

## **Pilot Study on Alleged Organised Ritual Abuse: Final Report**

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### **General Introduction and Definitions**

In the last decade there have been reports of organised ritualistic child sexual abuse in the USA (Finkelhor et al 1988), The Netherlands (Jonker & Jonker-Bakker 1991), Canada, Australia, (Johnson 1992) South Africa and the UK (Creighton 1991). Within the USA the figures of alleged ritual abuse are smaller than for other kinds of abuse (Bottoms, Shaver and Goodman 1991) and in 1991 2,292 patients identified themselves as ritual abuse survivors. With both children (Jones 1991) and adults in the UK the figures are smaller than for other kinds of abuse and a lack of forensic evidence is commonplace (Weir & Wheatcroft 1995).

Gallagher et al (1994) in the UK found the estimated national incidence for organised abuse was an average of 242 cases a year and allegations of ritual abuse involved 21 cases a year. After the Channel 4 Dispatches documentary (Satanic Ritual Abuse, February 19<sup>th</sup> 1992) 191 calls were dealt with on the helpline set up by the Broadcasting Support Services. However, the 15 lines set up were inadequate to the task as BT recorded 4, 500 attempted calls during the first hour. The organisation RAINS (Ritual Abuse Information and Network Support) for professionals dealing with such cases has 150 members, all of whom have at least one such current adult or child case. For as long as the forensic evidence for substantiating these accusations remains speculative, it is impossible to gauge the true extent of this phenomenon.

In South Africa there is a National Unit for Occult-Related Crimes. In the UK the Scotland Yard Research Unit on Ritual Abuse has been disbanded (1994) and its report on allegations of Ritual Abuse has not been published.

### **Definitions**

By organised ritual abuse we mean sexual abuse

- a) where there was more than a single abuser
- b) where the adults "appear to have acted in concert to abuse the children" (la Fontaine 1994) and
- c) in which there have been allegations of rituals associated with the abuse, whether or not these allegations have been taken further or tested in the courts.

By Satanist ritual abuse we mean a situation in which the discloser (whether a victim, perpetrator or both) believed there was a Satanist belief system involved in the alleged ritual organised abuse.

### **Background to current project**

Since 1992 there has been an increasing number of referrals to the Tavistock & Portman Clinics and other NHS Trusts, as well as to individual health service professionals, asking for consultation, assessment and treatment for children and adults alleging involvement in organised ritual abuse, particularly abuse within a Satanist context. Both children and adults presented affective states of extreme terror, and persistent problems including trance states, flashbacks, self-injury, substance abuse, sleep problems and difficulty concentrating. Their narratives included accounts of sado-masochistic acts, non-consenting heterosexual and homosexual acts, paedophilic acts, necrophilia, bestiality and

torture. Many of the referrals experienced these alleged activities in association with a Satanist belief system.

Following the publication of a collection of clinical papers (Sinason 1994) to explore and provide further understanding of this topic, the authors set out to conduct a more systematic survey of referrals concerning alleged organised ritual abuse. Our initial concerns were that due to the fear engendered by the topic, National Health Service patients and their families were not receiving an adequate service (Weir & Wheatcroft 1995). Health service professionals and the media (Scott 1992) were embroiled in religious discussions of belief and disbelief in which the patients were left without adequate treatment. We were also concerned by the initial impact of this work on clinicians as it became clear that even experienced forensic health service psychotherapists were more powerfully affected by the narratives and emotional interactions of these patients as compared with other vulnerable groups (Hale & Sinason 1994). Obviously, working with any severe physical or psychological trauma has a profound impact on the professional (Hale 1998).

Whilst therapists are normally primarily concerned with internal psychic truth, any case of sexual abuse that involves an interface with legal procedures requires an assessment of the external objective validity using, if possible, the resources of other services. Professor La Fontaine's preliminary report makes clear that within her sample of 84 child cases in which there were allegations of ritual abuse this was substantiated in three (La Fontaine, 1994). She did not find substantiation of ritual abuse allegations involving more than one adult perpetrator. Within the field of child abuse it is also well established that only a disproportionately small number of abuse cases get to court in the first place. Bentovim & Tranter (1994) found that where cases involving an alleged ritual element do succeed in court, the ritual element is often removed. Sometimes this is done at the suggestion of barristers and the ritual element is not mentioned in court and sometimes it is not possible to prove.

Evidence from experienced health service clinicians who have encountered cases of alleged ritual or organised abuse suggests that this kind of abuse is rarer than other kinds (Creighton, 1993) and that an even smaller number of cases of this kind of abuse have entered the legal process. Possible explanations might be that:

1. corroborative evidence simply does not exist; (Lanning, 1991);
2. corroborative evidence does exist but adequate methods of establishing its validity do not exist; or
3. the current views on the status of such abuse hinders investigation (Dawson, 1991).

The authors thus considered it of central importance to establish the validity of the clinical history and case material by external corroboration wherever possible.

#### **Aims and Outline of the Project**

A multi-disciplinary clinical approach was adopted, employing information from psychiatric, psychoanalytic and forensic methods of investigation. The project had three broad aims:

1. To systematically collect data on all referrals (telephone and letter) received at the Portman Clinic involving allegations of ritual abuse for a period of one year. This survey comprised the first stage of the project, and was essential to establish demographic data.
2. To offer clinical assessment to all referrals and to examine the nature of the clinical descriptions given by patients taking up this service. In line with psychiatric practice, corroboration was sought from both "non contentious" areas of personal history as well as from that concerning ritual abuse.
3. In a further refinement, a sample of those patients who took up the clinical assessment were offered further in-depth forensic investigation. This met the third aim of the project in which a formal comparison of clinical description with forensic evidence was made.

The results from the three studies that comprise this project will provide information on the profile of those referred for allegations of ritual abuse, enable a more accurate clinical picture to be drawn up of

this sample, and finally enable an understanding of the links between clinical description with forensic evidence.

The Department of Health funded the project for one year. This largely covered the costs for the therapist's time (5 sessions per week) and the research assistant's time (4 sessions per week). Dr Hale, as Director of the Portman Clinic, where the project was based, was paid for within his NHS time. Psychotherapy time for patients who required longer-term treatment, which was outside the remit of the project, were funded through Extra Contractual Referrals. It was part of the ethical planning of the project that the psychoanalytic psychotherapist kept time available for this provision.

A steering committee had oversight of the planning and execution of the project.<sup>1</sup>

### Method

1. All referrals (50) (by telephone or letter) were monitored and analysed for two years (although initially we had intended this stage to be completed in one year, the information took much longer to collect). The database included age, sex, source of referral, nature of first contact, nature of first response, presenting problem, alleged offences, actual psychiatric and medical symptoms, current religious involvement, reason for referral, any previous treatment and previous statutory involvement.
2. Fourteen index cases, where patients wished their case to be investigated for the first time, or re-investigated, were identified and referred to their local police department through the help of the Chief Constable for initial or further investigation. We decided at the outset to exclude from the cases we passed to the police, any, where, from our clinical interview, we considered that there was not a reasonable likelihood of a true statement being made concerning criminal offences.
3. Cases excluded were to be
  - a) Those from fundamentalist religious backgrounds (as Professor La Fontaine (ibid) has also observed) where it is sometimes possible that the ideology of adults has been imposed on children
  - b) where the alleged ritual abuse is likely to be a cover for paedophile activities
  - c) where we considered there was a psychiatric condition which would mitigate against the ability to provide a truthful statement.
4. Individual psychoanalytic psychotherapy and/or supportive psychotherapy would be provided to index or non-index cases who required it in liaison with other psychiatric and social service departments. Following the research period, a small number of cases were subsequently taken into formal psychotherapy.

### Outline of Police Liaison for Index Cases

All patients entering the project were told of the clinical and forensic aims. They signed a consent form for their material to be used in a non-identifiable statistical way for the database in the first instance. Background details were disguised where necessary at the patient's request without losing the essential

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<sup>1</sup> The steering group included a representative from the research team, Dr Hale, with Ms Sinason and Ms Gordon (research assistant) in attendance, a representative from the Department of Health, Dr J Lissamore, a representative from the Association of Chief Police Officers, Mr A J P Butler, and a representative from the Association of Directors of Social Services, Ms M Gibb.

Within the Clinic, discussions were held at the start of the project with various senior staff members including Ms S Dermen, Adult Psychotherapist and Psychoanalyst, Ms D Lloyd-Owen, Senior Lecturer in Social Work, Mr R Davies, Senior Lecturer in Social Work and Mr D Campbell, Principal Child Psychotherapist and Psychoanalyst. Advice was also provided by Professor Julian Leff and Mr Tony Lee.

data. Where patients were still concerned to take the investigation forward the research psychotherapist carefully outlined the procedure: In the first instance our co-ordinating Chief Constable was sent a letter stating that an alleged offence had occurred in a particular geographical area, but not providing a name or identifying details. He then notified the Chief Constable of that area about the research project and sent the research psychotherapist a contact name and number. At a further meeting the patient was told of the name and address of the police officer and police station; if they were still interested they signed a formal permission to proceed and a letter providing their name and basic details was forwarded. Apart from Scotland, in all other areas of the UK a joint meeting was then set up with the allocated investigating police officer, the research psychotherapist and the patient. In this meeting the patient told the police of alleged offences they had witnessed and discussed the consequences and implications of proceeding. Thus, ethically and clinically the patient had time in a safe setting to consider whether to pursue the forensic investigation of his/her testimony.

Because of the structure of multi-disciplinary co-operation, the number of agencies involved depended on the age of the alleged victims and the nature and number of the alleged perpetrators.

The clinical research team considered it would be appropriate to have a police officer experienced in this subject included as part of the team (as in *Working Together*, ). Such an individual was identified. However, due to the status of this topic, police authorities did not consider it appropriate at that point in time.

#### **Ethical Issues**

The clinical research protocol was submitted to the Ethical and Research Committees of the Tavistock and Portman NHS Trust. Great care was taken to determine the nature and meaning of clinical consent for (a) clinical research and (b) external investigation. This has also extended into preparing patients for the publication of this report, particularly the different meaning of clinical research as opposed to forensic investigation.

#### **Descriptive Definition of Ritual Abuse**

Whilst the project was open to any referral involving abuse within a ritual context, the researchers and the wider community were aware of particular concern regarding alleged ritual Satanist abuse. In particular, we agreed with Professor La Fontaine (La Fontaine, 1994) that the more serious allegations had not been proven in the UK. Hence, regardless of religious definition, for the purpose of this report we were particularly concerned by those allegations that included practices of:

- murder
- necrophilia
- abortion
- bestiality
- non-consenting impregnation
- cannibalism
- consumption of body fluids
- non-consenting sado-masochistic acts
- consumption of animal fluids
- despoiling of churches and cemeteries
- killing and/or torture of animals

The following list are not offences in themselves, but were mentioned so frequently in allegations that they are seen as contextually relevant to the establishment of a definition of ritual abuse:

- induction of trance states
- wearing of ritual apparel
- use of chanting
- use of ritual instruments

### **A further clinical note on definitions**

Satanism (Sinason 1994) is not an illegal belief system. We do not imply that Satanists in general are committing criminal offences. Similarly, witchcraft, both of a healing kind and otherwise has a long history and many branches and we do not imply criminal offences above that of the rest of the population. With any population, only a small percentage are likely to be involved in criminal offences. We are aware that some children may be tricked by paedophiles using ritual material (La Fontaine). However, it has been demonstrated that where the children believe the offences were committed within a religious belief system and then become believers themselves, it is irrelevant how that belief system was originally inculcated (*Working with the Children*, Childline 1994). The crucial element, therefore, in these cases is what the child believes.

### **The sample**

Fifty consecutive referrals were assessed by the research psychotherapist. Of these, 19 expressed an initial interest and willingness for police investigation. Accordingly, they were given a psychiatric assessment to exclude current mental illness that would impair their capacity to give accurate testimony. No one was excluded for psychiatric reasons. Five subsequently excluded themselves for other reasons (see page 6). Therefore 14 cases proceeded to the police investigation.

### **Findings**

#### **Method of Referral**

Comparison with referrals to the Portman Clinic over the period of the research project demonstrated that pattern of referral of patients alleging ritual abuse was markedly diverse from the usual Portman Clinic referral pattern. Referrals to the project (see table 1) were usually by telephone (70%) and cases were self-referred (38%). In comparison, the majority referrals to the Portman Clinic (See table 2) were made by psychiatrists or psychotherapists (24%), with only 18% of patients being self-referred. The Portman Clinic did not record any referrals made by telephone during this period.

#### **Reason for referral**

Referrals fall into three categories:

1. adults wanting treatment/redress for previous experiences;
2. parents wanting legal redress for alleged offences against their children- usually involving custody and with allegations against the custodial partner (with three exceptions where mother did have custody);
3. adults wanting treatment/redress for current experiences.

#### **Breakdown of DID & PTSD-like symptoms<sup>2</sup>**

- Eight out of the eighteen seen together by Valerie Sinason and Rob Hale had dissociative identity disorder
- Thirty-three out of the fifty had symptoms relating to PTSD
- Six out of the eight patients with DID seen by Valerie Sinason and Rob Hale required abnormally high levels of medication and anaesthesia for operations and other medical treatments compared with non-dissociative patients. This replicates American research on this topic. (Ref: )

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<sup>2</sup>Dr Butler commented that where the historical accuracy of the traumatic event(s) had not been externally established the diagnosis PTSD should include the caveat "alleged" PTSD.

### Allegations (see tables 3 & 4)

- Thirty-six cases (72% of the sample) allege witnessing murder;
- Twenty of those who alleged they witnessed a murder were speaking of infanticide (57% of the sample);
- 43% of those who alleged they witnessed a murder were speaking of an adult;
- 68% allege to have witnessed necrophilia;
- 66% allege to have witnessed or been subjected to illegal abortion;
- 64% allege to have witnessed or been subject to acts of bestiality;
- 64% allege to have witnessed or been subjected to non-consenting impregnation;
- 64% allege to have witnessed the killing and/or torture of animals;
- 62% allege to have witnessed cannibalism;
- 66% allege to have witnessed the consumption of body fluids;
- 80% allege to have witnessed or been subjected to non-consenting sado-masochistic acts;
- 64% allege to have witnessed or been subjected to the consumption of animal fluids;
- 68% allege to have witnessed the despoiling of churches and/or cemeteries

### Breakdown of previous statutory involvement (see table 5)

- 56% of cases had had previous statutory involvement
- 30% had had involvement with the police;
- 32% had had involvement with social services;
- 10% had received in-patient psychiatry.

It should be noted that in a number of cases the research team felt there was sufficient evidence for the case to be referred to the police for further investigation, but the person(s) involved would not proceed for the reasons summarised below.

Need for therapy but no funding	1
Fear of losing custody/access to child	3
Loyalty to alleged family abuser	5
Fear of punishment by group	8
Fear of losing job	1
Previous professional error	6
Other	6

As Weir and Wheatcroft comment (1995) it is necessary to emphasise the need for care in evaluating allegations of abuse because it has been noticeable that in cases where the possibility of ritual abuse occurs there can be such a level of professional anxiety that the normal procedures of investigation and protection of family rights are abandoned or curtailed (p.492).

### Index Cases

Fourteen cases were referred to the relevant police department using the protocol described above. The outcome was as follows:

1. Before proceeding to an initial meeting the subject decided to withdraw (n= 2)
2. After the initial meeting with a local officer the subject decided to withdraw (n=1)
3. After the initial meeting the police decided not to proceed (n=3)
4. After the initial enquiries post decision to proceed the Police concluded there was insufficient evidence to go further (n=6)
5. Prosecution (n=2)

## **Comment**

Of the twelve cases which proceeded to a police investigation, six were deemed by the police to merit further investigation which was duly carried out.

The only two cases to get to court were non satanist. This could be because they were the only two where there was sufficient evidence to proceed or the lack of bizarre elements made it easier for the offences to be considered. The researchers did not consider there was any significant difference in clinical presentation and mental state in the two whose cases proceeded to court compared with the rest of the sample. This fits with ACAL's awareness that some cases get to court by avoiding mention of ritual elements.<sup>3</sup> Of the other cases several peripheral aspects of 3 cases were confirmed whilst two peripheral aspects of 2 cases in the aforementioned sample of 3 were disproved.

## **Clinical results**

Clinicians would not be in the a position to prove or disprove events in legal terms but only to assess mental state and collect evidence that corroborates or disconfirms the history.

Patients were asked to provide corroboration of alleged family backgrounds, work, past medical histories, educational histories, etc.

## **Clinical Presentation**

1. Subjects brought as corroborative evidence weapons, ceremonial clothes and items, medical and educational records and photographic evidence of satanist emblems, despoiling of churches, unregistered children and injuries
2. Subjects took part, where they wished to, in three-way telephone discussions with allegedly abusive family members with the therapist involved. Permission was asked of family members first. Corroboration of gross family trauma including murder was provided.
3. Within the total sample two subjects (one from the index group and one from the total sample) had been involved in a recovered memory technique, but only after they had already made substantial allegations.

## **Psychiatric Assessment**

1. In the majority of cases known psychiatric disorder was not a basis for explaining or discounting the account given by the patient.
2. In none of them was there an enduring diagnosis of schizophrenia or other axis I psychotic illness. Equally, none of the patients had been previously diagnosed as Munchausen's syndrome.
3. In only two cases out of the total sample did we consider that the severity of the personality disorder could be a significant feature in lowering the credibility of testimony.
4. A significant number of the patients had a diagnosis of DID. (This is still a controversial diagnosis in the UK but has attained wide recognition in the USA.)

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<sup>3</sup> ACAL is an assoc of child abuse lawyers, a non-profit-making company formed as a response to concerns within the legal profession that people abused in childhood and the learning disabled were receiving poor standards of advice and assistance. They are concerned about adults claiming to be victims of satanist abuse who are also dissociative

## **Clinical Conclusions**

1. The patients alleging this abuse form a significant and discreet clinical group as judged by the following criteria
  - a) the consistency of their core accounts
  - b) these accounts cannot be discounted as being the products of mental illness (eg Munchhausen's syndrome, Munchhausen by proxy or psychotic illness ) or fundamentalist beliefs
  - c) the affective state of the patient when recounting experiences
  - d) the high frequency of Dissociative Identity Disorder
2. Fundamentalist religious belief was not a significant issue in our sample. In three of the total sample, there was involvement in fundamentalist religion. In two of these cases this was in seeking help after previously alleged satanist abuse. Both patients were ambivalent about their involvement but stated that these religious organisations had been the only ones to believe their testimony and offer them support. In the third case the organised abuse took place in the context of the religious organisation.
3. Recovered memory was not a significant issue in our project. In every case the original allegation of ritual abuse had already been established before the patient was involved in the project.

## **Overall Conclusions**

### **i) Police Liaison**

Our original hypothesis was that the clinical accounts would provide police with an evidential basis through which they could investigate or re-investigate and thereby prove or disprove the allegations made.

This expectation was not achieved except in two cases, which were the only two in which non-Satanist ritual allegations were made.

Clearly there were many factors, which complicate the police investigation of such cases. We would cite the following:

1. Where patients were unwilling to proceed further without a safe place
2. Where patients were unwilling to proceed further for fear of the legal consequences for if their own offending behaviour was confirmed.
3. Where patients were unwilling to proceed further for fear of the legal consequences to their allegedly abusing but loved family members.
4. Where patients were unwilling to proceed sensing scepticism in particular investigating officers
5. Where patients were unwilling to have their cases investigated by local police in areas where they feared social/familial overlaps.
6. Where patients were unwilling to proceed until they had received Extra Contractual Referral funding for therapy and this was not achieved within the time frame of the project
7. Where particular police did not receive adequate co-operation from other statutory services.

8. Where there is a lack of experience in professionals. In many cases of organised abuse there has been a breakdown of inter-agency working. In Cleveland (Butler-Sloss Inquiry HMSO 1988) and in the Orkneys (Orkney Inquiry HMSO 1992) interagency conflict led to serious problems in handling such cases. Whilst in the child sector area child protection committees exist with roles organised under the Working Together under the Children Act (1988, HMSO 1991) there is little adequate recognition of procedures needed to deal with organised abuse or the smaller sub-section of ritual or ritual organised abuse. Indeed, Professor La Fontaine comments that with organised abuse there is no adequate body of case experience for most child protection workers to draw on and the cases are difficult to handle.)
9. Where there was a custody dispute and, for whatever reason, one parent is given custody it proved extremely difficult for the non-custodial parent to have their case researched right from the start. As Bentovim (1992) has shown, the weight of the files in themselves precludes fresh rethinking and reinvestigating. Forces demand new evidence in order to re-open these files rather than starting from the beginning.
10. Where patients alleged taking part in cult activities that did not involve illegal acts, i.e., where there is not a child involved, cruelty between "consenting" adults is legal, so long as it falls within the parameters of Spanner's recommendations. A cult victim who is addicted through familial loyalty to returning to a group is seen as a consenting adult because they go without coercion. This highlights the need for Vulnerable Victim Co-ordinators
11. Where the need to involve local police frightened patients
12. Where patients were seen as unreliable witnesses due to Dissociative Identity Disorder

**ii) Conclusions regarding clinical services**

1. Regardless of proof or disproof, belief or disbelief a significant number of NHS patients are in great mental distress and are not receiving the treatment they need.
2. There is an almost total lack of Health Service in-patient and outpatient treatment facility for Dissociative Identity Disorder patients

**iii) Conclusions regarding the external reality of ritual satanist abuse**

We are left with a substantial number of cases in which the central allegations remain neither proven nor disproved by police

**Explanation of observed phenomena:**

1. It is an encapsulated psychosis, not based on any reality
2. Sexual abuse exists but the personality structure leads to an elaboration involving confabulation of ritualistic element.
3. That the events occurred but could not be proven and the psychological disturbance we are seeing was the result of the trauma.

**Recommendations**

Consideration should be given to establishing:-

1. Specialist investigator independent of local police forces with access to all material
2. Personnel involved in the investigation, as in the new rape suites and child protection units, need to offer a basic stance of belief in the patient's narrative until proven otherwise. This would be in line

with the specialist Occult-Crimes Unit in South African headed by Colonel Kobus Jonker ( which has proved and solved 29 ritualistic murders).

3. The provision of specialist therapeutic services, both inpatient and outpatient to contain the patient's fears during investigation and afterwards
4. The provision of specialist multi-disciplinary teams as advocated in "Working together" for child protection (Jonker, and Jonker-Baker, 1997)
5. The development of vulnerable victim co-ordinators with the police force to deal with "consenting" adults who are vulnerable.
6. Liaison with legal services to uncover the extent to which bizarre elements are removed from court presentations.

The report further highlights:

1. The need for clinical research and provision on dissociative identity disorders
2. The need for clinical research in elucidating the nature and severity of personality disorder when identified in this group.
3. The need to acknowledge the findings of experienced forensic clinicians (Sinason and Hale 1993) that these cases have been found significantly more difficult to deal with.

We have taken care in this report to exclude evidence brought by subjects in the context of a therapeutic encounter which would have high significance on clinical grounds.

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**Table 1: Referrals to the research project**

n	Method of referral*		Referral Body or Agency						
	Telephone	Letter	Self	Family	Friend	Social Worker	Therapist	GP	Other
37	26	10	14 (38%)	5 (14%)	3 (8%)	1 (3%)	5 (14%)	1 (3%)	8 (22%)

\* One male made a direct approach

**Table 2: Referrals to the Portman Clinic**

Comparative referrals to Portman Clinic 1.5.95 - 30.4.96								
Referral body or agency								
Self	Solicitors	Social Services	Psychiatrist/ Psychotherapist	GP	Psychologist	Counsellor	Probation Services	Other
67 (18%)	21 (6%)	54 (15%)	88 (24%)	52 (14%)	21 (6%)	15 (4%)	22 (6%)	27 (7%)