THE RISKS OF BEING AN EFFECTIVE ANTI-VIOLENCE CARER

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About the authors:

Jeanne Sarson, RN, BScN, MEd & Linda MacDonald, RN, BN, MEd have been active in the caring about persons victimized by ritual abuse-torture (RAT) since 1993; initiated a "kitchen table" research project in partnership with persons who reported being victimized by ordeals of RAT for the purpose of finding ways to educate others, to promote greater insight into the human evil actions of the perpetrators, are involved in activism to advocate for global changes that will help promote and prevent RAT from being inflicted unto innocent infants, toddlers, children, youth, and "captive" adults and seek ways to protect the human rights of the persons so victimized; and write and manage their website:

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About the article:

Outlines common risks most frequently encountered by effective anti-violence carers and discusses, in point form, eleven risks the authors encountered as effective carers during their early years of helping an adult person exit from a reported ritual abuse-torture family/group and from a destructive women's group in which she was entrapped.

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Violence within relationships between adult-infant, adult-toddler, adult-child, adult-youth or adult-"captive" adult requires understanding not only the relationship between the perpetrator and her/his victim—that is, what does the perpetrator want from his/her victim and what "trauma benefits" does the victim gain—it is also necessary to understand the relationship the perpetrator has with him/her-Self. That is, what needs and desires does the perpetrator feed by committing their acts of violence? Do they feed their needs and desires for feelings of superiority? Are they motivated to satisfy a need to have totalitarian power and control over their victim? Are they driven to fulfill their desires for cruel and inhumane pleasure and entertainment? And, if they see their victim as a marketable renewal resource are they driven by their greed to acquire wealth by "renting" and/or "selling" their victim into the exploitative "sex" trade and/or the pornography trade? The answer to these questions is yes—in ways that are varied and unique to the perpetrator. For instance, consider the priest jailed for his pedophilic crimes; he explained that once he got past the sin part all that was left was the pleasure.[1] He had no concern for his victims. His interest focussed on feeding his pedophilic needs and desires. Trauma benefits for the child, one might assume, started with a need for a trusting adult-child relationship filled with supportive attention, fun, and play; however, the child's needs would have been manipulated by the pedophilic priest so he could gain access to the child as a victim. And, should the pedophilic priest use religious-based threats such as, "don't tell your parents or they will go to hell," the child becomes burdened with the perceived responsibility of protecting her/his parents thus the child victim is tricked into the benefit for not-telling.

Understanding the needs and desires of the perpetrator gives insight into why there are risks for carers who are effective in helping the perpetrator's victim escape or exit from their state of victimism. The work of effective carers means the perpetrator will lose their victim, which the perpetrator uses as an "object"—an "it"—to satisfy their cruel and inhumane needs and desires. Much like the spouse who flees from her batterer, the batter frequently responds with escalated violence in an effort to keep his "property". Thus, the risks of being severely harmed escalate when she attempts to leave the violent relationship. This analogy of increasing risks fits for the effective carer who becomes a threat to the perpetrator(s) not only because the effective carer "is the reason" for the perpetrator(s) losing his/her victim but also there is increasing risks the perpetrator(s) may be exposed. It is reasonable, therefore, to expect what the literature is starting to disclose—effective carers, effective anti-violence workers, face many and varied risks.

[1] L. MacDonald (personal communication with criminal justice employee who had interviewed the priest, September, 2002)

As carers who have been effective in working with persons victimized by spousal torture and ritual abuse-torture, our risks have been many. Our experiences mimic the literature which discusses discreditation, burnout, oppression by peers and bystanders who reject, deny, or disbelieve especially in regards to the reality of ritual abuse-torture;[2] malicious complaints to professional licensing boards and/or civil suits;[3] perpetrator planned set-ups against effective carers in an organized effort to find a way to attack the carer's credibility,[4] or the initiation of discrediting rumours and accusations to cast doubt on an effective carers skills.[5] Additionally, alleged perpetrators may try to use the exiting victim in a manner that could be harmful to both their victim and the victim's relationship with the effective carer. For instance, perpetrators may try to distort the exiting victim's perceptions of the effective carer in various ways, such as using impersonation tricks to cause mistrust of the effective carer.[6] Perpetrators of violence may solicit family and friends to help them intimidate professionals, or harass them with phone calls and, as a comparison, in recent times, key players in the criminal justice system, such as justice professionals and witnesses, as well as their families, have been subjected to intimidation; additionally, vexatious complaints have also been used against justice professionals.[7] All of the above acts are purpose driven; these interfere with just and effective processes, exact revenge, and create fear. Thus, it becomes clear that there is universality in the modus operandi of the perpetrator(s) who try to derail the process of justice or the process of the effective carer who is helping a person exit from a ritual abuse-torture family/group, for example.

Professionals who are perpetrators commonly use their work sites as "safe" places for inflicting perpetration.[8] For instance, priests perpetrate in churches, teachers in schools, health professionals in their offices or in hospitals; as well, they use their "professional" skills to camouflage their acts of violence and/or as tools useful for inflicting violent acts. Consider the perpetrator therapist who uses hypnosis, the nurse perpetrator who uses drugging, or the priest perpetrator who uses religious dogma to maximize their client's

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[2] Singer, M. T. (2003). *Cults in our midst* (p. 209). CA: Jossey-Bass; The Canadian Panel on Violence Against Women. (1993). *Changing the landscape: Ending violence ~ Achieving equality* (pp. 45-47). Ottawa: Minister of Supply and Services Canada.

[3] Noblitt, J. R. , & Perskin, P. S. (2000*). Cult and ritual abuse Its history, anthropology, and recent discovery in contemporary America*, (p. xv). Westport, CT: Praeger.

[4] Spencer, J. (1997*). Satan's high priest A true story*. (pp. 282-283). New York: Pocket Books.

[5] Coates, D. (1992*). The role of discreditation in the issue of ritual abuse*. P.O. Box 29064, Delamont Station, Vancouver, B.C. Canada, V6F 5C2.

[6] Coates, D. (1992*). The role of discreditation in the issue of ritual abuse*. P.O. Box 29064, Delamont Station, Vancouver, B.C. Canada, V6F 5C2.

[7] Jamieson, Beals, Lalonde and Associates, Inc. (1999). *A handbook for health and social service professionals responding to abuse during pregnancy,* p.20. Health Canada, Ottawa: Minister of Public Works and Government Services Canada, 1999; Criminal Law Policy and Community justice Branch. (1999, July 20). Fear affects the decisions you make A consultation paper on the intimidation of key players in the criminal justice system. Department of Justice: Michael Zigayer, Criminal Law Policy Section, Department of Justice Canada, East Memorial Building – Room 5085, 284 Wellington Street, Ottawa, ON.

[8] Child and Youth Mental Health Services. (1994). *Multiple victim child sexual abuse: the impact on communities and implications for intervention planning*, pp. 7-8. Ottawa: Minister of national Health and Welfare; Krug, E. G. et al. (Eds.). (2002). W*orld-- report on violence and health.* ISBN # 92 4 154561 5. Geneva: WHO.

susceptibility to victimization. If the "professional" perpetrator is at risk of being exposed they may use discrediting complaints to attack an effective carer arguing, for example, that the effective carer's methods of practice are inappropriate. Professionals who are perpetrators with positional power within an institution can manipulate their positional power to add the weight of the institution to a discrediting complaint.

Below we list the risks we faced, the impacts we experienced, and the war we waged against those who were alleged perpetrators of abuse, torture, or ritual abuse-torture. Against those who misused and abused positional power and public trust for their own personal and professional benefit or for the benefit of the institution that employed them—a health care institution and our professional self-governing body.

1. **Battle fatigue**[9] can occur when helping a person exit/heal from ordeals of abuse, spousal torture, or ritual abuse-torture because helping the victim also means struggling to make sense of the perpetrator's patterns of victimization, it also means challenging the social policies and structures which attempt to deny, reject, minimize, ignore, or intentionally engage in acts of oppression which attack both the effective carer and the victimized person. Battling as we did—were forced into doing—caused us to experience many responses of battle fatigue. Physically our bodies ached with constant muscle pain. We struggled with on-going physical and mental fatigue that was at times extreme. A stressed bladder made for sleepless nights. Deep bone-chilling coldness, flu-like symptoms, and constant headaches accompanied emotional anger and moral outrage. Our responses included feelings of and being on guard for potentially unforeseen risks and the constant need to decrease any outside activities or extras in life in order to help our-Selves stay focussed on the battle at hand. We felt shock and grief. Working late into the night and sleep deprivation were constant companions.
2. **Discrediting complaints** were submitted to our professional nursing body, known today as the College of Registered Nurses of Nova Scotia, by persons a client alleged were some of her perpetrators. These complaints were dismissed.
3. **Discrediting statements** such as, "*they're well meaning nurses but they are in way over their heads*" were made about us to professional peers by professionals, a client alleged were her perpetrators of ritual abuse-torture and/or acts of torture. Discrediting statements is a technique used to cast doubt about an effective carer's abilities, the intention being the effective carer will be put out of practice removing effective support from the person being victimized. Without effective support the victimized person can be forced back into captivity by the perpetrator(s) or silenced by programmed suicide, for instance.
4. **Indirect threats and intimidation** can be deadly! A client reported that her perpetrators had drugged and ritually abused-tortured her and forced her to write a suicide note claiming she committed suicide because of her relationship with us. In addition, she alleged that her female perpetrators had counselled, then forced her to practice various ways on how she could commit suicide—"professional" lessons in "how-to" fabricate suicide—programmed murder! Suicide is very

[9] Virtual Naval Hospital. (2001, September 26*). Battle fatigue *GTA 21-3-4 Normal common signs: What to do for Self and Buddy*. Washington, DC: Headquarters, Department of the Army. http://www.vnh.org/GTA/GTA2134.html

effective, if successful, at protecting perpetrators. Their victim "disappears" leaving the perpetrator free to continue their perpetration of other victims. In our case, knowing that such a note possibly existed added mountainous stress to our relationship with the victimized woman because of the reality she was still attempting to exit her family/group of ritual abuse-torturers. Because suicide is always a high-risk reality for persons who have been so victimized, we knew we faced, every moment of every day for five years, the potential that she might commit suicide and her alleged perpetrators might produce the alleged suicidal note. Suicides do happen. Suicides happen every 40 seconds in the world![10]

5. **Impersonation techniques** happened when a client reported being drugged and ritually abused-tortured by perpetrators who then proceeded to role-play an impersonation of us as her real enemies, inflicting unto her horrendous acts of physical, sexualized, and mind-spirit torture, in a house the client refers to as "*the House of Horrors*". Experiences such as this caused the client confusion and questioning—who are my real enemies. Additionally, her renewed confusion and intense mistrust caused her to respond with brick-wall resistance blocking her ability to connect with us and us with her. Again, the intention of perpetrators is to fracture the effective support so the person they are victimizing will be abandoned by the carer and become a "captive" of the perpetrator(s).
6. **Creating constant crisis** was a technique used by a client's alleged perpetrators. Every assault the perpetrators inflicted, every verbal threat or intimidation uttered, triggered the client into absolute fear and terror. On one occasion this client found Linda's home and barged through the door, consumed by fear and terror she stated her alleged perpetrator had told her that, she, the alleged perpetrator "*would get us in her own way*". The client became distraught fearing we would be severely harmed; that it would be her fault, and that she would never escape her perpetrators. Threats which endanger life can and do over-whelm the body's physiological coping mechanisms, fatigue sets in, there is difficulty with concentration thus problem-solving, an increased sense of vulnerability is aroused which intensifies feelings of being unsafe. Hyper-vigilance escalates disrupting sleep, increasing fatigue, and triggering a pattern of crisis spinning—of crashing and running, of ups and downs, until exhaustion hits. The goal of such perpetrator tactics is to disable the victimized person and burden an effective relationship with never-ending crisis demands so the victimized person and the effective carer are both over-come by fatigue. The effective carer may be forced to withdraw from the relationship leaving the victimized person without safe and effective support.[11]
7. **Professional, moral and ethical dilemmas, misuses and abuses of power** arose when we were required to respond to discrediting complaints submitted about us to our professional licensing body. Discrediting complaints have the potential to inflict serious professional harm, for instance, a professional could lose their

[10] Krug, E. G. et al. (Eds.). (2002). *World—report on violence and health.* ISBN # 92 4 154561 5. Geneva: WHO.

[11] The Canadian Panel on Violence Against Women. (1993). *Changing the landscape: Ending violence ~ Achieving equality* (pp. 45-47). Ottawa: Minister of Supply and Services Canada.

licence to practice, so it is one of the most efficient tools perpetrators or others with unjust motivations can use to attack effective carers.

Our first experience confronting a discrediting complaint made by staff from a health care institution (HCI) took seven months before it was dismissed. It took us six years to gather documentation that illustrates how many injustices, biases, deceits, lies, falsehoods, the withholding of truthful information, and the telling of half-lies were embedded into the process. Pressures were also unsuccessfully applied unto us by our professional body to have us violate client rights.

During the unfolding of their complaint against us the HCI staff cited concerns about our skills and our contact with specific ex-HCI clients. When we asked that these ex-HCI clients be notified the HCI staff was using them to formulate their complaint our professional body declined, arguing "*There are many complaints which are heard . . . where the client is not even aware that the practice of the registered nurse has been called into question . . . For example, a client may be unconscious or sleeping and unaware of a particular action of a nurse.*"[12] This philosophy, in our opinion, was/is ethically and morally shocking and wrong. To comply with such a philosophy was to pressure us to comply with a standard of practice that was/is in violation of client's rights. We felt attempts were being applied that would have pressured us to engage in deceitful and unethical behaviour, to withhold information and truth from the ex-HCI clients, and to disregard professional trust-worthiness. We asked: Would a client ever be made aware of a particular action of a nurse, especially if it were revealed the action was in error? And: At what point would an unaware, sleeping, or unconscious client or their significant others be made aware, be informed that a particular action of the nurse attending to their care was being questioned or caused harm? And, are nursing errors routinely covered-up using the argument that the client (or their significant other) was unconscious, sleeping, and unaware so doesn't have to know?

Refusing to proceed under the mandate of such a philosophy we notified the ex-HCI clients about their involvement in the complaint and provided each of them with copies of the specific information that had been written about them by the HCI staff. Seven years later, following an access to information application, under the Freedom of Information and Protection of Privacy Act, made to the HCI, we learned that our actions resulted in a documented conversation between the HCI Human Resources person and the professional nursing investigator. The documentation read, *"[the investigator] called . . . and is very concerned that . . . [Jeanne and Linda] had chosen to release documents to the clients that could cause them harm. I [the Human Resources person] suggested that a second complaint relating to . . . [Jeanne and Linda's] actions in this regard might be appropriate and [the investigator] indicated that this would become part of the disciplinary hearing*."[13] In our opinion, this documented conversation shows the risks effective carers take when standing for the right's of clients—the right to be informed and to have access to all that is written about them on file.

[12] Registered Nurses Association of Nova Scotia. (1994, October 5). Written documentation.
[13] HCI Human Resources Staff. (1994, November 23). Written documentation.

It took seven years to gather such information because we, and others, first had to lobby to have all Nova Scotian health care institutions come under the Freedom of Information and Protection of Privacy Act (FOIPOP Act)—this took six years—followed by another year before our FOIPOP request for any and all information that was written about us by HCI staff was completed. The above documented conversation exposes that the professional investigator was indicating plans for disciplinary action and possible further complaints even before we had made our defence presentation to the Complaints Committee, the first step in the hearing of a complaint process. It is at this Complaints Committee stage that decisions are made as to whether a complaint is dismissed or moved to a disciplinary process. In our opinion, the investigator abused the power of the investigator's position by engaging in discrediting, judgemental, and biased remarks about us. Our ordeal demonstrates, in our opinion, that transparent and democratic processes are essential to ensure client rights and public safety, as well as ensure that effective carers do not fall victim to discrediting complaints and biased and unjust investigation practices.

Additionally, we eventually learned that the College of Registered Nurses of Nova Scotia had accepted and had in their possession the ex-HCI client's privileged and confidential HCI files,[14] which had been released by the HCI staff disregarding the mandate that the release of privileged and confidential HCI ex-client files requires written authorization from the ex-HCI clients.[15] Documentation showed the HCI staff and Human Resources staff repeatedly stated, "*there was no written documentation containing patient names [released]*"[16] and the professional nursing investigator "*was quite adamant that there had been no breach of confidentiality [by the HCI complainants], or RNANS [now known as the College of Registered Nurses of Nova Scotia]*.[17]

Each of the ex-HCI clients eventually submitted complaints against the HCI complainant, a registered nurse, to the College citing violations to their confidentiality; violations of trust, and untruthfulness of statements written about them—their complaints were dismissed by the College Complaint Committees. The College never told the ex-HCI clients that the College had in their possession the client's unauthorized privileged and confidential HCI files. We do not know if the members of the Complaint Committees, who dismissed the client's complaints, knew of the unauthorized release and use of the client's privileged and confidential HCI files. If the Committees did know their decisions reflect a philosophy that considers client's privileged and confidential HCI files to be "s*ituational data . . . and is not considered to represent a breach of confidentiality*".[18]

References to the fact the ex-HCI clients had histories of childhood and/or adulthood violence was used in the construction of the HCI staff's complaint. As was the suggestion that persons with histories of violence are "… *not capable of*

[14] Written documentation and verbal communication (1995, February).
[15] HCI policies on confidentiality, consent, and release and disclosure.
[16] HCI Human Resources Staff. (1994, November 23). Written documentation.
[17] Human Resources HCI Staff. (1994, November 23). Written documentation.
[18] Decision of the Complaints Committee.

making decisions that are in their best interests …" and "… a fully informed consent is not possible due to the seriousness of the psychological damage."[19] Because it was and remains our opinion that such a position was/is discriminatory, that it was professionally, ethically, and morally wrong to proceed with the complaint without informing the ex-HCI clients, and wrong to talk about them behind their backs as if they were non-persons, we asked the women, if, from their perspectives, we had taken the most appropriate action by informing them of the complainants involvement of them—their privileged and confidential HCI files, their histories—in the complaint. Without hesitation their response was "yes". The ex-HCI clients all reported how re-victimized—violated, used and abused—they felt because of the actions of the complainant, the HCI, and of our professional association.

In order to respond to the complaint it would have been necessary for us to disclose privileged and confidential information about the women. It was our professional opinion we could not do so without first seeking their consents. This was another reason we had to contact the women. Each woman immediately responded by contacting our professional body demanding that they attend the Complaints Hearing to address all statements and allegations the complainant had made about them and their relationship with us. Today, third party participation is now written into our professional Act. Third parties, that is what the women would have been considered, can now give written or oral explanations or give an interview. This represents a significant and successful outcome of our battle!

Such structural re-victimization—oppression, injustice, hierarchical abuses of power and trust—is a common occurrence that effective anti-violence workers and victimized persons struggle against when seeking transparency and equality-based justice! Going through this complaint process was a critical incident experience—exhaustive, expensive, oppressive, time-consuming, professionally, morally and ethically depleting, offensive, shocking, isolating, destructive, disgusting, and traumatizing.

8. **Traumatic stress, vicarious trauma,[20] ethical and moral violations** are preventable "hardships". Although integrating the horrors of human cruelty that victimized persons entrust us to hear requires long hours of debriefing to prevent traumatic stress responses, our work and our ability to Self-care was severely compounded by the traumatic ethical and moral dilemmas and duress we experienced as a consequence of the abusiveness of the investigative processes carried out by our professional association and by the behaviours of the HCI.
9. **Programming techniques** are commonly used by perpetrators of ritual abuse-torture. One technique, described to us by a client, was how her alleged perpetrators used physical torture—electric shocking—to inflict pain conditioning so that whenever she picked up the phone to call us she would experience the conditioned physical pain of electric shocking. When highly triggered or in a flashback the pain was so intense she could not hold the phone; she placed the phone on her pillow and talk into it. Again, the intention of the perpetrator is to

[19] Written document of HCI staff. (1994, February 24).
[20] Richardson, J. I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers*. Ottawa: Her Majesty the Queen in Right of Canada.

break their victim's effective support system, to isolate, silence, enslave and entrap their victim.

10. **Being set-up** is a risk as it can also be a technique used by ritual abuse-torturers to discredit an effective carer. Perpetrators send a plant into an effective carer's practice in an attempt to find a way to discredit the carer via a discrediting complaint to the professional's licensing association, for example. Our experience with this risk occurred when a professional referred a client to us; however, because this professional had been identified as an alleged perpetrator we refused the referral. Had we not known this alleged fact we may well have agreed to see the person referred. Following this experience we became acutely cautious in the screening of new clients.
11. **Trust violations** occurred repeatedly when we reached out for help. We were frequently told support would be forthcoming—it never materialized. Our concerns were ignored, silenced, made invisible, distorted, or covered-up. As a form of emotional, ethical, moral, and spiritual protection we became cautious and isolated our-Selves. The isolation was both personal and professional. The professional isolation was mainly a result of our response to oppressive abuses of power and trust and the moral and ethical issues we experienced in our relationship with both our professional College of Registered Nurses Association of Nova Scotia and the HCI.

THE BENEFITS: We take pride that our efforts contributed to democratic and transparent changes in both our professional nursing Act and Regulations and in the Freedom of Information and Protection of Privacy Act. By being honest, truthful, and respectful of the rights of others, by talking and supporting each other and our families, we moved from being harmed by organized evil-based attacks, discrediting and oppressive attack, into a victorious knowing of the power of doing the right thing!

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