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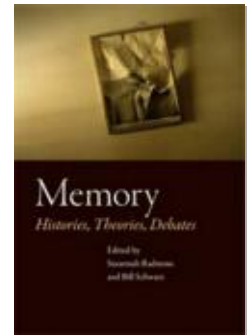
Published by Fordham University Press

Radstone, Susannah and Bill Schwarz.

Memory: Histories, Theories, Debates.

Fordham University Press, 2010.

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29. The Seventh Veil

Feminism, Recovered Memory, and the Politics of the Unconscious

Janice Haaken

The Seventh Veil, released in 1945, represents one of the earliest cinematic portrayals of gothic psychiatric narratives—stories that position the female psyche as a darkly shrouded mystery, revealed through the investigations of a pioneering psychiatrist.¹ As a prototype of this genre, *The Seventh Veil* registers the emerging position of the psychiatrist in facilitating modern forms of female subjectivity—forms that require a reworking of memory and a therapeutic encounter with a debilitating past.

The film opens with Francesca Cunningham, a talented young concert pianist, languishing in a catatonic state after a car accident. Physically recovered but emotionally paralyzed, she passively submits to psychiatric treatment. Her psychoanalyst, Dr. Larson, administers hypnosis to unlock the mystery of her traumatic illness, a conversion hysteria from which she has lost the use of her hands. In explaining clinical hypnosis to a wary colleague, Dr. Larson suggests that the psychiatrist must overcome the patient's inhibitions, just as the surgeon must get the patient to undress before performing the operation. Dr. Larson continues to explain the mysterious workings of the mind to his medical colleague:

The human mind is like Salome at the beginning of her dance. It is hidden from the outside world by seven veils. Veils of reserve, fear. Now with friends, the average person will first drop one veil, then another. With a lover, she will take off five, maybe six, but never the seventh. The mind likes to cover its nakedness and keep its private thoughts to itself. Salome drops her seventh veil of her own free will, but you will never get the human mind to do it. Now, I use narcosis. Five minutes under narcosis, and down comes the

seventh veil. And we can actually see what is going on behind it, and then we can really help.

In the 1980s and early '90s, many mental health practitioners united around the project of bringing down the seventh veil, exposing the deeply buried secrets of women. Chastising Freud for turning away from sexual abuse as the primary cause of female psychopathology, clinicians in the burgeoning field of trauma therapy expressed an unwavering commitment to one of Freud's earliest claims: that therapeutic exploration of female symptoms often leads to a traumatic sexual scene from childhood.²

As therapists worked their way through deeper layers of memory, the sexual scenes reported in the clinical literature of the 1980s and '90s took on an increasingly gothic tone. Recollections of incest became more violent and scenes of familial abuse more horrific, particularly as patients diagnosed with multiple personality disorder emerged as a prime source of recollections of familial barbarism and perverse sexual cruelty.

Clinical reasoning that guided the recovered memory movement established causal links between incest, trauma, and amnesia, but clinical passions also seemed to be stoked by the therapeutic process of uncovering graphic sexual scenes from childhood. In describing the appeal of the gothic, literary critic Diane Long Hoeveler suggests that "we, like the characters in the female gothic novel, want to find something hidden, mysterious, deep, and esoteric behind the black veil, and usually this elusive deep structure is imaged as some sort of sexual or psychic secret."³

Second-wave feminism opened up political space for women to talk about incest and other hidden forms of abuse, and the solidarity of the movement claimed important victories in "breaking the silence" around boundary violations suffered by women.⁴ At the center of the incest recovery movement was a critique of the patriarchal family, and particularly the illusion that the family is a place of refuge for girls and women. At the same time, the tremendous elasticity of sexual abuse as a political category was problematic, as was the increasingly dramatic and grisly genre of memories that emerged.⁵ In the aftermath of the women's movement of the 1970s, female grievances were not as readily silenced as in the past. But the bar was raised for what counted as a compelling story. As politics in the United States turned to the right, the public threshold for registering human misery and for responding to the grievances of women seemed to rise.

This chapter presents a psychoanalytic feminist analysis of the trauma and recovered memory movement of the 1980s and '90s and introduces an alternative to the true/false memory distinction that dominated the debates. In focusing on the trope of uncovering buried pathogenic secrets, the chapter draws out subversive dimensions to this dramaturgy while also outlining its pitfalls. Any project of progressive social change requires a capacity to transcend mundane reality, to probe for deeper meanings, and to uncover unrealized potentialities. Yet once the oppressed begin to speak, historical and social

dynamics intervene to shape both what is said and what is most readily heard and remembered.

Psychoanalytic traditions enlist various models of divided consciousness and unconscious remembering but stress the dynamic nature of representations of the past. The truth of a recollection may lie in the positions of various protagonists and the dilemmas represented, rather than in the factual content of the account. Psychoanalytic theory also provides a framework here for addressing the question of how stories that are not literally true may acquire believability within particular historical and social contexts.⁶ This chapter focuses on the rhetorical use of the concept of traumatic memory in late-twentieth-century mental health culture and the freight this category carried both for women patients and for feminist-informed psychology.

Science, Feminism, and the Recovered Memory Debate

For many clinicians schooled in trauma theory in the 1980s and '90s, therapeutic work required a willingness to face the grisly horrors patients had suffered in childhood—areas where previous generations of clinicians dared not look. A line of feminist analysis pursued in the mental health field centered on the complicity of the professions in covering the tracks of patriarchal power.⁷ Campaigns focused on the battered child syndrome and, later, the battered women's syndrome advanced the idea that professionals habitually cast a blind eye on the injuries of family dependents in deference to male authority.⁸

Feminists tended to align themselves with the position that women's memories must be "validated," whatever the conditions under which they were produced.⁹ As a corrective to the history of silencing women, or of labeling angry women as hysterics, this stance of "believing women" acquired the force of a moral mandate. One cost of the mandate to "believe" women, however, was to adopt a highly literalist view of memory, one that stripped women's stories of their rich complexity. Further, this literalist view downplayed how official translators on the scene (including therapists) shape the transformation of inchoate, unstoried experience into narrative accounts.

The genre of memories that came to dominate public discourse and to divide the mental health community in the late twentieth century departed in key respects from earlier descriptions of clinically facilitated recollections. First, there was a dramatic disjuncture between prior autobiographical recollections and the recovered memories reported in the trauma therapy literature during the 1980s and '90s. Women had begun to speak more openly about incest and other forms of sexual abuse during the 1970s, but their narratives generally stressed the prohibition to speak rather than the failures of memory.¹⁰

Most critics of trauma therapy and recovered memory drew a line between incest survivors who held previous knowledge of having been abused, cases thought to be non-problematic, and those women who "found" their memory through a therapy or recovery

group experience.¹¹ The scientific critiques generally focused on these latter cases, where hypnosis or other social influences were thought to account for the emergence of memories of abuse. Critics also relied heavily on the distinction between continuous and new memories to defend against charges that they were denying the scope and traumatic impact of childhood sexual abuse. Fixated on the factual veracity of recovered memories, many of these critics overlooked, however, the more troubling question of why large numbers of women were experiencing such a deep disjuncture in autobiographical recall.

Throughout the 1980s and early '90s, the claims of recovered-memory advocates were morally persuasive in part because the victim in the drama was cast as motivated to *not* remember the abuse rather than to confabulate a story. Why would women recall sexual scenes that were so abusive, therapists asked, unless such abuse really happened? By the mid 1990s, however, public discourse on this question shifted to include more of the arguments of skeptics. The moral high ground shifted away from trauma therapists, as successful legal challenges to hypnotically recovered memories gained momentum. The False Memory Syndrome Foundation, an organization of accused parents and their scientific allies, also mounted an effective campaign to intensify the controversy by casting accused parents and female patients as the victims of zealous therapists who “implanted” false memories in the minds of hapless patients.¹²

In *Rewriting the Soul*, the philosopher Ian Hacking argues that both sides in the debate over recovered memories of childhood abuse rely on the “sciences of memory” that emerged in the late nineteenth century.¹³ The sciences of memory, according to Hacking, intervene in the project of preserving the past by substantivizing the hidden, the secret, and translating it into publicly verifiable knowledge. While religion similarly holds the power of explicating the ineffable, science bridges this realm of uncertainty in a more decisive way. Whereas religion stirs awe before the ineffable, science is essentially anti-hypnotic in its aim, committed to a project of dispelling the aura of impenetrable mystery surrounding human experience.

Both sides of the recovered memory debate appropriated the authority of science in making public claims concerning private knowledge. Science presupposes a knowable, verifiable “truth” that is open to impartial scrutiny. Whether it took the form of calling for more reliable tests of memory, summoning charts documenting the neurological effects of trauma, or outlining procedures for avoiding the contamination of memory, the dominant discourses in the war over family recollections in the late twentieth century were scientific ones.¹⁴

For Hacking, the “deep structure” of the memory controversy is more philosophical than empirical, more fundamentally tied to ingrained cultural ambivalence over psychology’s role in secularizing the “soul”—what is felt to be the enduring, intimate core of human existence—than to the technical claims of various contestants. The “soul” that is lost, recovered, and rewritten throughout the history of the sciences of memory, feminist theorists might add, is not an abstract, ineffable essence but, rather, is related to those

domains of life most intimately associated with women. Even though men, like women, have bodies, emotions, and families, these dimensions of experience have been coded predominantly as feminine.¹⁵ The psychology of the “hidden”—with its dramatic plots, secret motives, and revelatory discoveries—has an unmistakable association with the feminine.¹⁶

Images of Hidden Trauma

The idea of a concealed reality, operating below the threshold of conscious awareness, has been one of the most generative concepts in the psychoanalytic tradition, particularly as it introduces tension between states of “knowing” and “not knowing.” Whether describing intrapsychic or social forces, theorists have enlisted the concept of the unconscious to explain conflict over self-knowledge.¹⁷ For women, as well as other oppressed groups, remembering involves a struggle to access more authentic versions of the past, against interpretations imposed by the more powerful. As the poet Adrienne Rich describes it, “whatever is . . . buried in the memory by the collapse of meaning under an inadequate or lying language—this will become, not merely unspoken, but unspeakable.”¹⁸

As a psychology of secrets—a theory of hidden knowledge revealed through narratives—psychoanalysis creates a more hospitable audience for female storytelling than does the highly operationalized world of scientific psychology.¹⁹ In contradistinction to cognitive theories of memory that stress the encoding and retrieval of memory, psychoanalysis asserts a narrative coherence to mental life.²⁰ From a psychoanalytic perspective, repression is not simply interference in the mental retrieval of information but, rather, signifies human conflict over self-knowledge. The concept of the unconscious introduces creative space for storytelling and for recognizing the importance of the unspoken and of experience located at the margins of what is most readily noticed.

The concept of the unconscious may also be used in mystifying or intrusive ways, particularly as therapists become over-invested in exposing hidden parts of the patient’s interior world. In bridging the distance between the private and the public, between fantasy and reality, many therapists and women patients in the burgeoning field of trauma therapy in the late twentieth century were guided by the curative aim of locating the toxic residue of early sexual invasions. Further, therapists assumed that fragments of trauma memory tended to leak into consciousness in the form of dream-like imagery.²¹

Since fantasy was associated in popular culture with “making things up” or hysterical ravings, feminist-informed therapies were committed to establishing an external cause for a wide range of disturbances reported by women. Post-traumatic stress disorder (PTSD) acquired tremendous currency among progressive clinicians and feminists during this era because it located the source of pathology in the magnitude of events suffered rather than

in dysfunctional mental processes.²² PTSD represented a compromise between the anti-psychiatry movement and critiques of labeling, on the one hand, and the movement to recognize the deep and sustained psychological effects of social problems such as war and sexual assault on the other. But trauma diagnoses such as PTSD also depended on establishing a history of trauma to meet the criteria for the disorder.

In much of the trauma literature of the 1980s and '90s, the problem of female disengagement from intrusive experiences was cast through the linking of sexual trauma and dissociation.²³ Since survivors of known trauma often exhibited symptoms of dissociation, many therapists enlisted the concept of dissociation in explaining why histories of sexual abuse may be forgotten, even as these same histories are expressed through a range of symptoms.²⁴ Unable to escape an abusive encounter, trauma therapists reasoned, the sexual abuse victim protected herself by entering a trance state.

Dissociation is a term used to describe a failure in the normal integrative processes of mind, such as fugue states or dissociative identity, or it connotes a means of establishing emotional distance. In the area of memory and identity, dissociation refers to a fragmented, unintegrated sense of self and chronic states of amnesia.²⁵ As a defense, dissociation encompasses a broad range of distancing responses, particularly in response to feeling captive to the will of another. Rape survivors, for example, often describe the experience as a feeling of “not being there.”²⁶ Trauma therapists drew on observations such as these to argue that early sexual violations produced fragmented identities in women. Further, they argued that feelings of disconnection or emotional flooding were the direct result of early sexual trauma.

Dissociation is sometimes confused with Freud's concept of repression in that both terms refer to unconscious forgetting. While he initially adopted Pierre Janet's dissociation model of “double consciousness,” Freud later rejected it. Freud's repression model, while undergoing significant shifts over time, was a more dynamic model of unconscious processes than was the dissociation model.²⁷ Repression implied that events with affect-laden, personal meaning are never passively stored in an unconscious realm of the mind but rather are filtered through motivational states and psychic structures. Internal demands upon the ego, such as impulses and fantasies, are the primary source of unconscious forgetting and of various splits within the ego. In other words, mechanisms of defense are organized intrapsychically, often in relation to anxiety-provoking internal images or sensations. As the child enters adolescence, for example, new moral capacities and preoccupations collide with intensified sexual awakenings, and these conflicting pressures heighten the meaning of earlier sexual recollections.

While many psychoanalysts believe that repression may be lifted under clinical conditions, it is generally assumed that the ego—a term encompassing various reality-monitoring and anxiety-regulating functions of the mind—continues to disguise unconscious material.²⁸ In the dissociation model, however, the unconscious is assumed to be more directly accessible, with divisions expressed through alternating states of awareness or

identity. Dissociationists claim that under conditions such as hypnosis, split-off areas of mind (such as traumatic memories) directly surface in consciousness. Repression, on the other hand, implies a “deeper,” less accessible unconscious.

Trauma therapists tended to routinely interpret women’s mental imagery that felt deviant as an indicator of trauma. This clinical foreclosure on disturbing imagery was costly for women patients in that the legitimacy of mental states—and particularly culturally “unauthorized” sexual and aggressive imagery—required the production of memories of sufficient magnitude to explain the intensity of such imagery.

Multiplicity and Female Psychic Distress

The burgeoning diagnosis of multiple personality disorder (MPD) in the late 1980s grew out of the widening array of therapists specializing in trauma disorders.²⁹ As “multiples” appeared on countless talk shows and films, this prototypical female patient assumed a historically unprecedented authority in the mental health field. As the oracle of traumatic visitations from the past, the multiple emerged as psychiatric heroine, displacing the emotionally and physically paralyzed hysteric, the people-pleasing codependent, and the manipulative borderline personality of previous eras.³⁰ Therapists in the dissociative identity disorders field were captured by the creativity of women diagnosed as multiples, expressed in the creation of a complex cast of characters, or “alters,” often numbering in the dozens.

After a flurry of intense psychiatric interest in “double personality” at the turn of the century, MPD had lapsed into obscurity until its robust revival in the 1980s. Indeed, a mere hundred or so of the tens of thousands of documented cases were diagnosed prior to 1980, when MPD was transferred from the category of hysterical neuroses, where it had been listed as a subtype, thought to be extremely rare, to the newly expanded cluster of dissociative disorders. This migration of MPD across categories went beyond the mere reclassification of mental disorders. Rather, it was part of a broader movement to shed the cultural baggage of hysteria, specifically its sexist associations with female emotional “excess” and fantasy proneness, and to extend the clinical applications of the trauma/dissociation model.

Multiplicity is most often described as a pathological elaboration of normal dissociation, which refers to the mind’s capacity for altered states of consciousness and for parallel processing of information.³¹ Dissociation theorists argue that in response to severe childhood trauma, and particularly sexual abuse, some children come to rely on dissociative mechanisms to defend against the emotional pain of abuse. Pretending she is someone else, assuming the position of an outside observer, or simply spacing out, the victim of childhood sexual assault develops whole systems of identity and memory that operate independently of one another. The child creates a separate persona that coexists with the original personality, and this second persona assumes the emotional task of managing knowledge of the traumatic experience. As repeated trauma occurs, further splits in

consciousness may develop and new “alter” selves or personalities are formed. These balkanized states within carry on a secret life, assuming control at moments of stress and then receding, unbeknownst to the “host.” While some hidden personalities or alters may be experienced as “inner helpers,” assisting the host personality by assuming control during times of emotional distress, others take more destructive forms, carrying out psychological guerrilla warfare with the host personality.

The clinical validity of this dramatic, mutating condition rests on establishing the presence of an amnesic barrier between at least two of the personalities. While the importance of amnesia, as a diagnostic criterion, has been the subject of ongoing, intense debates in the MPD field, most of the leading writers agree that amnesia separates most convincingly the “true” MPD cases from their various look-alikes.³² Amnesia includes both periods of lost time—blackouts or fugue states—and failures to remember alter personalities. In the clinical cases reported, the host personality is typically amnesic for all of the alters, particularly at the onset of treatment, whereas the alters may exhibit co-conscious properties. The therapist, more often than the patient, is the one who first discovers these latent, parasitic agencies within and who facilitates their entry onto the stage of consciousness. At the time of diagnosis, two to three personalities are generally discovered. Over the course of treatment, an average of thirteen to seventeen alters are identified, although many cases report more than a hundred.³³

Skeptics argue that psychogenic amnesia does not generally take the form of whole personality constellations. Traumatogenic events may be forgotten, although this is more likely to be ephemeral and specific to details of events than to apply to entire domains of identity. Further, critics argue that it is an enormous leap to move from the specific effects of psychogenic amnesia and fugue states to the elaboration of entire systems of personality organization, with their corresponding memories, identities (sex-, race-, and age-specific), modes of relating, and unique physiological responses.

MPD is described as “a pathology of hiddenness,” requiring intensive efforts on the part of the therapist to ferret out the layers of concealed alters.³⁴ Clinicians focus on missing time or gaps in the life narrative. Their reports of patient histories are filled with intrigue, with mysterious clothing and meetings with strangers. The multiple is the woman with a secret life, the woman who finds herself in unexpected places, arousing suspicion in others. In the clinical reports of male and female clinicians alike, there is a highly paranoid aspect to this psychiatric probing.

There is a *noir* as well as a gothic element to the psychiatric discourse on MPD, bearing striking resemblance to the “woman of the night” in the noir film genre.³⁵ Like the detective who moves between the masculine, rational world of the day and the feminine, irrational world of the night, MPD therapists are arbiters of the changing boundaries of gendered identity. In the noir convention, the detective is voyeuristically captured by the fantasy of a concealed, nocturnal world where female powers operate. Feminist film critics have argued that this male pursuit of the woman of the night, whom he ultimately brings

under control, mobilizes collective anxieties over a maleness readily overwhelmed by a culturally emergent but threatening female authority.

The search for more elaborate trauma memories was itself an anxious evasion of what might emerge from the whole of women's conflicts. The MPD patient expresses, through this psychiatric narrative, a creativity and rebelliousness much less evident in clinical portraits of the past. The clinical discourse of MPD permits women to dramatize socially prohibited feelings—murderous rage, lesbian fantasies, or grandiosity. Yet MPD therapists paradoxically intensify the very dissociation they seek to treat. The diagnosis and treatment of the disorder focused on ferreting out the trauma memories that gave rise to such florid imagery. As a repository of a bottomless sea of trauma memories, the female psyche was simultaneously an object of fascination and evacuated of any substantive capacities.

Much like the late-nineteenth-century hysterics and double personalities, the late-twentieth-century narrative of multiplicity registered unrealized potential on the cultural horizon. Multiplicity may very well describe a state of emotional and imagistic flooding, a groundless place between the refusal of old constraints and the discovery of new possibilities for female identity that are not yet integrated into a coherent sense of self. The paranoid and voyeuristic gaze of MPD therapists did capture concealed currents of female desire. But these same therapists remained fatefully blind, like Oedipus, to the operations of their own concealed desires.

Different historical periods create a tendency toward particular defenses and disorders. Historical factors also shape the cultural narratives available to therapists in interpreting clinical material. By the late twentieth century, women had made significant advances in public life that permitted new avenues of identity formation. The multiple's vast cast of alters, whose purported psychic function was to "hold" trauma memories, suggests an emergent sense of female entitlement, on the one hand, and fragmentation and helplessness on the other.

The MPD movement also enacts broader cultural anxieties over sexuality and female rebellion, translating them through the moral authority of the sexual abuse recovery movement. Multiplicity may emerge, as many practitioners claim, out of the desperate, creative efforts of girls in attempting to escape the trauma of childhood sexual invasions. But the chronic demands and neglects girls and women endure in daily life, along with stunted opportunities, may also be experienced as a form of captivity, and these more mundane forms of bondage are more difficult to dramatize, less arousing of psychiatric intrigue.

Descent into Hell: Satanic Ritual Abuse as a Feminine Narrative

As therapists searched for hidden memories that would explain the increasingly debilitated states of women patients, horrific accounts of childhood torture emerged. The MPD

field was inundated with reports of a vast, intergenerational conspiracy of Satan-worshippers, engaged in ritual sacrifice of animals and babies, sexual torture, and celebration of the Black Mass.³⁶

Patients diagnosed as suffering from multiple personality disorder were a primary source of the growing number of satanic ritual abuse (SRA) stories that circulated in the 1980s and '90s. In the therapeutic uncovering of deeper layers of trauma memory, often under hypnosis, the personalities or alters that surfaced brought with them tales of sexual torture carried out in the basements of homes and churches of respectable members of their own communities. In the clinical literature, satanic ritual abuse is described as multi-generational, multi-perpetrator assaults on children. According to believers, these satanic cults were elaborately organized networks of adults who engage in cannibalism, ritual sacrifice of babies and animals, sexual torture of children, and parody of the Christian religion through the Black Mass. The primary aim of the Satanists, believers insisted, was a simple dedication to evil. Many clinicians spoke of how listening to such stories changed their worldview; how through the accounts of survivors they had seen the face of absolute, unredeemable corruption of the human spirit.³⁷ Beliefs in these conspiratorial, large-scale cults remained unwavering for many, in spite of the lack of material evidence to support such claims beyond the stories of "survivors."

As these stories become more graphic and elaborate, they often extended beyond the ritualized torture of children to include the "programming" of cult members that left them like walking time bombs. The emergence of the programming delusion, which was widely endorsed by clinicians in the trauma therapy field, spawned a new subcategory into the differential diagnosis of MPD: some alters were designated as reactions to childhood trauma whereas others were regarded as having been implanted by the Satanic cult for maintenance of control over the survivor into adulthood. A new typology emerged for the differential diagnosis of the disorder with the distinction between "reactive" and "structured" MPD.³⁸

Cult survivors suffering from structured MPD were thought to be programmed to commit suicide on particular dates or were implanted with cryptic cues that prompted self-mutilation, particularly when the victim sought help from a mental health professional. Generally, the triggers for these more malevolent alters to surface corresponded to particular dates that held significance for the cult, such as pagan holidays, or to idiosyncratic symbols, such as hidden messages deciphered from greeting cards. Much of the self-destructive behavior of MPD patients came to be understood as part of the labyrinthine programming of the cult. Vampire-like, the cult was believed to operate in the realm of the hidden, under the cloak of various disguises, dreading the redemptive light of mental health practitioners who were committed to unveiling their nefarious deeds.

These accounts seem hysterical at best and psychotically paranoid at worst. How, then, could otherwise sensible therapists and feminist crisis counselors become convinced of their literal truth? One contributing factor centered on the "culture of belief" fostered

by the trauma therapy movement—one that left no ground for interpreting primitive mental imagery other than as the register of trauma. Since one of the axiomatic principles in working with sexual abuse in the 1980s was to “validate” the memories of survivors and to combat the culture of “denial,” graphic reports of childhood torture found a receptive clinical audience.

Clinicians were governed by a kind of Pascal’s wager: it was better to err on the side of belief than of disbelief. Clinical literature was rife with warnings about the dangers of retraumatizing the patient by questioning the authenticity of their reports. Indeed, treatment protocols codified “believing the survivor” as an essential element of healing. The patient’s memory of trauma, too horrific to reveal to conventional practitioners, could only emerge in a therapeutic environment of absolute receptivity to the “unthinkable.”³⁹

This clinical mandate to “believe the victim” overlooked, however, the influence of translators on the scene. In their analysis of reports of satanic ritual abuse that emerged in dozens of day care centers throughout the United States in the 1980s, Debbie Nathan and Michael Snedeker conclude that these SRA stories did not originate with children themselves.⁴⁰ In a ventriloquial fashion, the children began to report sexual abuse after hours of intensive police interrogation, with their stories cascading over a period of months into grueling tales of killing and eating animals and babies, sacrificial ceremonies, and pornographic encounters with devil worshippers. In the McMartin case in Manhattan Beach, police investigators and therapists who conducted the investigation held prior beliefs in satanic practices and were seeking evidence in support of them. Nathan and Snedeker’s interpretation of the SRA accounts emphasizes the convergence of Christian beliefs, ambient cultural anxieties over public care of children, and rank opportunism on the part of investigators and clinicians.

The tendency in the debate over SRA, however, as in the recovered memory debate more generally, was to inscribe the boundary between truth and falsehood too definitively. Once recovered memories of satanic orgies, past lives, and other fantastical tales were debunked, critics often smugly turned away from their defeated opponents, declaring a decisive victory. Yet this is where the real work of psychology begins—at the threshold between the imaginary and the “real.” Dramatization plays an important role in storytelling, although its role in trauma narratives is decisively downplayed in the clinical literature.

While satanic ritual abuse accounts are patently irrational, they may contain a concealed story of actual abuses or terrors. But they also may be enlisted to dramatize more everyday conflicts and crises in female development.⁴¹ The SRA drama is, at base, a tale of female heroic transfiguration in the face of evil, yet it draws heavily on ideas of female chastity and childlike innocence. In surviving the ravages of the cult, the girl child is anointed with special powers. As psychoanalyst George Ganaway has pointed out, it is remarkable how many of the stories of the cult center on the female protagonist’s preparation or training for the high priesthood.

In *Suffer the Child*, a book heralded in the dissociation field as a landmark study in the links between MPD and satanic ritual abuse, Judith Spencer presents a labyrinthine tale of female virtue overtaken by sinister forces.⁴² Her patient, a thirty-four-year-old woman who had been previously diagnosed as schizophrenic, became the surrogate child of Spencer and her husband, who together devoted many hours a day to her care.

The patient, we learn early on, was raised by a fundamentalist Christian woman who was preoccupied with the devil. Devoutly religious yet prone to frequent moral lapses, particularly in her sexual behavior, this mother is relentlessly abusive of her daughter. Beatings and forced enemas emerge as part of childhood recollections, mixed with Bible readings centering on cleansing the body of the devil's influence.

Yet this more conventional history of religious and everyday abusiveness is sidelined by the central story. The chronic hardship of her childhood comes to life in the plot that vitalizes the book: it is the cult, the shadowy world of devil worshipers, that emerges as the fascinating, main protagonist in the drama. At the same time, this alternative scene permits a profound specialness for the woman patient, a sense of her place in a maniacal but purposeful cosmos. Indeed, the cult, we are told, had recognized the special powers of "Jenny," the assigned childhood name of this patient who multiplied into a plethora of selves.

Throughout the clinical story, virtue and cleanliness are symbolically equated, as the young blue-eyed virgin enters into her ordeal of ritual defilement. The cult makes her do unspeakable things, forcing the heroine to actively engage in profane acts that are orchestrated from on high. As events turn monstrously sinister, culminating in the protagonist's participation in the murder of a woman, the text takes on a pornographic quality:

The high priest caressed the woman's face and breasts. Then, concealing his actions, he injected her with a drug to sedate her further. He continued to explore her body with his hands, now exaggerating the moves for the benefit of the observers. He entered her first with the tip of the dagger, then with his hands. He prolonged the sensual play. He presented first a symbolic phallus, then his own for her to fondle and take into her mouth. She offered no resistance to these acts, nor to his final act of coupling. The people became increasingly aroused.⁴³

This clinical narrative has strong echoes of the nineteenth-century female gothic novel, which flourished in a similar period of gender instability and feminist resistance to domestic confinement. As a feminine narrative of resistance, the satanic abuse memory shares with the gothic novel a veiled attack on the patriarchal nuclear family. Pursued and overtaken by corrupt older men, the beleaguered heroine escapes her state of desperate captivity and emerges the moral victor. The SRA story registers a similar sense of invasive corruption, represented in the imagery of bodily contamination.⁴⁴

Blind to the tremendous generativity of the human mind—its capacity to elaborate on everyday misery and to dramatize mundane suffering—many therapists in the trauma field lapsed into their own form of dissociated reasoning. In disavowing everyday sources of female conflict over the body and sexuality, therapists in the SRA field operated blind to the pornographic substrate of these stories, as well as to how the clinical situation reproduced wider cultural demands on female storytellers.

. . .

Although women (and the oppressed in general) often hauntingly remember what the more powerful choose to forget, this same potent truth suffers a terrible fate if it is applied in overly concrete or unreflective ways. In the context of the women's movement of the 1970s, feminism meant confronting imaginary fears generated by patriarchy as well as resisting actual bodily assaults. Consciousness-raising meant coming to terms with the seductiveness of power and our own complicity with patriarchy, as well as exposing perpetrators and bringing them to justice.

As an alternative to the either/or positions offered by trauma therapists and their critics, this chapter recasts the terms under which we might approach questions of the believability of childhood memories. The trauma therapy movement did help women remember sexual violations from childhood. In breaking through the threshold of unresponsiveness to everyday female suffering, many women patients were responsive to the clinical call to give dramatic form to undisclosed grievances. But in casting the female psyche as a conduit for trauma memories, the rich complexity of female subjectivity and the creative side of remembering were cast aside.

In adjudicating memory claims, it is important to distinguish between situations where the factual veracity of the story matters and those situations where truth lies in the motifs and dramaturgy of the account. Feminists resisted evidence of fantasy at work in women's disturbing recollections because the woman is so often portrayed in patriarchal society as fantasy-prone and dependent on masculine reason to steady her. Yet feminist-informed approaches to psychology must incorporate the uncertainties of memory and the vital role of fantasy and imagination in mental life, with all of their potential for distortion as well as for creativity.

The recovered memory controversy also serves as a reminder of the dangers of zealous moral campaigns. New insights are inevitably accompanied by their corresponding blind spots, particularly if they are carried out with an excess of self-righteousness. A reflexive invocation to "believe the victim" overlooks the complex social choreography of victim accounts, including the role of various helpers on the scene who assist with the translation. Further, it is important to recognize how survivor stories are structured through what victims anticipate that listeners are prepared to hear.

As trauma therapists so rightfully brought to public attention, memory operates protectively and according to what consciousness is able to bear. In addition to traumatic experiences, female ambivalence over sexuality, aggression, and authority works its way into the complex narratives and registers of memory. Repression of female desire remains part of the psychic legacy of patriarchy, as does the history of sexual abuse and other violations. In areas of life rife with anxiety and emotional pain, recovering memory, whether individually or collectively, is inevitably shaped by individual and social defenses. One defense involves minimization, or defensive denial or disavowal of human cruelty. Reports of perpetrators and victims often include the defensive minimization of the extent of the abuse, although for different reasons. The perpetrator minimizes to escape moral responsibility, whereas the victim may do so for protection from the enormity of what has been suffered. The other defensive tendency, one neglected by trauma therapists, centers on magnifying perceived threats. Disturbing scenes from the past may be dramatized in order to evoke a response in the listener. Hunger, hopelessness, and work exhaustion, much of the chronic suffering produced by economic policies pursued throughout the globe, are less readily translated into the trauma narratives available to Western audiences. Many human problems in the modern world do exceed our capacities to conceptualize and emotionally contain them. And many also exceed the capacity of therapists to offer a cure. Preoccupation with secrets, trauma, or the extremes in human cruelty may operate as a manic defense against these more mundane and less readily articulated grievances.

Stories about the past may weave images from horror and gothic genres in capturing the magnitude of what has been suffered. Women patients and therapists who were haunted by subterranean alter personalities and scenes of ritualized abuse undoubtedly were ciphers for such broader social anxieties. But the gothic heroine in these stories also dramatizes a key source of ambivalence in the wake of second-wave feminism. In entering public life and breaking down barriers, women may find that the gothic narrative holds nostalgic appeal. One motif in the narrative concerns concealed feminine desires, with the mystery centered on what forms of female agency are concealed behind the veils of consciousness. Women, including many feminists, have historically made use of the notion of a female mystery to both invite and elude male intrusions into female spaces. Yet there were considerable costs in relying so heavily on the gothic narrative, particularly for those women patients who, like the innocent heroines in their recovered memories, were bound by the terms under which they could speak about suffering and desire.