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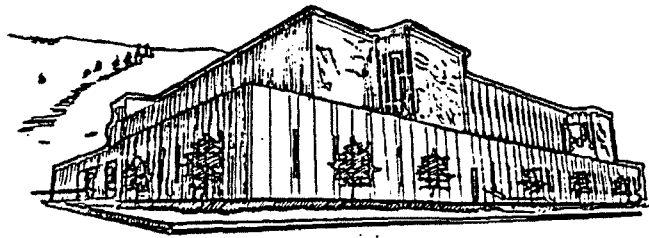
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University of
Montana

EMOTION AND PSYCHOTHERAPY

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Presented in partial fulfillment of the requirements


for the degree of

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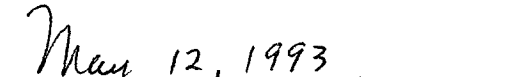
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Emotions and Psychotherapy

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If we lock away the fearful, painful experiences of our lives--- the death of a loved one, a betrayal, a passion not approved by society---we cut them off from their natural cycling. They are not exposed to the warmth of our heart or the light of our consciousness. And so these old emotions and memories cannot break down to become sources of new life. (Anderson & Hopkins, 1991, p. 80)

Emotional processes have played a central role in the development and practice of modern psychotherapy. Mahoney (1991) states that emotionality has clearly remained a primary realm for the conceptualization and practice of most of the more than 200 distinguishable forms of psychological services during the last century. Within these theories, there is great variation of the role and status given the area of emotion in the process of therapeutic change. This paper will begin by examining differing opinions as to the nature and function of emotion. It then describes different theories, some which emphasize the role of emotion in the healing process and others which do not. Furthermore, it will examine closely, within the specific context of repressed emotion, the theories which use emotive techniques, and it will conclude by looking closely and practically at the knowledge, skills, and person of the clinician utilizing such strategies. The purpose of this paper is to give understanding and aid to those clinicians who want to examine and evaluate affective modes of therapy.

The Nature of Emotions

Our Western culture encourages suppression of feeling and praises those who show little emotion in day-to-day living. Oatley and Jenkins (1992)

attribute to Darwin's evolutionary theory the basis for many theories regarding emotion which prevail today. Darwin's writing exemplifies the distrust of emotions in Western culture. Along with James, a fellow pioneer in the research on emotions in the late nineteenth century, Darwin opened the door to regarding emotion as an expression of an inner state. A side effect of this theory is the notion that emotions may need to be contained lest they "spill out" (Oatley & Jenkins, 1992). Hence, it would be advisable to regulate and manage one's own and possibly others' emotions. Mahoney (1991) summarizes what he regards as old stereotypes regarding emotions. Among these are that emotions were classified as either good or bad and should, therefore, be approached or avoided; the relegation of emotions to the lower, less human realms of functioning; emotions seen as volatile forces which influence the individual to act in irrational and possibly destructive ways; intense emotionality generally assumed to have a disorganizing influence on adaptation and purposeful behavior ("negative" emotions such as anger and depression seen as dangerous, undesirable, or intolerable); efforts to deal with intense emotionality focusing mainly on discharge, elimination, or control, thereby transcending such emotional patterns. Typically, under these stereotypical views of emotion, people are seen as the

passive recipients and stockholders of feelings that well up and need to be discharged.

There are current studies which offer a different perspective of the function of emotion in life. Emotions are seen by Oatley and Jenkins (1992) as communications to oneself and to others. Within individuals, they function in the control of goal priorities, and between individuals to communicate intentions and set the structure for interaction. Furthermore, these communications signal important events and goals and signify a readiness for action. They tell us of our needs, wants, what we are missing, and what we wish for in life. Being in touch with our feelings, according to Sharon Wegscheider-Cruse (1981), gives us the most reliable barometer to our personal reality at any given moment. Greenberg and Safran (1987) define emotion as an action organizer, beneficial to adjustment, and a facilitator of goal-directed behavior. More specifically, they write that, "Emotion is a complex synthesis of expressive motor, schematic, and conceptual information that provides organisms with information about their responses to situations that helps them orient adaptively to the environment" (Greenberg & Safran, 1989, p. 19). Anger, for example, can be seen as strength to defend ourselves from harm, and weeping a

specifically human function which normalizes brain chemistry. Therapist and author Joan Borysenko (1990) writes that when we deny or repress these messages about ourselves and the world, we remain in ignorance. Living in a state cut off from feelings loses a basic organic avenue for existence--one that provides much of the color, texture, pleasure, and appreciation of life, according to Schaef, Kirkman, and Ungashick (1981).

Studies of Nichols and Efran (1985) stress that emotions are not isolated entities separate from thoughts and actions. Feelings are not outside or inside in some container, but they are *of* people. Therefore, the individual is regarded as creating his/her own emotional state, and the goal of psychotherapy is to assist the client in realizing the extent to which they create their own lives, rather than regarding themselves as a victim of bottled-up affect. This concept is echoed in the writings of John Bradshaw, who views emotions as the foundation of all personal power (Borysenko & Taylor, 1991). With such an emphasis, clients are therefore seen by Bradshaw as creating their own lives even in the emotional domain, which has typically been considered out of their control.

Until recently, we have not understood the importance of emotions. As was previously mentioned, there is a strong tradition of repressing emotions

in our culture. Mahoney (1991) sees society as just now emerging from an era in which emotions were extensively neglected. An underlying assumption of this paper is the importance of conscious awareness and experience of emotion in enhancing the life of an individual. Focus will be on the use of affect in the process of therapeutic change.

Therapeutic Perspectives

The use of emotion for the healing process began in ancient religious and magical ceremonies. Nichols and Zax (1977) cite descriptions of primitive healing rituals which exemplify the therapeutic application of strong emotional procedures. Shamans often created highly charged emotional ceremonies, for example, in which sufferers were encouraged to re-enact past experiences. These re-enactments were heightened emotionally through the use of rhythmic music, chanting, and dancing.

A classical antecedent of today's affective theories is the catharsis (Greek "katarsis" meaning to clean or purify) of Greek drama (Greenberg & Safran, 1987, p. 190). The audience was the recipient of healing as they observed the action of the play and experienced a surge of emotion. As written in Aristotle's *Poetics*, "The task of the tragedy is to produce, through the

exercise of fear and pity, liberation from such emotions" (McCary & Sheer, 1955, p. 300). Aristotle may have been the author of the first explicit statement that full experience and release of repressed emotions were an effective treatment of mental illness. (Grof, 1988) The Greek philosopher, Plato, also saw remarkable therapeutic potential in emotional catharsis. He gave a vivid description of emotional catharsis in his dialogue *Phaedrus*.

Psychotherapists who have traditionally used some form of emotional experience in the healing process can be categorized into three major perspectives according to Greenberg and Safran (1989). The first is the psychoanalytic perspective, which has always had an appreciation of the role of neglected emotion in human affairs. Psychoanalysis began by focusing on the pathogenic nature of repressed or disavowed affect in the treatment of hysterical patients. Freud discovered the value of emotional discharge when working with women who, he believed, had not had appropriate emotional expression in response to traumatic life events. The goal of therapy was to bring repressed memory into consciousness and to facilitate the delayed discharge of affect. (Grof, 1988) In summary, Freud believed that the suppression of affect maintains maladaptive thoughts, and such thoughts can be changed by accessing and discharging the affect associated with them.

(Greenberg & Safran, 1987) Freud later abandoned the cathartic method in favor of free association as the method for patients to identify repressed emotion and memories. He thus no longer held onto the aim of creating catharsis or abreaction in therapy. However, contemporary thinking regarding the cathartic method is still dominated by Freud's work.

Psychoanalysis (and later emotive therapies) retained this focus on the pathogenic nature of repressed affect and the view of emotions as drive-related or instinctual and in need of being discharged in order to cure neurosis. (Greenberg & Safran, 1987)

The second major therapeutic perspective on emotion is that of the behaviorists and cognitive-behaviorists. There are no theories of emotion *per se* for the classical behaviorist. Emotions are considered predominantly as learned emotional behavior, learned in the same manner as overt behavioral responses, which will be extinguished in the absence of consistent reinforcement. (Greenberg & Safran, 1987). This perspective focuses on the problem of modifying undesirable affective state, such as anxiety and fear, with behavioral strategies, such as systematic desensitization, implosion, and flooding. (Greenberg & Safran, 1987). Implosive therapy utilizes a form of treatment in which the client is forcefully and repeatedly bombarded with

vivid descriptions of his or her greatest fears. Avoidance behavior is prevented, and the anxiety response is extinguished. Flooding is procedurally similar to implosion with the exception that it often employs the actual feared stimuli, and it does not employ the vivid imagery of implosion therapy. Whereas flooding uses total exposure to fear situations, systematic desensitization's exposure is gradual. Renowned behaviorist, B. F. Skinner, regards emotion as a cause for behavior, a hypothetical state, consisting of marked changes in viscera and skeletal muscles, which represent a disposition to act. (Plutchik, 1980).

In contrast, the cognitive-behavioral approaches regard affect as a postcognitive phenomena in which the meaning of an event determines the emotional response to it. Constructs such as automatic thoughts, irrational beliefs, and self-statements have been posited as mediating between events and emotional responses to events. (Greenberg & Safran, 1989) For example, A. Ellis writes that rational emotive therapy maintains, ". . . virtually all serious emotional problems stem directly from magical, empirically unvalidatable thinking, and that if disturbance-creating ideas are vigorously disputed by logico-empirical thinking, they can be eliminated or minimized . . ." (Corisini & Wedding, 1989, p. 199). The cognitive therapist,

therefore, tends to focus on eliminating emotional responses to faulty cognitions by rationally challenging beliefs, by providing schema-inconsistent evidence and by providing self-instructional training. The focus of cognitive therapy is on here-and-now problems, with little attention to childhood recollections, except to clarify present observations. The major thrust is toward investigating the patient's thinking and feeling during the therapeutic session and the time in between sessions. (Beck, Rush, Shaw, & Emery, 1979) In comparison to the behavioral theorists, a greater emphasis is placed on the patient's internal (mental) experiences (thoughts, feelings, wishes, daydreams), and there is an empirical investigation of the automatic thoughts, inferences, conclusions, and assumptions which formulate the patient's dysfunctional idea and beliefs about him/herself, and his/her experiences and the future.

According to K. Dobson (1988), cognitive therapy has been criticized because of its strict information processing model of cognition and affect (affect is the logical sequence of appraisal of the environment and necessarily follows cognitive appraisal). It is often argued that affective responses may arise after minimal or potentially no cognitive processing, and it has been repeatedly opined that cognition and affect are, "mutually

causative and interdependent and may occur simultaneously" (Dobson, 1988, p. 397). According to A. Ellis (1962), rational therapy cannot be termed unemotional, as emotions cannot be divorced from perceiving or thinking; however, it is questionable whether strong affective work alone can significantly change a client's basic philosophy. Rational Emotive Therapy, however, is capable of uncovering, analyzing, attacking, and significantly changing an individual's fundamental philosophic assumptions; therefore, according to Ellis, it goes far deeper than abreactive or cathartic techniques. (Ellis, 1962) In summary, while the cognitive therapist must be sensitive and empathetic to the patient's painful emotional experience, emphasis is placed on his/her ability to identify faulty cognitions and to assist the patient in the linkage between negative thoughts and negative feelings. (Beck, Rush, Shaw, Emery, 1979) In the end, according to Dobson (1988), Rational Emotive Therapy holds that the most long-lasting changes that humans can effect are those that involve the restructuring of irrational beliefs.

At the present time, however, there appears to be a re-examining of the cognitive perspective on emotion. Cognitive therapists are challenging the relationship between emotion and cognition. For example, the developmental cognitive therapist (or constructivist), M. Mahoney (1991),

finds emotions to be a powerful knowing process which integrate past, present, and anticipated experiences. He argues that thought, feeling, and action are structurally and functionally inseparable. (Dobson, 1988). From this perspective, therefore, emotional experience, expression, and exploration are encouraged.

The experiential tradition offers the third major therapeutic perspective on emotion according to Greenberg and Safran (1989). In contrast to the cognitive and behavioral views, experiential and humanistic therapists regard emotion as an important motivator of change. Emotions are viewed neither as expressions of instinctual impulses or as learned responses but are seen as providing the individual with adaptive information. They constitute, therefore, an important orienting system, are a valued aspect of experience, not something to be suppressed, expelled, or discharged. The goal of therapy is not to rid the client of feelings, but to facilitate an awareness of feelings and the meaning behind them, which will in turn make the client more responsive to the action tendencies toward which feelings prompt them. (Greenberg & Safran, 1989).

Client-centered therapy exemplifies this belief concerning the function of emotion in the therapeutic process. Carl Rogers, the founder of client-

centered (later termed person-centered) therapy, claimed that therapeutic change involved experiencing fully in awareness feelings that had in the past been denied awareness or had been distorted. He describes the transformation from one state to another in the following quotation: "When a hitherto repressed feeling is fully and acceptantly experienced in awareness during the therapeutic relationship, there is not only a definitely felt psychological shift, but also a concomitant physiological change, as a new state of insight is achieved" (Rogers, 1980, p. 132).

In Gestalt therapy, the experience and expression of emotion is regarded to be of critical importance for change. Emotion furnishes an awareness of what is important and helps to organize action in the environment, and dysfunction occurs when emotions are interrupted before they can enter awareness or help in organizing action. Fritz Perls, the originator of Gestalt therapy, writes of the necessity not just to recall the past but to "psychodramatically" return to past experiences in order to assimilate the interrupted feelings, which are mostly of intense grief. (Perls, 1973) "The awareness of, and the ability to endure unwanted emotions are the conditions, *sine quo non*, for a successful cure," he writes. (Perls, 1969, p. 179) In addition, as an experiential therapy, the Gestalt technique demands

that the client experience as much of him/herself in the here and now as is possible. This makes awareness of feelings in the present essential, along with awareness of gestures, breathing, voice quality, facial expression, and thoughts.

In summary, the goal of the experiential therapeutic approach, according to Greenberg and Safran (1989) is to "increase the clients' awareness of emotion so that it is available as orienting information to help them deal with the environment" (p. 21).

The following table summarizes the preceding perspectives.

| <i>Theory</i> | <i>View of Emotions</i> | <i>'Pathology'</i> | <i>Treatment Plan</i> |
|---------------|---|--|--|
| Psychodynamic | Emotions are expressions of the "spillover" of excessive psychic energy, which often take the form of neurotic symptoms, denied impulses, and defense mechanisms. | Disease and dysfunction are the result of "strangled" affect, disowned impulses, and inadequate discharge of psychic energy. | Emphasis is on facilitating <i>insight</i> into psychic conflicts and disclaimed impulses to action. Insight and "corrective emotional experiences" (including <i>discharge</i>) emerge from the <i>transference</i> relationship and therapist-guided interpretations. |
| Behavioral | Emotions are conditioned responses that can themselves serve as discriminative stimuli for other responses. They often have an undesirable <i>disorganizing</i> effect on skilled behavior. | Maladaptive patterns of emotional behavior are the result of skill deficiencies and/or pathogenic conditioning histories. | Emphasis is generally on "counter-conditioning" undesired emotional responses, with desensitization, extinction (in-vivo exposure), massed practice ("implosion" or "flooding") techniques most often aimed at <i>eliminating</i> or <i>controlling</i> such responses. |
| Humanistic | Emotions constitute value experiences that guide the person's sensing, acting, and reflecting. Feelings "fuel" both action and awareness, both of which are dynamic processes. | Dysfunctions develop when emotions are denied, suppressed, or interrupted (and left "unfinished"). | Emphasis is on facilitating <i>self-awareness</i> and <i>experiential</i> , emotional, and <i>expressive freedom</i> and spontaneity. <i>Feelings</i> receive primary focus as valuable guides to personal activity. |

| <i>Theory</i> | <i>View of Emotions</i> | <i>'Pathology'</i> | <i>Treatment Plan</i> |
|---------------|--|---|---|
| Cognitive | <p><i>Constructivist:</i> Emotions are primitive and powerful knowing processes that reflect individual patterns of organization and disorganization in experience.</p> <p><i>Holism:</i> thought, feeling, and action are structurally and inseparable.</p> | Dysfunctional and distressing patterns of emotional experience reflect the individual's imperfect attempts to adapt and develop. Some emotional disorganization reflects stages in overall systemic reorganization. | Emphasis is on the <i>experience</i> and appropriate <i>expression</i> of emotions, as well as on the <i>exploration</i> of their development, functions (past and present), and possible roles in emerging life developments. Within the limits and flexibility of each individual, periods of emotional disorganization may afford and reflect <i>opportunities</i> for change. |
| | <p><i>Rationalist:</i> Emotions are the products of thoughts and images, as well as interpretations of perceptions.</p> <p><i>Rational supremacy:</i> "higher" intellectual processes can and should direct feelings and actions.</p> | Negative emotions are the result of negative, irrational, and incorrect patterns of thinking. | Emphasis is on <i>eliminating</i> , <i>controlling</i> , or <i>replacing</i> intense negative affect by identifying and altering irrational thought patterns (via disputation and/or rehearsal of alternate thoughts). |

Note: From Mahoney, M. (1991). *Human change processes*. New York: Basic Books, pp. 205-207, 244.

Emotional Expression and Therapeutic Change

The remainder of this paper will consider those strategies of therapy which view emotion from the experiential or humanistic perspective. According to Greenberg and Safran (1989), reviews of the process and outcome literature are fairly consistent in concluding that high levels of client experiencing are related in some therapeutic approaches to positive outcome in therapy.

Furthermore, research on emotional expression in therapy indicate that both emotional arousal and affective expression are related to therapeutic change. (Greenberg & Safran, 1989) Without qualification, Mahoney writes that recent studies show that, "the experiential aspects of emotionality are important elements in the development of a sense of self and in psychological change" (Mahoney, 1991, p. 191). In addition, he writes that significant psychological change is frequently associated with episodes of emotional intensity, variability, and distress" (Mahoney, 1991, p. 191).

Much of the evidence linking emotional expression to therapeutic gain comes from research attempting to determine the relationship between the degree of strength of client feeling and the occurrence of categories of in-session good moments. The category of "good moments" in psychotherapy includes characteristics of therapeutic sessions such as provision of

significant material about self and/or interpersonal relationships, expression of insight/understanding, emergence of previously warded-off material, expression of a welcome general state of well-being and nine other items developed by Mahrer and his colleagues. (Mahrer, Nadler, Stalikas, Schachter, & Sterner, 1988) Mahrer, Lawson, Stalikas, and Schachter (1990) write that the strength of feeling may be regarded as a significant factor in psychotherapy, and overall findings indicated that the proportion of good moments increased with increased levels of strength of feeling. Furthermore, they found that each level of feeling strength had its own advantages and disadvantages. For example, they report that the higher levels of strength of feeling may be favorable for the occurrence of good moments of expressive communication, the expression of strong feeling toward the therapist, the expression of strong feeling in personal life situations, and the manifest presence of a substantially new personality state. (Mahrer et al., 1990) Greenbert and Safran (1989) state that the empirical evidence does indicate that emotion can affect therapeutic change; however, they are quick to emphasize the importance of future research on emotional processes.

Effects of Trauma on Emotion--Repression

The following section of this paper will address one of the areas appropriately addressed by strong affective therapy. Many modern psychoanalysts believe affective therapy to be a useful way to resolve symptoms arising from acutely traumatic incidents. In particular, this section will examine the circumstances surrounding these traumatic events, particularly, but not exclusively, those occurring in childhood, the effects of such trauma in terms of blocked or repressed emotions, and the subsequent effects on the body, mind, and spirit. Following this explanation will be a discussion of specific strategies of treatment using affective methods.

The blocking or avoiding of emotional response is often the result of a traumatic event, and many theorists pinpoint childhood trauma as a starting place for such repression. A. Lowen (1975), originator of the theory and therapy of Bioenergetics, states that it is during early childhood that trauma and stress cause a child to devise coping strategies, leaving permanent traces in the psyche and body. Arthur Janov (1970), creator of Primal Therapy, pinpoints the moment in a child's life when he/she represses the painful experience of not being loved for "who I am." He calls it the "Primal Incident." When this traumatic experience and the feelings of it are blocked

from awareness, Janov sees the distortion of growth and the emergence of neurosis, a disease which he believes has at its core the suppression of feeling. "From the day this event occurs onward," writes Janov, "real feelings will galvanize the unreal self so that the child no longer recognizes many of his feelings, which are suppressed, disconnected, and unavailable for resolution" (Janov, 1970, p. 31).

Likewise, Karen Horney (1950) describes the injurious influences that prevent a child's healthy development. Horney believed that the human being, if provided with favorable conditions, grows and develops in a way that leads to the actualization or realization of inner potentialities or self-realization. (Greenberg and Safran, 1987) "He will develop then the unique alive forces of his real self: the clarity and depth of his own feelings, thoughts, wishes, interests . . ." (Horney, 1950, p. 25); however, when a developing child meets with unfavorable environmental conditions, Horney believes that the child becomes alienated from the real self. The child learns that it is not acceptable to experience and express his or her own inner thoughts, feelings, and needs, and develops an attitude toward the world of "basic anxiety," which makes it impossible for the child to relate to self and others with true feelings. According to Horney, the child who

becomes alienated from his or her true inner self and feelings in this way establishes an "idealized self" that can provide a sense of identify and value. (Greenberg and Safran, 1987, p. 26) The child, therefore, sets about to mold him/herself into a supreme being of his/her own making and to forget about the disgraceful creature he/she believes exists inside. (Horney, 1950)

Alice Miller and Konrad Stettbacher, psycho-therapists who espouse much of Janov's theory of Primal Therapy, see the traumatic events of childhood at the hands of abusive parents or caretakers as the predominant factor leading to the repression of feelings and the creation of the false self, or, as Miller has described it, the mask a child creates in order to survive. In her book *The drama of the gifted child*, Miller writes that, "Accommodation to parental needs often . . . leads to the as-if personality . . ." (Miller, 1981, p. 12). The child, unable to develop a differentiated True Self because he/she is unable to live it, creates a mask, which puts him/her out of touch with the true feelings and the true being that is underneath (Borysenko, 1990, p. 59). Stettbacher (1991) writes that it is the injury to a child's primary integrity which leads ultimately to a stance of blocked emotion and suffering in life. A child's dependency arises from its cognitive weakness, which includes an inability to express concepts in words, undeveloped thinking, and an

incapacity to recognize and comprehend the motives underlying the actions of adults. As a consequence of its dependency, a child is forced to repress and forget the abuse it suffers, for it is unable to adequately protect itself. (Stettbacher, 1991, p. 28) When a child cannot get his/her primal needs met, it is the unconscious fear of the child that he/she is deficient, worthless, and bad. This, according to Stettbacher, is the root of negative compensations and development; it is termed the "suffering of life."

William Reich (along with A. Lowen) was a "body therapist" who attempted to deal with repressed feelings through a combination of biophysical and psychological elements. He also believed that early childhood trauma causes children to devise coping strategies in order to survive. In addition, these events and stressors leave permanent traces in the psyche and body. The body therapist brings to light these blocked or frozen feelings resulting from childhood trauma in order to facilitate new reactions and behaviors. (Grof, 1985)

Many therapists in the field of addiction recovery also theorize as to the origination of the repression of feelings, the loss of the true self, and the development of the mask or false self. The dysfunctional or troubled family in which a child's needs are not met is the time and place for the creations

of unhealthy and painful life patterns, according to Charles Whitfield.

(1987) The pain of not getting needs met and the absence of a person with whom to share resulting feelings cause a child to shut feelings out in order to survive. The child, and later the adult, becomes progressively numb and out of touch with what is happening inside. What emerges to help the child to survive is a false or co-dependent self, according to Whitfield. This false self assists in survival, but is incapable of getting the true needs of the child met. (Whitfield, 1990)

John Bradshaw, also a therapist and theorist in the field of recovery, writes of the split which occurs in the child who is shamed and exposed for being the person he/she is. Unable to protect him/herself, the child splits off from the aspects of the self that are shamed. The true self goes into hiding, and the child develops a false identity and becomes a master of impersonation to avoid the core agony and pain of shame. Bradshaw sees this child as being "soul-murdered" (Bradshaw, 1988).

In a recent book entitled *Guilt is the teacher, love is the lesson*, author and therapist J. Borysenko writes of the traumatic or stressful childhood events which lead to the loss of the soul:

In the childhood need to please parents and keep safe, the developing psyche splits into a public self or mask and a private

self or shadow, unknown even to ourselves . . . and in this split we lose our authentic sense of self and the ability to express our natural impulses. (Borysenko, 1990, p. 27)

Shamed and masked, the child no longer feels the affect which was suppressed in order to be lovable by those more powerful. In addition, Borysenko summarizes the repression theories of V. Satir, C. Jung, and R. Bly. Satir likens the repressed parts of the true self to a pack of hungry dogs scratching at the cellar door to get out; Jung called these disowned parts of the self the shadow, and Bly writes of the long bag a child or adult drags along which contains all the parts of the child (natural impulses and emotion), which the parent, teacher, or primary caretaker didn't accept. (Borysenko, 1991)

A quote from recovery therapist, J. Middleton-Mox, recaps the theories presented regarding the creation of the false self and the loss of all that is real and true for the child:

Children live out what they see reflected in their parents' eyes or in the eyes of others in the community. If what is reflected is the disdain and unacceptability of their developing self, that self will be discarded in order to meet the image in the reflective mirror of their world. (Middleton-Mox, 1989, p. 9)

The more we identify with the false self . . . the more we stay separated from the True Self and from an understanding of the life experiences we have stored within our souls. (Borysenko, 1990, p. 32)

The Effects of Emotional Repression

Many therapists believe that if left unheeded, repression can develop into a dangerous, self-destructive power. A. Miller states very simply that, "The drastic result of repressed emotion and trauma is mental illness. (1986, p. 217) As quoted by J. Bradshaw, M. Scott Peck writes, "The tendency to avoid emotional suffering . . . is the primary basis for all human mental illness. (Bradshaw, 1988, p. 115) Alice Miller continues to write of the process of repression which often begins in childhood in this graphic example, "The only recourse a baby has when his screams are ignored is to repress his distress, which is tantamount to mutilating his soul, for the result is an interference with his ability to feel, to be aware, and to remember" (Miller, 1986, p. 217).

J. Middleton-Moz (1989) uses Erikson's stages of identity to illustrate the lack of a sense of "who I am" in children who have suffered childhood trauma. Energy intended for development is used for repressing parts of the self, she explains, and the resulting anxiety often ends up in phobias, physical illness, depression, and compulsive behaviors.

J. Borysenko (1990) gives an overview of the effects of emotional repression as she writes:

We become one-dimensional caricatures who lack normal depth of human feeling. We may think we feel emotion, but more likely we are ruled by rage and fear of our inner child. Positive emotions are rarely experienced, and we cannot be fully present in life. We have lost much of our capacity for self-awareness and suffer from perilously low self-esteem." (p. 68)

The specific effects of repression on the body are recognized by Borysenko (1990) as she makes reference to the somatic symptoms, tension, and pain which our bodies experience when emotions are blocked and prevented from flowing in natural channels.

Primal Therapy, the affective theory developed by A. Janov, also sees the body as the storehouse for much of the pain from childhood (1970). Unmet needs, according to Janov, are not simply stored in the brain, but coded into the tissue of the body. The body remembers its deprivations and needs just as the brain does, and exerts a continual force toward satisfaction. Somatic symptoms, or cover-ups as Janov terms them, keep one from experiencing the Primal Pains of childhood, pains that are too harmful to let into consciousness.

Although not a well-researched subject, the area of recovery offers an emergent perspective with potentially useful information for understanding the effects of emotional repression. C. Whitfield, noted author in the field

of recovery, addressing, in particular, issues of the inner child, writes that chronic distress is created when the energy generated within from loss or trauma is not appropriately discharged. (Whitfield, 1987) Without appropriate release, this distress is stored within as discomfort or tension, and it may be felt through manifestations such as anxiety, fear, sadness, emptiness, confusion, guilt, shame, or numbness or no feeling at all. There may also be difficulty sleeping and other somatic complaints. He writes that mental, emotional, or physical illness may result. In addition, as a result of not feeling and grieving many of the losses of childhood, we may also develop a tendency toward self-destructive behaviors. (Whitfield, 1987) Also writing within the area of co-dependency treatment and recovery, Sharon Wegscheider-Cruse, J. Cruse, and G. Bougher reiterate the idea that, "The chronic stress created by unresolved emotional hurts can lead to serious health problems" (1990, p. 42).

Addictions and compulsive behaviors often serve as a protection against feeling the pain of life-long unmet needs. A reservoir of pain, which craves for relief, is created by the ungrieved losses. Bradshaw (1988) theorizes that this chronic pain, as well as the shame of the false self and the mourning for the authentic self, force the individual to seek a mood-altering experience,

either a substance or a behavior. According to Borysenko (1990), addictive behaviors reinforce the false self and dull the pain of an imagined unworthiness. An additional effect of repression for the emotionally shut-down person is an attitude and desperate need for control. The desperation exhibited as a result of the loss of practical judgment and the inability to see alternatives. (Bradshaw, 1988)

Elaborating on these characteristics, Bradshaw (1988) writes that emotional blockage narrows our ability to think and reason, contaminates our judgment, perception, and our ability to reason about concrete events in our life. Furthermore, practical judgment shuts down, and the will loses its ability to see alternatives. (Bradshaw, 1988, p. 136) Mill (1981) lists narcissistic disturbance, grandiosity (a defense against the depression of not being loved for who one is), and lack of individuation as the diagnosable symptoms of emotional repression. Stettbacher (1991) refers to the state of repression as that of "suffering," the unconscious anticipation that the painful and fearful past will somehow revisit one's life.

It is easy to understand that one of the sad results of the creation of the repression of the true self and the creation of the false or masked self is that the individual is capable of only unauthentic forms of human

interaction. Until one knows oneself, it is difficult to have a full relationship with another. The personality developed to minimize or dull suffering does not offer an opportunity for authentic contact with another. Above all, by denying our own unique spirit, we remain strangers to ourselves. Borysenko (1991) writes that masks cover over the true self and obscure the knowledge in our soul and our capacity for joy, peace, and wisdom.

We heal by remembering, literally bringing back into the wholeness of our being that which we have lost by hiding it from ourselves. (Borysenko, 1990, p. 5)

The Need for Affective Therapy

Repression, which appears as a life-saving function in childhood, is often transformed into a life-destroying force for the adult. As an adult, however, other ways of handling feelings become available to the individual. This paper continues with an examination of some of the affective theories and strategies found to be effective in treating the dis-ease which is created by blocking or avoiding adaptive emotional responses and masking the real self.

Before giving examples of specific emotive therapies, general support will be presented for the belief that the false self must be dismantled by the recognition and often by the re-experiencing of feelings in order for healing to occur. Both mainstream psychoanalytic and eclectic theorists view the mask as a defense against vulnerability whose discovery and disposal are critical to the development of the individual's freedom. (Borysenko, 1990)

In order to bring about this face-to-face encounter with the truth of the self, feelings must be acknowledged. A. Miller (1988) believes that what makes emotional illness is not the childhood trauma as much as it is the inability to express the trauma. Therefore, feelings must be acknowledged, experienced and given a voice. This is, according to Miller, tantamount to the discovery

and acceptance of the truth of one's life. All feelings are the trail markers on this path; however, Miller focuses on violent hate feelings and compulsive desires as especially dependable gatekeepers to the truth of childhood trauma. (Stettbacher, 1991) Therefore, the pain must be felt, grieved, and shared in order to complete it and to be free of it. (Whitfield, 1987) Miller states that, ". . . emotional access to truth is the indispensable pre-condition for healing" (Miller, 1991, p. 143). Valuing the emotive strategies and their importance in the therapeutic process, Yalom writes, "The problem in therapy is always how to move from an ineffectual intellectual appreciation of a truth about oneself to some emotional experience of it. It is only when therapy enlists deep emotions that it becomes a powerful force for change" (Yalom, 1989, p. 35). Pain is the way in, and pain is the way out, according to Janov (1970). The real self is locked away with the original pain, and the pain must be felt in order to provide liberation for the individual. "Feeling the pain shatters the unreal self the same way denying pain created it" (Janov, 1970, p. 35).

If fully experiencing emotion is considered necessary for purposes of living consciously, freely, and wholly, the question becomes how to become once again conscious of emotions and of the true self. If these emotional

experiences stored within the individual are retrievable, what methods can be used in this quest?

Corrective Experiences Using Affect

Abreaction or the cathartic or discharge method is a prominent feature of various emotive therapies. Catharsis generally means, "A process that relieves tension and anxiety by expressing emotion" (Nichols & Zax, 1977, p. 190). Abreaction is viewed as the revivification of past memory with the release of bound emotion and the recovery of repressed or dissociated aspects of a remembered event. (Hunter, 1990) J. Watkins (1991) suggests the use of abreaction in "emotionally unfinished business." For example, a situation which would normally precipitate strong emotions occurs, yet the normal affective response is blocked. The therapist's job is to unbind the frozen affect, release it, and achieve closure of the previously unresolved conflict. In summary, since the normal reaction was not completed, an abreaction is promoted to re-experience and complete the process. (Watkins, 1991)

Primal Therapy stresses the importance of recovering painful memories in a cathartic fashion. A. Janov, the originator of this theory, views neurosis as

a symbolic behavior that represents a defense against excessive psychobiological pain associated with childhood trauma. Primal pains are related to early occurrences in life that have not been acted upon, but rather the emotions have been stored as tension or in the form of defenses. (Grof, 1985) Janov stressed that in order for the client to dislodge the false self and to be rid of the fear and tensions in the body created from the repression of emotions from childhood trauma and deprivation, the original pain must be felt at the very core of the individual, or organismically.

(Janov, 1970) Therefore, it is not enough to simply know one's unconscious feelings and needs, as they are stored in the body as well as the brain, and the body remembers just as the brain does. The major therapeutic outlet in primal therapy is the "primal scream," which expresses, in a condensed way, the client's reaction to past trauma. (Grof, 1985) Janov writes that to become whole again, it is necessary to feel and recognize the split between the real and the false self and to scream out the connection that will unify the person once again. (Janov, 1970).

The goal for the client is to actually go through the feelings and physical sensations that could not be fully experienced at the time they happened. Therefore, emphasis in this process is on the re-experiencing of the initial

feeling which was repressed. Primal therapists believe that this total, felt experience of one's repressed feelings and emotions carried from childhood, is an indispensable prerequisite to liberation from psychopathology. (Brown, 1979) "The Primal Pain experience is not just knowing the pain, it is being the pain" (Janov, 1970, p. 41).

Another pioneer and intellectual leader of modern cathartic therapy was Wilhelm Reich. A contemporary of Freud, Reich made the transition from concern with talking about feelings to physical discharge of emotions, launching a combined psychological and physical attack on what he termed "muscular armor" (Nichols & Zax, 1977). Reich believed that early childhood trauma left permanent scars in the psyche and the body. Reich did not regard catharsis as an end in itself or believe that emotions are an unnecessary evil to be discharged. He was the first to emphasize sustained catharsis over the prolonged course of psychotherapy. (Nichols & Efran, 1985) Reich never treated emotion as the only valid expression of one's humanity; therefore, he emphasized understanding as well as cathartic strategies. In addition, in order to release the enormous amount of repression and emotional energy he felt lay under neurotic symptoms, he espoused treating the individual from a biophysical point of view. Thus, he

attempted to deal with repressed feelings in a physical way through bodily manipulation, which he felt deeply intervened in the body's energies to break up the muscular tensions holding in the repression of early trauma.

(Grof, 1985)

Bioenergetics, similar to the other affective therapies, is a study of how the body reacts to and then adapts to the stresses and traumas of childhood. Its goal is to reconnect with one's "first nature" (true self). (Grof, 1985) It has been described as a way of understanding personality in terms of the body and its energetic processes. A fundamental thesis is that the body and mind are functionally identical; that is, what goes on in the mind reflects what is happening in the body. (Coven, 1985) One of the basic aims of bioenergetic therapy is the abreaction and release of traumatic experiences that occurred during infancy. As with the Reichian theory, emotional conflicts of childhood are structured in the body by chronic muscular tension, which limits the individual's capacity for feelings. The expression of emotion is believed to aid the retrieval of memories and thoughts and is of central importance in therapy. (Greenberg & Safran, 1987)

A. Lowen, the most important neo-Reichian theorist and originator of Bioenergetics, states,

. . . one must "open up and vent these feelings, for their release makes available the energy necessary to the process of change . . . knowledge becomes understanding when it is coupled with feelings . . . Only a deep understanding charged with strong feeling is capable of modifying structured patterns of behavior." (Greenberg & Safran, 1987, p. 56)

Body manipulation is the technique which provides powerful emotional release and leads to insight concerning conflicts in childhood. The resulting combination of emotion, insight, and release of bodily tension leads to therapeutic change, according to bioenergetic theory. (Greenberg & Safran, 1987)

Gestalt therapy is yet another therapeutic approach which emphasizes the role of emotional discharge in the process of psychological change. According to this theory, deep personal pain is the living condition of many individuals, and by denying this pain, one remains stuck in unfinished business, which prevents appropriate living in the present. (Rudestam, 1982). In order to complete this experience of "Gestalt," the feelings associated with these old pains must be fully experienced. Both emotional awareness and expression are utilized as therapeutic tools in Gestalt therapy. Awareness is the primary focus and leads to the expression of old hurts and onto new perspectives and enhanced perceptions of the old unfinished business. The ultimate goal of this process is not to expel and be

rid of feeling, but to undo the interrupted process and become aware of and responsive to the actions toward which the feelings are leading the individual. (Greenberg & Safran, 1987) Therefore, the emphasis of the process is not so much on the discharge of emotion as it is the completing of interrupted experience. With such a process, the client is able to re-capture and re-own the discarded, disowned, or repressed parts of the self.

A Miller's theory of mental illness begins and ends with the experiences of childhood trauma. Miller sees childhood as the key to understanding all of later life. (Miller, 1986) She believes adults have the ability to reconstruct the history of wounds and to dispel the intellectual defenses created for survival against childhood abuse and neglect. The truth is discovered through the expression of feelings. Miller states this belief in writing that, ". . . emotional access to the truth is the indispensable precondition to healing" (Miller, 1991, p. 143). Thus, it is essential that therapy secure access to these sensations and feelings and enable the individual to articulate them. The goal of therapy, according to Miller, is to allow the once silenced child within us to feel and to speak. (Miller, 1991)

The method which Miller recommends for the safe resolution of childhood repression is that which brought about her own healing, the step-by-step

therapy of J. Konrad Stettbacher. Although both Miller and Stettbacher give much credit to the work of Janov, particularly in his recognition of the significance of grief work in bringing about healing, Stettbacher, in contrast to Janov, gives detailed guidance for his process. Stettbacher defines primal therapy as a supportive reevaluation of our primal relationships and the problems which arise from them. Its goal is to resolve primally-induced anxiety, pain, and confusion by uncovering their origins. (Stettbacher, 1991)

In summary, there are four steps formulated by Stettbacher to discover the truth of one's own life history: (1) expressing current state of mind, that is, what is sensed at the moment; (2) giving voice to sensations and feelings---how they affect the individual and what they mean; (3) unearthing the reasons for problems, critically thinking about situations, others, and the self; and (4) articulating needs and rightful claims to what would have prevented the initial trauma and helped one to live. (Stettbacher, 1991)

Through the use of these steps, the curtain of unconsciousness or repression is lifted, and the individual is able to determine and organize his/her life.

Karen Horney's theory and therapy also hinge on the desirability of letting feelings emerge. According to Horney, an important task of therapy consists of ridding the individual of illusions they have about themselves.

The idealized self---created because it is not safe to be who one is, with particular feelings, thoughts, and needs---consumes much of the energy which should be used for the actualization of the real self. Central emphasis is, therefore, on the importance of helping individuals experience their real feelings, not the feelings they think they should have to maintain their ideal. (Greenberg & Safran, 1987) According to Horney, an emotional (not an intellectual) experience is essential for change from the ideal to the real for the individual. She writes, ". . . only when experiencing the full impact in its irrationality of a hitherto unconscious or semiconscious feeling or drive do we gradually come to know the intensity and the compulsiveness or unconscious forces operating within ourselves" (Horney, 1950, p. 343).

Many of the techniques and theories using affect in the healing process are termed "experiential." For example, the group therapy process of the psychodrama of J.L. Moreno creates drama in which the actors are the patients who need catharsis and liberation from the tragic conflicts and emotions in which they are caught. (McCary & Sheer, 1955) The approach recommended by transpersonal theory has distinct experiential emphasis and stresses the activation of the unconscious, mobilizing blocked energies, and

transforming stagnant emotional and psychosomatic symptoms into dynamic experiences. (Grof, 1985)

Sharon Wegscheider-Cruse and Joseph Cruse have termed their theory and therapy in the area of recovery to be experiential. They have found it particularly useful in the treatment of what they term co-dependency, the main symptoms of which are blocked cognitive memory and blocked or repressed feelings. A large portion of co-dependent treatment, according to this theory, is the exploring and re-living of historically-repressed emotions. The purpose of this form of therapy is to enact or re-enact the emotional climate of the family of origin and/or other past and present significant relationships in life. In re-experiencing these events and relationships, an individual is able to release the emotions that may have been blocked or repressed. (Wegscheider-Cruse & Cruse, 1990) According to this theory, not only is the emotional therapy needed so that the individuals can re-experience their distorted thinking and suppressed emotion and better recognize their compulsive behaviors, but the cognitive component is also necessary, providing information and understanding. Following the healing process, therefore, education plays an important part in understanding what happened, why it happened, and how life can be different. The therapist

leads the client to experience new feelings of serenity, hope, and trust.

(Wegscheider-Cruse & Cruse, 1990)

A. Miller has written, "Experience has taught us we have only one enduring weapon in our struggle against mental illness: the emotional discovery and emotional acceptance of the truth in the individual and unique history of our childhood" (Miller, 1981, p. 3). According to many current theorists, especially those in the field of recovery, each individual has within him/herself an inner child of the past who may have suffered as a child, and who affects what one does and feels as an adult. The discovery and care of him/her is considered work on the inner child. According to J. Borysenko (1991), it is essential for one's mental health to have some way to dismantle the false self and retrieve what was disowned as not being good enough in childhood. In order to break through the masks of the false self, there must be a willingness to look into the shadow, which hides the disowned parts of the self. This work begins with understanding what the child is feeling, and goes beyond talking to include experiential work which contacts the memory stored within the cells of the body (cellular consciousness). (Borysenko, 1991)

J. Bradshaw sees the need to find the Inner Child as part of every human being's journey to wholeness. (Bradshaw, 1988) Making contact with the hurt and lonely child will release much of the blocked energy which creates the ill-effects within the body, mind, and spirit discussed earlier. The childhood which was lost must be grieved, according to Bradshaw, and this is accomplished through doing the work of "original pain" and dealing with feelings surrounding the family of origin; however, our false self keeps us from experiencing the feelings of unresolved grief. A factor which must be present for this resolution is support. Bradshaw writes that, "You cannot grieve alone" (Bradshaw, 1988, p. 138). Bradshaw's theory of original pain work is based on the premise that the neglect of our developmental dependency needs was a major impetus for the creation of toxic shame within the individual, which forged the false self. Because each developmental stage has its own needs, and, therefore, also its own unmet needs, Bradshaw sets the stage for clients' needs to be met stage by stage. Infancy needs include mirroring of unconditional love, touching, and feeding. Toddler needs include a need to separate and affirmation and acceptance of this need. Developmental stages progress through

adolescence. (Bradshaw, 1988) This process is one of re-experiencing, liberating, and integrating the lost inner child.

To discover our True or Real Self and heal our inner child, Whitfield (1987) recommends a process which has a strong emphasis on the affective work of identifying, re-experiencing and grieving the pain of our ungrieved losses or traumas from childhood. The work of discovering the real self or the true inner child is difficult when an individual is living from the false or co-dependent self, when feelings are covered up and denied, and when one lives with a multitude of defense mechanisms. What is needed is an awakening concerning the world. Consequently, what was thought to be true is turned upside down. An individual also must deal with his/her core issues, defined by Whitfield to be "any conflict, concern, or potential problem, whether conscious or unconscious, that is incomplete for us or need sanction or change" (Whitfield, 1987, p. 67). Whitfield lists 14 core issues to work through in the recovery of the inner child or true self. These include all-or-nothing thinking and acting, control, being over-responsible, neglecting our needs, having a high tolerance of inappropriate behavior, fear of abandonment, difficulty handling and resolving conflict, and low self-esteem or shame. Recognizing core issues and risking to deal with them

and not disguise them are important tasks in recovering the true self and discarding the false self. Becoming aware of feelings is crucial in this process. The temptation may be great to avoid the pain of grieving through drugs or alcohol, through continual denial of the loss, or through intellectualization, but there are many experiential techniques which will facilitate feeling or grief around losses of the child. Storytelling, psychodrama, the reconstruction of family or origin, Gestalt therapy, therapeutic body work, and experientially-based group therapy are some examples of these facilitating techniques.

For some people, one of the most difficult feelings to recognize and to express is anger, a major component of healing within. As the abuse and neglect of our lives is discovered, the process of grieving begins and awareness of anger and the expression of it is a major part of that grieving process, according to Whitfield. (1987) Feelings of confusion, sadness, shame, and emptiness result from an environment which forbids expression of feelings. The choices in dealing with these feelings of anger are: (1) numbness; (2) hold on till it gets unbearable; (3) repressing it which creates physical illness or emotional sickness and/or blowing up; (4) blotting out the pain with alcohol or drugs or other compulsive behaviors; (5) expressing the

pain and working through it in a safe place. (Whitfield, 1987) Whitfield states, "Eventually, after we have worked through our anger and the rest of our grieving, we let go of our anger and our suffering. We come to a point where we have had enough" (Whitfield, 1987, p. 105).

The transformation stage in healing the inner child follows the expressions of anger. There is a switch from one level of reality to another, and "We transform the burdensome and often dysfunctional parts of our lives into positive and more functional ones" (Whitfield, 1987, p. 107). It is a healing moment, indeed, writes Whitfield, when one becomes aware of a concern, experiences it, considers that there is a choice to stop suffering over it, and lets it go. The final work of healing the inner child is applying transformation to every-day living, or the state of integration. (Whitfield, 1987)

The implication that experiential therapy and re-experiencing emotions can actually change the function and structure of the brain can be overwhelming, but it is indeed possible.
(Wegscheider-Cruse, Cruse, & Bougher, 1990, p. 28)

Mechanisms of Change in Affective Therapeutic Process

There is a good deal of inquiry into the mechanism of therapeutic change using affective strategies. Greenberg and Safran (1987) write, for example, that research leads them to believe the evocation of emotional material is prerequisite to the change of certain memory structures. Tantamount to this understanding is the necessity of prior knowledge as to the psychological and biological effect of traumatic life events. Bessel van der Kolk is presently engaged in the study of a biologically based response to psychic trauma. In regard to his research, van der Kolk writes that, "Posttraumatic stress disorder [PTSD], perhaps more than any other mental disorder, demonstrates the close interdependence of psychological and physiological reactions" (van der Kolk, 1987, p. xi). Such inquiry into PTSD has provided an understanding of the nature of the biological alterations in the body that underlie the psychological response to trauma. In tandem with this growing knowledge comes information linking a dependence of these biological shifts on the maturation of the central nervous system, the development of cognitive processes and the social matrix of the person affected by trauma. (van der Kolk, 1987) Thus, the meaning an individual gives a traumatic event, the subsequent affective response, probable

physiological changes, and the ultimate posttraumatic complications are determined by many differing factors.

The implications of such findings for the treatment of trauma are enormous. The return in memory and the integration of traumatic memories into existing mental schemes, and the powerful process of transforming a memory into narrative language which may, ". . . actually produce a change in the abnormal processing of a traumatic memory . . . bringing relief of many of the major symptoms of PTSD" (Herman, 1992, p. 183), are several more credible possibilities emerging from research on the biological response to trauma. As has been stated, precautions are: that emphasis be on the individual uniqueness of each person and on careful investigation of each individual history and present diagnosis.

Psychotherapy and pharmacotherapy face great challenges in the treatment of trauma response, and van der Kolk stresses the importance of controlled clinical trials. (1987)

The area of recovery also offers speculation for this process. The literature of S. Wegscheider-Cruse and J. Cruse concerning co-dependency, describes co-dependents as having ingrained patterns of behaving, feeling, and thinking that get reordered during experiential therapy. Cruse writes

that in years to come researchers will establish links between hormones and other chemicals of the brain and human behavior. It will then be known, according to Cruse, ". . . how experiential therapy and other cerebrotherapeutic techniques actually affect the function, chemistry, and anatomy of our brain" (Wegscheider-Cruse & Cruse, 1990, p. 28).

According to these authors,

Structure, function, and behavior all affect one another. Actual structural changes in the connections between neurons and the workings of certain centers in our brain can occur. . . . We constantly adapt and change circuitry in our brains as we continue to cope with our environment. Other times we are "stuck" with our systems as they are and need an intervention to jog us free. We need to have our brains stimulated. One of the most effective ways to provide this stimulation is to direct the patient to establish and experience certain stimuli. . . . This is the purpose of the experiential therapy: to re-experience thoughts, behaviors, and emotions and deal with them in order to heal them and be done with them. (Wegscheider-Cruse & Cruse, 1990, p. 29)

Cruse further writes that although the brain was previously thought to be unchangeable, repetitive thinking, feeling, and behaving can change many of the working systems and can cause gain or loss in the number and size of certain brain cells and can also change the number and kinds of connections among brain cells (the anatomy is changed). (Wegscheider-Cruse & Cruse, 1990)

Another area of consideration in "what" happens in the use of affect to bring about change is that of the interaction between the affective and cognitive processes. Greenberg and Safran (1987) write that one of the effects of affective expression in therapy is its production of some form of cognitive reorganization of the individual's view of the world. This, in turn, brings about a change in behavior. Although the specific roles which cognition and emotion play with each other and their link to behavior or action is not clear, Greenberg and Safran see both as necessary in producing lasting effect. "It is in its effect on cognitive structures that the arousal of affect is significant in therapeutic change" (Greenberg & Safran, 1987, p. 198). After the expression of intense affect, cognitive reorganization is achieved by differentiating the various aspects of the experience that have been recalled, by acknowledging or affirming the new view or new meaning of this experience, and by validating a new image of the self implied by this new view. (Greenberg & Safran, 1987)

Furthermore, during the re-enactment or re-working of an experience, the client seems to be simultaneously experiencing, the client seems to be simultaneously experiencing him/herself as both participant and observer. They are, therefore, more able to examine different aspects of the

experience in order to achieve a more differentiated perspective on the situation. (Greenberg & Safran, 1987) Another aspect of change is based on the observations of Greenberg and Safran (1987) that through emotive expression, clients become aware of the automatic thoughts that are influencing their view of themselves, others, and the world. Greenberg and Safran believe that when they are aware of "what they are doing to themselves," there is a sense of responsibility, empowerment, and a motivation for combating negative self-statements.

A further explanation as to "what" may happen in the expression of strong affect is that in the experiential learning process, the individual actually experiences being cared for and valued. There is, therefore, a possibility for a new way of being in the world. After an awareness and expression of strong or painful feelings, with a trusted and supportive therapist, a client can say, "I can be myself and be loved without some dreaded negative consequence." With this realization comes another, "I can now relive this experience with no real threat." In summary, when people fully acknowledge an experience as their own, a change in their being-in-the-world occurs. "Direct emotional experience has a salience that overrides

other cues to reorganize and restructure people's views of themselves and their situation" (Greenberg & Safran, 1987, p. 192).

The Affective Therapist and Therapeutic Relationship

In his book, *Human change processes*, M. Mahoney (1991) states that the basic tenet underlying psychological services is: "Humans can . . . change; humans can help other humans change . . . some forms of helping are more effective than others in facilitating that change" (Mahoney, 1991, p. 254).

This paper continues with an examination of those who can help others change.

Before examining the skills, knowledge, and techniques needed by the therapist, the "person" of the therapist and the quality of the therapeutic relationship will be addressed. This relationship, in Mahoney's opinion, is much more central to the quality and effectiveness of therapy than are the specific techniques, explicit interpretations, and the theory underlying the experience of psychotherapy. (Mahoney, 1991) As viewed by Mahoney,

. . . the optimal therapeutic relationship creates a special and intimate human context in and from which the client can safely experiment with and explore familiar and novel ways of experiencing self, world (especially the interpersonal), and possible relationships. (Mahoney, 1991, p. 267)

An intense inner connection between therapist and client seems to be necessary for focusing on emotions, which may have never before surfaced or have never been fully experienced. The therapist must do whatever possible to establish a safe, accepting, and supportive environment which will allow deep exploration of feeling. Heretofore unacceptable or unconscious feelings are expressed and accepted by another; therefore, the client experiences being cared for and valued in a new way, and certain suppositions which they held about themselves as being unworthy are challenged. As previously mentioned, Greenberg and Safran (1987) write that experiencing this caring relationship leads to a schematic and conceptual reorganization. New information must be incorporated which says, "I am lovable, acceptable, and a worthy human being."

Another ingredient of this therapeutic alliance can be the concept of client and therapist as co-workers, overcoming obstacles together. Goals, therefore, are shared goals, and the basic belief that the affective work in which they are engaged will be helpful in reaching these goals is also shared. (Collins & Gabor, 1988) This form of bonding is looked upon by Watkins (1991) as an "adding of the therapist's ego-strength to that of the patient's" (p. 55).

As he writes of the conditions which must be necessary to warrant the use of abreactive techniques, Watkins (1991) believes that there must be a willingness and ability on the part of the therapist to co-experience and co-suffer an intense emotional experience with the patient. This requires a deep commitment and belief in the affective process. Implicit in this requirement is the therapist's own ability to face and accept his/her emotions. Alice Miller (1990) writes that the true need for the client is not a tutor, an interpreter, or confuser, but for an enlightened witness to accompany him on the journey. "Someone who has himself never learned to feel will not know that he makes it impossible for the other person, the patient, to feel" (Miller, 1990, p. 184).

The skills and the knowledge level of the therapist must necessarily include an ability to evaluate the suitability of the client for emotive therapy. Watkins (1991) writes that conditions which make abreactive therapy suitable include: a condition which is acute rather than chronic; specific symptoms which appear to be related to specific conflicts, and a patient with sufficient ego strength to undergo strong emotional work. Greenberg and Safran (1989) recommend assessing the type of emotion expressed by the client in therapy in order to guide the therapist.

Distinctions are made between four categories of emotions: (1) adaptive primary emotions, which provide information to the client about responses to situations; clients are often unaware of them and they need to be intensified and used as aids in problem-solving therapy; (2) secondary reactive emotional responses, which are not the client's direct response to situations but are secondary to primary reactions or are reactions to the thwarting of primary responses; these emotions are to be bypassed or explored in order to access underlying processes; (3) instrumental emotional responses are emotional behavior patterns which originate to influence others, such as crying to evoke sympathy; they are best bypassed or confronted but not explored to access adaptive information; (4) learned maladaptive primary responses; can be learned in response to trauma in childhood and do not play an adaptive role in human functioning.

When the determination is made by the therapist to access emotion, Greenberg and Safran recommend following several general principles of intervention to help clients engage in affective therapy. Keeping in mind these may be painstakingly slow processes, the principles are: (1) directing attention to inner experience; becoming aware of inner feelings and needs; (2) refocusing on inner experience; (3) encouraging present centeredness;

(4) analyzing expression of affective state; non-verbal cues; (5) intensifying emotional experience; physical acting out or increasing vividness of imagined representations; (6) symbolizing experience; words or concrete forms such as drawing, movement, sound; makes experience more accessible and more amenable to clarification; (7) establishing intents; move client toward making declarative statement of intent; action tendency integrated with goals and plans, with reality. These principles guide the interventions of the therapist and deepen the experiential process in order to promote new meanings for the client. (Greenberg & Safran, 1989) In summary, Greenberg and Safran write,

Thus, in an emotionally focused intervention, the therapist tracks the client's moment-by-moment experience. The therapist works continually to highlight and develop aspects of the client's experience. . . . All these emerging experiences are supported by the therapist until an experientially based core scheme emerges. The accessing of emotion is thus primarily a process of directing the client to attend to internal information and supporting the construction of new meaning structures based on newly accessed experiential information. (p. 26)

A tool which may be used by the therapist to bring about emotional restructuring through evoking affective memories is that of imagery, which involves guiding the client to generate images which activate expressive motor and autonomic responses and sensations associated with the feelings

memories. (Greenberg & Safran, 1987) Watkins (1991) regards imagery as an approximation to the hypnotic state which he induces in the process of abreaction. The traumatic scene must be made as vivid as possible in the present tense, according to Watkins, using every modality possible to create an experiential return to the traumatic episode at which time there is a breakthrough and feelings being to flow until the client is psychologically and physically exhausted. It should be reiterated here that Watkins puts a great deal of emphasis on the strong therapeutic relationship which underlies abreactive techniques. This is a relationship, according to Watkins, in which the therapist resonates with the client, establishing a "witness" which promotes a type of co-suffering of client and therapist.

(Watkins, 1991)

Another useful way to activate emotions is to use activities that produce kinesthetic feedback. Being rocked or striking a pillow, for example, produce feelings of vulnerability or hostility. The purpose remains the evoking of the emotion memory which is in need of restructure. (Greenberg & Safran, 1987)

In dealing with cathartic disclosure among children who have suffered very painful life experiences, Collins and Gabor (1988) note that an important

skill for the therapist is the ability to help make explicit content that the child is afraid to put into words. This could be an important skill for working with people of all ages in aiding emotional disclosure and the release of accompanying feelings. It also may be very important that the therapist not inhibit, block, or side-track the emotional discharge. This can occur, for example, if the therapist is too quick to provide comfort and offer assurance. Similarly, prematurely probing for details may be counter-productive. Quickly shifting from expressing and releasing feelings to answering questions can stop the disclosure process. According to Nichols and Efran (1985), asking analytic questions in the throes of an affective experience can divert the client from finishing the experience. A further skill of the therapist at this time in the emotive process is to resist the temptation to reinterpret and process the client's experience. Analyzing the client's resistance can also lead to more cognitive wheel-spinning and less emotional expression. (Nichols & Efran, 1985) Therefore, in such moments, simple encouragement such as, "Let go," or "Stay with it," are more appropriate than analysis. The qualities of empathetic responding, assurance, and basic human compassion are essential in a therapist using affective strategies.

When working with children or with adults, great caution must be used when encouraging disclosure of the trauma and releasing associated emotions. Repression can be the most adaptive response for children and a long-standing defense for many adults and must be disassembled with care. Mahoney stresses the use of caution in general when using techniques in the therapeutic process. He writes that, ". . . we can profitably use special techniques, but we should be cautious about empowering any tool to the point that it subjugates rather than serves its user" (Mahoney, 1991, p. 288).

Care must be taken that the therapist not fall into the fantasy of the "fast cathartic cure" (Herman, 1992). This caution is explicit in the writing of Judith Herman in her book entitled *Trauma and recovery*. Emphasis is placed on the importance of the "healing relationship" between client and therapist, with particular precautions to the potential complications of transference and countertransference, and the essential quality of safety in this relationship. This safety is guaranteed by careful attention to boundaries of the therapeutic relationship. Therefore, imperative is a high degree of self-awareness on the part of the therapist and a readily available clinical support system. Establishing the safety necessary for the client to proceed to the other steps of recovery from trauma (remembrance,

mourning, and reconnection) may be a long, client-initiated process, the timing of which must be respected by the therapist. Proceeding in an alternative fashion could be disastrous for the client.

Diagnosis is a further imperative for proper treatment of traumatic syndromes. The symptoms, diagnosis, and treatment of recent acute trauma, for example, may be vastly different from that of the client subjected to prolonged abuse in childhood. The uniqueness of each client necessitates a great deal of skill and knowledge, extensive details of which are beyond the scope of this paper, as well as a great deal of caution on the part of the therapist. The following quote captures this conviction of Herman: "Programs that promote the rapid uncovering of traumatic memories without providing an adequate context for integration are therapeutically irresponsible and potentially dangerous, for they leave the patient without the resources to cope with the memories uncovered" (Herman, 1992, p. 184). Specific steps and stages must be addressed in the recovery process.

Of utmost importance to many theorists is the stage of integration or interpretation which follows the release of strong emotion. According to many theorists, the cathartic ventilation is not an end in itself, but a

beginning. For example, Nichols and Efran (1985) conclude that some modern cathartic procedures, including a number of encounter group exercises, fail their participants by limiting emotional expression to isolated incidents which provide little rationale for integrating such experiences into day-to-day living. Watkins (1991) writes that after the tears, anger, and fear have subsided, comes the time for reassurance and interpretation.

The therapist must also, therefore, possess the skills to help clients use the new information to reorganize and create new meanings for themselves in the world. Lasting change comes about, according to Greenberg and Safran (1987) because of reorganizing and restructuring the view people have of themselves and their situation. And Nichols and Efran write that, "To be most effective, catharsis should be part of a larger, more complex feeling-thinking-acting process" (1985, p. 26).

Watkins (1991) suggests that an understanding of the client's experience immediately follow the emotional release. With resistance and defenses down, the therapist and client bring meaning through interpretation, at a time when new information can be accepted and integrated by the client. "Cognitive understanding can more easily follow after the emotional resistance to it has been exhausted" (Watkins, 1991, p. 57).

As was mentioned previously, Greenberg and Safran (1989) term the two working stages following intense emotional release those of symbolizing and of stating intentions. These two principles serve to promote new meaning and provide a sense of direction for action. In the symbolization process, patterns of meaning are drawn from experience. After the client has become aware of feelings and has symbolized the experience, the therapist helps the client toward statements of intent. The client is asked what he/she needs or wants based on the newly experienced feelings. This action tendency is then integrated with goals and plans, thus establishing a bridge between the subjective experience and what will happen in the life of the client.

Essential to the success of affective intervention is the belief of the therapist in its value. Greenberg and Safran (1987) believe that personal experience on the part of the therapist is necessary in order to have confidence that affective shifts can and do occur and to have confidence in the client's organismic response. The fear that could be present while working with strong affect is thus averted by the experienced therapist whose personal knowledge in this area helps with the realization that feelings do not overwhelm and that they can provide valuable adaptive

information. The underlying belief is present, therefore, that a desired direction or action will emerge when working with affective therapy.

Summary

Although affective methods in psychotherapy appear to be enjoying a renaissance, there is much controversy as to their efficacy as well as their place in the therapeutic process. In terms of empirical evidence, Nichols and Zax (1977) believe the growth in the use of emotional catharsis has not been matched by careful theoretical analysis or systematic research. In addition, numerous theorists question the effectiveness of using simple discharge techniques to bring about change in the therapeutic process. Mahoney writes, ". . . although evocative and expressive techniques . . . may have short-term effects on some measures of tension and distress, they are generally insufficient in facilitating significant and enduring psychological change" (Mahoney, 1991, p. 199). Leslie and Greenberg (1987; 1989) have also noted, ". . . the processes of therapeutic change are closely linked to affective experience but not adequately captured by simple catharsis hypotheses" (Mahoney, 1991, p. 199). It is not the intention of this paper to present a cathartic or discharge method as the major focus of treatment.

Rather it is the intention to present affective methods of therapy as an adjunct to treatment. Therefore, even when catharsis is not a central feature of therapy it is a useful component of successful treatment.

Yalom captures this conviction, in the opinion of this author, as he writes of the dual nature of the therapeutic process, therapy as an emotional and corrective experience. He writes, "We must experience something strongly; but we must also, through our faculty of reason, understand the implications of that emotional experience" (Yalom, 1985, p. 28). Research findings of Yalom and his colleagues provide ". . . much support for the dual emotional-intellectual components of the psychotherapeutic process" (Yalom, 1985, p. 29).

The role of emotion in psychotherapy is important, is complex, and there is much controversy surrounding its place in the process of therapeutic change. As more evidence is revealed concerning the cognitive-affective network, there is a re-examination of all theories of psychotherapeutic thought.

This paper has focused on emotion as an ally in the process of life change and adaptation. One's ability to experience and express affect, therefore, is an essential condition for dealing appropriately with one's environment in

the present and the future. Included in such a schemata is an experiencing and integration of emotions and parts of the self which may not have been fully experienced in the past. These ingredients for living a full life are the "grist" for the process of psychotherapy.

This paper has attempted to present the aspect of psychotherapy that is an emotional re-education. It is an opportunity for the client to "become" as never before. Through emotional experiencing, there is a reorganization of the person's body, mind, and spirit, and a new being emerges out of a never before thinking/feeling relationship or unity. That is the opportunity which psychotherapy offers in the hands and heart of the aware and emotionally experienced therapist.

References

- Anderson, S. R., Hopkins, P. (1991). *The feminine face of God*. New York: Bantam Books.
- Beck, A., Rush, A., Shaw, B., & Emery, J. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- Beck, A. (1976). *Cognitive therapy and the emotional disorders*. New York: Meridian.
- Borysenko, J. (1990). *Guilt is the teacher, love is the lesson*. New York: Warner Books.
- Borysenko, J., & Taylor, P. (1991). We can go home again. *New Age Journal*, 35-102.
- Bradshaw, J. (1988). *Healing the shame that binds you*. Deerfield Beach, FL: Health Communications.
- Brown, M. (1979). Beyond Janov: The healing touch. *Journal of Humanistic Psychology*, 19(2), 69-89.
- Collins, D., & Gabor, P. (1988). Helping children with cathartic disclosure of trauma. *Journal of Child Care*, 3(6), 25-38.
- Coven, A. (1985). The bioenergetic approach to rehabilitation counseling. *Journal of Applied Rehabilitation*, 16(2), 6-10.
- Dobson, K. (1988). *Handbook of cognitive behavioral therapies*. New York: Guilford Press.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. Syracuse, NY: Citadel Press.

- Ellis, A. (1989). Rational emotive therapy. In R. Corisini & D. Wedding, (Eds.), *Current psychotherapies* (4th ed.). Itasca, IL: F.E. Peacock, Inc.
- Gendlin, E. T. (1973). Experiential psychotherapy. In R. Corisini (Ed.), *Current psychotherapies*. Itasca, IL: Peacock Publ., pp. 317-352.
- Greenberg, L., & Safran, J. (1987). *Emotion in psychotherapy*. New York: Guilford Press.
- Greenberg, L., & Safran, J. (1989). Emotion in psychotherapy. *American Psychologist*, 44, 19-29.
- Grof, S. (1985). *Beyond the brain*. Albany, NY: State Univ. of New York Press.
- Grof, S. (1988). *The adventure of self discovery*. Albany, NY: State Univ. of New York Press.
- Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.
- Horney, K. (1950). *Neurosis and human growth*. New York: W. W. Norton.
- Hunter, M. (1990). *Abused boys, the neglected victims of sexual abuse*. Lexington, MA: Lexington Books.
- Janov, A. (1970). *The primal scream*. New York: Dell Publ.
- Lowen, A. (1975). *Bioenergetics*. New York: Coward, McCann, Geoghegan.
- Mahoney, M. J. (1991). *Human change processes*. New York: Basic Books.
- Mahrer, A., Lawson, K., Stalikas, A., & Schachter, H. (1990). Relationships between strength of feeling, type of therapy and occurrence of in-session good moments. *Psychotherapy*, 27(4), 531-541.

- Mahrer, A., Nadler, W., Stalikas, A., Schacter, H., & Sterner, I. (1988). Common and distinctive therapeutic change processes in client-centered, rational-emotive, and experiential psychotherapies. *Psychological Reports*, 62, 972-974.
- Mathieu-Coughlan, P., & Klein, M. (1984). Experiential psychotherapy: Key events in client-therapist interaction. In L. Rice & L. Greenberg (Eds.), *Patterns of change*. New York: Guilford Press.
- Middleton-Moz, J. (1989). *Children of trauma*. Deerfield Beach, FL: Health Communications.
- Miller, A. (1981). *The drama of the gifted child*. New York: Basic Books.
- Miller, A. (1986). *Thou shalt not be aware*. New York: Penguin.
- Miller, A. (1991). *Breaking down the wall of silence*. New York: Dutton.
- Moreno, J. L. (1955). Psychodrama. In J. McCary & D. Sheer, (Eds.), *Six approaches to psychotherapy*, New York: Dryden Press, pp. 288-340.
- Nichols, M. P., & Efran, J. (1985). Catharsis in psychotherapy: A new perspective. *Psychotherapy*, 22, 46-62.
- Nichols, M. P., & Zax, M. (1977). *Catharsis in psychology*. New York: Gardner Press.
- Oatley, K., & Jenkins, J. (1992). Human emotions: Functions and dysfunctions. In M. Rosenzweig & L. Porter, (Eds.), *Annual Review of Psychology*, Vol 43, Palo Alto: Annual Reviews, pp. 55-85.
- Perls, F. (1969). *Gestalt therapy verbatim*. Lafayette, CA: Real People Press.
- Perls, F. (1973). *The gestalt approach and eye witness to therapy*. Ben Lomond, CA: Science & Behavior Books.

- Plutchick, R. (1980). *Emotion, a psychoevolutionary synthesis*. New York: Harper and Row.
- Rudestam, K. (1982). *Experiential groups*. Monterey: Brooks/Cole.
- Rogers, C. D. (1980). *A way of being*. Boston: Houghton Mifflin.
- Salzman, N. (1989). Integrating intensely emotional with psychodynamic, gestalt, cognitive and behavioral therapeutic elements. *Psychotherapy in Private Practice*, 7(1), 54-67.
- Schaef, R., Kirkman, D., & Ungashick, B. (1981). Primal therapy. In R. Corisini, (Ed.), *Handbook of innovative psychotherapies*, New York: John Wiley & Sons, pp. 650-664.
- Stettbacher, K. (1991). *Making sense of suffering*. New York: Dutton.
- van der Kolk, B. (1987). *Psychological trauma*. Washington, D.C.: American Psychological Press, Inc.
- Vos, B. (1988). Guidelines for selecting experiential techniques in family therapy. *Family Therapy*, 15(2), 115-131.
- Watkins, J. G. (1991). *The practice of clinical hypnosis, Vol. II, Hypnoanalytic techniques*, New York: Irvington.
- Wegscheider-Cruse, S. (1981). *Another chance*. Palo Alto: Science and Behavior.
- Wegscheider-Cruse, S. (1985). *Choicemaking*. Pompano Beach, FL: Health Communications.
- Wegscheider-Cruse, S., & Cruse, J. (1990). *Understanding co-dependency*. Deerfield Beach, FL: Health Communications.
- Wegscheider-Cruse, S., Cruse, J., & Bougher, J. (1990). *Experiential therapy for co-dependency*. Palo Alto: Science and Behavior.

Whitfield, C. (1987). *Healing the child within*. Pompano Beach, FL: Health Communications.

Whitfield, C. (1990). *A gift to myself*. Deerfield Beach, FL: Health Communications.

Yalom, I. (1985). *The theory and practice of group psychotherapy*. New York: Basic Books.

Yalom, I. (1989). *Love's executioner & other tales of psychotherapy*. New York: Basic Books.