blood, urine, feces, etc., then any search warrant should descriptively include these items. Since children can be mistaken about the nature of a particular item (e.g., a child might identify a wooden crate or other container as a "coffin"), it is better for a warrant to be worded in an over-inclusive, rather than under-inclusive manner. For example, the warrant should preferably state "…coffin or other box-like structure/container with lid, within which a child might fit."

The scene of any alleged crime can provide a wealth of information. A child's description of his or her surroundings at the time of the abuse can sometimes be confusing and is best understood by a very careful and methodical investigation of the actual scene and related environment. For example, a child might relate that the wall in a particular room was black, when in fact, it was simply draped with black material. It is often possible to deduce the nature of such a discrepancy by observing pinholes or other damage to the wall which indicates that draping may have been used. The next logical step would be to check the premises for a storage area or container that might contain fabric or other draping material.

Since use of body fluids and body parts are common in allegations of ritual trauma, it is important to decide whether or not to search the premises for either direct or trace evidence of such material. If determined to be useful or necessary, this material should be collected with the same level of technical precision and care as similar evidence obtained in homicide cases. Since most of this material will need to undergo extensive laboratory analysis, it is important to maintain and document an uncontaminated professional chain of custody.

All children who have disclosed ritual trauma should be medically and psychologically examined as soon as possible. The process which is recommended in more detail below (see "Medical" and "Mental Health") is designed to document any physical or psychological evidence and/or damage to the child. It will also provide the victim with any therapeutic support necessary for healing, as well as help prepare the child for both in and out-of-court interviewing. Investigators and prosecutors should work closely with both medical and mental health professionals. When indicated by a child's disclosures, they should also request that toxicology and other specific tests be conducted on the child. Medical evidence supportive of the allegations should be photographically documented, and any statements made by the child throughout the process should be documented in writing.

While undercover surveillance may be difficult or impossible in most instances, electronic surveillance should be considered wherever possible. Inasmuch as many cults also engage in related criminal activity, there may be sufficient grounds to seek legal authority to tap a

phone line or access other information. Child pornography is a stable source of income for many cults. Such material must either be physically transported for sale and distribution, or transmitted through electronic means such as a computer. Other alleged criminal activity should be similarly investigated. “Following the money” can be one of the most productive routes to take when investigating a ritual trauma case.

Law enforcement professionals should be aware of the fact that polygraph testing often has limited value in ritual trauma cases. Not only are organized perpetrators unlikely to provide “normal” reactive responses to certain questioning, the presence of DID or extreme dissociation may result in totally inaccurate readings and conclusions. In such cases, it is highly probable that the polygraph examiner is actually questioning and testing an “alter” or “personality” who has no knowledge or culpability concerning the act(s) under investigation. Consequently, the use of polygraph testing in such cases is discouraged.

Finally, since prosecutors have the ultimate task of proving these complex cases in court, they should spare no expense when it comes to the assistance of expert witnesses and consultants. This assistance should be requested at the earliest stages of an investigation, before inappropriate action is taken which might jeopardize the case. Qualified experts can not only help you to properly investigate and prepare for trial, they can be invaluable in educating judges and juries to the unique dynamics of ritual trauma. They can also testify as to whether or not it is necessary or advisable to institute protective measures when taking the child’s testimony in court.

Children who have had extensive cult involvement may demonstrate a degree of dissociative disorder that is problematic in court. When required to testify before their alleged perpetrator(s) or anyone else knowledgeable about their abuse and conditioning, these children can be “triggered” into silence instantaneously by the mere use of a hand-cue or other external and pre-programmed mechanism. In such cases, it is imperative to request that the child’s testimony be videotaped and taken outside the presence of his or her perpetrator(s). Careful attention should be paid to subtle changes in the child’s behavior which appear to be related to the manner in which cross-examination is being conducted. Whenever it appears necessary, a recess should be requested to ensure that the child has not been unduly influenced or manipulated.

• B. PHYSICIANS/DENTISTS

All children who have been ritually traumatized should be medically examined by a knowledgeable and competent physician. Since very few medical doctors have much experience in working with victims of ritual trauma, it is important that any physician being asked to assist on a case be provided with detailed information regarding the child’s allegations. A qualified professional can provide the physician with additional input regarding the nature of any medical evidence being sought, depending upon information gleaned from the child’s disclosures.

It is highly recommended that a physician who is specially trained in conducting sexual abuse examinations in children be used to obtain evidence related to the child's sexual molestation. The use of a colposcope is likewise recommended so that minute fissures that may be invisible to the naked eye can be seen and photographically documented. Such an exam should ideally take place as soon as the child has disclosed sexual abuse - or even prior to disclosure if the child is exhibiting any signs of ritual trauma or a dissociative disorder.

Medical examination of the child's physical body should be undertaken with great patience and care. Victims of ritual trauma can become either passive or unnaturally agitated by medical procedures or the mere presence of various medical personnel. Any signs that the child is dissociating during the process should be noted in writing, as should the child's behavioral response and any related statements.

The physician should look for evidence of bruising, tatoos, cuts, burns, etc., on the child's body. Careful attention should be paid to hard-to-see areas such as the scalp, spine, ears, nipples, genitals, creases, and other crevices in the body (e.g., does there appear to be dried blood under the child's fingernail). Any abnormalities should be noted on the chart and compared with other medical records available for the child. When appropriate, photographs should be taken to document peculiar findings.

Frequent use of drugs by cults can create any number of problems in children to which a physician should be extremely sensitive. For example, over time many drugs or drug combinations can cause imbalances in blood chemistry, adrenal problems, and organ or liver damage. Hair and skin tone/texture may appear unhealthy, or the child may appear to be slightly bloated, emaciated, or otherwise abnormal. Such an appearance may indicate the need for toxicological testing beyond the normal bloodwork. In certain instances, a non-invasive method may be preferred, such as the collection of a hair sample for lab analysis.

Drug use can also have damaging effects on a child's teeth and gums. Any alleged victim of ritual trauma should be referred for a dental examination and follow-up care. Evidence of deteriorating teeth, enamel, and/or gums may boost the need for toxicological testing, as well as give support to other medical evidence regarding the child's trauma or neglect.

• C. PSYCHOLOGISTS, THERAPISTS, & MENTAL HEALTHWORKERS

[Note: Therapists should be familiar with the techniques used by perpetrators in ritual trauma. A lending library of training tapes on the topic is available for professionals and can be accessed by contacting the author.]Therapists, psychiatrists, psychologists, and other professionals in the mental health field play a particularly important role in cases involving the ritual abuse of children. Because these cases involve extremely challenging diagnostic and treatment issues, it is particularly important that such professionals seek assistance and input from other professionals with expertise or experience in diagnosing and treating ritual trauma victims. Additional support can be obtained through joining professional associations that focus on issues of severe trauma and/or dissociation. These organizations usually provide

periodic workshops and seminars to educate and train professionals in better identifying and treating victims of severe and/or ritual trauma and may also offer options for liability insurance and legal support.

It is important to recognize that dissociative disorders are commonly present in children who have been ritually traumatized. Unfortunately, dissociation can cause behaviors and symptoms in children that mimic other disorders and lead to inaccurate diagnoses and ineffective treatment of the problem. For example, a child with DID or other dissociative disorder can exhibit a wide-range of behaviors that are somewhat consistent with such diagnoses as ADD, ADHD, Oppositional Defiant Disorder, Bipolar Disorder, Tourette's Disorder, etc. The abrupt changes in a child's personality and behavior which accompany DID can be very similar to the aggressive and chaotic behaviors found in these other disorders, so practitioners must be very cautious in their assessment and avoid over-reliance on previous diagnoses involving the child.

It is better practice to get a complete medical and psychological history on the child and independently assess and evaluate him/her based upon both past and current indicators for the trauma. The child's medical history is essential to help determine whether or not the child's aberrant behaviors are primarily due to use (or abuse) of a prescription drug, or drug combination, which is producing negative side affects (e.g., ritalin and/or anti-depressants). Parents, teachers, day care workers, social workers, foster parents, and Guardians ad Litem/CASAs should be consulted to obtain details of the child's statements concerning the abuse, as well as descriptions of the child's behaviors and problems. The child's artwork and drawings should also be reviewed as they may contain subtle (and, sometimes, not-so-subtle) indicators for ritual trauma.

While virtually all victims of ritual child abuse suffer from PTSD and attachment disorders, older children and adolescents of this abuse may also exhibit eating disorders, addictions, depression and self-mutilation tendencies that are a direct result of their conditioning and/or programming during trauma. Particular attention should be paid to amnesic episodes, auditory and/or visual hallucinations, unexplained changes in handwriting, and other symptoms indicative of the presence of severe dissociation and/or multiple personalities. There are a number of questionnaires and assessment tools that have been developed to assist in the diagnosis of dissociation in children and adolescents.

Given the severity of trauma experienced by victims of ritual trauma, therapeutic intervention can be a costly and lengthy process. Whenever possible, it is valuable to establish a treatment team approach to therapy that provides the additional support necessary to advance healing. A physician should be consulted whenever possible to rule out any medical problems, and the assistance of a psychiatrist should be sought when drug intervention appears necessary or appropriate to stabilize the child. However, since the child's abuse may have included the use of drugs, it is important to insist that the child be medically tested to rule out any blood chemistry imbalances and/or damage to their organs or adrenal system. Due to possible overexposure to drugs during cult victimization which can result in desensitization, drug

intervention may be ineffective with ritually abused children. Furthermore, a child suffering from DID may simply "switch" into an alter personality which is unaffected by the drug prescribed.

Since ritually abused children usually dissociate their memories of trauma and are systematically conditioned not to verbally disclose, the use of adjunctive therapies can be invaluable to the therapeutic process. Art therapy, for example, can be very helpful in the treatment of dissociative disorders, and should be considered in the treatment of adolescents who have been ritually traumatized. In children under the age of three, memories of trauma are expressed more behaviorally than verbally. Consequently, play therapy may be a critical therapeutic tool.

Drs. Catherine Gould and Vickie Graham-Costain, recognized experts in the treatment of ritual child abuse victims, believe that "…play therapy constitutes the most powerful healing modality for ritually abused children from age two to 11 years of age, and sometimes older." Treatment of ritually abused children necessarily involves the surfacing and working through of dissociated memories. Consequently, Drs. Gould and Graham-Costain propose a three-part model using play therapy:

"First the therapist must treat the post traumatic stress disorder resulting from chronic, massive abuse. Second, the therapist helps the child identify and work with the dissociative, fragmented personality system that results from extreme abuse. Some ritually abused children exhibit fluid multiple personality disorder (MPD), whereas others exhibit less severe forms of dissociative disorder. Third, the therapist assists the child in finding and working through the indoctrinating messages that were received during the traumatic and abusive dissociation-producing experience. Disclosure of the abuse and appropriately structured abreactive play therapy, in which the therapist actively involves him or herself in the child's therapeutic play, constitutes the primary mechanisms of treatment of ritually abused children."

Gould and Graham-Costain recommend that play therapy involve access to a wide range of props and toys, including animal and small monster-type figurines, masks, hats, costumes, weapons, miniature coffins and cages, and other items that are typically used to terrorize children. During play therapy, children who have been ritually traumatized will almost invariably select items that have thematic significance to their abuse, e.g., being confined, held under water, "buried," hung upside down, etc. When security and trust are apparent in the therapeutic relationship, such children repeatedly act out their "trauma dramas" in a variety of ways which include chase and rescue themes, frightening perpetrator figures and monsters, as well as other related scenarios. For example, a child may use a sand tray to reenact scenes related to "burying;" pick up a toy stick or knife to act out the killing of a figure; etc.

It is important to remember that ritually abused children must be allowed to work through and re-associate their memories of abuse at their own pace. Certain therapeutic models can assist with this process, most notably the BASK and PACEM models which are used in the treatment of dissociative disorders, as well as the treatment of ritual trauma survivors. These

models can be incorporated very effectively into the play therapy process. “Unless the ritually abused child’s internal dissociative system is addressed, the therapy will not impact the most heavily dissociated, cult-created aspects of the child’s personality. Psychotherapy that fails to address the child’s dissociative system and the associated programming may improve the child’s level of functioning but still leave him or her vulnerable to recontact and ongoing exploitation by the perpetrating cult.”

If the child’s dissociative system manifests distinct and identifiable sub-personalities, it is possible that mind control techniques and programming have been deliberately used in conjunction with the ritual trauma. This usually involves a systematic process that results in layers of programming designed to ensure the child’s allegiance to and use by the cult. In such instances, the therapist may work steadily with the child to “neutralize” several programs, only to discover that there are back-up programs which must still be accessed by the child and dealt with in therapy. These intentionally created programs will often include both “animal” and “spirit” sub-personalities and alters which exist in the child’s consciousness or psyche.

Once a child has been able to work through the various components of his/her trauma, it will be necessary to address the mind control programming to which the child may have been subjected. This involves recall of the programming event, as well as the accompanying “trigger” that is designed to initiate a specific response on the part of the victim. As explained earlier in this material, triggers can be either internal or external and are often in the nature of hand-gestures, use of a particular word or name, a tone or sound, color, etc. Until all cult-created programs can be neutralized, a child will be unable to resist responding to triggers designed to control his or her behavior. This has profound significance when it comes to helping a child prepare for testimony in court. As a result, mental health professionals treating a child may need to provide testimonial assistance in support of any motions which are made to shield the child from contact with the perpetrator(s) during the proceedings.

It is also helpful to understand that, during the programming process, perpetrators may use very deceptive methods to name individual alter personalities in children that have been induced through trauma. For example, a part may be deliberately called “Sad,” “Scared,” “Grumpy,” “Brain,” “Bad-Devil,” or “Mean Momma.” As a result, when the child “switches” into one of these personalities and is then questioned about the change in his or her behavior, the conversation which ensues may resemble the following:

Adult: “June, honey, what’s wrong? You were playing just fine with little Johnny and now you’re over here in the corner sucking your thumb!”

Child: “I’m Sad!” (Meaning: I’m not June)

Adult: “Why are you sad? Did little Johnny do something to make you sad?”

Child: “I don’t know!” (Meaning: I don’t know ‘why’ I am this person called ‘Sad’ – and anyway, who is little Johnny or what would he have done to make me come out in the open like this?)

(OR)

Adult: “Bobby, are you all right? We heard you wake up screaming and ran down here to check on you!” (In response to nightmare or night terror)

Child: “I’m Scared, I’m Scared!”

(OR)

Adult: “Judy, what made you hit your friend Susie like that?

Child: “Bad-Devil made me do it!” (Meaning: There is a separate part inside of me called “Bad-Devil” which I do not control and that “came out” and did this; rather than “ I don’t want to take responsibility for doing this”)

Since ritually abused children in treatment commonly make progressive disclosures regarding their victimization, it is imperative that therapists and other mental health professionals take copious notes documenting a child’s statements as verbatim as possible. Videotaping of sessions may be advisable, as long the court, custodial guardian, or agency has provided consent and camera equipment is placed in a location that does not interfere with therapy. Any statements, disclosures, and recorded interviews should be shared with both the county prosecutor and the attorney representing social services, as they may meet admissibility standards for evidence in court. It is never appropriate to assume that any given statement made by a child is “hearsay,” and therefore inadmissible in a legal proceeding involving the child. Furthermore, statements pertaining to the identity of perpetrators, other victims, or the location(s) where abuse may have occurred should be shared with law enforcement officials as early as possible.

Finally, it may be very beneficial to familiarize yourself with ritual holiday dates that are commonly observed by cults. (This would naturally include the child’s birthday.) Ritually abused children often become agitated shortly before, during, and after these dates. They may exhibit aggressive behavior with peers, become regressed or withdrawn, experience a higher degree of night terror, etc. It is important to be aware of the influence that these dates may be having on the child so that they can be factored into the therapeutic process. At Halloween, for example, it may be appropriate to remove any celebratory decorations in the child’s home or placement until the child has worked through any triggering imagery related to the holiday.D. SOCIAL WORKERS

When dealing with the issue of ritual trauma, the role of a social worker can be pivotal in determining what services are made available to the child and his or her family. The majority of ritually abused children do not enter foster care or the legal system as a result of an allegation of ritual trauma. They are usually in the care of the state due to more common allegations of abuse and neglect for which rehabilitative services are being offered to the family. Frequently, children will have been in the system a minimum of 6-12 months, or even much longer, before disclosures and behaviors indicative of ritual abuse surface to an identifiable level.

Unless the allegation has arisen in a day care setting or outside a familial setting, it is the treatment worker who is most likely run across the various "red flags" that point to ritual trauma. This is primarily due to the fact the caseworker is interfacing with all aspects of the child's placement and treatment and may be given bits and pieces of information concerning the child which, collectively, give rise for greater concern. This can create interesting challenges for a treatment worker whose agency's plan for reunification is suddenly complicated or thrown off track.

Whenever any signs of ritual trauma arise, it is the duty of the social worker to refer the child and possibly other family members for further evaluation and assessment. Assistance of this nature should be sought from professionals who have some understanding, experience, or expertise in the area of ritual trauma. Otherwise, it is a useless effort and expense on the part of the agency which virtually ensures that the child will be denied timely services which are necessary for his or her full recovery from the trauma. Without significant intervention and treatment, children who have been ritually traumatized continue to suffer throughout their lives from a variety of physical, emotional, psychological, and relationship problems. Even worse, they are more likely to become perpetrators than other victims of abuse.

While child protection, treatment, and recovery efforts in cases involving ritual trauma require extraordinary resources from a system which is under-funded and overloaded, it is important to understand that the problem is one of "pay now or pay later." Limited resources should never be a reason for failing to pursue appropriate action in a ritual trauma case. Victims of ritual trauma are the most brutalized members of our society who, if returned to an abusive environment, may become the next wave of brutalizers. This is particularly true of young boys whose cult abuse appears to generate more anti-social and criminal behavior in adulthood.

In many cases, it may be impossible to identify a qualified therapist or medical doctor within reasonable driving distance of the child. In such instances, it is recommended that the agency contract with an out-of-town specialist who can provide phone consultation to the child's treatment professionals. Such a specialist can provide educational reading and resource information which may be very helpful in augmenting the child's level of service. Furthermore, the specialist can serve as an on-going guide to assist throughout the process, and provide testimonial support in court proceedings related to the child's abuse and trauma.

Individual caseworkers who have difficulty receiving the support of their agency should remind directors and supervisors of state statutory obligations and liability considerations. Since children who are ritually traumatized often fall into special needs or high risk intervention categories that qualify them for additional state and federal dollars, it is the duty of the agency to do everything in its power to ensure that the child is receiving the maximum treatment and benefits available. This would include any special educational needs that might result from the child's trauma and dissociation.

Treatment needs of the alleged perpetrator and/or family members will also be substantial and should be addressed as comprehensively as possible. Unfortunately, familial perpetrators

are unlikely to ever admit having been involved with anything as heinous as ritual trauma. In fact, if they themselves are suffering from DID, they may not be consciously aware of their involvement in the child's abuse. This problem even arises in cases involving protective mothers who may have a strong "sense" that their children are being brutalized, but have no recollection of their own participation at some level. Consequently, a child victim of intergenerational ritual abuse is almost always at risk if returned home.

An additional consideration is the foster care placement of the child. Once ritual trauma has been identified, it may be necessary to move the child to a more therapeutic foster home; or, if the child is in crisis, a temporary in-patient facility. If the child is attached to his or her foster parent and the foster parent is able to manage the additional time which may be involved in transporting the child to therapy and managing problematic behaviors, it may be best to leave the child in his current placement and look into the possibility of periodic respite care when needed. As mentioned earlier, verbal disclosures concerning ritual trauma do not generally occur until a child feels sufficiently removed in both time and space from the perpetrators and their environment to feel safe and secure. However, once the disclosure process begins, a child's behavior may rapidly deteriorate and necessitate placement adjustments.

There may be other, overriding factors to consider when making a placement decision for a child. If there are young infants or fragile children who also reside in the foster home under consideration, it may be too risky to place the ritually abused child there. This is particularly true with older children and adolescents who may have fully developed "perpetrator" parts concerning whom neither they nor others are aware. In such situations, strong consideration should be given to moving one child or the other(s), giving appropriate weight to the needs of each individual child in care.

Social workers, like therapists, should keep accurate and detailed records of the child's statements, disclosures, and progress throughout the course of a case. Signs of ritual trauma may mean that an organized perpetrator group is involved, of which law enforcement should be made aware. Any subsequent investigation or prosecution would naturally require cooperation from the social service agency having legal custody of the child. In addition, records of the child's statements and disclosures would be an essential source of information to police and prosecutors.

In light of the social service agency's legal and physical custody of the child, with all of its related responsibilities concerning the child's care, social service workers and administrators are encouraged to familiarize themselves with the "best practices" recommendations of all other professionals involved in the child's life. This will assist the worker and the agency in making referrals that are appropriate to the child's needs, and ensuring that adequate safeguards are in place during the process.

- ## E. CASA/GUARDIAN AD LITEM REPRESENTATIVES

The Guardian ad Litem or CASA who has been court-appointed to represent a child must always look to and advocate for the best interests of the minor throughout the child's involvement in the legal system. In cases involving ritual trauma, the efforts required of the Guardian ad Litem or CASA will be much more substantial than the average case. Obviously, this is due to the nature and complexity of the case, as well as the severity of the trauma that the child has endured. "Standing in the shoes" of a ritual child abuse victim requires tremendous patience, compassion, and fortitude, since the system rarely responds in a manner which is adequate or appropriate to the child's needs.

A Guardian ad Litem or CASA is similarly situated to the child's treatment worker in that he or she should be having regular interaction with the child, biological and foster parents, teachers, physicians, therapists, etc. In truth, social workers are notoriously overworked and may not have adequate time to engage in thorough casework and investigation related to the child's ritual trauma. Consequently, while zealously advocating for the child's best interests, the Guardian ad Litem or CASA can also serve as an additional pair of eyes and ears for the treatment worker. Obviously, important information regarding the child should be mutually shared so that efforts can be coordinated.

Most importantly, it is essential that the Guardian ad Litem or CASA become familiar with the dynamics of ritual trauma so that he or she can properly assess the case and make appropriate recommendations on behalf of the child. Information for such an assessment should come from every source available and would likely entail both third party interviews and a review of the child's medical, psychological, educational, and other histories which are necessarily relevant to the assessment. It may also be appropriate to seek expert advice, legal and otherwise, concerning how best to proceed on behalf of the child.

Unfortunately, it is not uncommon for a Guardian ad Litem or CASA to meet with opposition when it comes to advocating for treatment services which are necessary for the child. Nonetheless, the Guardian ad Litem or CASA should initiate whatever legal steps are necessary to ensure that the child is no longer at risk and is receiving services which are adequate and conducive to the child's healing. This may require the testimonial assistance of an expert witness. If monies for such services are unavailable, it is appropriate to request that costs be assessed against an appropriate party to the action. Usually, this is the social service agency or the alleged perpetrator.

The safety of the child should always be of paramount importance and concern. Unfortunately, cults attempt to infiltrate all areas of the system, and a child may end up being "routed" to a foster home that is under cult control and supervision. The Guardian ad Litem or CASA's independent status may provide a unique opportunity to observe problems that may go unnoticed by social service or other professionals. If there is reasonable concern or suspicion on the part of the GAL or CASA that the child's placement is a threat to his health, safety, or well-being, it is his or her duty to advocate for the child's removal and placement elsewhere.

While continuously gathering information which is critical to the court, as well as useful to every professional involved, the Guardian ad Litem or CASA should refrain from directly questioning the child concerning his or her sexual or ritual abuse. This process is best left to professionals trained in interviewing techniques and may only result in charges of contamination and influence by the perpetrators. On the other hand, spontaneous disclosures by the child should be carefully recorded and shared with other professionals treating the child, along with observations regarding the child's behavior and the behavior of others that may be of concern.

Finally, it is important to remember that the Guardian ad Litem or CASA may have more time than any other professional involved to serve as a coordinator and courier of important information between professionals that can serve to improve the level of services provided and have immediate impact on the child's well-being. As long as the actions of the Guardian ad Litem or CASA do not violate confidentiality and are consistent with the child's best interests, he or she should engage in as much formal and informal advocacy on behalf of the child as possible.

• VII. CONCLUSION

Since the early 1980's, there has been a surge in the number of reported cases involving ritual trauma. Professionals must understand that this surge in cases is directly related to reports from day care centers which have exposed this activity. Unfortunately, our increased dependence on day care has provided organized perpetrators with the perfect "structure" for their activities. At the same time, these centers have become the Achille's Heel of cults desiring to expand their power and influence beyond traditional boundaries. The reason for this is that non-offending parents whose children are abused in day care are not only more likely to notice subtle changes in their children, they are also more likely to believe and respond to their disclosures.

Skeptics argue that media coverage related to these day care cases has perpetuated false and contrived reports that have no basis in fact. They point to prosecutions that have either failed or been overturned on appeal to support these conclusions. Through the efforts of several organizations, a media campaign has been waged and lawsuits have been filed for the purpose of discrediting any and all allegations related to ritual trauma and recovered memory. The effect has been to discourage many professionals from becoming further involved or educated about the problem.

In spite of continuing disbelief, allegations of ritual abuse continue to be reported by children and adults in every state in this country, as well as other countries across the globe. Despite differences in the locations and ages of victims, the information revealed and experiences related are strikingly similar. If we continue to deny the existence of ritual abuse in light of these disclosures, then we risk believing in an international conspiracy between alleged victims who are culturally, geographically, and chronologically removed from one another. This is an absurd notion.

In truth, conspiracy is very rampant in ritual child abuse. However, the conspiracy comes from organized perpetrators who use fear, intimidation, and brainwashing techniques to cover criminal activity and protect vital economic interests rather than therapists and victims who have little to gain in this process. Perpetrators are “banking their money” on the probability that such allegations will be ignored, discounted, and swept under the carpet of our legal system. Our refusal to address the issue of ritual trauma with the same level of zeal as other forms of abuse has done little to erode the confidence of these groups.

We must remember that victims of ritual trauma have been subjected to the worst forms of abuse imaginable and suffer greater debilitating effects than other victims of child abuse. Their cases deserve the highest level of assistance possible, particularly in view of the fact that other child victims may be involved. We must also be careful not to label adult survivors, or protective parents who may suspect cult involvement of a spouse or other family member, as "hysterical," "paranoid," or "histrionic." Their perceived "hysteria" may be based upon a very real danger to themselves and others. A system that fails to believe and assist adult victims of ritual trauma is not likely to protect children any more effectively.

Children are the most vulnerable members of our society. Protection of their birthright and our future as a nation requires that we move beyond denial so that we can create new investigative strategies and paradigms that will effectively assist us in addressing the problem of ritual trauma. Without such a shift, future generations will have to deal with the exponential effects of this phenomenon.

• VIII. SUGGESTED READING

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