FROM

Cult Recovery:
A Clinician's Guide to Working with Former Members and Families
(pp. 215-240)
Published by International Cultic Studies Association (ICSA), 2017
Posted online with permission of ICSA

THE ROLE OF SELF-CARE IN CULT RECOVERY: ISSUES FOR PRACTITIONERS, MEMBERS, AND FORMER MEMBERS OF CULTIC GROUPS AND THEIR FAMILIES

Linda Dubrow-Marshall and Rod Dubrow-Marshall

Although the need for psychoeducation to play an important part in helping former members of abusive groups or cults[1] to recover from any harmful effects of their group involvement has been widely accepted (Langone, 1995), less attention has been given to the issue of self-care. Self-care has been widely discussed in medically related professions without a precise, commonly agreed-upon definition (Gantz, 1990). The term *self-care* is commonly referenced in modern literature as a process of increasing the responsibility for health to the person, from the medical professional (Lorig & Holman, 2003), and focusing on self-management of illness/health (e.g., Stanford Medicine's [2016] Chronic Disease Self-Management Program).

Amongst mental health practitioners, increasing emphasis has been placed upon practitioner self-care as a requirement for ethical practice, as reflected in the professional ethical codes (BACP, 2016; HCPC, 2016; APA, 2010; & BPS, 2009), with the responsibility to monitor one's own fitness to practice and to take appropriate steps if one becomes impaired. The ethical code of the British Association for Counselling and Psychotherapy (BACP) defines care as "benevolent, responsible and competent attentiveness to someone's needs, wellbeing and personal agency" (2016, p. 3) as a key personal moral quality, and BACP includes self-care within the self-respect principle as an ethical responsibility. In a literature review by Carroll, Gilroy, and Murra (1999), four clusters of self-care for psychotherapists were identified: intrapersonal work, interpersonal support, professional development and support, and physical recreational activities. To appreciate the significance of self-care by those working to help people recover from the adverse effects of abusive groups and relationships, "a good metaphor to consider is how on airplanes, we are instructed to first put an oxygen mask on ourselves before tending to our children, which can sound counterintuitive until reflecting on it" (Dubrow-Marshall, L., 2011, p. 8).

In this chapter, we present an argument for including a focus on self-care in the treatment of people who are exiting abusive and coercive groups and relationships. We also expand upon this view to include the need for attention to self-care for practitioners working with this population, in that survivors of abusive groups and relationships present unique challenges and require specific responses, which can be exacting, and which go to the fundamental questions about the role of the therapist or mental health professional. We also focus on the families of current or former members of cults and abusive groups who may

[1] We use these and related terms such as *cultic* or *cult-like groups, undue-influence environments,* and *extremist groups* interchangeably throughout this chapter in reference to examples of a broad set of phenomena that have broadly similar characteristics (Langone 1995; Singer 2003).

neglect their own needs while trying to help their loved ones, and for whom self-care is a vital tool in their survival and ability to help their family members. We therefore make suggestions for strategies for self-care that can be used by former cult members, both first generation (recruited) and second generation (born or raised in the group); mental health professionals and consultants working with former members; and the often long-suffering family members.

Using a swimmer metaphor for how family members (or other helpers, including professionals) sometimes feel that they are drowning in their worries about their loved one, or how former members who felt that they lost themselves and were also drowning in the group/abusive relationship, we present the SWIMMER model for how to get through the challenges of recovery and self-care, incorporating the key concepts of **S**elf-care **W**ith **I**nformation, **M**anagement, **M**oderation, **E**mpathy, and **R**esources:

Cultic and Abusive Environments

A core element of the experience of involvement with a person or group that exerts undue influence upon an individual is that the needs of the individual become secondary to the needs of the controlling and dominating person or group. From clinical accounts, Singer (2003) outlined that a thought-reform program in typical cults included the following characteristics: development of dependency upon the group, alteration of world view, acceptance of a new version of reality and causality, conversion of the person into a deployable agent of the organization, and destabilization of the person's sense of self. This account of thought reform in cult-like groups or relationships builds on the seminal work of Lifton (1961), who set out eight themes that describe the psychological process of cult indoctrination that leads ultimately to the *dispensing of existence*. It is clear that, in the most extreme forms and for certain individuals, a total identification with and reliance on the cult is the mirror image of the type of self-care that is recommended for individuals in healthy organizations and relationships, often referred to in occupational psychology as *work-life balance*" (Wang & Verma, 2012), and *employee well-being* (Kossek, Kalliath, & Kalliath, 2012).

The concept that involvement in a coercive group or relationship could destabilize a person's sense of self is fundamental to understanding the deeper psychological challenges associated with helping former members to recover. Put in its simplest terms perhaps, there can be no self-care if there is no clearly delineated sense of self in existence to care about! In such a thought-reform scenario in cults (Lifton 1961, 2000; Singer 2003; Dubrow-Marshall, R., 2010), a person's worldview is so altered that the individual accepts a new version of reality and causality, and it is then possible to manipulate that person to believe that his personal needs are not important or are selfish, and that he will feel better by devoting himself fully to the needs of the leader or group. He will not perceive it to be important to get rest, sleep, food, and exercise if the person or group requires marathon sessions of him to work on assigned tasks. Personal educational and career goals are easily

subsumed in this scenario as being unimportant, selfish, unnecessary to fulfilling the group mission, or otherwise negatively labelled; these goals become superseded by the all-important needs of the group leader and its mission. The leader, group, ideology, and milieu are deemed to take precedence over individual—and as perceived in comparison—petty, even selfish needs. Thus, in Lifton's terms, it becomes possible for the individual to become a deployable agent of the group or leader. Self-esteem becomes replaced by a vicarious sense of esteem from group membership.

As the dependency upon the leader or group, or both, assumes paramount importance, the person's sense of self is eradicated or compromised. This is particularly true for second-generation members who are immersed in the cultic environment during their formative years, and who are raised with demands of loyalty to the group taking precedence over personal and family members' needs. Indeed, second-generation members face unique problems when they are exiting their groups because they do not have a precultic identity to return to; and they often lack exposure to alternative points of view because many of the cultic environments were restrictive and may not even have allowed education outside the group or Internet access.

Totalistic Identity Theory

R. Dubrow-Marshall (2010) has advanced a totalistic identity theory to explain how the individual's broader self-identity (including interests and relationships) becomes completely dominated by the cultic group and is rendered largely inaccessible. R. Dubrow-Marshall cited self-categorization theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) as the basis for understanding the usual development of multiple aspects of self-identity, where self-categorization takes place at several levels in cognitive terms, and numerous categories are available to become salient, depending in part on the social context (*category fit*, as defined by Oakes [1987]). For example, at a superordinate level, people see themselves as human beings. At a group or basic level of categorization (Rosch, 1978), people identify with their job role, country, town, university, rugby or football team, and so on. At the personal level of categorization, people may self-categorize as a parent or a friend, with personal preferences and goals.

These various categories do not disappear for a person raised or recruited into a cultic or abusive environment, but the person's self-categorization becomes effectively stuck in one place, focused on the cultic-group category to the exclusion of other available self-categories. In this way, the cult identity becomes completely dominant within the person's cognitive repertoire of self-categories, and in a way that appears to relate to heightened levels of depression, dissociation, and anxiety in former members (Dubrow-Marshall, R., & Martin, 2005; Dubrow-Marshall, R., 2010).

Analogous Clinical Presentations of Totalistic Identity

It also is possible to apply the model of totalistic identity theory to people whose dependencies are on various addictive or obsessive-compulsive disorders, rather than on a leader or ideology. For example, Fairburn (2008), in his extensive collaborative research on eating disorders, documented how thoughts about shape and weight dominated a person's cognitive functioning and were seen as the most integral aspects of the person's self-worth. He recommended that psychotherapists help clients to broaden their self-view and worldview, and to reclaim their self-worth in a broad range of domains, such as achievements, family roles, and leisure activities. Strategies such as limiting the number of times to weigh oneself to a reasonable number for self-monitoring, perhaps once monthly rather than numerous times during the day, offered one step toward limiting the obsession with weight. Similarly, limiting the number of times of checking appearance in the mirror or otherwise checking body shape, such as by pinching body fat, had immediate benefits,

including freeing up additional time and thought capacities, and enabling the individual to begin to challenge the predominance of physicality in self-esteem.

Martin (1993) used a similar strategy in working with former members of abusive groups and relationships at the Wellspring Retreat and Resource Center, when he helped clients to look at their "slice-of-life pie" using diagrams to illustrate the dominance of cultic activity in their lives. Martin used good food, a comfortable place to sleep, and beautiful countryside, alongside their psychotherapy, to help clients to recover. We have loved visiting this peaceful site, complete with a wishing well, so symbolic of the potential to open up personal desires and wishes for the future free of abusive and unduly coercive relationships. Similarly, the annual International Cultic Studies Association (ICSA) Second Generation Adult (SGA) Workshop in Connecticut was deliberately planned to take place at a lovely rural retreat where SGAs would sleep in tasteful bedrooms and would be served delicious meals.

Ethical Principles Versus Abusive Principles

Various types of professionals help members and former members of cults to recover from their abusive relationships. These include mental health professionals from different disciplines (e.g., psychologists, counsellors, psychotherapists, social workers, family therapists) who are accredited, licensed, registered, or certified by a professional body, and therefore are bound to a code of ethics, which includes a procedure for client complaints. Other allied professionals who help current or former cultic group members and their families include thought-reform consultants, exit counsellors, mediators, spiritual/pastoral counsellors or leaders, and educators. These professionals also aspire to ethical practice, although they may not be governed by a regulatory agency. In this context, we use principles of sound psychotherapeutic practice, such as confidentiality, in this chapter as a model for all helping professionals.

An interesting feature not well known to the public is that the ethical codes of practice *require* that the professionals exercise self-care. Again, in line with our main focus in this chapter, we suggest this model of professional conduct as a good model for all those working with current or former cult members and their families.

The voluntary or regulated adherence to a code of conduct and a means for addressing complaints are core features that distinguish professionals from cult leaders and their acolytes, who cannot usually be held accountable to a regulatory or professional body (with the exception on occasions of psychotherapy groups, as outlined in Dubrow-Marshall, L., & Dubrow-Marshall, R., 2007). This principle has major implications for the human rights of current group members. For example, people are often influenced to reveal highly personal information in both cultic and abusive groups and psychotherapy or other helping interventions, but the various codes of conduct adhere to the common principle of confidentiality in the latter. This means that sensitive and personal information is stipulated in psychotherapy and other helping interventions, so as to be used in an effort to help the clients and *not* be used against them to cause harm. Cultic and abusive groups have been noted to violate confidentiality both by sharing personal information with the group at large and also in a sinister way of blackmailing people by threatening to reveal confidential information if those individuals exit the group. This phenomenon can occur more often amongst people who were high up in a cultic organization before they exited, and who therefore were privy to information about the group practices that the group does not want revealed.

The American Psychological Association's Ethical Principles

The American Psychological Association's (APA's) (2010) Ethical Principles of Psychologists and Code of Conduct is useful as an example because it has been widely emulated in other

professional groups internationally as a basis for other codes, having been first published in 1953. This document includes a range of well-worded principles that support human rights, and the General Principles section includes Beneficence and Nonmaleficence ("Do no harm"), Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity.

This document could arguably be the perfect blueprint for human-rights principles that guide the treatment of individuals in any group, organization, or relationship! We were members of a task group that attempted to get the British government to consider requiring an ethical code for all people who purport to help individuals, in an effort to hold cultic groups accountable in the same way that professions and businesses (with health and safety law) are, but this has not yet happened.

Following are a few examples from the APA code that illustrate sensitivity to the dynamics of undue influence:

- Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making (Principle E, p. 4).
- Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. *Psychologists strive to be aware of the possible effect of their own physical and mental health* on their ability to help those with whom they work (Principle A, p. 3, italics added).
- Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence (Section 5.05, p. 8).
- Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients (Section 3.08, p. 6). [Examples are multiple relationships, fees and financial arrangements, and sexual relationships.]

Significantly, both the APA and State licensing boards have procedures for reporting ethical violations, and psychologists are held to account and can lose their ability to continue their practice if they are found guilty of serious ethical violations. This standard is also true for the other professions that are regulated by the government.

When it comes to fitness to practice, the APA Code, Section 2.06 (p. 5) states:

- Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
- When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties.

It is noteworthy that the responsibility for fitness to practice extends to when psychologists *should* know when their personal problems will interfere with their work. In this regard, the APA Practice Organization (2009) has advocated a proactive approach to psychologists making an action plan for self-care.

The British Psychological Society Code of Ethics and Conduct

The British Psychological Society (BPS) (2009) similarly acknowledges the need for psychologists to "monitor their own personal and professional lifestyle in order to remain

alert to signs of impairment" (Section 2.4, p. 17). Helpfully, the BPS offers a preventative strategy when it states, "Reflective practice, peer support and transparency of professional activity would prevent problems occurring or developing into serious concerns" (Section IId, p. 7).

The BPS has recently launched a Charter for Psychological Staff Wellbeing and Resilience (BPS, 2016) based on a staff well-being survey that showed increasing amounts of stress and depression when compared to a similar survey in 2014. Thus, the BPS has taken a proactive approach to assisting psychologists in their self-care and well-being (Kinderman, 2016).

The Health and Care Professions Council Standards, United Kingdom

The Health and Care Professions Council (HCPC) regulates the practice of 16 professions in the United Kingdom, including practitioner psychologists, social workers, arts therapists, occupational therapists, and paramedics, and the Council publishes *Standards of conduct, performance and ethics* (2016) that apply to all of these professions. The standards include guidance on managing risk, which stresses that, "You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible" (p. 8). It also includes the self-care imperative that "You must make changes to how you practise, or stop practising, if your physical or mental health may affect your performance or judgement, or put others are risk for any other reason" (p. 8).

The Council considers concerns about fitness for practice that are raised by any member of the public, and it defines being fit for practice as having "the skills, knowledge, character and health they need to practise their profession safely and effectively" (2016, p. 11).

In the Standards of Proficiency that the Council developed specifically for Practitioner Psychologists, it implores that psychologists must "understand the power imbalance between practitioners and service users and how this can be managed appropriately" and "be able to recognise appropriate boundaries and understand the dynamics of power relationships" (2015, p. 7)—standards that stand in direct opposition to the abuse of power relationships usually found in cultic groups. Regarding fitness for practice, psychologists must "be able to manage the physical, psychological and emotional impact of their practice" (2015, p. 8).

The British Association for Counselling and Psychotherapy Ethical Framework for the Counselling Professions

Whereas the health and care professions legally regulate the practice of practitioner psychologists, the BACP maintains a *voluntary* register for the counselling professions. The BACP implemented a new Ethical Framework for the Counselling Professions in July 2016, which was a major revision of its previous ethical frameworks, based on extensive consultation with members and other stakeholders (Reeves, 2016). A significant change was that, instead of just applying to counsellors and psychotherapists, the counselling professions broadened the applicability of their standards to further include coaching and pastoral care, and the use of counselling skills in other contexts, and to include associated roles in supervision, education or training, management, and research (BACP, 2016, p. 5). Importantly, the revision included Good Practice in Action resources (BACP, 2016). As previously mentioned, we worked on a task group to broaden standards of care and accountability to include all people who purport to help individuals. A voluntary register of such people would be a good beginning step, and the BACP *Ethical Framework. . .* could serve as the standards for such a register.

Although the BACP *Ethical Framework. . .* emphasizes that practitioners "put clients first by making clients our primary concern while we are working with them" (2016, p. 1), at the same time it stresses the importance of "ensuring that our wellbeing is sufficient to sustain the quality of the work" (2016, p. 1). In common with the other professional codes, this framework cautions practitioners not to exploit or abuse clients and usefully requires "listening out for how clients experience our working together" (2016, p. 1). The values include "Facilitating a sense of self that is meaningful to the person(s) concerned within their personal and cultural context" (2016, p. 2), which is helpful to consider in fostering self-care of former members.

The BACP *Ethical Framework*. . . (2016, p. 13) delineates self-care as consisting of

- taking precautions to protect our own physical safety;
- monitoring our own psychological and physical health;
- seeking professional support and services as the need arises; and
- keeping a healthy balance between our work and other aspects of life.

A difference between practice in the United States and in the United Kingdom is that British practitioners are required to undergo monthly supervision of no less than one and half hours, whereas American practitioners are only encouraged to seek supervision and consultation as appropriate. Savic-Jabrow (2010) surveyed British independent practitioners to determine where they received their support for self-care, and the results indicated that the primary source of support was supervision. Similarly, the APA Practice Organization published an Action Plan for Self-Care (2009) in which a survey was reported which found that the most frequent response by therapists to problems in functioning was to talk to a colleague. In an analogous fashion, it can be argued that concerned families should seek support from peers or professionals or both, not only for the sake of their loved one, but also to help them maintain their own self-care and well-being.

Self-Care and Fitness for Professionals: A Model for People Affected by Cultic Influence and Those Attempting to Help Them

It is against the backdrop of these well-crafted ethical principles that the direct imperative for self-care and the obligation for demonstrable fitness to practice emerge. In contrast, the value of self-care would not fit in an environment where people abuse, manipulate, and exploit unequal power relationships, as in abusive cults or relationships.

We have described the ethical codes in detail because of the sharp contrast between them and abusive practices in highly manipulative cultic environments. At the right time—that is, when former members show readiness and interest in learning about healthier environments so that they can understand the impact of their experiences, they might find the ethical codes, and also information about healthy work environments and work-life balance, informative. Before then, mental health professionals would hopefully be adhering to these ethical principles overall; but they may not necessarily be focusing on self-care specifically because they may be working in a more intensive manner with former members and families (e.g., extended sessions, information seeking outside of the sessions). As such, mental health professionals should be reminded of the obligation for self-care at all stages. Likewise, it may be a fruitful metaphor for family members to think of themselves as helping professionals, and to adopt the commitment to self-care as part of their overall strategy.

In this spirit, we will now look at more guidance about self-care that has been offered to mental health professionals, followed by elucidation of the proposed specific SWIMMER model of self-care for former members, families, and professionals.

Self-Care Guidance for Professionals

Increasing guidance to mental health professionals about self-care is being offered. This is the result of observations that, although they are mandated to take self-care seriously and to monitor themselves for fitness to practice, mental health professionals do not necessarily practice what they preach, despite their attention to helping their clients to achieve better mental health and quality of life, including self-care (Weir, 2016). John Christensen, who was cochair of the APA Advisory Committee on Colleague Assistance, reflected that "Health is on a continuum, with well-being at one end and burnout at the other. And most of us, during a professional career, slide back and forth on that continuum depending on what's going on in our lives" (quoted in Weir, 2016, p. 44). Christensen further pointed out that psychologists might have a "false sense of invulnerability" (also in Weir, 2016, p. 44) similar to the concept of the "myth of the invulnerable psychologist" (Norcross & Barnett, 2008, p. 25). Clinicians working with former cult members will particularly benefit from a sense of humility and a realistic appraisal of their own limitations to counteract this potential tendency toward a false sense of invulnerability. Many cultic groups are led by *traumatic narcissists* (Shaw, 2013; 2014), and therefore it is imperative that clinicians provide a corrective experience in psychotherapy without abusing their perceived authority and power by engaging in a more genuine relationship with vulnerable people. The therapists' own vulnerabilities can be contrasted with the sense of grandiosity of cult leaders, and also that of some former cult members who have bought into the idea of the grandiosity of the group and its mission. Clinicians can serve as role models for self-care by protecting themselves with realistic work hours and vacation periods, check-ins with supervisors or peers, and by recognizing that they may need to return to therapy. Good therapists recognize that they have vulnerabilities and blind spots and, in contrast to the perceived infallibility of many cultic leaders, they apologize when they realize that they have made mistakes.

Some of the research-based strategies for self-care and work-life balance that have been suggested for mental health professionals with the potential to help former cult members, their families, and therapists have included practicing mindfulness; using positive psychology (e.g., expressing gratitude), positive reframing (looking for silver linings), and social support; seeking good supervision and consultation; staying active; going outside and appreciating nature; and finding a sense of meaning or spirituality (Weir, 2016). Specialist supervision and consultation with cult-aware professionals enhances self-care for both therapists and family members by providing understanding and empathy with an appreciation for the special challenges of supporting former cult members.

The Foresight Project (Aked, Marks, Cordon, & Thompson, 2008) examined evidence-based interventions for improving well-being, including ones based on positive psychology. The Project identified "Five ways to wellbeing: Connect, Be active, Take notice, Keep learning, and Give" (introductory content, p. 3), which was intended to be a simple way for people to remember some self-care strategies. The authors prepared cards for public distribution with these suggestions, and former cultic group members, family members, and helping professionals could use such cards or electronic notes with the reminders, which have been suggested as an accompaniment to the nutritional advice for five a day (vegetables and fruit).

As another example, facilitators of the ICSA SGA Workshop established a Game Night, whose purpose was to give participants a sense of the importance of simply enjoying life. Recovery is enhanced through self-care and having fun, which is a stark contrast to life in the cults, which emphasizes work over recreation, and where life is often taken very

seriously, with little respite. SGAs with whom we have worked have often reported missing out as children on recreational activities such as watching cartoons and humorous films, and they have had to learn to give themselves permission to laugh out loud.

Norcross and Barnett (2008, p. 26) have offered 12 self-care strategies for psychologists:

- Valuing the person ("make self-care a priority, not an indulgence," and use writing to help self-monitor vulnerabilities and sabotages)
- Refocusing on the rewards (make an effort to express gratitude)
- Recognizing the hazards (accept the stressors; cultivate self-empathy)
- Minding the body (focus on exercise, nutrition, rest, contact comfort)
- Nurturing relationships (nurture a support network)
- Setting boundaries (maintain boundaries between self and others, and between personal and professional life)
- Restructuring cognitions (monitor internal dialogue and set realistic expectations)
- Sustaining healthy escapes (incorporate days off, play activities)
- Creating a flourishing environment (determine "What is unsatisfactory and what can be done?")
- Undergoing personal therapy (sustain support and self-development activities)
- Cultivating spirituality and mission (combine your vocation with personally meaningful activities, which might include activism)
- Fostering creativity and growth (practice self-renewal)

Former members of cult-like groups may find it hard not to view self-care as a selfish indulgence that is bereft of the formerly all-consuming and more important world-changing group mission and identity. Psychotherapists can help them to rebuild a sense of self that supports their individual needs for nurturance and well-being, particularly if the psychotherapists are also seen to be following this advice themselves. Recognizing the hazards for former members of high-demand groups might include recognizing triggers that pull them back into their less critical way of thinking that was evident in the group. Restructuring cognitions can be achieved through the application of cognitive-behavioral techniques (Greenberger & Padesky, 2016), and therapists can also benefit through cognitive-behavioral self-reflection and self-practice (Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015). Family members also can profitably use cognitive-behavioral approaches to help fend off the depression and anxiety that frequently accompany having a family member in a destructive group. Cultivating spirituality and mission is often demonstrated by former members and families who share their experiences and try to help others, publicize the unethical practices of the cult, or advocate for legal action. Creativity and growth have been viscerally demonstrated in the ICSA conferences through the Phoenix Project, led by Diana Pletts (2015).

A former cult member who we helped was triggered by any group activities and found it difficult to attend staff training days after he had found employment, particularly if the training included any self-awareness exercises. His group experience had used marathon confessional sessions in which people publicly exposed the "abuses" of their childhood and were encouraged to express rage toward their parents by pounding on pillows. We guided the client to give himself time to adjust to the social demands of his employment, and to limit his sharing of deeply personal experiences with the group, keeping the sharing on a shallower level so he could maintain a sense of safety and self-integrity.

We also have helped parents to examine their irrational beliefs about their loved one's involvement in a cultic group, which have included

- I have not been a good enough parent or my child would not have joined a cult.
- I cannot share my estrangement from my child with others because they will know what an inadequate/bad parent I have been.
- No one will possibly understand what I am going through.
- My child is not speaking to me now, and therefore I know that she will never speak to me again.

When an empathetic and supportive therapeutic relationship has been established with families, including the sharing of experiences of other (anonymized) families, family members can be gently guided to challenge these irrational beliefs and to consider alternative healing beliefs.

Clinicians working with former cult members and their families can benefit from the self-care suggestions offered generally for practitioners. Professional ethical guidelines have emphasized the importance of self-awareness and self-monitoring as a fundamental tenet of self-care; Ricky Greenwald (2005) has suggested the following questions for a self-care check-in:

When is the last time that you. . .

- Got what you consider a good night's sleep?
- Spent quality time with a friend?
- Did your favorite kind of exercise?
- Had time to yourself when you didn't have to take care of others?
- Put food into your body that you consider nutritious?
- Spent quality time with your romantic partner or a family member?
- Left work on time or early, even though there was more to do?
- Took time for a meal without doing something else at the same time?
- Talked to a supportive colleague about challenges in your work?
- Did something you really enjoy doing when you have the time? (pp. 50–51)

Greenwald (2005) recommended that self-care strategies cover the areas of nutrition, exercise, sleep, substance avoidance (given that many people turn to substances to avoid painful feelings), stress management, social support, and time away/refreshing activities. He advocated asking the following questions as the basis for devising a self-care plan:

- What one self-care practice do you feel that you should be doing, and that, realistically, you can actually do?
- What's your next step? Start small, with one realistic example of the desired behavior.
- How will you do it? What day, what time, what place, what action?
- What are the obstacles? What could keep you from doing it?
- How will you handle this to keep yourself on track? (p. 52)

Of course, if people are distressed, it may feel like a burden to try to take on a self-care plan or to adopt self-care strategies because they may already feel overburdened. Then, it

is wise to think about how to incorporate self-care strategies in a way that is nurturing and might even free up energy and resources for other areas of difficulty. For instance, Sandra Lewis recommended, "Find self-care strategies that you can integrate in rather than add on," and she recommended focusing on personal energy management rather than time management because "If you have enough energy, you make better use of your time. In the same way we charge our cellphones, we need to charge ourselves" (quoted in Weir, 2016, p. 46).

Psychological factors also can get in the way of self-care and can sabotage efforts for well-being. L. Dubrow-Marshall (2010) has recommended being mindful if the following beliefs start to interfere with self-care:

- I do not deserve self-care.
- I am not responsible for my own self-care.
- I can afford to skimp on my self-care when other matters are more pressing.
- It is more important for me to take care of others than myself, especially when other people's needs may seem so pressing.
- External factors will not allow me to take care of myself. (p. 15)

These beliefs, including those that are the result of cultic group indoctrination, might represent irrational thinking and can be sensitively challenged by deploying the self-care strategies as outlined previously. It can also be helpful to discuss the beliefs openly with other people who can help to offer counterstatements that are supportive of self-care.

The SWIMMER Model: Self-Care for Former Members, Families, and Mental Health Professionals

People coming out of cults, family members, and the mental health professionals who assist them all face distinct challenges to self-care. Cultic groups foster the sacrifice of personal goals and relationships for the sake of the leader/group/cause, and cultic environments are often neglectful or abusive in relation to self-care. Former members may have to radically change their beliefs and self-identity to be able to accept the validity of, and to feel deserving of, self-care. Because they are used to responding to group pressure and undue influence, they may feel a lack of responsibility for themselves and hold the belief that they should skimp on their own needs for the sake of the cult. Therefore, mental health professionals and family members should not expect former members to suddenly and completely embrace the value of self-care. Probably the best place to start is by offering these former members the precious commodities of rest and sleep, nutritious food, peaceful surroundings (nature), and time for themselves (as Martin and colleagues at the Wellspring Retreat and Resource Center illustrated in practice).

Family members and mental health professionals can be powerful role models for self-care, and they also need to tackle their own irrational beliefs, such as "I can afford to skimp on my self-care when other matters (e.g., my family member being in a cult) are more pressing"; "It is more important for me to take care of others than myself"; and "External factors will not allow me to take care of myself." An additional problem arises for family members who may neglect tending to the emotional needs of siblings of the cult member, themselves, and their marital relationship while they focus their primary attention on the cult member. The other siblings may suffer, as has been observed in families in which parents may feel compelled to devote unequal attention to particular siblings for other reasons, such as when one child is physically ill (Hodges, 2016). Brody (1998) noted that discrepancies in parents' treatment of their children can lead to sibling rivalry and anger, and is often associated with marital discord. Another challenge is that family members may

disagree amongst themselves about the extent of harm the family member's cultic involvement is causing, and this can on occasions contribute to a marital rift.

The term *compassion fatigue* has been used by Figley (2002) and others (Beaumont, Durkin, Hollins-Martin, & Carson, 2016) to describe *caregiver burnout* in relation to psychologists, counsellors, psychotherapists, and other professionals. Many mental health professionals working to help former cult members were themselves members of destructive groups, and they may be triggered and suffer flashbacks, countertransference issues, and other symptoms of post-traumatic stress disorder by hearing experiences similar to their own. For example, one countertransference response might be that they might overly identify with the cult member or situation at hand and feel the need to rescue. They may respond to "emergency" calls by family members who feel that an intervention must be done imminently, so they work extra hours to try to respond to this concern, even in circumstances in which it would be wiser to wait, to more thoroughly plan an intervention. In addition, they may be harassed by the cultic group if they become known as someone who is helping former members to exit the group.

For these reasons, the first task in self-care is to fully embrace and value the need to take care of oneself. If it is not possible to achieve this, sharing the experience with supportive people, including colleagues, can be extremely helpful in validating the need for self-care. For families and mental health professionals, it may be useful to remember the analogy from the airlines about putting on one's own oxygen mask first. And for a former member, it may be important to begin with a reexamination of the person's identity and close attention to personal physical or psychological needs that the individual may have neglected, and that may help him to think more clearly once he has achieved a greater degree of self-care and self-nurturance.

Information Management

With the availability of information about cultic groups through books, journals (e.g., the *International Journal of Cultic Studies*), and websites (including www.icsahome.com), family members are often fairly well educated about cultic processes and sometimes even the specific group their loved one is involved with before they seek help from mental health professionals or others. It is not uncommon for them to eagerly want to share this information with their family member, assuming that just doing so will help their relative to exit the group. This information also can be overwhelming for families or for cult members: Families may become increasingly distressed and believe that they must take immediate action, although cult members have often been given counterarguments by their cultic group, and their critical thinking has been impaired by being in an environment with an oversimplified worldview and strict rules for behavior. Additionally, their emotional attachment to the group/leader/mission may preclude former members from being open to criticism. These issues demonstrate the importance of information *management* as a means of self-care, particularly for members and their families.

Information should be shared with cult members when they show an openness to this information, and not before, although hints or seeds can be planted as a means of piquing their curiosity. Mental health professionals can prepare families on how to observe their family member, to look for signs of openness to information while paying attention not to overwhelm them. Family members themselves can also become overwhelmed by the amount of information and may not be able to tell the difference between accurate and inaccurate information. Both mental health professionals and other people with similar experiences can help family members to manage the information uptake. We have helped family members to selectively choose the most appropriate books and articles to read, including materials from the cultic groups (which can be deeply disturbing to them), and to discuss these materials in subsequent sessions to see whether they are understanding

important points or are focusing on unnecessary or irrelevant details. Publications on the ICSA website also have served as a good starting place for people to become informed about psychological processes involved in cultic recruitment and membership.

It is also critical for mental health professionals who are working with former members and their families to have accurate and sufficient information about the psychological processes of mental manipulation, coercive control, power dynamics, and attachment issues, and to obtain specific information about the group where that is possible. (Sometimes it is possible to be effective without knowing about the specific group because this information is not always available, particularly if it is a small family, or one-to-one cultic relationship.) At the same time, the mental health professionals should be mindful not to neglect their self-care because they think they must collect all the available information; usually, a critical mass of information is sufficient to inform their work appropriately, and the quantity of what information they share can grow during the client relationship (with input from the client, other professionals, and other former members and their families).

Moderation

We have already given examples in the previous section that illustrate how family members can give a moderate response to their relative rather than overwhelming them with negative information about the group. Moderation therefore is also a potentially a helpful self-help strategy in relation to emotions as a means of dealing with fears, anxieties, and very challenging situations. This means trying not to panic about a loved one's involvement in an abusive situation, and developing patience and faith that there will be more than one opportunity for the person to exit. Reading accounts of people who have left groups after many years should also be reassuring.

Harm reduction, developed in the field of addictions (Daley & Marlatt, 2006, Tatarsky & Marlatt, 2010), is another useful moderating therapeutic model that can be applied to cult recovery. Although abstinence from an addiction might be the best overall goal, it might not be achievable for all addicts; and if behaviors can be modified that reduce harm, this can represent a significant improvement. Harm-reduction models have led to programs that offer hygienic needles to addicts, or in which a person works in counselling to avoid driving while drinking, both of which are potentially life-saving interventions. In work with former cult members, it is similarly important to try to reassure families that they are making progress when their loved one is still involved in the group's activities, but perhaps moves out of the community or starts to show an interest in nongroup activities as part of a slower transition out of the group. For example, one family continued to feel very depressed about their daughter's involvement in a cult, even after she and her husband decided to move away from living with the group and to try to have a child, which was actively discouraged by the high-demand group. The parents were helped to see that these steps represented important progress in their daughter's moving away from being dictated to by the group, a reduction in harm and a movement toward autonomous thinking and decision making.

Moderation is particularly pertinent to self-care because a sense of balance is of critical importance to well-being. Weir (2016) cites research to help psychologists strive toward balance and equilibrium. Suggestions to exercise, for example, should not be taken to the extreme. When people leave a cultic group, they experience a profound transition, as do their families and communities in reintegrating them, and this transition has to be done at a reasonable pace, which is not to be determined by any formulas, but with individual characteristics as the guiding principle.

L. Dubrow-Marshall (2011) advocated for moderation within social supports by fostering relationships

> . . .across a spectrum, from superficial to intimate. It is helpful to have friends with whom we do not disclose deep private thoughts and feelings, but instead focus on shared activities and having fun. It is important to have some sense of community and belonging, so it is useful to spend some time in groups—whether these are activity based, volunteer work, spiritually based, or groupings of family and/or friends. (p. 10)

L. Dubrow-Marshall also suggested having someone to share one's deeper self, even if one does not have an intimate partner. She further noted that counsellors might be suffering from compassion fatigue and not feel like talking to anyone, and similarly that family members and former cult members may feel reluctant to open up to others for fear of being judged and shamed (2011).

Empathy

The most important aspect of empathy in relation to self-care is the development of self-empathy. Family members are often blamed by uninformed members of the public, who think there must have been something wrong in the family of origin for someone to join a cultic group. People who have been recruited into a cult are often judged as being somehow inadequate or foolish for having been deceived by people in a cult. Second-generation cult members may never have had a good example of empathy provided to them because their group may have been highly critical and demanding throughout their lives. A good strategy for developing self-empathy is to take yourself out of the story and imagine that it has happened to a friend or acquaintance, and then to ask how you would feel about that person. This change in perspective can change your emotional response to a much more tolerant and empathetic view.

Feddes, Mann, and Doosje (2015) evaluated a resilience training program for adolescents designed to help them strengthen self-esteem, increase agency, learn how to take different perspectives, and develop empathy; the researchers found the training was effective in reducing positive attitudes toward ideology-based violence and therefore had a potential to prevent violent radicalization. This is an intriguing example of the possible benefits of increasing empathy.

In first-generation cases, empathy from the family toward the cult member based on an understanding of the psychosocial forces at work in undue influence can help to reduce feelings of anger toward the person and to reduce any feelings of self-blame, thereby having the added benefit of adding to self-empathy. In a similar manner, as the member goes through the process of leaving a group, she may develop empathy toward her family members and the difficulties that they experienced as a result of her cult involvement; as she sees these difficulties through the perspective of her family, she may come to appreciate the damage that they experienced and to feel increased self-empathy.

In second-generation families, empathy toward family members who have remained in the group may develop as former members learn about the dynamics of cult recruitment, which may further lead to an increased appreciation of what they have experienced as a result of the group involvement. Despite this knowledge, SGAs may have difficulty with the concept of forgiveness and self-forgiveness after having grown up in an unforgiving, harsh, cult environment. In circumstances where learning to forgive is very hard for SGAs, overcoming a reluctance to forgive may need to be a focus of therapeutic work. It should be noted that SGAs have reported some situations that were so egregious that they would rather not forgive (see "Helping First-Generation Parents and Second-Generation Children Heal the Impact of Cult Harm," by Lorna Goldberg, p. XX).

Resources

Former cult members, families, and mental health professionals have numerous resources available to them to help them to cope with the effects of the cult involvement on themselves or the person they care about. We have focused in this chapter on the need for self-care, wherein meeting other people who have been through similar situations can be very nurturing, or reading about cultic influence or self-care in general can be very helpful.

L. Dubrow-Marshall has offered self-care workshops at ICSA conferences and events. A film of one of these workshops is available on the ICSA YouTube channel at https://www.youtube.com/watch?v=nGzsDpTUF0k

L. Dubrow-Marshall also has advocated that family members consider what they have done that they might feel proud of during their time of difficulty in dealing with a relative being in a cultic group, and that they consider the following questions:

- How much have you grown as a result of your difficulty?
    - New perspectives on life?
    - More compassionate?
    - More grateful?
    - More sensitive?
    - More patient?
    - More tolerant?
- How has the difficulty positively affected any of your relationships?
- Have any of your relationships been strengthened in any way?
- Have you become closer to anyone, more intimate, more supportive?

These are all examples of using a positive psychological approach to reframe difficult and negative experiences in an attempt to be resilient and move forward (Grenville-Cleave, 2016; Ivtzan, Lomas, Hefferon, & Worth, 2015; Joseph, 2015; Seligman, 2003). It is useful to

- develop a repertoire of resources, including supportive people, nurturing activities, self-soothing strategies;
- develop a sense of balance and moderation;
- practice positive affirmations to be part of a self-care plan that can be applied to former cult members, their families, and all those who try to help them; and
- to consider that, as the professional organizations have stressed, to care for oneself is an ethical responsibility.

In Conclusion

The self-care strategies we have outlined in this chapter for members and former members of high-demand or cult-like groups, their families, and those who help them, including mental health professionals, are in many ways the antithesis of the undue influence and lack of positive personal self-regard that is commonly evident in cults and with harmful psychological effects (R. Dubrow-Marshall & Martin 2005, 2008). Self-care is therefore posited and also evidenced as a crucial part of the recovery journey for former cult members, and is cited as an equally important component of the vital work of family members and helping professionals in their respective roles. In these ways, and for the

person emerging out of a totalistic group environment, the unconditional positive self-regard and care for self stands in stark contrast to the all-consuming demands of the group that are never ending. For the survivor of abusive groups or relationships, the journey to authentic relationships is sometimes a long one, which can at times also appear to be without end. The role of mental health and other professionals is therefore vital in gradually showing these individuals that self-care and care for others is both empowering and rewarding. In this way, these professionals serve as important role models as the survivors' trust in others is gradually restored.

Self-care, then, is a vital component for former cult members in building a healthy identity, step by careful step, without the mystical and revelatory promises so liberally vaunted and so little delivered in the cultic group. Hard as these small steps may be sometimes, as much for professionals as for cult survivors, they are agentic ways in which a nurturing and loving world can become a living reality, and in which care for self and others is paramount, authentic, and life affirming.

References

Aked, J., Marks, N., Cordon, C., & Thompson, S. (2008). Five ways to wellbeing: A report presented to the Foresight Project on communicating the evidence base for improving people's wellbeing. London, UK: The New Economics Foundation.

American Psychological Association (APA). (2010). Ethical principles of psychologists and code of conduct. Washington, DC: Author.

American Psychological Association (APA) Practice Organization. (2009). An action plan for self-care. *Good Practice,* Spring/Summer, 16–17.

Beaumont, E., Durkin, M., Hollins-Martin, C., & Carson, J. (2016). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: A quantitative study. *Counselling and Psychotherapy Research, 16*(1), 15–23.

Bennett-Levy, J., Thwaites, R., Haarhoff, B., & Perry, H. (2015). *Experiencing CBT from the inside out: A self-practice/self-reflection workbook for therapists.* London, UK: Guilford Press.

British Association for Counselling and Psychotherapy (BACP). (2016). Ethical framework for the counselling professions. Lutterworth, UK: Author.

British Association for Counselling and Psychotherapy (BACP). (2016). Good practice in action resources. Retrieved from http://www.bacp.co.uk/ethical_framework/newGPG.php

British Psychological Society (BPS). (2009). *Code of ethics and conduct.* Leicester, UK: Author.

British Psychological Society (BPS). (2016). Charter for psychological staff wellbeing and resilience. Retrieved from https://www.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/charter_2016.pdf

Brody, G. (1998). Sibling relationships quality: Its causes and consequences. *Annual Review of Psychology,* 49(1), 1–24.

Carroll, L., Gilroy, P., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. *Women and Therapy, 22*(2), 133–143.

Daley, D., & Marlatt, G. (2006). *Overcoming your alcohol or drug problem: Effective recovery strategies* (2nd ed.). Oxford, UK: Oxford University Press.

Dubrow-Marshall, L. (2010, May). Developing self-care: Small steps beyond "ticking boxes." *AUCC Journal,* 12–15.

Dubrow-Marshall, L. (2011, October). Healthcare professionals: Commission your own self-care quality! *Healthcare Counselling and Psychotherapy Journal, 11*(4), 4–11.

Dubrow-Marshall, L., & Dubrow-Marshall, R. (2007, May). *Undue influence in psychotherapeutic context: A case study of a psychotherapy cult.* Unpublished poster presentation at the Annual British Association for Counselling and Psychotherapy Research Conference, York, UK.

Dubrow-Marshall, R. (2010). The influence continuum—The good, the dubious and the harmful—Evidence and implications for policy and practice in the 21st century. *International Journal of Cultic Studies, 1*(1), 1–13.

Dubrow-Marshall, R., & Martin, P. (2005). *Building a model of post-group pathology in ex-members of cultic groups.* Unpublished manuscript presented at the Annual Conference of the International Cultic Studies Association, Universidad Autonoma de Madrid, Spain.

Dubrow-Marshall, R., & Martin, P. (2008). *Exploring and developing a model and theory of totalistic identity in ex-cult members.* Unpublished manuscript presented to the Annual Conference of the International Cultic Studies Association, University of Pennsylvania.

Fairburn, C. (2008). *Cognitive behavior therapy and eating disorders*. New York, NY: Guilford Press.

Feddes, A., Mann, L., & Doosje, B. (2015). Increasing self-esteem and empathy to prevent violent radicalization: A longitudinal quantitative evaluation of a resilience training focused on adolescents with a dual identity. *Journal of Applied Social Psychology, 45,* 400–411.

Figley, C. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433–1441.

Gantz, S. (1990). Self-care: Perspectives from six disciplines. *Holistic Nursing Practice*, *4*(2), 1–12.

Greenberger, D., & Padesky, C. (2016). *Mind over mood* (2nd ed.). London, UK: Guilford Press.

Greenwald, R. (2005). *Child trauma handbook: A guide for helping trauma-exposed children and adolescents*. Abingdon, UK: Routledge.

Grenville-Cleave, B. (2016). *Positive psychology: A toolkit for happiness, purpose and well-being*. London, UK: Icon Books.

Health and Care Professions Council (HCPC). (2015). *Standards of proficiency—Practitioner psychologists*. London, UK: Author.

Health and Care Professions Council (HCPC). (2016). *Standards of conduct, performance and ethics.* London, UK: Author.

Hodges, A. (2016). *The family centred experiences of siblings in the context of cystic fibrosis: A dramaturgical exploration*. PhD thesis, Cardiff University, UK. Retrieved from http://orca-mwe.cf.ac.uk/91005/

Ivtzan, I., Lomas, T., Hefferon, K., & Worth, P. (2015). *Second wave positive psychology: Embracing the dark side of life*. Abingdon, UK: Routledge.

Joseph, S., (2015). *Positive therapy: Building bridges between positive psychology and person-centred psychotherapy* (2nd ed.). London, UK: Routledge.

Kinderman, P. (2016). The importance of psychologist wellbeing. Retrieved from http://www.bps.org.uk/blog/presidential/importance-psychologist-wellbeing

Kossek, E., Kalliath, T., & Kalliath, P. (2012). Achieving employee wellbeing in a changing work environment. *International Journal of Manpower, 33*(7), 738–753.

Langone, M. (1995). *Recovery from cults: Help for victims of psychological and spiritual abuse.* New York, NY: W.W. Norton.

Lifton, R. (1961). *Thought reform and the psychology of totalism.* New York, NY: W.W. Norton.

Lifton, R. (2000). *Destroying the world to save it: Aum Shinrikyo, apocalyptic violence, and the new global terrorism.* New York, NY: Henry Holt.

Lorig, K., & Holman, H. (2003). Self-management education: History, definition, outcomes and mechanisms. *Annals of Behavioural Medicine, 26*(1), 2–7.

Martin, P. (1993). *Cult-proofing your kids.* Grand Rapids, MI: Zondervan.

Norcross, J., and Barnett, J. (2008). Self-care as ethical imperative. *The Register Report*, Spring, 20–27.

Oakes, P. (1987). The salience of social categories. In J. Turner, M. Hogg, P. Oakes, S. Reicher, & M. Wetherell, *Rediscovering the social group: A self-categorization theory* (pp. 117–141). Oxford, UK: Blackwell.

Pletts, D. (2015). 2014 Phoenix Project: Ex-member art and literary reports. *ICSA Today*, *6*(1), 16–22.

Reeves, A. (2016). A portal to ethical practice. *Therapy Today*, July, 14.

Rosch, E. (1978). Principles of categorization. In E. Rosch & B. Lloyd (Eds.), *Cognition and Categorization* (pp. 27–48). Hillsdale, NJ: Erlbaum.

Savic-Jabrow, P. (2010). Where do counsellors in private practice receive their support? A pilot study. *Counselling and Psychotherapy Research*, *10*(3), 229–232.

Seligman, M. (2003). *Authentic happiness: Using the new positive psychology to realise your potential for lasting fulfilment*. London, UK: Nicholas Brealey.

Shaw, D. (2013). *Traumatic narcissism.* Abingdon, UK: Routledge.

Shaw, D. (2014). The relational system of the traumatizing narcissist. *International Journal of Cultic Studies, 5,* 4–11.

Singer, M. (2003). *Cults in our midst.* San Francisco, CA: Jossey-Bass.

Stanford Medicine. (2016). Chronic disease self-management program. Retrieved from http://patienteducation.stanford.edu/programs/cdsmp.html

Tatarsky, A., & Marlatt, G. (2010). State of the art in harm reduction psychotherapy: An emerging treatment for substance misuse. *Journal of Clinical Psychology, 66*(2), 117–122.

Turner, M., Hogg, M., Oakes, P. Reicher, S., & Wetherell, M. (1987). *Rediscovering the social group: A self-categorization theory*. Oxford, UK: Blackwell.

Wang, J., & Verma, A. (2012). Explaining organizational responsiveness to work-life balance issues: The role of business strategy and high-performance work systems. *Human Resource Management, 51*(3), 407–432.

Weir, K. (2016, July/August). Seeking more balance. *Monitor on Psychology, 47*(7), 42. Washington, DC: APA.

Linda Dubrow-Marshall, PhD, Reg. MBACP (Accred.), is Research Coeditor of *ICSA Today* and is a cofounder of RETIRN, a private practice that provides services to individuals and families who have been affected by cultic influence and abusive relationships. She is the Programme Leader of the MSc Applied Psychology (Therapies) Programme at the University of Salford. She is registered with the Health and Care Professions Council, United Kingdom as both a clinical and a counselling psychologist, and she is a registered counsellor/psychotherapist with the British Association for Counselling and Psychotherapy. She is a licensed psychologist in Pennsylvania, USA, and a registered psychologist with the National Register of Health Service Psychologists, USA. She attends as corepresentative of RETIRN/UK as correspondent to the General Assembly of FECRIS (European Federation of Centres of Research and Education on Sects). Dr. Dubrow-Marshall is a Consultant in Clinical Hypnosis (advanced certification) with the American Society of Clinical Hypnosis and is certified by the Eye Movement Desensitization and Reprocessing Institute. She has a Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders issued by the American Psychological Association. She is a member of the Mental Health and Research committees for ICSA.

Rod Dubrow-Marshall, PhD, MBPsS, is a Professor of Psychology and is Visiting Fellow at the Criminal Justice Hub, in the School of Nursing, Midwifery, Social Work, and Social Sciences at the University of Salford, UK. Rod is a social psychologist who has been researching the psychology and aetiology of undue influence and cults or extremist groups for over twenty years, and he has developed the Totalistic Identity Theory as an evidence-based theory to explain and tackle ideological extremism and ideologically driven violence. He is also an active researcher in a variety of other areas including organizational behavior and healthiness, the social psychology of identity and prejudice, and public policy and

education. A graduate member of the British Psychological Society, Rod is a member of the Board of Directors of the International Cultic Studies Association and is also Chair of the ICSA Research Committee and Network, and he is Coeditor of the *International Journal of Cultic Studies* (since its inception in 2010). In 2006, he was awarded The Herbert L. Rosedale Award, jointly with Dr. Paul Martin, for their psychological research on undue influence. Rod cofounded the Re-Entry Therapy Information and Referral Network (RETIRN) UK in 2004 with Dr Linda Dubrow-Marshall, where he serves as a consultant in helping individuals and families who have been adversely affected by destructive or damaging cults and other extremist and high-demand/manipulative groups or relationships; he operates out of offices in Pontypridd, Wales and Buxton, Derbyshire, UK (please also see www.retirn.com). Rod has also served on more than a dozen governing boards of schools, colleges, and universities over the past two decades; he is currently a governor and director of the Akaal Primary School in Derby and is also a longstanding member of the Board of the homelessness charity the Wallich (headquartered in Cardiff, Wales). In addition, he is a member of the Board of Directors of the Buxton International Festival and is Chair of the Board of the Preston Guild Link charity (in Lancashire, UK), which is fundraising for the next Preston Guild cultural festival in 2032! Rod is also an experienced senior leader and manager in higher education, having served for 15 years in the roles of Deputy Vice-Chancellor at the University of Derby, Pro Vice-Chancellor at the University of Central Lancashire in Preston, and as Dean of Humanities and Social Sciences at the University of South Wales and Dean of Applied Social Sciences and Humanities at Buckinghamshire New University.