Contemplative Cults, Time Spent in a Cult
and Dissociation and Depression in Former Members

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Donna L. Adams
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by

DONNA L. ADAMS

has been approved for

the Department of Counseling and Higher Education

and the College of Education by

Dana Heller Levitt

Associate Professor of Counseling and Higher Education

Renée A. Middleton

Dean, College of Education
Abstract

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Director of Dissertation: Dana Heller Levitt

Little research has been done overall to explore the effects that cults have on individuals. Clinical observations noted in the literature have included a connection between contemplative techniques such as prolonged chanting and meditation and speaking in tongues that are used by some cults to disrupt critical thought processes, and symptoms such as trance-like dissociation and depression (Singer and Ofshe, 1990; West & Martin, 1994). Duration in a cult is thought to lead to transient and longer lasting effects (Singer & Ofshe). Using a two-way factorial MANOVA design and a two-way ANOVA design, pre-existing data from 477 former treatment seeking cultists was studied to examine the levels of depression and dissociation in former members of those who have been in contemplative-type cults compared to those who have been in cults where such techniques were not used. The variable of time spent in the group was also examined. Those who have been in contemplative-type cults were found to have higher levels of depression and dissociation. Time spent in a cult does not appear to have an effect on the level of depression and dissociation.

Approved: _____________________________________________________________

Dana Heller Levitt

Associate Professor of Counseling and Higher Education
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Cults have existed perhaps since the beginning of time, yet it has been only within more recent years that they have received more attention. Concerns about the harmful effects of cult involvements became more widespread among helping professionals during the late 1970s. These concerns were often proliferated by former cult members who “went public” with the negative experiences and psychological problems that they had attributed to their involvement in cultic relationships (Aronoff, Lynn, & Malinoski, 2000). It is thought that the influences of former members on public perceptions have led to negative perceptions of cultic groups (Anthony & Robbins, 1992). Former members’ perceptions have then spread to clinicians and researchers about the potentially dangerous influence of destructive cults on individuals and society as a whole.

The media has also influenced public perceptions of the dangerous influences of cults. Since the mass murder in Jonestown in 1978 where nearly 1,000 followers allegedly died at the hands of Jim Jones, several other tragedies have made headlines in the media: David Koresh and the Branch Davidians and the tragedy at Waco, Texas where nearly 80 followers died during an FBI siege, Marshall Applewhite and Heaven’s Gate where approximately 40 followers were convinced to commit suicide so that their souls could ride on a spaceship that they believed was hiding behind the comet carrying Jesus, Shoko Asahara and the group Aum Shinrikyo that gained international notoriety when it carried out a Sarin gas attack in the Tokyo subways killing 12 commuters,
seriously harming 54 and affecting nearly 1000 more people. Sadly, these are just a few named incidents in the last 30 years.

In recent years, court cases have been highlighted in the media that have suggested that stressors in the environment or a thought reform environment were present that caused a follower to commit murder and acts of terrorism or to be an accomplice: State of Ohio v. Daniel D. Kraft, Jr., 1990, where a follower named Kraft assisted the leader in killing a family of five; Commonwealth of Virginia v. Lee Boyd Malvo, a/k/a John Lee Malvo, Indictment Nos. 03-3089, 03-3090, 03-3091, 2004, where Malvo, who was 17 years old at the time was involved in the Washington, D.C. sniper attacks at the direction of John Allen Muhammad; United States of America v. Zacarias Moussaoui, Case No. 1:01cr455, 2006, where Moussaoui became known as the “20th hijacker” of the terrorist events of September 11th, 2001 after having been recruited into radical Islam outside of the moderate Brixton Mosque in London a few years earlier.

Clinicians and researchers have given explanations for these types of extreme situations where followers would not normally have engaged in such behavior. West and Martin (1994) assert that normal integrative functions of personality can be disrupted during prolonged environmental stress, or life situations profoundly different from the usual. Individuals subjected to such forces through a thought reform environment may adapt through dissociation by generating an altered persona, or pseudo-identity (West, and Martin, 1994). West and Martin explain that individuals may engage in activities that they would not think of doing outside of the group while assuming a cult pseudo-identity that may include rape, murder, and torture. Membership in some groups appears to lead
to certain dissociative symptoms. Membership in these destructive groups appears to inhibit decision making and thought processes. Given the potential harm to individuals, families, and societies, it is important to study the effects of the cultic milieu on the individual and what shapes dissociative pseudo-identity.

Singer and Ofshe (1990) note that the techniques that are used to induce belief, change and dependency by various thought reform programs appear to be related to the type of symptoms the program tends to produce. As mentioned in the previous paragraph, it has been suggested that those groups that employ contemplative techniques can produce symptoms of dissociation in their members.

Depression has also been widely observed by clinicians in former members of cults (Singer, 1978, 1979; Singer & Ofshe, 1990). Tobias and Lalich (1994) have noted that former members of cults often feel an overwhelming sense of loss as they are no longer a part of the relationship or group. Grief and mourning and dealing with broken promises and disillusionment can lead to incapacitating depression.

**Background of the Study**

Cults have not been without their defenders. Researchers in the field generally join the ranks of one of two opposing parties. One camp is that of the “cult sympathizers” who proclaim that cults represent an alternative culture or religion. Several individuals wrote from this perspective in the 1980s and 1990s (Alexander, 1985; Anthony & Robbins, 1992; Bromley, Shupe, & Ventimiglia, 1983; Coleman, 1984; Levine, 1984; Malony, 1994) and others assert that cults can have positive effects on participants (Galanter, Rabkin, Rabkin, & Deutsch, 1979). Others of this camp hold the credibility of
the accounts of former members’ harmful experiences into question as the “cult sympathizers” term the recollections of their experiences as “atrocity tales” (Bromley, Shupe & Ventimiglia). This viewpoint maintains that former members are generally in need of self-justification, seeking to reconstruct their past to excuse their former affiliations with the group, while blaming those who were formerly their fellow cohorts. Bromley and Shupe suggest that former members’ reports of psychopathology are simply exaggerated in conformance with demand characteristics of having been influenced by counter-cult information exposure.

Others, the “cult critics” contend that these same former members are another group who have fallen into categories of individuals who are universally blamed for being victimized, just as women who get raped or victims of muggings are often blamed. They assert that when somebody gets involved in a cult, the tendency is for society to say that there must be something wrong with that person. There must be some defect or psychological problem with that person, otherwise they would not have joined such an abusive group (Singer & Lalich, 1994). Singer and Lalich also describe the concept of “the just world.” This concept contends that there is a widely held belief that if a person obeys the rules of society, nothing bad will happen to him or her. Rule-breakers on the other hand get punished. This punishment comes in the form of bad luck, disasters, illness or loss. So victims of crime, illness or misfortune fall into the category of those who are worthy of blame. It is explained that cult members often are thought of as individuals who “must have done something bad to have bad things happen to them, they went out looking for what they got” (Singer & Lalich). The person is blamed for being a
seeker, gullible or for having some psychological defect. The deceptive and manipulative actions of the cult that induces dependency are overlooked in the assessment.

Literature as it relates to the study of cults, regardless of the sympathy or criticism perspective, is divided into two areas. One area focuses on various aspects of the effects of cult involvement such as reasons why people become involved in a cult (Levine & Salter, 1976), pre-cult characteristics (Spero, 1984), childhood family environment as a predictor to cult involvement (Ash, 1985; Deutsch & Miller, 1983; Nicholi, 1974), and how cults affect individuals after they decide to leave their groups (Conway & Siegelman, 1982; Lewis & Bromley, 1987; Martin, Langone, Dole, Wiltrout, 1992; Singer & Ofshe, 1990). The other main body of literature that is available regarding the cult phenomenon relates to the dynamics of cults. The latter topic often highlights mind control or thought reform, why people join and depart from cults, and how leaders maintain control over their followers (Hassan, 1988; Martin, 1993; Singer & Lalich, 1994; Tobias & Lalich, 1994).

Cults differ in their themes and the variety of techniques that they employ (Singer & Lalich). Indeed, many different types of cults have been identified. Much of the literature focuses on religious cults, however cults can revolve around any theme (Aronoff et.al., 2000). Examples of the types of cults in terms of the theme include psychotherapy, political, and commercial (Singer, 1978). For the purposes of this study, the theme of cults will not be explored; rather it is the methods that cults use that are more of a concern as is stated in the following chapter.
Although some literature exists concerning the cult problem in general, there is a paucity of literature as a whole, and particularly when studying specific techniques of groups and their effects. As related in the next chapter, very little literature exists that addresses dissociated trance-like symptoms that are often seen in members of cults where contemplative exercises such as chanting, meditation or speaking in tongues are practiced (West & Martin, 1994). Singer and Lalich (1994) explains that meditation, in itself, is not good or bad, and certainly, at least in some circumstances it may be seen as beneficial. However, as cults using thought-reform systems do not have a visible product to sell, but offer psychological, political, or spiritual transformations and enlightenment, they have learned that either they need to prove that they have special knowledge of some kind and that a follower will have something to gain through participation, or they need to use specific persuasion techniques that will convince followers to stay with them. Members’ predictable physiological and/or psychological responses to these activities are reinterpreted in desirable ways by group leaders so as to convince the new recruit that the processes are good for them. The leaders of cults often interpret the effects to their benefit as they attribute the predictable effects to fit into the philosophy that they are promoting. Leaders use these activities in exploitative ways. These contemplative activities may help to alter a person’s general state of awareness and put them in a more suggestible state where they may be at risk of losing personal autonomy (Singer & Lalich).
Statement of the Problem

Parents and others close to individuals who have become members of thought reform groups such as cults are often astonished at the sudden and catastrophic changes that they see in their loved ones after they joined the group, saying “he has become a completely different person.” Sudden personality changes that are seen in individuals who become involved in such groups would seem to indicate cult involvement has led the individual to behave in ways that are out of the ordinary for the individual. Indeed, some clinicians believe that these sudden personality changes are actually a form of dissociation known as cult pseudo-identity and can be the result of cult involvement (West & Martin, 1994). Some clinicians have also observed significant and problematic dissociated trance-like states that they believe result from contemplative practices that some cults employ (Singer & Lalich, 1995; Singer & Ofshe, 1990; West & Martin, 1994). Conway and Siegelman (1982) found a variety of symptoms including dissociative floating and altered states as well as the inability to break mental rhythms of chanting as being significant symptoms that former members experience. They also noted that these symptoms increased with length of time that was spent in the group. Singer and Ofshe also noted that those who have been in thought reform programs for longer durations report transient to longer lasting effects.

As the review of the literature will show, scholars oftentimes disagree about the harmfulness of cults (Anthony & Robbins, 1992, Malony, 1994). The cult literature is dominated by rhetoric that blames the public’s negative perceptions of what is called “New Religious Movements” (Anthony & Robbins, 1992; Malony, 1994) and former
members’ “pre-existing psychopathology” (Spero, 1984). Aronoff et al. (2000) explain little organized empirical investigation into the cult phenomenon has actually occurred. The fact that little empirical research exists concerning cult-related issues remains, even as the public is faced with the 30th anniversary of the suicide/murders at Jonestown.

This study sought to address the issue of harm and cults, and specifically to empirically examine the levels of dissociation and depression in former members of contemplative-type cults to determine if they experience higher levels of dissociation and depression above and beyond former cultists who have been exposed to groups who did not employ contemplative exercises. According to clinician observations, former members from other types of cults who did not employ contemplative-type techniques still may experience cult dissociative pseudo-identity as well as depression. The amount of time spent in a group has been clinically observed as a factor that leads to increased symptoms. This leads to the questions that were addressed by this study:

1) What are the differences in the levels of dissociative experiences for individuals who have left contemplative-type cults versus those who have left cults that do not employ contemplative exercises?

2) What are the differences in the levels of depression for individuals who have left contemplative-type cults versus those who have left cults that do not employ contemplative exercises?

3) What are the differences in the levels of dissociation for those who have spent eight years or less in the group versus those who have spent more than eight years in the group?
4) What are the differences in the levels of depression for those who have been in their groups eight years or less versus those who have been in their groups more than eight years?

5) Does the amount of time spent in a cult interact with involvement in a contemplative-type cult in respect to dissociation?

6) Does the amount of time spent in a cult interact with involvement in a contemplative-type cult in respect to depression?

**Research Hypotheses**

This study sought to explore whether former members’ involvement in a contemplative-type cult contributes to higher levels of dissociation as measured by the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) and the Hopkins Symptom Checklist Dissociation Screen (HSCL: Briere & Runtz, 1990) and to higher levels of depression (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) than those who have left cults that do not employ contemplative techniques. This study also sought to explore the effects that the amount of time spent in a cult (more than eight years) has on levels of depression and dissociation in former members.

$H_{A1}$: Former members who have left contemplative-type cults (chanters) will have higher mean scores than those former members who left cults that did not engage in contemplative exercises (non-chanters) with respect to the two measures of dissociation (Dissociative Experiences Scale and the Hopkins Symptom Checklist Dissociation Screen).
This hypothesis is an alternative to the null $H_{O1}$: Former members from cults that do not employ contemplative techniques have the same mean score on the DES and the HSCL than those who do employ contemplative techniques.

$H_{A2}$: Former members who have spent more than eight years in a cult will have higher mean scores than those who have been in a cult for eight years or less with respect to the measure of dissociation (DES and the HSCL).

$H_{O2}$: Former members who have spent more than eight years in a cult will have the same mean scores as those who have been in a cult for eight years or less with respect to the measure of dissociation (DES and the HSCL).

$H_{A3}$: There will be an interaction as demonstrated by a statistically significant difference between the time spent in the group and involvement in a contemplative-type group with respect to the dissociation measures of the DES and the HSCL.

$H_{O3}$: There will be no interaction between the time spent in the group and involvement in a contemplative-type group with respect to the dissociation measures of the DES and the HSCL.

$H_{A4}$: Former members who have left contemplative-type cults (chanters) have higher mean scores on the Beck Depression Inventory (BDI) than those who leave cults that do not employ contemplative techniques (nonchanters).

$H_{O4}$: Former members who have left contemplative-type cults have the same mean scores on the BDI as those former members who were not in contemplative-type cults.
HA5: Those who have spent more than eight years in a cult will have higher mean scores on the BDI than those who have spent eight years or less duration in their groups.

HO5: Those who have spent more than eight years in a cult will have the same mean scores on the BDI as those who have spent eight years or less in their groups.

HA6: There will be an interaction as measured by a statistically significant difference between the time spent in a group and involvement in a contemplative-type group with respect to the depression measure of the BDI.

HO6: There will be no interaction between the time spent in a cult and involvement in a contemplative-type cult with respect to the depression measure of the BDI.

Significance

Clinical Identification

Even after an individual has left the abusive group or relationship, the former cultist oftentimes continues to engage in the cult-prescribed sets of thoughts and behaviors that some clinicians refer to as cult pseudo-identity (West & Martin, 1994). The former cultists may experience difficulties in re-integrating themselves into the larger society that they had once isolated themselves from. The goal of treating a former cultist is to relieve the client’s cult-induced symptoms and to restore pre-cult personality after an abusive group has placed stressful demands on the client’s sense of identity, values, mood, thought and behavior. Awareness of symptoms such as various types of
dissociation and depression that former members may experience can help the clinician identify these symptoms early.

Many people throughout the ages have used primarily one of the two traditional methods of meditation, one based in the Hindu tradition, and the second method based in the Judeo-Christian tradition, and has found those practices helpful. However, there are many kinds of meditation being promoted by various cult groups. Cults often use various forms of meditation as well as other types of physiological and psychological persuasion techniques to exploit and gain control over their members. Many former members of contemplative cults have engaged in involuntary meditative states that intrude into their waking consciousness when they were not deliberately meditating (Singer and Lalich, 1994). Singer and Lalich and West and Martin (1994) explain that the usage of these contemplative techniques may increase suggestibility, thus inhibiting decision making, and in severe cases may lead to more permanent types of dissociation that is disruptive to the individual’s life long after they have left the cultic milieu. Dissociative and other symptoms resulting from contemplative cult practices may endure long after other symptoms have improved (West & Martin, 1994).

The literature reviewed in chapter two will indicate that the cult problem is widely misunderstood by scholars. The problem is that many counselors who see these former members misunderstand the clinical picture and oftentimes relegate the client’s symptoms and their stories as pre-existing pathology (Singer and Lalich, 1994) or even worse, as gross over-exaggerations. Many former members have sought counseling with little or no relief of their symptoms. This may be due to mental health professionals not
being appropriately trained to treat or identify these types of problems (Martin & Orchowski, in press). The personal cost of emotional suffering, loss of occupational productivity, and relational isolation that former members many times find themselves in as a result of their cult involvement can be devastating as they feel they have nowhere to turn, no one who understands their demise (Singer & Lalich, 1994). Studying the cult phenomenon is necessary to alert mental health care professionals of clinical diagnostic and treatment issues with former cultists so that these individuals may be properly diagnosed and treated in a timely fashion. Studying the cult phenomenon may alert counselor educators and others who are in the profession of training mental health care professionals of this dire mental health care issue.

_A Public Health Concern_

Pinpointing the number of people who are in cults or have been affected by them has seemingly been a daunting task, probably due to the fact that most cultists do not raise their hands to be counted. Estimates of cult membership in America have ranged between two and twenty million by some in the literature (Martin, 1993). There is much variability in the literature on the estimates of the number of people involved with cults as this broad estimate speculates tentatively, which may be expected as there are differences in the way cults have been defined and measured that may not accurately reflect a true number of people involved in cults. A survey conducted in 1993 by the ICR Survey Research Group for the American Family Foundation (AFF) points to the aforementioned estimate of cult membership. As has been mentioned, accurate estimates seem impossible due to the definition of a cult that individuals hold (Martin, 1993). It has
also been suggested that perhaps as many as one hundred thousand people enter and leave
cultic groups each year and that one to two percent of the U.S. population have been
involved in cultic groups (Langone, 2001). Similar percentages have been found in a
study in Spain (Atencion e Investigacion de Socioadicciones, 2005). If it is true that these
large numbers of cultists do indeed exist, when one considers the number of family
members and friends that cultists also affect as they see their loved ones isolate
themselves, the numbers of those affected by the cult problems become insurmountable.
If it is true that these large numbers of cultists are involved in the United States alone, the
cost to society and to national security as seen in more recent years of terrorist activity
could be enormous. With the tentative estimates of those involved in cults in America, if
cults were a disease, they would be the number four most common cause of morbidity in
America (Martin, 1993). No literature was reviewed that studied the prevalence of
dissociative disorders in those who are in cults or in former members. However as one of
the most reliable antecedents of dissociation in clinical populations is trauma, if it is true
that there are large numbers of cultists in the United States alone, cult involvement could
pose a significant public health concern.

Cults and their effects need to be studied not only because of clinical treatment
issues as mentioned above, but for prevention activities that could save lives and health
care dollars. Examples of prevention activities could include school counselors offering
high school students prevention workshops related to warning signs of cultic
relationships or counselors working on college campuses offering prevention programs in
the residence halls and providing training programs for the residence assistants in the dorms.

**Limitations**

One of the great limitations of research involving former cult members, including this study, is that it is impossible to collect standardized test data on them before they join their cults. It is also difficult to study current cultists, as cults that rely on recruiting are likely to be reluctant to assist with research into their prospective new members or potential new members. Certainly, many life experiences, not just those related to a cult experience, may lead to the development of dissociative disorders and depression in individuals. Drawing cause and effect relationships are therefore next to impossible as former member pre-cult dissociation and depression levels are not known. As many former members have been out for a number of years prior to seeking treatment, it is not known if there have been any other post-cult experiences that may have led to elevated levels of dissociation or depression. Research must depend on recollections of abuse by former members and their self-report histories. Former members of cults may be biased against the group due to the fact that they chose to leave the group and seek treatment, implying, at least in some cases, that they perceive they were harmed by the group.

Another limitation of this study is that participants are limited to just those who were seeking treatment at a residential facility. It is impossible to find the total population of former members and then find an adequate random sample from the population.

Data used in this study comes from a pre-existing data set with clients who were seeking treatment at Wellspring Retreat and Resource Center, a residential treatment
center in Ohio that specializes in the treatment of former cult members. Data collected were from the years 1995 through 2006. Societal trends in the popularity of certain contemplative practices within cult groups may have increased or decreased during this time frame. The results of this study could not be generalized to all former members of cults or to current members.

*Delimitations*

Those receiving treatment at Wellspring were motivated enough to travel from various parts of the United States and Canada, Australia, and various countries in Europe. Individuals seeking treatment at Wellspring do so voluntarily, and no one in the study was legally mandated into treatment. Client data was gathered upon intake into the treatment program, and all gave written permission for their data to be used for research purposes. The potentiality of bias on the part of these treatment-seeking former members against the cult must be taken into consideration. This study largely excludes those whose experience in the group may have been a positive one, a group that would be difficult to study due to identification reasons.

Most of Wellspring’s clients discover the facility through various cult information networks, former members and through the Wellspring website. The difficulty of finding Wellspring may be seen as a significant delimitation. Wellspring has received considerable media attention over the years, however, the radio shows, documentaries, newspaper articles, magazine articles and news shows that have given Wellspring media attention only target select groups of individuals. Those who do not view or listen to these media outlets or do not have internet access would not know of its existence.
Definition of Terms

Cult

Zablocki (1997) explains that sociologists often distinguish “cult” from “church,” “sect,” and “denomination.” Cults are innovative and fervent groups, that if in his view, they become accepted into the mainstream, they lose their fervor and become more organized and integrated into the community; they become churches. Zablocki defines a cult as “an ideological organization held together by charismatic relationships and demanding total commitment.” In contrast, the definition proposed in this study embraces elements that emphasize more of the destructive methodology of the group. Furthermore, cults take on themes that can be religious, but can also exist outside of this realm to include other themes such as psychotherapeutic, political or commercial.

Cults are groups that often exploit members psychologically and/or financially, by making members comply with leadership’s demands through certain types of psychological manipulation, or thought reform, and through the inculcation of anxious dependency on the group by its leaders (Chambers, Langone, Dole & Grice, 1994). Cults have an emphasis on authoritarian structure, and employ deception and manipulation upon recruitment. One of the more commonly quoted definitions of “cult” was articulated at an American Family Foundation/UCLA Wingspread Conference on Cultism in 1985. This definition sees a cult as a group or movement that exhibits a great or excessive devotion or dedication to some person, idea, or thing and employing unethically manipulative techniques of persuasion and control. These techniques are designed to advance the goals of the group’s leaders, to the actual or possible detriment of members,
their families, or the community (West & Langone, 1986). Singer and Lalich (1995) used the phrase “cultic relationships” to signify more precisely the processes and interactions that go on in a cult. To further clarify the definition of a cult, Singer and Lalich described three factors that encompass the label “cult”:

1. The origin of the group and role of the leader.
2. The power structure, or relationship between the leader (or leaders) and the follower or followers.
3. The use of a coordinated program of persuasion (which is called thought reform, or, more commonly, brainwashing) (p. 7).

Singer and Lalich (1995) described cults as using a combination of persuasion techniques: physiological techniques such as meditation, hyperventilation and repetitive motion; and psychological techniques such as trance and hypnosis, manipulation and reframing. It is noted that not all groups use every technique. The goals of the use of these techniques are to get the member to do what the leader wishes.

*Contemplative-type Cult*

A contemplative-type cult is one where contemplative exercises are practiced, such as chanting, meditation or “speaking in tongues” simultaneously while members are encouraged to push doubts or negative thoughts out of consciousness. Dissociated trance-like symptoms are often seen in former members of these cults (West & Martin, 1994).

*Thought Reform*

Thought reform is a systematic behavioral change strategy that is designed to change an individual’s worldview, which will change his or her behavior. It is
distinguished from other forms of social learning by the conditions from which it is conducted and by environmental and interpersonal manipulation that are meant to destabilize a person’s sense of self, get the individual to drastically reinterpret his or her life’s history, and accept a new version of reality. Induced dependency upon the leader and the organization is the result. The new recruit then becomes an agent of the organization (Singer and Lalich, 1994; Ofshe & Singer, 1986).

*Depression*

Depression in this study is measured by the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Each item taps into behaviors and symptoms associated with depression, including depressed mood, negative attitude, psychomotor retardation, and somatic complaints.

*Dissociation*

Dissociation in this study refers to a range of factors related to the disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment (*DSM-IV*; American Psychiatric Association [APA], 1994) as measured by the Dissociative Experiences Scale or DES (Bernstein & Putnam, 1986) and the Hopkins Symptom Checklist Dissociation Screen (HSCL). The DES has proved to be a reliable and valid instrument to measure dissociation in many groups and was developed especially as a screening instrument to identify subjects with Dissociative Identity Disorder (Carlson, Putnam, Ross, Torem, Coons, Dill, Loewenstein & Braun, 1993). The DES and the HSCL will be described in more detail in chapter 3.
Dissociative Pseudo-identity

Dissociative pseudo-identity is a type of dissociation that is observed among cult victims where there is classic transformation through deliberately contrived situational forces of a normal individual’s personality into that of “a different person.” (West & Martin, 1994, p. 274). This study alleges that many of those who have been exposed to a thought reform system develop this type of dissociation that disrupts identity.

Contemplative Dissociation

Contemplative dissociation is a type of dissociation that produces trance-like symptoms and is often seen in members of cults in which contemplative exercises were practiced such as chanting, meditating, hypnotic exercises and “speaking in tongues” (West & Martin, 1994) and is also the focus of this study. These symptoms are frequently seen in addition to the often clear-cult examples of dissociative pseudo-identity that are observed among cult victims.

Summary

This study investigated the levels of dissociation and depression that former members of destructive cults may experience, and in particular whether or not former members of contemplative cults experience higher levels of dissociation and depression than former members of cults that who do not employ contemplative techniques. The duration of time spent in a cult was also examined for its effects on dissociation and depression. A causal link between a former member’s experience in a contemplative cult and their levels of dissociation and depression could not be established without more controlled experimental conditions that would involve access to members before their
cult experience to examine any pre-cult levels of dissociation and depression, which due to access issues is difficult if not impossible. In any case, it is of dire importance that mental health care professionals be responsive to the issues at hand.
Chapter II

Review of the Literature

Literature regarding cults has been dominated by personal, scientific, and political agendas (Aronoff et al., 2000). The academic polarization that developed during the 1980s has diminished somewhat in recent years (Langone, 2000). Cult sympathizers, who tend to be academics in sociology and religious studies, have published widely (Anthony & Robbins, 1992; Barker, 2005; Bromley, 1998; Coleman, 1984) while critics, who for the most part tend to be mental health professionals, have not published as much (Langone, 2000). Cult critics (Martin, 1993; Singer & Ofshe, 1990; West & Martin, 1994; Tobias & Lalich, 1994) assert that some cults cause psychological harm. Those who hold this perspective proclaim that some cults give birth to negative reactions in their former members that can range from depression, anxiety, dissociation, guilt, psychotic episodes and fear of the group reprisals (Singer & Ofshe, 1990). The literature regarding both of these perspectives, the “cult sympathizer” and the “cult critics” views, observations, and studies will be further examined.

More specific to this study, literature regarding dissociation and depression will be examined. It is noted in clinical observations (Martin & West, 1994; Ofshe & Singer, 1990) that there are differences in dissociative symptoms that former members of cults experience depending on the type of cult group that an individual has been in. The literature regarding these differences will be examined.

The electronic database PsycInfo was used to locate books and articles that were pertinent to this study. The keyword search included the following terms: cult, cultic,
cultism, brainwashing, thought reform, dissociation, meditation, pseudo-identity, trauma, and new religious movements. The names of authors who frequently publish articles in the field were also included in the search.

*Introduction to the Literature*

The search uncovered a number of articles from both those who are sympathetic to cults as well as cult critics. Much of the literature is more concerned with the assertion of opinions rather than the contribution of any knowledge base. More research-oriented articles are largely based on interviews and on testing instruments that are of questionable validity and reliability as the measures were not standardized (Aronoff et al., 2000).

Studies that try to assess psychological problems of members before they join are oftentimes riddled with challenges. Accessibility to subjects before they join has proven to be quite a challenge. Studies that seek to assess characteristics of “pre-joiners” have studied current cultists and asked how they felt before joining (Spero, 1982). It is reported that many of the subjects viewed their lives prior to joining in a negative light. Non-cultists were not studied, so it cannot be determined if these were just characteristics of those who had joined, or if these current members were hand-selected by leaders so as to put the group in a more positive light. Many reports of pre-cult characteristics are marred by the fact that the accounts of precult adjustment are retrospective in nature (Ash, 1985; Levine & Salter, 1976; Maron, 1988).

Studies that involve former members may also be biased by the researcher who may also be a former member of a cult. These researchers may be more sensitive to the former members who report negative symptoms and therefore are guilty of confirmatory
bias. Former members who are currently or have been in treatment are more easily identifiable, and therefore their data may be more accessible (Aronoff et al., 2000). These individuals may be experiencing more negative symptoms than other members by the fact that they have sought treatment.

Critical Review of Relevant Literature

Thought Reform

The concept of thought reform, or more commonly known as “brainwashing” has been considered by many (Galanti, 1993; Hassan, 1988; Martin, 1993; Singer & Ofshe, 1990; West & Martin, 1994) to be related to many of the changes that members of cults experience as the new recruit finds his or her sense of self under attack by the thought reform environment. Thought reform was initially described by Robert J. Lifton (1989). The term “coercive persuasion” was used by Edgar Schein (1961) to describe the organized “remolding” programs introduced by the Chinese Communists in “revolutionary universities” and prisons after their 1949 takeover. Lifton, Schein, Margaret Singer and Louis Jolyon West were among those who interviewed Chinese dissidents of the Chinese Communist regime as well as former American prisoners of war (Hassan, 1988).

After several years of study, Lifton (1989) described eight criteria of thought reform that he found to be common elements among former prisoners of the Korean War and dissidents and survivors of the thought reform programs of China. Lifton (1989) concurs in a later edition of the preface of his book Thought Reform and the Psychology of Totalism, that indeed the dynamics of thought reform could be applied to modern day
cults, and that from the very beginning, the book was designed to provide principles of a
general kind and criteria to evaluate any program in relation to ideological totalism.

Lifton explains that individuals who are exposed to these eight processes could be
induced into adopting a new sense of self and a new worldview that would result in them
making rapid changes in deeply held beliefs, values, attitudes and behavior. Descriptions
of Lifton’s (1989) criteria for a thought reform environment are paraphrased in the
following paragraphs. These criteria are: milieu control, mystical manipulation, sacred
science, loading the language, cult of confession, demand for purity, doctrine over person
and dispensing of existence.

*Milieu control.* This consists of total control of communication in the group. It
often involves discouraging members from contacting those with conflicting ideas or
alternative ideas that are contrary to the phenomena being brought forth in the group.
Individuals may be discouraged from reading anything not approved by the leaders or
organization. Members may be discouraged from communicating anything but positive
endorsements. Milieu control can be accomplished by physical separation, however,
when in combination with the other seven elements, physical control of the environment
becomes unnecessary as a sort of psychological separation occurs due to a loss of interest
or fear of the outside world and its competing ideologies (Lifton, 1989).

*Mystical manipulation.* The group manipulates members to think that their new
emotions and behavior have arisen spontaneously in the new environment. The leader
gives the impression that this group is a chosen, select group with a higher purpose.
Members begin to view for example their leader as the “spokesperson for God on Earth.”
The individual feels elation when exposed to an exercise supposedly special and unique to the group and the resulting elevated mood is framed as a logical response to correctly applying the group’s principles. Opposing ideas are framed as lacking wisdom. Eventually, the new recruit feels trapped in a world ruled by forces that only the group understands and that only the group has the means of controlling, the Sacred Science (Lifton, 1989).

_Sacred science._ The leader’s wisdom is given an aura of science, giving him or her a sort of credibility to their central philosophical, psychological, religious, or political notions. The leader then can proclaim that the group’s ideas can be applied to all of humanity and anyone who disagrees or possesses alternative ideas is immoral, irreverent, and unscientific. The world is viewed as black and white and any failure to measure up perfectly with the demands of the Sacred Science must be confessed as personal flaws (Lifton, 1989).

_Loading the language._ As members continue to formulate their ideas using group jargon, the language then begins to constrict one’s thought processes thereby inhibiting one’s critical thinking capacities. This jargon oftentimes is only understandable by group members and serves as “thought terminating clichés.” Eventually using the group jargon becomes second nature and speaking with outsiders can become awkward. Through use of loaded language, the group gradually controls how the member thinks about the Sacred Science (Lifton, 1989).

_Cult of confession._ Confession is used to reveal one’s past and present feelings and behavior seemingly to unburden them and to become free. However, such
information is often used to further conform one to the group ideal, thereby estranging oneself further from their previous lives. This information is frequently used to lead the new recruit to feel guilty, powerless, and how much in need they are of the group and its’ ultimate authority or moral goodness. One becomes more estranged from family and friends through this technique as one begins to denigrate their past life (Lifton, 1989).

*Demand for purity.* The demand for purity is based on the notion that absolute perfection is possible and any deviation from perfection is intolerable. The inner world of the new recruit is slowly reduced to endless rounds of guilt and shame. An “us-versus-them” orientation is promoted by the all-or-nothing belief system of the group; we are right; they (outsiders, nonmembers) are wrong, evil, unenlightened. The guilt and shame that is created magnifies one’s dependence on the group (Lifton, 1989).

*Doctrine over person.* Doctrine over person is the acquired ability of the new recruit to reframe the events of life only in the context of the teachings of the group, the Sacred Science. Those experiences that support the Sacred Science are accepted, those that are not are rejected. Eventually, members rewrite their own personal history so that one learns to fit oneself into the group’s interpretation of life. The members begin to lose the ability to believe they can make sense of the events they experience, choosing the doctrines of the group as more trustworthy than their own experience in defining reality (Lifton, 1989).

*Dispensing of existence.* As a person’s sense of self is squeezed, the need to connect with the group increases. At the same time, the group makes it clear that it alone has the wisdom and authority to decide who is qualified to exist on the superior plane the
group defines and who is not. This develops naturally from the idea that the group has the ultimate knowledge and truth. Outsiders simply do not measure up, and in failing to do so, threaten the forward progress of humanity, or of God. The group and its leader make it clear that the group is the elite, having more right to exist than non-members. Usually held non-literally, in some cases this Dispensing of Existence gives members the right to terminate outsiders’ lives (Lifton, 1989).

Lifton (1989) explains that these eight criteria of a thought reform environment are carefully orchestrated so as to elicit certain responses from group members. Obedience is the result, as well as total commitment to the mission and goals of the group.

Singer and Ofshe (1990) explain the necessary conditions for a thought reform program to be effective. They explain that the conditions of maintaining a closed system of logic and an authoritarian structure, and maintaining a noninformed state in the member in a thought reform environment are effective because there is no effective way for the subject to influence the system and because the program moves along in such a way that the individual is unaware of the changes that are taking place within themselves for a hidden organizational purpose. In a closed system of logic, criticism, complaints or non-compliance is handled by showing the member that he or she is defective and not the organization.

*Cults and Thought Reform*

Singer and Ofshe (1990) distinguished between the “first generation” of thought reform programs of the Soviets and Chinese that were studied in the 1960s and the
second generation of thought reform programs that are currently operating such as what we see in cults today, or have been in existence during the last decades in the Western world. Singer and Ofshe notes that the second generation of thought reform programs, such as those used by cults today attack a person’s evaluation on their self, whereas the first generation of thought reform programs primarily focused on the political aspects of an individual’s self-concept. The newer programs that attack central aspects of a person’s sense of self is used to undermine a person’s basic consciousness, sense of reality, beliefs and worldview, emotions and defense mechanisms. Singer and Ofshe state that the newer programs are efficient and effective and use the long recognized elements of thought reform as well as a variety of new influence techniques. They may also produce more psychiatric casualties. The older and newer programs both attack a person’s evaluation of the self.

Thought reform and its effects formed the foundation of the definition of the term “cult” by Langone (1993):

…a group or movement that, to a significant degree, (a) exhibits great or excessive devotion or dedication to some person, idea, or thing, (b) uses a thought reform program to persuade, control, and socialize members (i.e., to integrate them into the group’s unique pattern of relationships, beliefs, values, and practices), (c) systematically induces states of psychological dependency in members, (d) exploits members to advance the leadership’s goals, and (e) causes psychological harm to members, their families, and the community.
Aronoff et al. (2000) explain that a lack of consensus of the definition of the term cult exists. Rosedale and Langone (1998) describe a cult as lying on a continuum that consists of a range from being extremely cultic to completely non-cultic in nature. They explain that a gray area separates “cult” from “noncult.” The destructive effects of cult involvement can range on this continuum. It is the level of the potential harmfulness of a group’s practices that are considered important rather than merely labeling them as cults.

Cults are not all alike, and certainly many different types of cults exist. Some various types of cults include religious, psychological, political, and commercial (Langone, 1993). Most of the literature on cults is related to groups that are of a religious theme. Other cults have been studied however, such as psychotherapy cults (Singer, Temerlin, & Langone, 1990). A cult can form itself around any theme as long as there is some common ideology to follow. A cult is defined more in terms of its methods rather than its beliefs.

Clinical Impressions and Empirical Studies of Current Members

Some researchers have given descriptions of experiences of current members. Robbins and Anthony (1972) interviewed current members as participant-observers and reported that current members decreased their use of illicit drug use relative to what they were using before entering the group. One major flaw of this study is that no standardized measures were used. The results were more anecdotal in nature. It is also not known if there were any demand characteristics present from the group that would cause the members to report their behaviors in a more positive light.
Levine (1984) studied more than 400 cult members in several different groups. He determined that the cult experience was beneficial as it provided adolescents an opportunity to cope with separation from their parents. Again, no standardized measures were used, and the results were described in an anecdotal fashion.

Spero (1982) described far more negative experiences of current cult members than the previously mentioned researchers. He found that 74% of 65 clients in therapy were displaying the dissociative symptom of “floating.” Floating is described as a sudden abrupt shift or reversion in identity to a set of behaviors and emotions that were cult prescribed. He also noted dependency and weakened critical judgment and reasoning. Many of the descriptions of current members’ experiences were vague and non-descriptive. None of the data was taken from standardized tests, and like the Levine (1984) and Anthony and Robbins (1992) studies, the results were anecdotal in nature.

Galanter, Buckley, Deutsch, Rabkin, and Rabkin (1980) studied drug use in the Divine Light Mission (DLM) and in the Unification Church. They were administered self-report measures concerning their drug use for four different two-month time periods which examined before group and current use. Both the DLM groups and the Unification Church groups reported decreased drug use over time. As is problematic in many studies regarding cult research, standardized measures were not utilized. Also, the DLM discouraged use of drugs and the Unification Church strictly prohibits drug use. With these demands, current members may feel pressure to answer questions based on what the group expects from them and not necessarily based on their actual behaviors (Aronoff, et. al., 2000).
Galanter and Buckley (1978) engaged in another study where members of the DLM were assessed for drug use and psychiatric symptoms using a multiple-choice questionnaire developed by the authors. No validity or reliability data was available for the measure utilized. A decrease in drug use and psychiatric symptoms was noted across time. Also, meditation activities were assessed. It was found that 99% of participants reported that they meditated at least some of the time during the day. Many reported experiences that were out of the ordinary which do not conform to reality. In this sample, 34% reported that “time passed faster or slower than usual in a very special way…very intense;” 49% reported that they “had a special unfamiliar feeling in my body…very intense;” 30% reported that they “saw something special that no one else could see clearly with my eyes.” The researchers concluded through statistical analysis that increased time that was spent in meditation and transcendental experiences were predictors of decreases in psychiatric symptoms. Aronoff and Lynn (1996) note several problems with this study. First, the questionnaire was not standardized or validated. Second, retrospective reporting was used. And third, the researchers considered certain transcendental experiences as being predictors of decreased psychiatric symptoms, which in and of themselves are potential symptoms.

Personality and psychopathology characteristics have also been evaluated with members in particular groups. Personality characteristics of members of the Hare Krishna and a control group of nonmembers were measured by the Comrey Personality Scales (Weis & Comrey, 1987). The Hare Krishna members’ scores were assessed as more compulsive and distrustful than the nonmembers, however they were within the normal
range. The researchers interpreted the members’ distrust as the possible reflection of their perceptions that society is critical of their group, or conversely that perhaps that the distrust in society caused members to seek out an alternative lifestyle in the group.

Ungerleider and Wellisch (1979) compared current and former members from a variety of unspecified groups. These researchers used a variety of measures that included a structured interview, a mental status exam, a short form of the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), and the Interpersonal Check List (ICL). Current members scored higher on the MMPI Lie scale than the former members. These internal validity measures on the MMPI measures social desirability and an elevated score indicates that the individual is “faking good” or attempting to place themselves in a favorable light in terms of pathology. The actual scores were not reported. As these Lie Scale scores were not reported, interpretation of clinical scale scores is difficult. Some of these clinical scale scores may have been invalidated. It is stated that current members had elevations on two clinical scales, and that former members had elevations on two different clinical scales. In the first part of the results section, it states that current members had elevations of scales 6 (Paranoia) and 8 (Schizophrenia), and the former members had elevations of scales 3 (Hysteria) and 4 (Psychopathic Deviate). However, later in the data it is written that the two scales that former members had elevation on were scales 6 (Paranoia) and 8 (Schizophrenia), and the current members had elevations of scales 3 and 4 (a reversal of what was previously stated). The contradictions in the reporting of this data make it difficult to come to any conclusions on this research as a result. Like many of the studies reviewed, actual scale
scores are not given in the reporting of the data making it difficult to ascertain what the researchers were really attempting to report.

Levine and Salter (1976) interviewed members of several nonmainstream religious groups. When asked about their reasons for remaining in the group, 80% stated intrapsychic or interpersonal reasons. Twenty percent stated spiritual, transcendental, or mystical reasons. Some members were randomly selected and received a more extensive interview. It was stated that most of these members did not meet the criteria for psychiatric diagnoses, however it was reported that a large number exhibited psychiatric symptoms. Again, no well-normed standardized measure was used. It was not stated how many exhibited symptoms and it was not reported what the symptoms were. These results seem to imply that even though current members may seem to be well-adjusted in the group, further interviewing and assessment with standardized psychometric measures may reveal underlying psychopathology.

Spero (1984) assessed 51 current members with pre and post tests after psychotherapy treatment using the WAIS, the Bender Gestalt Test, the Rorschach and the Embedded Figures Test. Increases were reported for the Verbal and Performance areas of the WAIS. The post test of the Bender Gestalt Test indicated more perceptual openness. Based on the Rorschach and Embedded Figures Test, it was concluded by the researcher that those current members who have not received treatment may have more difficulties in perceptual and cognitive tasks. Spero did not include a control group of noncult members.

Critique of Studies of Current Members
In conclusion, the majority of studies with current members appear to indicate that current cult members are somewhat psychologically well-adjusted. However, it should be noted that many of these studies do not use well-standardized measures (Galanter & Buckley, 1978; Galanter et al., 1980; Levine & Salter, 1976). Only a few of the studies include comparison groups (Galanter et al., Levine & Salter, 1976). None of the studies has an appropriate control group. Some studies fail to report scale scores from their measures (Ungerleider & Wellisch, 1979). None of the studies surveyed mentions current members’ levels of symptoms such as depression.

Aronoff et al. (2000) explain there are many problems that must be considered in studying current members. Since obtaining and maintaining access to groups is difficult, it may be that those researchers who are sympathetic to the cultic environment may be the ones who are successful in accomplishing this task. Also, it is not known how current members are selected. Perhaps those members who are chosen are hand-selected by the leaders to be participants, and they may be choosing those who are more emotionally and psychologically healthy in order to place the group in a more favorable view.

Most of the measures that were used in the studies reviewed do not indicate validity or social desirability scales (except the Ungerleider and Wellisch (1979) study that used the MMPI). It may be important for researchers to utilize measures that may point to participants’ level of honesty as it may be possible that members may not report honestly on the questionnaires or tests that are given to them. Members may be influenced by the demands placed on them by the group and its leader. Aronoff et. al. (2000) explain that members may be fearful of disapproval or the possible negative
consequences of displaying pathology. For example, some groups may see that certain feelings such as depression or anxiety may be indicative as an attack from Satan and therefore they would be hesitant to express such feelings.

Finally, additional potential problems of researching current members have to do with how researchers deal with culture shock of assessing current members, handling their own emotions in dealing with the group experience, and handling conversion attempts (Ayella, 1990). Cults may be taking a risk in allowing researchers to study them, especially without interference. If the results of the study show a positive outcome, they receive an elevation in social standing. Current members may be hesitant to be cooperative with researchers who are known to study cults as they are sensitive to public opinion. Leaders therefore often control who has access to their members, and may have influence over the members and the perceptions of the credibility of the researcher (Ayella, 1990).

Clinical Impressions and Empirical Studies of Former Members

During the 1970s, clinicians began seeing clients who were presenting with various symptoms after involvement in various groups. During this era and into the 1990s, several clinicians began writing about their observations. Perhaps the most common symptom reported, and the symptom that most concerns this study was that of dissociation in former members (Clark, 1979; Halperin, 1990; Singer, 1978, 1979; Singer & Ofshe, 1990; West 1993; West & Martin, 1994). Dissociation has been noted as often taking the form of the floating phenomenon where one begins to engage in the cult prescribed set of thought and behavioral patterns that they engaged in while in the group,
and the experience of profound ambivalence toward the group even years after leaving (Goldberg & Goldberg, 1982; Halperin, 1990; Singer, 1978, 1979; West & Martin, 1994). Cognitive deficiencies have also been noted such as simplistic, all-or-nothing or black and white thinking, as well as difficulty making decisions (Burks, 2002; Singer & Ofshe, 1990). Depression, which will be addressed later in this chapter (Martin, 1993; Singer, 1978, 1979) and anxiety (Ofshe & Singer, 1990; Martin, 1993) have also been noted. Psychotic symptoms have been less frequently noted in the literature reviewed (Singer & Ofshe, 1990).

Clinical observations by mental health professionals working with former members greatly influenced empirical studies. Although there are relatively few empirical studies with this population and they come with their own shortcomings in methodology, they all point to resulting mental health concerns as a result of cult affiliation.

Conway and Siegelman (1982) found that seven symptoms were predominant in 400 former cult members who were surveyed: floating/altered states (52%), nightmares (40%), inability to break mental rhythms of chanting (35%), amnesia (21%), suicidal/self-destructive tendencies (21%), hallucination/delusions (14%), and violent outbursts (14%). Conway and Siegelman’s findings regarding floating and the inability to break mental rhythms of chanting are of particular interest to this study. Conway and Siegelman also found that these symptoms increased with length of time of involvement in the group. Conway, Siegelman, Carmichael, and Coggins (1986) found significant, although small, correlations between reported emotional, cognitive and physical
symptoms and the amount of time spent in ritual activities. They also found that people who were deprogrammed experienced less depression, loneliness, disorientation, insomnia, sexual dysfunctions, guilt, anger at group leaders, and fear that current members of the group would harm them.

Lewis and Bromley (1987) assessed for the same symptoms as the Conway and Siegelman (1982) study and found lower percentages of people who reported the same symptoms. They also noted that symptoms were unrelated to length of membership in the cult. In terms of method of exit, those who did not undergo exit counseling or deprogramming were less likely to report symptoms than those who had voluntary exit counseling, whereas those who had voluntary exit counseling were less likely to report symptoms than those who were deprogrammed. Aronoff et al. (2000) noted that a problem with this study is that Pearson correlations were calculated between method of exit variables and presence of symptoms, which was an inappropriate statistical method because the method of exit variable consisted of three categorical levels (no counseling, exit counseling, and deprogramming).

Many of the empirical studies in recent years involving former members have involved participants from Wellspring Retreat and Research Center in Albany, Ohio. Wellspring Retreat and Resource Center is a residential treatment facility for former members of cultic relationships. Wellspring only accepts clients who are voluntarily seeking treatment as a result of their self-reported involvement in a cult. Studies that involve the Wellspring population will be discussed in the remaining studies of former members.
Martin and Orchowski (in press) conducted a study of 523 individuals who sought psychological services at Wellspring Retreat and Resource Center. To assess a variety of psychological symptoms and the relationship between symptoms and the method by which former members leave their groups, they analyzed results from the Beck Depression Inventory (BDI), the Dissociative Experiences Scale (DES), the Symptom Checklist-90, and the Impact of Events Scale (IES). The results of this study concur with the Conway et al. (1986) study and conflict with the Lewis and Bromley (1987) study in that overall, those who undergo exit counseling appear to have lower levels of symptoms such as depression, anxious/dependency, somatic symptoms, PTSD symptoms and avoidance than those who walk away. Significant to this study is that Martin and Orchowski found that those who received exit counseling reported significantly lower levels of dissociation on the DES (mean of 11.83) compared to individuals who listed “other” as the method of exit (mean of 21.44). Levels of depression as indicated on the Beck Depression Inventory varied as a function of method of exit, $F(5, 434)=4.43$, $p<.01$. Those who received exit counseling reported lower levels of depression ($M=13.05$, $SD=8.27$) compared to individuals who walked away ($M=20.31$, $SD=10.80$), individuals who were forced to leave the group ($M=23.34$, $SD=11.79$), and individuals who listed “other” as the method of exit ($M=21.24$, $SD=11.77$).

Martin and Orchowski (in press) also found in this study that individuals who walked away from the cult and individuals whose cult group disbanded reported significantly higher number of years in the group compared to individuals who reported leaving via exit counseling. Individuals forced to leave reported higher levels of intrusion
on the IES, which is a measure consistent with the DSM IV (APA, 1994) criteria for post-traumatic stress disorder. They concluded that there is not sufficient evidence to suggest that individuals who join coercive groups are already “damaged.” Martin and Orchowski also noted that the length of time that a person was out of the group before seeking treatment appeared to be associated with the method of exit. For example, those who were exit-counseled out of the group sought treatment sooner than those who had walked away from the group or than those whose group had disbanded.

From these results of the Martin and Orchowski (in press) study, it seems to be inconclusive whether those who had higher levels of symptoms were really associated with the method in which they exited the group, or if it was a function of time, whereby the longer a person has been out of the group, the more their symptoms may have a compounding and solidifying effect. Unlike many early studies involving former members as well as current members, well-standardized instruments were utilized.

Martin and Orchowski’s (in press) study conflicts with studies by Wright and Malony (1989) and Galanter (1983). Wright and Malony found former members’ symptoms fade quickly with time, and Galanter found former members do not report greater psychopathology than nonmembers. Galanter suggests that the method of exit was responsible for increased reports of negative symptoms and not the group itself.

Martin, Langone, Dole and Wiltrout (1992) used well-standardized and validated instruments to assess psychopathology in 124 former cult members. Of these members, 13 were members of FOCUS, a support organization for ex-cultists, and 111 were clients at the Wellspring Retreat and Resource Center. In this study, Martin et al. (1992)
administered the Millon Clinical Multiaxial Inventory (MCMI), the Beck Depression Inventory (BDI), Hopkins Symptom Checklist (HSCL), and the Staff Burnout Scale (SBS-HP) to the Wellspring Retreat and Resource Center population. The MCMI was given to the FOCUS members. There were no significant differences between the FOCUS members and the Wellspring participants on the MCMI. The sample size of the FOCUS members was small at 13 participants, and there were no significant differences. The remaining results in the following paragraphs pertain solely to the Wellspring population from this study (Martin et. al. (1992).

A score of 75 on any of the MCMI subscales is regarded as clinically significant. In the Martin et. al. (1992) study, the MCMI subscales that had the highest mean scores are: Anxiety (76), Dysthymia (72), and Dependent (72). Also, 95% of the 111 Wellspring participants achieved clinical significance on at least one MCMI subscale score. Those who completed the HSCL (n=42), the mean was 102, where scores of 100 or greater are indicative of the need for psychiatric care. The mean score on the SBS-HP (n=46) was 72. Scores greater than 70 is indicative of burnout and stress. The mean score on the BDI was 14 (n=98). Scores of 10 or more are considered to be outside the normal range, and scores of 17 or more suggest a depressive disorder (Martin, et. al., 1992).

It was impossible to gather data on participants before their cult experience, so participants’ elevated scores could have been due to participants’ experiences prior to getting involved in the group. To address this, the 111 participants were sent another MCMI to complete six months after treatment. The return rate for this survey was 59.5%. Differences were found between the pretreatment and posttreatment MCMI scores.
Scores on the Histrionic, Narcissistic, and Antisocial Scales increased. The elevation in these three scales is not considered unusual in treatment studies in that successful treatment tends to increase self-esteem, self-expressiveness and to release inappropriate inhibitions. Therefore, elevations in these scores are considered a positive treatment effect. Scores on the Schizoid, Avoidant, Dependent, Negativistic, Aggression, Schizotypal, Borderline, Anxiety, Somatoform, Hypomania, Dysthymia, Alcohol Abuse, Psychotic Thinking, and Psychotic Depression scales decreased. Overall the results show that former cult members exhibit a variety of symptoms after they leave the group and begin treatment at Wellspring. However, these former members also report clinically significant improvements in their functioning 6 months after treatment (Martin et al., 1992).

The Millon Inventory was chosen with this population in the Martin et al. (1992) study as the belief was that the former members’ distress resembled various personality disorders, which is the primary focus of this instrument. The fact that these former members overall experienced significant improvement in their six month follow-up test results, was found by these researchers to not indicate long-standing personality traits such as those that would be found in those who have personality disorders. Personality disorders, by definition, change little over time. Therefore, it was concluded that the environment of the cult tends to induce and/or exacerbate dependency and compulsiveness in individuals.

Martin, Aronoff, Zelikovsky, Malinoski, and Lynn (1996) conducted a follow-up study to the earlier Wellspring study. These researchers assessed another group of 110
Wellspring clients and compared the results to a non-clinical sample. The results were nearly identical to the earlier study that seemed to indicate that former members experienced a variety of psychopathological symptoms after leaving their groups. Also, the Wellspring participants attained higher means on the Dependent (71.4), Self-Defeating (73.65), and Avoidant (74.97) subscales of the MCMI. The mean HSCL score was 112.78 which is of a clinical level, and the mean score on the BDI was 19.77 which is also an elevated score. Aronoff et al. (2000) questioned the use of the MCMI in this case as the MCMI was constructed using a comparison group of psychiatric patients, not a non-clinical group as in the comparison group in this study.

Burks (2002) assessed the relationship between the level of thought reform in a cult and the level of cognitive impairment in 132 former members presenting for treatment at Wellspring Retreat and Resource Center. These former members completed the Group Psychological Abuse (GPA) Scale to assess for the former members’ perceptions regarding the level of thought reform in the group, as well as the Neurological Impairment Scale (NIS) that would measure for cognitive deficiencies at both pre-treatment and post-treatment. A correlation was found between cognitive impairment scores (NIS) and exposure to thought reform (GPA) Scale. However, the correlation was only .24, not unusual for studies in the social sciences. The correlation was statistically significant, but so weak that, at face value, was not considered very important by the researcher. Burks studied a heterogeneous sample of former members seeking treatment. Perhaps more revealing information could have been gleaned if he would have studied a sample of treatment-seeking former members from specific types of
groups and compared the results to other groups. Also, no control group was used for this study.

The review of the studies thus far suggests that perhaps former members of cults report significant psychopathological symptoms while current members do not exhibit the same level of symptoms. Aronoff et al. (2000) questioned why there is an apparent change in levels of psychopathology from the time of being in the cult to the time after leaving the group and postulated several ideas to explain this difference. First, it could be that only after leaving the cultic environment that former members have the opportunity to realize and thereby fully react to the stress that they have undergone. Langone in Martin, Langone, Dole and Wiltrout (1992) further explains this position:

And yet the majority eventually leave (Barker, 1984). Why? If they were unhappy before they joined, became happier after they joined, were pressured to remain, left anyway, and were more distressed than ever after leaving, what could have impelled them to leave and to remain apart from the group?

The inescapable conclusion seems to be that the cult experience is not what it appears to be (at least for those groups that deem it important to put on a “happy face”), either to undiscerning observers or to members under the psychological influence of the group. Clinical observers, beginning with Clark (1979) and Singer (1978), appear to be correct in their contention that dissociative defenses help cultists adapt to the contradictory and intense demands of the cult environment. So long as
members are not rebelling against the group’s psychological controls, they can appear to be “normal,” much as a person with multiple personality disorder can sometimes appear to be “normal.” However, this normal-appearing personality, as West (1992) maintains, is a pseudo personality.

When cultists leave their groups, the flood gates open up and they suffer. But they don’t generally return to the cult because the suffering they experience after leaving the cult is more genuine than the “happiness” they experienced while in it. A painful truth is better than a pleasant lie. (p. 239)

Aronoff et al. (2000), also propose a second explanation as to why there is an apparent change in symptoms from the time of being in the cult to after leaving the group. People who leave a group of which they were completely committed will naturally experience difficulties in coping with the loss and readjustment after they leave (Galanter, 1983). Thirdly, it may be that people who become involved in cults tend to come from poor family environments and they may become involved in the cult as they become a surrogate family. Returning to the poor family environment after leaving the group may cause distress (Ash, 1985; Deutsch & Miller, 1983). Another reason is that current cult members may minimize their pathology (Ayella, 1990). The last reason speculated is that former members are simply faking their symptoms.

Aronoff and Lynn (1996) addressed the notion some researchers have proposed (Anthony & Robbins, 1992; Barker, 1995; Lewis & Bromley, 1987; Robbins & Anthony, 1980) that the negative view that the public has of cults may influence former members
to go along with society’s perceptions, thereby caving in to societal demands and making their experiences seem as bad as the public perceives them to be. Aronoff and Lynn studied 45 former members of cults along with 58 college students who were presumed to be aware of the public’s negative view of cults. The college students were given the same battery of psychological tests that the former members were given and were told to simulate how they thought former cult members in treatment would answer the items. A control group was enlisted of a group of college students (n=56) who completed the tests with no instructions to simulate. Simulators reported more extreme scores than actual former members. Former members also scored higher on the battery than non-simulators who were the control group. This seems to suggest that it would be unlikely that former members would be faking psychopathological symptoms.

Critique of the Studies of Former Members

Some of the early studies regarding former members’ experiences are plagued with many of the same problems that studies with current members have. There is a lack of standardized instruments in the early studies of former members (Conway & Siegelman, 1982). However, more recent studies involving former members use well-standardized instruments with known validity indices.

The absence of a control group of noncult members in the majority of studies reviewed makes it difficult to draw any conclusions regarding the available evidence of former members’ symptoms. The fact that many of the studies lack control groups is important to consider in being able to compare how former members and their symptoms compare to the rest of the population. Another problem is that many researchers studying
former members are former members themselves and may be more sympathetic to negative experiences. Experimenter bias may have an effect on results of the studies.

One important point to consider is how representative the samples of former members are to the general population of cult members. Random sampling is not generally achieved in the studies reviewed. It is difficult to identify former members who have not presented themselves for treatment. Therefore most of the studies of former members have been individuals who have presented themselves for treatment. These individuals may be biased in how they review the group as they obviously perceive that there has been harm done to them. These former members then may not be representative of former members as a whole.

Much of the data collected were also from former members of many different types of groups. The effects of different types of groups could be assessed if samples of members from specific groups or types of groups were gathered.

The methodological problems that have been mentioned in this review limit the conclusions one can make about the destructiveness of cults on their members. Despite somewhat limited evidence that current members appear relatively well-adjusted, no research has been found that indicates that the cult involvement actually assisted the individual in post-cult adjustment. Indeed, most studies have pointed to psychological symptoms and adjustment problems with former members. One recent empirical study reviewed has addressed dissociative symptoms in a heterogeneous group of former cultists (Martin & Orchowski, in press) and the literature does make general discussion of dissociation in former cultists which is of particular interest to this study.
Dissociation

In the last several years there has been an increase in research regarding dissociative phenomena. However, despite these developments, there is no consensus on what dissociation actually means (Cardeña & Gleaves, 2003; Spitzer, Barnow, Freyberger, Grabe, 2006). Despite the theoretical processes underlying dissociative phenomena, there does appear to be essential agreement among scholars regarding the overall phenomenology of dissociation. Nemiah (1991) describes dissociation as “the exclusion from consciousness and the inaccessibility of voluntary recall of mental events, singly or in clusters, of varying degrees of complexity, such as memories, sensations, feelings, fantasies, and attitudes” (p. 248). Spiegel and Cardeña (1991) defined dissociation as “a structured separation of mental processes (e.g. thoughts, emotions, conation, memory, and identity) that are ordinarily integrated.” The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994) defines Dissociative Disorders as being characterized by a “disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.”

Dissociative experiences have been associated with several different conditions and biological factors: damage to the central nervous system, prescription and non-prescription drugs, seizure disorders, somatoform and panic disorders, psychosis, and some severe types of depression (Cardeña & Gleaves, 2003). It is also noted that dissociative experiences lie on a continuum of severity. Even though dissociative phenomena may be present as part of a clinical condition, they are also experienced
within normal individuals (Eisen & Lynn, 2001) and have been known to be associated with hypnosis, rituals, artistic activities, or practices such as meditation (Cardeña, 1997). Pica and Beere (1995) examined the experience of dissociation during positive situations in 33 of 90 randomly selected undergraduate students. In order of ranked frequency, the experiences included sports, sexual encounters, prayer, contact with nature, anticipating good news, hearing good news, acting, hobbies, musical performances and listening to music. Low as well as high dissociators reported these experiences.

Contradictive to the notion that dissociation lies on a continuum, Waller, Putnam, and Carlson (1996) found that some dissociative symptoms overlap in clinical and nonclinical populations. They found that other dissociative symptoms seem to distinguish non-pathological from pathological symptoms (e.g. severe depersonalization and chronic amnesia). They conclude that some types of dissociative experiences that may occur in the general population may be qualitatively different from those experienced by people with dissociative disorders. Other elements that may help to distinguish pathological from non-pathological presentations can include controllability, recurrence, and organization of the experience (Cardeña & Gleaves, 2003).

In contrast to relatively benign dissociation that is found in daydreaming and fantasy (known as absorption), pathological dissociation is thought to have some serious long-term personal consequences (Eisen & Lynn, 2001). Pathological dissociation is characterized by disturbing global dissociative symptoms. These symptoms and disorders are commonly organized into five core dissociative symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration (Steinberg,
These symptoms can be so severe and debilitating that they can lead to a diagnosis of a dissociative disorder (Eisen & Lynn). For the purposes of this review, discussion will focus on the pathological types of dissociation as these types of dissociation have been noted in former cultists (Ofshe & Singer, 1990; West & Martin, 1994).

Dissociative amnesia has been defined as the absence from memory of a specific and significant time (Steinberg, 1993). Functional memory loss is distinguished from ordinary forgetting at one end, and organic amnesia on the other end. Dissociative amnesia is divided into categories of pathological and nonpathological. Nonpathological amnesia would include childhood amnesia, sleep and dream amnesia and hypnotic amnesia (Spiegel, 1994). Pathological amnesia would include loss of personal identity and large parts of one’s past, which may be characteristic of dissociative fugue. This may also be seen in clients with dissociative identity disorder (Spiegel, 1994).

Depersonalization is described in the literature as a sense of detachment from the self. Features may include a sense of unreality or strangeness of the self, a sense that one is observing the self as an outside observer, and a loss of all affective response except for the unpleasantness of the symptom (Spiegel, 1994). Reality testing remains intact. Transient depersonalization has been noted in close to 40% of inpatients and 30% of patients who had experienced a life-threatening trauma (Noyes & Kletti, 1977).

Derealization is defined as a sense that one’s surroundings are unreal. A client with this symptom may feel that his or her friends or family are unfamiliar or unreal, and yet they may still be aware of his or her identity and history (Spiegel, 1994).
Definitions regarding identity confusion describe a feeling of subjective uncertainty, or conflict about one’s own identity. Identity alteration consists of behavior that indicates the presumption of a different identity. These individuals may use different names, they may develop different skills for which they have no account of, and they may find things in their possession that they are unaware of how they acquired the item (Spiegel, 1994).

Pathological dissociation has consistently been linked to a history of trauma (Eisen & Lynn, 2001), however, the DSM-IV does not assume that dissociative disorders develop as a result of a defense mechanism brought about to cope with ongoing trauma (Cardeña & Gleaves, 2003). Although traumatic events are related to dissociative disorders, they are not a sufficient cause for these conditions (Eisen & Lynn). Certain risk factors have been associated with the development for these conditions. Repeated exposure to trauma in an inescapable situation, especially by a parental figure in childhood (Putnam, 1997), sexual abuse and disturbed forms of early attachment can predict pathological dissociation (Eisen & Lynn).

Studies in the United States and Europe suggest that at least among nonclinical populations, dissociation is at its highest in early adolescence and then gradually declines with age. In studies that assess dissociation and demographic variables, socioeconomic status has not been conclusively found to be a factor, nor has ethnicity, although these studies have been conducted mainly in Western cultures (Cardeña & Gleaves, 2003).

The dissociative disorders not otherwise specified category in the DSM-IV (APA, 2004) includes dissociative symptoms of consciousness, identity, or memory that do not
fill the criteria of the other dissociative disorders. It is thought that a substantial proportion of dissociative clients fall under this category (Cardeña & Gleaves, 2003). Cardeña and Gleaves note studies by Mezzrich, Fabrega, Coffman and Haley (1989), and Saxe, van der Kolk, Berkowitz, Chinman, Hall, Lieberg, et al. (1993) that indicates there is some evidence that around 60% of dissociative disorder diagnoses are atypical.

Of particular interest to this study is the DSM-IV (APA, 1994) category of dissociative disorder not otherwise specified (NOS) that includes the following example:

States of dissociation that occur in individuals who have been subjected to prolonged and intense periods of coercive persuasion (e.g. brainwashing, thought reform, or indoctrination while captive).

_Dissociation in Former Members of Cults_

_Cult dissociative pseudo-identity_. West and Martin (1994) have described the presentation of personality change in victims of cults and captivity. Among the phenomena they describe in cultists are having an emotionally and intellectually restricted “pseudo-identity,” which at least temporarily superimposes the previous identity. This pseudo-identity enables the individual to better cope with the extraordinary circumstances with which he or she is faced. It is explained that sometimes the pseudo-identity becomes destabilized when internal defense mechanisms break down, when changes in the group occur that the member cannot tolerate, when information is received from outside sources that contradicts the currently held belief, or when the cult member experiences trauma of humiliation from the group or its leader (West & Martin).
Individuals who have left the group after a pseudo-identity is formed in a thought reform environment may become destabilized after departure from the cult. The phenomena of “floating” is described (Singer & Lalich, 1995; West & Martin, 1994) where the former member suddenly switches back to the cult pseudo-identity that is often triggered by certain sights, smells, sounds, or other senses in everyday life but common in the cult environment. This phenomenon characteristically occurs in cult members who have left the group but have received incomplete counseling or in the beginning phases of counseling (West & Martin).

*Cult contemplative dissociation and contemplative techniques.* The induction of dissociative states is thought of as a distinguishing characteristic of contemporary cults. Cult leaders routinely emphasize that understanding their message must involve more than routine self-evaluation. As a result, cults often highlight their presentations with meditations, chanting, dancing, guided fantasies, and prayers (Zeitlin, 1985). Clark, Langone, Schecter and Daly (1981) note that these activities are used to neutralize critical thinking while giving the lectures and social activities a sense of importance.

Zeitin (1985) explains how the use of dissociative techniques by the leader maintains a member’s allegiance to the cult. As new members become integrated into the cult lifestyle, every aspect of inner life comes to revolve around the cult worldview. Those experiences which confirm the worldview are highly valued, while those that do not are the ones from which one seeks refuge and healing. To accomplish this, most cults teach some ongoing practice of thought stopping which results in a sort of self-hypnotic technique. These methods can range from breath meditation, speaking in tongues, to the
incessant chanting of mantras or prayers. The trance like state that results from this practice is considered the refuge from the outside world (Zietlin). West and Martin (1994) refer to dissociated trance-like symptoms that are often seen in members of cults in which contemplative practices such as chanting, “speaking in tongues,” or meditation have occurred from a clinical observation standpoint.

Appel (1983) distinguishes the techniques that are commonly used in hypnotherapeutic applications that trained professionals use versus techniques that are continuously applied in cults. She notes that many of the contemporary cults do not allow the individual to return to normalcy, and they actually work to maintain the dissociated state. She goes on to explain that the very predictable effects of these states are relabeled as evidence of the healing power at work by the leader, and are interpreted as evidence of what the cult claims they have to offer, such as higher consciousness. Appel (1983) describes the relabeling of the dissociated state that is a predictable response to the dissociative methods that are being used, as a sort of hoax on the part of the leader who is trying to get the cultist to believe that they have some special power.

Singer and Ofshe (1990) categorized thought reform programs that relied heavily on meditation, trance, and dissociation techniques into one grouping and those groups whose main effects are the product of intense adverse emotional arousal states. Singer and Ofshe did note however, that the thought reform systems that they had studied tended to use a variety of techniques and did not restrict themselves to only one or the other of the categories.
Singer and Ofshe (1990) explained that a program that relies on meditation, trance, and dissociation techniques is likely to include elements of intense emotional arousal devices and the reverse is also true. However, in their categorization they use the division of “primarily emotional arousal” or “primarily dissociative” in their classifications of the type of program.

Based on clinical interviews, Singer and Ofshe (1990) note that the techniques used to induce certain beliefs and to induce dependency by various thought reform programs appear to be related to the type of psychiatric casualty the program tends to produce. Programs that are more likely to induce mood and affect disorder are more likely to be large-group awareness training programs. Programs that are more likely to induce enduring fears, self-mutilation, self-abasement, and artificial display of emotionality are more likely to be programs that are based in therapeutic community groups. Thought reform programs that use prolonged mantra and empty-mind meditation, hyperventilation, and chanting appear more likely to have participants who develop relaxation-induced anxiety, panic disorder, significant dissociative symptoms, and cognitive inefficiencies. They also note that those that have been in the thought reform program for longer durations report transient to longer lasting cognitive inefficiencies, impaired concentration, and attention and memory difficulties (Singer & Ofshe, 1990). This is in contrast to Lewis and Bromley (1987) who noted that symptoms were generally unrelated to length of membership in a cult.

Singer and Lalich (1995) explain that many who have been in groups where prolonged meditation, chanting, and other dissociative techniques are utilized often have
difficulties after leaving the group in that they find themselves falling into contemplative type states even when they do not intend to do so. Eventually, an automaticity develops. This state has become known as the “sustained altered state” (Conway & Siegelman, 1978, p. 155). To illustrate this point Appel (1983) provides an example from a former member:

The whole point in the cult was to stay in the Kingdom of God, which basically meant staying in the Spirit of God. You kept on repeating “Thank you Jesus, thank you Lord…It could be done out loud or internally. After a while I could snap into that state of mind after only a word like “Hallelujah” or “Praise be.” I didn’t need to go through the whole chanting (Appel, 1983, p. 89).

Lazarus (1976) noted some clinical observations of individuals who had been in Transcendental Meditation (TM). He described various “psychiatric casualties.” He noted in some cases, that such meditation exacerbated depressive affect, repeating mantras tended to heighten ongoing tension and restlessness in some, and led to severe depersonalization in others. He concluded from observations that TM and other systems of meditation and relaxation can undoubtedly prove extremely beneficial to a large number of individuals, but may be contraindicated in others.

Depression in Former Members of Cults

Depression is one of the most common affective symptoms noted by clinical observation of former cult members from the literature surveyed (Levine, 1980; Martin, 1993; Singer, 1978, 1979). Tobias and Lalich (1994) note that grief and mourning,
especially combined with despair, ennui, anxiety, inward anger, and shame, can produce incapacitating depression for those leaving cults. They state clinical observations of depression in former members for some time after leaving the group. Tobias and Lalich explain that commitment to an ideal, group, or leader fills life with purpose and direction, and when that relationship no longer exists, one must deal with the meaning of the loss.

Conway, Siegelman, Carmichael, and Coggins (1986) discussed results of their study of 353 former members and found significant yet very small correlations between reported emotional states such as depression, $r = .21$, and cognitive states such as disorientation, $r = .15$, physical symptoms such as sexual dysfunction, $r = .12$ and the amount of time spent in the ritual activities.

Several empirical studies have noted depression as being a significant symptom that former members experience (Aronoff & Lynn, 1996; Conway et al., 1986; Martin et al., 1992; Martin et al. 1996; Martin & Orchowski, in press). Martin et al. (1992) in a study of 308 former cultists from 101 different groups, found that 67% of participants reported depression. In the study by Aronoff and Lynn (1996), they compared former cult members’ scores on the Beck Depression Inventory to those who were simulating the way they thought a former cultist would respond and to a comparison group. The simulators obtained higher scores on the BDI than the former treatment-seeking cult members who obtained higher scores than the comparison group. No differences between the comparison group and the former treatment-seeking cult members were found.

Martin and Orchowski (in press) found that levels of depression as indicated on the BDI varied as a function of method of exit ($F(5, 434) = 4.43$, $p<.01$). Those who
received exit counseling reported lower levels of depression (\(M=13.05, SD=8.27\)) compared to: individuals who walked away (\(M=20.31, SD=10.80\)), individuals who were forced to leave the group (\(M=23.34, SD=11.79\)), and individuals who listed “other” as the method of exit (\(M=21.24, SD=11.77\)). Martin and Orchowski also found that levels of depression as reported on the Symptom Checklist-90 (SCL-90) varied as a function of method of exit from the group. Those who received exit counseling reported lower levels of depression (\(M=1.88, SD=0.82\)) compared to: individuals who reported walking away from the group (\(M=1.33, SD=0.82\)) and individuals who were forced to leave the group (\(M=2.11, SD=0.96\)). No studies were reviewed that compared depression in former members based on type of group.

**Summary and Conclusions**

**Strengths and Weaknesses of the Literature**

Much of the data that has been gathered regarding experiences of current and former members have been based on clinical observation and opinion. Much of the literature reviewed provides conflicting information regarding clinical symptoms of those who have had cult experiences.

Most of the instruments used were generally not standardized and therefore of questionable reliability and validity. However, some recent studies such as those by Orchowski and Martin (in press) have utilized well tested instruments. Due to former member identification, it is difficult to access former members who are not treatment-seeking. The danger of biased responses among current members who might want to portray their group in a favorable light, and former members who may be angry at their
groups may indicate the use of cautiousness in the interpretation of results of the studies. As many researchers are former members themselves, researcher bias may also be a factor to consider. Also, many of the studies lack adequate control groups.

This study cannot completely overcome the challenges that previous studies have encountered. Pre-existing data was gathered from former members who sought treatment. Therefore, results of this study may not be applied to the larger population of former cult members.

Those individuals who have been in groups that have utilized contemplative exercises such as chanting, meditation and speaking in tongues, will be identified by using already collected data regarding whether or not they engaged in such practices while in the group. Wellspring utilizes standardized measures with known reliability and validity. Only those instruments will be used in this study. No control groups will be used as the norming populations of these particular instruments are known.

This study will use Wellspring client scores on the DES, the HSCL and the BDI to determine what differences in the level of dissociation and depression former members of contemplative-type cults experience, if any, over those who have left all other types of cults. The amount of time spent in the group and the effects on symptoms of depression and dissociation will also be examined.

How the Literature Supports the Need for This Study

Given the paucity of literature documenting the experiences of harm in cults, and with relatively few empirical studies on current and former members of cults regarding symptoms, more studies regarding this topic are warranted. Literature that involved
clinical observations of the experiences of current and former members was reviewed along with empirical studies that primarily addressed depression, anxiety, cognitive symptoms and dissociation in general. However, no empirical studies were discovered that addressed the clinical observational issue that Singer and Lalich (1994) and Singer and Ofshe (1990) raise of the differences in psychiatric sequelae, namely dissociation, based on the type of group that a former member has been involved in. Again, West and Martin (1994), Singer and Lalich, and Singer and Ofshe all addressed the issue of contemplative-type dissociation in former members from a clinical observation standpoint that stemmed from years of work with former members, and not from an empirical study standpoint. It is the observations of Singer and Lalich, West and Martin, and Singer and Ofshe that provides the platform for this study.
Chapter III
Methodology

Research Design

*Operational Definition of the Variables*

The principal self-report measures that were the main focus of this study included the Dissociative Experiences Scale (DES), the Hopkins Symptom Checklist (HSCL) and the Beck Depression Inventory (BDI). The DES and the HSCL are this study’s operational definition of dissociative experiences. They are used in this study to measure the level of dissociative experiences in former members. Both of these measures were used to detect any subtleties in dissociative experiences that may be missed by using just one measure. For example, one measure may reveal higher levels of dissociation among one group over another group. Dissociation is defined by elevations in scores on these scales. Depression as a variable for this study is defined as elevated scores on the Beck Depression Inventory. Those who have been exposed to contemplative techniques in their groups are those who responded to question #64 on the Group Psychological Abuse Scale (GPA; Chambers, Langone, Dole & Grice, 1994), “The group teaches special exercises (e.g. meditation, chanting, speaking in tongues) to push doubts or negative thoughts out of consciousness” with “Characteristic” (4) or “Very characteristic” (5) responses. The individuals who were exposed to contemplative techniques in their groups were then labeled “chanters,” and those who were not exposed to these techniques were labeled “nonchanters.”
Identification of the Population

The target population for this study is treatment-seeking former members of cults and cultic relationships. Specifically, the target population includes those who sought treatment at Wellspring Retreat and Resource Center in Albany, Ohio, a residential treatment facility that specializes in the treatment of former members of cults. There were 523 former members who sought treatment from 1995 through 2006 from which data was available. Forty-eight of these individuals were in cultic one-on-one relationships. Data was chosen from this time period due to consistency in the types of instrumentation that were used for data collection by staff at Wellspring during this time frame, and therefore the data was comparable. All were entering into treatment at Wellspring for what they felt were after-effects of their experiences in the group or relationship. All entered treatment voluntarily and signed a statement to that effect upon admission and before testing. No clients were referred by courts. Clients were also screened over the telephone, through examination of counseling records, and consultation with clients’ previous mental health professionals if appropriate. Screening was conducted to include only those individuals who have experienced some form of perceived psychological trauma that was done to them by another individual or group of individuals. The nature of the psychological abuse was considered cultic in nature. Screening was also done to ascertain the appropriateness of treatment that is offered at Wellspring compared to the clients’ needs. For example, a client who cannot take part in a structured treatment program due to active psychotic symptoms may not be appropriate for the treatment offered and therefore would be excluded from admission.
All clients who are admitted report having experienced repeated verbal or emotional abuse and were harmed in the process. The data comes from clients who believe they are impaired or harmed enough to seek treatment. Therefore, this study does not include those former members who feel they have benefited from their cult experience and moved on for whatever reason and those members who remain in cults because they feel that it is in their best interest to remain in the group.

Sampling Plan

The size of the sample was determined by the number of cases available at the time of this writing. The sample for this study originally included 523 former members of groups or relationships identified by a group evaluation instrument to be former members of high demand groups, and were very likely to be using thought reform techniques. Those who were in groups that utilized contemplative techniques were identified by question #64 on the GPA Scale (continuous number on the test battery and not the actual question number on the GPA; see Appendix D): “The group teaches special exercises (e.g. meditation, chanting, speaking in tongues) to push doubts or negative thoughts out of consciousness.” Respondents who answered “Not at all characteristic” (1), “Not characteristic” (2) or “Can’t say / not sure” (3) were considered as not having been in a group that practiced contemplative techniques. If respondents answered “Characteristic” (4) or “Very characteristic” (5), they were considered as having been exposed to contemplative techniques. From these responses, 46 cases were deleted due to missing data. This left a sample N=477. Of the sample of 477, 48 were from cultic one-on-one relationships. Those who were found to have been in a group that practiced contemplative
techniques were labeled “chanters” (N=250). Those who were found not to have been in a group that practiced contemplative techniques were labeled “nonchanters” (N=227).

In order to minimize the likelihood of making a Type II error, that is to maximize the possibility of finding a difference if there is one, considerable statistical power must be available when conducting the analysis (Light, Singer, & Willett, 1990). Due to the controversial nature of this research, saying that involvement in a cult that practices certain types of contemplative exercises leads to higher levels of dissociation and depression when it is, in fact, not the case (Type I error), must be avoided. This study will use an α level of < .05. Stevens (1986) indicates that 50 persons per group (N=100) would give power of 0.88 to detect a moderate effect size of D-squared = .64 at alpha=.05. As this study is using a sample size of over 450 with more than 200 persons in each group (chanters and nonchanters), power has been controlled.

Instrumentation

The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986). The DES is a 28-item self-report measure designed to measure dissociative experiences and symptoms. A typical DES question is, “Some people have the experience of finding new things among their belongings that they do not remember buying. Mark the line to show what percentage of the time this happens to you.” The respondent then slashes the line, which is anchored at 0% on the left and 100% on the right, to show how often he or she has this experience, and then writes in the numerical percentage in a blank space to the right of the line. The overall DES score is obtained by adding up the 28 item scores and dividing by 28. This yields an overall score ranging from 0 to 100. The DES contains a
variety of dissociative experiences, many of which are normal experiences and therefore considered non-pathological.

The DES has proved to be a reliable and valid instrument to measure dissociation in many groups and was developed especially as a screening instrument to identify subjects with Dissociative Identity Disorder (Carlson, Putnam, Ross, Torem, Coons, Dill, Loewenstein & Braun, 1993). The DES has high test-retest reliability of .84 and the items had reliability coefficients ranging from .19 to .75. Construct validity is excellent, which means it measures what it purports to measure as reflected in highly significant Spearman correlations of all items with the overall DES score. The ranges were from .50 to .79 (Bernstein & Putnam, 1986). In a meta-analytic validation of the DES, Ijzendoorn and Schuengel (1996) found that the DES showed excellent convergent validity with other dissociative experiences questionnaires and interview schedules with an impressive combined effect size (the overall mean Cohen’s d=1.82; N=5,916). The DES also showed excellent predictive validity concerning dissociative disorders. This scale may be found in Appendix E.

*Hopkins Symptom Checklist Dissociation Screen (HSCL; Briere and Runtz, 1990).* Briere and Runtz developed this 14-item checklist to supplement the Hopkins Symptom Checklist (Derogatis, et al., 1974). Respondents choose on a four-point scale ranging from Not at All (1) to Extremely (4) to indicate the intensity of their experience. The authors found that this instrument had internal consistency among two non-clinical groups (α=.85 and .90). The mean was 20.95 (SD=5.80). This mean score is used as the “norm” for this study. Scores more than one standard deviation above the mean are
considered “above average” and therefore representative of a dissociative disorder. The authors found that scores were correlated with childhood histories of sexual abuse (r=.14, p < .007) and physical abuse (r=.23, p < .001). They found that scores were congruent with the dissociation scale of the standard HSCL. For the purposes of this study, the 14-item screen, not the original full checklist is referred to as the HSCL. This scale may be found in Appendix F.

*Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).* The BDI is a 21-item, multiple choice scale. Each item is associated with symptoms and behaviors with depression, including depressed mood, negative attitude, psychomotor retardation, and somatic complaints. The participants were asked to read each statement and select from four choices given. The range of total scores on this measure is 0 to 63, which is obtained by summing the scores for each of the individual items.

The BDI was found by Beck et al (1961) to have a high degree of internal consistency with the mean alpha coefficient being .87. Item analyses have shown positive correlations between each of the items and the total score. The BDI has a test-retest reliability that ranges from .48 to .86.

The BDI was used in a meta-analysis of studies on its psychometric properties (Richter, Werner, Heerlein, Kraus, & Sauer, 1998). They found that there were a lack of representative norms, there were high item difficulty, factorial validity problems, there were instability of scores over the course of one day, and poor discriminate validity against anxiety. They found that its advantages were its high internal consistency, high
content validity, and high validity in differentiating between depressed and non-depressed participants. Yin and Fan (2000) studied the BDI for reliability estimates across studies in a meta-analysis. They found that only 7.5% of the articles reviewed reported meaningful reliability estimates. Regardless of its many limitations, the BDI remains useful in distinguishing levels of depression and has high validity in differentiating between depressed and non-depressed clients. These strengths made it useful for this study. This scale may be found in Appendix G.

Data Collection Procedures

This study examined a small part of a battery of tests that is given to individuals upon admission at Wellspring. This study used the DES, HSCL, and BDI scores at intake. Those instruments that are relevant to this study are: 1) A consent form to be signed by the individual indicating his or her participation in the study found in Appendix B; 2) A demographic questionnaire found in Appendix C; 3) Tests that are included in this study are in Appendices E, F, and G; 4) The Group Psychological Abuse Scale (GPA) from which it was determined whether an individual was in a contemplative-type group is in Appendix D. Participants generally took 2 to 2.5 hours to complete the full battery of tests.

Clients generally arrived at Wellspring each Sunday in the afternoon or evening and received the test battery on Monday afternoon. They completed the battery over the first couple of days after arrival. Batteries that were not completed by the end of the third day of treatment were not included in the study. The sample was gradually collected from 1995 to 2006.
All persons presenting themselves for treatment were offered three options. They could complete the battery of tests and sign a consent form to include their data in research studies. Second, they could complete the tests for the purposes of their treatment only and to provide information to their clinicians, but not for the use of the study, or third, they could choose not to take the battery of tests at all. If they chose to include their data in the study, they were told the study would not make use of their names and that only their answers and non-identifiable demographic data would be used by researchers other than their clinician. Each individual was assigned a number as a separate identifier.

After each individual completed all of the instruments and the demographic survey, the batteries were scored by the Office Manager on an Excel spreadsheet. Item level data were loaded into the statistical software program SPSS (SPSS Inc, 14.0, 2005) for analysis.

Policy at Wellspring requires that client test profiles be kept with the clients’ treatment file in a locked cabinet. All computer scoring files and electronic datasets containing names of clients are only accessible by electronic password.

Data for this study was taken from a pre-existing data set from the years 1995 – 2006. This data had been loaded onto an Excel spreadsheet by the Office Manager at Wellspring, and then item level data was loaded into SPSS statistical software. Data was password protected in the computer database. The Ohio University Institutional Review Board granted exemption for using data collected in the past under its auspices and is included in Appendix A.
Data Analysis Procedures

This study sought to explore whether former members’ involvement in a contemplative-type cult contributes to higher levels of dissociation as measured by the Dissociative Experiences Scale (DES) and the Hopkins Symptom Checklist Dissociation Screen (HSCL) and depression as measured by the (BDI). The duration of time that a person has spent in a thought reform system (more than eight years or eight years or less) was compared to those who have left cults that do not employ contemplative techniques. Former members who have left contemplative-type cults (more than eight years or eight years or less) was also examined to see the effects, if any, that time in a cult had to the levels of dissociation and depression of former members. The cut-off of eight years was chosen as that is the arithmetic mean number of years that individuals from this sample spent in their groups. A review of the literature did not point towards any particular length of time spent in a group and the effect of post-cult symptoms.

\( H_{A1} \): Former members who have left contemplative-type cults (chanters) will have higher mean scores than those former members who left cults that did not engage in contemplative exercises (non-chanters) with respect to the two measures of dissociation (Dissociative Experiences Scale and the Hopkins Symptom Checklist Dissociation Screen).

This hypothesis is an alternative to the null \( H_{01} \): Former members from cults that do not employ contemplative techniques have the same mean score on the DES and the HSCL than those who do employ contemplative techniques.
HA2: Former members who have spent more than eight years in a cult will have higher mean scores than those who have been in a cult for eight years or less with respect to the measure of dissociation (DES and the HSCL).

HO2: Former member who have spent more than eight years in a cult will have the same mean scores as those who have been in a cult for eight years or less with respect to the measure of dissociation (DES and the HSCL).

HA3: There will be an interaction as demonstrated by a statistically significant difference between the time spent in the group and involvement in a contemplative-type group with respect to the dissociation measures of the DES and the HSCL.

HO3: There will be no interaction between the time spent in the group and involvement in a contemplative-type group with respect to the dissociation measures of the DES and the HSCL.

HA4: Former members who have left contemplative-type cults (chanters) have higher mean scores on the Beck Depression Inventory (BDI) than those who leave cults that do not employ contemplative techniques (nonchanters).

HO4: Former members who have left contemplative-type cults have the same mean scores on the BDI as those former members who were not in contemplative-type cults.

HA5: Those who have spent more than eight years in a cult will have higher mean scores on the BDI than those who have spent eight years or less duration in their groups.
H_{05}: Those who have spent more than eight years in a cult will have the same mean scores on the BDI as those who have spent eight years or less in their groups.

H_{A6}: There will be an interaction as measured by a statistically significant difference between the time spent in a group and involvement in a contemplative-type group with respect to the depression measure of the BDI.

H_{O6}: There will be no interaction between the time spent in a cult and involvement in a contemplative-type cult with respect to the depression measure of the BDI.

This study employed a two-way factorial MANOVA design. The independent variables are the dichotomous variables of “chanters” and “nonchanters” (those who have been exposed to contemplative techniques and those who have not) as one independent variable. The other dichotomous independent variable is those who have been exposed to a cult more than eight years and those who have spent eight years or less in the cult. The dependent variable is dissociation as measured by the Dissociative Experiences Scale and the Hopkins Symptom Checklist Dissociation Screen. A two-way MANOVA was conducted to determine whether there are differences in chancers and nonchanters with respect to the two scales that measure dissociation. Any differences between those who have been in a cult more than eight years and those who have been in eight years or less on the two dissociation scales were examined. Also using the two-way MANOVA design, any interaction between the time spent in the cult and the use of contemplative exercises with respect to the two dissociation scales were also examined. Using a two-
way ANOVA design, the data was examined to determine any significant differences between chanters and non-chanters with respect to the dependent variable of depression as measured by the BDI. Another effect that was examined is any difference between those who have spent more than eight years in a cult and those who have been in eight years or less in terms of depression as measured by the BDI. Finally, data was examined to determine any interaction between the time spent in a cult with the use of contemplative exercises with respect to the measure of depression.

This study used an α level of < .05. Stevens (1986) indicates that 50 persons per group (N=100) would give power of 0.88 to detect a moderate effect size of D-squared = .64 at alpha=.05. As this study used a sample size of over 450 with more than 200 persons in each group (chanters and nonchanters), power was controlled. The literature surveyed indicated that the effects of cult involvement, while largely debilitating for the former member, any single, discrete effect is likely to be quite subtle (Martin et al., 1992). Therefore, the effect, if any, of exposure to a thought reform system in a cult on dissociation or depression is likely to be small. This would also be true for the effects of contemplative techniques that one was exposed to in the group on dissociation and depression. However, small amounts of pathological dissociation and depression could present problems on a day-to-day basis for the individual and are therefore relevant.

Further tests included factor analyses using the two dependent measures of the Dissociative Experiences Scale, and the Hopkins Symptom Checklist Dissociation
Screen, that examined specific items on each of these measures that stand out among those who have been in contemplative cults and those who have not.

Summary

In chapter III, the process of data gathering and the instruments used in this study were discussed. The original sample consisted of 523 clients of Wellspring Retreat and Resource Center. Forty-six cases were deleted due to missing data which left a sample size of 477. All had been screened before being admitted to treatment to insure their experiences and symptoms were appropriate for the facility’s expressed treatment specialty.

Data for this study was drawn from scores on the Dissociative Experiences Scale, the Hopkins Symptom Checklist Dissociation Screen, and the Beck Depression Inventory. The Group Psychological Abuse Scale was used to determine who had been exposed to contemplative techniques in their groups and who had not.

A two-way factorial MANOVA was employed to examine the effects between the independent variables of having been exposed to contemplative techniques or not as well as the independent variable of duration in the group (more than eight years or eight years and less), and the dependent variables of dissociation (DES and HSCL). A two-way ANOVA design was also employed to examine the effects between the independent variables of having been exposed to contemplative techniques or not as well as the independent variable of duration in the group and the dependent variable of depression as measured by the BDI.
Chapter IV

Results

Missing Data

The data for the study came from an existing data set from clients who sought treatment at Wellspring Retreat and Resource Center, a residential facility specializing in the treatment of those who have identified themselves as having been in a cult. As presented in chapter III, the sample for this study included 477 former members of cult groups or cult one-on-one relationships identified through a screening interview to be former members of cults, groups that were very likely to have used the thought reform techniques as defined in the first chapter. This was the number that is left after 46 cases were eliminated due to missing data that would identify them as having been in a contemplative group situation from question #64 of the Group Psychological Abuse Scale. This number of 477 was used for the descriptive analyses. Two outliers were eliminated when evaluating time spent in the group and comparing them to the dependent variables, leaving an N = 475.

This number of 475 becomes further reduced however when analyzing results between chanters and nonchanters and comparing data on the Dissociative Experiences Scale (DES), the Hopkins Symptom Checklist Dissociation Screen (HSCL) and the Beck Depression Inventory (BDI) for various reasons. Wellspring Retreat and Resource Center, from which this sample was derived, has a policy that data derived from questionnaires from participants who do not complete their questionnaires within 24 hours of the commencement of intake will not be utilized for research purposes in order
to get a true baseline of symptoms from clients upon intake. Many did not fill out their test packets within these time limitations. Many participants did not fill out their test packets from which these tests were taken. Some only partially answered the questions. Further, some participants filled out their questionnaires with multiple answers circled making it impossible to determine what the participants’ intentions were. All of these cases were treated as missing data.

Descriptive Analyses

Demographic material was obtained from this existing data set on gender, annual income of family, educational level of participants, religious upbringing, and percentages of those who received counseling before joining their group. Raw scores were recorded from each item and means, frequency counts and percentages were computed. All analyses were performed using SPSS (SPSS, Release 14.0, 2005).

Those who were identified as having been in a group that practiced contemplative techniques (chanters) were 250 of the participants in the sample. Those who indicated that they did not practice contemplative techniques in their group (nonchanters) were 225 participants in of the sample. Of the nonchanters, 68 (30%) were male, and 154 (67.8%) were female. Of the chanters, 71 (28.4 %) were male, and 177 (70.8%) were female.

Religious backgrounds of nonchanters included 64 who endorsed Protestant fundamental (29.5%), 32 Protestant liberal (14.7%), 54 Roman Catholic (24.9%), 5 Jewish (2.3%), 2 Eastern (0.9%), 48 other (22.1%), 4 reared in the group (1.8%), 1 Islamic (0.5%) and 1 none (0.5%). Religious backgrounds of chanters included 60 who endorsed Protestant fundamental (25.6%), 58 Protestant liberal (24.8%), 57 Roman
Catholic (24.4%), 5 Jewish (2.1%), 1 Islamic (0.4%), 3 Eastern (1.3%), 33 other (14.1%),
12 reared in the group (5.1%) and 1 none (0.4%). A chi square analysis examining
chanters and nonchanters and protestant liberal backgrounds was conducted. There is a
statistically significant proportion of chanters from the protestant liberal background, \( \chi^2 (1) = 7.5, p < .01 \).

The income levels for nonchanters varied from $90 reported by 1 participant to
$350,000 reported by 2 participants. The item was left blank by 42 participants.
Nonchanters whose incomes were $20,000 or less were 36.3%. The income levels for
chanters varied from $766 reported by 1 participant to $600,000 reported by 1
participant. The item was left blank by 25 participants. Chanters whose incomes were
$20,000 or less were 44.8%. The mean income for nonchanters was $50,895.65, SD =
$56,557, n = 134. Chanters’ mean income was $43,370, SD = $64,200, n = 181. A t-test
was done to determine if there were differences between chanters and nonchanters on
income. The t-test did not reveal any statistically significant difference between chanters
and nonchanters on income, t (313) = 1.081, p > .05.

The mean number of years of education for all participants was 14.50 years,
SD=3.44. Analyses were done to determine any relationships between educational level
and income level on all participants, and for chanters and nonchanters. For all
participants, there was no relationship between educational level and income (r = -.015, p
= .78). There was no relationship between educational level and income for chanters (r =
-.031, p = .684), and there was no relationship between educational level and income for
nonchanters (r = -.016, p = .85).
Nonchanters who had received counseling before their group experience consisted of 66 participants (29.1%) and 153 indicated that they had not received counseling before their group experience (67.4%). Nonchanters that failed to answer the item were 8 (3.5%). Chanters who had received counseling before their group experience was 89 participants (35.6%) and 156 indicated that they had not received counseling before their group experience (62.4%). Chanters that failed to answer the item were 4 (1.6%). A chi square analysis was done to determine if there were differences between chanters and nonchanters and those who sought counseling prior to their group’s experience. There was no statistically significant difference between chanters and nonchanters, $\chi^2 (2) = 2.88$, $p>.05$.

The duration of time spent in the group measured in years ranged from .0 to 51.71 years. The outliers of 51.71 years and 45.51 years were eliminated for analyses with the dependent variables. One participant answered zero because their involvement in the group was for only a few days. The mean for all participants was 8.05 years (SD = 8.37). The standard deviation speaks to the broad range of time spent in the group. Figure 1 indicates that duration of time spent in the group was skewed towards the higher end.
Figure 1: Time Spent in a Cult

Measures of Dissociation

Two-way multivariate analyses of variance (MANOVA) were conducted to determine whether there were differences in the mean scores between those who engaged in contemplative exercises while in their cult (chanters) and those who did not (nonchanters) with respect to the two measures of dissociation, the Dissociative Experiences Scale (DES) and the Hopkins Symptom Checklist Dissociation Screen
(HSCL). Also, the MANOVA was conducted to determine any interaction between time spent in the group and involvement in a contemplative-type cult and the two measures of dissociation. Ns of both measures were 311 and are smaller than the original sample due to missing items. This change in sample size does not affect power in a significant manner however, as Stevens (1986) indicates that 50 persons per group (N=100) would give power of 0.88 to detect a moderate effect size of D-squared = .64 at alpha=.05, therefore power is controlled.

The multivariate analysis reveals a significant main effect for chanting status and the dissociation measures, Wilks’s Λ = .974, F (2, 310) = 4.189, p < .05. Thus, it can be concluded that there is a significant difference between chanters and nonchanters on at least one of the dissociation variables. Univariate tests indicate chanters had statistically significant higher scores for the DES (M = 16.94, SE = 1.04) than nonchanters (M = 12.65, SE = 1.13). A significant main effect for chanting was found on the DES, F (1, 311) = 8.176, p < .01, partial η² = .026. Chanters had statistically significant higher scores for the HSCL (M = 30.64, SE = .72) than nonchanters (M = 28.17, SE = .79). A significant main effect for chanting was also found on the HSCL, F (1, 311) = 5.314, p < .05, partial η² = .017. According to the authors of the HSCL Dissociation Screen (Briere & Runtz, 1990), in studies with non-clinical populations the mean was 20.95 (SD=5.80), so the mean scores for both chanters and nonchanters on the HSCL were well above the mean scores for non-clinical populations. These results supported the research hypothesis that those who have been in contemplative-type cults will have higher mean scores than
those former members who left cults that did not engage in contemplative exercises with respect to the two measures of dissociation.

There were no statistical differences between former members who have spent more than eight years in a cult with respect to the DES compared to those former members who had been in a cult eight years or less, $t (355) = .007, p > .05$. Also, there were no statistical differences between former members who have spent more than eight years in a cult with respect to the HSCL compared to those former members who had been in a cult eight years or less, $t (332) = .401, p > .05$. Moreover, there was no relationship between the number of years spent in the cult and scores on the DES ($r = .02$, $p = .68$), or for nonchanters and years in the cult and the DES ($r = -.031, p = .69$) or for chanters and years in the cult and the DES ($r = .025, p = .73$). There was no relationship between the number of years spent in the cult and scores on the HSCL ($r = -.001, p = .98$), or for nonchanters and years in the cult and the HSCL ($r = .102, p = .22$), or for chanters and years in the cult and the HSCL ($r = -.10, p = .191$). The multivariate analysis reveals that there is not a significant interaction between chanting status and the time spent in the group on the DES, $F (1, 312) = .22, p > .05$, and there was no significant interaction between chanters and nonchanters and the time spent in the group on the HSCL, $F (1, 312) = 2.78, p > .05$. As time was divided by the mean number of years spent in a cult (8.0 years), time in the group was also divided by the median (5.0) and the mode (1.0), and the way that time was divided seemed to make little difference in the outcomes. Plots of the estimated marginal means of the DES and the HSCL as it interacts with time.
spent in the group for the chanting and nonchanting variables are listed in Figures 2 and 3.
Figure 2: Estimated marginal means of the DES
Figure 3: Estimated marginal means of the HSCL
Factor analyses were done for the DES and the HSCL to see if there were differences in how chanters and nonchanters responded to items on these measures. For the DES and both chanters and nonchanters combined there is a five factor model with eigenvalues greater than one accounting for 57.5% of the variance. A scree plot for the DES for both groups combined is listed in Figure 2. Each of the factors was given subjective labels. The first factor represents memory issues, the second factor represents depersonalization and derealization issues, the third factor represents cult pseudo-identity or floating symptoms, the fourth factor represents concentration or attention span issues, and the fifth factor represents absorption or nonpathological dissociation.

A principal component analysis for the DES was done for chanters and nonchanters. Chanters take a four factor model, with the first 4 principal components accounting for 58.0% of the variance that can be attributed to dissociation. Factor one for this group represents dissociative trance states, factor two represents memory issues, the third factor represents cult pseudo-identity or floating symptoms, and factor four represents absorption.

For nonchanters and the DES, a six factor model emerges with the first 6 factors accounting for 59.6% of the variance in responses attributing to dissociation. Factor one represents depersonalization and derealization issues, factor two represents cult pseudo-identity or floating symptoms, factor three represents memory issues, factor four represents concentration and attention span issues, factor five represents absorption, and factor six represents memory issues. So for chanters and nonchanters the number of
factors were different, however, the percent of variance was similar. The pattern of responses differed slightly.

For the HSCL and chanters, 33% of the variance can be attributed to dissociation. For the HSCL and nonchanters, 34.4% of the variance can be attributed to dissociation. Again, the number of factors and pattern loadings were similar for both chanters and nonchanters on the HSCL. The scree plots for the HSCL and chanters and nonchanters indicate two underlying factors present with eigenvalues greater than 1. The first factor represents depersonalization and derealization symptoms, and the second factor represents memory and cognitive awareness issues. Scree plots for chanters and nonchanters for both the DES and the HSCL are listed in Figures 4 through 8.
Figure 4: Chanters and nonchanters combined on the DES
Figure 5: Nonchanters and the DES
Figure 6: Chanters and the DES
Figure 7: Nonchanters and the HSCL
Figure 8: Chanters and the HSCL
Reliability statistics for the DES indicated that this measure was a reliable instrument for this population (Cronbach’s alpha = .933). Reliability for the HSCL was also good (Cronbach’s alpha = .916).

Measure of Depression

A two-way analysis of variance (ANOVA) was conducted to determine if there were any statistical differences between the mean scores of those who have left contemplative-type cults (chanters) and those who have left cults that do not employ contemplative techniques (nonchanters) with respect to the measure of depression, the Beck Depression Inventory (BDI). Also, the ANOVA was conducted to determine if there were any interactions between the time spent in a group and involvement in a contemplative-type cult with respect to the scores of the BDI. The Ns for this measure were 308. This is a smaller number than the original sample size due to missing items, however, power remains controlled.

The main effect for the chanting variable yielded an F ratio of \( F(1, 308) = 8.30, \ p < .05, \ \eta^2 = .029 \), indicating that chanters had statistically significant higher mean scores on the BDI (\( M = 21.52, \ SE = .84 \)) than for nonchanters (\( M = 17.95, \ SE = .91 \)). This supported the research hypothesis that those who have left contemplative-type cults have higher mean scores on the Beck Depression Inventory than those who leave cults that do not employ contemplative techniques. There was no statistically significant main effect for those who spent more than eight years in the cult on the BDI (\( M = 19.61, \ SD = 10.91 \)) than those who spent eight years or less duration in their cult (\( M = 19.93, \ SD = 10.66 \)), \( t(312) = .254, \ p > .05 \). The interaction effect was non-significant, \( F(1, 308) = \)
.409, p > .05. Time in the group was also divided by the median (5.0) and the mode (1.0), and the way that time was divided seemed to make little difference in the outcome.

Reliability for the BDI for this population was good (Cronbach’s alpha = .898). The plot of the estimated marginal means of the BDI as it interacts with time spent in the group for the chanting and nonchanting variables is listed in Figure 9.
Estimated Marginal Means

Figure 9: Estimated marginal means of the BDI
Summary

Mean scores for two measures of dissociation and one measure of depression were compared between those who have been in contemplative-type cults and those who have been in cults where contemplative techniques were not employed, as well as for any interaction involving the amount of time spent in these two groups. Main effect results that yielded statistically significant mean scores for chanters over nonchanters are listed in Table 1.

Table 1

<table>
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<th>Comparison</th>
<th>DES</th>
<th>HSCL</th>
<th>BDI</th>
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</thead>
<tbody>
<tr>
<td>Chanters</td>
<td>16.94</td>
<td>30.64</td>
<td>21.52</td>
</tr>
<tr>
<td>Nonchanters</td>
<td>12.65</td>
<td>28.17</td>
<td>17.95</td>
</tr>
<tr>
<td>df</td>
<td>(1, 311)</td>
<td>(1, 311)</td>
<td>(1, 308)</td>
</tr>
<tr>
<td>F</td>
<td>8.176</td>
<td>5.314</td>
<td>8.301g</td>
</tr>
<tr>
<td>Sig.</td>
<td>.006</td>
<td>.021</td>
<td>.004</td>
</tr>
<tr>
<td>Partial $\eta^2$</td>
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<td>.018</td>
<td>.029</td>
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Statistically significant mean scores were indicated for both measures of dissociation as well as for depression for those who have been in contemplative-type cults over those who have been in cults that did not employ such techniques. There was no relationship between scores on the two measures of dissociation and time spent in the
group, and there was no statistically significant effect of time spent in the group and scores on the measure of depression. There was no significant interaction effect for the two measures of dissociation and depression and time spent in the group.

In the following chapter, these results will be discussed in terms of implications for mental health counselors, college counselors, counselor educators and for outreach and prevention. Recommendations for further research will also be given.
Chapter V
Discussion of Implications, Conclusions and Recommendations

Overview

This chapter summarizes the study, and the findings presented in the last chapter as they relate to the hypotheses. The hypotheses examined the effects between the independent variables of having been exposed to contemplative techniques or not as well as the independent variable of duration in the group (more than eight years or eight years and less), and the dependent variables of dissociation (DES and HSCL). Other areas that were examined included the effects between the independent variables of having been exposed to contemplative techniques or not as well as the independent variable of duration in the group and the dependent variable of depression as measured by the BDI.

Reason for the Study

This study examined whether former members’ involvement in a contemplative-type cult contributes to higher levels of dissociation as measured by the Dissociative Experiences Scale (DES) and the Hopkins Symptom Checklist Dissociation Screen (HSCL), and to higher levels of depression as measured by the Beck Depression Inventory (BDI) than those who have left cults that do not employ contemplative techniques. This study also examined the effects that the amount of time spent in a cult (more than eight years) has on levels of depression and dissociation in former members, as well as any interaction effects that time spent in the group and involvement in a contemplative-type cult has on levels of depression and dissociation. The idea for this study was based on articles by Singer and Lalich (1994), West and Martin (1994), and
Singer and Ofshe (1990) that discuss clinical observations of the differences in psychiatric sequelae, namely dissociation, based on the type of group that a former member has been involved in. Also, Singer and Ofshe noted individuals who have been in the thought reform program for longer periods suffer from longer and more transient symptoms. This is in contrast to Lewis and Bromley (1987), who noted that symptoms were generally unrelated to length of membership in a cult. This study sought to test Singer and Ofshe’s clinical hypothesis that time in a cult leads to longer and more transient symptoms.

Participant Demographics

The original data that was available came from 523 clients who were treated at Wellspring Retreat and Resource Center. Of this original number, 477 completed question # 64 on the Group Psychological Abuse Scale that would identify them as having been in a group where contemplative exercises were used to push negative thoughts or doubts out of consciousness (thereby labeled “chanters”) or whether they were in a group that did not practice those exercises (“nonchanters”). Two outliers were eliminated for time spent in the group for analyses of the sample on the dependent variables. Of this number, 311 were left that completed both the Dissociative Experiences Scale and the Hopkins Symptom Checklist Dissociation Screen. Also, 308 completed all items on the Beck Depression Inventory.

Gender data was unremarkable with females outnumbering males 154 to 68 for nonchanters, and 177 to 71 for chanters. This ratio of men to women with women outnumbering men is consistent with several studies that have confirmed that men seek
psychiatric services, psychotherapy, and counseling less often than women (Addis & Mahalik, 2003).

Religious backgrounds of participants appear to indicate they were of a particularly religious sample of former members and perhaps of the general population. Further research that examines this demographic data could confirm this. The level of religious practice on the part of the former member prior to becoming involved in the group bears further research. It is possible that some participants may have listed a particular religious background when they may have only had a fringe involvement with the particular congregation or organization but never really practiced or had regular involvement. Data that could add to this study would be data that related to the practice of contemplative exercises prior to becoming involved in their group. Outcomes of this particular type of data could examine religious practice as being contributors to pre-existing symptoms or perhaps delineate between their lack of religious practice prior to the group and the practice within the group. The presence of religious practice prior to cult involvement might exacerbate any negative effects that were received in contemplative-type cults where they were asked to push out any doubts or negative thoughts out of consciousness. Those who engaged in contemplative exercises prior to joining the group may be more attracted to cults that practice contemplative exercises.

Protestant liberal and protestant and protestant fundamental religious backgrounds were by far the religious background of the largest number of participants. This finding is consistent with Burks (2002) and Martin et al. (1992) as the samples for their studies were from the Wellspring population. This data on the other hand, may suggest that those
who have come from religious backgrounds may be at more risk of becoming involved in a cult. Chanters’ and nonchanters’ religious backgrounds prior to their group experiences are largely similar except that chanters have notably higher percentages than nonchanters coming from Protestant liberal backgrounds (nonchanters 14.7%, chanters 24.8%). Indeed, chi square analysis demonstrated a statistically significant proportion of chanters from the protestant liberal background, \( \chi^2 (1) = 7.5, p < .01 \). One explanation for this could be perhaps those from protestant liberal backgrounds may be open to exploring practices that are outside the realm of what some fundamental Protestants consider being “orthodox” in practice such as the chanting of empty-mind mantras or hyperventilation procedures. Donahue (1993) noted in his study that those who were more supportive of what he called “New Age” beliefs were those who came from Protestant backgrounds that were more theologically liberal. One could only speculate that if these individuals were open to these belief systems, that perhaps they may be open to practices that may be found within those organizations that practice those beliefs.

Income levels of chanters compared to nonchanters appears to be very similar although chanters appear to report lower incomes. Nonchanters whose incomes were $20,000 or less was 36.3%, and for chanters 44.8%. This indicates that more than one third of both chanters and nonchanters have incomes if based on U.S. Federal poverty guidelines that would be poverty level for a family of four. A t-test to detect differences between chanters and nonchanters on income did not reveal a statistically significant difference however. Data regarding differences in percentages of those who have secured disability benefits between chanters and nonchanters may be useful. Income data would
also be more meaningful if data would have been available regarding number of persons in the household (this data was only recently being gathered) to determine poverty level differences between the groups, and if it were clear if the income reported were family of origin income or personal income. Many former members return to their family of origin’s home after the group experience for financial reasons and it is not clear on earlier versions of the demographic data form if this income is to be of the family of origin or personal income. In earlier years, those coming to Wellspring may have been reluctant to divulge their income on the survey as their treatment was being paid for by victim’s assistance funds based on stated need. If they underreported their income in order to get the cost of treatment paid for by outside funding, they may underreport on the survey. In more recent years, Wellspring requires proof of income based on W-2 income tax reports for victim’s assistance funding which may make income data more meaningful as the temptation to underreport may be at least partially eliminated.

Chanters reported somewhat higher percentages of receiving counseling before their group experiences. Nonchanters who had received counseling before their group experience consisted of 66 participants (29.1%) and 153 indicated that they had not received counseling before their group experience (67.4%). Nonchanters that failed to answer the item were 8 (3.5%). Chanters who had received counseling before their group experience was 89 participants (35.6%) and 156 indicated that they had not received counseling before their group experience (62.4%). Chanters that failed to answer the item were 4 (1.6%). However, there was no statistically significant difference between
chanters and nonchanters and receiving counseling before the group experience, $\chi^2 (2) = 2.88, p > .05$.

Further research could explore whether or not chanters may have had compounding experiences previous to their cult experience that would lead to higher mean scores on the Dissociative Experiences Scale, the Hopkins Symptom Checklist Dissociation Screen and the Beck Depression Inventory upon admission to Wellspring. It could also mean that perhaps those who have had distressing symptoms or life events that warranted counseling prior to their group experience may have been more drawn to groups that practiced contemplative exercises as the new recruit may have perceived the exercises as something that would potentially offer symptom relief and be beneficial, at least initially. This would seem to parallel Lazarus’ (1976) statements regarding how some individuals find that the benefits that had been promised them in the group simply did not emerge, and sometimes their problems were exacerbated. Further studies may benefit from an investigation of previous mental health diagnoses and pre-cult traumatic experiences, to examine compounding effects of trauma as it relates to previous experiences prior to the cult experience and how it interacts to any differences between chanters and nonchanters.

The duration of time spent in the group measured in years ranged from .0 to 51.71 years. Two outliers from time spent in the group were eliminated for statistical analyses of the dependent variables. The mean for all participants was 8.05 years (SD = 8.37). The histogram for the duration of time spent in the group was skewed towards the higher end.
There would be considerable difficulty in generalizing the findings of this study to other populations of those who have had cult involvement, particularly current members and former members who have not sought or received treatment as this sample consisted of treatment-seeking former members. This study may prove beneficial in advancing the knowledge of the challenges of some former members of both those who have been in contemplative-type cults as well as some who were in groups that did not employ contemplative techniques.

_Hypotheses of the Study: Discussion and Comment_

The first research hypothesis was: Former members who have left contemplative-type cults (chanters) will have higher mean scores than those former members who left cults that did not engage in contemplative exercises (nonchanters) with respect to the two measures of dissociation (Dissociative Experiences Scale and the Hopkins Symptom Checklist Dissociation Screen). The multivariate analysis reveals a significant main effect for chanting status and the dissociation measures, Wilk’s $\Lambda = .974$, $F(2, 310) = 4.189$, $p < .05$. It can be concluded that there is a significant difference between chanters and nonchanters on at least one of the dissociation variables. Univariate tests revealed that on the Dissociative Experiences Scale, chanters had statistically significant higher mean scores ($M = 16.94$, $SE = 1.04$) than nonchanters ($M = 12.65$, $SE = 1.13$). A significant main effect for chanting was found on the DES, $F(1, 311) = 8.176$, $p < .01$, partial $\eta^2 = .026$, however, effect size was small, which is not unusual for studies in the social sciences. Even though effect sizes are small, even small differences in symptoms may affect individuals in terms of daily functioning, and therefore should be considered
Chanters also had statistically significant higher mean scores for the HSCL ($M = 30.64$, $SE = .72$) than nonchanters ($M = 28.17$, $SE = .79$). A significant main effect for chanting was also found on the HSCL, $F (1, 311) = 5.314$, $p < .05$, partial $\eta^2 = .017$, again with a small effect size. Therefore the null hypothesis is rejected in favor of the research hypothesis. The mean scores for both groups were well above the mean score that the authors of the HSCL Dissociation Screen (Briere & Runtz, 1990) found in non-clinical populations of 20.95 ($SD = 5.80$). The mean scores on the HSCL for chanters and for nonchanters ($M = 28.17$, $SE = .79$) is also similar to Burks (2002) findings of overall elevated mean scores for former cultists seeking treatment ($M = 29.33$, $SD = 29.33$). This finding supports and to some degree, quantifies Singer and Ofshe (1990), Singer and Lalich (1994) and West and Martin (1994) and their clinical observations regarding the levels of dissociation in those who have been in contemplative-type cults.

The second research hypothesis is: Former members who have spent more than eight years in a cult will have higher mean scores than those who have been in a cult for eight years or less with respect to the measure of dissociation (DES and the HSCL). There were no statistical differences between former members who have spent more than eight years in a cult with respect to the DES or the HSCL compared to those former members who had been in a cult eight years of less. In addition, there was no relationship between the number of years spent in the cult and scores on the DES or the HSCL. Therefore the research hypothesis is rejected in favor of the null hypothesis. The third research hypothesis is: There will be an interaction as demonstrated by a statistically significant difference between the time spent in the group and involvement in a
contemplative-type group with respect to the dissociation measures of the DES and HSCL. Again, the research hypothesis is rejected in favor of the null hypothesis as there was no significant interaction between chanters and nonchanters and the time spent in the group on the DES or the HSCL. Dividing time by the median and mode did not appear to affect the outcome.

These findings contradict those by Conway and Siegelman (1982) and the clinical observations of Singer and Ofshe (1994) who noted that the level of former member symptoms increased with the length of involvement in a cult. Therefore the results seem to favor Lewis and Bromley’s (1987) findings that symptoms are unrelated to length of involvement in a cult, although it is important to note that Lewis and Bromley did not use the same standardized measures as this study. These results, although unexpected, appear to be noteworthy and remarkable. These outcomes appear to suggest that time in a group does not affect the level of symptoms of dissociation that a former member experiences, particularly those that are treatment-seeking former members.

The fourth research hypothesis is: Former members who have left contemplative-type cults have higher mean scores on the Beck Depression Inventory (BDI) than those who leave cults that do not employ contemplative techniques. Chanters had statistically significant higher mean scores on the BDI ($M = 21.52$, $SE = .84$) than for nonchanters ($M = 17.95$, $SE = .91$). The main effect for the chanting variable yielded an $F$ ratio of $F(1, 308) = 8.30, p < .05$, partial $\eta^2 = .029$, indicating that chanters had statistically significant higher mean scores on the BDI than for nonchanters, although as in the dissociation measures, a small effect size was rendered albeit relevant. Therefore the null hypothesis
is rejected in favor of the research hypothesis. This finding seems to support the study by Conway, Siegelman, Carmichael, and Coggins (1986) where they found significant yet very small correlations between reported cult involvement emotional states such as depression, $r = .21$, and cognitive states such as disorientation, $r = .15$. It is noteworthy that chanters’ mean scores on the BDI ($M = 21.52, SE = .84$) is considered a moderate level of depression by the authors of the BDI (Beck et al., 1961), and that nonchanters mean scores ($M = 17.95, SE = .91$) is still considered a significant level of depression, albeit a mild level.

The fifth research hypothesis is: Those who have spent more than eight years in a cult will have higher mean scores on the BDI than those who have spent eight years or less duration in their groups. There was no significant main effect for those who spent more than eight years in the cult on the BDI than those who spent eight years or less duration in their cult. The research hypothesis is rejected in favor of the null hypothesis. As with the hypotheses that those who have spent more than eight years in a cult will have higher mean scores on the DES and the HSCL than those who have spent eight years or less duration in their groups, this contradicts the findings of Conway and Siegelman (1982) that length of involvement in a group plays a role in the symptoms of former members. This is true even after dividing the sample based on the median and mode number of years in the group. Again, this finding seems to support Lewis and Bromley’s (1987) findings that length of involvement is unrelated to symptoms.

The sixth research hypothesis is: There will be an interaction between the time spent in a cult and involvement in a contemplative-type cult with respect to the
depression measure of the BDI. The interaction effect proved to be non-significant. Therefore the research hypothesis is rejected in favor of the null hypothesis. As was mentioned previously with the dissociation outcomes, this outcome that the length of time in a cult does not appear to have a significant effect on the level of depression is consistent with Lewis and Bromley’s findings (1987) that symptoms were generally unrelated to length of membership in a cult. As with this study’s findings on dissociation and time spent in the group, these outcomes with depression and time in the cult appear to suggest that time spent in a cult does not affect the level of depression that former members who are treatment-seeking experience.

In an effort to determine differences in how chanters and nonchanters were responding on the DES and the HSCL, a factor analysis was performed. For the DES and both chanters and nonchanters combined, there is a five factor model with eigenvalues greater than one accounting for 57.5% of the variance. Each of the factors was given subjective labels. The first factor represents memory issues, the second factor represents depersonalization and derealization issues, the third factor represents cult pseudo-identity or floating symptoms, the fourth factor represents concentration or attention span issues, and the fifth factor represents absorption or nonpathological dissociation.

A principal component analysis for the DES revealed a four factor model for chanters. The first 4 principal components accounted for 58.0% of the variance that can be attributed to dissociation. Factor one for this group represents dissociative trance states, factor two represents memory issues, the third factor represents cult pseudo-identity or floating symptoms, and factor four represents absorption.
For nonchanters and the DES, a six factor model emerges with the first 6 factors accounting for 59.6% of the variance in responses attributing to dissociation. Factor one represents depersonalization and derealization issues, factor two represents cult pseudo-identity or floating symptoms, factor three represents memory issues, factor four represents concentration and attention span issues, factor five represents absorption, and factor six represents memory issues.

The number of factors for chanters and nonchanters differed, however the percent of variance was similar. Also, the pattern of responses differed somewhat. The labeling of the factor “pseudo-identity” or “floating symptoms” is subjective, as is the labeling of all of the factors. The label of “pseudo-identity” was given as many of the items took on that common theme among the combined group, the chanting group and the nonchanting group. Some examples of this factor of “pseudo-identity” that were common among the combined grouping, the chanter grouping and the nonchanter grouping are: “Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them,” “Some people sometimes find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people,” and “Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example sports, work, social situation, etc).” Whereas responses that indicate high percentages of time spent experiencing these items may be suspicion of perhaps dissociative identity disorder symptoms, in this population, high
scores to these items may be more indicative of “floating symptoms” or “cult pseudo-
identity.”

There is some dispute about the factor structure of the DES for clinical and
nonclinical samples. Wright and Loftus (1999) indicate that anywhere from one to seven
factors have been found in clinical and nonclinical samples. This could be due to
disagreements about the best way to determine the number of factors. However, the
number of factors extracted in the analyses of this study are similar to what has been
found in the literature. What appears to be different is the labeling of the factors of
“pseudo-identity” and “dissociative trace states.”

For the HSCL and chanterers, 33% of the variance can be attributed to dissociation.
For the HSCL and nonchanterers, 34.4% of the variance can be attributed to dissociation.
Again, the number of factors and pattern loadings were similar for both chanterers and
nonchanterers on the HSCL. No comparison data was noted in the literature. The first
factor represents depersonalization and derealization symptoms, and the second factor
represents memory and cognitive awareness issues.

Clinical observations of those who have been in contemplative-type cults where
techniques such as chanting, empty-mind mantras, hyperventilation and speaking in
tongues were used simultaneously while encouraging members to empty the mind of
negative thoughts and doubts, have found that different dissociative symptoms are unique
to this group as compared to others who have been in groups where those techniques
were not practiced (Singer & Ofshe, 1990, West & Martin, 1994). Cronbach’s alpha was
.933 for the DES in this study.
The results of this study might contradict Galanter (1983). Galanter found that former members do not report greater psychopathology than nonmembers. He proposed that those who had been more or less forcibly removed from their groups reported more negative feelings toward the group. However, it is important to note that dissociation and depression were not specifically studied in that particular study, nor were standardized measures used. It is also important to note that in the current study, participants were presenting themselves for treatment and were therefore self-selected. Further research could compare treatment-seeking former members and former members who did not seek treatment in terms of what factors about the former members’ overall experiences or their various personality features that cause individuals to seek treatment or not seek treatment. As Galanter’s (1983) study is now more than 25 years old, it could be that cult membership has changed or practices within cults have changed.

Martin and Orchowski (in press) did study method of exit from a cult as a predictor of the level of symptoms former members experienced and confirmed that method of exit did play a role for reported levels of depression and dissociation. However, the Martin and Orchowski study seemed to be inconclusive whether those who had higher levels of symptoms were really associated with the method in which they exited the group, or if it was a function of time, whereby the longer a person has been out of the group, the more their symptoms may have a compounding and solidifying effect. The relationship of method of exit as well as the length of time out of the group as compounding variables, and reported symptoms of depression and dissociation was beyond the scope of this study and would be an important avenue of further research.
For this study, length of time spent in the group was divided into two groups, those who spent eight years or less in a cult, and those who spent more than eight years in a cult. This division was based on the arithmetic mean of length of time in the group for this sample ($M = 8.05, SD = 8.37$). Time was also divided by the median and the mode with little differences noted. In future studies it may be more meaningful to breakdown the length of time spent in a group in various timeframes for more specific detection of differences in dissociation and depression on time spent in the group.

Limitations of the Study

Limitations in terms of the application of this study lie partially in the limitations of self report measures and the participants in the study. Self report measures are convenient to use. Even though the Beck Depression Inventory has been researched extensively, it is known only as a fair predictor of depression as a DSM diagnosis (Richter et al., 1998). However, the BDI, the DES and the HSCL Dissociation Screen were found in this study to have good reliability. This study improved upon some other previous research in that it utilized standardized measures. More than one measure of dissociation was also used to detect any differences in dissociative symptoms assessed by these measures if any differences existed, which was not done in previous studies of former cultists.

The availability of possible participants is limited by the factors presented in chapter II. Current members of cults may be biased in their responses that would cast a favorable light on the group and their experiences and therefore may be biased in their report of conditions and affect that they may experience. Former members may be biased
against the group that they feel deceived them and manipulated them, thereby motivating them to over-report negative symptoms and conditions. Using data from participants from a treatment facility has the limitation of research that is done after the fact. Adequate controls or comparison groups of other former members are difficult at best to acquire. It may be beneficial to have a comparison group of those who practice contemplative exercises in groups where they are not asked to cast out negative thoughts or doubts and are not considered cultic. The lack of history of symptoms before cult involvement makes it difficult to ascertain what effect the group methods such as contemplative exercises had on the “chanters”.

The homogeneity of the participants in this study may be seen as one of its strengths in terms of performing statistical analyses, however it becomes a limitation for generalizing the results to non-clinical populations of former members. Certainly the results of this study could not be generalized to current members of cults.

Implications for Mental Health Counselors

This study performed a statistical, quantitative analysis of dissociation and depression in former members of contemplative cults as well as an analysis of the effects of length of time in a group on these symptoms. These symptoms had previously been clinical observations of former members of this type of cult. This study served to confirm these clinical observations of increased levels of depression and dissociation in those who have been in contemplative-type cults. However, it is important to note that the sample in this study consisted of treatment-seeking former members who may be a biased population of former members. Counselors should be aware that former members who
present for treatment after leaving a contemplative-type cult may be doing so because they may be experiencing depression and dissociation. These symptoms may have a profound effect on their ability to perform everyday tasks, including their ability to perform work-related tasks, and it may deeply affect their interpersonal relationships and their ability to seek gainful employment.

Many counselors may be apprehensive of addressing contemplative issues as they may appear at least initially, to be a religious issue, especially in those groups where contemplative exercises are used in a group that has a religious theme. Counselors should be sensitive to issues of religion and culture with their clients. However, after further investigation into the nature of the exercises that were used in a client’s group that may have included casting out negative thoughts and doubts, the clinician may find that the contemplative exercises may have been used as an exploitative tool by the leader to get the recruit to do what the leader wanted. Focusing on the exploitative, contemplative techniques and how they were unethically used may assist the client in focusing on methods used in the group, as opposed to the theological aspects. In other words, it is not the theology, but the methodology that the leader uses that is of concern. By separating the exploitative techniques that were used from the religious theology of the group, and by presenting a standardized model of thought reform such as presenting Lifton’s criteria for thought reform, the counselor can thereby be respectful of the religious or theological aspects of the group that the former member may have found to have actually been useful and positive about their group experience. The former member can then decide for themselves what they would like to hold onto from their experience, and what they would
like to in essence, throw away. This stance can be helpful in assisting the former member in integrating their experience and to walk away from their group with some positive experiences, while being mindful of the aspects of the group that they may have found to be damaging.

As with other types of trauma counseling where the counselor assists the client in understanding the nature of the trauma, it is important for the former member of a contemplative cult to understand the nature of the techniques that were used to exploit them. Working with former members of cults requires the counselor to take a more educative stance than it would perhaps with other types of clients. Many former members of cults doubt their own decision making abilities after their cult experience as their line of thinking may be something like “how could I have believed I was so right about what I was doing, but yet have been so wrong?” By taking an educational stance about the techniques that were used such as contemplative techniques, the clinician may assist the former member in putting their own experience into perspective, as well as empower them to be better able to protect themselves from exploitative techniques in the future. This of course requires the counselor to be educated about the nature of the techniques that are used by cults and their leaders.

One remarkable finding of this study is that it appears that the length of time in the group does not appear to affect the levels of dissociation and depression experienced by former members seeking treatment. Some counselors may be tempted to dismiss former members’ experiences and the potential effects when they have had brief encounters in their groups. The results of this study seem to suggest that counselors
would be wise and prudent to not disregard the level of impairment due to dissociation and depression just because the client has had a brief encounter with a cult. This becomes particularly important when counseling families who are distressed about their loved one’s current involvement in a cult, but believe that perhaps because they have only spent a short time in the group that the family member will not need counseling when they leave the cult or cultic relationship. Counselors can better prepare these families of what their loved one might need in terms of counseling treatment once the family member has left their cultic group or relationship based on the results of this study.

West and Martin (1994) have suggestions in terms of treatment for those who experience the type of dissociation seen in those who leave contemplative-type cults. They suggest that the individual get regular exercise, identify aspects of the environment that leads to stimulus overload, setting a kitchen timer while reading to slowly build up stamina in reading while maintaining concentration, and learning to counter magical thinking through a series of reality checks. Cognitive strategies can be quite useful in countering irrational thought processes that may have developed through the cultic milieu.

**Implications for College Counselors and School Counselors**

It is of utmost importance that mental health professionals working on college campuses as well as in high schools educate students about recruitment strategies of cults and the importance of investigating a group thoroughly before making a decision to attend. This is especially important as this study suggests that time in the group may not affect the levels of depression and dissociation that former members who seek treatment
experience. As many students have busy schedules and may find it inconvenient to thoroughly investigate a group before becoming involved, the importance of investigating a group before getting involved needs to be stressed. Other topics that need to be addressed in educational activities include group dynamics of cults and the nature of techniques that are often used by cults and their leaders to exploit and to gain control of their new recruits. These prevention activities need to be a part of college campus orientation for new students. Current studies need to be conducted as to the prevalence of cult-recruitment on college campuses.

Implications for Counselor Educators

It is important for students in counseling programs to be aware of the various predictors of symptoms such as depression and dissociation. This study suggests that cult involvement, particularly where contemplative exercises were used by the leader, may be a predictor of such symptoms. Classes need to be offered in counselor education programs that addresses the effects of exposure to exploitative techniques of cults and appropriate treatment modalities so that counselors may be better prepared to treat clients who are former members of cults and cultic relationships. These issues could be integrated into various classes that are standard classes in counseling programs such as diagnosis and treatment, lifespan and development and multicultural counseling, as well as in special electives that specifically addresses the issues of former cultists. By offering such classes and thereby informing future counselors of these important issues, former members of cults may be in a position of receiving more timely and appropriate treatment.
Suggestions for Future Research

Further research is called for by this study in several areas. Comparisons with groups that use contemplative techniques that are considered non-cultic would be useful in expanding the knowledge base of the effects of contemplative exercises that may be used by leaders to exploit members. Studies that control for compounding traumatic symptoms that happened pre-cult, as well as other conditions that may contribute to variation in levels of dissociation and depression such as time away from the group before treatment may be helpful in trying to determine what levels of dissociation can be attributed to the group involvement.

A study similar to one performed by Burks (2002) where cognitive impairment, dissociation and depression in a homogeneous population were investigated, needs to be done by comparing outcomes of those who have been in contemplative cults and those who have been in groups where contemplative techniques were not used. Perhaps Burks may have had more meaningful results by investigating outcomes of these two groups.

Information regarding the level and amount of contemplative exercises that those who were in contemplative-type cults used may be particularly useful in further research to determine if there is a certain threshold of practice that contributes to more dissociation and depression in former members.

Further research into how former members of cults rate compared to national averages of earning potential could be conducted. Studies that examine how long it takes for former members of contemplative cults or cults in general to earn national average
income could be examined. If the time is significant, there may be an economic impact to former members and their families and to society as a whole due to cult involvement.

As was previously mentioned, further investigation into the religious backgrounds of former members may reveal important findings into any precursors there are to involvement in a contemplative cult. Also, the effects of contemplative techniques used in the group should be examined as it related to the length of stay in the cult.

Studies need to be done on college campuses for baseline data on the awareness levels of college students regarding cult recruitment practices, dynamics, and exploitive techniques used in cults. Studies could also be done on the amount of cult recruitment activity that is currently being done on college campuses. This data could serve as a starting point for the development of prevention programs.

**Conclusions and Summary**

The purpose of the present study was designed to provide empirical data regarding the use of contemplative techniques, duration in the cult and the symptoms of depression and dissociation in former members. Until this point, the literature on contemplative techniques used in cults and its effects on former members were largely based on clinical observations.

In this study, pre-existing data from former members of cults who presented themselves for treatment was examined. Data from the Dissociative Experiences Scale, the Hopkins Symptom Checklist Dissociation Screen, and the Beck Depression Inventory were examined to see if there were any differences in mean scores between those who had been involved in cults where contemplative techniques were practiced (chanters) and
those who were involved in cults where those techniques were not used (nonchanters).

Chanters had higher mean scores on both measures of dissociation as well as on the measure of depression.

Also, the amount of time spent in the cult was also examined in terms of its effect on dissociation and depression in chanters and nonchanters as well as overall cult involvement. It was found that the amount of time spent in a cult does not appear to have an effect on the level of dissociation or depression.
References


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Appendixes
Appendix A

IRB Letters
A determination has been made that the following research study is exempt from IRB review because it involves:

Category 4 - research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens if publicly available or recorded without identifiers.

Project Title: Contemplative Cults, Time Spent in a Cult and Dissociation and Depression in Former Members

Project Director: Donna Adams

Department: Counseling and Higher Education

Advisor: Dana Levit

Robin Stack, C.I.P., Human Subjects Research Coordinator
Office of Research Compliance

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.
Appendix B

Consent form Used by Participants in this Study
CONSENT FORM

TITLE OF RESEARCH: Coercive Techniques
PRINCIPAL INVESTIGATORS: Dr. Paul Martin 740-698-6277
                           Dr. Rod Dubrow-Marshall (44) (0)1443-482344
                           Dean of Faculty University of Glamorgan
CLINICAL SUPERVISOR: Dr. Paul Martin, Ph.D.
DEPARTMENT: Wellspring Retreat and Resource Center
             University of Glamorgan – Wales

I. Federal and University regulations require us to obtain signed consent for participation in research involving human subjects. After reading the statement in Section II below please indicate your consent by signing this form.

II. Statement of Procedure: The purpose of this study is to examine the relation between a number of life events, personality characteristics, and psychological functioning. The results will further our understanding of these relations. If you choose to participate, you will be asked to fill out various questionnaires during today’s session. This should take approximately 2 hours.

This study involves no physical risks for the participants. However, some individuals might experience minor, temporary emotional discomfort. Some of the items ask personal and sexually explicit question. Participation is voluntary and you may stop at any point.

You will be assigned an identification number to put on your answer sheet. Your name will only appear on this consent form which will be collected at the beginning of this session and kept separately from your answer sheet. All answers will be kept strictly confidential. Only the experimenters and supervisor will have access to them.

The principle investigators for this study are Dr. Paul Martin and Dr. Rod Dubrow-Marshall. If you have any questions that need immediate attention, please fell free to ask. Some administrators will be available after the study to answer any questions or address any concerns that you would like to talk about.

I certify that I have read and fully understand the Statement of Procedure and agree to participate as a subject in the research described therein. My participation in this study is given voluntarily and without coercion or undue influences. I understand that I may discontinue participation at any times.

I certify that I am at least 18 years of age.

Signature: ________________________________

Print Name: ______________________________ Date: ____________________
Appendix C

Demographic Questionnaire

(*Scanned from original, misaligned copies)
Questionnaire #1

Please write directly on this form

Packet ID #: ____________________________
To be entered by scorer

Demographic Information

1. Date of Birth __________ / ______ / ______

2. What is your sex? Male Female

3. What is your marital status?
   1) Single, never been married
   2) Married
   3) Separated
   4) Divorced
   5) Divorced and Remarried
   6) Widow/Widower

4. Please indicate the number of children you have. ________

5. How many of your children were born while you were in the group? ________

6. What is your race or ethnic background?
   1) White
   2) Black
   3) Hispanic
   4) Asian
   5) Native American
   6) East Indian
   7) Middle Eastern
   8) Other: ____________________________

7. In what religion were you raised?
   1) Protestant (Fundamental)
   2) Protestant (Liberal)
   3) Roman Catholic
   4) Jewish
   5) Islamic
   6) Eastern
   7) Other: ____________________________
   8) None

8. Years of education completed
   i.e. 8 = Grade school education completed
   12 = High school education completed

   Add 1 for each full year of higher education completed

   Total years of education: __________

9. Please circle all degrees you have earned:
   A) Associate's Degree
   B) Bachelor's Degree
   C) Master's Degree
   D) Ph.D.
   E) Other Professional Degree
   F) No Professional Degrees
10. Please indicate the approximate annual household income in dollars of the family in which you grew up. $

10 (a) Please indicate your current household income. $ 
(If you are unemployed, enter 0)

11. What was the name of your group? (If you were involved in more than one group, list all groups; indicate the most recent group first.)

12. Month and year you joined the (most recent) group

13. Month and year you left the (most recent) group

14. How did you leave your (most recent) group?
   A) Walked away
   B) Exit Counseling
   C) Deprogramming
   D) Group forced you out, asked you to leave
   E) Group disbanded
   F) Other:

15. Please indicate on a scale of 1-5 the degree to which you were a leader in your group. 
   (Follower role) 1 2 3 4 5 (Leadership role)

16. Please indicate on a scale of 1-5 how clearly defined your role was in the group. 
   (Not clearly defined) 1 2 3 4 5 (Clearly defined)

17. Did you ever seek services from a mental health professional for any reason before joining your group? Yes No

18. Were you ever hospitalized for mental health reasons before joining your group? Yes No

19. Did you ever seek services from a mental health professional while in your group? Yes No

20. Were you ever hospitalized for mental health reasons while in your group? Yes No

21. Did you ever seek services from a mental health professional after leaving the group? Yes No
22. Were you ever hospitalized for mental health reasons after leaving your group? 
   Yes  No

23. Are you currently in therapy with a mental health professional? 
   Yes  No

24. If you are in therapy, how long has it been since you started? _______ Years, _______ Months

*Indicate your answer on a scale of 1-5*

25. Indicate the quality of your relationship with your mother before you joined the group.
   (Poor) 1  2  3  4  5  (Excellent)

26. Indicate the quality of your relationship with your father before you joined the group.
   (Poor) 1  2  3  4  5  (Excellent)

27. Indicate the quality of your relationship with your mother while you were in the group.
   (Poor) 1  2  3  4  5  (Excellent) Mother was deceased

28. Indicate the quality of your relationship with your father while you were in the group.
   (Poor) 1  2  3  4  5  (Excellent) Father was deceased

29. Indicate the quality of your relationship with your mother currently.
   (Poor) 1  2  3  4  5  (Excellent) Mother is deceased

30. Indicate the quality of your relationship with your father currently.
   (Poor) 1  2  3  4  5  (Excellent) Father is deceased

31. Did you participate in a survey exactly like this at a 1994 or 1995 CAN conference or at Wellspring Retreat & Resource Center between August 1994 and the present? 
   Yes  No
Appendix D

The Group Psychological Abuse Scale
GPA SCALE

This scale is designed to evaluate certain aspects of religious, psychotherapeutic, political, commercial, and other groups. Please rate, as best you can, the degree to which the following statements characterize the group under consideration. Rate each item according to your experience and observations (in retrospect) of how the group ACTUALLY functioned. If your group had different levels of membership (in which the group’s dominant features differed), please apply your ratings to the level with which you have greatest familiarity. Think carefully about each answer so you give the most appropriate rating.

Circle the appropriate number.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>49.</td>
<td>The group does not tell members how to conduct their sex lives.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>50.</td>
<td>Young women are directed to use their bodies for the purpose of recruiting or for manipulating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>51.</td>
<td>The group advocates or implies that breaking the law is okay if it serves the interest of the group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>52.</td>
<td>Members are expected to postpone or give up their personal, vocational, and educational goals in order to work for the group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>53.</td>
<td>The group encourages ill members to get medical assistance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>54.</td>
<td>Gaining political power is a major goal of the group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>55.</td>
<td>Members believe that to leave the group would be death or eternal damnation for themselves or their families.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>56.</td>
<td>The group discourages members from displaying negative emotions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>57.</td>
<td>Members feel they are part of a special elite.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>58.</td>
<td>Teaches that persons who are critical of the group are in the power of evil, satanic forces.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>59.</td>
<td>Uses coercive persuasion and mind control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>60.</td>
<td>The group approves of violence against outsiders.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>61.</td>
<td>Members are expected to live with other members.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
1 = not at all characteristic  
2 = not characteristic  
3 = can't say/ not sure  
4 = characteristic  
5 = very characteristic

62. Members must abide by the group's guidelines regarding dating or intimate relationships.  
63. People who stay in the group do so because they are deceived and manipulated.  
64. The group teaches special exercises (e.g., meditation, chanting, speaking in tongues) to push doubts or negative thoughts out of consciousness.  
65. Medical attention is discouraged, even though there may be a medical problem.  
66. Members are expected to serve the group's leaders.  
67. Raising money is major goal of the group.  
68. The group does not hesitate to threaten outside critics.  
69. Members are expected to make their own decisions without consulting the group's leader(s).  
70. Members are just as capable of independent critical thinking as they were before they joined the group.  
71. The group believes or implies that its leader is divine.  
72. Mind-control is used without conscious consent of members.  
73. Members feel little psychological pressure from leaders.  
74. The group's leader(s) rarely criticized members.  
75. Recruiting members is a major goal of the group.  
76. Members are expected to consult with leaders about most decisions, including those concerning work, child rearing, whether or not to visit relatives, etc.
Appendix E

The Dissociative Experiences Scale
QUESTIONNAIRE #4

DES

This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and mark the line with a vertical slash in the appropriate place. Also, fill in the line to the right of the scale with the appropriate percentage, as shown in the example below.

EXAMPLE: If your answer to the question is “50%”, then make a vertical line (slash) in the middle of the scale to indicate 50% and also fill in the space to the right with “50”.

\[
\begin{array}{ccc}
\hline
& 0\% & 100\% \\
1 & \hline
\end{array}
\]

\[\text{[Make sure you don't forget to fill in the space to the right with the appropriate %]}\]

1. Some people have the experience of driving a car and suddenly realize that they don’t remember what has happened during all or part of the trip. What percentage of the time does this happen to you?

\[
\begin{array}{ccc}
\hline
& 0\% & 100\% \\
1 & \hline
\end{array}
\]

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part of what was just said. What percentage of the time does this happen to you?

\[
\begin{array}{ccc}
\hline
& 0\% & 100\% \\
1 & \hline
\end{array}
\]

3. Some people have the experience of finding themselves in a place and having no idea how they got there. What percentage of the time does this happen to you?

\[
\begin{array}{ccc}
\hline
& 0\% & 100\% \\
1 & \hline
\end{array}
\]

4. Some people have the experience of finding themselves dressed in clothes that they don’t remember putting on. What percentage of the time does this happen to you?

\[
\begin{array}{ccc}
\hline
& 0\% & 100\% \\
1 & \hline
\end{array}
\]
5. Some people have the experience of finding new things among their belongings that they do not remember buying. What percentage of the time does this happen to you?

\[
\begin{array}{c}
0\% \\
100\%
\end{array}
\]

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. What percentage of the time does this happen to you?

\[
\begin{array}{c}
0\% \\
100\%
\end{array}
\]

7. Some people sometimes have the experience of feelings as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. What percentage of the time does this happen to you?

\[
\begin{array}{c}
0\% \\
100\%
\end{array}
\]

8. Some people are told that they sometimes do not recognize friends or family members. What percentage of time does this happen to you?

\[
\begin{array}{c}
0\% \\
100\%
\end{array}
\]

9. Some people find that they have no memory for some important events in their lives (for example, a wedding for graduation). What percentage of important events in your life do you have no memory for?

\[
\begin{array}{c}
0\% \\
100\%
\end{array}
\]

10. Some people have the experience of being accused of lying when they do not think that they lied. What percentage of the time does this happen to you?

\[
\begin{array}{c}
0\% \\
100\%
\end{array}
\]

11. Some people have the experience of looking in a mirror and not recognizing themselves. What percentage of the time does this happen to you?

\[
\begin{array}{c}
0\% \\
100\%
\end{array}
\]
12. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real. What percentage of the time does this happen to you?

| Percentage | 0% | 100% |

13. Some people sometimes have the experience of feeling that their body does not seem to belong to them. What percentage of time does this happen to you?

| Percentage | 0% | 100% |

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. What percentage of the time does this happen to you?

| Percentage | 0% | 100% |

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. What percentage of the time does this happen to you?

| Percentage | 0% | 100% |

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. What percentage of the time does this happen to you?

| Percentage | 0% | 100% |

17. Some people find what when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. What percentage of time does this happen to you?

| Percentage | 0% | 100% |

18. Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. What percentage of the time does this happen to you?

| Percentage | 0% | 100% |
Appendix F

Hopkins Symptom Checklist Dissociation Screen
Please circle the appropriate number for each item according to your observations during the past week, including today.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not At All</th>
<th>A Little Bit</th>
<th>Quite A Bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.</td>
<td>Feeling outside your body</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>35.</td>
<td>Forgetfulness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>36.</td>
<td>Not feeling like your real self</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>37.</td>
<td>&quot;Spacing out&quot;</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>38.</td>
<td>Watching yourself from far away</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>39.</td>
<td>Your mind going blank</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>40.</td>
<td>Things feeling unreal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>41.</td>
<td>Feeling disconnected from yourself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>42.</td>
<td>Daydreaming</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>43.</td>
<td>Periods of memory loss</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>44.</td>
<td>Feeling like you are two or more people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>45.</td>
<td>Absent-mindedness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>46.</td>
<td>Losing touch with reality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>47.</td>
<td>A feeling of being far away</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix G

Beck Depression Inventory
BDI

On this questionnaire are groups of statements. Please read each group of statements carefully. Pick out the one statement in each group which best describes the way you have been feeling over the past week and including today. Circle the appropriate letter. Be sure to read all the statements in each group before circling your answer.

138. a) I do not feel sad.
   b) I feel sad.
   c) I am sad all the time and I can’t snap out of it.
   d) I am so sad or unhappy that I can’t stand it.

139. a) I am not particularly discouraged about the future.
   b) I feel discouraged about the future.
   c) I feel I have nothing to look forward to.
   d) I feel that the future is hopeless and that things cannot improve.

140. a) I do not feel like a failure.
   b) I feel I have failed more than the average person.
   c) As I look back on my life, all I can see are a lot of failures.
   d) I feel I am a complete failure as a person.

141. a) I get as much satisfaction out of things as I used to.
   b) I don’t enjoy things as I used to.
   c) I don’t get real satisfaction out of anything anymore.
   d) I am dissatisfied or bored with everything.

142. a) I don’t feel particularly guilty.
   b) I feel guilty a good bit of the time.
   c) I feel quite guilty most of the time.
   d) I guilty all of the time.

143. a) I don’t feel I am being punished.
   b) I feel I may be punished.
   c) I expect to be punished.
   d) I feel I am being punished.

144. a) I don’t feel disappointed in myself.
   b) I am disappointed in myself.
   c) I am disgusted with myself.
   d) I hate myself.

145. a) I don’t feel I am any worse than anybody else.
   b) I am critical of myself for my weaknesses or mistakes.
   c) I blame myself all the time for my faults.
   d) I blame myself for everything bad that happens.
146. a) I don’t have any thoughts of killing myself.
   b) I have thoughts of killing myself, but I would not carry them out.
   c) I would like to kill myself.
   d) I would kill myself if I had the chance.

147. a) I don’t cry any more than usual.
   b) I cry more now than I used to.
   c) I cry all the time now.
   d) I used to be able to cry, now I can’t even though I want to.

148. a) I am no more irritated now than I ever was.
   b) I get annoyed or irritated more easily than I used to.
   c) I feel irritated all the time now.
   d) I don’t get irritated at all by the things that used to irritate me.

149. a) I have not lost interest in other people.
   b) I am less interested in people than I used to be.
   c) I have lost most of my interest in other people.
   d) I have lost all my interest in other people.

150. a) I make decisions about as well as I ever could.
   b) I put off making decisions more than I used to.
   c) I have greater difficulty in making decisions than before.
   d) I can’t make decisions at all anymore.

151. a) I don’t feel I look any worse than I used to.
   b) I am worried that I am looking old or unattractive.
   c) I feel that there are permanent changes in my appearance that make me look unattractive.
   d) I believe that I look ugly.

152. a) I can work about as well as before.
   b) It takes an extra effort to get started at doing something.
   c) I have to push myself very hard to do anything.
   d) I can’t do any work at all.

153. a) I can sleep as well as usual.
   b) I don’t sleep as well as I used to.
   c) I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
   d) I wake up several hours earlier than I used to and cannot get back to sleep.

154. a) I don’t get more tired than usual.
   b) I get tired more easily than I used to.
   c) I get tired from doing almost anything.
   d) I am too tired to do anything.
155. a) My appetite is no worse than usual.
    b) My appetite is not as good as it used to be.
    c) My appetite is much worse now.
    d) I have no appetite at all anymore.

156. a) I haven’t lost much weight, if any lately.
    b) I have lost more than 5 pounds.
    c) I have lost more than 10 pounds.
    d) I have lost more than 15 pounds.

157. a) I am no more worried about my health than usual.
    b) I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
    c) I am very worried about physical problems and it’s hard to think of much else.
    d) I am so worried about my physical problems that I cannot think about anything else.

158. a) I have not noticed any recent change in my interest in sex.
    b) I am less interested in sex than I used to be.
    c) I am much less interested in sex now.
    d) I have lost interest in sex completely.