

SADISTIC ABUSE:  
DEFINITION,  
RECOGNITION,  
AND TREATMENT

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### ABSTRACT

*The term "sadistic abuse" is proposed to designate extreme, adverse experiences which include sadistic sexual and physical abuse, acts of torture, over-control, and terrorization, induction into violence, ritual involvements, and malevolent emotional abuse. Individuals with these extreme childhood histories may present with severe and multiple symptoms and a prolonged complicated treatment course. Adherence to basic principles of trauma-based treatment is recommended as is reference to relevant databases which include not only those materials concerning severe child abuse and family violence, but also literatures describing torture, the holocaust, prostitution, pornography and sex rings, cult abuse, and sadistic criminals.*

### INTRODUCTION

This review proposes the term "sadistic abuse" to describe severe abuse, often occurring in childhood, that may include torture, confinement, extreme threat and domination, overlapping physical and sexual abuse, and multiple victim or multiple perpetrator patterns of abuse. The term focuses on the presence of sadistic behaviors, exhaustively catalogued in the works of the Marquis de Sade (1789/1987). Its use does not require a diagnosable sadistic paraphilia in the perpetrator. Krafft-Ebing (1894/1965), who coined the term in the Nineteenth Century, held that all human beings have potential to engage in sadistic acts. Focus on the presence of extreme abusive behaviors allows systematic data collection about such behaviors without attributing a motivational system as the term "ritual abuse" tends to do. It facilitates understanding of these cases as part of a spectrum of child abuse accounts that include mild and moderate cases as well as these more extreme situations. It allows us to test the hypothesis that more severe child abuse will be correlated with more severe sequelae.

#### *The Reluctant Discovery of Sadistic Abuse*

The need to name and define this construct has arisen in the last fifteen years as medicine began its reluctant dis-

covery of the sadistic abuse of children in much the same intermittent and ambivalent way that medicine discovered the physical abuse of children in the 1950s and 1960s and the sexual abuse of children in the 1970s (Summit, 1988).

In the 1980s, therapists began to hear accounts from children and adults of extreme sexual and physical abuse. Some children abused in nursery school settings, for example, described scenes in which multiple children were victimized by multiple adults. These adults were described as using elaborate planning to execute multiple perverse acts often including bondage, incarceration, forced eating of non-food, torture of children and animals, sodomy, and threatened or actual killings with mutilations (Kelley, 1989; Jonker & Jonker-Bakker, 1991). Some adults with dissociative disorders were recounting similar extreme abuses beginning in childhood often in association with images of altars, ritual orgies, infant sacrifice with cannibalism, and use of candles, circles, chants, and other elements or reversals of Judeo-Christian symbolism (Hill & Goodwin, 1989).

Finkelhor and co-workers (1988) estimated that extreme abuse was a factor in about 15% of nursery school sexual abuse cases. Children reporting extreme abuse were more symptomatic, especially around loss of toilet training and presence of sexual and aggressive enactments.

Adults describing extreme abuse in childhood often presented severe and atypical dissociative syndromes with dense amnesia even for recent violent experiences and intrusive hypnotic phenomena such as flashbacks seemingly indistinguishable from reality. Some described the deliberate use of hypnotic techniques by perpetrators. Physical and neurological problems complicated the emotional and psychological morbidity (Young, Sachs, Braun, & Watkins, 1991).

These apparently new clinical problems tended to split concerned therapists into opposing camps. Some therapists believed that well organized and powerful groups of perpetrators needed to be detected by law enforcement and deterred by legal or other safety measures from abusing known and future victims. Others believed that therapists were somehow fostering these extreme accounts and that a more skeptical therapeutic stance toward such patients would reveal alternative explanations for both the patients' accounts and their extreme symptoms (Ganaway, 1989).

### TERMINOLOGY: SADISTIC ABUSE VERSUS RITUAL ABUSE

"Ritual abuse" (Smith & Pazder, 1980) was the term

first used to describe these new clinical situations. From the beginning, there have been problems with the term. It emphasizes religious or pseudo-religious practices rather than the extreme violence that lies closer to the center of the clinical experience. As a new term, "ritual abuse" implies a new reality rather than a phenomenon indigenous to human history, a phenomenon that can be placed on a continuum of severity of abuse and sequelae, and connected to bodies of extant knowledge and research about other types of physical and sexual abuse. The term's connotations of the religious and the occult have led to a search for data about "ritual abuse" in the history of religions, rather than in the history of family violence, political torture, crime and sexual perversion. To believe a patient's account of "ritual abuse" has become subtly connected to a propensity for belief in secret religious conspiracies or in the magical powers of witches or spirits. Questions have arisen about whether clinical work in this area might infringe on basic religious freedoms.

The author (Goodwin, 1993) has proposed substituting the older term "sadistic abuse" and reserving "ritual abuse" only for subtypes of sadistic abuse in which pseudo-religious or cult elements predominate. Sadism was defined by Freud's mentor, Krafft-Ebing (1894/1965), in the Nineteenth Century, as follows: "The experience of sexual or pleasurable sensations...produced by acts of cruelty, as bodily punishment inflicted on one's own body or witnessed in others, be they animals or human beings. It may also consist of innate desire to humiliate, hurt, wound, or even destroy others..." Krafft-Ebing's seven editions of *Psychopathia Sexualis* constitute an encyclopedia of clinical accounts of extreme abuse, mostly drawn from perpetrators rather than from victims. No element found in contemporary accounts is missing from this Nineteenth Century text, published in Latin to deter its use as a handbook for sadistic perpetrators. Death threats, use of religious settings and costumes, bodily mutilations of all sorts, bondage, use of excretions and blood, animal torture, and cannibalism - all are well described not only in Krafft-Ebing, but also in the works of the Marquis de Sade who lived one hundred years earlier and whose name Krafft-Ebing gave to these behaviors.

Careful study of de Sade and other sadists can broaden our approach to the study of extreme sexual abuse. The Marquis de Sade (1789/1987) was a famous Eighteenth Century libertine, sexual criminal, and pornographer. He developed a philosophy largely devoted to rationalizing his sadistic deeds, by claiming sexuality as the fundamental motivation of natural man. He spent most of his adult life imprisoned for sadistic crimes. He poisoned the inhabitants of a brothel with aphrodisiacs, tortured a prostitute in his private chapel, abducted and tortured a beggar, and sexually abducted his wife's younger sister. Even while incarcerated, he continued to pay mothers to bring him their daughters as sexual victims; bones were found in his castle garden, probably from sexual victims who died "accidentally" during sadistic orgies (Dworkin, 1981). It was in prison that he began his career as a writer of sadistic pornography. He denied personal sexual interest in homicidal sadism and necrophilia, although he wrote about such practices; indeed, when

he was recruited as a judge in the aftermath of the French Revolution, he refused to execute prisoners on grounds that the guillotine did not excite him sexually.

The case of de Sade as well as other cases collected by Krafft-Ebing would lead us to look for extreme abuse not only in pseudo-philosophic cult contexts, but also in criminal contexts, in the worlds of prostitution and pornography, in extreme family violence, and also in settings of political and institutional torture. Use of this broader behavioral category (Durkheim, 1895/1984) facilitates both cross-cultural and historical comparisons.

## TERMINOLOGY: TERRORIZATION VERSUS PROGRAMMING

As we access earlier research about sadism, recent accounts of perpetrators' attempts to gain mind control over their victims come into contextual focus. As Krafft-Ebing noted, emotional terror and successful deception are as important to sadists as is the infliction of bodily harm. One study found that the victim's facial expression of pain and terror, achieved by whatever means, provided the sadist's most direct source of satisfaction (Heilbrun & Seif, 1988). As a sadistic serial killer put it: "The pleasure in the complete domination over another person is the very essence of the sadistic drive" (Dietz, Hazelwood, & Warren, 1990). Careful interviewing of sadists and their victims indicates that many methods are used to achieve total domination or "soul murder" (Shengold, 1989) of the victim. Such methods, used by political torturers as well as by criminal sadists include: control of basic bodily functions as eating, sleeping, and elimination; physical beatings; physical torture; psychological torture; control of information and misinformation, confinement and sensory deprivation; rape and genital mutilation; witnessed violence and threats; forced labor and poisoning. Gelinis (1993) has used the term "malevolence" to describe the emotional abuse found in these contexts. Induction into violence is an ultimate technique and test of this process in which an initial victim recruits new victims and eventually becomes a co-perpetrator.

This review proposes "terrorization" as a descriptor for sadistic efforts to gain absolute levels of control. "Programming" would be reserved for the subgroup of terrorization tactics involving combinations of modern hypnotic, behavioral, and psychopharmacological techniques. Terrorization has been described in situations of extreme family violence, in holocaust and other prison camp settings, and in hostages and other victims of political torture (Goldfield, 1988).

## HISTORICAL EXAMPLES OF SADISTIC PERPETRATORS

De Sade is not the only sadist in history whose career combined criminality, family violence, political violence, the creation of a pseudo-religion, and involvement in pornography and prostitution. Caligula (Suetonius, c. 120/1979) is described as marrying his sister and then killing her after she became pregnant. He is said to have delighted in watch-

ing prisoners tortured. He replaced the heads of the statues of all the gods with his own head and created a brothel for the wives and daughters of his enemies.

Hitler is another historical figure whose sadism emerges not only in the "final solution," but also in his sexual use of whipping and sadistic pornography, his sexual abuse of a niece who later suicided, and his creation of a private pseudo-religion made up of fragments of grail legends and European and Tibetan black magic (Ravenscroft, 1973).

Gilles de Rais (Opie & Opie, 1974), a French noble who fought with Joan of Arc and became the model for "Bluebeard," and Aleister Crowley (Greaves, 1992), one of the rediscoverers of witchcraft folklore at the turn of the century, are other historical figures for whom the practice of black magic was only one aspect of a sadistic lifestyle that included the perpetration of crimes and family violence and dependence on sadistic sexual practices and pornography.

These historical examples illustrate aspects of sadistic abuse that, while absolutely typical, may strain the credulity of observers unfamiliar with the daily life of a *de Sade* or a *Caligula*. Violence is extreme. Victims and perpetrators are multiple. Enormous energy and planning are expended on perpetration. The diagnostic manual (American Psychiatric Association, 1987) and recent studies of criminal sadists (Dietz, Hazelwood, & Warren, 1990) describe in detail some of these characteristics. We do not yet have adequate data on the psychological characteristics of sadists. Extensive psychological testing on Nazi war criminals showed normal profiles (Harrower, 1976). Milgram's studies (1974) and more recent work (Gibson, 1990) indicate that almost any male can be taught to engage in sadistic behavior; females have not yet been studied in detail. Some theorists suggest that the association of pleasure with the process of killing is biological and connected to human evolution as hunters (Nadelson, 1992). Professionals need to acknowledge realistic difficulties in identifying sadistic perpetrators.

## RECOGNIZING VICTIMS OF SADISTIC ABUSE

In many cases, the presence of sadistic elements in the child abuse account is readily available either in the patient's initial report, in medical or police observations, or in the patient's responses to a detailed lifetime violence history or lifetime sexual history. Examples include: (1) patients who describe ritualistic punishments in childhood as kneeling on chains or being bitten on the nipples (Goodwin, 1989); (2) patients whose sexual abuse led to damage requiring hospitalization or surgical repair; or (3) patients whose childhood sexual abuse involved bondage, or beatings as a constant precursor, or other bizarre elements such as the active pursuit of an incest pregnancy or use of excretions in sexual encounters. Even when such elements are documented, professionals may have difficulty recognizing sadistic abuse.

For example, the presence of lifetime foster care, of one or more intrafamilial murders, of broken bones due to parental abuse may not be noted in a later psychiatric record or, if noted, may not be connected to symptoms (Goodwin, Cheeves, & Connell, 1990). A child's offhand mention of

being tied up, threatened with a weapon, or forced to eat vomitus may not be followed up because the therapist assumes this to be fantasy. Even when the presence of childhood adversity is known from collateral sources, a lifetime violence history is necessary to understand the childhood environment, to determine whether other types of emotional, physical, or sexual abuse or witnessed violence were part of the context and to understand the patterns developed in childhood for communicating and containing emotions.

In those patients whose accounts of sadistic abuse surface later in treatment, narratives about abusive experiences may be interrupted by dissociative gaps or distortions. In some cases sadistic elements appear only in vivid flashbacks, traumatic nightmares, reabuse re-enactments, or body memories. In others, severe post-traumatic, borderline, and dissociative symptoms, often in an atypical presentation, co-exist initially with a bland childhood history or with a dense childhood amnesia.

The presence of multiple severe symptoms in individuals whose dissociative problems impair both symptom description and the recounting of life history makes these victims' pain preparations in search of a misdiagnosis. Spirit possession, past life trauma, abduction by space aliens, culture-specific syndromes, or schizoaffective schizophrenia become attractive pseudo-explanations when the alternative involves disclosure of severe childhood abuse and neglect.

Even when indicators of severe or sadistic abuse are noted, it is often wiser to pursue the symptoms and childhood memories that are at the surface, postponing use of special memory retrieval techniques until a safe treatment setting has been established. If the patient cannot yet deal with a parent's alcoholism or put into words his responses to it, he will have difficulty metabolizing memories of more severe abuse. A prolonged interval of education about normal development and its disruptions and of ego-building to increase skill levels and independence may be necessary before a patient gains enough trust and autonomy to disclose severe levels of abuse.

The most serious risks around recognition and disclosure are conveyed by images of the Jonestown massacre of 1978 (Lasaga, 1980). Here, a large pseudo-religious cult committed mass suicide just as airplanes were landing bringing investigators to document the cult's abuses. The psychiatric syndrome that describes such phenomena is "shared delusional disorder." In this condition, the partners of a delusional leader come to share the leader's grandiose views about his own powers as well as his persecutory fears of the outside world. Separation is necessary to restore the passive partner's reality testing but is also a feared catastrophe (Goodwin, 1989). Therapists should refrain from imposing their own beliefs on a victim in a way that substitutes a new set of grandiose delusions and persecutory fears for the old system imposed by the perpetrator.

TABLE 1  
Safety/symptom control: Useful techniques

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Treatment Plan  
Crisis Plan  
Hospitalization  
Medication  
Addictions Programming  
Medical and Nursing Care  
Hypnosis, Imagery  
Structured Living  
Networking

TABLE 2  
Reconstruction of life history: Useful techniques

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Physical signs and symptoms  
Interviews with collaterals  
Narration  
Journaling, charting  
Group therapy  
Sibling group  
Natural history of symptoms  
Managing anxiety and regression  
Hypnosis, imagery  
Bibliotherapy, films  
Sand tray therapy  
Art therapy  
Planning and titrating memory work  
Amytal interviews

### SPECIALIZED TREATMENT TECHNIQUES

Therapists skilled in treating other victims of child abuse should be able to apply similar techniques in approaching patients describing sadistic child abuse. In general, symptoms are more severe in these victims so more time and more specialized techniques may be required (Chu, 1992). The goals, however, are the same: (1) establishing safety and symptom relief; (2) achieving life history narration without retraumatization; and (3) defining developmental lacunae and establishing an environment in which behavioral, emo-

tional, and cognitive development can resume (Herman, 1992).

For each treatment phase we will describe potential complications and list special techniques which may be useful in that phase. At present we are working from anecdotal evidence. More precise definition of symptoms, treatment techniques, and stages in the natural history of treatment will be necessary as we begin to collect data on larger numbers of patients and design treatment trials.

### SAFETY/SYMPTOM CONTROL

The autobiographical novel *I Never Promised You a Rose Garden* (Greenberg, 1964/1989) conveys the difficulties that may arise in trying to establish symptom relief and basic safety while treating someone whose abuse and self-defensive self-abuse are longstanding. In the book, as in other complicated treatments, the symptoms become a battleground between patient and therapist with the patient feeling paradoxically that self-mutilation or suicide is the only way to regain a place of safety.

Relevant co-morbid psychiatric syndromes that may be present include borderline personality disorder, compulsions, addictions, eating disorders, paraphilias, and masochism. However, the available literature in all these areas tends to underestimate the role of trauma.

Table 1 lists technical interventions that may be introduced to achieve symptom control. Severely symptomatic patients with histories of severe abuse by human agency tend to require a great deal of treatment. Symptoms are usually concealed and minimized rather than exaggerated. Requests for increased therapy should be taken seriously, not dismissed as "borderline manipulation."

Therapists, however, must refrain from being drawn into over-activity or boundary loss. Over-protective over-activity can lead to self-aggrandizing over-activity and even to re-abuse by the therapist. Being listened to remains the patient's most urgent need. Understanding the symptoms is the key to controlling them (Gardner & Goodwin, in press).

When symptoms are uncontrolled or when the environment is dangerous or unsupportive, serious reconstructive work must be postponed in most cases.

### RECONSTRUCTING LIFE HISTORY

Most psychiatrists are familiar with the Schreber case, a case of florid psychotic symptomatology which developed in a Nineteenth Century German judge after several years of psychiatric treatment. Not until one hundred years after his psychosis did it become clear that his symptoms had been re-enactments of his childhood abuse and of his childhood reactions to that abuse (Niederland, 1959). The major risk of reconstructing life history when abuse has been severe is that abreactions will lead to psychotic-level regression and distress which will be so destructive as to preclude, distort, or obliterate the construction which is being attempted.

The techniques listed in Table 2 emphasize integrating and pacing insights about life history. Patients often corn-

plain they need to know more about gaps in childhood memory when the more urgent problem is grasping the full implications of memories already retrieved. It is important to keep in mind that it is not only childhood abuse that needs to be reconstructed, but also childhood coping strategies, symptoms, rescue and revenge fantasies, and at times in dissociative disorders, adolescent and adult experiences in these same categories. One of the most frightening aspects of reconstruction is realizing how unreliable, fragmented, and confabulated the memory system has become.

Abreaction may be accompanied by loss of orientation to time, place, and person. Psychotic transferences may emerge when the patient cannot differentiate the therapist from the sadistic abuser. When the victim becomes psychotic, it is important (1) to shift the focus to safety and reality issues; (2) to screen for non-traumatic causes of the psychosis as a co-existing major mood disorder, drug toxicity, or physical illness; and (3) to identify with precision the post-traumatic issues which led to the break with reality and the roles of anxiety and dissociative processes in mediating the psychotic presentation. Understanding the interrelationships among triggers, memories, anxiety, and dissociative symptoms will help control remaining baseline symptomatology as well as abreactions.

Sand tray therapy has been an effective modality in allowing continued narration even when regression and anxiety impair verbal capacities.

Even if hypnosis is not used formally, intrusive trance states are likely to appear and the therapist needs to be skilled enough in hypnotic techniques to communicate with the patient in trance and help him gain more control of state changes (Braun, 1986).

**RELEARNING**

Once symptom control has been achieved and a working life history has been reconstructed, the victim of severe childhood abuse is ready to embark on treatment as it is more traditionally conceived, with goals of rehabilitation, self-understanding, and personal change. (See Table 3) . Here the work of Winnicott, (1971) and Kohut (1984) and related psychoanalytic theorists becomes relevant. (Fairbairn, 1952/1978; Modell, 1990).

Even at this point the treatment maybe complicated by an excessively prolonged course, therapeutic impasses, and persistent relational problems due to deficient social skills despite important gains in other areas, as creativity. Freud's patient, "The Wolf Man," illustrates some of these issues (Gardiner, 1971). He experienced transference psychoses; his need for psychotherapy was lifelong; after he ran out of money he paid for therapy with his paintings, and later he paid by being a wonderful teaching case. However, given the multiple and severe abuse in his family and the numerous suicides, his outcome was positive.

Medical economics is at present unfriendly to situations in which long-term outpatient psychotherapy is the treatment of choice. Human as well as economic resources may become depleted. Therapist burn-out can be mitigated

TABLE 3  
Relearning: Useful techniques

- Managing own treatment plan
- Formal education
- Vocational guidance
- Parenting training
- Sex and marital therapy
- Physical education, body therapies
- Dynamic psychotherapy
- Creative work
- Friendships, voluntary families
- Wilderness therapy
- Volunteer work, political action
- Spiritual development

TABLE 4  
Defining sadistic abuse: A summary mnemonic

- Sadistic sexual and physical abuse
- Accounts of torture
- Despotic over-control, intentional terrorization
- Induction into violence
- Satanic, cult, and/or ritual involvements
- Malevolent emotional abuse and neglect

through the multi-disciplinary team approach, which allows shifts in primary therapist as treatment progresses. For example, a therapist skilled in safety issues might maintain a commitment as a consultant or family therapist even after a more psychodynamically-oriented person has assumed responsibility for individual therapy as it becomes more oriented to developmental issues. At this point, managing the treatment plan becomes a therapeutic modality in itself as the patient learns to distinguish benevolent from malevolent therapeutic environments and learns to create a world not ruled by terrorization (Turkus, 1991).

Part of the therapist's task is to maintain hopefulness through this prolonged treatment. It is helpful to review in an ongoing way the natural history of the victimization syndrome and the strengths, accomplishments, and wellness that have been manifest even during periods of maximal abuse and maximal symptoms.

## DISCUSSION

Table 4 summarizes in mnemonic form elements in a patient's account of childhood adversity that may alert the clinician to the possibility of sadistic or severe abuse in the developmental history. Such experiences may remain closely guarded secrets or confused mysteries even in those patients whose abuse was disclosed in childhood. Identification of extreme cases will become a priority as research in this area begins to quantify and differentiate the developmental impacts of different types of childhood adversity.

Use of the term "sadistic abuse" emphasizes the severity of the childhood adversity and the possibility of sadistic or sado-masochistic types of re-enactments and transference. It reminds the clinician to utilize available research data, including the child abuse literature and also databases concerning torture and torturers, holocaust survivors, victims and users of prostitution and pornography, sadistic criminals and their targets, and violence as it occurs in cult and pseudo-religious contexts. Use of the older term, "ritual abuse," risks distracting the clinician or researcher with arcane details while the extreme violence and destructiveness of the sadistic behaviors may be lost to focused awareness (Eco, 1990).

Treatment of patients who present with histories of sadistic abuse involves trauma-based principles well described in the treatment of other child abuse survivors. Symptom variety, severity, and duration seem to reach higher levels in this group, and there are risks of complication and relapse in every phase of treatment. ■

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