Chapter 33

Creating sanctuary
Ritual abuse and complex post-traumatic stress disorder

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Names, identities and background details have been changed wherever necessary to protect confidentiality.

FROM PERSONAL EXPERIENCE

In 1980, two years after completing my psychiatric training, I was asked to see a young university student who had accused a man of raping her. The police had investigated the case, discovered that her accusations were false, and she was then referred for psychiatric treatment when she became anxious, depressed and suicidal, having recognised that her experience of reality was distorted. When I began treating her, I understood that she was suffering from a dissociative disorder, but I cannot say that I really knew what a dissociative disorder actually was, other than a weird constellation of neuritic symptoms, presumably expressing some covert sexual or aggressive conflict. I began seeing her in weekly psychodynamically-oriented psychotherapy, and I developed a strong therapeutic alliance with her. Gradually, she improved, and she appeared to develop insight into her behaviour, and then her functioning improved. Eventually, she successfully completed college and postgraduate studies.

By 1985, I had been running an in-patient unit in the general hospital of a middle-class, semi-rural community in America for five years. In this capacity, I had already been personally involved in hundreds of cases of the most severe variety. I received an emergency call from this same young woman in 1985 from another state to which she had moved. She requested in-patient hospitalisation after she once again became seriously depressed and suicidal. In no way was I prepared for the situation that greeted me when I entered her hospital room that day to perform the admission evaluation. There before me sat this woman that I thought I knew so well. And yet, it was not precisely her. Instead, this person had the mannerisms, the gestures, and the speech of a 5-year-old child. She gave her
phone number and address appropriate to that age, where she had lived eighteen years previously; and her mother confirmed the veracity of these domestic details.

I immediately grasped that I was in the presence of another 'personality', but I was profoundly shocked. I had trained at a time when multiple personality disorder was, at best, a rare and highly exotic phenomenon that I would never expect to see and, at worst, a figment of the imagination of some eccentric therapists. At the time, Dr Richard Kluft was on the faculty of my psychiatric training institution, but his work, although considered interesting, was also regarded with much suspicion, since he had begun to claim that the syndrome of multiple personality disorder was anything but rare.

I found myself totally unprepared with a plan as to how to address this clinical situation. Fortunately for both me and for my patient, her trust in me was well-established, and the child alter quickly revealed the history of paternal incest and sadism, a history later corroborated by other family members, information that had lain hidden for so long. I realised that I had in fact communicated many times before with this alter, usually over the telephone, blithely unaware that I was conferring with anyone other than my patient in a seemingly 'regressed' state. I had never discovered, because I had never asked, that there was an absence of continuity of memory between the adult self and the alter personality, and that, in fact, my adult patient had little or no recall of our previous telephone contacts. When I finally grasped the situation, many hitherto confusing aspects of this case became clear for both the patient and for myself. Using traditional and non-traditional forms of intervention, including videotaping the child alter for the adult self to 'meet', the two selves became integrated and they have remained so ever since.

Certainly, I was pleased with the outcome of this case, but like so many of my colleagues with similar experiences, I was devastated by the apparent huge gap in my body of knowledge, and by the emotional demands placed upon me to grasp the reality of horrendous childhood maltreatment. The gap became an increasingly huge one as I began asking more pointed questions, and began receiving confirmatory responses about the abusive childhood experiences of other patients, many of whom I or members of my treatment team knew well, and who confirmed with great relief that they had been hoping someone would ask them for a long time. More startling and unexpected was the often rapid and dramatic improvement that these patients made once their horrific experiences had been validated and understood.

The pain I finally allowed myself to see in the lives of my patients made it morally necessary that I ask myself several discomfiting questions. How could my psychiatric knowledge be so woefully lacking that I could have missed understanding dissociation and its origins in traumatic experience for so long? How could I have had so little knowledge about the real events of childhood? And even when I knew about the realities of childhood, why had this information played so small a role in treatment formulation? How could it be that, within
apparently respectable, financially secure and loving homes, so many children could be undergoing such experiences of torture, torment and neglect? How was I to cope with the overwhelming demands made upon my empathic capacities, in order to provide the necessary empathy so that validation and not denial could be my therapeutic stance? And most importantly, perhaps, what kind of world do we really live in when the modus operandi of the death camps and totalitarian regimes applies equally well to the well-heeled, Western, nuclear family? What is wrong with us?

Thankfully, at about this time, researchers and clinicians from around the world were beginning to share information gained from various traumatised groups about the biopsychosocial and moral implications of trauma. It became clear that there is a universal human response to trauma regardless of the particular traumatic experience, a response that has become known as post-traumatic stress disorder (PTSD). As data on PTSD has continued to accumulate, a new and meaningful cognitive framework has evolved and coalesced, with major implications for theoretical formulation, diagnosis and treatment, as well as forming the basis for major social policy change (Herman, 1981, 1992; Figley, 1985, 1986; Van der Kolk, 1987; Courtois, 1988).

It is within this context of experience that my comments on ritual abuse survivors must be understood. Ten years ago, if a patient had come to me and told me that he or she had been sexually and physically abused in a satanic cult, and that this person had been forced to engage in the most degrading of acts, participating in the sacrifice and cannibalism of infants and adults, I would probably have diagnosed such a patient as suffering from some form of paranoid disorder, and I would have tried anti-psychotic medications in order to treat the delusions. I would have labelled such dissociative experiences as psychotic. I would have found any excuse to get such patients out of my practice and out of my life. I could not bear to believe that such things could be possible. But now I recognise that there is a very long continuum of human pain and human possibility.

We now specialise in the treatment of adults who have been abused as children. Our treatment context is a 22-bed in-patient unit called 'The Sanctuary', located in a private psychiatric hospital in suburban Philadelphia. The name derives from a reference made in one of the early books on trauma by the psychologist Steven Silver referring to 'sanctuary trauma', that experience which Vietnam veterans suffered when they returned from the war and sought refuge within Veterans Administration institutions, only to find these institutions to be further traumatising (Figley, 1986). Struck by the concept, we began reflecting on how many psychiatric patients have been retraumatised within psychiatric institutions themselves, and we began to have a dialogue about the necessary components of a system that would not create that kind of traumatic experience, but rather one which would instead provide an environment within which true healing could be promoted. The result is the 'Sanctuary Model' of in-patient treatment (cf. Bloom, in press a, b).
We treat patients who present with many different psychiatric syndromes, including multiple personality disorder (MPD). Patients suffering from MPD comprise about 20–25 per cent of our in-patient population, and about one-quarter of those claim to have been ritually abused. Although the ritually abused patients have certain distinguishing characteristics in their presentation, which will be discussed later, in the main, they differ little from other patients who suffer from severe and complex post-traumatic syndromes.

ASPECTS OF TREATMENT

One of the difficulties in treatment concerns the dangers when these patients seek help from poorly trained therapists. Adults who have been abused as children often present with a complex array of symptoms that have been unresponsive to other interventions. One beginner therapist error would be an adherence to the naive belief that abreaction alone will cure the person. Abreaction can be effective for a single traumatic event in adulthood; however, people abused in childhood suffer not only from PTSD, but also from severe developmental problems as a result of the abuse and the chronic PTSD symptoms. Abreaction is only a relatively minor part of the recovery process.

Another beginner error is the use of splitting, believing that the patient is unequivocally good, and that the parents or perpetrators are unequivocally bad, and that the solution to the patient’s problem is simply a 'parentectomy'. People who have been abused as children have had a serious insult to their attachment systems, and it is possible to do even further damage by creating yet another bind for the patient over divided loyalties. Because of traumatic re-enactment, the patient will often unconsciously set up therapists to do exactly that, so that they do not have to work through or contain their own ambiguity or ambivalence about their families of origin. Trauma leads to increased, not decreased, attachment difficulties; and separation under these circumstances is an enormous undertaking, certainly not a 'simple solution'. The decision about how to interact with the perpetrator must reside with the patient, not with the therapist, and this may be a process which takes many years to negotiate successfully, and to resolve.

Another typical novice error would be to become an unwitting part of the patient’s re-enactment of trauma, and to believe that it is possible to re-parent the patient and hence undo the damage of the abuse. Recovery can only work if the survivors can learn to re-parent themselves. Premature confrontation can do more harm than good, as Christine Courtois (1988) has cogently pointed out in her excellent book on the healing of the incest wound.

In treating suspected survivors of ritual and satanic abuse, as well as survivors of complex post-traumatic stress disorders, the most important starting-point is the provision of a safe environment. We agree with Dr Judith Lewis Herman (1992) that the establishment of safety is the first stage in all the treatment regimens. This includes biological safety, psychological safety, social safety and
moral safety. Safety is a particularly difficult issue for the ritual abuse survivor who has often had few real experiences with safety outside of the confines of the decidedly unsafe cult system. Firm treatment contracts must be agreed upon that limit the self-damage of the patient, so that the therapist too can feel safe with the patient. An unwillingness to engage in such a contract bodes ill for the success of the treatment. Clinicians are advised to evaluate their treatment plan with great care, and to obtain close supervision.

In our work at The Sanctuary, we have been struck by the way in which even seemingly trivial details can make patients feel extremely unsafe and terrified. For example, most therapeutic groups occur with patients sitting in a circular arrangement of chairs. This has been the established model of group treatment for nearly one whole century. But unlike other patients, the cult survivors cannot tolerate being in a circle, a situation which almost immediately triggers dissociation, since many of them had undergone experiences of profound abuse in a circular cult gathering. This is particularly the case when music groups occur on the ward, which can sometimes trigger memories of ritual chanting in the satanist cults. The patients do not become exhibitionistic within the group setting; instead they find it intolerable and they make efforts to withdraw and isolate.

In the general milieu, there are also characteristic forms of re-enactment behaviour that occur. Our staff team has also noticed the profound tendency for cult abusers to band together rapidly in order to form a mini-cult which then isolates this subgroup from the general community and excludes others. These patients will often articulate the thought that no-one else can understand them, developing a certain kind of elite atmosphere that forces a split in the community, and then sets these patients up for experiences of rejection.

Also noticeable is the preoccupation with 'triggers', once the cult abuse has been admitted. Virtually anything can serve as a trigger for flashbacks, including certain articles of jewellery, paintings on the wall, holiday decorations; in fact, almost anything that contains a highly charged symbol. This is particularly problematical since many of the triggering symbols are inherent in every single cultural context, such as triangles, circles, stars, moons, etc. Triggers for dissociation that are apparent in everyday surroundings are quite typical for all forms of childhood abuse victims. What distinguishes the ritual abuse survivor from the others is this patient's insistence that the environment remove the triggers rather than recognise that they need to become desensitised to the triggers. This angry insistence, when it occurs, can be seen as a re-enacting tendency on the part of the survivor to exert power and control over the environment, reminiscent of the way power and control was exerted over them. The treatment team needs to be sensitive to the patient's need to alter and master the vicissitudes of the treatment environment, without succumbing to the temptation of being controlled by the patient, thus unwittingly playing a role in a re-enactment.

Once one has provided the right sanctuary environment for patients, then one can progress to the next two stages outlined in Herman's (1992) very clear and carefully considered model. The next stages in the process are remembering and
grieving, and then establishing a reconnection with ordinary life. The stage of 'rememberance and grieving' focuses on the reconstruction of memory and the metabolism of the attendant affect. The purpose of this stage is to tell the story, to transform the horrific imagery and repetitive re-experiencing of the trauma into a cohesive narrative, attached to previously dissociated affect, that can then become a part of a true memory rather than a living reality. This is an extremely difficult stage for the ritual abuse survivor to negotiate. It requires the establishment of a safe attachment to other people when attachments within their experience have been consistently traumatizing and dangerous. Within the context of such a relationship, the patient must learn 'affective re-education', meaning that the severe deficits in affect management must be corrected.

In the final stage of reconnecting with ordinary life, this is often rather difficult for survivors who have never had anything which approximates an ordinary life in the first place. These patients have never experienced a sense of ease with other human beings, and they have little if any sense of humour. Their thinking is often magical and concrete, particularly in the early stages of recovery, and they lack the capacity for self-soothing in other than the most primitive and often destructive of ways. But with carefully considered and monitored in-patient containment, it is possible to plant the seeds of an alternative way of living and being, one which patients can gradually begin to internalise.

Although there are specific techniques and skills that are being developed to deal with the population of abuse victims, more important than any particular technique is the understanding of how to establish a context, a sanctuary, in which new therapeutic options and skills can be developed.

It has become increasingly clear that we have reached the limits of usefulness of the individual model of treatment. This is not a realisation unique to the mental health field. The limits of our current models of thinking about clinical problems and about world problems become increasingly obvious when faced with the extreme traumatic degradation of global, economic, ecological and social systems. We need a new paradigm within which we can develop innovative methodologies that enable us to address critical problems that affect both individuals and groups. The concepts of treatment that are evolving within 'The Sanctuary' are rudimentary steps towards the development of the orchestra as a whole. The instruments can be damaged and in need of repair, or perhaps they can be just simply out of tune. The musicians, as well as the conductor, can be ill, out of sorts, unpractised or inadequately trained. Even if the instruments, the musicians and the conductor are all functioning properly, the orchestra requires the musical direction of the composer, a proper acoustical setting and a culture within which the making of music is appreciated and welcomed. Harmony is only achieved when all of the components successfully interact with and play off of each other.

It is vitally important that the world of psychiatric knowledge be reconnected to and utilised by the world in general. Our work with victims of the most extreme forms of trauma serves as a social laboratory for necessary social change, as well as serving as a reminder of the need for improvements in our
clinical repertoire, particularly in view of the fact that the mental health profession has failed these patients for years, through our ignorance and blindness. But the pain that our patients have suffered as children and as adults is not in vain if from their pain, and from their attempts at self-healing, we can learn some vital lessons about healing the world within which we all live.

Rejected by mankind, the condemned do not go so far as to reject it in turn. Their faith in history remains unshaken, and one may well wonder why. They do not despair. The proof: they persist in surviving – not only to survive, but to testify.

The victims elect to become witnesses. (Elie Wiesel)

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REFERENCES


