RECOVERY FROM CHURCH, INSTITUTIONAL AND CULT ABUSE: A REVIEW OF THEORY AND TREATMENT PERSPECTIVES

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July, 2015

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OVERVIEW

This document is designed for three key stakeholders: agencies involved in prevention and intervention of institutional, church and cult abuse; practitioners working directly with individuals who have experienced a range of abusive group systems; and ex-members of abusive groups and their families.

Abusive group systems can be imbedded in formal, publicly sanctioned organisations such as well-established churches and government run services. Abusive groups can also be lesser recognised entities such as informal spiritual groups and community/sporting groups. This document will present theoretical understanding and research on a range of abusive groups- which can be referred to by different terms: cults, destructive cults, personal development movements, manipulative groups, high demand groups, high control groups, charismatic groups, new religious movements, formal churches (eg., Catholic Church), and institutional organisations/community groups such as orphanages and welfare agencies. For the current purposes the term abusive group will be used to refer to all of the above mentioned terms, except for when a particular term is required for clarity of context and discussion of unique characteristics.

Abusive groups can be of a political, spiritual, religious and/or social orientation. This document will attempt to be applicable across all of these types of abusive groups. While there are differences across abusive groups in their structure and impacts on members this document will attempt to address similarities as well as recognising differences where they may occur. Due to the breath of coverage we acknowledge that not all group contexts will be explored in the depth and complexity desired. However, we hope that this document assists in understanding the common characteristics and impacts of abusive groups, the relevance of power and control in human systems, and current recommendations for treatment.

This document is divided into two parts. Part (i) will discuss the common characteristics of abusive groups and how they operate, characteristics of abusive group leaders, personal and life-stage characteristics of members upon entry into an abusive group, and common post-group symptoms experienced by individuals who have exited. Part (ii) will address the state of research on treatment efficacy for ex-members of abusive groups. The literature review will discuss common treatment approaches and outcomes. Treatment is divided into two types: individual and group. The structure and outcome literature for both individual and group treatment will be discussed. Considerations for treating therapists and group facilitators will be outlined. Suggested directions for future research will be provided.

EXECUTIVE SUMMARY

Theory and treatment, as discussed in this document, takes into consideration that individuals who have experienced abusive groups- from cults to formal institutional abuse are suffering from highly complex and multi-factorial presentations. Multi-factorial presentations include: (1) pre-group vulnerabilities, (2) destabilising and potentially traumatising experiences while in the group and (3) post-group resources and adjustment difficulties. Abusive group leaders such as cult leaders and church/agency representatives such as clergy and institutional staff can be conceptualised as exhibiting sociopathic and/or authoritarian personality structures. These individuals use power and control to manipulate, dominate and exploit those dependent upon them. Individuals can be classified as either first generation members of an abusive group i.e., they chose or were recruited into the group or second generation members i.e., they were born into the group and their parents or guardians are either first or second generation members themselves. Typically, ex-members who entered an abusive group experienced pre-disposing factors that increased initial vulnerability to such groups; most commonly this is psychological and/or life transition resulting in stress or search for meaning and direction, as well as in some cases disturbance and disruption to personality structures through historical trauma. While in the abusive group individuals may have experienced physical and sexual abuse in addition to psychological abuse and/or were aware and/or witnessed and failed to intervene in such acts. Lastly, ex-members of abusive groups may have had to severe relationships with partners, family, friends who remain in the group, resulting in profound grief. This can also be the case for individuals who have left a formal church in which family remain practicing. Added to this there are often complex factors pertaining to current status of welfare due to life stage delay, educational and career limitations, financial vulnerability and social and interpersonal isolation. These difficulties are usually exasperated for second generation ex-members who do not have a former identity to return to and have limited external resources.

As a result of these multiple factors, effective treatment requires an appreciation of this complexity. Clients should expect a well-structured, non-coercive and transparent therapeutic intervention, which seeks to slowly and sequentially move through the stages of exit-counselling in a manner most likely to support their re-integration into normal society and relationships. In addition, understanding the client from a trauma response model is considered necessary. Therapy is thus structured to enable multi-modal interventions that provide coherent exit-counselling strategies, framed within a best-practice model for dealing with issues of trauma, grief, mental illness (PTSD, depression, suicidality), redefinitions of self, agency, and autonomy.

Despite the availability of literature discussing theory and approach to treatment there is a significant lack of research on the efficacy of such approaches. The current

review found research often focused narrowly on risk factors for group conversion; effects of membership in a variety of abusive groups; or treatment that utilised one particular method i.e., most often support group or individual exit-counselling. Treatment outcomes were frequently based on self-report. Qualitative data was not readily obtained pre-treatment as well as post-treatment resulting in limitations in drawing conclusions about treatment efficacy. Comparison of therapeutic interventions is lacking: individual versus group therapy and single treatment modality versus combined (individual and group) requires examination. Further, long-term studies on ex-member psychological adjustment and recovery are lacking.

Future research can address the gaps in current knowledge by using standardised measures of psychological health pre-post treatment along with self-report of cognitive/emotional/behavioural functioning; re-treatment, post-treatment and longitudinally. Further, relatively unexplored areas for research exist; possible avenues for exploration include: the relationship between attachment style, parenting style, experience of psychosocial stages of development and vulnerability to abusive groups; educational programs for inoculating individuals to abusive contexts – ranging from intimate relationships to large group structures; and the relationship between characteristics of abusive groups and more general and pervasive issues of power and control in society.

PART 1

UNDERSTANDING ABUSIVE GROUPS: THEORY ON CHURCH, INSTITUTIONAL, AND CULT ABUSE

COMMON CHARACTERISTICS OF ABUSIVE GROUPS

In 2000 there were approximately half a million Australians directly or indirectly affected by charismatic groups (Joint Standing Committee on Foreign Affairs, 2000). Such groups can be of a political, spiritual, religious and/or social orientation (Salande & Perkins, 2001). In addition, according to the 2011 Australian Census, Australia's population was 21,507,717, of that 10,784,485 (or 50.2% of the population stated they were part of one of the four major formal churches). The four major church nominations based on congregation figures were: Catholic- 25.3%, Anglican- 17.1%, Uniting- 5% and Presbyterian/Reformed- 2.8%. Adding prevalence figures for Judaism, Islam, Buddhism and Hinduism, a picture forms of widespread involvement by the Australian public with some form of organised group (Australian Census, 2011). If one includes figures for exposure to orphanages, youth group homes/various residential housing units, educational settings and high intensity workplace teams it becomes apparent that experience with groups of various structures of power is fairly unavoidable.

People have a desire for belonging, meaning and purpose. These needs can be satisfied in healthy ways in groups that function to promote safety, respect for the individual and open discussion. However, even the most socially recognised and respected groups can become abusive through violation of one or more group principles. The International Cultic Studies Association (ICSA) provides the following definition which can be applied to most abusive groups:

> "A group or movement exhibiting great or excessive devotion or dedication to some person, idea, or thing, and employing unethical manipulative or coercive techniques of persuasion and control (e.g., isolation from former friends and family, debilitation, use of special methods to heighten suggestibility and subservience, powerful group pressures, information management, suspension of individuality or critical judgement, promotion of total dependency on the group and fear of leaving it), designed to advance the goals of the group's leaders, to the actual or possible detriment of members, their families, or the community".

Abusive groups can be led by an ultimate figurehead or [charismatic] leader. This leader may exist in living physical form, be deceased or metaphoric. Metaphoric representations include gods, deities, and mythical beings. Therefore, abusive groups can vary in complexity and structure, ranging from a flat level group with

one ultimate leader (more common in cult like groups) through to a complex power structure that includes a number of figures of authority, sometimes ordered hierarchically, who may act on behalf of a living, deceased or mythical leader (more reflective of formal church structures) (Edelstein, 2011; Lalich & Tobias, 2006; Singer, 1995).

Margaret Singer and Michael Langone have described some attributes of cults [that distinguish cults from other communities or groups]. Note mainstream religions may share some [not all] of these characteristics, adapted to their context:

1. The group displays excessively zealous and unquestioning commitment to its leader, and regards his/her belief system, ideology, and practices as the Truth.

2. Questioning, doubt and dissent are discouraged or even punished

3. Mind altering practices (e.g. meditation, chanting, work) are used in excess and used to suppress doubts about the group and its leader

4. The leadership dictates, sometimes in great detail, how members should think, act, and feel (about themselves, others, the world)

5. The group is elitist, claiming a special, exalted status for itself, its leader and its members, e.g. we are gaining enlightenment, we are morally virtuous

6. The group has a polarised, us-versus-them mentality, which may cause conflict with the wider society

7. The leader is not accountable to any authorities

8. The group teaches or implies that its supposedly exalted ends justify whatever means it deems necessary

9. The leadership induces feelings of shame and/or guilt in order to influence and control members. This can be done through peer pressure and subtle forms of persuasion

10. Subservience to the leader requires members to cut ties with family and friends and radically alter the personal goals and activities they had before entering the group. This will often be enhanced by the adoption of a new name and hence new identity

11. The group is preoccupied with bringing in new members

12. The group is preoccupied with making money

13. Members are expected to devote inordinate amounts of time to the group or group activities

14. Members are encouraged to live and socialise with other group members

15. Loyal members feel that there is no life outside the group. They believe there is no other way to be, and often fear reprisals to themselves or others if they leave-or even consider leaving-the group

(Singer, Temerlin & Langone, 1990; Langone, 1991)

How do abusive groups operate?

Like groups in general, most abusive groups appeal to the normal desires of ordinary people, but group recruitment tends to increase those desires through a type of courtship ritual. The prospective devotee is encouraged with the promise of reward [such as belonging and connection, heavenly/soul salvation, spiritual growth or enlightenment]. "In a way the group leader becomes like a genie holding out the promise of wish fulfilment" (Lalich & Tobias, 2006, p.43). While the courtship ritual is being enacted the individual is also slowly being desensitised to a variety of mind control techniques.

Robert Lifton (1961), identified eight "psychological themes" of mind control present in destructive groups:

1. Control of all communication and information (known as Milieu control). This includes each follower's internal self-communication. This sets up what Lifton calls "personal closure", meaning that people no longer have to struggle or think about what is true or real: prevents doubting and self-questioning. Expressions of doubt are not tolerated.

2. Mystical manipulation is the idea that the group operates for a higher purpose. Events are staged by the group leader(s) to appear as spontaneous mystical messages and learnings, which affirm the importance and rightness of the group.

3. The demand for purity is essentially a black-and-white worldview with the leader as the ultimate moral judge. Individuals are good or bad/evil; this usually extends to the group being good and the outside world being bad. This cognitive distortion creates an atmosphere of guilt and shame, where punishment and humiliation are expected. It also sets up an environment where members are expected to spy and report on one another: members lose their moral bearing as a result.

4. The cult of confession is the pressure to confess personal details under the guise of "confession will set you free". Such confession in fact is an act of surrender and total exposure that renders the individual often shamed and bound to the group. The follower experiences a loss of boundaries between what is secret (known to the inner self) and what the group knows.

5. The sacred science describes how the group's doctrine is seen as the Ultimate Truth: the group leader's claims are infinitely wise and applicable to all of humankind. No questioning is tolerated- to question makes one immoral, blasphemous, misguided, and/or unenlightened.

6. Loading the language is the use of jargon internal to (and only understandable by) the group. Constricting language constricts the person. Capacities for thinking and feeling are significantly reduced.

7. <u>Doctrine over person</u> is the denial of the self and any perception other than the group's perception. Personal experiences that conflict with the group doctrine need to be disregarded. There is no longer any personal reality.

8. <u>Dispensing of existence</u> is the process whereby the group becomes the ultimate arbiter of existence, all nonbelievers become doomed to meaninglessness, condemned to hell, or non-people: in the extreme this translates to non-members do not have the right to exist (an aspect of terrorism; Aron, 2011). This process creates us-versus-them mentality that breeds fear in followers who learn that life, enlightenment and salvation depends on a willingness to obey.

(Lalich & Tobias, 2006)

Double bind is a specific manipulation tool defined as 'a psychological predicament' in which a [usually dependent] person receives, from a single source, conflicting messages that allow no appropriate response to be made. Often the group member faces disparagement no matter what she or he does. The double bind imparts a message of hopelessness: you are damned if you do and damned if you don't. Further, it results in a form of 'crazy-making or gaslighting" whereby the group member no longer trusts their own thoughts, judgements, and even basic instincts (Edelstein, 2011; Jenkinson, 2008; Lalich & Tobias, 2006).

Once the individual is desensitised to the mind control techniques employed by the group, more overt methods are used to control day to day activities, which commonly include (Lalich & Tobias, 2006, p. 41):

- Induced dissociation and other altered states e.g., chanting, extended periods of meditation
- Control of information passing in and out of the group
- Isolation from family and friends
- Control of members financial resources
- Sleep and food deprivation
- Peer and leadership pressure
- Extensive indoctrination sessions, such as extensive one-on-one sessions with leaders, processing sessions, intense group activities
- Rigid security regulations and daily rules/rituals

Aron (2011) and Salande & Perkins (2011) provide a discussion of how abusive groups operate to induce dependency over time by weakening ego function. Ego function refers to the sense of personal self, including the individual's thoughts, experiences, and moral reasoning. The mechanisms used to weaken ego functioning include the use of methods which induce dissociation- depersonalisation and derealisation; techniques to diminish critical thinking, and implicit and explicit expectations of compliance. They conclude "the cult experience degrades the ego, effectively causing the individual to regress into a transient state of borderline

personality organisational style functioning that may resolve itself once the individual leaves the group" (Salande & Perkins, 2011,p. 386).

CONCLUSIONS AND KEY RECOMMENDATIONS: UNDERSTANDING ABUSIVE GROUPS

- Abusive groups (which can include small groups through to formal churches) abuse power and control over members to create dependency, obedience, conformity and silence.
- Abusive groups utilise a number of mind control techniques: control of all information and communication, mystical manipulation, demand for purity, cult of confession, sacred science, loading the language, doctrine over person, dispensing of existence, and double-bind.
- Abusive groups exhibit controlling behaviours to induce dependency in members: induced dissociation and other altered states, control of information passing in and out of the group, isolation from family and friends, control of members financial resources, sleep and food deprivation, peer and leadership pressure, extensive indoctrination sessions, rigid security regulations and daily rules and rituals.
- If we only recognise the extreme form of these psychological themes and behaviours we as a society risk enabling abusive structures to continue, failing to protect future generations from such groups. Further, we fail to acknowledge and respond adequately to the trauma already experienced by countless individuals and families (Ellis & Ellis, 2013; Fogler, Shipherd, Rowe, Jensen, & Clarke, 2014).
- There is a need for investigation into the extent these psychological themes occur in groups we may not readily identify as cult-like. How many of these psychological themes, which essentially collapse into two underlying drives- power and control- occur in full form or in some diluted sense in community, professional, and formal church structures.
- We recommend research informed program development to: understand the use of psychological mechanisms of control and abuses of power across various interpersonal relationships and societal structures (ie., intimate partner, education, sporting, community care, church). Program development can target prevention of abuses of power by increasing awareness of mechanisms of power and control. Further, there is scope for the development of appropriate targeted intervention at various levels (one-to-one through to complex hierarchical agencies) when such abuses do occur.

CHARACTERISTICS OF ABUSIVE GROUP LEADERS

Individualism and self-responsibility fails to take into account the power of human influence to control and manipulate, through the subtle and complete mechanisms of thought reformation. Further, there can be too readily a dismissal of the damaging effects that such exposure has on individual autonomy and sense of self. Many people understand the experience of being under the influence of drugs or alcohol and yet can find it difficult to conceive of how a personality can exhibit just as much influence, if not more, upon another's free will and autonomy.

Before moving into a description of the charismatic leader in abusive groups perhaps a more familiar example of individual power and control can be found in the area of domestic violence. Battered wife syndrome, is an example where a supposedly free and autonomous person has through a constant process of physical, psychological, and emotional abuse lost the ability to act in ways, which many people simply take for granted. In many ways "working with current and exiting cult members is similar to working with battered women" (Lalich & Tobias, 2006). It should also be noted that under Australian law spiritual abuse and control is a form of domestic violence (Family Law Act 1975, amended 2006). A number of studies have highlighted the importance of appreciating the profound destructive impacts of psychological abuse and emotional abuse on the individual. Thought control techniques are part of the repertoire of psychological abuse. Such abuse is usually insidious and highly corrosive of identity and sense of self. Being harder to detect than physical abuse, the victim may find themselves caught on the receiving end of a destructive cycle of "crazy-making" (Almendros, Gamez-Guadix, Rodriguez-Carballeira & Carrobles, 2011; Langone, 1992; Rodriguez-Carballeira, Almendros, Escartin, Porrua, Martin-Pena, Javaloyn, Carrobles, 2013; Wolfson, 2003).

It is important to recognise that those involved in cults are ordinary people who have been exposed to extraordinary levels of manipulation, control, and abuse. Leaders of abusive groups such as cults tend to possess what in psychology is termed an authoritarian style personality. An authoritarian personality has a tendency to:

- Organises through hierarchy
- Move towards acquisitions of power and wealth
- Tendency to use people and see others as inferior or wrong
- Hostility, hatred, and prejudice
- Superficial judgements about people and events
- One sided scale of values favoring the one in power
- Perception of kindness as weakness
- Tendency to use people and see them as inferior

- Have a tendency towards sado-masochism
- Incapacity to be fulfilled and satisfied
- Suffer from feelings of paranoia and persecution

(Lalich & Tobias, 2006, p.53)

It is important to note that the authoritarian personality and these specific associated behaviours are not exclusive to cult leaders. If we fail to recognize how pervasive these behaviours are in society we risk continuing to fail to recognise abuse perpetrated by respected group structures, including the major church and community groups (Wolfe, Jaffe, & Jette, 2003). The authoritarian personality gravitates towards situations where they are able to garner control and power over others. The authoritarian personality structure can be seen expressed in various human social relationships: one-to-one intimate relationships, family, schools, sporting clubs, community groups and church. To this extent individuals can be exposed to and accustomed to accepting some degree of authoritarian behaviour prior to coming into contact with more clearly defined abusive groups. Acceptance of authoritarian behavior may possibly increase vulnerability to abusive groups. Further, such acceptance of authoritarian behavior can be seen in the lack of sufficient acknowledgement and response to abuses, for example, in state run orphanages, the stolen generations, church pedophilia, and institutional mental health. As a result survivors have struggled to receive adequate justice and treatment. Therefore, authoritarian behave may be directly associated with the act of abuse as well as the denial of the abuse.

Another type of abusive group leader is the charismatic leader, common in cults. Such a leader possesses strong talent for self-expression coupled with the ability to sense and read the needs of followers. These needs are then normally converted into the form of seductive promises that slowly lure the individual into the personalised ideology of the leader. Cult leaders are often incredibly manipulative and whilst they spend a great deal of time creating an image for their followers the essence of their personality is predatory. Therefore, charismatic leaders exhibit many of the features required for formal diagnoses under the DSM category of personality disorders. Two personality disorders in particular- Anti-social Personality Disorder (psychopathy) and Narcissistic Personality Disorder- share many of the characteristics of abusive group leaders (APA, 2014; Aron, 2011; Edelstein, 2011; Shaw, 2003).

In the text "Take your Life Back" by Lalich and Tobias (2006) they suggest a checklist to help individuals identify and demystify the traits of a psychopathic/sociopathic, charismatic leader.

- *Glibness and Superficial Charm:*

The charismatic leader is able to beguile and confuse and convince through the use of language; they are able to disarm and persuade with incredible proficiency.

- *Manipulative:*

The inability to recognise the rights and needs of others enabling any self-serving behaviour to be permissible. They divide the world into (1) those who can be manipulated, (2) those who are one's enemies, and (3) themselves. Many people involved in a cult have been allocated to the category of those who can be manipulated and anyone who objects to behaviours quickly finds themselves in the position of the enemy.

- *A Grandiose Sense of Self:*

Leaders have a tremendous feeling of entitlement, they by nature believe that they are owed and have the right to whatever behaviour they wish hence nothing is immoral or out of reach if it is in the quest to quench their insatiable desire.

- *Pathological Lying:*

The leader is able to lie and be untruthful without any sense of impropriety. The cult leader will often construct complex self-aggrandizing narratives, which will represent them as having special or unique powers. This kind of lying is connected to something called pseudologica fantastica, which is the term given to the complex belief systems and traditions which they themselves develop (eg., they are the manifestation of some supreme power).

- *Lack of Remorse, Shame and Guilt:*

The leader exhibiting sociopathic tendencies is unable to experience shame or guilt for their hurtful and damaging behaviours thus they see others as mere objects for the gratification of their needs. These needs are often carefully hidden and concealed within the subtext of some system of thought, which condones the lack of care and concern. They also tend to lack the capacity for genuine empathy but may disguise this with false displays of care and understanding.

- *Lack of Emotional Depth:*

The leader who is unable to express remorse is also likely to have difficulty with anything but shallow displays of emotion. Due to the power imbalance the emotional lack on behalf of the leader is often mistaken for some kind of profound equipoise gained through diligent adherence to the group values and practices. Much of the emotional display is designed simply to manipulate the followers.

- *Impulse Control:*

Leaders can exhibit problems with impulse control (otherwise referred to as acting out). This acting out normally takes a number of forms, the most common of which are sexual and physical abuse. This behaviour is often known only to a select few yet when it is publicly known complex explanations are offered. Usually this involves the leader behaving in ways that are simply beyond the understanding of their "less enlightened" followers. Thus there is often a claim to a special kind of teaching; this is particularly the case in sexual exploitation within spiritual cults. Spiritual cult

leaders may claim they are passing on or helping their victim's consciousness or spirituality. In the history of cultic studies it is usually the case that the sexual behaviour of the cult leader towards the followers is never truly consensual as it has arisen through sustained and deliberate degradation of personal will via threats of violence, control, and slow and surreptitious psychological manipulation over extended periods of time.

CONCLUSIONS AND KEY RECOMMENDATIONS: PROFILE OF ABUSIVE LEADERS

- Psychological abuse, a powerful weapon of abusive leaders, is usually insidious and highly corrosive of identity and sense of self. Being harder to detect than physical abuse, the victim may find themselves caught on the receiving end of a destructive cycle of "crazy-making".
- Authoritarian style personality is linked to abuse of power and control. Authoritarian personality characteristics: organise through hierarchy, move towards acquisitions of power and wealth, tendency to use people and see others as inferior or wrong, have a tendency towards sado-masochism, incapacity to be fulfilled and satisfied, suffer from feelings of paranoia and persecution.
- Two personality disorders in particular- Anti-social Personality Disorder (psychopathy/sociopathy) and Narcissistic Personality Disorder- are found in abusive group leaders.
- Characteristics of sociopathic group leaders: glibness and superficial charm, manipulativeness, a grandiose sense of self, pathological lying, lack of remorse, lack of emotional depth and impulse control.
- We may expect such sociopathic characteristics in cult leaders but consider leaders of new age movements, that proclaim a superior way of life; and survivors of clergy abuse who have frequently described a process of "grooming", whereby their dependency and powerlessness was used to abuse and threaten them into silence. People in power who abuse others may share some if not all of the characteristics of authoritarian personality, charismatic, sociopathic and narcissistic personality styles.
- We recommend when dealing with individuals exiting an abusive group to appreciate the impacts of exposure to authoritarian and personality disordered group leaders and fellow members who may have emulated the behaviour of the leader.
- We recommend fully recognising the extent to which psychological control and influence have been used to disempower the individual. Working with ex-members of abusive groups is a process of rehabilitation; the supporting and rebuilding of a person that has been violated psychologically and possibly physically, sexually, and financially.
- Greater awareness, prevention and intervention of psychological abuse is required. Prevalence and impacts of psychological abuse across all levels of interpersonal relationship (ie., intimate relationships, schools, sporting, community and church) requires investigation and appropriate intervention.

PERSONAL AND LIFE-STAGE CHARACTERISTICS OF MEMBERS UPON ENTRY INTO AN ABUSIVE GROUP

It is important to note here that no one actively seeks to join an abusive group, rather they are attracted to a community, a set of values, or a set of ideals, and it is only once they have been thoroughly groomed and indoctrinated into the institution/cult that the mind control and other abusive qualities begin to emerge.

A debate continues around whether individuals are "recruited" into abusive groups or instead encounter them as they are seeking something, usually certainty during times of major life transition or loss. Those that argue the recruitment pathway tend to focus on the brain-washing thesis of abusive groups. This viewpoint portrays the individual as somewhat of an unknowing victim that is aggressively pursued by the group and rapidly indoctrinated. Although some abusive groups would fit this profile research also suggests that individuals can be introduced to an abusive group through important interpersonal relationships such as friends or family. Further, individuals may be seeking personal answers, direction, spiritual/religious guidance and enlightenment and social connection, all of which may appear to be available through the group (Coates, 2010).

Although some individuals are first generation members, the abusive group may also include second generation members. First generation members are members who have entered the group as opposed to being born into it (second generation members). Although there are commonalities in experience, there are also key differences. Second generation members lack any frame of reference for life outside or without group membership. They have no former self to attempt to regain and they can often lack any support system outside of the abusive group. Such factors can complicate recovery and need to be understood and factored into treatment. Individuals, such as children, the mentally unwell and the aged who are placed in institutional care where abuse has occurred (e.g. orphanages, youth group homes, residential care) have experienced involuntary entry to an abusive context, coupled with high dependency needs. A further discussion of specific issues in the treatment of second generation members of abusive groups can be found in Part (ii). This discussion will include impacts of individuals who were placed involuntarily into abusive group situations.

In regards to first generation members, the literature is divided on the pre-entry characteristics of members, namely whether they are essentially psychologically healthy individuals in search of self-improvement, guidance and direction or individuals with psychological difficulties who are more likely to have experienced traumatic events, have negative family of origin relationships with potential current and/or historical abuse, substance abuse issues, and be struggling to cope with major life transitions and losses. Research attempting to determine

pre-group mental health status and life circumstances faces the limitations of retrospective reporting.

It would appear that there are a number of different pathways into abusive groups. Some individuals may be seeking to re-establish a sense of safety and security especially following traumatic events that have resulted in major life upheaval and loss of a sense of self. Others may be seeking a spiritual path and a rejection of more mainstream approaches (Lalich & Tobias, 2006; Langone,1993).

In the case of established church faiths such as Catholicism, individuals may share similarities with second generation cult members. Born into families that are practicing a certain faith the choice of whether or not to practice may never be presented to the individual. Further, if the individual is enrolled in a school governed by that faith, the messages become all encompassing. To disclose abuse under these circumstances, especially if still a minor and dependent upon family, could expose the individual to the risk of further abuse and family rejection.

It is useful to remember that structures of coercive power and control exist throughout human experience: in family of origin, peer friendships, intimate relationships, workplace relations, political systems, social media/marketing, welfare systems, and religious systems. Humans are essentially, from the time of birth, conditioned to except some degree of power dynamic in their relationships. We can even rationalise abusive dynamics with little awareness of doing so especially more subtle forms of psychological and emotional manipulation. Hence characteristics of abusive groups share many similarities to other groups which individuals are already accustomed to navigating. As a result entry into abusive groups, especially when done gradually, may be far easier than we appreciate and recognising when in one may take far longer than first expected.

CONCLUSIONS AND KEY RECOMMENDATIONS: VULNERABILITY TO ABUSIVE GROUPS

- In terms of research and therapeutic intervention, it is important to assess whether ex-members of abusive groups are first or second generation members.
- For first generation members it is important to understand why individuals enter abusive groups which requires fully assessing their life prior to joining.
- For first generation members- joining an abusive group, individuals may be seeking personal answers, direction, spiritual/religious guidance and enlightenment and social connection, all of which may appear to be available through the group. Others may be seeking to re-establish a sense of safety and security especially following traumatic events.
- For second generation members of abusive groups, members of established religious faiths born into that faith by family, and individuals placed involuntarily into abusive structures it is important to understand the impacts of the lack of choice, often high dependency needs, and potentially few resources available to such individuals.
- Structures of coercive power and control exist throughout human experience: in family of origin, peer friendships, intimate relationships, workplace relations, political systems, social media/marketing, welfare systems, and religious systems. Humans are essentially, from the time of birth, conditioned to except some degree of power dynamic in their relationships. This may also contribute to vulnerability to abusive groups. There is scope for further research in this area.
- We recommend intervention include a full assess of the individuals mode of entry into an abusive group i.e., first or second generation/involuntary admission into the abusive structure. This assessment may need to be part of any therapeutic intervention.
- We recommend specific research and intervention to improve conditions for individuals placed into care situations. Their lack of choice and dependency should be matched with vigilant scrutiny of power structures and potentials for abuse by such structures. Responses to abuse needs to avoid replicating disempowerment and secondary trauma. Appropriate support and recovery services need to be provided.

COMMON EXPERIENCES OF INDIVIDUALS WHO HAVE EXITED ABUSIVE
GROUPS

Ex-members of abusive groups report a range of difficulties in adjusting to life after the group. Coates (2010) conducted qualitative inquiry with seven participants from a range of abusive groups. Participants reported experiences of loss (interpersonal and personal meaning), difficulties with low self-esteem, lack of confidence, difficulties adapting to life outside of the abusive group, and feelings of self-blame and guilt. Although extent of loss (in leaving the group) had the strongest influence on post group adjustment (the greater the extent of loss the greater the degree of adjustment difficulty). Lastly, they found that manner of leaving the group (cast out, or walk out) had an impact on post-group adjustment; those that were cast out i.e., rejected by the group reported greater difficulties than those who walked out. Similar findings have been reported in other studies, as cited below (Almendros, Carrobles, Rodriguez-Carballeira & Gamez-Guadix, 2009).

This section is informed by the following literature and research which examined a range of groups including: cults, orphanages, compulsory residential care, and formal Churches (Aron, 2011; Coates, 2010; Fitzpatrick, Carr, Dooley, Flanagan-Howard, Flanagan, Tierney, White & Daly, 2010; Gearing, Brewer, Elkins, Ibrahim, MacKenzie & Schwalbe, 2015; Hassan, 2000; Knefel, Garvert, Cloitre & Lueger-Schuster, 2015; Lalich & Tobias, 2006; Leenarts, Vermeiren, van de Ven, Lodewijks, Doreleijers & Lindauer, 2013; Lueger-Schuster, Kantor, Weindl, Knefel, Moy, Butollo, Jagsch, & Gluck, 2013; Robinson, Frye & Bradley, 1997; Spero, 1982).

Adjustment difficulties experienced by individuals who have experienced abusive group structures can be categorised by: (1) cognitive difficulties, (2) affect/emotional disturbance, (3) physical wellbeing, (4) psychological/mental health concerns, and (4) behavioural/lifestyle difficulties.

<u>Cognitive difficulties include</u>: slipping/floating experiences (similar to dissociation- depersonalisation and derealisation- a tendency to experience trance like states whereby the individual may disengage from their surroundings and themselves), difficulty organising thought and completing sentences, poor problem-solving and decision making, difficulty separating personal thoughts from those of the group leader, cognitive distortions (particularly, black and white thinking, overgeneralisation, mental filter, emotional reasoning, and labelling), dependence on external approval for thoughts and beliefs, memory loss, intrusive memories, obsessive thinking. Some abusive groups place a heavy emphasis on deconstructing personal ego, in order to facilitate a regression back to earlier states of dependency. Ex-abusive group members may exhibit significant ego state impairment and personality disorganisation. Language used may be heavily infused with cult jardon.

Affect/Emotional disturbance includes: limited emotional range- disowning or suppression of negative states, mania, difficulty dealing with intense feelings of anger, anxiety, shame, guilt, sadness, betrayal, loneliness, and grief (over loss of community, connection, meaning, faith, purpose, identity). Emotional dysregulation. Experiences of overwhelming fear and panic.

Physical wellbeing: ill health from poor diet while in the group. Medical and dental issues untreated resulting in more serious ailments. Poor muscle tone and aerobic fitness from poor exercise routines. Sexually transmitted infections. Sleep disturbance/nightmares.

Psychological/mental health concerns include: traumatic flashbacks, Post-Traumatic Stress Disorder, depression, anxiety and panic attacks. Loss of self-esteem and sense of self. Further individuals may re-live unresolved trauma experienced prior to entering the abusive group. Risk of suicide.

Behavioural and Lifestyle difficulties include: lack of acquisition of life skills across any or all life domains. Study/career delay. Complete muting of creativity. Social isolation, powerlessness/passivity. Deficits in basic personal hygiene. Poor inter-personal boundary setting. Impaired ability to trust. Loss of spirituality/loss of religious faith.

CHURCH CLERGY ABUSE SURVIVORS: SPECIAL CONSIDERATIONS

When abuse occurs within socially recognised and respected institutions/groups there is potential for double betrayal (Fogler, et al., 2014). Rossetti (1995) and Wolfe, et al., (2003) examined the impact of child abuse in community institutions and organisations. They found child abuse in such circumstances is enabled by power structures that bestow authority (sometimes unquestioningly so) to groups and individuals who then abuse that authority. Their authority offers them protection from scrutiny and leaves children vulnerable to being abused and then further traumatised through not being believed if they should disclose abuse. They identified the following dimensions of harm resulting from abuse within socially recognised and respected groups such as churches, schools, sports and recreational groups: (1) betrayal and diminished trust, (2) shame, guilt, and humiliation, (3) fear of or disrespect for authority, (4) avoidance of reminders, (5) injury and vicarious trauma (this includes self-destructive behaviours and suicide). When an individual is abused by a member of a major religious faith they encounter reminders of their trauma on a regular, sometimes daily basis. To avoid painful reminders they may increasingly socially isolate. Commonly their family is also of that faith, which further serves to isolate them from a key source of support; if they disclose they may not be believed, even punished by family. At best, with a supportive family, such disclosure may result in familial guilt, shame, anger and potential loss of faith. If the individual does not

disclose they carry a secret that alienates them from those around them, trapping them in shame, guilt and humiliation without opportunities for recovery.

Abuse by religious representatives of recognised faiths is doubly traumatic for individuals. Formally recognised churches and religious faiths are part of society, referenced by regular ceremonies, major holidays, and commonly used language. They are socially sanctioned and can have significant impact on various aspects of life such as baptism, bar/Bat Mitzvah, marriages, and funerals. Continuing to practice the faith exposes the individual to reminders of their abuse, while removing oneself from the faith involves a multitude of losses. Further, religious doctrine may amplify an individual's trauma. Looking at the Catholic religious doctrine, this doctrine holds representatives up as direct representatives of God, and God is "a theistic being with omniscience and complete power. This god micromanages lives and has a plan for every person born" (Doyle, 2009, p. 244). This results in "abuse victims seeing their abuse as retribution or far worse, as a sexual assault by God" (Doyle, 2009, p. 247). Further, in order to live in accordance with the Catholic churches' position on forgiveness the abuse victim is then "strongly encouraged" to forgive their perpetrator. The church further abuses the victim through internal processes that pressure the victim to not pursue internal redress or external legal process. Finally, the Catholic churches' practice [not to say that this strategy is not employed by other faiths] of relocating rather than excommunicating priests conveys the importance of the church over individual parishioner welfare [or Lifton's (1961) doctrine over person] and essentially an acceptance of the abuse. Healing from trauma occurs through (1) acknowledgment of the trauma, (2) supportive, structured and skilled intervention to address all aspects of the trauma, as well as (3) the practice of restorative justice, where applicable. Handling of clergy abuse can fail to meet most if not all requirements of healing. If the Church can shift its objective from protecting its own clergy to genuine provision of care to its parishioners it will need to address how it has and continues to handle survivors of clergy abuse.

CONCLUSIONS AND KEY RECOMMENDATIONS: IMPACTS OF ABUSIVE GROUPS

- There is significant research reporting the nature of difficulties individuals are likely to experience upon leaving an abusive group.
- Individuals can experience profound disturbances after leaving abusive groups, in terms of: cognitive difficulties, affect/emotional difficulties, physical wellbeing, psychological/mental health, behavioural/lifestyle difficulties.
- Evidence shows that while some members report greater traumatic symptoms, which also need to be discriminated from pre-group functioning, others report difficulties that can be summarised as difficulties in transitioning into life outside the group or faith. Difficulties that ex-abusive group members face will be shaped by age and pre-existing functioning upon entering the group, length of time in the group, range and intensity of abusive behaviours employed by the group, and extent of resources (internal and external) available to the individual who has left the group. For individuals leaving a religious faith, they may face some of the above mentioned experiences as well as loss of connection with family and friends who remain in the church; loss of faith itself resulting in the struggle to find meaning; and reminders of the faith in daily life, which may trigger trauma responses.
- We recommend any treatment service be delivered by professionals/agencies equipped and trained to understand and response to the complex presentations of individuals who have experienced abusive groups. Services need to be able to create safety (from basic physical needs to psychological stabilisation) as well as treat the cognitive, emotional, physical, psychological, behavioural difficulties these individuals experience. The capacity to work with complex trauma and grief as well as resulting psychological disturbance (PTSD, generalised anxiety, fear/panic attack, depression, and suicide risk) is required.

PART 2

A REVIEW OF TREATMENT FOR CHURCH, INSTITUTIONAL AND CULT ABUSE

This section will first detail a review of the research on treatment approaches and outcomes. This will be followed by a description of a proposed structure for treatment for ex-members of abusive groups (cults, institutional, and churches). Treatment will be divided into three core elements: (1) assessment and diagnosis, (2) one-to-one counselling, (3) group support/therapy. Lastly, recommendations for future research will be discussed. Although medication may be an important adjunct to therapy, especially in assisting to manage anxiety and emotional dysregulation, a review of the use of medication has not been included in the current review.

LITERATURE REVIEW OF TREATMENT APPROACHES AND OUTCOMES

INSTITUTIONAL AND CHURCH ABUSE

Flynn (2008) undertook a qualitative study of 25 women aged between 23 and 68 years of age; all had experienced Christian clergy abuse, seven had been abused as minors. The study found the women experienced a range of symptoms of PTSD and Complex PTSD: re-experiencing/ intrusion of thoughts and feelings related to the abuse, avoidance behaviours, hyperarousal, trauma dialectic, affect regulation difficulties, attention alteration, heightened need for personal safety, somatisation, relational difficulties, trust difficulties, social isolation, and stigmatisation. The women reported the importance of the following: "social consensus and support including open acknowledgement of the abuse and belief of the women's experiences". Further, validation by the women's own faith communities and family was a positive factor in recovery: "being believed created psychological confirmation". Other significant factors in recovery were: "prompt removal of the paster by church leaders, correctly identifying the problem as the clergyman's abrogation of professional responsibility and putting support groups in place during disciplinary processes when individuals sought accountability all helped to lessen devastating residues of traumatic impact" (p. 235).

Lueger-Schuster, et al., (2015) analysed quantitative and qualitative data from a large scale sample of survivors of childhood abuse by Catholic clergy. Abuse was predominantly emotional, however, sexual and physical abuse was also reported by 68.8% and 68.3% of the sample respectively. They found that social support played a critical role in higher levels of mental health. In terms of treatment, support groups are a key way of delivering social support while addressing the needs of recovery.

Fitzpatrick et al., (2010) did not investigate treatment outcomes directly however through their analysis of the impacts of sexual, physical and emotional institutional abuse they recommended therapists who work with survivors of child institutional abuse be trained to assess and treat: anxiety, mood, substance use, personality disorders, trauma symptoms, adult attachment problems, and significant life problems. Further, they concluded that research on efficacy of treatment is needed.

Isely et al., (2008) found similar impacts in their qualitative study of nine men who had experienced sexual abuse by Catholic clergy; all were abused as minors. Most of the men in their study required extensive therapy, which in some cases lasted many years. They presented the following key recommendations for treatment: (1) therapeutic relationship with an authority figure who offers safe opportunities for the men to risk intimacy and vulnerability is vital, (2) therapist needs to be skilled in assessing and working with PTSD, depression, suicidality, affect regulation, relationship and sexual dysfunction (3) a multidimensional clinical approach is preferred, (4) the therapeutic relationship should be gradual and not impose disclosure and recovery timelines on clients, (5) as clients may be socially isolated, therapy should address interpersonal skills building and establishment of peer relationships, and (6) important that therapy addresses the effect of abuse on spiritual beliefs and practice. Finally, they proposed that "the unique nature of clergy-perpetrated sexual abuse suggests that individual treatment might be successfully augmented by a support group that can both validate and decrease the interpersonal isolation evidenced among survivors" (p. 212).

Mart (2004) also recommended individual therapy be combined with group therapy. They proposed individual therapy address social isolation behaviours and negative self-beliefs; while group therapy could provide validation and social support. Further, their study of 25 men who had experienced Catholic clergy abuse as minors found similar traumatic impacts to the studies mentioned above. However, they argue that the men in their study are better conceptualised using the four traumagenic dynamics model proposed by Finkelhor (1990). They argue this model is more comprehensive and flexible than the DSM-IV diagnosis of PTSD. The traumagenic dynamics model attempts to account for the wide range of reactions to sexual abuse by using four categories and their associated dynamics: "sexuality (sexualisation), problems with trust in interpersonal relationships (betrayal), self-esteem (stigmatisation), and the sense of being able to affect the world (powerlessness)" (p. 466).

In terms of assistance with recovery, it is worth noting the dangers of litigation and recovery services such as counselling being provided directly by the abusive group. Such examples are more likely to be found within large organisational settings and churches, namely the Catholic Church. Ellis & Ellis, (2013) discuss a personal experience of the Catholic Church's *Toward Healing*

protocol. The paper presents a number of difficulties that result from an organisation attempting its own direct process with victims namely: a motivation for resolution over healing resulting in adversarial interactions; a lack of transparency about the process; significant power imbalance, which can result from even an independent facilitator but which is appointed by the Church; little flexibility or ability for victims to direct the healing process. These experiences may replicate the original trauma, at least in the extent to which they disempower and deny the victim their reality. Ellis & Ellis propose The Conversational Model of psychotherapy to work with survivors of institutional abuse. The model has been developed to address trauma. It is an integrated model, combining psychodynamic, developmental and trauma theory, linguistics, neuroscience and the neurobiology of attachment. There is a strong humanistic element with emphasis on the therapeutic relationship, attunement and resonance with the client, warmth and empathy.

ABUSIVE GROUPS AND CULTS

Treatment approaches for ex-members of abusive groups include exit-counselling, trauma therapy, grief therapy, existential therapy, and cognitive-behavioural therapy. Given the complex multi-factorial presentation of individuals, a multi-approach to treatment is recommended. Exit counselling is best applied in such a way as to not only address the experience of the abusive group but also the following factors: pre-entry vulnerabilities after the individual has been stabilised, trauma responses (using principles of trauma therapy and which can include neuroscience on the effects of trauma), grief therapy and humanistic therapy (to address the need to re-establish connection and belonging, helping the client make meaning from their experience and how they continue to find life meaning post group) (Lalich & Tobias, 2006).

Matthews & Salazar (2014) explored the experiences of recovery for 15 second generation adult former cult members using constructivist grounded theory and a social justice-focused inquiry. They found support for the elements of exit counselling- the need to assess and assist individuals with: decision making, obedience to authority, capacity to form relationships, relationship to family of origin, religiosity and spirituality, addressing trauma and abuse symptoms, assisting with integrating into the world outside the cult, integrating their cult experience into personal meaning, and developing a sense of identity. Further, they argue it is critical that therapists be informed about mind control tactics and trauma informed practice. Therapists should engage in a full assessment of individual's background and experiences in the cult. In their study, they found former cult members reported particular benefit from involvement in support groups. Support groups were viewed as significant in helping to education about abusive group tactics, assisted participants to make meaning of their experience and to understand the resulting trauma and navigate the outside world. Regarding

therapists characteristics, study participants reported the need for therapists to take a non-authoritarian stance in order to not mimic negative power dynamics, as used in the abusive cult. Finally, they concluded from their own review of the literature that research into the experiences of second generation ex-members is lacking and recommended this be a direction for future research.

Similar findings were found by Spero (1982). This study detailed symptoms of cult involvement, which need to be considered in treatment: "deteriorated physical health or neglect of former health habits; single-mindedness and sometimes manic enthusiasm with cultic lifestyle; inability to carry on normal conversation uninterrupted by cultic jargon; hyper-cautiousness and possible paranoia; phobia; constricted thought processes with a marked tendency for black and white thinking; spontaneous emotional expression isolated behind polar and often times autistic preoccupations; distanced from early identifications; devalued former self-image; defensive tendencies of denial, projection, externalisation, and depersonalisation; oscillation in moods from insecurity and disgruntlement to a loving blissful acceptance of religious teachings" (p. 334). They studied 65 ex-cult members, who had spent on average 3.5 years in a cult- the shortest amount of time was 13 months. It is unclear how many, if any in their sample, were second generation members. Treatment (psychotherapy) consisted on average of 15 months of 1 sometimes 2 hour sessions three to four times per week for several months graduated to two times per week. No individuals in their sample of 51 recovered cases received less than 9 months of psychotherapy. Two years post therapy, no patients had returned to either the original abusive group/cult or found a new abusive group. However, of the 14 who dropped out of therapy after four-five sessions, 10 had re-entered cult life while four could not be located. Unfortunately, their study does not provide a detailed outline of the psychotherapy approach employed. However, they emphasise the importance of (1) therapists being informed of the tactics utilised by abusive groups and (2) characteristics and capacity of the therapist namely a non-authoritarian stance, ability to establish safety, management of trauma symptoms- emotional overregulation/under-regulation, management of dissociation, and skills in the development of a differentiated self. Robinson, Frye, & Bradley (1997) also provided similar considerations and recommendations for therapists: to prioritise the establishment of a therapeutic alliance; the therapist should be aware of common presentations and characteristics of ex-cult members, in order to fully assess the impacts and adequately adopt the principles of exit counselling.

In support of including an emphasis on pre-existing vulnerabilities Coates (2011) argues reasons for joining abusive groups need to be a focus of recovery. These reasons can include a need for certainty, friendship, meaning, belonging, as well as pre-existing trauma. However, Rosen (2014) argues for caution in including a focus on why someone entered an abusive group, particularly in the early stages

of therapy. The concern with such a focus is that it may result in a form of blaming of the victim, further heightening negative beliefs about oneself and prolonging the phase of stabilisation. Rosen also draws on the view that anyone is susceptible to cult involvement. Although, such a focus may not be appropriate during the early stage of therapy, Rosen does state addressing pre-entry life themes (which can include traumatic experiences) may arise during the "trauma-processing phase", when discussion of trauma experienced in the abusive group activates memory of pre-group patterns and experiences. Robinson & Frye (1997) drew more specific links between cult involvement and family-of-origin dynamics, stressing the need in recovery to address family issues and problems which existed prior to joining a cult and also family dynamics while the individual was a member of a cult. Part of such an emphasis is also to attempt to heal these family relationships and provide the individual with social support.

Social support is a well-recognised factor in psychological well-being. Enhanced social support protects against depression, trauma-related responses, anxiety and risk of suicide. Durocher (1999) found a support group structured so as not to resemble the abusive group in any way helped ex-cult members to talk about their experiences, have social contact with others and obtain mutual support. This involvement assisted participants to re-integrate into life outside of a cult. Further, such groups provide the distinction between a healthy group experience and an abusive group experience. Participants in Durocher's study stressed the importance of the therapist being aware of ex-cult member's needs and adjusting therapy in accordance. The support groups Durocher studied was humanistic in structure. Group size was viewed as important- for energy and flow of ideas (membership was not larger than 15). Other support group factors considered important were: establishment of safety as paramount, regular attendance, the group should consist of the same people rather than different people each session [which lends support for a closed group model as opposed to an open group], physical security and safety, psycho-education provided by experts (e.g. from a lawyer), frequency of meeting was important- once a month was not viewed by participants as frequent enough, they nominated groups should met at least fortnightly or even once a week. Other participant feedback included: running more than one support group distinguished by amount of time out of the abusive group as needs would be different, ie a group for those newly exited and another group for those post two years out of the group. Finally, participants reported an acceptance of groups being run by ex-cult members but also desired the presence of a psychologist or social worker to ensure safe and appropriate group facilitation. Participants reported the importance of avoiding the following factors: rituals, teachings, isolated locations/retreats, negative facilitator characteristics (facilitator should not have a strong overriding presence, should focus on group input). In conclusion, Durocher recommended more research be conducted into the outcomes of support groups in helping ex-members of abusive groups.

Looking more closely at therapist's characteristics, Dubrow-Eichel (2001) reported on an important consideration for therapists: the abusive groups conditioning to be wary of psychology. "Most HDGs are vehemently opposed to psychologists and psychotherapists" (p. 154) It is important for the therapist to be aware of such programming as it can help to understand client mistrust, fear and reluctance to negatively discuss the group. This has important ramifications for the development of the therapeutic alliance. Further, an individual may have left an abusive group for a variety of reasons- if they have been cast out [as opposed to voluntarily chose to leave, otherwise known as walk outs] they may desire re-joining the group, thus they will present to any form of therapy with particularly heightened ambivalence. Therapists should not assume that ex-members are ready to address abusive characteristics and mind control tactics of the group; they may be reluctant to do so for fear of further losses (loss of the idealised experience). Therapists need to assess the individual's stage of change and target therapy to meet the individual where they are. Salande & Perkins (2011) also point out the importance in appreciating the degree to which the abusive group may have regressed/eroded the individuals ego and personality organisation and indoctrinated them into thinking ego is bad. Such group beliefs will impacted on how the individual experiences any therapy that attempts to address sense of self. It is important that the therapist explores overtly yet gently such beliefs with the individual.

OVERALL CONCLUSIONS: TREATMENT APPROACHES AND OUTCOMES

There is a reasonable body of research detailing the effects of involvement in cults. There is less research on the effects of experiencing abuse within other abusive group structures such as educational, residential care, sporting clubs. There is also ample scope to extend on the small number of studies that have attempted to draw links across various abusive contexts through examining core themes of abuse of power. There is a small body of literature and research that has discussed abuse in cults compared with other interpersonal contexts such as domestic violence, abusive workplaces, and formal Church groups (Lalich & Tobias, 2006; Rodriguez-Carballeira, et al 2013; Wolfson, 2003).

Overall, there is a significant lack of methodical research on the efficacy of treatment approaches. Outcome studies predominantly focus on adult survivors of abusive groups. This can include abuse experienced as a child. However, research on treatment approaches and outcomes for children is an area is in need of further efficacy research. Further, there is significant scope to increase outcome studies for survivors of church and institutional abuse.

The current review found research often focused narrowly on risk factors for entry to an abusive group; effects of membership in a variety of abusive groups or treatment that utilised one particular method i.e., most often support group or individual exit-counselling. At the time of writing no study could be found that compared recovery outcomes for individual therapy versus group therapy and either of these options versus concurrent individual and group therapy. Treatment outcomes were frequently measured using self-report of symptoms only (ie. qualitative data only). Qualitative data tended to be retrospective rather than being obtained pre-treatment as well as post-treatment, resulting in limitations in drawing conclusions about treatment efficacy. Further, long-term studies on ex-member's psychological adjustment and recovery are lacking.

RECOMMENDATIONS FOR FUTURE RESEARCH

Future research could address the gaps in current knowledge by using standardised measures of psychological health pre-post treatment along with self-report of cognitive/emotional/behavioural functioning; following treatment and longitudinally. Research on the impacts of abuse by recognised, socially sanctioned organisations, including churches, needs to be integrated into treatment services that can support recovery across the multiple complex factors these individuals face. This includes not just trauma therapy but issues of restorative justice. Further, relatively unexplored areas for research exist in the relationship between attachment style, parenting style, experience of psychosocial stages of development and vulnerability to abusive groups; educational programs for inoculating individuals to abusive contexts – from the intimate relationship group to the large group structure and relationship between characteristics of abusive groups and more general and pervasive issues around power and control in society.

DESCRIPTION OF TREATMENT

The following description of individual counselling and group treatment has been informed by the literature review provided in this document and accounts of treatment structures and protocols provided by: Courtois & Ford (2009); Gold, (2009), Lalich & Tobias (2006), Martin (1993) and Yalom (2005) as well as clinical practice conducted at Integrative Psychology, Victoria Australia.

ASSESSMENT AND DIAGNOSIS

Trauma: Across the range of abusive group experiences there are a number of key clinical presentations that can be expected and that any systematic treatment must be able to contain and address. The most obvious presentation is trauma; trauma of omission and trauma of commission. Clients may also meet clinical criteria for a diagnosis of Post-Traumatic Stress Disorder. An added layer of complexity that is often present in such populations is that trauma may also relate to pre-existing or early developmental traumatic experiences that cannot be easily separated from the trauma sustained during their involvement in the abusive group.

Grief and loss: Complex issues of grief and loss are often present for those persons leaving abusive groups. Grief and loss can occur through loss of interpersonal connections such as fellow group members, family and friends still part of the group who now refuse to have contact with the ex-member. Ex-members may also find it difficult to form new networks outside of the group resulting on loneliness and isolation. Grief and loss can also include loss of faith, loss of sense of identity (which up until leaving was defined by the group), and loss of meaning and purpose. Assessment should include the extent of grief and loss and individuals' capacity to manage the associated symptoms.

Disorders of personality and ego functioning: Another key presenting factor that needs to be considered are disorders of personality organisation, which can result from ego regression and disintegration. These personality disturbances may also be exacerbations of pre-existing developmental disturbance that left the individual vulnerable to initial entry into the abusive group. Destruction of the ego in abusive groups has implications for therapy. If ego was something that was seen as "bad" in the abusive group any assessment of ego strength and sense of self may evoke feelings of shame, fear, anxiety, guilt, anger and distrust. Therapists need to respond to such responses when they occur, as failing to do so may result in the client disengaging from the therapeutic process at the assessment point. Further, beliefs about ego and level of ego functioning needs to inform treatment particularly aspects of affective regulation, boundary setting, and ego reconstruction.

Other psychological disturbance: Other common comorbid factors that must be considered are depression, anxiety, dissociative disorders and substance abuse. Treatment duration can range from six months to four years depending on

variables of exposure, control and abuse. It is important to recognise that clients coming from different abusive groups will have different needs, and that there will be variation required of the conceptualisation of treatment to meet these needs. Practitioners should be vary of diagnosing psychosis. Thought and behavioural characteristics that may look to be psychotic may be better interpreted within the context of what was appropriate and part of the doctrine by the cult/abusive group. Therefore, the individual is displaying what the abusive context required of them.

In addition to mental health and psychological trauma, assessment should also gauge the individual's Stage of Change, sense of subjectivity, autonomy and personal/interpersonal and occupational functioning.

Assessment of individuals needs to include whether they were first or second generation group members. Specific questions asked in an assessment include: age of entry, mode of entry, degree of support outside of the group, extent to which the group has shaped beliefs and sense of self, perceptions of the external world.

It is recommended that the client is not only assessed before and after the treatment program, but monitored throughout the treatment.

CONCLUSION

It is not necessary for those working with ex-members of abusive groups to be ex-members themselves. However, an understanding of the nature of the abusive group and trauma is expected. Practitioners should undertake a course in a *Therapeutic Program for Institutional and Cult Abuse* prior to delivering any form of treatment. Assessment of depression, anxiety, personality disorders, and PTSD symptoms should be conducted using DSM-V and diagnostic measures. In addition to an initial detailed interview assessment, standardised measures for trauma and PTSD and depression can be used to assess pre-treatment symptoms, as well as to conduct repeated assessments during therapy to monitor the course of treatment.

TREATMENT: INDIVIDUAL COUNSELLING AND GROUP TREATMENT

Following assessment, treatment requires integration of a number of aspects in order to create optimum therapeutic outcomes. Treatment should include individual psychotherapy and counselling which focuses on an exit counselling model, Stages of Change, trauma therapy, and humanistic principles. In conjunction with individual therapy of no prescribed duration, a well-structured time limited support group program (which includes psychoeducation) can be undertaken.

A comprehensive model for treatment proposed in this paper involves: individual counselling, a support group and following on from the support group a 12 week structured cognitive narrative orientated group and lastly an Interpersonal Therapy group. Support groups provide stabilisation, psycho-education, validation, clarification of experiences, and social connection. The cognitive narrative group

builds on the elements of the support group by assisting individuals to develop deeper understanding of their experiences prior, during and post involvement in the abusive group; using in-session and out-of-session journaling tasks. The Interpersonal Therapy group further develops individuals' relational skills, autonomy, ego strength and sense of self. The above treatment model has been drawn from the best practice guidelines of the American Association of Group Psychotherapy. These stages of treatment are outlined in more detail in Appendix A,B,C, and D.

Added to the issue of treatment is the matter of restorative justice. Restorative justice is important for support through any legal process, which should include support for any criminal or civil actions directed at the institution involved in the abuse. Also of great importance is a need for medical support, survivors of institutional abuse can suffer a wide array of medical problems, due directly to their involvement with the abusive institution. Another often significant matter is sexually transmitted diseases particularly where there has been sustained sexual abuse or coercion. Finally, survivors of abusive groups may need information and referral to housing and financial assistance services. Working within the framework of comprehensive psycho-bio-social needs can resemble therapy with domestic violence survivors.

ONE-TO-ONE COUNSELLING

One-to-one counselling utilises an integrated approach incorporating the following therapeutic modalities and principles: Exit-counselling, Stages of Change, Trauma Therapy, Cognitive Therapy and Humanistic therapeutic principles.

Exit counselling evolved out of deprogramming. Its focus is on addressing the mind-control experiences of ex-members, helping them to disentangle manipulative and thought control techniques in order for them to being developing their own thought patterns, beliefs and sense of self.

Embedded in exit counselling is an understanding of Stages of Change. Assessing for where the individual is in terms of Stages of Change is necessary to appropriately respond to the individual's ambivalence, confusion and emotional response style.

Counselling should also draw on trauma therapy, in order to address trauma experienced while part of the abusive group AND for individuals identified through thorough assessment to have exposure to trauma unrelated to the abusive group.

Finally, elements of cognitive therapy and humanistic therapy are included. Cognitive therapy can be important to provide a framework for exploring thought patterns and distortions. Humanistic therapeutic principles aid in addressing concepts of self, other and the world, as well as issues of trust, betrayal and meaning.

Counselling protocol for former cult group members is influenced by whether the individual is a first or second generation member. Other relevant factors also include: length of time in the cult, was the cult homogenous or heterogeneous in nature, history of trauma and nature of vulnerability factors. See Appendix A for an outline of one-to-one exit counselling for first and second generation ex-members of abusive groups.

GROUP TREATMENT

SUPPORT GROUP (EARLY STAGE TREATMENT)

The early stages of group support for ex-members of abusive groups marry with stages of exit counselling. The early stage group focuses on personal and interpersonal safety and stabilisation. Group support is advised for both first and second generation survivors due to the effects of transitioning from the abusive group to life outside the group. The early stage group is focused purely on safety and support. This stage may need to be repeated by the client. Hence they may attend multiple time limited support groups. Progression to other models of practice should only be undertaken once the client exhibits sufficient stabilisation in psychological functioning.

THERAPEUTIC GROUP: COGNITIVE NARRATIVE GROUP (MIDDLE STAGE)

The second stage of group treatment using group psychotherapeutic principles is designed to connect in with the review and re-evaluation stages of exit counselling and begin to move towards reconciliation. At this stage the group process shifts from regulation and safety which were the key focuses of the support group and moves towards more left brain structuring through the formation of a clear and personalised narrative. The process here is to essentially address the damage done by long-term involvement with abusive institutions by beginning to form a narrative of both self-description and involvement in relation to the abusive institution. This process may be understood as an act of differentiation whereby each individual group member begins to form a new narrative of self, which includes a process of separating out one's individual and personal differences from those which had been assumed through coercive actions by the institution/abusive group. In this stage of recovery the group process should involve both in-group and take home activities.

THERAPEUTIC GROUP: INTERPERSONAL GROUP (FINAL STAGE)

The third stage of group intervention is designed to complement the re-integration phase of exit counselling. This stage should be focused on healthy boundaries and addressing underlying distortions and vulnerabilities.

Rationale is to provide an opportunity for individuals with histories of institutional abuse and trauma to use the protected, supportive therapeutic space to learn about their intrapersonal and interpersonal selves and to reconnect with

the larger society as a whole person and part of the human community. This phase may take a lengthy period of treatment to be adequate in the fulfilment of the therapeutic tasks.

CONCLUSIONS AND RECOMMENDATIONS: ASSESSMENT AND TREATMENT GUIDELINES

- Survivors of abusive groups, including institutional, church and cults require comprehensive psychological assessment for trauma and PTSD, grief, depression, anxiety, substance use, disturbance of personality, and suicidality. Assessment should also include the individual's developmental stage functioning, life skills, relationship to spirituality/religion/God, functioning in social and intimate relationships, and sexual functioning.
- A multidimensional approach to assessment and therapeutic treatment is recommended.
- Individual counselling (informed by exit-counselling and psychotherapy), support group and therapy group is recommended: tailored to the needs and level of functioning of the individual.
- Therapist characteristics are critically important: a non-authoritarian stance, skills and capacity to understand and work with survivors of abusive groups, specific knowledge of similarities and unique impacts of the specific context-institutional/church/cult or other abusive group context. Therapist capacity to utilise the therapeutic relationship to address trust and vulnerabilities issues. Therapist patience in the process, which may take a number of years, depending on extent of trauma, age at time of traumatic experience, extent of client resources.

APPENDIX A: A MODEL FOR ONE-TO-ONE COUNSELLING

The following is adapted from: Rosanne Henry, TREATMENT OF FORMER MEMBERS OF DESTRUCTIVE CULTS, http://www.cultrecover.com/clinicians; Courtois & Ford (2009); Gold, (2009), Lalich & Tobias (2006) and Martin (1993).

The duration of each phase and degree of focus on trauma varies depending on the actual experiences of the client. If the client has experienced sexual abuse there needs to be attention paid to the ramifications of such abuse. The therapist needs to be aware whether the client is involved in restorative justice/legal processes regarding the abuse and whether assistance in supporting the client is required via speciality services for sexual assault such as CASA.

STAGES OF RECOVERY FOR FIRST GENERATION MEMBERS:
STAGE 1. REVIEW AND RE-EVALUATION
This stage involves reviewing and reframing the past experience. The focus is on assisting the client to learn how they were under the influence of manipulations and mind control, what mind control techniques were used and how this has impacted their sense of self, dependency, responses to others and why they stayed as long as they did. This helps reorient the problem to be the abusive group, not themselves.

(Caution: individuals will be at different stages of readiness to undertake this process. The principles of trauma therapy apply- do not re- traumatise the client by expecting them to discuss content they are not ready and capable of exploring resulting in excessive physiological hyper-arousal and disempowerment).

Focus on assisting the client to understand trauma and manage traumatic responses to reactivating events/cues. It is also important to assist the client explore and re-evaluate personal beliefs and values before, during, and after their involvement in the abusive group.

Therapeutic goals may include:
- Psycho-education on abusive groups, trauma (including brain/neurobiology of trauma)
- Encourage questioning of techniques for manipulation and mind control
- Identification of coping skills to manage anxiety, low mood and dependency
- Exploration of vulnerability factors in group recruitment

STAGE 2. RECONCILIATION
This stage focuses on coping in the present, including day-to-day emotions and pragmatic challenges. The focus should be on: allowing and encouraging the client to grieve for both real and perceived losses, validating and normalising emotional distress, anger, shame, and volatility, addressing arrests in personal, inter-personal, and professional development, redefining purpose and meaning, promoting resilience and developing and enhancing a sense of self.
Therapeutic goals may include:
- Process and differentiate guilt, shame, fear, and anger
- Explore the basis of shame, how it was manipulated in the cult and their relationship with shame now
- Rebuild their ego strengths
- Enhance their resiliency

STAGE 3. REINTEGTRATION

This stage focuses on goal setting and future planning. Focus on helping individuals to fully integrate their cult/institutional/church abuse experience into their sense of self and their understanding of the external world.

Therapeutic goals may include:

- Learning and practicing healthy boundaries in healthy relationships
- Assertion and identification and promotion of own needs in a healthy way
- Making meaning of the experience, including possibly Post Traumatic Growth
- Evaluating their spirituality, religious faith

STAGES OF RECOVERY FOR SECOND GENERATION FORMER GROUP MEMBERS (GOLD, 2009)

STAGE 1: PERSONAL AND INTERPERSONAL SAFETY AND STABILIZATION.

At this stage it is important to take into consideration that the client may have no alternative internal operating system from the one the cult/institution/church provided. Hence, the focus is to newly develop internal and external resources. Therapy begins by assessing the client's capacity to regulate emotion and traumatic hyper arousal, and to map their capacity for critical thinking. A solid foundation of cognitive skills and adaptive coping must be developed before the detailed review and re-evaluation of the traumatic experiences begins.

Therapeutic goals may include:

- The establishment of a safety plan
- The development of a good therapeutic alliance
- Skills training in affect regulation

STAGE 2: REVIEW AND RE-EVALUATION

This is similar to Stage 1 for first generation former group members. However, greater emphasis is placed on the shock and trauma of leaving the familiar and the fear of the unknown.

Therapeutic goals may include:

- Establishing clear boundaries between past and present feelings and experiences
- Psycho-education on abusive groups (tailored to the specific abusive group) and trauma (including brain/neurobiology of trauma)
- Encourage questioning of techniques for manipulation, shaming, and mind control
- Identification of coping skills to manage anxiety, low mood and dependency
- Exploration of vulnerability factors in recruitment

STAGE 3: RECONCILIATION

This is similar to Stage 2 for first generation former group members. However, greater emphasis is placed on basic coping and dealing with pragmatic challenges.

STAGE 4. REINTEGRATION

This involves working on with the client on unresolved developmental deficits and on reinforcing their self-regulation skills. Individuals may require targeted interventions for negotiating social and intimate relationships, parenting, and career options and in managing major life decisions.

Therapeutic goals may include:

- Continued development of a sense of self that is whole, integrated, and self-valuing

- Restoration or development of a sense of purpose and meaning
- Mindful engagement in relationships

A copy of the full treatment manual can be obtained by contacting: Integrative Psychology, Victoria Australia.

APPENDIX B: THERAPEUTIC GROUP: SUPPORT GROUP (EARLY STAGE)

The early stages of group support for ex-members of abusive groups marry in with stages of individual exit-informed counselling. The early stage group focuses on personal and interpersonal safety and stabilisation. Group support is advised for both first and second generation survivors due to the effects of transitioning from the abusive group to life outside the group. The early stage group is focused purely on safety and support. This stage may need to be repeated by the client. Hence they may attend multiple time limited support groups. Progression to other models of practice should only be undertaken once the client exhibits sufficient stabilization in psychological functioning.

Rationale: To use the healing qualities of the group such as cohesion, normalisation and containment to help the members cope with their physical, cognitive and emotional reactions to the abuse, trauma and confusion. The following provides are guide for delivery of trauma related support groups for adults. This structure may be suitable for survivors of a variety of abusive group contexts.

Group Goals

- Establish safety.
- Help members to cope with reactions and symptoms that interfere with everyday functioning.
- Encourage self-care.
- Diffuse overwhelming affects and contain overwhelming feelings and reactions.
- Reduce isolation and alienation.
- Use validation to help members normalise their reactions to their experience.
- Help members connect with others who have had similar experiences.
- Begin the process of norming a narrative and cognitive framework of individual experiences with the institution in order to:
    - Help members to develop new perspectives to encourage hope.
    - Help members to use their strengths to cope with reactions and return to daily functioning

Phases of Model

Beginning Phase

- Task is to address concerns about safety
- Facilitator(s) focus on helping members introduce themselves
- Clarifying group goals, similarities and differences in personal experiences; opportunity for participants to discuss where they are at in their recovery process
- Discussion of personal anchors, safety behaviours

Middle Phase

- Task is to accomplish main goals of group including validating and normalising the experience of being involved in abusive groups
- Psycho-education about trauma: flight/fight/freeze; fear, anxiety and panic, anchors

- Psycho-education around mind control, manipulation and use of shame and dependency to control, abuse of power, betrayal
- Experiencing emotions and developing skills to tolerate feelings
- Facilitator(s) encourage the expression of affect/emotions in measured way and help members to pace their experience and expression of feelings
- Discussion of issues of: identity, losses (personal, inter-personal, faith etc), fears, desires for recovery/growth
- Provision of information, referral, and support regarding restorative justice, legal processes social and financial services.

Termination

- Task is to say good-bye and plan for future treatment, if appropriate
- Facilitator helps members to focus on feelings about ending and helps them plan for the future. This may include development of personal goals.

This structure may need to be adapted under certain circumstances such as trauma experiences in childhood (e.g., sexual abuse by clergy) which has resulted in long established patterns of adult destructive behaviour. A greater focus on shame and betrayal may be required. Further an emphasis on coping with regular reminders/triggers of trauma may need to be included in the group work.

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APPENDIX C: THERAPEUTIC GROUP: COGNITIVE NARRATIVE GROUP (MIDDLE STAGE)

The second stage of treatment using group psychotherapeutic principles is designed to connect in with the review and re-evaluation stages of exit counselling and begin to move towards reconciliation. At this stage the group process shifts from regulation and safety which were the key focuses of the support group and moves towards more left brain structuring through the formation of a clear and personalised narrative. The process here is to essentially address the damage done by long-term involvement with abusive institutions by beginning to form a narrative of both self-description and involvement in relation to the abusive institution. This process may be understood as an act of differentiation whereby each individual group member begins to form a new narrative of self, which includes a process of separating out one's individual and personal differences from those which had been assumed through coercive actions by the institution/abusive group. In this stage of recovery the group process should involve both in-group and take home journaling activities; the purpose of this is to begin to allow individuals to experience boundaries.

Rationale: To use the safety of the group container to provide an opportunity for members to construct and tell their narratives in the presence of witnesses, to give meaning to their experiences and to start the process of mourning in the context of a supportive social environment

Group Goals

1. "Sharing and working through of the traumatic experiences—the telling and witnessing of each person's narrative, and the restoration of trust." (Klein & Schermer, 2000)
2. Over the course of the group to develop and achieve personal, behavioural or emotional goals related to their involvement with the abusive organisation.
- Provide each person with an experience of feeling understood and recognised
- Help each person achieve a sense of mastery over their experience
- Help each person to initiate the process of mourning
- Help each person participate in the termination process and acknowledge the gains he/she and others have made

Phases of Model
Beginning phase

- Therapist(s) works to create therapeutic space for work of group
- Therapist(s) works to establish clear boundaries and enthusiasm for group in order to foster strong group cohesion
- Members meet each other and define goals

Middle phase
- Therapist(s) focuses on accomplishing the goals of the group
- Therapist(s) actively introduces tasks and teaches coping skills
- Members participate in telling their story, practicing skills and accomplishing personal goals

Termination phase

- Therapist(s) reminds members of approaching end of group
- Participants acknowledge gains and discuss impending loss of group
- Sometimes group participants develop good-bye process, which may include an acknowledgment of each member's accomplishments

Outline of weekly sessions

Each weekly session utilises: Meditation or mindfulness, journaling, reflections, art work, poetry.

Suggested areas of focus per week/session:

   Session 1 – Where Am I Now?
   Session 2 – Stepping Stones
   Session 3 – Crossroads
   Session 4 – Dialogue with Persons
   Session 5 – Dialogue with Events
   Session 6 – Dialogue with the Body
   Session 7 – Dialogue with Sexuality
   Session 8 – Your Creative Life
   Session 9 – Inner Wisdom
   Session 10– Internal Resources
   Session 11 & 12- Integration

A copy of the full treatment manual can be obtained by contacting: Integrative Psychology, Victoria Australia.

APPENDIX D: THERAPEUTIC GROUP: INTERPERSONAL GROUP (FINAL STAGE)

The third stage of group intervention is designed to complement the re-integration phase of exit counselling. This group structure has also been informed by Yalom (2005).

Rationale: is to provide an opportunity for individuals with histories of institutional abuse and trauma to use the protective supportive therapeutic space to examine their intrapersonal and interpersonal selves and to reconnect with the larger society as a whole person and part of the human community.

Group Goals

1. To help participants to develop an awareness of and ability to express feelings in the here and now
2. To provide opportunities for each participant to learn how he/she affects other people and how they affect him/her through exploration of group interactions
3. To help participants to learn about the distortions they bring to their interactions by examining and understanding transference reactions to the group facilitator and the other group participants
4. To help participants use the protected environment of the group to take risks to change maladaptive behaviours
5. To help the individual to experience a sense of commonality with a wide range of individuals and come to see his/her trauma story as one among many
6. To provide an opportunity for participants to understand the ways that their experience is carried inside of them and influences reactions to others and gives meaning to their experiences.
7. To emphasize the commonalities with others and discourage the primary identification of self as a trauma victim

Variation of the Model

1. Often used in combination with individual treatment
2. May be used as a homogeneous open-ended psychodynamic trauma group
3. Often used in combination with medication

A copy of the full treatment manual can be obtained by contacting: Integrative Psychology, Victoria Australia.

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