ICSA Annual Conference Washington DC 4th July 2014

The Unique Characteristics of Post Cult PTSD (Post Traumatic Stress Disorder) and Suggested Therapeutic Approaches

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Purpose:

- This presentation asserts that Post cult PTSD is a unique form of complex PTSD and, with this knowledge incorporated with understandings in neuroscience, to recommend appropriate therapeutic interventions.

Content

- Define complex PTSD.
- Using Herman's model, present the unique characteristics of post-cult PTSD.
- Add to the understanding of post- cult PTSD, using recent developments in neuroscience.
- Discuss the implications of these knowledges for therapy and recommend appropriate therapeutic interventions.

Definition of Complex PTSD

- Multiple traumatic events; frequently involving coercion.
- Examples: POW, Domestic Violence, Cults, Child sexual abuse.
- Incorporates multiple incidents of *hyperarousal* (emotionally aroused, easily startled – "flight or fight")
- And multiple incidents of *hypoarousal* ("freeze", submission)

Herman's Model

Three distinct symptoms of complex PTSD:

1. Hyperarousal
2. Intrusion
3. Constriction

Note: Each of these three incorporate symptoms which are both ***psychologic*** (*relating to the mind or mental phenomena*) and ***somatoform*** (*physical symptoms without physical cause*)

The First of Herman's Symptoms: Hyperarousal

- **Hyperarousal**: A combination of phobias and generalised anxiety
- Experienced physiologically as an increased "startle response" to *general* stimuli
- Also experienced as an intense response to stimuli *related to the traumatic event(s)*
- Includes hypervigilance – "*an elevated baseline of arousal: their bodies are always on the alert to danger*"(McFall et al)

Uniqueness of Cult Induced *Hyper*arousal

- Cult members are consistently maintained in a *highly structured* state of *hyper*arousal via, e.g., Bateson's double bind:

  "if you're not getting this, it's not because my (the cult leaders) dogma is wrong, its because you are just not trying hard enough"

- Public confessions by cult members
- Poorly defined and ever changing boundaries
- Accompanied by sleep and food deprivation

… and many other *structured practices*.

Uniqueness of Cult Induced *Hypo*arousal

- Cult members are *also* consistently held in a *highly structured* state of *hypo*arousal through extensive sessions of meditation, chanting and hypnotic guided sessions.
- Many phobias are *deliberately installed* by the cult leader(s) during these vulnerable altered states (Hassan)
- Consistent repetition of these phobic threats
- Phobias frequently relate to catastrophic events if the person leaves the cult
- Also frequently directed at vulnerabilities uncovered during public confession sessions

The Second of Hermans Symptoms: Intrusion

- The experience of the traumatic event as though it were continually recurring in the present.
- Set off by "triggers"
- Experienced as "flashbacks" during waking states or "traumatic nightmares" while asleep

Uniqueness of Post-cult Intrusion

- Post cult nightmares are different: "distinctly themes of death, dying, violence and/or loss, helplessness" (Whitsett)
- An extensive range of "triggers": sights, sounds, smells, tastes, sensations, emotions (Lalich & Tobias)
- Phobic avoidance of triggers: a phobic response to the whole idea of triggers themselves ("the fear of the fear") (Whitsett)

The Third of Herman's Symptoms: Constriction

Differing terminology to describe this phenomenon:

- Constriction and numbing (Herman)
- Floating (Lalich & Tobias)
- Dissociation (Lifton, Martin et al, Singer)
- Splitting (Lifton)

Similar to primitive "freeze" states, submission, limb passivity.

Other Characteristics of Constriction

- Similar to hypnotic states
- Surrender of voluntary action
- Suspension of initiative and critical judgement
- Subjective detachment or calm
- Enhanced perception of imagery
- Detachment from your body ("depersonalisation")
- The world seems unreal ("derealisation")
- "A change in the sense of time"
  (Herman)
- Motor weakness – paralysis, ataxia, numbing
  (Ogden et al)

Uniqueness of Post Cult Constriction

- "People who go into a *dissociative state* at the *time of the traumatic incident* are among those most likely to develop long-lasting PTSD"(Cardena & Speigel)

- As a result of participation in extensive periods of *hypo*arousal (meditation, chanting, hypnotic guided sessions, food & sleep deprivation), cult members have *greater predisposition* to dissociation, leading to an increased likelihood of long-lasting PTSD (Lalich & Tobias)

Uniqueness of Post-cult Constriction (contd)

Also the unique post cult symptom of "floating" between pre-cult and post cult identities/personalities has been noted by multiple authors:

"doubling" , "false self", "adaptation", "pseudo-personality", "altered persona", "double self", "new identity", "surrender their identity", "cult pseudo personality"; "someone being inside me"

Constriction:

"*Traumatised people suffer damage to the basic structures of self. They lose trust in themselves, in other people, and in God. Their self-esteem is assaulted by experiences of humiliation, guilt and helplessness. Their capacity for intimacy is compromised by intense and contradictory feelings of need and fear. The identity they have formed prior to the trauma is irrevocably destroyed*."
(Herman)

… Summary so far

- Defined complex PTSD
- Used Hermans model to identify symptoms of complex PTSD
- Identified the unique characteristics of cult induced, post cult complex PTSD, manifested as both *psychologic* and *samatoform* symptoms
- Next, explore neuroscience understandings to extend our knowledge of symptoms and effects of post cult complex PTSD
- From this, make recommendations for appropriate therapeutic interventions

Neuroscience: Background

Simplistically,
The brain structured into three "hierarchically" organised areas :

1. Reptilian

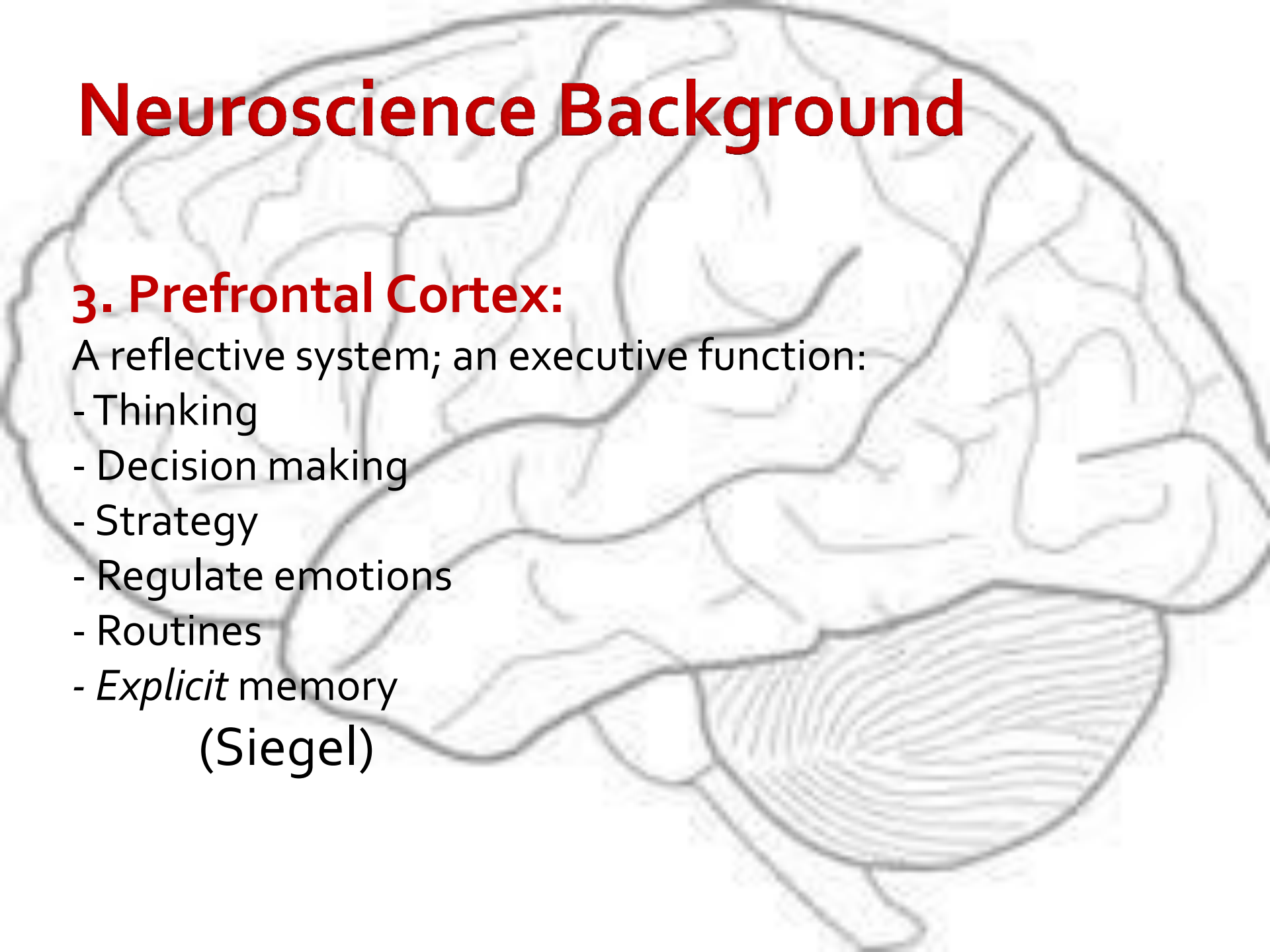
- eat, sleep and sex

2. Limbic

- flight, fight, freeze
- emotional, relationships, automatic processes, and habits
- *Implicit* memory centre

(Siegel)

Neuroscience Background



3. Prefrontal Cortex:

A reflective system; an executive function:

- Thinking
- Decision making
- Strategy
- Regulate emotions
- Routines
- *Explicit* memory

(Siegel)

Hierarchic organisation – "top down" and "bottom-up" processing

- Top-down

  Pre- frontal cortex executes a veto power over limbic responses ("Emotional Intelligence"/ affect regulation)

- Bottom-up and "bottom-up hijacking"

  In the context of complex trauma, emotions and sensorimotor reactions *disorganise* the pre-frontal cortex

Use of "fuel"

- Limbic brain: neurochemicals – adrenaline: comprising Epinephrine (fast acting and short lasting) and Cortisol (slower to increase and stays longer) (Whitsett)
- Pre- frontal cortex: multiple "fuels" but dopamine is a major one and is a "gas guzzler"(Langley)
- Cortisol blocks pre frontal functioning
- Also, if limbic brain predominating, e.g., under extended periods of both *hyperarousal* and *hypoarousal*, long recovery time for pre frontal cortex.(Gordon). Cortisol staying longer
- Potential for functioning in limbic brain to become habitual
- And difficulty "recalibrating" autonomic arousal: the return to baseline (Ogden et al)

Neuroscience and Memory Systems

Implicit memory : "riding a bike"

- is not conscious, focused attention
- no sensation of recalling from past
- does not involve the pre frontal cortex

Explicit memory: "recalling the first time you rode a bike"

- does require focused attention
- invokes the pre frontal cortex
- integrates elements of our experience into factual or autobiographical representations; creates the narrative

Memory Systems and "Triggers"

- Triggers are a flooding of "*implicit only*" memory activation
- The pre frontal cortex is not involved: cortisol is inhibiting it
- "Top down" regulation is lost; "meaning making" is inhibited
- Experienced not as memories of the past, but being experienced in the present
- With little, if any, *explicit* awareness of these original traumatic incident(s)

> "*Operating in either hyper-aroused (too much activation) or hypo-aroused states (too little activation) means information cannot be effectively processed"* (van der Kolk et al)

Memory Systems and "Triggers" (cont'd)

- And, the limbic brain's activation of adrenaline *further reinforces* the neural wiring established with the original traumatic incident(s) ("what fires together, wires together")
- Risk of becoming an ***habit***ual response
- Becoming increasingly more vulnerable to progressively minor triggers (Post et al)
- Lose somatic connection to present reality
- "Speech centre" (Broca's Area) shuts down
- and reinforces the "phobic avoidance of triggers"

Checkpoint … so far

- Reviewed Complex PTSD
- Considered unique characteristics of Post Cult complex PTSD
- Reviewed developments in Neuroscience
- Next, discuss the effects on how former cult members present in therapy
- Make recommendations re appropriate therapeutic interventions

How some former cult members "present" in therapy

- Loss of sense of safety
- Been abused (psychologically, sexually , physically) by people in positions of power
- Have a predisposition to be influenced by authority figures
- Highly reactive to a wide range of triggers with phobic avoidance of triggers
- Readily dissociate
- Float between pre-, in- cult and post cult personality
- Hypervigilant

How some former cult members "present" in therapy (cont'd)

- Disempowered
- Lack of critical thinking – prefrontal cortex "muscle" has "atrophied"
- Similarly, unable to make decisions.
- Operating from implicit memory
- Predisposed for "speech centre" to shutdown
- Frequently in limbic state with limbic "muscle" overused
- Can display motor symptoms of numbness, paralysis and ataxia.

"Avoid at all costs"

- Not hypnosis: re-traumatise
- Not meditation: re-traumatise
- Diagnosis : disempowering
- Decision-making on their behalf : disempowering
- Acting as authority figure: triggering and disempowering
- Ignoring power imbalance: re- traumatise

Cautions for Therapists

- Recognise potential for multiple triggers in what are normally safe environments (Herman)
- Exposure to episodes of past trauma can exacerbate rather than resolve symptoms (Ogden et al; White) including re-experiencing of distressing somatoform symptoms (Ogden et al)
- Consequence: Highly likely to drop out of exposure therapy (Ogden et al)

Implications for Therapists

- When operating in limbic state: ("flight fight freeze") is not possible to connect with another person… *Running away from*!
- Means they can't be "open enough" to hear therapists words accurately.
- Also "speech centre" may be impaired
- This makes it difficult for "talking therapies" to be effective initially.

> "*Talk therapy tends to address the explicit, verbally accessible components of trauma. They emphasise the role of narrative, emotional expression and meaning making, none of which is readily available to a person operating essentially in the limbic state*" (Ogden et al)

Recommended Path

- A "bottom up" approach with sensorimotor psychotherapy using bodily experience as the primary entry point (Ogden et al)
- Working in a state of "optimal arousal"- the "window of tolerance" between the extreme physiological states of *hyper* and *hypo*arousal (Siegel) "in which the individual can experience psychophysiologic arousal as tolerable" (Ogden et al)
- "*by keeping the treatment focused on the patient's here and now somatic experience in the session (by mindfully noticing the trauma as it manifests in changes in heart rate, breathing and muscle tone)the individual is encouraged to experience being "here now" while acknowledging the "there and then" of traumatic experience".* (Ogden et al)
- An Integrated approach with "talking therapies" – "top down", incorporating psycho-education and addressing the narrative/ "meaning making" elements.

Conclusions

- Cult induced PTSD is a unique form of complex PTSD.
- A key element of this is the *highly structured* practice of maintaining cult members in states of both Hyper and Hypo-arousal.
- The consequences of this are a predisposition to function in the limbic state accompanied by an "atrophy of the prefrontal cortex muscle". There is a risk of this becoming a "hard wired" habit.
- The implication of this is that "talk therapies" that relate to the cognitive state of the prefrontal cortex are *initially* ineffective.

Conclusions

- It is therefore recommended that the entry point of therapeutic interventions for former cult members is initially sensorimotor therapy subsequently integrated with “talk therapies”
- It is also highly recommended that further study be conducted into the effectiveness of therapeutic modalities and methods for former cult members.