

When Friends or Patients Ask About . . .

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Cults 279

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THE PRACTICES of a rapidly expanding number of groups or cults, most calling themselves religions, are of great interest and concern to physicians, for frequently they must face either direct family involvement or a clinical problem of real urgency as a result of cult activities. To respond with professional competence is most difficult without some prior knowledge of the nature of these organizations and the problems generated by their activities.

Members

The new youth cults, though usually self-styled as religious for purposes of first amendment privileges, are increasingly dangerous to the health of their converts and menacing to their critics. Estimates of total US membership extend anywhere from 3 to 10 million people involved in more than 3,000 groups ranging in size from two or three members obeying a guru to many thousands. Their prominence is best demonstrated by the fact that almost everyone now knows some family who has had the personal experience of a member joining a cult.

At present, most of these deviant cults that have been studied have been composed mostly of middle class or upper middle class converts.

Whether political or religious, their belief systems are uniformly absolutist and intolerant, polarized and provocative, simplistic and certain.

However, it is not the private beliefs of the members of these groups that matter—in specifics their doctrines vary enormously—it is their behavior toward those outside their worlds and the effects on the health of both the involved persons and their families that deserve our attention.

Goals of Cults

The destructive cults are usually first-generation entities with living leaders. Their primary goals are expansion through rapid, aggressive conversion and the amassing of money. They rarely launch truly charitable projects as they claim, largely because those needy unconverted persons outside their groups are seen as different and undeserving. A member of such an organization must not only bend his will to the group and its leaders but must yield control of his mind as well. Failure to do so is punished or corrected; banishment is the ultimate sanction in some groups, death in others.

Susceptibility to Conversion

With respect to a specific susceptibility to conversion, the usual psychiatric categories do not entirely satisfy and indeed are confusing. A great variety of persons from the

early teens to the 50s, with a wide variety of personality strengths and weaknesses, have entered these groups. The cults themselves select a segment of the marketplace and, as with any new enterprise, thrive only if they develop technical skills to build a core group and maintain internal congruity. The attempts of many observers to describe salient personality traits that render converts vulnerable and place them in pathological categories have been misleading, because they have tended to obscure the fact of nearly universal susceptibility to sudden change in the general population. In my studies^{1,2} of more than 60 subjects in all stages of involvement, about 60% by examination and by history obtained from relatives have been substantially and chronically disturbed and unhappy for many years. A large share of this group actively had sought conversions repeatedly. About 40%, however, were by history and examination essentially normal, maturing persons. Their susceptibility to conversion was either an artifact of the aggressive manipulation of a proselytizer or the result of a normal painful crisis of maturation. Singer's³ estimate indicates an even larger percentage of

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normal persons (75%), while Galanter et al.¹ in their questionnaire study of 237 members of the Unification Church, found "39% who felt they had serious emotional problems in the past" that had "led to professional help (30%) and even hospitalization (6%)."

Effects of Conversion

Though the physician is all too likely to become aware of the more destructive effects of cult memberships through clinical experience, he may not immediately appreciate the degree to which the medical profession as a whole is under attack by these organizations. For one thing almost all embrace magic in many forms, including faith healing, and in their general rejection of their surrounding culture discard scientific linear thinking; thus, they reject modern medicine and consider physicians as enemies. In practice even those cults who occasionally use medical facilities are extremely reluctant to seek this help or to pay the bills. In many emergency services, physicians have faced untreated injuries, badly managed diabetic cases, broken bones that had been "prayed over," or the kinds of infectious and deficiency diseases that result from unclean communal living, poor nutrition, and exposure. Dermatologic problems from ulcers to scabies, venereal diseases associated with religious prostitution, untreated acute abdomens, retinal separation, tumors, nutritional anemia and vitamin deficiencies, and occasional gross obesity or dangerous cachexia are among the presenting problems. Therapeutic compliance and follow-up are poor.

The unique capacity of these absolutist groups to cause harm stems from the central activity of all the cults—the sudden conversion through aggressive and skillful manipulation of a naive or deceived subject who is passing through or has been caused to enter a susceptible state of mind. Through highly programmed behavioral control techniques and in a controlled environment, the subject's attention is narrowed and focused to the point of becoming a trance. Within the totally controlled atmosphere provided by each group, this state is maintained during several sleep periods until it becomes an independent

structure. The loss of privacy and sleep in a bizarre new atmosphere, change of language, and continuous control of excitement level amount to an onslaught of information that sustains the continued state of dissociation; throughout this period of focused attention, new information is absorbed at an accelerated rate and rapidly becomes integral to the available mechanisms of the mind. As a result, the convert becomes dependent on this new environment for definitions of reality. From this stage the group controls not only the forms of action but also the content of thought through confessions, training, and conditioning. To think for oneself is suspect in many groups; to think wrongly is satanic and punishable by psychophysiological reactions such as migraine headaches, terror and panic, sharp depressions, or gastrointestinal symptoms. The basic controls of the CNS seem to have altered; the menstrual periods may stop, or beard growth may be substantially slowed.

While in this state, personality changes drastically—a fact that often brings terrified parents into the physician's office. Converts often seem drab and dreamy outside the group, stereotyped, and somewhat expressionless when discussing anything other than their new experience. They lack mirth and richness of vocabulary. The devices of expression—irony, metaphor, and delight in the use of abstraction—are gone. Many converts report hallucinations, even olfactory ones, and experience group-validated delusions as well as nightmares. The sense of current history is quickly lost. If challenged they may become excited or even violent but at best answer difficult questions with memorized clichés.

Most converts are used for proselytizing and begging; they work extremely long hours to meet impossible goals. Some have reported sleeping less than four hours nightly for many years. They are often aware of their prior personality through dreams or shadowy memories.

Shapiro,² whose family involvement with a cult prompted his studies, correctly labeled the entity of destructive cultism as a public health problem and a sociopathic illness. It was his cry for help from one physician to another that prompted my

own studies of this problem. I would prefer now to describe the effects on persons as a syndrome of sudden change and interpret it as manipulation of the innate capacity of human beings to adapt either to overwhelming stress or to biological or social necessities. Whether from falling in love; or temporal lobe epilepsy; or head injuries; or metabolic illnesses, grief, psychoactive drugs; or involvement in a mob; dissociation is the central adaptive mechanism. The subsequent changes in the body, postconversion, such as the alteration of menses, and other disturbances of vegetative functions, are most interesting and in need of careful research.

Those who have left such groups poignantly illustrate the seriousness of subjection to sustained dissociative states. Whether by deprogramming through acute psychoses or by an extraordinary exertion of will, those cult members on leaving face major problems. Singer³ points to the special disabilities of these ex-cult members—"slippage into dissociative states, severe incapacity to make decisions and related extreme suggestibility," which she believes "derives from the effects of specific behavior-conditioning practices on some especially susceptible persons." She also confirms the depressions, loneliness, and indecisiveness that seriously interfere with reemergence into ordinary life of these injured persons. They are often aware of a double personality, designated by parents especially as *floating*. A simple decision such as choosing socks may take inordinate time and energy. They are frequently physically sick and seem to have some difficulty in returning to normal health. The sense of guilt is most painfully double-edged guilt for their damage to parents and to themselves and for leaving the loving cult family.

There are a number of scientific questions to be asked about the particular form of involvement just described; research must continue. The degree of manipulation of the minds of so many involved subjects offers an ideal opportunity to study the psychophysiological system of the human being in rapid change to delineate further a theory of psycho-

pathophysiology of mental illness, which is so conspicuously absent in modern psychiatric practice. But at the same time, it is disturbingly ironic that as ethical physicians and citizens of an open society we must deplore these most illuminating experiments. It has always been possible to doubt the validity of many criticisms of the cultic phenomenon and to hope that the alarm had been prematurely sounded. However, many of us who have studied the wide range of dangerous cults were not surprised by the Guyana suicides and murders nor the punishing rattlesnake of Synanon nor the increasing violence of many of these groups. There have always been suicides and psychoses, but recently flagrant political manipulations⁴ and the amassing of

firearms and the menacing behavior of a number of groups have been reported in many countries.

Most troubling of all are the burned-out rejects of these groups who are beginning to be seen (some apparently have disappeared completely; their parents are unable to find out from the cults if they are alive or dead). Others who have been dropped out of their groups are simply not able to use their minds as tools of survival and are supremely difficult to treat; they are mutilated.

Comment

Cults of various sorts have been useful to society as change agents. In such roles, as antagonists to the status quo, they may very well serve as a leavening in a stagnant culture.

There is no question of their right to stand against other opinions, nor, as Delgado⁷ persuasively argues, should there be any question of the right of others to stand against them. It is through this kind of confrontation that change may be negotiated safely. But in groups organized in the ways I have been describing, there is an inherent danger, from their techniques and from their doctrines of deviancy, that they can become destructive for the sake of destruction or intolerant beyond the capacity to negotiate. At that stage they are willing to injure other human beings without scruple. This is already happening, and it must not be condoned by the medical profession.

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Pregnancy Following Double Ovariectomy

[Correspondence, p 210]

Chicago, June 26, 1904

To the Editor.—Having read the report of I. W. Hunter's article on "Pregnancy Following Double Ovariectomy," in the *Medical Age*, Detroit, of recent date, I can not resist the temptation to offer my opinion as explaining the phenomenon of fecundation of an ovum, after extirpation of ovaries and tubes in a given case.

We know from experience that pregnancy can and does take place in a woman who has had performed ovariectomy and salpingectomy, unilateral or bilateral.

We know that cases such as this have occurred where a woman has conceived

and become pregnant after having but one single congress with her husband, as the sailor who had to leave home immediately after his marriage. . . . We know that after the ovum matures and rupture of the graafian follicle takes place, that the ovum continues along the canal outward toward the fimbriated extremity where it fertilizes. After resting here for a while, it takes its inward course, propelled by the peristaltic movements of the tube and its own flagellation, meeting the wandering spermatozoon, which it receives within its integrity.

At or near the internal atrium of the tube, this impregnated ovum rests for an indefinite period before it escapes into the lumen of the fundus uteri, where it experiences the changes concomitant with its fixation to the mucosa.

We know that the mucosa of the tube is wrinkled, or thrown up into folds, longitudinal and oblique, this fact entailing the necessary formation of little valleys or depressions, in which an ovum may rest with perfect safety from any disturbing mechanical agency. . . . For the experience of such men as Minot, Dalton, Wagner, and others, shows us that an ovum or spermatozoa, after having left or sepa-

rated themselves from their original sources, may and do exist within the genital tract of the female, for periods from one day up to three and four weeks, all the time subsisting on the natural fluids and lymph derived from the rich blood supply of the mucosa, which reaches them by an osmotic process.

Furthermore, how many operators do actually extirpate every vestige of a true fallopian tube? One must bear in mind the anatomic construction of these organs. The tube itself does not stop at the plane of the junction of the serous investments of fundus and tube. The mucosa of the tube goes well into the body of the uterus, and this means that there are those villi formations there also, to which I have referred.

My opinion is that if operators would make a wedge-shaped or cone-shaped incision in the wall of the uterus when removing the adnexa, even going so far as to remove the entire cornua of the organ, that we would hear no more of such occurrences as have given food for thought or argument in basing the subject matter on such grounds.

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