

Psychiatric Disturbances Associated with Erhard Seminars Training: I. A Report of Cases

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Erhard Seminars Training (est) is a large-group experience that is becoming widely available in this country. This is the first case report in the professional literature of psychiatric disturbance following est training. Five patients, only one of whom had a history of psychiatric disturbance, developed psychotic symptoms including grandiosity, paranoia, uncontrollable mood swings, and delusions. Further work is necessary to ascertain the factors that determine outcome in est.

CONCERN OVER psychological injury to participants in encounter groups has received considerable attention in the literature (1-5) and was discussed in a 1970 report from the American Psychiatric Association Task Force on Recent Developments in the Use of Small Groups (6). The psychological complications of participation in large quasi-therapeutic group experiences has been a neglected topic; we have been unable to find any case reports in the professional literature relating to the effects of Erhard Seminars Training (popularly known as est). The spread of the est "movement" and the gravity of the cases that have come to our attention contribute a sense of urgency and importance to the communication of these preliminary findings.

Est is a nationwide phenomenon (7); in 5 years some 84,000 persons have "graduated." Since its founding in San Francisco, est has established branch organizations in Denver, Oakland-Berkeley, Honolulu, Chicago, Washington, D.C., Boston, New York, and several sites in southern California. The training occurs over two weekends in groups of about 250 trainees who pay \$250 for the 60- to 70-hour experience.

Several sources have described est training (8, 9), and it is now receiving attention in the popular media (7, 10). The training is typically conducted in large hotel convention rooms. Trainees sit before a trainer who is located on an elevated central stage equipped with a blackboard. Trainers employ a confrontational, authoritarian model and often respond to disagreement

from the participants with intimidation and ridicule. The leader dictates a set of rules that includes the following: no watches, no talking unless recognized by the trainer, no leaving one's seat, and no smoking, eating, or going to the bathroom except during announced breaks. Alcohol, drugs, and unprescribed medication are not permitted. Individuals who break the rules are usually escorted from the room and may be dropped from the program. The usual training day begins in the early morning and continues for about 15 hours with two breaks. Trainees may eat only during the second break.

The format of the experience is repeated with little variation for each new group of trainees. The program consists of three basic activities: didactic presentation of est's precepts, self-disclosure before the entire group, and "processes." The didactic material, which is delivered by the leader in a forceful manner, borrows heavily from psychoanalytic theory, Jungian psychology, transactional analysis, and Eastern philosophy. During scheduled periods of self-disclosure, trainees are exhorted by the leader to "share"; they respond with testimonials, confessions, and cathartic outpourings. The "processes" are large group exercises that use Gestalt, relaxation, guided imagery, and psychodrama techniques.

The est organization is explicit in not representing itself as a psychotherapeutic endeavor (8, p. 2); nonetheless, it attracts at least some clients who are searching for relief of intrapsychic and interpersonal distress. The cases we will describe represent a segment of est trainees who came to our attention in a variety of emergency psychiatric settings.

CASE REPORTS

Case 1. Mr. A, a 39-year-old married executive, was admitted involuntarily to a closed psychiatric ward midway through his est training. Mr. A is the second of three sons born to a struggling immigrant couple on the West Coast. He recalls boarding with relatives as a child and being separated from his parents because of economic hardships. The sudden death of his mother when he was 23 was "traumatic," but Mr. A considered the issue resolved until he started est. There is no history of mental illness in the patient or his family.

Mr. A completed secondary school without difficulty and served on active duty in the Air Force. He then graduated from a prestigious university, married, and began a family

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that now includes five children. Over the past 10 years he has steadily advanced in a large corporation, where he is now an executive officer.

Mr. A and his wife took est at the urging of several close friends. He hoped to better his marital relationship and improve his executive skills. After the second day of training, he experienced a marked increase in energy, self-esteem, and knowledge. He had, in est terminology, "gotten it." Concurrent with his elation, powerful feelings of remorse related to his mother's death 15 years before emerged. He said, "She died before I could prove my worth to her." Memories of her funeral were intrusive and caused him to cry, yet he felt strangely calm and powerful. He jumped into his swimming pool at home nude and tried to breathe under the surface. He felt he was god-like and could survive without air and ignored his family's entreaties. He attempted increasingly hazardous feats to validate his grandiose self-image. After 2 days of manic activity his wife called local police and involuntary hospitalization was instituted.

Mr. A was treated for 6 days in a closed-ward setting. The first day was spent in seclusion, where he received antipsychotic medication by injection. His psychosis cleared rapidly with moderate dosages of oral thioridazine, and he was able to return to work in 3 weeks. He saw a psychiatrist intermittently for 4 months and gradually discontinued his medication. Mr. A has returned to his previous level of functioning and has had no recurrences in the 10 months since his hospitalization.

Case 2. Mr. B, a 26-year-old single man, had his initial psychiatric admission 5 days following the first est weekend. He is the second of three sons born to a middle-class family. His parents were divorced when he was 15. He completed college, had few friends, and continued to live at home while working as a high school teacher. Neither he nor any of his relatives has a history of mental illness.

Mr. B took est training when he was 25 after hearing of it from several students. In the evening of the second day of training, he experienced visual illusions during a "staring process" in which trainees were instructed to "contact" someone else by intense visual confrontation. During the following 3 days he began "knowing what other people were thinking." At the next session, he left his chair and took the trainer's seat on the stage. The patient reported that at that time he did not know who he was, or rather that he could be anyone. He ran from the room after the meeting ended and later was told that the trainer was quite concerned about him.

Mr. B did not finish the training. He contacted relatives to tell them of his impending death and to confess sexual guilt. He was unable to sleep and believed he was possessed. A local priest was called. Auditory hallucinations and escalating delusions of grandiosity resulted in his admission to a closed psychiatric ward, where he was given intramuscular phenothiazines.

During the first hospital day, believing "nothing was real," he put his hand through a hospital window and severed tendons in his wrist, which required full surgical repair. He was discharged to his home after 7 days of inpatient care. Follow-up treatment consisted of moderate doses of phenothiazines and outpatient psychotherapy for the next 14 months. He remains in weekly psychotherapy at this time and has returned to his previous job, but he is reportedly withdrawn, insecure, and unable to resume his earlier level of social interaction.

Case 3. Mr. C, a 28-year-old married fourth-year dental student, developed ideas of reference midway through the est program. The patient and his fraternal twin were the oldest children of five siblings. His twin had died a year previously in an auto accident, possibly as a result of alcohol intoxication. Mr. C was deeply upset by this loss but apparently had grieved successfully, and he was enjoying the childhood of his 18-month-old son at the time he began taking the est course. He had had no previous psychiatric treatment, and there is no family history of treated mental illness.

The patient had been urged to attend est by his mother, who paid his enrollment fee. He experienced the first weekend as highly confusing and disturbing. He recalls being told, "Personality is a lie and okay," a statement he said "totally destroyed me." He recalls the trainer asserting "You're not real; you can do anything because it isn't real." He left the session and began to experience uncontrollable mood swings. An initial sense of elation rapidly gave way to a profound depression, and Mr. C found the pain "more unbearable than when my twin died; I wouldn't have believed it; any physical punishment would have been more merciful." He began to feel estranged from himself, his wife, and his role in the dental clinic. He developed ideas of reference and influence and became convinced he could read his son's mind. He spent hours pacing the city streets, afraid to let anyone see his face lest they control his mind.

This state continued for 2 weeks. The patient dropped out of the est course, briefly left his wife and child, but was able to "go through the motions" on his clinical assignment. He elaborated and began implementing a life-threatening project while he was severely depressed.

His psychosis cleared gradually without formal psychiatric treatment, but he continues to have marital discord; his wife perceives him as "a robot" since he attended est.

Case 4. Ms. D, a 34-year-old married mother of three, was transferred from the emergency room of a local general hospital in an acutely agitated and delusional state a few days after her second weekend of est.

The patient had no history of psychiatric disorder. She is the oldest of three siblings, one of whom had committed suicide 6 years previously. The patient and her living sibling had both completed college, married, and worked successfully. As a teenager, the patient attracted considerable attention when she heroically rescued a camping companion who was being mauled by a bear. The companion died, but the patient's heroism was recognized in the media, and she was given an award in Washington, D.C.

After her brief period of public notice, Ms. D led a largely uneventful life until the fall of 1972, when she elected to enroll in the est program. She had experienced stresses immediately before the training, including a hysterectomy and learning of a close relative's serious illness. Following the first weekend's training, she began to note strange coincidences (ideas of influence) and became overactive, writing at length of grandiose projects and getting little sleep. During the second weekend, to a rapt assemblage, she broke her silence on her "secret identity" as a heroine; she recalls feeling immensely gratified when she heard the est trainer order his assistants to "get this on tape." During a "process" later that weekend she rolled on the floor and laughed uncontrollably for no apparent reason but was not interfered with.

Within the next few days her hyperactivity, grandiosity, and instability mounted, and she was taken to a local emergency room. The mental status examination revealed hypomania and some exhaustion, but she was able to be treated

as an outpatient with daily appointments and moderate doses of chlorpromazine.

This episode cleared in several weeks but gave way to a profound depression that lasted many months. A year later she had a second manic attack (in which she felt herself to be the "power behind Werner Erhard" and became fearful of his jealousy) followed by a briefer and more moderate depression. She has been free of recurrence for 2 years and continues in twice weekly psychotherapy.

Case 5. Mr. E, a 30-year-old single man, developed a recurrent paranoid psychosis 6 weeks after completion of the est program.

The younger of two sons of a professional couple, Mr. E competed unsuccessfully with his more gifted brother. After an adolescence marked by depression and a paucity of friends, he completed college and obtained employment as a junior executive in a bank. A mescaline trip in 1969 precipitated a transient psychotic episode characterized by paranoid and grandiose delusions, which resolved without treatment in 2 weeks. He found himself unable to return to his position at the bank and instead found work as a typist for a large electronics firm, a job he has held until the present.

During the last 6 months of 1973 Mr. E was treated in group therapy by a psychiatrist who thought that the patient suffered from a severe obsessive-compulsive neurosis. In December 1973 he completed the est course. Initially there was an intensification of his arrogance and aloofness with a concurrent sense of elation and renewed self-confidence. He believed est had provided him with the answers he had been searching for and left therapy. Six weeks later he abruptly broke off contact with his immediate family, secluded himself in his house, feared that he would be harmed if he ventured out, and spent his days praying. After 3 weeks of isolation, in response to family pressure he recontacted his former therapist, who found him to be overtly psychotic and paranoid. After five individual sessions he was able to return to work, but he again discontinued therapy.

Eight months after the est experience, Mr. E barricaded himself in his house, refusing to answer the phone or admit family members. When the police and family entered the house forcibly they found him disheveled and mute in a room replete with religious figures and booby traps fashioned from wire. He was hospitalized for the first time at his community mental health center but eloped after only a brief stay. His discharge diagnosis was schizophrenia, paranoid type.

A week later, armed with a bow and arrow and a handgun, he approached a group of men on a street corner. In the ensuing struggle, the gun fired and Mr. E was seriously wounded and required emergency surgery. Currently, he is in weekly psychotherapy and is receiving antipsychotic medication. He has returned to his former job.

DISCUSSION

Any unsystematic collection of cases in which exposure to a specific experience is shown to be followed by a variety of untoward results can never rise above its unsystematic origins. We wish to emphasize that no assertion can be made on the basis of this evidence re-

garding the critical issues of causation and rate of occurrence of the serious and sometimes tragic outcomes that are reported here. Nor is it asserted that the est experience per se is necessarily noxious to all participants. It is likely that specific characteristics of individual trainees may predispose them to serious adverse reactions. Indeed, such factors also may determine, in part, the experience of positive outcomes. Definitive comment on these questions must await systematic study.

Nonetheless, some speculation seems merited in view of the gravity of the findings we have presented, the exponential spread of exposure to the est experience, and the absence of previous consideration in the literature. Such a discussion should include consideration of the psychodynamic mechanisms that might account for the major regressions reported here. We are impressed that an authoritarian, confrontational, aggressive leadership style coupled with physiologic deprivation fosters an "identification with the aggressor" (11). The inability of this defense mechanism to contain overwhelming anxiety aroused by the process may lead to fusion with the leader, ego fragmentation, and psychotic decompensation.

Additional case material and a comprehensive discussion of the psychodynamic mechanisms as well as other potential psychotogenic influences (e.g., stress response syndromes, coercive persuasion, leadership style, and the double-bind hypothesis) will be presented in a second paper (12).

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