Organised abuse: A neglected category of sexual abuse with significant lifetime mental healthcare sequelae

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Some mental healthcare workers are aware of clients with high needs, such as dissociative disorders and personality disorders, who have histories of sexual abuse (contact offences), usually from early childhood, involving two or more adults acting together and multiple child victims (Gold et al., 1996; McClellan et al., 1995; Middleton & Butler, 1998). This has been defined as “organised abuse” (Bibby, 1996; La Fontaine, 1993). Excluded from this definition are cases where a child is sexually abused by multiple perpetrators who are unaware of one another, such as survival sex amongst homeless youths, or where abuse is limited to a single household or family and there are no extra-familial victims (La Fontaine, 1993). Organised abuse is associated with a range of trauma-related mental illnesses amongst victims as well as other poor life outcomes (Gold et al., 1999; Leserman et al., 1997; Williams, 1993).

Challenges to the study of organised abuse

Organised abuse has been one of the most controversial issues in debates on child sexual abuse over the last 30 years (Kitzinger, 2004). While research suggests that families are an important site of organised abuse (Itzin, 2001; Kelly et al., 2000; Scott, 2001), a general reluctance to acknowledge the role of families in organised abuse has resulted in a disproportionate focus on extra-familial and homosexual exploitation rather than on the serious abuse of younger children (Kelly, 1996). Speculation on the unusual characteristics of some organised abuse cases, such as ritualistic sexual practices with children, has tended to obscure the familial contexts of organised abuse, and the gendered dynamics of organised abuse (Clapton, 1993), as well as the presence of domestic violence, physical abuse, emotional abuse and neglect in families involved in such abuse (Scott, 2001). Allegations of ritualistic abuse have been met with intense scepticism that has impacted upon perceptions of cases of organised abuse (e.g. Guilliatt, 1996; Loftus & Ketcham, 1994; Ofshe & Watters, 1996).

Research in health and welfare settings has found that adults with histories of organised and/ or ritualistic abuse are presenting in a range of health and welfare contexts (Cooper, 2004; Schmuttermaier & Veno, 1999) although their complex mental health needs often go unmet (Courtney & Williams, 1995; Freer & Seymour, 2003; NSW Health, 1997). Child protection investigations have also identified children subject to organised abuse (e.g. Doherty et al., 1999; Galey, 1995; Goddard, 1994). Clinicians have noted the severely disturbed and disturbing conduct of such children in treatment (O'Driscoll, 1994; Svedin & Back, 1996; Uherek, 1991). The evidence that organised abuse has significant mental health sequelae, and that health and welfare services encounter such clients not infrequently, calls for a reassessment of the available evidence on the topic. This paper will review evidence for the prevalence of organised abuse and discuss the implications of this for mental health policy and practice.

It is important to note that the literature on organised abuse is beset with definitional problems in which key terms are left undefined or unclear. Hence, the available data may be provocative but its utility is limited. For example, Creighton's survey of British child protection teams' awareness of organised abuse did not define the term “organised” although the survey was designed to collect data on network abuse with multiple perpetrators and multiple children (Creighton, 1993). Similarly, both an American and a British survey of cases of ritualistic child abuse allegations encountered by mental health workers presume, but do not explicitly state, that the abuse could involve multiple perpetrators and multiple victims (Bottoms et al., 1996; Ost et al., 2011). Such ambiguities are evident throughout the literature on organised abuse. As a result, any conclusions drawn from this literature must be necessarily tentative rather than definitive.

This review has been undertaken as part of a larger study of organised abuse (Salter, 2012). A systematic review of research on organised abuse is not possible since the available studies involve such diverse methodologies and sampling techniques as to elude comparison and meta-analysis. Instead, the authors employed both structured and informal searches of databases pertinent to
psychology, public health, medicine and the social sciences, which reflects the interdisciplinary nature of research on organised abuse. References from other published works were also consulted to ensure that all relevant literature have been incorporated. Results are presented here in a narrative form in order to facilitate an overview and critical analysis of the available information. Data are drawn from developed and mostly Anglophone countries. Much of the literature on organised abuse is focused on psychotherapeutic treatment or else it involves commentary rather than research; hence, gaps in the available literature have been addressed by analysing the relevant findings of epidemiological and clinical surveys and, in some cases, qualitative research with adults disclosing organised abuse.

How common is organised abuse?

Establishing the prevalence of any form of sexual abuse is difficult. Cases reported to the authorities are probably an unrepresentative minority of the overall incidence of sexual abuse (Bromfield & Higgins, 2003). Prevalence study findings vary according to recruitment methods, gender of the sample, methodology and definition of sexual abuse (Goldman & Padayachi, 2000; Wynkoop et al., 1995). Methodological difficulties for sexual abuse research are further complicated in organised abuse. Abuse characteristics associated with inconsistent reporting and disclosure behaviour amongst victims, such as multiple perpetrators, repeated incidents of abuse, longer duration of abuse, early initiation of abuse, threats of death or harm during abuse, and a relation of dependence with a perpetrator (Briere & Conte, 1993; Loewenstein, 1996; Schultz et al., 2003) are common features of organised abuse (Creighton, 1993; Gallagher et al., 1996; Waterman et al., 1993).

Sexual abuse in childhood has been measured differently in population surveys, with between 3% and 12% of men and between 10% and 20% of women reporting sexual “touching”, contact or coercion in childhood (de Visser et al., 2003; Fanslow et al., 2007; Laumann et al., 1994). Higher rates of sexual abuse are found amongst women in clinical settings (Leserman & Drossman, 2007; Makhija & Sher, 2007; Wise et al., 2001), men who have sex with men (MSM; Paul et al., 2001), prisoners (Butler et al., 2010), intellectually disabled children (Herschkowitz et al., 2007) and homeless women (Goodman et al., 1995).

From population surveys, we cannot directly ascertain how many respondents have been subjected to organised abuse, but we can see evidence suggestive of the same pattern in a minority: people who have been sexually coerced by multiple people in childhood, people abused by both men and women, and people whose abuse started before the age of 6. In community self-report studies, between 5% and 10% of women report sexual abuse by multiple perpetrators (Kendler et al., 2000; Long & Jackson, 1991) as have half of sexually abused MSM (Paul et al., 2001) and at least 29% of sexually abused homeless women (Goodman et al., 1995). Rates of multi-perpetrator sexual abuse are higher in clinical samples of women than in community samples of women (Bulik et al., 2001; Fanslow et al., 2007; Russell, 1986). Where the question is asked, between 2% and 17% of women in treatment for sexual abuse report organised and ritualistic/sadistic abuse (Briere, 1988; Gold et al., 1996) and between 5% and 17% of sexually abused children and adolescents report organised and ritualistic/sadistic abuse (Finkelhor & Williams, 1988; McClellan et al., 1995).

Sexual abuse by both women and men is suggestive of organised abuse because female sexual offenders commonly abuse with one or more male co-offenders (Grayston & De Luca, 1999; Faller, 1995; Vandiver, 2006). In the American National Health and Social Life Survey, 2% of women and 5% of men reporting “sexual touching” under the age of 12 or 13 reported victimisation by both men and women (Laumann et al., 1994). Approximately 6% of teenagers at residential alcohol and drug treatment centres in North America reported sexual abuse by both male and female perpetrators (Baker et al., 2006). This indicator was higher in the Sexual Health and Attitudes of Australian Prisoners (SHAAP) study, with 6% of men and 22% of women reporting sexual coercion in childhood reporting abuse by both men and women. Organised abuse: a neglected category of sexual abuse.

Sexual abuse prior to the age of 6 is associated with sexual abuse by multiple perpetrators (Alfred et al., 1999; Dickinson et al., 1999; Leserman et al., 1997), and this is reported by between 20% and 30% of women in treatment for sexual abuse (Dickenson et al., 1999; Herman et al., 1986; Pettigrew & Burcham, 1997). Among male prisoners in SHAAP, 11/128 (9%) of those coerced by men, 3/103 (3%) of those coerced by women and 5/37 (14%) of those coerced by both men and women were under 6 the first time. Among female prisoners, 20/185 (11%) of those coerced by men were under 6 the first time, as was one of seven women coerced by both men and women.
In summary, between 10% and 20% of women and 3% and 12% of men in the community report contact sexual abuse in childhood, with higher rates reported amongst women in clinical settings, prisoners, MSM, homeless women and adolescents, and the disabled. Of those who have been sexually coerced, 2% of women and 5% of men in the community report contact sexual abuse by both men and women, which is an indicator of organised abuse. According to this indicator, 2–4 women in 10 000 women and 1.5–6 in 10 000 men have been subject to organised abuse. Other indicators of organised abuse, including sexual abuse prior to the age of 6 and sexual abuse by multiple perpetrators, are reported by a significant proportion of women in treatment for sexual abuse, as well as by homeless women and prisoners. In clinical settings, up to one-fifth of sexually abused women and children report organised abuse when asked, but the majority of prevalence or clinical surveys have not included such questions (Briere, 1988; Finkelhor & Williams, 1988; Gold et al., 1996; McClellan et al., 1995).

**Worldwide awareness of organised abuse as a problem**

Much of the available literature on organised abuse is focused on ritualistic abuse, possibly because allegations of ritualistic abuse have proven very controversial, and ritualistically abused clients present with clinically challenging traumatic and dissociative symptoms (Fraser, 1997), and they disclose the most severe experiences of abuse (Gallagher et al., 1996). Three surveys in Britain and North America suggest that between 10% and one-third of mental health workers have encountered a case of ritualistic abuse (Andrews et al., 1995; Bottoms et al., 1996; Ost et al., 2011). While the generalisability of these surveys is limited by low return rates and, in the case of Bottoms et al. (1996) and Ost et al. (2011), a vague definition of ritualistic abuse, they suggest that a significant minority of clinical practitioners have encountered a child or adult client reporting a history of ritualistic abuse, and that the majority find their disclosures to be convincing. In Australia, Schmuttermaier and Veno (1999) had similar findings in their survey of mental health workers who specialised in trauma and abuse.

Workers in dissociative disorder clinics are particularly likely to encounter a client disclosing organised abuse: between 4% and 8% of clients report a history of ritualistic abuse (Coons, 1994; Putnam, 1997) and 11% report abuse by “paedophile rings” (Middleton & Butler, 1998). The revised guidelines for the treatment of dissociative identity disorder (DID) published by the International Society for the Study of Trauma and Dissociation (ISSTD) (2011) acknowledged that a substantial minority of dissociative clients disclose “sadistic, exploitive, and coercive abuse at the hands of organized groups” (p. 168). They note that, while mental health workers evince a range of views regarding the veracity of such disclosures, clients disclosing organised abuse “are likely to be among the most traumatized dissociative patients” (pp. 168 and 169).

Some researchers have attempted to measure the prevalence of reports of organised abuse to child protection agencies and the police. Wild collected data on child sexual abuse cases reported to police in Leeds, Britain, from July 1984 to June 1986 and found that, over the 2-year period, six “sex rings” involving multiple perpetrators and multiple children were reported to the police (Wild, 1989). Creighton's (1993) survey of the 71 child protection teams of the National Society for the Prevention of Cruelty to Children (NSPCC) in Britain found that 41% of the agencies were aware of a case of organised abuse in their area between the period of December 1989 and April 1991. Twenty percent of teams reported working with children who were suspected of having being victimised in organised abuse during this period. In interview, these teams reported 19 cases of suspected organised abuse involving 61 children from 43 families. These cases represented 0.3% of the total cases of child abuse and neglect in the workload of NSPCC teams nationwide throughout the period under study. As previously stated, Creighton did not define the term “organised abuse” in her survey and hence, although her results clearly pertain to cases of sexual abuse involving multiple children and adults, it is possible that the accuracy of her study has been adversely affected by this ambiguity.

In Britain, Gallagher et al. (1996) undertook a comprehensive review of child protection cases within eight local authority areas, encompassing 20 000 files across 32 sites. They concluded that “if the per capita rate of known cases of organised abuse in the eight areas combined was the same as that in the whole of England and Wales, then there would have been 1111 cases of organised abuse in England and Wales between 1988 and 1991, or a mean incidence of 278 cases per annum” (p. 220). The cases identified by the authors accounted for 1% of all child protection cases and 2% of sexual abuse cases reported to the police, and 1% of child protection cases and 3% of sexual abuse cases reported to child protection agencies nationwide during the period under study. On the whole, the researchers found that
each case involved multiple settings and forms of abuse: “In short, there was no typical organised abuse case, but rather a set of factors that tended to cluster” (p. 226). In the case of medium- to large-scale cases of organised abuse, the authors observed that:

The sexual abuse these children suffered tended to be extreme. On occasions, they would be exposed to bizarre and sadistic practices, such as being forced to eat excrement, and bestiality (p. 227).

**Mental health care needs of people who have been subject to organised abuse**

The research literature links sexual abuse or coercion in childhood to a range of mental, physical and sexual health problems in adulthood (Maniglio, 2009) although not all sexually abused children experience such long-term effects (Rind et al., 1998). The impact of sexual abuse upon victims is related to such factors as the child’s familial and community environment and relationship between perpetrator and victim (Briere & Elliott, 1993) and particular characteristics of abuse. The factors associated with long-term harm amongst sexual abuse victims, such as multiple perpetrators, more frequent incidents of abuse, a longer period of abuse, familial perpetrators, the use of force/threats/drugs and penetrative abuse (Briere & Runtz, 1988; Casey & Nurius, 2005; Dube et al., 2005) are common features of organised abuse (Gallagher et al., 1996). In particular, these characteristics are associated with complex forms of post-traumatic stress disorder and dissociative spectrum disorders. In cases of organised abuse, clinicians have suggested that traumatic and dissociative psychopathology may be deliberately induced by sexually abusive groups to inhibit victim disclosure and reduce the likelihood of detection (Epstein et al., 2011; Miller, 2012; Sachs & Galton, 2008), resulting in what Chu (2011, p. 263) has described as “massive Organised abuse: a neglected category of sexual abuse 503 devastation of the self”. Shengold (1979) employed the term “soul murder” to describe the subjective experience of “living-deadness” produced by early, chronic and repetitive abuse.

There is ample evidence that people with histories of organised abuse constitute a population of mental health patients with acute and complex needs (Ross, 1995; Noblitt & Perskin, 2000; Sachs & Galton, 2008). This literature overlaps with the body of clinical literature and research on dissociative spectrum disorders, particularly DID, that has developed since the 1980s (Fraser, 1990; Kluft et al., 1984; Mollon, 1996). Middleton (2005, p. 41) describes a typical DID presentation as a:

- dissociative and traumatized individual besieged by self-denigrating internal voices, who is affectively unstable, readily triggered, prone to suicidal ideation, who self-soothes by cutting, burning or using drugs/alcohol, who loses time, who is prone to derealization/depersonalization, and who struggles to have any clear boundaries or sense of personal identity.

Adults with undiagnosed or untreated DID have extremely high suicide rates several thousand times the American national average (Kluft, 1995). However, Ross (1997) observes that, in his clinical experience, the suicide risk for this population reduces dramatically once they have established a working rapport with a mental health professional. Moreover, people with DID are at heightened risk of physical and sexual victimisation and may require mental health care to bring ongoing abuse to an end. The ISSTD (2011) has emphasised the ways in which ongoing abuse, or renewed contact with one or more primary abusers, profoundly compromises the treatment of survivors of organised abuse. Middleton (2005, p. 44) reports that “Many [DID] patients presenting, even as adults, are still being repetitively abused by the same people who abused them as children, or by facsimiles of them.” In his view, mental health care is, therefore, a mode of intervention through which the therapist can facilitate “cessation of abuse” through a period of hospitalisation, or otherwise helping the patient secure safe accommodation.

Chu (2011) and others (Fraser, 1997a,b; ISSTD, 2011; Middleton & Butler, 1998) have emphasised a careful and conservative approach to the treatment of clients disclosing histories of organised abuse, acknowledging the challenges associated with the treatment of this population. Whilst much of the relevant treatment literature emphasises post-traumatic stress disorder and dissociation, research has found that severity and frequency of child sexual abuse, including abuse by multiple perpetrators, is associated with severity of borderline psychopathology and psychosocial impairment (Zanarini et al., 2002). The complexity of need evident amongst this population, including “suicidal or parasuicidal
behaviors, alcohol or substance abuse, enmeshment in violent or exploitative relationships, eating
disorder symptoms, violence or aggression, and risk-taking behaviours” (ISSTD, 2011, p. 137),
foregrounds the importance of long-term therapeutic support. However, the degree of disability evinced
by many survivors suggests that many or most are unable to privately afford the expense of
psychotherapy whilst long-term therapeutic treatment is rarely available in the public health system. In
the absence of specialised and affordable care, survivors of organised abuse are instead presenting to a
range of services that are not tasked to meet their acute needs, including domestic violence services,
sexual assault services and community health services (Cooper, 2004; Courtney & Williams, 1995). It
is perhaps unsurprising that survivors of organised abuse frequently describe histories of suicide and
self-harm (e.g. Itiz, 2000) and are over-represented amongst the homeless and transiently housed
(Harper & Scott, 2005) and amongst prisoners (Kilroy, 2000).

Conclusion

Organised abuse is rare but it is associated with very poor mental and physical health outcomes. It is
well acknowledged in the psychological literature that adults with histories of organised abuse are
frequently amnesic for their abuse (Briere & Conte, 1993; Chu et al., 1999; Williams, 1993) and so
retrospective self-report studies may not be a suitable methodology for this population. Thus, findings
based on self-report are likely to be an under-estimation. However, surveys with adults reporting sexual
abuse in mental health contexts suggests that a significant minority have a history of organised abuse.
Questions have been raised about the veracity of these reports, and since research into organised abuse
has involved methodologies of varying quality, the available data need to be interpreted with caution.
However, it is notable that research with patients who disclose organised abuse or characteristics of
abuse associated with it (such as multiple perpetrators, sexual abuse by women as well as men, and/or
very early sexual abuse initiation) has consistently found higher levels of psychopathology and
psychosocial impairment compared with other sexually abused populations. Despite the complex needs
of this group, they are frequently unable to access integrated and effective care. Some support is being
provided by sexual assault services, domestic violence services and supported accommodation
programs, but these interventions are often ad hoc and crisis orientated (Cooper, 2004). Many survivors
end up in prison or homeless, chronically disabled by illness, or dead. It is clear that further research
and investment in specialist treatment and support options for this population is necessary to address
the challenges posed by organised abuse.

Note 1. Goodman et al. (1995) state that “most” of their sample of 99 formerly homeless women have
been subject to “severe abuse” (physical and/or sexual) by multiple perpetrators in childhood. They did
not report specifically on the percentage of women reporting child sexual abuse by multiple
perpetrators but they did specify that 29% of women reporting sexual abuse reported perpetration by at
least one family member as well as at least one stranger.

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