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PSYCHOTHERAPY:
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PSYCHOTHERAPY CULTS: AN IATROGENIC PERVERSION[1]

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ABSTRACT: *Clinical observations of 5 teachers of psychotherapy and 26 of their patients, who themselves were practicing psychotherapists, show that psychotherapy may be misused to produce cults. These psychotherapists produced cults by failing to maintain professional boundaries with their patients: They treated their friends, students, lovers, relatives, employees, and colleagues, and brought them together to form cohesive, psychologically incestuous groups, of which they were the leader. They did not consider their patients' idealization of them to be a transference, to be understood as part of the treatment, but used it to encourage submission, obedience, and adoration, as in religious cults. Patients became "True Believers" (Hoffer, 1951) with totalistic (Lifton, 1961) patterns of thought, increased dependence, and paranoia. Both therapist and patients became trapped in a closed system which encouraged mutual exploitation and corruption.*

Ethical practitioners of psychotherapy avoid multiple relationships with their patients; the APA Code of Ethics prohibits treatment of one's own relatives, friends, employees, lovers, colleagues, or students (American Psychological Association, 1980).[2] Yet ethical codes may be little more than unenforced cosmetics for the profession (Zemlick, 1981).

We studied five bizarre groups of mental health professionals which were formed when five teachers of psychotherapy consistently ignored ethical prohibitions against multiple relationships. Patients became their therapists' friends, lovers, relatives, employees, colleagues, and students. Simultaneously

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[2] Ethical codes prohibit treating close associates to avoid conflict of interest and bias. Lest some therapists consider the training analysis a successful institution indicating that such restrictions are not necessary, we note the following: The mixed roles of the training analysis (the analyst simultaneously is therapist, teacher, and administrator with veto power over the students' graduation) approximates having judge, jury, and executioner on the same committee. This condition has been described as threatening to intellectual and scientific honesty (Wheelis, 1958), to the self-assertion and growth of the trainee, and even to the freedom and tranquility of the analytic institute (Glover, 1952; Jaspers, 1964; Rogow, 1970; Szasz, 1958; Thompson, 1958; Wheelis, 1958). There is little doubt that the intense, intimate mixed role relationship of the training analysis constitutes a powerful indoctrinating procedure (Erikson, 1962; Frank, 1974) which in many ways resembles brainwashing (Winokur, 1955; Wyatt, 1956) and thought reform (Lifton, 1961) and has contributed cult-like features to psychoanalysis (Rubins, 1974), which now has much of the schismatic fractionalization that has always characterized religious sects (Singer, 1980).

they became "siblings" who bonded together to admire and support their common therapist. We called these groups psychotherapy cults since they exhibited many characteristics of religious cults.[3] These cults were an iatrogenic perversion of therapy because the character problems their patients brought to therapy were not worked through, but were replaced in consciousness by a "True Believing" acceptance of their therapists' theories, selfless devotion to their therapists' welfare, unrecognized depression, and paranoid attitudes toward non-believing professionals.

SUBJECTS AND METHOD

The modern American cults first appeared in the middle 60s (Singer, 1979). Since that time one of us (MKT) worked with 17 patients in long-term psychotherapy who were practicing therapists: 13 clinical psychologists, 2 social workers, and 2 psychiatrists. Each previously had been a member of one or more psychotherapy cults. As these hundreds of hours of clinical experience were studied, patterns appeared. These emergent patterns were compared with the perceptions of the second author in the manner of clinical and investigative research described by Levine (1980). The hypotheses which emerged from this process then were checked against exploratory interviews conducted with 9 other therapists, who were not our own patients, but who had been cult members. In addition we interviewed 12 colleagues who had treated former therapy cult members. They shared their experiences with us and helped interpret our own. We compared some of our clinical observations with the naturalistic observations of an investigator who had studied a cult by impersonating a patient. Finally, we attended lectures, workshops, seminars and social functions to observe group functioning and the leader's behavior. We attended none of the public functions of one cult as we thought it would be too dangerous to ourselves if our purposes became known.[4]

Our study thus has all the classic limitations and virtues of clinical methods. On the other hand, information obtained from former cult members in the intimacy of clinical interviews is available nowhere else.

We shall describe first the observable characteristics of these therapists and their groups, reserving for later our inferences about the internal processes which shaped these bizarre patient-therapist interactions and produced cults.

THE CULT-CREATING THERAPIST

Two were psychoanalysts (M.D.s, American Psychoanalytic Association), two were clinical psychologists (Ph.D.s from APA-approved programs) and one a Ph.D. who called himself a clinical psychologist, a psychoanalyst, and a lay analyst. All five were charismatic, authoritarian, and dominating men with narcissistic, grandiose features and a strong tendency to paranoia, characteristics typical of the leaders of religious cults (Conway & Siegelman, 1978; Lifton, 1979; Rudin & Rudin, 1980; Singer, 1979). Each leader was verbally facile and could embrace simultaneously all sides of a complex position. They could exhibit a tearful sincerity, intense anger, or seductive charm in support of the omnipotent stance they maintained toward their own work:

> A young psychologist who had been in treatment for 10 years without significant progress told his therapist, "I think we are stuck, getting nowhere, and we should have a consultation." The therapist replied, with apparent sadness and near-tearful sincerity, "I'm

[3] *Webster's 1966 Third New International Dictionary* defines a "cult" as: 1) a system for the cure of disease based on the dogma, tenets, or principles set forth by its promulgator to the exclusion of scientific experience or demonstration; 2) great or excessive dedication to some person, idea or organization; 3) a religion or mystique regarded as spurious and unorthodox.

[4] We have disguised the clinical material to prevent the identification of these therapists and their cults. We regret that the preservation of anonymity prevents us from thanking publicly the colleagues who provided clinical material, and some colleagues who read earlier drafts of the manuscript. We can thank the following for a critical reading of the manuscript: Charles Chediak, Anthony Kowalski, Allyn and Natalie Friedman, George Prigatano, Margaret Singer, and Hans Strupp. As an additional protection for our patients and for ourselves, for cults have a history of slander, harassment, and violence toward defectors, critics, and those who study them, we have destroyed all patient records, process notes, data sheets, and audio recordings used in this study.

sorry. I wish we could, but there's no one else in the state that is any good. I've had to be my own consultant for years." A social worker, making the same request for identical reasons, encountered anger: "In spite of all our close work together, you want to bring someone else into our relationship. How stupid and self-destructive can you get? You know there's no one else in the state that's any good. I've had to be my own consultant for years."

None of these therapists maintained clean, fee-for-service relationships with patients. They took their patients into their homes, personal and business affairs, classrooms and hearts. Four had married patients, and one lived with an ex-patient. They were rarely seen except in the company of patients, who would also be their assistants, colleagues, secretaries, bookkeepers or students. They elaborately rationalized their lack of boundaries with patients, and were derogatory toward therapists who maintained "orthodox" or "classical" relationships with patients, claiming such therapists "could not handle intimacy," "tolerate closeness" and "kept their patients at a distance."

These therapists acted as if their own conception of personality and psychotherapy was the only valid one, and were hostile or condescending toward other therapy and therapists. They presented interpretations as "truths," not as hypotheses designed to facilitate exploration or synthesis of the patients' experience. These characteristics often led patients to credit them for symptomatic changes produced through hypnosis without trance, the placebo effect, or faith healing.

THE THERAPY CULTS

Cults varied from 15 to 75 mental health professionals, held together by their idealization of a shared therapist and the activities which they conducted jointly: workshops, seminars, courses, business and professional ventures, and social life. Patients were proud to be members of their therapist's "professional family" and "not just patients." They often described themselves as an elite group with "the best therapist" or the "best therapy training program in the world." Groups were cohesive and intimate but members maintained great distance from outsiders. They frequently discussed one another's therapy and the personal life of the leader. Each group had its own clinical jargon, which also was used to communicate intimacy and status. For instance, A might say to B, about C: "I'm delighted to hear that C is making progress on his narcissism." The implicit communication being: "You and I are close, since we gossip about C in our leader's language; I am close to the leader, since I know about the progress of one of his patients; and I can express my love for my sibling, C, by taking pleasure in his growth, while expressing my rivalry by recognizing his character defects."

Members identified with the leader; some emulated his dress, manner of speech, and life style. While they took pride in being his associate, and might call him by his first name, they were submissive behaviorally. A common sight was a patient doing menial work for the therapist: housekeeping, cooking, gardening, home and automobile repairs, running errands, and the like. We sometimes would forget that these patients were practicing mental health professionals.

Four leaders controlled their patients' personal life with dictatorial authority, for the spouse who was not in therapy was regarded as a threat to group solidarity. One thus said: "If you don't have the guts to decide what to do, I'll decide for you. Divorce that woman or I'll throw you out of treatment." The fifth therapist was equally authoritarian, but typically sent the message wrapped in pious prose: "I would never tell you to divorce your wife. You have an ego of your own, and you know as well as I do that the marriage is destructive to your growth in therapy, but I would never tell you to get a divorce or threaten to stop treatment if you don't."

We have compared religious and psychotherapy cults in Table 1.

THE CULT'S PATIENTS

The major religious cults train recruiters to recognize depressed, lonely, and confused people; approach them and establish a warm and friendly relationship; encourage them to join a "new family" based on love; and, finally, to reject their old family and friends and work full time for the "new family" (Conway & Siegelman, 1978; Rudin & Rudin, 1980; Singer, 1978, 1979).

TABLE 1. Comparisons Between Religious Cults and Psychotherapy Cults.

*Religious Cults**	*Psychotherapy Cults*
1. Leader a preacher with charismatic, authoritarian, dominating personality; narcissistic, grandiose and paranoid features.	1. Leader a therapist with charismatic, authoritarian, dominating personality; narcissistic, grandiose and paranoid features.
2. Followers adore or idealize leader. The leader is called God, or Perfect Being, or Perfect Parent, or Master, etc. S/he is supreme authority.	2. Followers are patients who idealize their therapist. Consider her/him a genius. S/he is supreme authority.
3. Followers accept leader's simplistic philosophy. It may not be doubted or questioned. Belief in it is supposed to solve life's problems. Rational thought is discouraged, faith encouraged.	3. Patients are, or become, "True Believers," accepting therapists' theory and therapy as valid, true and superior to all others. This belief is encouraged, and rational-empirical research is discouraged.
4. Followers joined when depressed and/or in confused transition between developmental stages; *i.e.*, when identity and security needs greatest. Followers alientated from original family and society.	4. Followers joined by becoming patients of the therapist in periods of transition when identity and security needs greatest, as in graduate school. Followers alienated from other professionals.
5. Members totally involved in cult which controls every aspect of personal life—sex, marriage, diet, dress, work. Little or no social life outside the group.	5. Members organize their lives around their therapist, who is consulted on all aspects of personal or professional life. Little social or professional life outside group.
6. Group cohesive, considered an elite family, and original family depreciated and scorned. Members consider one another "brother" and "sister." Leader keeps all love, veneration and allegiance directed toward self.	6. Group cohesive, considered an elite professional family. Members consider themselves superior to other professionals. Therapist keeps love, veneration and allegiance directed toward self. Idealizing transference not analyzed.
7. Group is suspicious, fearful and hostile toward outer world; members gradually lose capacity for critical thinking, independent decision making and emotional autonomy. Dependence increases.	7. Group suspicious, fearful and hostile toward other professionals. Therapist controls or interprets for members all contact with other professionals. Dependence and submissiveness increase; critical thinking decreases.

* Characteristics of religious cults summarized from Singer (1979), West & Singer (1980), Rudin & Rudin (1980), and Lifton (1979).

Most subjects had joined psychotherapy cults by a similar process of leaving old identities and relationships for new ones in their therapist's professional family: They first entered psychotherapy for depression, confusion, anxiety, or low self-esteem. After a positive transference was established, the therapeutic contract was diluted with additional roles and relationships of gradually increasing intimacy. As patients became more involved in the social and personal life of their therapist, they gradually withdrew from old friends and family, leading to increased dependence upon the therapist. The therapist then became a mentor, and encouraged patients to become her/his students, employees, friends, or colleagues.[5] Social invitations were offered patients, and any "resistances" against accepting them were "explored" or "analyzed." Financial entrapment often followed. Patients were given financial aid, or gifts exchanged. One therapist sold his patients' land, homes, and automobiles on credit. Another had patients pay cash for therapy in advance, sometimes for years in advance, so there were pressures to stay in therapy to receive fantasied benefits for which they already had paid. Two therapists had their patients pay by making "tax deductible" charitable contributions to foundations and institutes which they controlled indirectly.

Some patients were attracted by training opportunities. All five cults operated psychotherapy training programs, two within universities and three financed by private institutes. Training opportunities recruited many new members because these cult leaders depreciated the cognitive transfer of therapeutic knowledge and techniques and recommended being treated by themselves as "the greatest learning experience." This arrangement was mutually satisfying: The therapist had admiring student-patients, and patients were close to the master and learning by identification. Training thus became confused with conversion. Differences with one's leader-teacher-therapist could mean disloyalty; disagreement could mean lack of mastery of the leader's ideas; individuation was seen as rebellion. Students therefore used the leader's jargon, embraced her/his theories, and practiced her/his techniques. Conformity flattered the therapist, attracted therapist and peer approval, and provided the student-patient with a new and "safe" identity in the therapists' professional family, an identity often devoid of the pains and complexities of the old one. Referrals outside the group were discouraged and students who worked with therapists "outside the family" were considered unable to handle intimacy, disloyal, and lacking in insight and sensitivity. They had trouble completing the program.

Each extra-therapeutic social and professional situation in which patient and therapist participated had unconscious transferential and countertransferential aspects which were not a recognized part of the treatment. For example, only after leaving the cult did many patients realize they unconsciously had lived out a fantasy of having found a "magical healer," a Personal Savior, or of pleasing an omnipotent parent. Several felt childhood religious teachings of selflessness had influenced their wish to "be as a little child" in the service of a God (therapist) who suffered for them. Two had a psychotic parent, others had severely depressed parents, one had been an abused child, and two had had alcoholic parents. As children these patients had tried to heal their parents and, in the cult, to heal a therapist they felt was misunderstood and rejected by a jealous professional world (see Searles, 1975, for a detailed description of this form of transference). Therapists perpetuated acting out such fantasies by accepting idealization as a deserved status; gratifying infantile needs of patients; and manipulatively confiding that they mentored and befriended only those patients with the potential for greatness.

Upon joining the group, many patients felt a sense of being loved and of belongingness. Anxiety, confusion, and depression often disappeared in the exhilaration of being a friend, student, and colleague of an adored therapist—but such changes were not the result of any understanding of self or improvement in ego fuctioning. It was pseudo-growth, based

[5] Not only cult-creating therapists may be tempted to take advantage of the colleague in treatment. Harold Searles tells how he had to actively resist his therapist's invitations to share an office in order to preserve the integrity of his therapy (Langs & Searles, 1980, p. 58).

upon what Langs (1978) called "Lie Therapy," the therapist having provided ideas, situations, and misalliances which strengthened defenses and acted as a barrier to a genuine understanding of the self.

> B. J., a young psychiatrist who entered therapy because of sexual problems and low self-esteem, attended a dinner party at the home of his therapist. His therapist's wife, a former patient of her husband, drunkenly confided to B.J. that her husband " . . . sure was a lousy lover." Enormously disturbed, B.J. told his friends about it before his next therapy hour. Since they were in treatment with the same therapist, they also were disturbed. After a moving group discussion, they concluded that to marry an alcoholic patient proved the superiority and benevolence of their therapist. It meant he was "above" countertransference problems, possibly he was so well-analyzed he did not even have an unconscious, and given the need, he would sacrifice equally for them. Consciously reassured by the group's support, but sliding deeper into an unrecognized depression and therapeutic impasse, B.J. continued in therapy for three years without mentioning the incident, attempting to be as accepting and benevolent as his therapist.

When a transference or countertransference cannot be distinguished from a realistic response to the personality of the other, the higher status and omnipotent stance of the leader creates a bias which blames the patient for impasses:

> T.M., a graduate student in psychology, was in treatment with his major professor. Usually an honor student, he suddenly became unable to work on his dissertation without experiencing massive attacks of anxiety, accompanied by vomiting, sweating, and insomnia. When therapy brought no relief, he decided to discontinue graduate study, go to medical school, and become a psychiatrist. Faced with the loss of an excellent patient, group member, and research assistant, the therapist became enraged: "Your lack of courage in facing your problems would nauseate a vulture," and "You will also be a failure in medicine unless you stay in therapy and work through your problems."
>
> T.M. became severely depressed and contemplated suicide. In the intimacy of the "family" he told his fellow patients, who defended their therapist's actions. T.M. had not realized that " . . . to be told he would nauseate a vulture was a spontaneous expression of authentic feeling made possible by the intimacy of the therapeutic relationship in the family,"and T.M. " . . . should feel flattered that his therapist trusted him enough to be so honest with him." The therapist continued to make hostile, contemptuous remarks, which the patient now interpreted consciously as love and unconsciously as hate. Identifying with his hostile therapist, he rejected himself and made a serious suicide attempt.

ISOLATION AND PARANOIA

When transferences and countertransferences cannot be clarified, and when reality testing is impossible because of the isolation of the group and the homogeneity of groupthink, ego deterioration may occur. The most serious example is the development of paranoia which occurred in all 5 groups. This observation was verified by each colleague we consulted. Furthermore, each subject reported that their previous group, and themselves when in the cult, had been hostile, suspicious, and fearful that outsiders would criticize, condemn or punish them. The paranoia of these groups seems to be a multiply determined function of 4 variables:

1. *Incest.* Both psychological incest and sexual abuse exist in the cult, where they create, intensify and perpetuate dependency, shame and guilt. By definition, the cult-creating therapist is incest-oriented, and his female patients are at high risk for sexual abuse. Father-daughter incest is particularly common in families with an extreme imbalance of power between the parents (Harvard Medical School Letter, 1981) and these therapists exercised extremely imbalanced power over their spouses (usually former patients) and over their patients. These isolated groups, like the isolated family in which incest is practiced, were vulnerable to paranoia because of a chronic fear of discovery. Cult members often suspect their leaders of sexual abuse of female patients (and have many fantasies about it) yet protect themselves from really knowing by splitting, rationalization, or blaming and ostracizing the victims who tell them about it. Analogous to biological incest, which may be a defense against the anxieties of separation, individuation, and anticipated loss in troubled families (Gutheil & Avery, 1977), professional incest may be a defense against the anxieties of a field in which many ideas are not supported either by scientific research or general consensus, yet need to be believed for emotional reasons.

2. *Fusion or identification with the leader.* There are many pressures for the patient to think and be like the leader, and these dominating, charismatic therapists had many paranoid features.

3. *Lack of experiential boundaries.* The mul-

tiple role relationships either cause, reflect, or reinforce an inability to distinguish accurately between inner and outer, so that the categorization of experience is confused and inner dangers are perceived as outside the self.

4. *Displacement of hostility.* The cult-creating therapist channels hostility toward the outer world. If members can hate external dangers, it focuses their attention away from their exploitation by the therapist or conflicts within the cult.

The interaction of these four classes of variables creates a paranoid world view and group structure which is amazingly resistant to change. The leader of one cult had taught and practiced the same therapy, and held the group together with few defections, for thirty years.

THE PSYCHOTHERAPY CULT MENTALITY

Some cult members exhibit characteristics described by Adorno *et al.* (1950), Hoffer (1951), Lifton (1961), and Bettelheim (1979): escaping personal and social uncertainty by identification with authority and devoted submission to it, denying or projecting complexity and ambiguity, and substituting a rigid organization of consciousness. Thinking in dichotomies and stereotypes, the experience of peace is created through order, but individuality, flexibility, and critical thinking are lost in the process. Notice the similarity between such psychopolitical authoritarianism and therapists who avoid the complexities and uncertainties of the field (and of self) by a slavish devotion to "The Master's" theory and therapy. Cultic therapists and their patients thus collaborate in the ultimate resistance to individuation and maturity: An intense faith in the therapist and her/his theory—repeatedly reconfirmed by the therapist's interpretations of the patient's daily experience in the family—are substituted for the anxieties of self study and life with a separate and open mind. This process results in gross distortions of perception: the psychotherapy cult mentality believes the therapist's most banal nonsense as though it were revealed truth. Examples: "There is no democracy in nature, so the therapist must dominate the patient to restore a natural freedom and spontaneity." "Love conquers fear." "People are the real meaning of being."

> Four psychologists thought that their therapist was a genius, but unrecognized because he was so secure he had never played " . . . the phony game of publish or perish." To honor him and disseminate his clear and simple truths they recorded his lectures, transcribed them, and planned to publish them as a book, entitled "Therapy Without Theory." However, the transcriptions turned out to be gibberish: pithy sayings, psychoanalytic esoterica, philosophical paradoxes, biblical and poetic quotations, and metaphors from ethology mixed randomly together without definition of terms or complete sentences. When informed the therapist raged: "Of course you can't understand it! You're not only ill-informed but crazy as well. You never will understand me until you go further in your own treatment!" Crestfallen, but unshaken in their faith, they returned to their own treatment. Ten years later three of the four were still in therapy and praising him as a leader in the field, although he still had published nothing. The fourth had defected.

The authority of the cult-creating therapist and the submissiveness of her/his patients may be hidden in the benevolent prose of humanism.

> One therapist told some of his patients, who also were his students, employees, and friends, that because of their multiple relationships he did not want to dominate them, and would insist upon their freedom, because freedom was essential to the development of individuality. To protect it he would hypnotize them and leave them with the post-hypnotic suggestion that they must be free, spontaneous and dominant in their relationship with him.

COGNITIVE PATHOLOGY

The psychotherapy cult mentality misuses technical concepts and language. Hypothetical constructs may be reified without awareness so that cult members may speak passionately of abstract concepts as if they were concrete realities upon which personal identity depended. Theory is generally preferred to observation and the empirical referents of theory are rarely clarified; individuals thus may speak about themselves or others using concepts about personality and therapy but be unable to describe the words or deeds which prompted the use of the concept. In extreme cases behavior cannot be described without jargon; words are separated from thoughts; and both words and thoughts are divorced from personal experience, producing a patois of thought-stopping clichés

about therapy. The mindless quality of this process may be conveyed by caricature if one imagines a patient describing personal therapy:

> "I'm lowering my defenses and analyzing my transference and resistance to find my authentic self. Right now I'm working on losing my mind and coming to my senses because I want to stop playing games, take responsibility for myself, and not give my power away so I can be my own best friend. It's a long way from child to adult but if I meet the Buddah on the road I'll scream, 'I'm OK, you're OK,' because I was Born to Win."

Such use of jargon removes ambivalence and uncertainty while maintaining an illusion of knowledge, sophistication, and personal growth. It sounds as though the leader's favorite interpretations have become stable internal structures, freezing the prose of the patient in *Psychobabble* (Rosen, 1977)—A language to communicate non-thoughts. When the leader speaks in the same fashion, the incomprehensibility is mistaken for brilliance, for the cult mentality fails to realize that the therapist will not or cannot make herself/ himself clear. One disciple put it this way: "Today, in 1980, there are thousands of people who cannot understand Jacques Lacan. In the 1950s there were only 20 or 30 people who could not understand him. This is progress." (*Newsweek*, 1980). The therapy cult mentality assumes that any utterance of its leader is meaningful, whether it makes sense or not.

PSYCHOTHERAPY WITH FORMER CULT MEMBERS

Cult-creating therapists interpret wishes to terminate therapy as a resistance, disloyalty, or avoidance of closeness, and a therapy of 10–15 years is not unusual. Our subjects had terminated only after a psychotic episode, an affair with their cult therapist, a severe depression, seduction of their spouse, a suicide attempt, or a transcendental experience. Whatever the specific experience preceding termination with their cult therapist, all were extremely confused, depressed, dependent and anxious, and could barely maintain their positions and practices. Not surprisingly, they expected or hoped their new therapist would lend them money, invite them to dinner, refer them patients, and provide the security and gratification they had enjoyed in the cult.

We have found it best to maintain a benevolently neutral stance, trying to understand and support without gratifying such requests or evaluating, manipulating, judging, seducing or, indeed, doing anything which might be experienced as a repetition of cult therapy. It is important, for example, not to criticize the previous therapist, for such might be experienced as the hostile criticality of the cult therapist, and because it would be an implicit rejection of the part of the patient's personality which had been attracted to the previous therapist. Similarly, we avoid any authoritative stance which might be experienced as domination: directions, advice, reassurances, homework, or exercises. It is difficult to maintain this position because of the confusion and dependency, but we have found it best to recognize, clarify and accept the patients' confusion and dependency and support their just bearing it until it is worked through.

It is important to understand the idealizing transference as a projection, and not to accept the admiration as a tribute. We maintain the neutral position and observe that the patient is idealizing another therapist, and explore what that means: Is this the kind of idealization which occurred with the previous therapist? What is the wonderful therapist supposed to do? What fantasies go with the idealization?, etc.

There often is considerable guilt and regret about staying so long in a destructive therapy, or for doing immoral or illegal acts at the direction of the previous therapist. We have found it a mistake to take the seductive position "you couldn't help it," for while such a tactic may reduce guilt temporarily, it is a depreciation of the patient's powers and a denial of the part of the patient that was gratified by cult membership. Instead, we encourage a concept of therapy as a continuous growth process, like life itself, and rather than rejecting the cult experience, we view it as an opportunity to learn, so that the patient may explore the parts of the self which maintained the destructive symbiosis with the previous therapist.

DISCUSSION

Psychotherapy cult membership is an iatrogenically determined negative effect of psychotherapy. On occasion, most subjects had perceived themselves as deteriorating, or at a therapeutic impasse, and their cult therapist as inadequate, manipulative, dishonest, destructive or sadistic, but they could not terminate unilaterally because they were bound to the therapist and her/his "professional family" by a pathological symbiosis just as they previously had been bound to their family of origin. The nature of this pathological symbiosis was that the therapist, like parents previously, was an externalized object in terms of which the self was defined, and membership in the therapist's group was a reliving, however unconsciously, of the family situation in which the self originally was formed. Patients therefore could not terminate without experiencing dissolution of personal identity, for both negative and positive parts of the self had been projected onto the therapist and the group. These projections could not be understood as such, and worked through as part of the therapy, because these therapists needed the idealizing projections of their patients to maintain their own unstable integrity and to control their groups. The isolation of the group also prevented reality testing, and group dynamics opposed individuation.[6] Patients also dreaded the consequences of termination without approval of the therapist because of fantasies—which the therapist often provided—of personal and professional destruction should they leave the group, which bears a remarkable resemblance to some of the techniques of thought reform and brainwashing (Frank, 1974; Lifton, 1961). Cult membership perverted psychotherapy from an ego-building process of individuation into an infantilizing and destructive religion, which these patients could no more leave than most people can leave the religion of their youth.

CONCLUSIONS

One can observe a cult mentality in many therapists—humanistic, experiential, or psychoanalytic—who do not live or practice within a cult, but who nonetheless accept uncritically the teachings of an idealized therapist, ignore other approaches (and the lack of evidence for the effectiveness of their own) and treat all patients with the same therapy. Though psychotherapy cult membership may be rare, a psychotherapy cult mentality may be widespread. For example, it now is common practice to advertise workshops on psychotherapy in brochures by praising the leader for warmth, benevolence, and humanity, implying an opportunity to love or be loved if one participates; or by praising the brilliance and genius of the therapist, appealing to needs to idealize and identify; or even, in some cases, by praising the leader for having human imperfections and frailties, noting their involvement in astrology or fad diets, thus metacommunicating an opportunity to participate without the restrictions imposed by scientific knowledge or intellectual discipline.

There is ample evidence from five different reviews of the research literature that psychotherapy is generally effective (Bergin & Lambert, 1978; Luborsky *et al.*, 1975; Meltzoff & Kornreich, 1970; Parloff *et al.*, 1978; Smith & Glass, 1977), even though there also is evidence that psychotherapy may be harmful in a certain percentage of cases (Strupp *et al.*, 1977).

We interpret our study to mean that the benefits of psychotherapy may be realized, and most dangers avoided, only in a "clean"

[6] When these therapists were loving, supporting, and mentoring and then, often only moments later, critical, punishing and rejecting, they were stabilizing the inner splits of the patient by affirming both positive and negative internal self images without recognizing and bringing together either their own splits (from which they spoke) or the patients'. When the therapist represents externalized and projected images of the patient's self, ". . . it is very important to gather the transference, as Meltzer (1967) advises. Otherwise the analysis exists in a split-off, polarized state and never seems to emerge from a paranoid solution to the patient's problem" (Grotstein, 1981, pp. 168-169). Note also: "All group formations, as Freud (1921) and Bion (1959*b*) have pointed out, involve the projection of the ego ideal from members of the group onto the group leader—in the form of authority and responsibility. The group members may also project their egos, ids, and superegos altogether onto the group leader, as with Jim Jones in Jonestown" (Grotstein, 1981, pp. 178-179).

relationship uncontaminated by mixed roles and boundary problems. Once these patients had an identity, status, and role in their therapists' professional family, their intelligence, sophistication, scientific and psychotherapeutic training was no protection against gross distortions of perception. It is tragic that methods for opening the mind may be used so effectively to close it, but accurate evaluation of self, therapist, and the progress of one's own therapy, requires checking against external reference points which are not available in mixed role relationships and psychologically incestuous groups. These conclusions should not be surprising since the accuracy of interpersonal evaluation in the formulation of diagnostic opinion is distorted by the suggestion of authority figures (Temerlin, 1968; Temerlin & Trousdale, 1969); family and social class membership (Hollingshead & Redlich, 1958; Lee & Temerlin, 1970); and location in mental health settings (Temerlin, 1970; Rosenhan, 1973).[7]

The avoidance of multiple relationships between therapist and patient always has been required by the ethics of medicine, psychology, psychiatry, and psychoanalysis (except for training analyses). Unfortunately, ignorant, insensitive, or grandiose therapists may not be inhibited by ethical codes, and the therapeutic disciplines have not always been successful in enforcing them.

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[7] See Dulchin and Segal (1982) for a sociological study of the systematic violations of therapeutic confidences, and their use by the power structure of a psychoanalytic institute, which occur even though the institute is committed to a clear separation of psychoanalysis, the training of psychoanalysts, and the administration of the psychoanalytic institute.

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