

THE ADDICTIVE NATURE OF PERPETRATORS OF RITUAL ABUSE

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THE ADDICTIVE NATURE OF PERPETRATORS OF RITUAL ABUSE

The premise of this paper is that perpetrators of intergenerational ritual abuse are addicted to negatively exciting behaviors and substances which serve to mask primitive feelings of horror and fear. These feelings result from emotional scarring in their own childhood, usually by their family of origin or the cult in which they were raised. Consequently, they have wounded and dissociated selves who are horrified by the early experience and must be protected.

Bass (1990) has noted that sexual abuse is related to many forms of addiction. Putnam, Guroff, Silberman, Barban & Post (1986), in reviewing 100 cases of multiple personality disorder, reported that in the families of origin 21 percent of fathers and 8 percent of mothers of multiples had a history of alcohol abuse. This is important because many survivors of ritual abuse are also multiple personalities.

Perpetrators need to manage their inner turmoil all of the time. Periodic involvement in ceremonial activities serves only to deaden buried feelings for short periods. As soon as these activities are over, they need to re-engage in additional addictive and dissociative patterns in order to avoid being overwhelmed by feelings of panic and despair.

Cults are social institutions which perpetuate intergenerational post-traumatic stress disorder (PTSD). Both perpetrators and victims are suffering from the effects of trauma and both must dissociate using addictive processes in order to protect the inner selves who are horrified by the dehumanizing experiences they have endured. What is actually taught in intergenerational cults is to live with PTSD through denial.

PTSD and the Loss of Ontological Security

In an earlier paper (Smith, 1987), I looked at post-traumatic stress as the evidence of the loss of ontological security. I believe that the stress in PTSD is the tension of suppressing the unresolved feelings of mourning and grief following the loss of ontological security. Laing (1969) defined ontological insecurity as a progressive disintegration of the self that leads to an endpoint of chaotic non-entity, a complete sense of

disconnection of self and other. This collapse of the self-system parallels the progressive deterioration found in neurogenic shock.

Chaotic non-entity is perceived by the traumatized child as near disintegration and an impending annihilation. During trauma, the function of the neo-cortex is disrupted so that perception, evaluation and response become impaired. Motor co-ordination may be affected. The circulatory system no longer functions and the vascular system collapses. This descent through numbness, shock, unconsciousness and near death replicates Laing's endpoint of chaotic non-entity.

Cycle of Trauma and Shock

Dysfunctional families can engender a cycle of trauma and shock in their children. Trauma causes an optimal arousal of the sympathetic nervous system with a consequent release of adrenaline (Mason, Giller, Kosten & Wahb, 1990 and Hollingsworth, 1973). However, optimal arousal can only go on for so long before a rapid and precipitous reversal takes place and the recipient of trauma goes into a state of shock. Cults habitually engage in traumatizing activities which brutalize children and commence this cycle of trauma and shock (Ritual Abuse, 1989). Once habituated to this cycle, children continue this extreme level of arousal and sedation by remaining in violent situations and abusing substances to parallel the cycle of trauma and shock.

A central source of trauma and conflict which necessitates denial through dissociation and addiction is that cult members must be socialized into two ideologies. In order to pass in the larger culture, they must learn the stated value system of that society and how to behave according to those standards. At the same time, they are socialized into a group whose values include the torture and sacrifice of children. These children live in enormous conflict since they are aware that their behavior within the cult opposes the stated value system of the larger culture. They are similar to undercover spies who need to protect their true identities in both the cult and the greater society. Those who remain in the cult long enough to become perpetrators themselves still hold the conflict they learned as children and have a greater need to dissociate.

Misguided Pain Management

In an attempt to soothe their pain and comfort their inner children, perpetrators are caught in a cycle of misguided pain management. As soon as memories or feelings begin to emerge, perpetrators must re-engage in negative excitation and numb themselves through various addictions. For the purposes of this paper, addiction is defined as physical and emotional dependence on an exogenous or endogenous substance. One aspect of misguided pain management is a sense of reassurance which comes from being included in the cult. This gives a sense of belonging and esteem which combines with the painkilling effect of addictions.

Power and Control in Perpetrators

Much is made of perpetrators' drive for power -- the ability to cast spells, call forth demons and to commune with spirits. It is usually thought of in terms of the power they exert over their victims. In reality it seems to be the power to control their various security operations, or rituals of security, with which they kill their pain. Children become objects of addiction which are manipulated by the perpetrators to receive their addictive payoff. In effect, perpetrators are addicted to the negative excitement of power -- bullying, terrorizing and intimidating small children.

Roles

At a certain point, children in a cult identify primarily with the role of a sadist or of a masochist (victim). Those who identify with the victim role must force themselves to be non-protesters in order not to enrage those who identify with and take on the role of perpetrator. Victims are reduced to objects of addiction to be manipulated in a way that feeds the negative excitement of the remaining cult members and continues their addiction.

Those who remain in the cult and become perpetrators switch from receiving trauma to the satisfaction of giving trauma while performing the role of a sadist. Their continuation in sadism increases their addiction to violence and negative excitement. However, they are caught in a conflict since the PTSD of their inner selves who were once victims

is restimulated and they inflict harm on themselves in the act of harming others.

Cult members who have passed into the role of perpetrator are co-dependent (Beattie, 1987) with each other. They mutually support the security operations or rituals of addiction in order collectively to manage the pain in the members of the cult.

Those who identify with the victim role have their own problems in that despite their wish to reject cult membership, they have internalized the values of the perpetrators. Young children so socialized internalize the addictive/dissociative patterns used in the cult and thus have their own difficulties in breaking free of these introjected patterns.

Addiction and Dissociation

It is important to understand the relationship between addiction and dissociation. Addiction and dissociation combine together to function as a denial system against ontological insecurity that prevents a re-encounter with the experience of near disintegration or annihilation.

People who have been traumatized cannot afford to forget what they are terrified of remembering. The early memories of trauma represent how they view the world and must remain as reminders of what to fear and what to avoid in order to maintain some degree of ontological security.

Dissociation is usually thought of as a cognitive process. However, it is the complete traumatic experience that needs to be blocked: cognitive, affective and physical manifestations. Functional dissociation is rarely a sufficient defense mechanism against the re-experiencing of ontological insecurity because of the physical and affective components. To increase the effectiveness of the denial system, the person must use exogenous and endogenous substances.

Any substance that reduces anxiety or increases security can become an addiction. For perpetrators of cultic abuse, upset and chaos have become familiar and serve to reduce anxiety brought about by the intrusion of early memories of trauma.

Purely functional dissociation uses nonattention as a dissociational strategy. This includes suppression, amnesia and self-hypnosis. Functionally-induced dissociation uses phobias, obsessions, dreams and taboos to stimulate the release of and maintain the addiction to adrenaline and endorphins (van der Kolk, Greenberg, Boyd & Krystal, 1985). These substances arouse, sedate and anesthetize, thus continuing the dissociation of cognitive, affective and physical manifestations of trauma.

Addictions to exogenous substances such as alcohol, nicotine, caffeine, and sugar function to keep people above and below the feeling zone (Janov, 1980) and dissociated from awareness of the various components of trauma.

Cognitive memories and their attendant feelings exist as a whole. If traumatic memory threatens to break through into conscious awareness, related feelings also become evident. Conversely, if feelings threaten to push past the threshold of awareness, they will bring memory triggers into consciousness. Thus, dissociation and addiction work together to prevent any elements representative of early trauma from coming into conscious awareness.

Survivors of ritual abuse relate that their perpetrators used many addictions including exogenous substances and negatively exciting behaviors and thoughts which lead to the release of endogenous substances. In the category of endogenous substances are: gambling, workaholicism, sports, TV and radio, excessively loud music, cannibalism, religion, torture and violence, degradation and humiliation, weapons, obsessions, phobias, dreams, taboos, and sexual addictions which include sadism, necrophilia, fellatio, cunnilingus, sodomy, pornography, masochism, bestiality, prostitution, urinating and defecating on people, rape, incest and fetishes.

The category of exogenous substances includes alcohol, food, legal and illegal drugs, nicotine and caffeine. Alcoholism in particular seems to be cited most often by researchers as a component of ritual abuse. It is a profound disinhibitor of the central nervous system which allows violence to be easily expressed and then becomes an equally profound sedative which is used to forget the events which have just taken place.

Functional dissociation and addiction are combined to create an idiosyncratic arrangement which mixes the various possibilities into a personal ritual of security (Smith, 1987).

Addiction and the Problem of Good and Evil

Since so much emphasis is put on good and evil in considering ritual abuse, it is important to harmonize the religious and psychological perspectives. The psychological and religious are not that far apart if you consider the actions of perpetrators as addiction to sinful behavior (negative excitement). Sinful behavior may be defined as behavior that is self or other destructive. This conceptualization can allow religiously oriented counselors to maintain their focus on good and evil while addressing the addictive nature of their clients.

Neophobia

A basic problem in ending dissociative addictions is neophobia (Mitchell, Osborne & O'Boyle, 1985 and Smith, 1987). Traumatized people fear new behavior. They no longer use pleasure and pain as their primary reinforcers. They revert instead to a more primitive form of anhedonic behavior in which novelty and familiarity govern activity. Familiar defensive behavior, no matter how destructive, is equated with continued existence. Novelty or new behaviors, on the other hand, could lead to the collapse of the defensive system resulting in chaos and the fear of annihilation.

Implications for Treatment

The importance of the addiction model should not be underestimated. Millions of people use addictions to cover their pain. It is not surprising that extreme elements in society, such as ritual abusers, also employ addictions. The end goal of therapy in intergenerational PTSD is to radically reduce the level of systemic tension and maintain this new equilibrium by re-establishing an internal locus of control such that clients understand that they can deal with pain without resorting to misguided pain management.

Removal of the addictions must be done very carefully with the full understanding that they are an intrinsic part of an elaborate defense mechanism. Too abrupt cessation of endogenous or exogenous addiction could lead to flooding and a premature abreaction of suppressed material which then could not be fully integrated.

Given the secretive nature of ritual abusers, active perpetrators will rarely present themselves for therapy. However, understanding the addictive nature of perpetrators is valuable in treating the perpetrator introjects or satanic alters of survivors who are in treatment and clients who are trying to break away from the cult but who periodically return to cultic activity. Those in therapy employ the same addictive/dissociative techniques as their perpetrators. Both use a combination of functional dissociation and exogenous/endogenous addiction to deny their experience of trauma.

Proper pain management and recovery require that both current and former cult members stop the ritualized addictive behavior, end their dissociative denial of trauma, and process their inner pain.

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