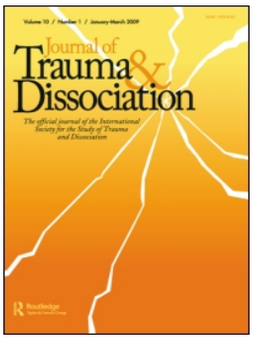

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Michael Salter

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# Organized abuse in adulthood: Survivor and professional perspectives

Michael Salter, PhD

School of Social Sciences and Psychology, Western Sydney University, Sydney, Australia

**ABSTRACT**

This paper reports on the preliminary findings of a qualitative study of Australian women disclosing organized abuse in adulthood and the mental health professionals who treat them. Drawing on interviews with survivors and mental health professionals, the paper analyses the fraught relationship between mental health and physical safety for adults subject to organized abuse. The therapeutic progress of adult organized abuse victims can be disrupted by ongoing threats, stalking, and group violence, which in turn reinforces the dissociative responses and pathological attachments that render them vulnerable to revictimization. The paper argues that breaking this cycle requires intervention from multiple agencies, and describes the responses of police, medical services, and child protection services to adult organized abuse from the perspective of survivors and mental health practitioners. Highlighting systemic failures but also opportunities, the paper calls for a coordinated response to organized abuse in adulthood, including inter-agency partnerships to support safety and bolster the efficacy of therapeutic interventions.

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Organized abuse; adulthood; therapy; safety

## Introduction

This paper reports on the preliminary findings of an Australian interview study with women disclosing organized abuse in adulthood and the mental health professionals who support them. The term organized abuse refers to the sexual abuse of multiple children by multiple perpetrators acting in a coordinated way (Salter & Richters, 2012) and is reported by up to 11% of clients in dissociative disorder clinics (Middleton & Butler, 1998). The International Society for the Study of Trauma and Dissociation Chu (2011, p. 168) recognizes that, in the course of treatment, it is "not unusual" for adult organized abuse victims to indicate that "they are still being exploited by one or more primary perpetrators". The veracity of reports of adult organized abuse is contested. Mental health practitioners are often unable to definitively verify reports of adult organized

**CONTACT** Michael Salter, PhD michael.salter@westernsydney.edu.au Locked Bag 1797, Penrith, NSW, 2751.

abuse (Fraser, 1997). Accurate disclosures of adult organized abuse can be difficult to distinguish from "contagion, unconscious defensive elaborations, pseudomemories, delusion, or deliberate confabulation" (ISSTD, 2011, p. 168). Indeed, organized abuse survivors regularly question their own memories, recognizing the blurring of dreams, flashbacks, and hallucinations into their lived experience (Salter, 2013a). The "reality testing" of unusual disclosures or strange recollections of abuse is therefore important both clinically and forensically (Dalenberg, Hyland, Cuevas, Eisen, & Quas, 2002). However, where clinicians conclude that a client is experiencing ongoing organized victimization, it is unclear how they should respond. While reports of the ongoing victimization of organized abuse clients dates back to at least the early 1990s (Young, 1992), the clinical literature on the treatment of dissociative disorders is largely silent on how to enhance the safety of organized abuse victims.

While disclosures of organized abuse have been the subject of considerable skepticism, supporting evidence has accumulated to a "tipping point" (Middleton, 2015) albeit to varying degrees. Internationally, there are criminal prosecutions in cases of multi-generational incest (Middleton, 2013), technologically-facilitated organized abuse (Wolak, 2015) and the ritual abuse of children and adults (Salter, 2012). However, other features of organized abuse disclosures are less easily confirmed. "Mind control" or "programming", in which dissociation is deliberately inculcated and manipulated in organized abuse victims, has been described by a number of clinicians (e.g. Chu, 2011; Miller, 2012; Schwartz, 2013) although verification by other means, such as criminal prosecutions, is difficult to find. Claims of international conspiracies of ritual abuse, sometimes advanced under the rubric of "satanic ritual abuse", are entirely speculative, and perhaps illustrative of the challenges of coping with very traumatic experiences and disclosures of abuse (Fraser, 1997). Nonetheless, recent inquiries into child exploitation networks in England demonstrated that organized abuse can be geographically extensive, involve sophisticated grooming behaviors, and persist over many years without intervention by the authorities (Coffey, 2014; Jaye, 2014). While recognizing the limitations of the available evidence, it is important to avoid the premature foreclosure of knowledge in relation to organized abuse. Our understanding of organized and complex forms of victimization is still unfolding.

Given that adult organized abuse victims continue to present in a range of contexts, there is a need for empirical research that documents the experiences of this group of clients in their efforts to find care, and the "practice wisdom" of mental health professionals who are currently providing it. Drawing on interviews with survivors and mental health practitioners, this paper emphasizes the links between psychological wellbeing and physical safety for dissociative women with organized abuse histories. Eschewing simple dichotomies of "real" and "imagined"

abuse, the paper acknowledges that the victim's[1] experiential world of dissociative symptoms and traumatic attachments can be manipulated by perpetrators to coerce them into organized abuse, which further exacerbates dissociative and traumatic symptoms and increases their vulnerability to revictimization. The efforts of mental health practitioners to break this "vicious cycle" is complicated by uncertainties over the factual accuracy of disclosures of ongoing abuse and their limited capacity to provide for the safety of the client. The reflections of survivors and professionals suggest that the cooperation of multiple agencies can support the physical safety of the survivor (and their children), enhancing the efficacy of therapeutic work. However, a lack of shared understanding and training amongst responding professionals and services can result in the premature dismissal of reports of adult organized abuse, the stigmatization of victims, and retraumatizing or potentially harmful interventions. The paper concludes with some thoughts on the implications of adult organized abuse for practice and policy.

## Methodology

The paper is based on interviews with 16 survivors and 18 mental health professionals (with more interviews forthcoming).[2] Recruitment took place in partnership with key stakeholders and agencies in the field of dissociation, child abuse, sexual assault and domestic violence. The recruitment and interviewing strategy of the project has been approved by the Human Research Ethics Committee at Western Sydney University (H11234). The study has received funding from Western Sydney University and the Cannan Institute.

Survivor participants ranged in age from their early twenties to their late sixties, with most in their thirties and forties. The survivor cohort described organized abuse beginning in early childhood, typically facilitated by a father or both parents, and continuing into their twenties or beyond. All survivor participants disclosed sadistic forms of sexual violence (that is, abuse that is intended to cause extreme pain and fear, see Goodwin, 1994), and two thirds of survivor participants disclosed ritualistic experiences of abuse, often although not always with "satanic" overtones. About half of the survivor participants described the apparently deliberate inculcation of dissociation in childhood (ie "mind control") although this could be difficult to distinguish from the highly coercive dynamics within their families of origin. The professional cohort included psychiatrists, clinical psychologists, social

[1]The terminology of "victim", "survivor", and "perpetrator" is fraught in relation to organized abuse, since an adult may have survived organized abuse in childhood but continue to be victimized, and part of their victimization may include coerced perpetration (Salter, 2013b). This paper will use the term "victim" to refer to adults presently being victimized in organized abuse, recognizing that they are also "survivors" in the sense that they continue to survive extreme trauma and other obstacles. "Survivor" is used to refer to interview participants, the majority of whom have experienced a cessation of organized abuse. The term "perpetrator" is used to refer to those adults actively engaged in organized abuse, but the term is used provisionally, since they may be acting under coercion and have their own significant trauma history.

[2]The survivor interviews include seven interviews that have been incorporated from a prior study in which participants disclosed organized abuse in adulthood (Salter, 2013b).

workers, sexual assault workers, therapists, and counselors. The majority had been practicing for between 10 and 20 years with postgraduate clinical and therapeutic qualifications. Two thirds were in private practice with one third in community-based services such as rape crisis centers. The project did not aim to recruit a representative sample of survivors and the professionals in contact with them, but rather to analyze diverse accounts of organized abuse in adulthood in order to identify the range of circumstances in which it occurs and responses to it.

Interviews were conducted face to face or over Skype. Interviews with the professional cohort were between one to two hours in length, while interviews with the survivor cohort were generally between three or four hours. Multiple interviews were necessary for some survivor participants. Interviews were digitally recorded and provided to a professional transcription service. The researcher then removed identifying information from the transcripts and imported them into Nvivo, a software program that facilitates qualitative data analysis and enables users to assign a code to specific lines or segments of text. The interviews were analyzed according to a thematic methodology (Braun & Clarke 2006) in which data is coded to identify common themes in participant accounts. A critical psychosocial framework drawing on criminological frameworks of gendered violence, and theories of trauma, dissociation and attachment, structured the analysis of the interview data. An analysis of the preliminary findings of the study is presented below. Pseudonyms are used for all participants and details may have been changed where necessary to protect their identity.

## Findings

In interview, survivors and professionals detailed the obstacles to recovery and safety at the intersection of the dissociative disorders and adult organized abuse. These obstacles are illustrated by the following case study, based on the account provided by Leona, an art therapist. Leona had been working for five years with Rosie, who was a woman in her forties disclosing ongoing organized abuse. Rosie's psychiatrist had diagnosed her with dissociative identity disorder and attributed her complaints of the current victimization to "flashbacks". However, he was troubled by her lack of therapeutic progress, and referred her to art therapy in the hope that another modality might assist her recovery. After a few months of treatment, Rosie began to speak to Leona about a group of men who sometimes waited for her in car parks, or forced her to the side of the road, triggering a dissociative response that left her vulnerable to group sexual sadism. Leona said:

> They would come up to her in the car park, when she was getting back into her car to leave from the shops. And as soon as she saw them, there would be a part that would get out of the car and go.

> And the other thing was that they would sometimes stop her on the road, because she has to travel quite a distance from work to home, and she said they worked with two cars. One car would go in front of her and slow down. The car would come up behind her and force her to the side.

Rosie recounted being taken to a property where she was sexually assaulted and subject to electroshock amongst other sadistic abuses. The electroshock was, according to Rosie, punishment for not going to the property of her own volition. After these events, Rosie presented in therapy in a profoundly traumatized state, in apparent physical pain and with unusual injuries. Leona said "I know the mind is an incredible thing, and theoretically she could be recreating all these symptoms". However, the consistency and coherence of Rosie's reports of stalking and abduction led Leona to conclude she was reporting actual events. Some external verification was available via Rosie's friends who confirmed that they had interrupted coordinated attempts to stalk and abduct Rosie.

Leona worked with Rosie to develop strategies so that she didn't dissociate and comply with these men when confronted by them. For instance, Rosie could call Leona when she saw the men, and Leona would talk with Rosie to ground her until the threat had passed. However, Leona said that Rosie would sometimes "lose consciousness and find herself at their property", after another part had "taken her there, from herself, in her own car". Feeling that the abuse was inevitable, Rosie began making arrangements with the men: her compliance with sexual assault if they stopped the electroshock. Leona said: "Sometimes they'd meet her in a car park and she'd go in their car and be returned to her car".

Leona attributed Rosie's lack of therapeutic progress, which had so puzzled her psychiatrist, to her lack of safety and the ongoing impact of severe traumatization. According to Leona, therapy could only offer Rosie brief respite from ongoing violence and hyper-arousal:

> Rosie in many ways is so receptive to the therapeutic process, and I see her make improvements, I see her make strides, I see her being able to work on something, and then it all just gets torn down. No matter what we do, it gets undone.

> … A lot of the time the session is just keeping her alive. Is just comforting her, helping her nervous system to have at least two hours where she's not in a state of terror, where she feels safe, and held, and cared about. A lot of the therapy is just spent doing that. It's just band aids, survival therapy.

In effect, a lack of safety kept Rosie within the initial or "first phase" of trauma therapy (Herman, 1992), but Leona found it difficult to connect Rosie with other potential supports or agencies that might improve her safety. Rosie refused to speak to police after a negative experience a number of years ago, in which a child part called a children's help line:

> The police came round to the house and discovered she was a woman in her thirties, just dismissed the whole thing. After that, she never trusted them again. That was it. She must have been just so wounded by that experience.

Leona's efforts to find medical care for Rosie fared poorly, after the general practitioner insisted that she was bound by mandatory reporting laws to report Rosie to the police.[3]

> I got her to agree to come to a GP [general practitioner] with me, because she was talking about stuff that was being done internally. And wounding her, and there ought to be evidence there. And I said, 'Well, if I came with you, would you allow a GP to look at you?'
>
> And she said, yes, she would, because she trusted me. We got to this GP in the clinic that I go to, who I thought I could trust, and as soon as we started telling the story, she said, 'Well you know I have to report this'. And I said, 'No you don't, she's an adult'. She said, 'Yes, I do. I have to report this, you know that. I'm sorry, I have to report this'. I was furious. So Rosie of course walked out and said, 'That's it, I'll never go do that again'.

While committed to Rosie as a client, Leona expressed despair at the prospect of improving Rosie's treatment trajectory while she was being targeted by a dedicated group of perpetrators, and while other agencies and services responded inappropriately to Rosie's complex presentation and needs. A number of professionals interviewed for this study described the paradoxical situation in which the efforts of adults to escape from the trauma of organized abuse were met with retraumatizing responses in mental health, law enforcement, and other settings. Social worker Charlotte said:

> It's my experience generally, the worse the abuse, the worse the system's response. But the more severe the abuse, the more likely the system isn't going to be able to manage it. And the response will be then turn on the client.

Mental health professionals working with this client group were not immune to such backlash, either from skeptical colleagues or from other agencies as they advocated on their client's behalf. A sexual assault manager interviewed for the study described this as "system abuse" and positioned it as amongst the most significant of the multiple traumatizations facing adult organized abuse victims. Addressing the impact of system abuse, it would seem, is crucial to securing the wellbeing and safety of adult organized abuse victims overall. The following discussion provides an overview of the responses of a range of agencies when

[3]All Australian states have mandatory reporting laws that require doctors to report child abuse where they have "reasonable grounds" to suspect or believe that a specific child has been, or is at risk of, abuse. The doctor in this instance is not required to report the sexual assault of an adult to the police, but may have felt obliged to report due to the likelihood that children were being victimized by the abusive group.

contacted by survivors or mental health professionals about adult organized abuse.

## System responses to adult organized abuse

This section focuses on survivor encounters with (a) the police, (b) medical services, and (c) child protection services, drawing together some broad themes across survivor and practitioner interviews. Participants are of varying ages, and describing system responses from the early 1990s to the present day. These differences will be noted where appropriate.

## Police and criminal justice system

It was fairly common for survivors to have had some contact with the police in relation to organized abuse. This may happen without the knowledge or consent of the survivor, generally with poor outcomes. For instance, one survivor was admitted to the emergency department of a public hospital after being abducted, assaulted and left semi-conscious on the side of the road, and the attending physician contacted police who then attempted to interview her in hospital. Traumatized and bedridden, she was unwilling to speak to them about the assault and they left exasperated.

Other victims actively sought out police assistance in maintaining their safety. However, a lack of training and understanding of complex trauma and dissociation amongst law enforcement was a major barrier to investigating and prosecuting adult organized abuse complaints. For instance, Claudia described how her complaint of organized abuse was quickly derailed when the investigating officer specializing in sexual offences was replaced with a non-specialist detective:

> I've got this strong sense of justice. I was sort of like, 'I need to tell the police, and get these twenty-plus people arrested, or at least one of them to send the message'. You know, like 'Let's tell the neighbours so their kids are safe' and all this sort of stuff.
>
> So I went to the police. Had initially had a really good experience with a woman in the sexual offenses unit. But she got moved. And then instead of being with the sexual offenses unit, my case went straight to general criminal investigation. And I got a real cowboy.

Following the appointment of a new detective, there were a number of changes in the investigation that made Claudia highly anxious. For instance, Claudia was obliged to attend a police station close to the suburb where much of her abuse took place, raising the prospect that perpetrators might see her as she entered the station. She was no longer permitted to provide her statement in writing, as the detective insisted that she continue her statement on video,

which she found triggering. On at least two occasions, the detective visited Claudia at home without warning and against her explicit instructions. With the support of a pro bono lawyer and her psychiatrist, Claudia extricated herself from the investigation entirely, and it closed as a result.

Another significant barrier to making contact and establishing trust with police was alleged police involvement in organized abuse. Julia, a rape crisis worker, had been working for five years with a former police officer who refused to contact police about her own ongoing organized abuse because, when she was serving in the police force, she had been forced to participate in the abusive group and cover up their activities. Julia said:

> The woman described to me how she'd been in the police, and that she, being forced to do things to other people, and that's what made her feel unable to tell anybody [about her own abuse]. As a young woman she was recruited, she was a rookie. She was a young police officer and in uniform- she helped the men to do things.

This account dovetailed with the recollections of other survivors, who described adult organized abuse by men they were certain were serving police officers. Survivor participant Zoe made a formal complaint regarding the involvement of police officers in her organized abuse as an adult. The police investigation concluded that the sexual activity had taken place but was consensual. Trained from childhood to obey these men under threat of violence, Zoe did not resist when they came to her door. As she said, 'What are you supposed to do? These are, these are uniformed police officers that you're not supposed to say no to, and they have weapons, and they've got everything'. In the course of a police investigation into her complaint, her fear of the perpetrators and her dissociative patterns of compliance were misconstrued as consent.

### *B. Medical services*

Survivors frequently required medical attention following abusive incidents, however, their atypical injuries and presentations could raise questions about their credibility in medical contexts. Health workers and doctors frequently assumed that their injuries were self-inflicted despite their complaints of victimization. Self-harm is indeed common amongst people with dissociative disorders (Middleton & Butler, 1998) who may be, in some instances, amnestic for the infliction of the injury. However, in this study, mental health workers were that concerned that the uncritical presumption of self-harm by health workers could obscure criminal victimization and legitimate safety concerns.

For instance, Maya was a psychiatrist working with a young woman who is presently extricating herself from organized abuse. This has triggered retaliation from the abusive group, including assaults that left burns and cuts to the

client that Maya concluded could not have been self-inflicted. However, when the client presented at the emergency department after an assault, physical evidence was misdiagnosed as self-harm:

> Just before I started looking after her, the, the abuser came to the house and tortured her. He said, 'You're nothing but a filthy root' [Australian slang for sexual intercourse]. And took twigs, roots and leaves—like he had put—and inserted I think 12 or 15 large sticks into her vagina. All the way up, and she has gone to ED [emergency department] and she had them removed. Of course, they think she stuck them up there.

The correct assessment of such injuries is vital to ensure the appropriate treatment of the survivor. For instance, a client of Julia's had significant gynecological complications and Julia was worried about her impending surgery since the client was disclosing the current organized abuse. Julia's supervisor questioned whether the client's was disclosing actual events (rather than flashbacks or memories) so, with the client's permission, Julia contacted the woman's general practitioner. The doctor had over a decade of medical documentation of injuries consistent with the women's complaint of sadistic sexual violence. Julia recalled:

> [The client] had been seeing a doctor since she was a young woman. She gave me the name of the doctor, she said 'The doctor is ready to talk to you'. I rang the doctor, I confirmed. The doctor said that she is all prepared for if we got to court. She's got documentation of all the medical records, and she confirmed for me that this is real.

Medical confirmation of the client's disclosures of ongoing abuse had a number of important impacts. It changed how Julia supported the client to address her gynecological needs, so that surgery did not exacerbate her injuries or leave her vulnerable to further harm. It also gave Julia certainty that the client was presently unsafe rather than experiencing intensive flashbacks and memories. Finally, medical documentation provided another source of confirmation and evidence if the client wanted to press charges against her abusers. In this circumstance, the failure of either the mental health practitioner or the general practitioner to take the client's disclosures of ongoing organized abuse seriously could have had adverse implications, including the scheduling of major surgery during a period in which the client was at risk of sexual violence. This illustrates the importance of remaining open to the possibility of ongoing victimization, while nonetheless recognizing the frequency and complexity of self-harm in this population.

### *Child protection*

Adult organized abuse raises important, and largely unaddressed, questions about the safety and protection of the children of victims. The specific patterns of victimization evident in adult organized abuse can be misunderstood by child

protection agencies with serious implications for women and children. Richard, a psychiatrist, described a client married to a man, who was part of an organized group that abused her since childhood. He had sadistically assaulted her, resulting in her hospitalization on a number of occasions. The child protection officer accused the woman of injuring herself in front of her daughter, and permanently placed her daughter with the husband, despite advice from Richard and attending physicians that her injuries were not self-inflicted.

> [Child protection] have formed the belief that, oh, that the husband is wonderful, and that she's got a mental illness, and that she's self-harming, and that she needs to apologize to her daughter for self-harming. And, this is someone who's been actively, sadistically assaulted by someone who's trying to kill her.
>
> As of last week, child protection took the daughter away from her and put her in the hands of the husband. … The hospital has now said that the nature of the injuries is that they're impossible to be self-inflicted, 'please do your job and find out who's doing it'.

The child protection officer, I have had a conversation with him, and then he tries to—Honestly, he tries then to completely misquote me to the patient. You know, "Your doctor agrees with us".

Other professionals described circumstances in which women experiencing organized abuse were either accused of self-harming or blamed for not leaving an abusive situation by child protection workers. Sexual assault worker Tamsin described this as a form of 'mother blaming' that denied adult organized abuse victims the support they needed to keep themselves or their children safe:

> Suddenly these clients, who've had really, really complex trauma histories, who've landed in DV [domestic violence], which isn't so unusual, and some of them with organized perpetrator group histories and some of them current—they suddenly come to the attention of child protection, who have taken their children. So we've gone, all of a sudden, it's back- flipped into mother blaming. And again, the perpetrators are invisible over here.

Nonetheless, child protection services can play a vital role in supporting women to escape from organized abuse and protecting their children. In the mid-1990s, Rhea was extracting herself from the abusive group that had abused her since childhood and was abusing her son. During this period, she endured a period of heightened threats and sexual assaults that included break-ins at her home. Her therapist was able to broker a placement for her son through a child protection manager who had experience in the area and was supportive of Rhea's aspirations to escape organized abuse.

> In the year that it was really bad, it got so bad that they took, they took my son into care. Child protection took my son into care. My therapist had to disclose to social services what was going on in terms of the threats that were being made against me and the things that were happening. And so they took him into care.

> There was one person that knew, she only, my therapist contacted the one person that understood what was going on in this area, who was a child protection manager called Vicki. Vickie had been involved in the removal of kids from a famous cult, and she'd done quite a lot of training.

In this instance, Rhea's victimization was acknowledged (rather than dismissed or misconstrued), and she was not blamed for her own ongoing abuse or indeed for the abuse of her child. Nonetheless, child protection recognized the danger to her son and took appropriate action. This enabled Rhea to focus on establishing her own safety, which included working intensely with her therapist, and cooperating with a larger police operation that she credits with bringing organized abuse to an end. Her son was returned to her care and she was able to raise him safely and continue her life free from victimization.

## Discussion

Clinical treatment for the dissociative disorders has developed considerably over the last thirty years with outcome studies demonstrating significant gains across multiple clinical domains (Brand, Classen, McNary, & Zaveri, 2009). However, the preliminary findings of this study suggest that the responsiveness of multiple systems to dissociative adults has not kept pace with treatment improvements, although they are a high-needs group who often come to the attention of a range of agencies. In this study, the professional and survivor cohorts described a lack of consistency in service responses to adult organized abuse across mental health, law enforcement, medical and child protection agencies. A supportive response to a complaint or disclosure of adult organized abuse was largely a matter of luck. It was more common for the professional and survivor cohorts to describe trying to manage ongoing victimization and mental illness against the broader backdrop of systems and services that did not recognize either dissociation or organized abuse. Both cohorts described the difficulties in maintaining therapeutic boundaries and a sense of perspective during periods of crisis in the absence of a broader network of support and protection.

The balance between enhancing the survivor's wellbeing and autonomy while managing and reducing their risk of victimization was a difficult one for both survivors and professionals to strike. The dominant presumption that, upon reaching the age of majority, adults are independent and largely autonomous beings making choices of their own free will provides a poor lens through which to understand the actions of adult organized abuse victims. What may appear, to an external observer, to be an adult's "decision" to participate in sexual activity (however unusual or sadistic) or to engage in some other risky behavior is in fact better understood as a coerced response underpinned by a history of abuse, fear and manipulation. Some agencies treated the adult organized abuse victim as hyper-responsible when, for instance, they faulted her for her injuries, the risks

to her children, or her apparent "non-compliance" with police instructions. Other agencies characterized the victim as incapable of responsibility by labeling her as "crazy", delusional or entirely passive in response to victimization. Such polarized responses could intensify dynamics of humiliation and self-blame, and further compromise the recovery and safety of the adult organized abuse victim. Survivors and practitioners alike remarked upon the irony that adults might escape the abusive system of organized abuse only to become enmeshed in another series of abusive systems.

## Conclusion

The preliminary findings of the study suggest that there is a need for increased training and capacity building for a range of systems and agencies in contact with adult organized abuse victims. Positive outcomes for victims and their children can be secured when cooperation between relevant agencies created a context of relative safety. However, there were a number of fracture points evident in service and system responses. A lack of recognition of dissociation or organized abuse, and the stereotyping of women with mental illness as liars and fantasists, resulted in unconstructive skepticism, and sometimes outright hostility, to women reporting adult organized abuse. Where evidence of organized abuse was available, it was often used to impugn the victim's credibility e.g. injuries after assaults were misdiagnosed as self-harm, and dissociative compliance was misconstrued as consent to sexual activity. This maintained women and their children in a state of ongoing vulnerability to organized abuse, and could lead to misinformed child protection and medical interventions with potentially deleterious impacts. Training and knowledge of organized abuse was the critical factor that distinguished a supportive and effective intervention from an ineffectual or harmful one. This has implications not only for clinical practice and treatment but also for policy and service frameworks, as adult organized abuse is a specific pattern of victimization that is poorly addressed within existing responses to violence against women and children.

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