

Psychiatric Disturbances Associated with Erhard Seminars Training: II. Additional Cases and Theoretical Considerations

BY MICHAEL A. KIRSCH, M.D., AND LEONARD L. GLASS, M.D.

In a previous article, the authors reported on 5 individuals who developed psychoses after participation in Erhard Seminars Training (est). Two additional cases are reported, and the combined case material is discussed in terms of group and psychodynamic theories. The authoritarian est leadership style may mobilize in trainees an overdetermined and pathological reliance on identification with the aggressor. Such a mechanism may be central to the production of psychiatric casualties, particularly in individuals with defective ego boundaries. Future controlled research is necessary to ascertain the rate of occurrence of psychiatric disturbances associated with est and to test the authors' hypotheses.

IN THE FIRST part of this report on psychological complications associated with Erhard Seminars Training (est) (1), we described 5 cases of psychosis temporally related to the training. A large, quasi-therapeutic group experience, est is becoming widely available in this country. The training occurs over two weekends, usually in hotel convention halls, in groups of 250 trainees who now pay \$300 for the 60-70 hour experience. The trainer employs an authoritarian model, and trainees are not permitted to leave, talk, eat, or go to the bathroom during the marathon sessions except as dictated by the leader. The training consists of Gestalt-like exercises, didactic material, and scheduled self-disclosure, carried out in a forceful, confrontational style. A fuller description of the est training program appears in our earlier report (1).

The est organization does not advocate the training for people who have a history of psychiatric hospitalization. Applicants who are in psychotherapy but are dissatisfied or believe they have fared poorly in therapy in the 6 months before the course are also report-

When this work was done, Dr. Kirsch was a Resident in Psychiatry, Langley Porter Neuropsychiatric Institute, University of California, San Francisco, where Dr. Glass was Director, Emergency Service. Dr. Kirsch is now in private practice at 2154 Broderick St., San Francisco, Calif. 94115, and Dr. Glass is Assistant Psychiatrist, McLean Hospital, 115 Mill St., Belmont, Mass. 02178, and Instructor in Psychiatry, Harvard Medical School. Address reprint requests to either author.

The authors wish to acknowledge the collaboration of Dr. Frederick N. Parris in the preparation of this work.

edly discouraged. If the prospective trainee chooses to disregard these recommendations, clearance from the therapist and the therapist's pledge of availability to the enrollee during and after the training is said to be required (2).

There is no formal follow-up procedure. Post-training contact by the est organization consists of telephone calls and mailings urging the graduate to return for continuing "postgraduate" seminars.

Our experience with the est program includes 7 cases of psychological distress temporally related to the training, 5 of which were included in our first report. This group of est trainees came to our attention through our work in a variety of emergency psychiatric settings. In addition, one of the authors of the first article (F.P.) personally completed the basic est training.

CASE REPORTS

Case 6. Ms. F, a 26-year-old single high school teacher, developed hyperphagia and an acute depression after the est training. The oldest of two children born to parents of Asian extraction, she has a master's degree in education and her brother has a bachelor's degree. Her father had a successful health food business and her mother increased the family fortune by investing wisely in the stock market. When Ms. F was 21, her mother died of gastrointestinal cancer. Ms. F had many friends while growing up and energetically involved herself in church activities during adolescence. She excelled in school. Neither she nor any member of her family has a prior psychiatric history.

When she was 24, a long-term involvement with a man floundered, and Ms. F enrolled in est in an effort to salvage the relationship. During the training, she recognized her pattern of being the "victim" in her relationships, a painful insight that shook her self-esteem. She could not "share" her discomfort with the group because she felt "the leader did not want to hear negative experiences," and "the group would not be supportive."

During the first weekend of the training, Ms. F began gorging and in the next month gained 30 pounds. After completing the training, she became "apathetic" and "lost interest" in life. She broke off contact with friends and moved back into her father's house. Her life became a drab routine of attending school and returning home to eat and sleep. She contemplated suicide intermittently (but made no attempts) and describes this period as "the worst time in my whole life." In an attempt to ameliorate her psychic distress, she took a postgraduate est course entitled "Be Here Now." This course intensified her depression and made her feel like

a "misfit" because she could not "get it."

Two months after the initial training and a total of 40 pounds heavier, she sought professional help and initiated twice-weekly psychotherapy. Five months into therapy, her depression began to clear, she began to lose weight, and she recontacted friends. Ms. F finished her master's degree and obtained work as a teacher. She is currently in uncovering psychotherapy twice weekly and continues her teaching career.

Case 7. Ms. G, a 24-year-old unemployed single woman, became confused, disoriented, and frightened immediately after the est training. This reaction improved spontaneously in a few days. Six months later during an est postgraduate seminar the patient developed delusional thinking.

Ms. G is the youngest daughter of an abusive alcoholic father; her mother, described as warm and loving, died when she was 11 years old and she was cared for by a series of foster parents until she was 18. Her two older siblings are both professionals. Although she was a poor student and a disciplinary problem, she graduated from high school. After graduation she worked intermittently as a cashier in a grocery store. Ms. G sporadically abused amphetamines while "dieting." She has no formal psychiatric history; her father was hospitalized several times for alcohol-related problems.

In the fall of 1975, after separating from a boyfriend, Ms. G enrolled in est to help her "communicate with people," "lose weight," and "pull out of a depression." On the last day of the second weekend of training, she became "confused" and was unable to locate her car without police assistance. Her confusion subsided in the next few days, but she felt inadequate and isolated herself from her friends. She did, however, reconcile with her boyfriend.

Five months later, Ms. G took the "Be Here Now" course. During the program, she felt "propagandized" and was bewildered by such statements by the trainer as "Let it be okay not to be something before you can be it." She stated that the concept, "talking in the back of my head," "blew my mind." During the training, her "thinking went wild" and she began "thinking about thinking." In the midst of the course she became delusional, thinking that she was the Virgin Mary, that the trainer loved her, and that Werner Erhard was inside her. Following the postgraduate est course, Ms. G became more isolated, her personal hygiene deteriorated, and she stopped doing housework.

Three months later she became preoccupied with est, isolated herself from her family, began staring into space, and heard voices. She had become convinced that Werner Erhard was inside her and that she was in communication with him. She was hospitalized at her community mental health center and treated with antipsychotic medication. During her 6-day stay, her behavior became more appropriate, but at the time of discharge, she continued to report occasional auditory hallucinations. Her discharge diagnosis was acute schizophrenic episode. She was referred for outpatient treatment with a recommendation that she continue taking haloperidol, 15 mg/day. Five months later she is able to work part-time, supported by antipsychotic medication and weekly psychotherapy.

RESULTS

Our population consists of the 5 cases reported in our previous article and the 2 presented above. Demo-

graphic characteristics and psychopathology are summarized in table 1. The average age is 30, and the group is nearly equally divided between men and women. Five individuals are Caucasian and two are of Oriental extraction, which is probably a reflection of the ethnic makeup of the San Francisco Bay area. Educational attainment of the group is above average, which is consistent with reports that est appeals to a more established, middle-class population than other popular psychological movements, which draw participants from the alienated subcultures.

Of the 6 patients who had clear psychotic episodes, only one had a history of psychosis. It is striking that the modal individual in our study was well educated and productive, with no history of treated psychiatric illness or hospitalization.

Five patients experienced schizophrenic episodes, 3 of the paranoid type and 2 of acute schizophrenia. The remaining cases were 1 first-break manic-depressive illness and 1 depressive neurosis. The severity of these difficulties is suggested by the diagnoses. The participants' subsequent courses (over a period of several months to 3 years) are consistent with those expectations. Only 1 patient has had no recurrence or evident impairment. The others have had marked constriction in life activities and/or relapses into psychotic states.

DISCUSSION

As we have stated previously, no determination can be made on the basis of our findings alone regarding the causation or frequency of associations between est and psychiatric morbidity. Nonetheless, we believe a discussion of possible etiologic mechanisms is warranted to aid clinical management and future systematic study. In this effort, consideration will be given to group and psychodynamic explanations.

Group Dynamics

The paucity of literature on complications of participation in large quasi-therapeutic groups necessitates a review of the relevant experience with encounter groups. Recognition of psychological injury to some participants of encounter groups led to the American Psychiatric Association task force report, *Encounter Groups and Psychiatry*. After outlining the shortcomings of research in this area, the task force concluded that

no generalization may be made save that, in the hands of some leaders, the group experience can be dangerous for some participants. The more powerful the emotions evoked, the less clinically perspicacious and responsible the leader, the more psychologically troubled the group member, then the greater risk of adverse outcome. (3, p 17)

More recently, Lieberman and associates (4) wrote a book-length prospective study of encounter groups, including a case-by-case analysis of the 16 individuals

TABLE 1
Characteristics of Seven Patients Who Developed Psychoses After est Training

Case Number	Age	Marital Status	Education	Psychopathology	Course
1	39	Married	College	Acute schizophrenic episode	No recurrence
2	26	Single	College	Schizophrenia, paranoid type	Constriction
3	28	Married	Postgraduate	Acute schizophrenic episode	Constriction
4	34	Married	College	Manic-depressive illness	Recurrences
5	30	Single	College	Schizophrenia, paranoid type	Constriction
6	26	Single	College	Depressive neurosis	Constriction
7	24	Single	High school	Schizophrenia, paranoid type	Constriction

in a sample of 206 who suffered significant psychological injury. While conceding that their methods clearly underestimated the number of casualties, the authors stated that "a casualty rate approaching 10% is alarming and unacceptable in an endeavor calculated to foster positive growth."

It is reasonable to assume that some awareness of the possibility of similar injury to participants in est's large-group experience led the organization to adopt the screening procedures described earlier. However, in our small sample, 2 individuals failed to meet the stated est screening criteria (case 5, Mr. E; and after the first episode, case 4, Ms. D) and either were not detected or not acted upon. No contact was made with either treating psychiatrist and no authorization from the physician was required for further participation in the est program. Thus profoundly disturbed individuals may not be excluded by the est screening procedure.

The lack of emphasis on screening is consistent with est practice, which provides essentially the same training experience for each new group without consideration of the specific psychological needs of the individuals enrolled. Fenwick (5) has pointed out that sophisticated assessment of individual psychopathology is beyond the competence and training of the est personnel; it is also outside the est value system, since the training is held to be almost universally beneficial. Fenwick also believes that "est uses techniques indiscriminately which, in a certain proportion of the population, are known to be harmful and potentially quite dangerous."

The est organization does not follow its clients in a manner that would mitigate the deficiencies of the screening process or attempt to rectify whatever disruption might result from the training itself. Several of our patients commented that the only further attention they received after the course was pressure and inducements to enroll in additional est activities.

Clearly, much of the toxicity of any injurious group

experience is determined by the approach and conduct of the leader.¹ Lieberman and associates (4) examined the contribution of the style of encounter group leaders to subsequent psychological injury of participants in the group they led and found that one leadership style was associated with a disproportionate number of the casualties and tended to produce the most severe injuries. These "Type A—Energizers" are intense emotional stimulators, most committed to an articulated belief-system and to the founder of their school of thought; they are highly charismatic, proselytizing, "religiostic," and intent on firmly directing participants toward "the road of salvation." Elsewhere, Yalom and Lieberman (6) have described these leaders as "aggressive stimulators—intrusive, confronting, challenging and authoritarian."

Although we did not observe the est trainers in the sessions our patients attended, information from our patients and other sources (5, 7) leaves little doubt that est leaders could be classed as Type A. This style so uniformly typifies the est trainers as to defy coincidence. Apparently this authoritarian, confrontational style is sought and developed to transmit the est message in an unmistakable and characteristic mode. However, this approach systematically replicates the leadership style with the greatest known capacity for

¹Reference to the encounter group literature may be helpful in understanding specific mechanisms of psychological injury to group members. Lieberman and associates (4) have identified five factors that resulted in casualties to encounter group participants: attack by the leader, rejection by the leader, failure to attain unrealistic goals, coercive group expectations, and input overload. Descriptions of their experience of the est process make it clear that all of our patients believed they were harmed in one or several of these ways. Indeed, attack and rejection by the est trainer occurs universally in the training process. While expectations (by the leader and the mobilized group of trainees) have been experienced as coercive, they are also contradictory and bewildering. The possibility of input overload is structurally enhanced by the marathon format aimed at overwhelming defenses by sustained pressure. Finally, the trainee's unrealistic goals are experienced as being simultaneously encouraged and disavowed by the leader.

psychological injury and exposes a virtually unscreened and highly stressed population to it.

Psychodynamics

Speculation about the psychodynamic mechanisms that might explain the major regressions seen in our cases can only be tentative, since our data are not based on long-term controlled study.

The est training is structured to promote regression. Oral intake, urination, and defecation are regulated by the trainers, as are motility and communication. This infantilizes the participants while elevating the leader to a position of omnipotence. Trainees deal with this regressive pull in a variety of ways. Some become observers and distance themselves from the process. Some submit passively. Others may question the process aggressively; the leader's response to their challenge is often delivered in an authoritarian, confrontational, and ridiculing manner that may produce anxiety, humiliation, and fear of future retaliation. Fear of the powerful leader is contagious and is enhanced by the agreed-to proscription against leaving the training room and by a mass psychology of ambivalent submission.

One mechanism of defense that may be used to handle anxiety aroused by forced submission to this powerful leader is identification with the aggressor (8), i.e., attempting to deal with the frightening dominance of the leader by becoming like him or her. However, the defensive identification with the aggressor, invoked to ameliorate the participant's anxiety, may also set up conditions that increase the likelihood of psychiatric disturbances. Shafer, in his definition of identification, says,

In its fullest, the process of identifying with an object is unconscious, though it may also have prominent and significant preconscious and conscious components; in this process, the subject modifies his motives and behavior patterns, and the self-representations corresponding to them in such a way as to experience being like, the same as, and merged with one or more representations of that object. (9, p. 140)

The experiences of merging with and being the same as an object are fundamentally primary process phenomena, while the experience of being like an object is essentially a secondary process phenomenon. Identifications are composites of both of these.

The conduct of the est training elicits conflicts over dominance and submission that often generate signal anxiety. In response to this signal, an identification with the aggressor is mobilized in addition to other characteristic defenses. Difficulties may occur when a participant whose ego boundaries are defective because of early problems with self-object differentiation identifies with and unconsciously experiences merging with the feared leader. This unconscious experience of merging may precipitate self-object confusion, fear of loss of the self, dissolution of the self, and concomitant

instinctual anxiety. In the face of the intensely and unselectively stressful est experience, the identification with the aggressor fails to contain the signal anxiety and paradoxically leads to what may be termed a pathological identification. Psychotic symptoms (alterations in ego functions, delusions, and hallucinations) are then mobilized to prevent the emergence of overwhelming id anxiety (10).

Evidence for a universal (and not necessarily pathogenic) identification with the trainer may be inferred by observation. During the two-weekend course, the trainees' style of dress often begins to mirror the characteristic open-collar style of the leader (2). The est terminology enters the graduate's vocabulary, and graduates often are identifiable outside of the training by virtue of their aggressive, stiffly self-confident, and proselytizing manner.

Examples of a more pathological identification with the aggressor include Mr. B (case 2 in our first paper), who, after taking the trainer's seat on the stage, experienced dissolution of the self, overwhelming anxiety, and subsequent delusions and hallucinations. Ms. D (case 4) felt she was the unacknowledged "other half of Werner Erhard." In case 7, Ms. G's pathological identification was probably associated with fantasies of incorporating the leader.

We have postulated that an overdetermined and pathological reliance on identification with the aggressor is central to the production of psychiatric casualties among est participants. How then would one account for positive outcomes, i.e., those people who report major improvements in emotional well-being and adjustment after est? (We assume that such improvements may occur, even after placebo-effects and other artifacts are considered. A determination of the frequency, extent, and duration of such changes transcends our data.)

We believe the same elements to be at work, but in a more favorable climate. An individual may have contact early in life with a threatening and ambivalently held object, without being as intensely traumatized as we speculate our est casualties were. Their earlier relationships may have been less noxious because the object was not as intrusive or menacing, or the contact may have been moderated by circumstances, e.g., availability of other need-satisfying objects or later or briefer exposure to the ambivalently valued and powerful object. In such a manner, the individual may retain some identification with the powerful object without being as inclined to fuse with him. In the setting of the est experience, a regression may occur that does not threaten ego-integrity but does provide the opportunity for an integration of the old introjects and a mastery of this early trauma.

CONCLUSIONS

Seven cases of psychological complications associated with exposure to est have been presented and

discussed. The nature of our material does not permit generalization with regard to causality and rate of occurrence. However, the group and psychodynamic explanations we have presented may, if substantiated by future systematic research, explain these findings. Specific consideration should be given to the potential significance of the leadership style of est trainers and the defensive maneuvers mobilized in trainees.

REFERENCES

1. Glass LL, Kirsch MA, Parris FN: Psychiatric disturbances associated with Erhard Seminars Training: I. A report of cases. *Am J Psychiatry* 134:245-247, 1977
2. Bry A: *est—60 Hours That Transform Your Life*. New York, Harper & Row, 1976, pp 39-66
3. American Psychiatric Association, Task Force on Recent Developments in Use of Small Groups: Encounter Groups and Psychiatry. Task force report 1. Washington, DC, APA, April 1970
4. Lieberman MA, Yalom ID, Miles MB: *Encounter Groups: First Facts*. New York, Basic Books, 1973, pp 167-210
5. Fenwick S: *Getting It: The Psychology of est*. Philadelphia, JB Lippincott Co, 1976, pp 13-114
6. Yalom ID, Lieberman MA: A study of encounter group casualties. *Arch Gen Psychiatry* 25:16-30, 1971
7. Leo J: *est: There is nothing to get*. *Time Magazine*, June 7, 1976, p 53
8. Freud A: *The Writings of Anna Freud, vol 2: The Ego and the Mechanisms of Defense*. New York, International Universities Press, 1966, p 116
9. Shafer R: *Aspects of Internalization*. New York, International Universities Press, 1968, p 140
10. Arlow JA, Brenner C: *Psychoanalytic Concepts and the Structural Theory*. New York, International Universities Press, 1964, pp 144-178