Counseling Former Cultists:

The Brief Intermittent Developmental Therapy (BIDT) Approach[1]

Mental health professionals who ask me about working with individuals who are or once were involved in High Demand Groups (HDGs, "cults") or High Demand Relationships (HDRs, "cultic relationships") often want to know how this work differs from work with "regular" patients or clients. I sometimes find myself at a loss to provide a comprehensive yet understandable response. Over the years, research on how experienced and "master" therapists work has consistently shown that, no matter what our education, training, theoretical orientation or general methodology, effective therapists are far more similar to each other than they are different (Sundland & Barker, 1962; Prochaska & Norcross, 1983; Ackerman & Hilsenroth, 2003). Yet many who have worked with HDG/HDR-affected clients believe specialized knowledge and experience are necessary to be effective (Dubrow-Eichel, 2001; Venter, 1999; Singer, 1995; Sirkin, 1990; Singer, 1974). To my knowledge, no formal study has been conducted to delineate exactly what kind of specialized knowledge and experience is needed; however, over the years I have heard a number of specific topics repeatedly mentioned as part of a core knowledge base. At a 2103 conference in Philadelphia on exit counseling and mental health interventions with HDG/HDR clients (Eichel et. al., 2013), the following topics were specified: the social psychology of influence and "thought reform," hypnosis, family dynamics, human development, and the history of religion. There is no formal credentialing process (beyond state licensing for mental health professionals) in the field

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of cult intervention/counseling. There has been a general consensus, repeated in the Philadelphia conference, that effective interventionists and therapists should undergo an "apprenticeship" of unspecified length and loosely-defined parameters. For mental health professionals (as well as for many paraprofessional "interventionists") that apprenticeship typically consists of attending cultic studies conferences, meeting and networking with a range of individuals (including former HDG/HDR members), significant independent study, and supervision by or consultation with a more experienced practitioner.

The conference in Philadelphia highlighted the range of work and diversity of approaches to this population, which includes working with the individual and family members in individual, family, and brief and ongoing group settings[2]. Theoretical approaches and modalities utilized range from psychodynamic to cognitive-behavioral to family systems and Steven Hassan's (2000, 2012) systems-oriented "strategic interaction approach." All presenters agreed that, as in all other psychological interventions, the establishment of a trusting, empathic relationship is crucial.

I have previously described my own theoretical orientation to working with HDG/HDR clients as "brief intermittent developmental therapy" (BIDT) within a "transtheoretical" framework that emphasizes individual choice and self-efficacy and motivational enhancement (Dubrow-Eichel, 2001, 2002). A primary and necessary characteristic of

[2] A noteworthy exception is interventionist Rick Ross (2014), who believes in a strict separation between cult interventions and mental health counseling for former cultists. He argues that interventions are or should be strictly educational and information-based; the interventionist should not attempt to deal with family dynamics or engage in any form of family counseling. In her preface to Ross's book, Dr. Cathleen Mann argues for a strict separation between the initial intervention, aimed at getting a cult member to exit, and any form of counseling or psychotherapy of current or former members. This is an approach that I have generally supported. Mr. Ross was invited to but did not attend the Philadelphia conference.

BIDT is that it is first and foremost grounded in a solid understanding of human, and especially child through young adult, development. As such, it relies heavily on what Greenspan (1997) termed "developmentally-based psychotherapy" in which the therapist's primary concern is to "build on the patient's natural inclinations and interests to try to harness a number of core developmental processes at the same time" (Greenspan, 1997, p. 8). The developmental processes I concern myself with involve age appropriate ego[3] functions, including autonomy, decision making, and affect and impulse regulation. These ego functions, especially autonomy and decision-making, are especially targeted by HDG/HDRs and hence are typically in greatest need of repair. Identity, an ego function that Erikson (1968) believed was primarily resolved during late adolescence/early adulthood but is now considered to be an ongoing process (cf. McWilliams, 1994), is another primary target for HDG/HDRs. Adults recruited into an HDG/HDR may develop a "pseudo-identity" (West & Martin, 1994) or "totalist identity" (Dubrow-Marshall, Dubrow-Marshall & Eichel, 2011); those born and raised in a cultic environment (second-generation adults, or SGAs) appear to develop somewhat differently. To me, the BIDT approach is a natural expression of an underlying goal (emphasized by all HDG/HDR-aware therapists I know), to support and encourage the "rebooting" of natural development processes that are typically stymied in cultic groups and relationships.

[3] Throughout this chapter, I use the term "ego" in its psychodynamic definition, as "a set of functions [both conscious and unconscious] that adapt to life's exigencies, finding ways that are acceptable within one's family to handle id strivings. It develops continuously throughout one's lifetime…[and] operates according to the reality principles [and] secondary process" (McWilliams, 1994, p. 26) The ego is the psychic structure that is the seat of identity, conscious memory, awareness and cognition.

The second characteristic of BIDT is that it is, as the term implies, generally a brief form of treatment, lasting anywhere from one to 20 or so sessions; in my clinical experience, a single "brief" therapy episode typically lasts up to a year. However, rather than being defined by the number of sessions, brief therapy is better understood as being focused and purposeful, involving the use of very specific concepts (in these cases, knowledge of HDG/HDR dynamics as well as non-coerced, "normal" developmental processes) and principles (Wells & Gianetti, l993). Brief therapy defines problems as temporary and changeable. Even in the clearest HDG/HDR situation, the causes of a client's current struggles can be complex and may take considerable time to unfold; therefore, the initial focus may be on what to do to change the situation in the present and the future. The focus of brief therapy is usually on the client's strengths and the possibilities for change. Therapy tends to be solution-oriented with conscious and conscientious use of time. However, BIDT differs significantly from formally-defined brief therapies in its clear understanding that therapy does not "end" but rather terminates for the time being, to be resumed in the future when appropriate and/or necessary, often when the client arrives at a developmental crisis or decision-making point. Thus, more than being merely brief, BIDT is an *intermittent* treatment.

A major criticism of brief and/or intermittent therapies is that they can undermine attachment, or fail to adequately address attachment in those clients whose problems are fundamentally concerned with difficult and ambivalent attachment patterns. Cultic attachments are generally not only marked by high degrees of ambivalence but by dissociation as well; they often mimic and can be easily mistaken for borderline splitting.

Negative experiences of and affects toward the leader or leadership, and doubts about the cultic enterprise, are reframed as failures in the devotee or cult member and subjected to taught and learned thought reform strategies, such as meditation or prayer in the service of thought-stopping. In my experience, BIDT often does allow an "acting out" of cultic attachment patterns. However, in my opinion, confronting this potentially self-destructive acting out pattern is less important than agreeing to allow the patient or client to control his/her level of attachment to the therapeutic enterprise and, ultimately, the therapist. Respect for and facilitation of self-efficacy, control over one's destiny and interacting with an authority figure who trusts his/her client are among the most important corrective experiences therapists can provide.

As a transtheoretical approach to counseling HDG/HDR clients, I have described BIDT as intrinsically associated with a "stages-of-change" model of growth that employs "motivational enhancement therapy" (MET) as a primary theoretical framework to guide actual interventions. The term "transtheoretical" describes an acknowledgment that (1) all change, whether facilitated by therapists who describe themselves as cognitive-behavioral or psychodynamic, follows a predictable path ("stages")--and some therapeutic styles are more appropriate for some stages but not others (Prochaska & DiClemente, 1984; Prochaska, 1999)—and, (2) ultimately, real growth occurs when the individual becomes an active agent in his/her own life (i.e., self-efficacy and self-empowerment). Thus therapy should always involve enhancing and maintaining the patient's motivation to change and grow (Miller & Rollnick, 2002) . Therapists can engage in MET from a range of perspectives, although as a relatively active therapeutic modality, it is probably easier

to learn and be utilized by therapists comfortable with cognitive-behavioral, modern psychodynamic or humanistic (as opposed to traditional psychoanalytic) approaches to their work. Therapists trained in brief dynamic, supportive-expressive and experiential therapies would also find themselves comfortable working from a MET perspective.

It is worth describing the stages-of-change model and motivational enhancement therapy in order to better illuminate how they fit into BIDT. Briefly, the stages-of-change model predicts that in all significant, planned behavioral changes, people begin the process by thinking about what they want to change and imagining the steps necessary to realize the change; hence, the stage is referred to as "Contemplation." Awareness and insight are required at this stage. However, an individual may not yet acknowledge the necessity of change, in which case they might first need to become aware or gain insight they presently lack; this stage, which is actually the precursor to change, is referred to as "Pre-contemplation." People currently involved in an HDG/HDR but who are at least willing to talk to someone outside their relationship about their involvement would probably be considered in Pre-contemplation. Insight-oriented therapies (e.g., psychodynamic, experiential) are typically best-suited for people in Pre-contemplation. Among interventionists, those who practice non-confrontational or mediation-oriented approaches often do best in this stage; years ago I heard some exit counselors refer to this stage as "planting the seeds." At this stage, confronting the HDG/HDR-involved individual is almost invariably fruitless; rather, at this stage I see my goal as establishing rapport and sparking curiosity. It is not unusual for interactions to be informal; they may even appear superficial. At this stage, I have met several patients outside my office, at

homes, restaurants and even at ashrams or other communal settings. Interventions are typically highly intermittent; weeks or months may pass before there is another meeting. For many patients, this allows them to feel reassured that I am not going to "deprogram" them or engage in any kind of high-pressure tactic, which fosters a sense of safety.

When enough curiosity has been piqued, or some other event has generated a small amount of conflict, the HDG/HDR-involved individual may move into the first formal stage of change, Contemplation. This stage is marked by a willingness to be open, to consider alternative views, and some admission of discontent over or distress about one's current situation. My position toward the HDG or HDR, as in Pre-contemplation, remains fairly neutral. To achieve a neutral stance while remaining genuine, it is imperative that I see the way the group and/or relationship is a positive force in my patient's life. I need to know how it meets his/her needs and may in some way be beneficial. Interactions at this stage may be quite intense, both emotionally and in terms of time. The patient may want (and need) extended appointments, and/or several appointments in the course of a week. For many, this can be a very exciting but conflicted stage in treatment, replete with many "Aha!" experiences as the client begins to re-evaluate his/her experience in light of discoveries made while talking with other ex-members, learning about the psychology of influence, and examining information that was withheld or previously denigrated by the group. Many also begin to engage in self-admonishment and even self-condemnation at this stage ("how could I have been so stupid!?"), a process that must be strongly challenged by the therapist. Cautious introduction to research-based psychological concepts (like the tactic of "blaming the victim") can be incredibly helpful at this stage. I

have often provided psychological literature—sometimes the older the better!—to prove that others have felt the same way, and that "blaming the victim" is a well-understood, extremely well-documented and almost universal means of social control utilized by abusive individuals, groups and even entire societies. Toward the end of this stage, the client begins wondering if it is possible to formulate a plan for moderating involvement in the HDG/HDR or exiting altogether. The client now moves to the next stage, Preparation (also sometimes called Determination). It is universally accepted by therapists that change does not occur absent some degree of conflict and anxiety (Davenloo, 2000). In Contemplation, the therapist must try to carefully balance interventions that are conflict- and anxiety-inducing (e.g., reminding the client how the HDG/HDR violated his/her individual ethical code) with those that are supportive and guilt-reducing. Once again, however, people sometimes opt to "take a break" (I typically refer to the times between therapeutic contacts as "sabbaticals") between the Contemplation and Preparation/Determination stages. Some clients feel the conflict and need time outside therapy to process it (or try to suppress or avoid it).

Ex-members who have exited groups without any kind of counseling or intervention nevertheless typically go through the "stages of change" on their own; they may have difficulty pinning down when they went through the first two stages, but they typically remember the Preparation stage in vivid detail. For those in communal group settings or those who have escaped controlling, abusive partners, this stage may involve saving money, obtaining passports, finding or setting up a "safe house" to escape to, etc. Many go through this stage alone, or with highly secretive assistance from a close friend or

relative. Those who go through this stage while in an active therapy relationship may find the process less stressful and somewhat easier to negotiate, especially when the therapist has succeeded in establishing a nonjudgmental relationship, and after reminding the client not only of their right to therapeutic privacy, but to *legal* confidentiality.

For therapists, the next two stages (Preparation/Determination and Action) are often the "fun" stages. The HDG/HDR-affected client may express significant closeness and trust during this stage as he/she and the therapist work together as collaborators to decide how, when and what to do next. Treatment tends to be very solution-focused at this stage, and it lends itself extremely well to cognitive-behavioral strategies, active participation by the therapist, and support as the client explores, practices, modifies and then learns new coping strategies and methods for modifying the HDG/HDR experience or exiting it altogether. In my clinical work, I often experience great joy and contentment as I hear reports of my client making demonstrable strides toward autonomy and controlling his/her destiny in general. In these two stages, clients often become at least somewhat involved (either online or *in vivo*) in support groups or communities, which tend to strengthen the work they've done before and help to facilitate identity development. These can be exciting, heady times for the client; during the Action stage I sometimes find myself in the ironic position of reminding my client that it is often good to go slow, to take time to breathe, rest and process as they tackle their new-found independent lives with renewed vigor and energy. The same energy the client may have brought to recruiting, witnessing, evangelizing, or fund-raising in the HDG now finds expression in daily life as an increasingly autonomous human being. Sometimes the rediscovery of

intellectual, sensory and emotional curiosity leads the client to engage in social, sexual and other forms (e.g., drugs and alcohol) of excess.

It is crucial to realize that people typically progress through these stages repeatedly, with both immediate and subsequent problems and concerns. For example, relapse is common with alcohol dependency, and it is not unusual for a client who has achieved fairly long-term sobriety to eventually "slip" or relapse back into old patterns of substance abuse and all its related sequelae. When that client returns to treatment, we often begin anew at the Contemplation stage, this time focused on gaining insight into the causes of the slip or relapse. In HDG/HDR-related cases, a client may go through the entire stages-of-change cycle as he/she struggles with leaving a group, and then repeats the cycle as other life issues present themselves.

The Action stage can theoretically be brief and highly focused (e.g., the actual process of moving out of a communal HDG setting and formally exiting the group); more often it spans a greater period of time and involves spurts of meaningful acts. In some cases, the client may quietly move forward with separation plans, such as saving or otherwise obtaining necessary funds, enrolling in college course, applying for employment, etc. In other cases, it may involve arrangements for a very public split, especially when someone high up in the hierarchy of a well-known HDG publicly criticizes and then leaves the group (e.g., director Paul Haggis' very public split with the Church of Scientology). At this stage, some ex-HDG/HDR clients engage in therapy on a very intermittent basis over an extended period of time (typically a year or more) as they seek "fine tuning" while

involved in long-term actions in line with their post-cult developmental goals. After deciding to leave an HDR, one client remained in therapy to support and guide her through a complicated legal process that involved building a criminal case against a man who at various points held her hostage. Once that situation was resolved to her satisfaction, she went on "sabbatical," content to work at a job and re-enter the "normal" life of a young woman. After two years, she became restless at her work and with her "normal" life and engaged my services to focus on trying to wrench deeper meaning out of her cultic experience. This process led her to conclude that she wanted to go back to college with the ultimate goal of becoming a clinical social worker. In therapy she sometimes sought my feedback on relatively mundane but highly important tasks like writing college application essays or preparing for admissions interviews. After she was accepted to the college of her choice, we began working on getting her prepared to deal with her new life direction; after all, she would be entering college as an older freshman with somewhat atypical life experiences.

The Maintenance stage can be tricky. At this point, the client has made one or more important decisions and taken the actions implied by those decisions; now he/she must be vigilant against "backsliding." Therapy is typically very brief and intermittent at this stage. Sometimes the client and I agree to a formal schedule of very intermittent appointments (e.g., one appointment every two months); at other times, appointments are made on a strictly as-needed basis, at various and unpredictable times. Precipitating reasons for re-entering therapy vary widely, but have included "new" developmental issues such as: whether or not the client should become actively involved in a religion

(can this be done in a non-fanatical fashion?); how to partner or marry without becoming "co-dependent" or engulfed; how to deal with newly arising guilt over "normal" impulses, such as sex; how to find meaning in a tragedy or severe loss (e.g., death of a parent) without succumbing to the cultic view that negative experiences and traumas are punishment for leaving the group. For some clients, the Maintenance stage involves learning to (as one client described it) "skate the thin ice" between being deeply (and productively) committed to a person, group or cause without giving up one's newly-acquired respect for critical thinking and analysis, even skepticism.

Decades of research in the treatment of addictive disorders dispelled the myth that relapse meant failure. A significant number (40-60% depending on the study) of substance-dependent clients relapse (McLellan & Lewis, et. al., 2000); rather than amount to failure, however, relapse can provide an opportunity to learn more about oneself and ultimately strengthen one's recovery. This "relapse can be part of recovery" approach revolutionized and greatly improved addiction treatment (Hubbard, Flynn, Craddock, & Fletcher, 2001), and led Prochaska and Di Clemente (1984) to include relapse as one of the stages in their original stages-of-change model.[4] In working with HDG/HDR clients, I have found that (depending on how one defines "relapse" in these situation) many in fact do find themselves struggling with relapse, often expressed as an unwanted, unconscious tendency to repeat their previous cultic experience. For decades, some cult-aware clinicians have described "cult-hopping" as a tendency to leave one highly-conflicted

[4] This is not to say that relapse is a wanted, welcome or necessary recovery stage. I have never heard a substance-dependent client or anyone in his/her family state that they looked forward to relapse. However, relapse can be informative and it often does not ultimately signal failure.

HDG/HDR for the false refuge of a different relationship, one that on the surface seems safe, affirming and constructive but ultimately turns out to be another HDG/HDR (Dubrow-Eichel & Dubrow-Eichel, 1988). Others may become involved in highly dependent or co-dependent intimate relationships. A very unfortunate few will become involved with highly charismatic therapists or interventionists, re-enacting their former cultic relationship with a truly damaging and ironic twist. However, others become counter-phobic; that is, they become rebellious and excessively hostile to anything that even looks like commitment or "dependency," including the therapeutic process.

The BIDT approach, relying on the principles of MET, is client-centered and highly nonjudgmental; at my best, I work with the client's set of values (not necessarily identical to my own) and avoid any statements or reflections on my client's experience that might blame the victim or be otherwise shaming. While not guaranteeing anything, this approach seems to convey the (very sincere) sense that my door is always open and I will not shame a client if he or she relapses. As a result, I have had several cases in which a client progresses through the Action stage, seems to be maintaining their changed thinking, feeling and behavior, and then goes on "sabbatical" from therapy, only to return because he or she has become involved in another situation with another group, cause or person(s) and have begun to question whether this new involvement may be cultic. I heartily and happily welcome these clients back and do whatever I can to reassure them that their relapse is indeed part of their recovery. Sometimes I then find myself paradoxically encouraging my client to slow down, to not try to skip the Contemplation

stage, to not necessarily move too quickly toward taking action (unless their physical/emotional/psychological core is in immediate danger).

To my knowledge, nobody has studied the theoretical orientations and treatment modalities of therapists who work with HDG/HDR-affected clients. Lorna and Bill Goldberg are clinical social workers who are trained and certified psychoanalysts, and their writing often reflects that tradition (c.f., Goldberg, 2012), as is Daniel Shaw. In private communications, others have indicated that they tend toward cognitive-behavioral approaches. Because so many HDGs utilize quasi-hypnotic (or even overtly hypnotic) techniques, most post-HDG therapists avoid using hypnosis or guided imagery (Zeitlin, 1985). MET is generally thought of as a transtheoretical approach; that is, there are basic principles that can be utilized in any of the major, known therapeutic modalities. Several concepts are central in MET. These include empowering the individual, a belief in a fundamental human drive toward growth and health, and the importance of involving clients in directing and being invested in their own developmental change.

In addition to (1) *supporting self-efficacy* (which includes an acceptance of mistakes and a commitment to learning from mistakes), MET utilizes the following principles: (2) A deep understanding of the client's experience and world, and most importantly the ability *to express that empathy*; (3) careful listening to the client to discern his/her core principles and ethics, and in a skillful and well-timed manner, reminding the client how the HDG/HDR violates those principles (*developing discrepancy*); (4) *avoiding argumentation* in the realization that such arguing can result in the client defending the

HDG/HDR and actually lead to solidifying his/her resolve to remain in the group; (5) an ability to circumvent, or *roll with resistance* rather than confront the client head-on and "break through" his/her resistance. This latter principle is one of the most important ways in which MET differs from traditional "deprogramming," although in my own research on successful deprogramming the deprogrammers seemed to naturally understand this and often worked around resistance in an organic fashion (Dubrow-Eichel, 1989, 1990).

While MET principles are fairly easy to understand and learn, in practice the techniques are difficult to master. Guidance is best found in the works of master therapists who emphasize empathic listening and the ability to express understanding of the client's phenomenological field and experience. Of the many works of this nature available, Paul Wachtel's (1993, 2011) *Therapeutic Communication: Knowing What to Say When* stands out for me, and has become somewhat a classic in teaching advanced integrative counseling methods (Eichel, 2006). Similarly, it can be difficult to accurately discern in which stage of change a client is currently functioning, especially since he or she may be simultaneously in different stages of change stage depending on the issue being considered. One of my clients, a young woman who grew up in a small Bible-based cult, was well into the Action stage with regard to exiting her group and handling the disruption that caused in her extended family (some of whom had remained in the group), but was struggling with her developmental lag in dealing with relationships and her sexuality; in these areas, she vacillated between Pre-contemplation and Contemplation. Almost by definition, HDGs and HDRs typically induce developmental regression and/or

stagnation in those recruited in late adolescence or adulthood; for second-generation adults (SGAs) born and raised in an HDG, development delays in psychological, social and sexual functioning can be very pronounced. Without a "pre-cult" life and personality underlying the cultic "pseudo-identity" (Martin and West, 1994), a reparative developmental approach (whether ongoing or brief and intermittent) to therapy is almost always necessary.

The transtheoretical Stages of Change model and MET approach to the actual work of therapy are perfectly suited for BIDT. In BIDT, the therapist provides an extremely permissive yet boundaried "holding" environment in each contact with the client. In this approach, clients "come and go" almost at will; while a therapist may invite clients to be curious (I often use phrases like "it might be interesting to wonder…" and "this can be fascinating to explore….") about their reasons for stopping therapy, confrontation and discussions of "resistance" are rarely if ever employed. At some point early in our work, I will often introduce the possibility of therapy being intermittent; I rarely talk of "termination" but instead use terms like "taking a break" or "going on sabbatical." Within this context, I typically discuss the relationship between "therapeutic" and "therapy." I explain that, while I certainly want and expect our sessions to be therapeutic, many actions and experiences outside of therapy can also be highly therapeutic. If one understands "therapy" and "therapeutic" to involve any reparative learning experience, then it is easy to understand "therapy" never really ends. Taking sabbaticals from formal therapy does not mean taking a break from learning and growing; conversely, returning to

formal therapy is simply a shift in the mode of learning and growing. I sometimes explain that it is similar to reading great books (including literature) on human psychology away from formal schooling and then deciding to take a semester- or year-long, structured class that expands on and advances the material one has already encountered in "real life."

Example: BIDT with a Second Generation Adult (SGA)

Dana[5] came upon my website on the internet almost five years after her Bible-based cult was rocked by sexual abuse scandals involving her pastor (the cult's leader) and several of the group's elders. Born into her cult, as a child and well into her mid-adolescent years she had been molested by both male and female adults in the group. Tall, slender and attractive as both a child and a teenager, she was labeled a "temptress" and a "Jezebel" by her abusers. Family betrayal was heaped on top of the abuse when, upon reporting her abuse to her parents, she was blamed for her victimization and subsequently forced to undergo a series of lengthy exorcism-like prayer vigils (often involving her perpetrators as well as her parents) in attempts to vanquish her "demons." She might have been formally shunned if she weren't so bright; Dana was the only cult member who could reliably and competently serve as the group's network engineer, web designer and overall electronics expert. So she was kept around but, as her "evil" became known to the elders who were the group's insiders and second-in-commands, she became routinely ostracized and relegated to the periphery of the only community she knew. "I was the goat, the black

[5] "Dana" is a fictitious name. To protect my clients' privacy, I have changed or left out important biographical details that might identify an individual and/or a family. My description of my work with "Dana" is actually based on a combination of several similar cases.

sheep, the Jezebel who was kept under constant watch, even as the pastor and several elders continued to engage me sexually. Parents told their daughters to avoid me. A few of the more nasty and rebellious boys tried to have their way with me. My parents, my brother and two sisters tolerated my presence and prayed for me, but withdrew all their affections and support" as they waited for proof of her repentance and redemption. It was perhaps an indicator of her internal strength and nascent autonomy that she somehow "knew in my gut that there was something wrong with the pastor, the elder and even my family." When a newspaper broke the story of the cult's ongoing pattern of abuse (leading eventually to the leader being imprisoned on multiple charges of sexual assault) Dana had just turned 20 and was beginning to question whether or not she would stay in her group. With the pastor facing criminal charges, the group initially disbanded but hardcore elements moved to a satellite community in the Deep South, where they continue to practice their faith and await vindication of their leader, whose imprisonment they compared to the trial and crucifixion of Christ. Dana's family split over the revelations; her mother and one sister remained in the group but her father, brother and other sister left. None sought outside help or support, and to this day have not rejected their pastor's teachings or faith and continue to practice in their own way. They have become more "forgiving" and accepting of Dana, but they still to some degree blamed her for her victimization.

When her group crumbled and moved, Dana remained in the Philadelphia metropolitan area to attend a fundamentalist Bible college. Her share of a class action lawsuit settlement along with scholarship aid provided her funding; the same fund paid for her

initial round of therapy with me. She had hoped a formal course of Bible study would address her ongoing SGA concerns, but although she earned top grades and a B.A., she continued to experience flashbacks, anxiety, rapidly changing moods, nightmares and dissociative episodes…all the classic signs of complex, delayed post-traumatic stress disorder (PTSD). In addition, her extremely cloistered childhood and adolescence left her unprepared for urban life outside her college. Her history of sexual trauma and extremist religious dogma that she still somewhat believed left her ill-equipped to deal with the attention she received from men (and some women) on and off campus.

So far, Dana has come in for three "doses" of therapy, separated by one to two years. We initially worked on dealing with her PTSD symptoms and achieving some degree of emotional stability. She continued to read her Bible and pray on a very regular basis throughout the day; after about four months she noticed some religious commentaries on my bookshelf and rather sheepishly asked if she might examine a few of them. One of her first choices was Karen Armstrong's best-seller, *A History of God.* She eventually borrowed my copy and then bought her own. Armstrong, an award-winning former Roman Catholic religious sister known for her personal and intellectual journey from a conservative to a liberal/mystical faith in Christianity, fascinated Dana. Reading *A History of God* led Dana to more closely examine the historical roots not only of her own religious upbringing but of monotheism in general. For the first time, she also began reading (but ultimately rejecting) contemporary works highly critical of all theisms, such as Christopher Hitchens' *God is Not Great: How Religion Poisons Everything.* For several months during our initial work together, Dana led a fairly isolated, solitary life.

She rented an attic apartment from a husband and wife who had left her group years before the scandals; this couple had not adjusted well to the general culture and were heavy drinkers and substance abusers. Her understandable distrust of even social gatherings let alone organized groups left her with no feeling of community.

Dana had difficulty finding employment. While she was a highly proficient network engineer, she did not have the credentials for "standard" employment in the IT/NE field. She was embarrassed by her past and at a loss as to how to explain her educational background (a GED and a B.A. in Bible Studies from a post-secondary institution whose name made it clear it was a fundamentalist Bible college). Moreover, she had deep hesitations about working in a corporate environment with what she imagined was its own authoritarian structure and after-work happy hours. Toward the end of our first therapy together, she was able to cobble together a living by becoming an independent contractor.

Dana's first sabbatical from therapy coincided with the termination of the treatment benefit she received from the class-action lawsuit settlement. The timing was actually quite good; Dana was concentrating on getting her career going and her livelihood stable. I next heard from her almost a year later. At this point Dana had begun her own business, a limited liability company, and had a reasonable number of clients and a somewhat steady income stream. However she felt she had reached a kind of crisis; she was drinking heavily on weekends and had recently discover that her first post-cult romantic partner, a significantly older man, was actually married. She was now able to afford a

reduced fee. We met once every two weeks for about eight months, and during that period of time Dana was able to quickly resolve to reduce her drinking and (a bit more slowly) end her affair. It took her longer to deal with her guilt and anger over being involved with a married man, and still longer to admit to herself that a major reason for tolerating the affair was that she had come to greatly appreciate and enjoy the sexual aspect of her relationship. For a few months, she entered into a series of one-night stands, but when one of these adventures ended up with being police interrupting a sexual engagement in a parking lot she felt humiliated and immediately ended this behavior. She also initially found it difficult to believe that I was not disappointed in her, that my suggestion (consistent with MET principles) that we approach her sexual behavior with an attitude of "more curiosity, less judgment"[6] was sincere.

During the initial phase of our first therapy, Dana seemed to be in the Contemplative and Determination/Preparation stages in struggling with her cult upbringing. She eventually moved into the Action stage as she took it upon herself to challenge her extremist beliefs. She also began to explore the psychosocial precursors and dimensions of her beliefs, feelings and behaviors as, with some guidance, she began reading the literature on indoctrination and thought reform. When it was clear that her exit was solid, she had moved into Maintenance. However she was in Pre-contemplation with regard to her sexual trauma and sexuality issues in general. During her second round of therapy, Dana was clearly interested in exploring her sexuality, including her desires and conflicts. She periodically but consistently sought information, primarily from scientific studies, that

[6] "More curiosity, less judgment" is the unofficial slogan of, and a popular bumper sticker distributed by, the American Academy of Psychotherapists.

challenged much of the misinformation she received while being indoctrinated in her HDG. Later in this time frame she began to realize that some of her behavior was actually counter-phobic, an attempt to "undo" all the shame and guilt she had learned. What was more difficult for her was the slowly-developing realization that some of the abuse she experienced had, against her wishes, been somewhat arousing and that her post-HDG indiscriminate or self-destructive sexual behavior was on one level an unconscious attempt to exert control of others and herself, and on another level an unconscious re-enactment of her abuse, complete with consequential shame and guilt. With a more complete understanding of and appreciation for the complexity of her behavior (Contemplation), Dana moved quickly through Determination into the Action stage. She continued her sexual self-exploration through reading, journaling and self-pleasuring (including experimenting with various forms of masturbation) while ceasing casual sexual encounters with others. Eventually, Dana met a man who seemed appropriate, fell in love and moved in with him with the intention of marrying. She made plans to participate in her first SGA workshop sponsored by the International Cultic Studies Association (ICSA) and attend a subsequent ICSA conference. Her second round of therapy encounters with me ended at this point.

In the three years between her second and third series of appointments, Dana remained intermittently in touch with me, primarily through email. She kept me informed of important events in her life, including her marriage and subsequent birth of her daughter, and she occasionally asked me questions or sought feedback. She made a third round of appointments about six months after her marriage ended; it had become clear that her

husband was hiding an increasingly severe drug abuse problem, and might also have an underlying and severe personality disorder. Her life became more stressful when, after completing an addiction rehabilitation program, her ex-husband then sued for joint custody of their child. As she was still highly cognizant of her own childhood abuse, Dana felt adamantly certain that she did not want her daughter to grow up in a dysfunctional parental environment and was actively fighting her ex-husband's challenge to the original custody decree. To make matters worse, he was using his knowledge of Dana's past to portray her as "damaged goods" and undeserving of primary custody of their child. Further complicating matters, Dana had become involved with a professor at a local university and was considering moving in with him. My role this time was primarily one of supporting her through a contentious custody evaluation. In addition, I met with Dana and her new boyfriend on several occasions to help her better communicate her past experiences and current needs. The couple also attended several meetings of an ICSA chapter. Ultimately, the custody evaluator's conclusions were acceptable to Dana, and her new relationship seemed to benefit from her boyfriend's improved understanding of her past. Dana was able to divert some of her attention back to her slowly-but-surely growing business. Dana ended this series of appointments feeling she was back on track with her life.

Saying Good-bye to the Guru: Follow-up and Continuation

In 2002, "Saying Good-bye to the Guru: Brief Intermittent Developmental Therapy with a Young Adult in a High Demand Group" was a chapter published in the book, *Casebook*

of brief psychotherapy with college students edited by Dr. Stuart Cooper (Dubrow-Eichel, 2002). In my chapter, I introduced readers to David,[7] whose family initially consulted with me when he was 16, and whom I began seeing shortly thereafter and continued to see intermittently well into adulthood. In total, I saw David over a span of almost 19 years (well over half his lifetime). David has honored me with an unusually detailed look into his adolescent and adult development both within and then outside his Eastern-based HDG.

When I actually wrote the chapter (in 2000), David was on "hiatus" from therapy; I had not seen him in over a year. In the chapter, we left David shortly after he decided to attend a college that emphasized the study and creation of art. In early 2001, at age 23 he requested to see me, and we met on a weekly and then biweekly basis through Spring, 2002. He was struggling with consistently attending college classes and as a result had failed three classes. During our first session, he reluctantly admitted that his poor attendance was at least partially due to marijuana and alcohol abuse. He did not want to attend a twelve-step program (e.g., Alcoholics or Narcotics Anonymous) or any other group-focused treatment progam. After several months, David was able to commit to decreased (i.e., primarily weekend) use of alcohol and marijuana. He negotiated alternative course requirements with the professors of classes he was in the process of failing. With his behavior somewhat under control, he opted to take another sabbatical from therapy.

[7] "David," like Dana, is a fictitious name.

I next heard from David four years later, when he invited me to attend the presentation of his senior project. I learned that in 2004 he had taken a year off from college and worked as a bicycle courier. In Spring 2007 David graduated from college; that Fall, David briefly re-engaged in therapy, until Spring 2008. After he received his B.F.A. degree, his alcohol and marijuana consumption had skyrocketed. David was unable to decrease or cease his substance abuse, and even came intoxicated to a few sessions. I gently but firmly reminded him that our treatment contract did not allow for me to see him when he was drunk and/or stoned; David seemed to understand this boundary and did not repeat the behavior, but weekly outpatient therapy did not seem to be helping. I again recommended attending a twelve-step program; he again refused. Therapy terminated. I did my best to be clear that I would continue to be open to working with him; I did not hear from him for 5 years.

In Spring, 2013 David called from his new home in New Mexico; he was planning to visit the Philadelphia area for a few weeks and wanted to make a series of appointments. We met several times, and had a few phone sessions when he returned to his home. The first news he shared was the fact that he'd been clean and sober for 3 years, thanks primarily to his ongoing commitment to AA and NA. He was working full-time, albeit not in an occupation he expected or would choose; his goal now is to become an artisan landscaper. He had become deeply involved with a woman in New Mexico; she has a young daughter by a previous marriage, and David's primary reason for contacting me was to discuss some issues related to his employment and relationship, and especially with regard to the growing relationship that was developing with his girlfriend's

daughter. David looked the same and yet different; his youngish face was now weather-worn, and he reminded me of a young Robert Redford. His challenges were now the "typical" ones of a man in his early thirties: career, family, maturity. Perhaps what struck me the most was his smile. David always had an excellent if offbeat sense of humor and an infectious laugh. Those were still in evidence, but now there was a different, more mellow look. David seemed content.

CONCLUSIONS

The two cases I described--one involving a young man who had been recruited into an HDG, the other a young woman born into an HDG—are reasonably representative of several others with whom I have employed the BIDT approach to treatment. Both would have initially been viewed as "resistant" to therapy, albeit in very different ways. David had a "pre-cult" life and personality; when he became involved in an HDG, he saw, felt and was pleased with the "changes" he experienced in himself. He did not want to exit his group and was not very interested in hearing critical information about them. It wasn't until we'd established some kind of mutually-respectful relationship that he was willing to look at (and then widen) the few "cracks" I saw in his defense of his HDG involvement. There was never any guarantee that he would exit his group, nor did I seek one. I sincerely supported his right and ability to make an informed choice about remaining involved. The issue I slowly encouraged David to consider was the degree to which his personal experience—knowing that his group had manufactured and manipulated that experience to a large degree in order to obtain his commitment—was in

an of itself sufficient to justify committing his life and resources to this particular HDG. Did the behavior of his group toward others and the rest of society—its corruption and abuses toward others and even those within its own membership—matter to David? Could he maintain a faith in the group's leadership without ongoing "brainwashing," without the use of thought-stopping and doubt-crushing techniques like chanting, praying and meditating, as was taught in and demanded by his HDG? Then, once he'd exited the group, how would he handle the developmental challenges of moving toward consolidated identity, personal authenticity and autonomy?

For Dana, the tasks were very different. She'd grown up and been socialized in her HDG. She had no "pre-cult" identity or personality to guide her post-HDG development; her entire existence was intertwined with her HDG experience. Although she'd exited on her own, like many SGAs, her leaving was fraught with ambivalence and confusion. Although she was in her mid-20s when we began working together, in some ways working with her was reminiscent of working with many bright but highly confused and conflicted adolescents. In other ways, working with her was very similar to working with young people who had been sexually abused by a trusted adult for many years. She exhibited "betrayal trauma" (Freyd, 1998). If she had been evaluated by a psychologist with no post-HDG and/or complex/chronic sexual trauma experience, she probably would have been mistakenly diagnosed as having narcissistic personality disorder with borderline features. It was important to be consistent with Dana, to have somewhat flexible boundaries while always encourage exploring their meaning, to be supportive

and yet firm, and to encourage her self-efficacy even when I suspected her choices would likely lead to unwanted consequences.

With both David and Dana, I spent relatively little time lecturing about or even discussing the "mind control" literature (e.g., Lifton, Schein). I encouraged exploring the broader social psychological literature on influence when my clients had theoretical questions. In most cases, clients begin to figure out on their own that "mind control" consists primarily of an organized program of intensified "normal" social influence techniques, sometimes outside the "target's" awareness, that are always interpreted as necessary for spiritual and personal growth. Both David and Dana took significant time to sort out the differences between "good" and "bad" social influence.

The BIDT approach may not be the most effective approach with some current/former members of HDG. Those in ongoing and even life-threatening situations that impair daily functioning need a more intensive, uninterrupted form of treatment. I recently evaluated a young man who was born and raised in a well-known, infamous cult with a long history of encouraging sexual abuse, including incest, in the name of "Christ's love." He had grown up in an isolated cult "collective" (compound) in a foreign country, had witnessed and experienced significant sexual trauma, and had been denied any formal education; after he left his group, his chronic abuse and exposure to harmful influence ("mind control") culminated in over a decade of paid sex work (male "escorting") and severe alcoholism. BIDT would have been inappropriate for him. I urged him to petition for Medicaid health insurance and enter a long-term, trauma-based inpatient alcohol

rehabilitation program to begin his long process of recovery. I have little doubt that afterwards, he will require consistent, long-term therapy and support, probably in a long-term residential facility or halfway house.

According to most clinician "cult-specialists" with whom I've talked, the majority of those who exit HDG/HDRs are not as severely damaged as this young man. The BIDT approach is well-suited for many clients, and with its foundation in the transtheoretical "stages of change" and motivational interviewing models, enjoys the added benefit of being relatively easily learned and incorporated into a broad range of therapeutic modalities.

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