



Durham E-Theses

Catharsis in psychotherapy

Hawkins, Peter John

How to cite:

Hawkins, Peter John (1986) *Catharsis in psychotherapy*, Durham theses, Durham University. Available at Durham E-Theses Online: <http://etheses.dur.ac.uk/6884/>

Use policy

The full-text may be used and/or reproduced, and given to third parties in any format or medium, without prior permission or charge, for personal research or study, educational, or not-for-profit purposes provided that:

- a full bibliographic reference is made to the original source
- a [link](#) is made to the metadata record in Durham E-Theses
- the full-text is not changed in any way

The full-text must not be sold in any format or medium without the formal permission of the copyright holders.

Please consult the [full Durham E-Theses policy](#) for further details.

CATHARSIS IN PSYCHOTHERAPY

Thesis submitted for the degree of

Ph.D.

University of Durham

by

Peter John Hawkins

May, 1986

The copyright of this thesis rests with the author.
No quotation from it should be published without
his prior written consent and information derived
from it should be acknowledged.



15. FEB. 1987

ACKNOWLEDGEMENTS

Throughout the time of the preparation of this thesis I have been actively encouraged, and wisely counselled by my supervisor Dr. Arthur Still. I warmly appreciate his active support. Special thanks must also go to all the co-researchers who attended the weekly research sessions. Without their enthusiastic and consistent support the research inquiries would not have been possible.

CONTENTS

Acknowledgements.....i

Abstract.....iii

List of Figures.....v

List of Tables.....vi

Chapter One Catharsis in Retrospect.....1

Chapter Two Catharsis in Psychotherapy.....21

Chapter Three The Effectiveness of Catharsis -
Research Evidence.....95

Chapter Four Research Inquiry One.....138

Chapter Five Research Inquiry Two.....187

Chapter Six Catharsis: Clinical Application..239

Appendix One Catharsis Research Schedule.....263

Appendix Two Techniques.....271

Appendix Three Tables.....286

Appendix Four Physiological Data: Inquiry One..294

Appendix Five Physiological Data: Inquiry Two..302

Appendix Six California Personality Inventory:
Scale Descriptions, Profile
Sheets, & Results.....313

Appendix Seven Personal Reports.....328

References.....340

ABSTRACT

Catharsis in Psychotherapy

The historical context of catharsis in psychotherapy is discussed, with particular reference to drama and ritual. The 'cathartic technique' of Freud and Breuer is then presented as part of the continuing development of approaches that advocate feeling-expression as a way of promoting personal change. The contemporary approaches considered include Reichian therapy, bioenergetics, primal therapy, and reevaluation counselling. Heron's theory of catharsis in human development is emphasized, and is central to the two experiential research inquiries presented later.

The evidence for the efficacy of catharsis is reviewed from the perspective of the various 'schools' of emotionally-expressive therapy, and reference to the psychosomatic and bereavement literature is also made.

Two research inquiries are presented which investigate the effects of catharsis on human functioning. A new paradigm experiential approach was adopted in which co-researchers engaged in a collaborative inquiry. 'Inside' measures of subjective experiencing, contingent upon emotional catharsis, were gathered through self-report, as well as 'outside' measures of blood pressure, pulse rate, and personality functioning. Results suggest that

physiologic tension decreases following somatic emotional catharsis, but that longer term changes in psycho-somatic functioning require the development of insight into the genesis of the 'symptom', as well as complementary therapeutic strategems. It is further suggested that the development of insight is contingent upon historical somatic catharsis. The results also show that where cognitive catharsis occurs without affective release, an increase in psycho-physiologic tension is effected, as shown in both the physiological measures and subjective experiencing.

Finally, the implications of catharsis for therapeutic practice are discussed.

TABLES

Table 1	Changes in blood pressure following emotional catharsis - Inquiry One.....	286
Table 2	Changes in pulse rate following emotional catharsis - Inquiry One.....	287
Table 3	Total number of cathartic events.....	288
Table 4	Changes in blood pressure following emotional catharsis - Inquiry Two.....	289
Table 5	Changes in pulse rate following emotional catharsis - Inquiry Two.....	290
Table 6	Catharsis: Summary - Inquiry Two.....	291
Table 7	Total cathartic events - Inquiry Two.....	291
Table 8	Changes in baseline blood pressure.....	292
Table 9	Changes in baseline pulse rate.....	292
Table 10	Differences in standard scores between pre- & post- inquiry measures on the CPI.....	293
Table 11	Incidence of somatic emotional catharsis (historical), insight, & mean changes on the CPI scales.....	293

FIGURES

Figure 1	Summary chart of Heron's theory of Catharsis in Human Development.....	88
Figure 2	Relationship between insight and mean changes on the CPI scale.....	224
Figure 3	Relationship between number of somatic emotional cathartic events and mean changes on the CPI scale.....	225
Figure 4	A model for change.....	252

CHAPTER ONE

CATHARSIS IN RETROSPECT

And with tears of blood he cleansed the hand,
The hand that held the steel
For only blood can wipe out blood,
And only tears can heal.....

(Oscar Wilde)

Emotional occasions, especially violent ones,
are extremely important in precipitating
mental rearrangements.

(William James)

Catharsis derives from the Greek **katharsis** meaning 'to clean or purify'. However, the term has taken on different meanings in different contexts. In a medical context, it referred to purgation, or the elimination of offensive humours. In a religious context it means rebirth or initiation, and in a moral and spiritual context it refers to relief of the soul and spirit by purification. Thus its semantic origins suggest that catharsis has always included two ideas: purgation or purification; and rebirth or initiation into a new state. Inherent within this view of catharsis is that of emotional discharge which brings relief to emotional tension, and a concomitant or consequent change in the individual's state of being, with



appropriate emphasis given to somatic, psychological or spritual dimensions.

The value of catharsis has been debated for more than 2000 years, commencing with Aristotle's response to Plato's condemnation of drama for arousing the passions.

Aristotle, in writing of catharsis achieved through art, music and drama, emphasized its aspect of purgation. These art forms drive the passions to a peak and then exorcise them. Tragedy arouses pity and fear, and purges these emotions; it is therefore of value despite the attacks of certain moralists and philosophers. In the Poetics he wrote, "Tragedy, then, is the representation of an action that is serious, complete, and of a certain magnitude; in language pleasurably and variously embellished suitably to different parts of the play; in the form of actions directly presented, not narrated; with incidents arousing pity and fear in such a way as to accomplish a purgation (katharsis) of such emotions." It should be noted at this point that Aristotle did not state that a similar purging of hostile and angry feelings may also occur and may not even have believed it possible, although many modern writers (e.g. Feshbach, 1961) have made such an assumption. Emotions are aroused and then purged because the audience is able to identify with the tragic hero to the extent that his pain has relevance and meaning to them. The

Aristotelian concept of tragedy is thus not simply a passive intellectual exercise, but a profound upheaval, charged with emotion through similarities between the tragic hero's experience and the audience's experiences. The shock of the emotional arousal and purgation helps to rearrange perception and so leads to a modification of the audience's self concept and world view. Aristotle believed that the powerful intellectual and affective experience of having anxiety dissolve in tears fosters personal exploration and development. However, Aristotle did not define catharsis nor did he describe very clearly the conditions under which it occurs and the specific consequences it may have.

Whatever Aristotle's intention may have been, his doctrine of tragic catharsis has been conscripted as a rationalization of Western man's inability to accept emotions as natural, and the resultant need to approach the affects through ritual which is supposed to serve some 'higher' purpose. Plato had already banished poets from his Republic, making his gravest charge that by writing tragedy the poet gratifies and indulges the natural instinct for tears and the desire to give full vent to our sorrows, and thereby has a terrible power to undermine the state and disturb its citizens (Pierce et al., 1983).

The debate over the value of catharsis has continued until the present time, in several different contexts,

including that of psychotherapy. This issue will be returned to in Chapters Two and Three.

Since the time of Aristotle, emotional evocation and release has been advocated and utilized in many different settings. Ellenberger (1970), in his masterly work on the history and evolution of dynamic psychiatry, The Discovery of the Unconscious, demonstrates that techniques of provoking an emotional crisis and guiding the release that follows were the same for temple priests, religious exorcists, sonnambulists, mesmerists, hypnotists, and, as we shall see, the early cathartic psychotherapists such as Janet, Breuer, and Freud. All that changed was the language and beliefs used to describe and explain the phenomenon of crisis-release-relief. In the remainder of this chapter, an examination will be made of the utilization of emotional release in religious and magic healing rituals, in order to provide a richer understanding of the historical and socio-cultural aspects of catharsis.

Religious and magical ceremonies have featured a great variety of rationales and procedures; but in many instances, they are characterized by powerful emotional arousal and catharsis. Most primitive magical practices are concerned with emotional tension and methods of releasing or preventing the build-up. Evans-Pritchard (1965) points out that ".....magic is a substitute activity in situations in which practical means to attain an end are lacking, and its function is either cathartic or

stimulating, giving men courage, relief, hope, tenacity" (p. 73). Also, ordinary social living generates emotional tension which, if not discharged in the situation that evokes it, must be vented in some substitute activity. And for this magic serves admirably.

Malinowski (1955) believed that the essential function of both religious and magical rites is cathartic, in that they reduce fears and tensions. Furthermore, the mimetic form of many rites suggest the desired ends. He says, ".....In the magic of terror, in the exorcism directed against powers of darkness and evil, the magician behaves as if he himself were overcome by the emotion of fear, or at least violently struggling against it. Shouts, brandishing of weapons, the use of lighted torches, form often the substance of this rite. Or else in an act, recorded by myself, to ward off the evil powers of darkness, a man has ritually to tremble, to utter a spell slowly as if paralysed by fear" (1955, p. 79). Such acts, though rationalized and explained by some principle of magic, are clearly expressions of emotion. As a result of such a catharsis a reduction in tension occurs. The magician serves as a model by behaving as if he is overcome by fear himself, and in an atmosphere of ritual and mystery, his expression of these feelings may well prove to be contagious. Furthermore, by trembling ritually a man is liable to generate a great deal of genuine emotional arousal and discharge.

Other cathartic rituals have been reported (Levine, 1963), for example among the Gusii of Kenya, where hostile feelings are ventilated against personal enemies but where the aggression remains fantastic and verbal, rather than actual and physical. Moreover, in such societies, non-aggression is maintained as an ideal. Beattie's (1963) descriptions of witchcraft and sorcery in East Africa also demonstrate that cult activity in this region has always been markedly expressive. He says, "...the excitement and colour of these occasions, contrasting vividly with the drab everyday life of agricultural labour, may be presumed to have a strong cathartic effect on participants, and so to provide at least a partial means to the release of inner tensions. There is evidence, too, that 'cures' by these means of quite serious conditions are not uncommon" (p. 51).

Medicine men perform several functions, some of which may be called folk psychiatry. Such primitive folk psychiatries are substantially psychological, and are practiced by those whose standardized cultural role gives them the power to instil hope, exert suggestion, and modify psychological defences. As a folk psychiatrist, the primitive healer uses techniques still practiced in modern psychiatry: rest, removal from stress, relaxation, hypnosis, suggestion and catharsis. The occult powers attributed to the shamans creates a powerful expectation that after the sufferers have expressed the strong feelings called forth, the

healing rites would be successful. Furthermore, the highly ritualized and authoritative nature of the proceedings give the afflicted permission to depart from emotional norms and emotional restraint. Various examinations of religious healing rituals in primitive societies have shown that catharsis has played a central role. Shamans typically began the rites by performing feats of magic to demonstrate their power, enhance expectations of success, and generate an emotionally charged atmosphere. Sufferers were encouraged to re-enact past experiences, their excitement being intensified by rhythmic music, chanting and dancing. One of the key elements in the success of these 'healing ceremonies' was confession. The cognitive aspect of confession involves admitting one's sins and hearing from the non-judgemental listener that he/she isn't wicked (c.f. Roger's person-centered counselling). This often leads to somatic-emotional catharsis involving the expression and discharging of pent-up feelings. Clearly the cognitive aspect of confession and exoneration has somatic consequences and vice versa.

So far the anthropological evidence presented suggests that ritual served an important function by alleviating the anxieties of participants in areas of uncertainty. Malinowski (1945) represents this positive orientation towards catharsis. However, Radcliffe-Brown (1952), suggested that it was just as reasonable to assume that ritual created emotional distress, as it was to assume

that it alleviated distress. In contemporary anthropology, the emphasis has shifted away from catharsis to a concern for cognitive and symbolic functions (Douglas, 1970), a shift that is paralleled in psychotherapeutic practice.

Shamanistic healing rituals provide somatic-emotional catharsis through bodily movement and vigorous expression of emotion. They also provide cognitive-emotional catharsis through remembering and confessing a series of distressing experiences. Often such ceremonies provide a ritualized outlet for culturally tabooed emotions. Following this ceremonial catharsis, 'patients' are given comfort and support from the assembled family members as well as the shaman.

Let us now turn our attention to religious healing. Knox (1961) points out that nearly every new religious sect is founded upon the discovery or rediscovery of practices which lead to cathartic release. High emotional levels of tension and fear in people are created, and then a new ideology is suggested as the path of salvation. It is now well known that individuals are often highly suggestible in immediate post-cathartic states (Heider, 1974). From a psychological perspective, it may be said that revivals appeal to emotional mechanisms for disrupting old behaviour patterns and creating new ones. A religious explanation for revivals was offered by Charles Finney, a nineteenth century revivalist: ".....God has found it necessary to

take advantage of the excitability there is in mankind to produce powerful excitements among them before he can lead them to obey" (McLoughlin, 1959). Revivalism invariably includes intense emotional excitement and discharge of feelings. Revival meetings are conducted by a minister, skilled in oratory and in the ways of creating high levels of emotion in his listeners, who are primed to anticipate an intensely emotional experience. Such meetings often end with conversions occurring in the individuals present, frequently dramatic and sometimes involving long-lasting behaviour changes. Of one eighteenth century revivalist, Eleazar Wheelock, Loud (1928) wrote, ".....Large assemblies burst into sobbing and outcries under his preaching and the converted went to the floor as if under sledgehammer blows." John Wesley was able to make his audience start, ".....trembling, weeping and swooning away, till every appearance of life was gone, and the extremities of the body assumed the coldness of a corpse. At one meeting not less than a thousand persons fell to the ground apparently without sense or motion" (Knox, 1961, p. 81).

Knox (1961) quotes from John Wesley's Journal, ".....We called upon God to confirm his word. Immediately one that stood by (to our no small surprise) cried out aloud, with the utmost vehemence, even as in the agonies of death. But we continued in prayer, till a new

song was put in her mouth.....Soon after, two other persons.....were seized with strong pain, and constrained to roar for the disquietness of their heart. But it was not long before they likewise burst forth into praise to God their Savior. The last who called upon God as out of the belly of hell was I.E., a stranger in Bristol. And in a short space he also was overwhelmed with joy and love" (p. 520-521). The 'healing power' of such revivalist meetings was recognized by John Wesley, as is illustrated by the two following quotes from his Journal.

Under the date April 30th, 1739:

"We understand that many were offended at the cries of those on whom the power of God came; among whom was a physician, who was much afraid there might be fraud or imposture in the case. Today one whom he had known many years was the first who broke out 'into strong cries and tears'. He could hardly believe his own eyes and ears. He went and stood close to her, and observes every symptom, till great drops of sweat ran down her face and all her bones shook. He then knew not what to think, being clearly convinced it was not fraud nor yet any natural disorder. But when both her soul and body were healed in a moment, he acknowledged the finger of God" (Knox, 1961, p. 344).

He also records:

"I will show you him that was a lion till then, and is now

a lamb; him that was a drunkard, and is now exemplarily sober; the whore-monger that was, who now abhors the very 'garment spotted by the flesh'" (Knox, 1961, p. 446).

Wesley attributes such 'successes' to the intervention of the Holy Ghost: "..... It is the Lord's doing and it is wonderful in our eyes." Wesley's own success was due to his finding that 'habits of thought and behaviour' were most easily implanted or eradicated by a tremendous assault on the emotions. Wesley had 'rediscovered' the emotions in an 'Age of Reason', where the intellect was held to be far more important. He hit upon an extremely effective technique of conversion. Firstly, Wesley would create high emotional tension in his potential converts, by promising hellfire if they did not achieve salvation. This sense of urgency increased the prevailing anxiety which, as suggestibility increased, could infect the whole group. As well as inducing mental stress by threatening hellfire, he offered the audience a way out, i.e. external salvation won by faith. Emotionally disrupted by this threat, and then rescued from everlasting torment by a total change of heart, the convert is now in a state to be helped by dwelling upon the complementary gospel of Love. Once conversion has taken place, love rather than further fear can be used to consolidate the change.

Revivalist styles have varied with the times but typically have included clapping, singing, rhythmic

dancing, wailing and shouting. Many revivalist meetings featured 'exercises', jerking, rolling on the ground, and sometimes barking, to free the devil. Some of these techniques are not unlike those used in some of the 'new' psychotherapies (see Chapter Two). These violent muscular spasms served to let out 'built-up' tension, and were explained as evidence of divine grace and conversion. In other words, the manifest behaviour was explained with reference to the prevailing religious and philosophic frameworks, thereby providing a certain degree of truth and 'validity', with a consequent increase in plausibility and acceptance. Another manifestation of the presence of supernatural forces was speaking in tongues or **glossolalia**. This hysterical babbling of gibberish is still thought to be a prerequisite to the baptism of the Holy Spirit by many Pentacostals. In certain North Carolina cults, poisonous snakes are handled and passed around in a group, the procedure being accompanied by rhythmic singing, dancing, and hand-clapping. Sargent investigated this cult in 1947 and states: ".....the descent of the Holy Ghost on these meetings was supposedly shown by the occurrence of wild excitement, bodily jerkings, and the final exhaustion and collapse, in the more susceptible participants." (Sargent, 1957, p. 199). Revivalists have occasionally used lengthy protracted meetings to intensify emotional arousal, similar in many respects to marathon 'personal growth' groups, weekend encounter workshops, and Janov's three week

intensive.

Other groups discovered, explored, and finally discarded catharsis. The Quakers, and also the followers of John Wesley, found that 'conversions' frequently did not last. Knox (1961) states that the "more violent symptoms of convincement only belong to the very early days" (p. 150). Knox quotes an early observer, Baxter (1664) as saying: ".....at first they did use to fall into violent Tremblings and sometimes Vomitings in their meetings, and pretended to be violently acted by the spirit; but now that is ceased, they only meet, and he that pretendeth to be moved by the Spirit speaketh; and sometimes they say nothing, but sit an hour or more in silence, and then depart" (p. 150). It will be shown later (Chapter Three) that early psychoanalysts noted the fact that the effects of catharsis were not lasting, and that symptoms often reappeared. Consequently, these psychoanalysts turned away from catharsis as a method for inducing change. However, the literature on religious revivalism (McLoughlin, 1959) contains many reports of genuine and lasting behaviour changes resulting from these emotional events. As William James wrote, "Emotional occasions, especially violent ones, are extremely important in precipitating mental rearrangements" (1914).

In general, it can be said that primitive magic and religion include what are now called non-specific

psychotherapeutic healing mechanisms - the power of suggestion, faith, hope, support and catharsis. Catharsis **may** have been beneficial in giving rise to positive changes in individual functioning, although specific evidence is not available. The major drawbacks to religious and magical rites was their infrequency, ritualization and isolation from everyday experience. Pierce et al. (1983) write, ".....the catharsis they provided was also isolated, rather than being incorporated into everyday experience. Although they unquestionably did a great deal of good, we think that vivid expressions of feeling are therapeutic not because they exorcise 'evil spirits' or 'repressed affects', but because they help people to become more feelingful, thoughtful and active" (p. 30).

Another cathartic procedure with a long history is hypnotherapy, and I propose to examine the work of the early 'hypnotists' now as it has an important bearing on the development of the cathartic psychotherapies (see Chapter Two).

Altered psychic states akin to hypnotism have been recorded from the earliest times, and would probably include many of the states that were described earlier in this chapter. Ornstein (1977) discusses the ways in which altered states are achieved in many traditions, by using methods of concentrative meditation, in order, as he puts it, to depotentiate left hemispherical

consciousness. From time immemorial people have probably brought on some form of self-induced hypnotic state by sitting quietly beside a murmuring stream, listening to the monotonous rhythm of a chant, or staring at some bright object. Descriptions of behaviour suggestive of the use of hypnosis, though attributed to the action of the gods, are to be found in the early history and folklore of the Druids, Celts, Africans, Chinese, and peoples of almost every culture.

In the more recent past many names have been associated with hypnosis - Mesmer, Braid, Elliotson, Charcot, and Freud, to mention but a few. However, the father of hypnotism is usually acknowledged to be Anton Mesmer (1733-1815). Mesmer (1779, 1948) spoke of animal magnetism (an emanating fluid, visible to some!), of universal fluids in the healthy body, of the magnetization of inanimate objects such as wood, metal and water, of the importance of bodily stroking ('passes'), of the influence of the planets on man, and of many other strange phenomena. The efficacy of various inanimate metals to be magnetized or to produce cures varied, he claimed, from the chief of the metals, gold, to the basest, lead. This metalo-therapy had in its time many adherents. At the same time that Mesmer wrote and spoke of these unusual ideas he obtained some rather startling and dramatic cures. Such cures, often with individuals who were 'incurable' by traditional medical approaches, occurred as a result of crises that his

procedure of hypnotic induction would bring about. When he had created the proper attitude in the patient, he caused a crisis, with its attendant convulsive muscular twitchings and trance, to occur. After this had passed, the patient would feel limp (emotionally and physically exhausted) but the illness would have disappeared. At this time an active state of hypnosis with convulsions was the rule, and it was only later that Mesmer accidentally came upon the passive, sleep-like hypnosis described today.

The central feature of Mesmer's treatment room was the **baquet**. This contraption, considered to be the focal point for the magnetic fluid, consisted of a large oaken tub filled with iron filings, water, and powdered glass. This tub had a number of projecting handles by which the patient might obtain a 'magnetic flow', usually directed to the pain areas. These handles or rods were frequently up to thirty in number and consequently that number of 'patients' could be magnetized simultaneously. Mesmer himself added to the solemnity of the situation, not only by using appropriate music but by walking majestically around in flowing silk robes and carrying a wand! He passed among the patients, touching some, making passes at others with his wand, and occasionally fixing patients with a stare and commanding them to sleep. Gradually, individual patients became restless and agitated until a 'crisis' occurred. One patient would scream, break into a sweat and convulse, and this would be followed by others until most of those

present would be emotionally ventilating. Mesmer argued that animal magnetism produced the crisis, but that the 'cure' was effected by the crisis itself. It should also be noted at this point that Mesmer created a very trusting atmosphere by establishing a good relationship with his patients, thereby allowing them to 'drop their defences', so that discharge was free to occur. He must also have realized that emotional states are 'contagious', and that some degree of expectancy is required.

Later on, other medical workers, notably, John Elliotson and James Braid, used hypnosis in surgery, but without the dramatic emotional catharsis associated with 'mesmerism'. It seems reasonable to say that hypnosis relaxes a person's defences, but that other conditions must be present for catharsis to occur. Such conditions probably include an expectation that something emotional will happen, as well as undischarged distress in the psycho-somatic system.

In 1882, Charcot delivered a paper on hypnotism at the **Academie des Sciences**, in which he provided a detailed description of the trance state (Charcot, 1882). This event brought about a radical change in the negative attitude toward mesmerism in France. In 1884 and 1885, Charcot succeeded in 'artificially' reproducing non-organic paralyses with the use of hypnosis. He also pioneered the uncovering of unconscious memories in his studies of 'dynamic amnesia', in which he showed that forgotten memories could be recovered under hypnosis (Sulloway, 1979).

Charcot exerted a profound influence upon Freud. Charcot's demonstrations concerning hysteria and hypnotism captured Freud's imagination during his stay in Paris. These dramatic demonstrations first revealed to Freud that multiple states of consciousness existed. He wrote of them: ".....I received the profoundest impression of the possibility that there could be powerful mental processes which nevertheless remained hidden from the consciousness of men" (1925, p. 17). Charcot was the first to understand the hidden mechanism of hysterical phenomena, as well as the psychogenic nature of hysterical symptoms, and was one of the two most important personal influences (the other being Josef Breuer) that started Freud on the pathway to psychoanalytic theory. Freud's association with Breuer, and the implications for cathartic therapy, will be explored in Chapter Two, along with other developments in hypnotherapy.

Summary

In this chapter it has been shown that there is an ancient tradition of catharsis in drama, ritual and healing. Debate over the effects of catharsis dates back at least to Plato, the ultimate rationalist, who condemned theatrical drama for arousing the passions and thereby undermining the State. Aristotle responded by praising the theatre for its cathartic function, saying that it is

therapeutic because it directly presents incidents that arouse fear and passion. This dispute illustrates two opposing views of catharsis, that still exist today within the field of psychotherapy.

When catharsis was used deliberately in various healing rituals the rationale was based upon the Aristotelian notion of catharsis as purgation and rebirth into a purified state. Even when catharsis was achieved unwittingly in the process of various religious and magic ceremonies, it was reported to produce a feeling of relief and clarified thinking. Healing rituals and magic rites were preceded by the expectation that catharsis would occur, and began with various devices to overcome resistance to emotional release. Although these cathartic ceremonies were apparently therapeutic they did not work by exorcising demons. Instead, they provided a culturally sanctioned occasion for experiencing and expressing significant but taboo thoughts and feelings.

From the perspective of modern psychotherapists interested in lasting personality change, a major drawback of these cathartic rites is their infrequency and ritualized nature. Because the rituals are isolated from everyday experience, catharsis is insulated from, rather than incorporated into, daily living. More important, there is only limited acceptance of primitive impulses, which needed to be rationalized - seen as involuntary and magical, rather than as intrinsic and natural.

In Chapter Two the broad historical development and significance of cathartic procedures in psychotherapy will be discussed.

CHAPTER TWO

CATHARSIS IN PSYCHOTHERAPY

Have they brought her warrior dead,
She nor swooned nor uttered cry,
All her maidens watching said,
"She must weep or she will die."

Alfred, Lord Tennyson.

Freud and Psychoanalysis

We have already noted (p.17) how Freud was profoundly influenced by Charcot, particularly with respect to the psychogenic nature of hysterical symptoms, as well as to the recovery of forgotten memories under hypnosis. Freud endeavoured to present Charcot's finding to his scientific colleagues in Vienna, although he continued to use the conventional physical techniques of treatment in his own practice. It was only on December 2nd, 1887, that Freud acknowledges his use of hypnotism in a letter to his friend, Wilhelm Fliess, ".....I have plunged into hypnotism and have had all sorts of small but peculiar successes" (Kris, 1952, p.53). However, Freud used hypnosis in ways other than mere hypnotic suggestions, as used by Charcot. The other approach, utilizing the **cathartic manner**, was a direct influence of Josef Breuer, and in particular his account of the treatment he had carried out with Anna O. (Bertha Pappenheim). A short account of this

case will demonstrate Breuer's method.

Anna O. was twentyone years of age when, towards the end of 1880, she began to show signs of severe psychological disturbance. It should be noted that at this time her father was gravely ill, and Anna devoted much of her time caring for him. Breuer treated Anna from December 1880 until June 1882, during which time she presented numerous and severe symptoms. Breuer writes of her condition as it was early in 1881:

"There developed in rapid succession a series of severe disturbances which were apparently quite new: left sided occipital headache; convergent squint (diplopia), markedly increased by excitement; complaints that the walls of the room seemed to be falling over (affection of the obliquus); disturbances of vision which it was hard to analyse; paresis of the muscles at the back of the neck.....; contracture and anaesthesia of the right upper, and, after a time, of the right lower extremityLater the symptoms appeared in the left lower extremity and finally in the left arm....."

(Breuer and Freud, 1895, p. 75).

Other symptoms described by Breuer included sporadic deafness, a nervous cough, aversion to nourishment and liquids, suicidal impulses, loss of her ability to speak the German language, and by absences or 'secondary' states of confused delirium, accompanied by alterations of her entire personality. During the daytime

these **absences** would mount with increasing frequency into somnolence, and, after sunset, they would give way to a state of autohypnosis, which the patient referred to as her period of "clouds". Breuer immediately recognized the case as one of hysterical double personality, stating that, ".....two entirely different states of consciousness were present which alternated very frequently and without warning and which became more and more differentiated in the course of the illness. In one of these states she recognized her surroundings; she was melancholy and anxious, but relatively normal. In the other state she hallucinated and was 'naughty' - that is to say she was abusive....." (Breuer & Freud, op.cit., p.76).

Breuer soon discovered that he was able to induce a transition from Anna's normal personality to what she called her "bad self". He also found that if he repeated to Anna each evening, when she entered a state of autohypnosis, the frightening words that she had uttered during her daytime **absences**, she was able to recall the forgotten details of her hallucinations. This process relieved her symptoms, and was referred to by Anna O. as her "talking cure" and, jokingly, "chimney sweeping".

Gradually Anna O. evolved the methodical routine of informing Breuer about each and every past experience of a given symptom. She proceeded in this manner until she reached the point of the first occurrence of each symptom, at which moment the symptom disappeared. This was the

method of 'catharsis' (Breuer's term). Breuer soon demonstrated that all of Anna's symptoms could be dealt with using the same technique: ".....each individual symptom in this complicated case was taken separately in hand; all the occasions on which it had appeared were described in reverse order, starting before the time when the patient became bedridden and going back to the event which had led to its first appearance" (Breuer & Freud, 1895, p. 70). After two years of such treatment the very first of Anna O's symptoms, paralysis of the right arm, was finally relieved after she reported a previous hallucination of a large black snake while sitting beside her father's bedside. After Anna had relived this dream, the paralysis of her right arm, which had lasted two years, and her inability to speak her native German, vanished.

According to Ernest Jones, Anna O's cure was by no means as successful as Breuer himself suggested in Studies on Hysteria (1895), with the patient having many relapses, particularly in the first five years after the termination of treatment. However, the case remains seminal with respect to 'cathartic psychotherapy'. What emerged from this case was that a symptom can be talked away; that this 'talking away' occurs in a hypnotic condition; and that to be effective, it takes the form of reciting the original cause of the symptom. Breuer's overall hypothesis was that, ".....until cure is achieved, the symptoms may appear in normal consciousness but the stimulus remains in

the unconscious" (Breuer & Freud, 1895, p. 66).

Freud was slow to apply Breuer's new cathartic technique himself, probably because many of his patients presented explicit neurological problems, and it was not until May, 1889 that he systematically applied the method (Ellenberger, 1977). There are five known cases that Freud treated in this way, that of Frau Emmy von N. being the first. Freud says of this case, "This was my first attempt at handling that therapeutic method. I was still far from having mastered it; in fact I did not carry the analysis of the symptoms far enough, nor pursue it systematically enough" (Breuer & Freud, 1895, p. 103). Up to this time Freud was still using the method of hypnotic suggestion, and rather than let patients experience their distresses and discharge them, he sought to eliminate them through hypnotic and post-hypnotic suggestion. Although Freud at first used hypnosis to overcome the forces of repression, he later found that it was not necessary.

In the treatment of Miss Lucy R. (1892), Freud states that he ".....conducted her whole analysis while she was in a state which may in fact have differed very little from a normal one" (Breuer & Freud, 1895, p.171). When he came to a point at which the patient seemed unable or unwilling to remember, he used a device he learned from Bernheim, that he called "head pressure". In the case of Miss Lucy R., Freud writes, "I placed my hand on the patient's

forehead or took her head between my hands and said: 'You will think of it under the pressure of my hand. At the moment at which I relax my pressure you will see something in front of you or something will come into your head. Catch hold of it. It will be what we are looking for. - Well what have you seen or what has occurred to you?'" (Breuer & Freud, 1895, p.173). He also reports using this method with Elizabeth Von R.

The therapeutic effectiveness of the 'cathartic' procedure employed in the cases presented in Studies on Hysteria is explained as follows: if the original experience, along with its affect, can be brought into consciousness, the affect is by that very fact discharged or abreacted, the force that has maintained the symptom ceases to operate, and the symptom itself disappears. Breuer and Freud say that, ".....neurotic reactions are cured successfully by bringing clearly to light the memory of the event(s) by which it was provoked and in arousing its accompanying affect; the patient must describe the event(s) in the greatest possible detail and put the affect into words." (Breuer and Freud, 1895, p. 40). Breuer and Freud called this process abreaction, and defined it as: ".....the whole class of voluntary and involuntary reflexes - from tears to acts of revenge - in which, as experience shows us, the affects are discharged" (Breuer and Freud, 1895, p. 42). However, they do not say which specific reflexes are cathartic, nor do they relate

particular motoric actions to internal subjective states except in a very general way.

However, what is important is Freud's recognition of the 'primal process', that all neurosis is the result of early childhood trauma. Breuer and Freud state that, "neurosis is caused by psychical traumas. Any experience that calls up distressing affects - such as those of fright, anxiety, shame or physical pain may operate as trauma.....if there has not been an energetic reaction to the event that provokes an affect sufficient to discharge it" (Breuer and Freud, 1895, p. 48). Freud believed that the cause of hysteria begins with a violent emotional shock. Hysterical symptoms were, "residues - precipitates, they might be called - of emotional experience" (Freud, 1910, p. 14). In addition there must have been circumstances which prevented the emotion from being expressed. Any situation impeding the expression of negative emotions can result in neurosis. Freud goes on to indicate a third feature responsible for the genesis of neurosis, namely, that traumatic events are virtually always part of a **series**, rather than a single occurrence. Of the cases presented in Studies on Hysteria the most common traumatic events are concerned with loss, either the death of a relative or the break-up of a relationship (this is related to Heron's 'secondary frustration' hypothesis discussed later on in this chapter), and incestuous sexual assault.

With respect to method, Freud's technique was considerably more active than that of Breuer's, and apparently discouraged complete catharsis. Freud was more interested in unravelling the sequence of events leading up to the development of hysterical symptoms than he was in how well catharsis might get rid of them. Indeed, Freud had a number of reservations about the cathartic method, which he discusses in Studies on Hysteria (Chapter IV, The Psychotherapy of Hysteria). Firstly, he believed that hypnosis was necessary to evoke catharsis, but he found that some of his patients could not be hypnotized at all, and that many others were only partially susceptible. Consequently, he began to treat patients in a normal state of consciousness, using **free association** to uncover early memories aetiologically significant in relation to symptoms. Secondly, he believed that the cathartic method ".....cannot affect the underlying causes of hysteria: thus it cannot prevent fresh symptoms from taking the place of the old ones that had been got rid of" (Breuer & Freud, 1895, p. 344) Thirdly, he was of the opinion that the method dealt with symptoms rather than with predisposing factors. He believed that other techniques, more cognitive in nature, were necessary for this. These other techniques involved bringing to conscious awareness an understanding of the aetiological factors, and allowing the ego to deal realistically with the hitherto unconscious forces that had been directing behaviour.

Thus, Freud moved away from the cathartic manner to methods utilizing calm, quiet and logical analysis of free association, dream analysis and transference for its therapeutic effect. In other words, Freud had given up working with primal process because it seemed so irrational, and had turned to the rational analysis of secondary process (psychoanalysis), in order to uncover the unconscious memories whose forces combined to generate symptomatology. This change in emphasis led to a downgrading of the role of catharsis in psychoanalytic therapy. However, Freud abandoned catharsis because he thought he had found a more reliable method (free association) for overcoming repression, **not** because he made a major transition from an emotional to a cognitive form of treatment.

The fact that Freud abandoned the 'cathartic method' is often taken as evidence that he found catharsis to be an ineffective method of treatment. However, he was never really an emotivist, and may have been uncomfortable in the face of intense emotional display (Jones, 1953). He was a seeker after memories, who saw affect as a signal that critical memories were being uncovered.

Although Freud eventually rejected the cathartic method it is important to recognize the importance of his early work with Breuer during the period 1888-1894. Freud and Breuer, as well as Janet, shifted towards a modern theory of releasing feelings, by inducing an emotional crisis and

guiding the feeling release to specific events in the patients past. This abreactive catharsis had the merit of shifting the emphasis from a symbolic crisis and release, understood in terms of, for example, some belief system about spirits and devils (as described in Chapter One), to a specific and personal release. Although the goal of psychoanalysis moved away from the cathartic uncovering of the traumatic origin of symptoms to overcoming resistance to recalling past events so that conflicts between libidinal impulses and repressing forces could be brought into awareness, catharsis was still acknowledged to play a subsidiary role. Freud's belief that buried feelings must be made actual and manifest, so they can be dealt with directly, suggests that catharsis may be a useful part of the process. Later on many psychoanalysts (e.g. Ferenczi, 1930; Rank & Ferenczi, 1925; Strachey, 1934; Bibring, 1954; Reik, 1948; Greenson, 1967) all believed that catharsis was not only useful, but essential to the process.

Although many early psychoanalysts recognized the limitations of psychoanalysis as a therapy (Rank, 1929; Fodor, 1949; Ferenczi, 1920), they were unable to improve on the therapeutic method, although Fodor had considerable success with dream analysis in working with birth trauma.

In his book The Trauma of Birth (1929), Rank presented the idea that all births are deeply disturbing, so much so that they structure all subsequent 'psychic development. In

order to 'undo' the negative effects of this prototypical experience, Rank suggested that the 'therapeutic task' involved an active, 'cathartic' transference leading to a 'reliving' of an actual birth trauma. The purpose is to break the tie with the therapist upon whom mother - ultimately the desire to return to the womb (the place of 'primal bliss') - is projected. There is no question of 'dissolving' the birth trauma and primal anxiety. The thrust of Rank's work vis a vis that of orthodox psychoanalysis, was upon fostering an active, cathartic transference. The birth is 'relived' under the pressure of the decided termination date of the analysis. Rank says, ".....it is a matter of allowing the patient who in his neurosis has fled back to his mother fixation, to repeat and to understand (in the deepest sense) the birth trauma and its solution during the analysis in the transference, without allowing him the unconscious reproduction of the same (the mother tie) in the severance from the analyst" (1929, pp. 213-4). Rank took this 'reliving' to be directly concerned with the original, physical birth; he called it the earliest "analytically comprehensible trauma". Rank says that in the reliving of the actual birth experience the client makes movements and goes into physical positions which are directly linked to their present day neurotic and psychosomatic symptoms.

More recently other clinicians have gone into greater detail regarding the links between symptoms and birth

experiences (e.g. Lake, 1981, 1978; Grof, 1976; Laing, 1982; Janov, 1978, 1985; Verny, 1982; Winnicott, 1949). All of these writers believe that the birth experience has to be worked with cathartically, although the importance ascribed to catharsis varies. More recently, the 'primal scene' - a first cause- has been 'pushed-back' to an even earlier time in development. Lake (1981), for example, suggests that prototypical experiences responsible for the genesis of many psychosomatic and neurotic behaviours occur during the first trimester of pregnancy. These 'rebirthing therapies' will be examined in greater detail later in this chapter.

Ferenczi (1920) attempted to intensify the patients emotional experience with the aid of 'artificially produced accentuations of tension'. He writes, ".....I tried to induce freer repetition of early traumatic experiences and to lead up to a better solution of them through analysis" (Ferenczi, 1930, p.432). Active encouragement and prohibition of patient activities were utilized in the hope of increasing psychic tension, thereby mobilizing unconscious material. Ferenczi noticed that some patients discharged repressed emotions by automatic and habitual behaviour patterns. To force inadvertently discharged tensions to become conscious, Ferenczi forbade patients to carry out stereotyped patterns which occurred under emotional stress. This was often successful in

forcing unconscious tensions, formerly discharged, into consciousness. Ferenczi believed that indirect contact through interpretation was insufficient with certain disturbed patients. He opted for a more direct approach to the childish, infantile part of the patient, which involved hugging, kissing, and non-erotic fondling. Ferenczi subsequently abandoned these techniques, but he never gave up his efforts to develop a more active approach to analytic therapy.

In 1925 Rank and Ferenczi published an exposition and critical review of the analytic process. Anticipating Alexander's concept of 'corrective emotional experience', they placed central importance on the patient's emotional experience. They saw the goal of analysis as substituting affective factors of experience for intellectual processes. Emphasis was placed on reliving maladaptive patterns in relation to the therapist (transference) and recognizing their inappropriateness. However, they met with strong opposition from traditional analysts, and their views did not flourish (Bauer & Kobos, 1984).

It was not until 1946 that the ideas of Rank and Ferenczi were revived by Alexander and French (1946). Once again they emphasized the central importance of emotional experience in therapy, and they provided the foundation for other developing systems of short-term psychodynamic therapy (e.g. Malan, 1963, 1976; Balint, 1968; Davanloo, 1978, 1980; Paolino, 1981). These workers have modified the

analytic technique to make it more active and cathartic. They believe that, by becoming increasingly passive, psychoanalysts have needlessly increased the length of treatment. Short-term psychodynamic therapy is more anxiety provoking (e.g. Sifneos, 1979), and cathartic (e.g. Davanloo, 1980) than long-term analytic therapy (e.g. Langs, 1973). Short-term dynamic therapists are in the mainstream of psychoanalytic treatment, but are more active in "releasing hidden feelings by actively working on and interpreting resistance of defences; paying strict attention to the transference relationships; and actively making links between the transference and significant people in the patient's current life and past" (Davanloo, 1980, p. 45).

It can be seen that catharsis was very important in the development of psychoanalysis, but its role is now minimal **vis a vis** the importance given to intellectual analysis and insight. However, one former member of Freud's inner circle, Wilhelm Reich, developed powerful techniques for breaking through to primal processes, and this led to the many cathartic approaches as represented in the 'new post-Reichian psychotherapies'.

Wilhelm Reich

Reich, who was closely associated with Freud between 1922 and 1930, realized the limitations of psychoanalysis as a

psychotherapy and developed a new technique that could break through to primal processes. Much of his work is clearly rooted in psychoanalytic theory.

Reich's early contributions were primarily based on his concept of character and character armour, which developed out of the psychoanalytic conception of the ego's need to defend itself against instinctual forces. According to Reich, an individual's character includes a consistent, habitual pattern of defences. This was an elaboration of the concept of character first discussed by Freud in Character and Anal Eroticism (1908). Reich found that the character forms as a defence against the anxiety created by the child's intense sexual feelings and the accompanying fear of punishment. The first defence against this fear is repression, which temporarily restrains the sexual impulses. As ego defences become chronically active and automatic, they develop into character traits or character armour. Reich's concept of character armour includes the sum total of all repressing defensive forces, which are organized in a more or less coherent pattern within the ego. Reich states this as follows: "The establishment of a character trait.....indicates the solution of a repression problem; it either makes the process of repression unnecessary or it changes a repression, once it is established, into a relatively rigid, ego-accepted formation" (Reich, 1949, p. 161).

Reich found that each character attitude had a

corresponding physical attitude, and that each individual's character is expressed in the body in terms of muscular rigidity or muscular armouring. He says, ".....the rigidity of the musculature is the somatic side of the process of repression, and the basis for its continued existence" (Reich, 1948, p. 236). What Reich found was that releasing the unconscious ideas behind a particular symptom (the talking cure tradition in psychoanalysis), was often insufficient to produce a change in the patient's behaviour, but that loosening the muscular armour released considerable libidinal energy and aided the process of psychoanalysis. Reich's psychiatric work increasingly dealt with freeing the emotions (i.e. emotional abreaction) through work with the body, which evoked a more intense experiencing of the infantile material uncovered in analysis. He found that only after the 'bottled-up' emotion had been expressed could the chronic muscular tension be abandoned fully. He says, ".....I finally could not avoid the impression that the physical rigidity..... represents the most essential part of the process of repression. Without exception, patients relate that they went through periods in their childhood when they learned to suppress their hatred, anxiety, or love by way of certain practices which influenced their vegetative functions (such as holding their breath, tensing their abdominal muscles, etc.).....Again and again it is striking to find how the

dissolution of a muscular rigidity not only liberates vegetative energy, but, in addition, brings back into the memory the very infantile situation in which the memory had taken effect" (Reich, 1948, pp. 234-235). This liberation of vegetative energy is the release of the "expansive, pleasure-giving, outgoing, life-enhancing forces contained in the parasympathetic vegetative centres" (Reich, 1948, p. 236). The slogan that Reich adopted for this process was, "Toward the world, out of the self".

Reichian therapy, or vegetotherapy, consists primarily of dissolving the armour in each of seven armour segments, beginning with the eyes and ending with the pelvis. Three major tools are used in dissolving the armour: 1) building up energy in the body through deep breathing; 2) directly attacking the chronically tense muscles (through pressure, pinching, stretching etc.) in order to loosen them; and 3) maintaining the cooperation of the patient by dealing openly with whatever resistances or emotional restrictions arise (Baker, 1967). Powerful body expression like shouting, pounding or kicking may also be suggested by the therapist. Waal et al. (1976) write, "...with contact and palpitation, later with massage and pressure on local tense muscles, patients began not only to experience themselves more fully, but a series of new phenomena came to light. Pressure on muscles, for example, can often release spontaneous cries, biting, whimpering, etc. Touching can set the contracted muscle, even the whole muscle complex,

into movement, and this can result in the release of infantile impulses and feelings. What is released is so full of memories of childhood situations and infantile conflicts that the material can be worked on consciously and verbally afterwards" (P.269). A full and interesting account of the process is given by Orsen Bean in his book Me and the Orgone (1971).

Reich's major contribution is that he recognized the somatic concomitants of 'psychological' defences, and developed cathartic procedures for dealing with them, alongside an intellectual, analytic approach. His influence upon later psychotherapists has been substantial, with a number of his students (e.g. Lowen) developing distinctive 'cathartically-oriented' therapeutic systems. One of his students, Fritz Perls, played a large part in the development of the Human Potential Movement at the Esalen Institute in California, and as a consequence influenced a whole generation of psychotherapists.

Gestalt Therapy (Fritz Perls)

The major intellectual trends that directly influenced Fritz Perls, the originator of Gestalt therapy, were psychoanalysis (primarily Freud and Reich), Gestalt psychology (e.g. Kohler, Wertheimer, Lewin, Goldstein), and existentialism and phenomenology. Perls also incorporated some of the ideas of J.L. Moreno

(1946), a psychiatrist who developed the notion of the importance of role-playing in group psychotherapy (see below for discussion). As was mentioned above, Perls was a pupil of Wilhelm Reich, and was considerably influenced by him, particularly his early work viewing the body in relation to the psyche. The first book that Perls wrote, Ego, Hunger and Aggression (1947), was not intended to provide a new theory of personality, but instead was to constitute a revision of psychoanalytic theory. However, Perls' disagreement with Freud was primarily with Freud's psychotherapeutic treatment methods rather than with more theoretical matters such as the importance of unconscious motivations, the dynamics of personality, and patterns of human relationships. "Not Freud's discoveries but his philosophy and technique have become obsolete" (Perls, 1969, p. 14).

Although Gestalt therapy is not often appreciated as a cathartic therapy *per se*, in that catharsis does not play a key role, the essence of the approach is 'an attempt to heighten a person's awareness of their immediate personal experience', and 'to encourage them to take responsibility for their behaviour'. Many of the techniques are designed to keep the clients in contact with what they are doing. Although Gestalt therapists are more directly concerned with facilitating awareness of personal experience than with emotional expression, the two are inexorably intertwined. When awareness of experience is blocked, so

are feelings. This repression leaves the person with little energy and a great deal of unfinished business. With sensitively selected exercises clients can begin to deal with the 'unfinished business' and begin to release all the emotions that they have held back because of the catastrophic expectations that others will not love or approve of them if they are truly human. Unfinished business usually involved unexpressed feelings, although highly distinct memories, fantasies, and images may be connected with this affect. Because such feeling has never allowed to become fully 'figured', it stays in the background, is carried over into the present, and interferes with effective 'contact functioning', that requires a present-centered, reality-bound awareness of oneself and other people. According to Perls, unacknowledged feelings create unnecessary emotional debris that, "clutter up present-centered attention and awareness, usually in the form of excessive preoccupation and rumination" (Perls, 1969).

The ultimate goal is not to expel and be rid of feelings, but to undo repressions and to become aware of and responsive to the actions that feelings prompt us to. Catharsis focusses attention on and liberates suppressed feelings, thus freeing the person to respond with well-modulated affect in the present. In other words, Perls does not adhere to Freud's 'excremental theory' of emotions. He believes that emotional discharge, carried to

its logical extreme, leads to inaction. Not only must the individuals become aware of and express feelings, but ultimately they must take responsibility and learn to be guided by them.

Psychodrama

As was stated above, Perls was influenced by the work of Moreno (1946). Moreno developed a group therapeutic approach designed to evoke the expression of feelings involved in personal problems in a spontaneous, dramatic role-play (psychodrama). He developed his idea of catharsis in drama from Aristotle's conception of the purgative aspects of tragedy. However, Moreno's view of catharsis goes beyond the Aristotelian conception. The actors in psychodrama are dealing with events and emotions from their own personal experience and consequently total catharsis is experienced. This is unlike acting in a structured and formulated play. Similarly, the audience in psychodrama can develop almost total involvement and empathy, and the attendant cathartic release, because of the immediacy and reality of the enactment. According to Moreno, total catharsis is most likely to occur in a situation where the person is allowed to deal with real life experiences and concerns by using an action oriented technique that facilitates spontaneous expression. In psychodrama group members role-play past, present, or

anticipated conflict situations to release pent-up feelings and to practice more adaptive behaviour. As well as having some influence on Gestalt methods, the technique of psychodrama has also influenced the methods used in encounter groups and behaviour therapy groups.

The modern encounter group is an integration of a wide range of influences, both ancient and modern. Historical influences include Greek drama, medieval morality plays. Mesmer's large groups of the 1700's, and the religious services of the Quakers and Pentecostals (Schutz, 1973). More recent influences include social psychology and group dynamics (Lewin, 1948; Bion, 1961; Tannenbaum et al., 1961; Cartwright & Zander, 1953); psychodrama (Moreno, 1946); Gestalt therapy (Perls et al., 1973); body methods (Lowen, 1969; Rolf, 1975; Feldenkrais, 1972; Alexander, 1969; Vishnudevananda, 1960); theatre and dance (Stanislawski, 1924; Grotowski, 1963), and the transpersonal (Assagioli, 1975). It has already been established earlier in this chapter that many of these influencing and contributory approaches encourage emotional expression.

Encounter is "a method of human relating based on openness and honesty, self-awareness, self-responsibility, awareness of the body, attention to feelings, and an emphasis on the here-and-now" (Schutz, 1973, p. 5). During the course of an encounter group (often over a week-end) participants engage in exercises, many of which are

designed to encourage emotional arousal and ventilation. Such emotional arousal may be related to interpersonal encounters within the group. or they may be intrapersonal. In the latter case historical feelings in the individual are often **restimulated** by something that has happened in the group.

Bioenergetics (Alexander Lowen)

Alexander Lowen (1910 -) is probably one of Wilhelm Reich's most notable students. He is the theorist and therapist most responsible for the survival, revival, and advancement of Reichian therapy. Although his theory offers little in the way of originality, it does contain some interesting extensions of Reich's therapeutic technique. Lowen rejected Reich's notion that the attainment of orgasmic potency was the exclusive goal of therapy, believing instead that pleasure is the goal (Lowen, 1975). Lowen believes that psychopathology involves the repression and "rigidification of life". For every rigidity of psychic functioning there is a corresponding rigidity of metabolic orgasmic functioning. He believes that the rigidification of the body and the self originate in the early conflicts between parent and child, when children learn to suppress their feelings. The rigidifications eventually become the neurotic character structure and the muscular armour that Reich (1942, 1949)

has described, i.e. feelings become encapsulated by muscular contraction.

Bioenergetics includes the cathartic release of the body within the context of an analysis of the patient's infantile character structure. Lowen writes, ".....before there can be a free and full flow of feelings, clients must become aware of the chronic characterological and bodily tensions used to control feelings" (Lowen, 1972, p. 76). To become free of their infantile characters, they must connect their present inhibitions with the past and become aware of the bodily impulses they were forced to repress by their behavioural and bodily inhibitions.

In bioenergetic body work, patients are more active than in vegetotherapy. They do not just lie on their backs and have their muscles manipulated. Lowen helps patients experience their chronic stiffness and limited motility by subjecting various muscle groups to some stress, which often evokes intense emotion. Patients may be asked, for example, to pit themselves against the world's field of gravity in such a way as to intensify their negative feelings against giving in or collapsing. They may be encouraged to arch their bodies off the ground by making contact with the floor only with their hands, head, and feet. After considerable struggle to stay up, they can experience the feeling of their bodies giving in to the inevitable, to the reality of life, as they tire and

collapse to the floor. They can experience the fear and anger of giving in, and through analysis can become aware that such negative emotions may be the result of early conflicts with parents who insisted on submission.

Following Reich, Lowen places heavy emphasis on full and deep respiration designed to release energy. When breathing is deepened the patient's resistance falls apart, resulting in a flood of repressed material together with its accompanying affect. Breathing is deepened by the use of various 'positions' designed to reduce diaphragmatic blocks, e.g. patients arch their back over a 'breathing stool' and attempt to breathe deeply. Patients also practice such exercises as yelling, or kicking and hitting the couch both to release anger and to experience the inner ability to focus energy on the world. Such exercises may evoke childhood memories of wanting to strike out against parents but dreading the thought. Such exercises also help patients experience a sense of bodily grounding, so that they can express their anger intensely without going entirely out of control, and attack the therapist as they might have fantasized. The therapist encourages patients to surrender to the body, to let emotion and energy flow, and to trust the body as their direct link to reality (Keleman, 1973). As the patients surrender to the life that is their body, they will encounter pain, sadness, tenderness, anger, and anxiety. With the release of such emotions, patients discover a tremendous increase in

bioenergy, the energy of life that flows within them and outside them. The release of such emotions and energy is then grounded in the person's expanding awareness of reality, the reality they are willing to support and help create through the investment of their new-found energy. This view is succinctly stated by Kirsch (1973), ".....the ability to experience and express affects will give the individual the energy and positive feelings which will be the impetus for further changes in the personality" (p. 68).

Keleman (1970), a practitioner of the bio-energetic approach developed by Lowen, encourages his clients to hit, kick, scream, and ventilate their feelings, usually in a large group workshop format. Keleman believes that people are not 'grounded'. He says, ".....grounding means being anchored in our physical-psychic growth processes; expanding, contracting (contact, withdrawal), charging, discharging. Grounding means being rooted in and partaking of the essence of the human animal function. The opposite of grounding is flight, or interference with our human essence; its products (our common ailments) are fear, rage, frustration and dissatisfaction. Separation from the biological ground results in anguish and despair instead of the great potential for vitality, love, contact and growth with which we have been endowed" (1970, p. 192-193).

A therapeutic approach that bears some similarity to Lowen's bioenergetic analysis is psychomotor therapy

(Pesso, 1969). It was developed by Albert and Diane Pesso in Boston in 1962, from knowledge of body movement and emotion, and especially from their experience as choreographers, in helping people overcome their inability to express emotion physically. They found (Pesso, 1969, 1974), as had Alexander (1950), that this inability was often symbolized in a symptom (e.g. "a pain in the neck," etc.), and that some degree of symptomatic relief could be obtained if underlying conflicts could be resolved. They hypothesized, as had others, that chronic muscle tension often indicated conflicting intentionalities within a person. The Pessos' technique of analysing physical symptoms, correlating these with emotional conflicts, and facilitating the resolution of these psychophysiological impairments in a therapeutic setting became the Pesso system of psychomotor therapy.

Psychomotor theory assumes that when a person is in 'pain' and does not have acute physical trauma, the pain may be a sign of unresolved conflicts. This theory suggests that the pain can be decreased or eliminated if the patient externalizes the conflict, expresses the suppressed feelings around it, and receives a sympathetic and accepting response from significant others. Once the conflict has been located, it is expressed verbally and physically, thus commencing a release of tension. As a person's suppressed feelings - anger, sadness, fear, need for warmth and closeness, nurturance etc. emerge, they are

responded to in a validating manner by group members designated to represent the appropriate target figures. These will usually be either negative aspects of remembered punitive figures or positive (ideal) figures, who can provide satisfaction for unmet needs. Often, these figures are designated negative or positive parents, the process being known as 'accommodation'.

The emphasis on parental figures stems from the fact that negative treatment or neglect by parents often leads much later to symptom formation (Kaufman & Aronoff, 1983). This can happen in two ways: through 'acting-in' (somatization), often a factor in ulcerative colitis, peptic ulcer, labile hypertension, arthritis, tension headaches etc. (Frazier, 1965) and through 'acting-out', as in injury caused by self-abuse. To break up the pattern of 'acting-in' or 'acting-out', the parental figure's negative response or neglect which was internalized must be countered with a more positive response. "This new response can then be internalized, clearing the way for future healthy expression and satisfaction, as opposed to continued suppression, tension, illness or acting-out" (Kaufman & Aronoff, 1983, p. 451).

Primal Therapy and Primal-Oriented Approaches

The most widely known recent cathartic approach is Arthur Janov's primal therapy, presented in a number of

books (1973, 1978, 1982, 1985). Janov and most of his first co-workers were strongly influenced by their direct and indirect contact with Fritz Perls, who, as we have already established was a student of Wilhelm Reich.

According to Janov, the essence of neurosis is the encapsulation of pain within both the psyche and the body. This pool of pain, primal pain, is the natural consequence of a child's inherent needs being unmet by significant others. The primal needs to be fed when hungry, to be held and stimulated, to be kept warm, to have privacy, and to be allowed to develop inherited potentials will result in pain if denied. To the extent that these needs are satisfied by the parents and others, the child will grow to become a loving, pleasure seeking, creative human being capable of reaching its own unique potential. If these needs are denied repeatedly, the child eventually comes to face primal trauma, the terribly painful trauma of being unloved. The child concludes: "If I go on striving to be who I am meant to be, my essential needs will be denied, I will be in constant pain. Let me then repress my painful memories of being unloved. Let me twist and turn to contort myself into whatever distorted human being it is that my parents can love. If I must be clean or constantly achieve, if I must be submissive or sick or asexual, then I will be, since the pain of being me is intolerable" (Janov & Holden, 1975, p. 68). This 'unreal self' produces a split in personality. The unreal self consists of the traits which

the child feels will attain the fulfillment of unmet primal needs. Every child experiences primal pain to some extent because a parent cannot possibly always fulfill every need of their quite vulnerable child. The denial of the real self may cause children to develop any combination of the neuroses, psychoses, character disorders and psychosomatic symptoms, because they feel that their unreal self must take over.

The psychic need to repress pain is accompanied by biological mechanisms that provide for repression. Janov and Holden (1975) postulate three pain gates in the brain: 1) a somatosensory gate in the brainstem, 2) an affective gate in the limbic midbrain, and 3) a cognitive gate in the orbitofrontal-hypothalamic area. These three lines of defence keep the pain from conscious experience, as well as preventing the pain from dissipating. To be oneself is to risk reactivating this 'primal pool'. The pressure of primal pain being disconnected from awareness results in neurotic tension, which is channelled into increased heart rate, body temperature, and brain activation. Eventually the end organs 'collapse' as a result of the sustained tension, the result being a psychosomatic 'illness' such as ulcers, colitis, or a heart disorder. Janov believes that tension also leads to a myriad of symptoms designed to prevent the reactivation of pain, such as phobias of crowds, phobias of enclosed spaces that threaten to stimulate painful memories of being all alone, or

homosexuality designed to gain the love of many men in order to deny the lack of love from one's father. Neurotic behaviours are the idiosyncratic ways each of us finds to release tension. Janov (1973) writes, ".....neurosis (is) the synthesis of the two selves, or systems in conflict" (p.35). Neurotics cannot change because they cannot let themselves confront the pain that would have been devastating for the vulnerable infant but need not cripple the mature adult. Liberation from neuroses requires that the adult must once again go through the primal process in order to find the beginning of the path away from the real self. "In order to be what he is, the neurotic must go back and **feel** what he was before he stopped 'being'." As one patient put it, "In order to be what you are, you have to be what you weren't" (Janov, 1973, p. 227).

Primal therapy is designed to liberate people from primal pain, by having them relive primal hurts. This results in a cathartic release of pain (i.e. a 'primal') and a curative increase in consciousness as present events are reconnected to previously repressed memories of pain. Freundlich (1973) defines a primal experience as, "the reliving of those early life events during which the child turned off his primal needs and pains and developed a personality split and unreal self. The therapeutic value of a primal is in abreacting repressed affect and making feeling connections between past traumas and current

neurotic symptoms, compulsive behaviour, and acting out. Primals vary tremendously from one person to the next and with one person over a period of time, and may involve screaming, crying, silence, words, sounds, physical movement, and stillness" (p. 3).

For the first three weeks of Janov's primal therapy clients are expected to devote themselves entirely to the 'process', and for 48 hours before therapy commences they are encouraged to give up all smoking and drinking, compulsive eating and snacking, biting nails, keeping busy and on the run, oversleeping, etc. The purpose of these preparations is to increase the client's level of tension as much as possible. When the client arrives for the first session, they are asked to talk freely about early painful experiences. Techniques from Gestalt (Perls et al., 1973) are employed, and clients are asked to speak with and project their feelings onto parents and love objects as though they were actually present ('empty chair dialogue'). As clients begin to experience deep emotion, techniques of vegetotherapy are often employed, the client being encouraged to breathe deeply and fully. Reich's concept of character armour is utilized, and a client who is "being bright, humble, polite, obsequious, hostile, dramatic - whatever the front he presents" is confronted with the defence of his character attitudes in "an effort to get him beyond the defence and into feeling" (Janov, 1973, p. 83). Finally, there is an intensive, profoundly

felt outpouring of emotion, 'the Primal', usually accompanied by a deep piercing scream which is "felt all over the body" and which is both "the cause and the result of a crumbling defence system" (Janov, 1973, p. 74).

Once clients have discovered key traumatic memories, they must continually re-experience the episodes, releasing more and more of the painful emotions connected to them. This repeated cathartic confronting of critical memories is the longest stage of primal therapy taking up to as long as a year or more. In the later stages of the therapeutic process clients begin to synthesize their corrective emotional experiences and their increases in consciousness, and eventually, they can follow their own feelings without the terrible fear and pain of losing the parents' love and approval. Having no longer to please their parents they can give up their neuroses and be 'themselves'. Janov writes, "Primal man is a truly new kind of person on this earth.....who.....should survive longer because he has rediscovered his youth" (Janov, 1978, p. 115). Several research projects have been undertaken by Janov and his co-workers into the effectiveness of primal therapy (Janov, 1978; Janov and Holden, 1975; Karle et al., 1973, 1976), and these will be examined in Chapter Three.

A number of critiques have been made of primal therapy (e.g. Lonsbury, 1978; Kaufman, 1974; Broder, 1976; Hart et al., 1975; Adzema, 1985), in some cases leading to the development of alternative primal-oriented systems of

psychotherapy, e.g. feeling therapy (Hart et al., 1975), primal integration (Swartley, 1975), new identity therapy (Casriel, 1972), and feeling-expressive therapy (Pierce et al., 1983).

In Going Sane: An Introduction to Feeling Therapy (1975), Hart, Corriere and Binder have written a thorough and useful discussion of emotional suppression and cathartic treatment. They describe a theoretical framework they call the 'feeling cycle'. The first phase of this cycle is especially helpful with clients who abreact easily but who appear to be making few changes in their lives. They stress that defenses should not be broken through as in primal therapy, but must be felt and expressed as fully as possible. The function of the defence is to mask and reduce feelings that could not be expressed in childhood. The therapist helps the client initially to feel what it is like not to express feelings and thoughts in the present, so that defences are experienced fully. Once the client is able to be fully in the present, it is increasingly possible to feel what the past was like. Once the client has learned to differentiate between expressing a defence and expressing a feeling behind that defence, the choice between expressing a feeling or holding back becomes a more conscious one. This is counteraction; the first stage of the feeling cycle.

Providing an atmosphere of support, safety, and

acceptance, the therapist assists the client in moving through the next phase of the feeling cycle, the abreactive phase. Hart et al. do not accept Janov's belief that abreaction is in itself curative. The release of tension and an understanding of how childhood experiences have given rise to disordered feelings, which is accomplished through intense abreactions, must be integrated not only with a conscious effort to distinguish between past sensations and meanings and present ones, but also with the choice to live fully in the present. Openness to one's feelings can only be maintained if present feelings with present meanings are expressed. After clients have abreacted past repressed feelings, they must give adult expression to feelings that were blocked off in the past (proaction stage of the feeling cycle). The final phase of the feeling cycle is integration. That is living from the new level of feeling awareness and expressiveness that becomes available after completing a feeling. Hart et al. write, "Every Feeling Therapy session tries to move patients from incomplete, disordered feelings to integral feelings, from defensive substitutes to direct expressions.....He needs to express completely the feelings that are already conscious. He needs to live the present he already has. Then he will be functioning at some definite level of integration in his life and will have a reality to expand" (1975, p. 44).

The vitality of feeling therapy is based on refined

eclecticism and creative innovation. It blends theories and techniques from a number of approaches (e.g. Gestalt, psychoanalytic, hypnoanalytic, transactional, behavioural, and client-centered therapies) with innovations of its own. Hart et al. argue that their approach overlaps and extends the basic ideas first recognized by Breuer and Freud, and Janet, namely the concepts of trauma, abreaction, catharsis, resistance, defence and splitting. To these basic ideas, which they argue are held in common by all feeling release therapies, they add the following elaborations (1975, pp. 61, 62): 1) repression is undone through expression (abreaction) ; 2) before expression of a blocked feeling can occur the patient must be guided to express the defence that is in front of the feeling (counteraction); 3) abreaction and counteraction must be followed by proaction; 4) openness to feeling can only be maintained if newly available feelings with present meanings are expressed (integration); 5) together, abreaction-counteraction-proaction constitute a dynamic that allows the person to integrate his life by living from feelings in the present and releasing blocked feelings from the past (dynamic of transformation); 6) every increase of feeling access to the past must be matched by an equal increase of feeling in the present. If it is not, the acquired openness to feeling will be lost (principle of balanced therapeutic movement). They add, "we want to state emphatically that abreaction is insufficient by itself"

(1975, p. 89).

In a development of primal therapy called primal integration, William Swartley (1976) states that there are four basic primal feelings: longing, the craving for the fulfillment of unmet needs, such as love, terror, the extreme fear or dread of not being fulfilled; rage, the overwhelming angry passion directed at those who have not fulfilled the child's needs; and joy, the intense feeling of happiness and pleasure. The approach of primal integration (Broder, 1976), is, like Feeling Therapy, a synthesis of many orientations, including the use of free association (psychoanalysis), stress positions (bioenergetics), massage of body armour (vegetotherapy), acting out key relationships (psychodrama, Gestalt), and working in supportive pairs (co-counselling). Throughout, the emphasis is on inner-directedness, a shared philosophic view of the humanistic approaches. Broder sums up the primal process as follows, ".....all feelings are part of being human. Neurosis is formed when a negative judgement is imposed on one's feelings. To discard neurosis, one must discover that all feelings are OK. One arrives at negative conclusions in his own unique way and can only arrive at positive conclusions in his own unique way. That is what Primal Integration is all about" (1976, p. 37).

Feeling-expressive therapy. (Pierce et al., 1983) "strives to liberate people who have chosen defensive security at the expense of satisfaction and zest" (p. 41). Like the other cathartic therapies we have examined, vigorous and sustained expression of feelings is the hallmark of feeling-expressive therapy. Pierce et al. write, "we begin by focussing on the feelings described by our clients: we track them, amplify them, and try to understand how they effect behaviour. Accepting feelings.....is not enough. Mere description of feelings is not therapeutic, full expression is" (1983, p. 42). Their implicit message to the clients they are working with is, "Feel free to express fully to us the pain that you felt growing up. You can expect comfort, support and acceptance. But know that in the present, you are responsible for your own life - for making it good or letting it founder" (p. 46). They acknowledge an indebtedness to the long tradition of catharsis in healing and therapy, including, amongst others, Breuer and Freud, Reich, Lowen, and Janov. They also utilize the approach of peer counselling (Jackins, 1962), and acknowledge Harvey Jackins as "the first to show us how to elicit strong feelings in clients and in ourselves, and he gave us our first theory about how feeling-expression helps" (Pierce et al., 1983, p. vii). The cathartic approaches of Jackins (1962) will be discussed later in the chapter.

It is increasingly becoming recognized that pre- and peri-natal experiences constitute determining events in a person's life (e.g. Orr & Ray, 1977; Janov, 1977, 1978; Grof, 1976; Lake, 1976, 1981 (a), 1981 (b); Emerson, 1978; Laing, 1976, 1982; Leboyer, 1977; Verny, 1982; Alberry, 1985). This view is succinctly stated by Laing: "Our human life is a unit - from conception to death. How our life is shaped, biologically (zygote, blastocyst, embryo in chorionic vesicle, foetus, umbilical cord, placenta, newborn baby to death), finds a homology in the way, psychologically, we shape ourselves" (1976, p. 37)..... "It is at least **conceivable** to me that myths, legends, stories, dreams, fantasies, and conduct **may** contain strong reverberations of our uterine experience. If this were so, such later affections could properly and appropriately be called **hysterical** (i.e. uterine)" (1976, p. 38).

Otto Rank (1929) built an entire theoretical system out of the birth trauma, which he believed to be universal. Essentially, it was believed that birth was intrinsically traumatic because a child was being injected into a hostile environment. Janov (1977) believes that births are not necessarily traumatic, but when they are, as in strangulation by the cord or excessive labour times, then these traumas, combined with subsequent physical and psychological hurts, produce an eventual overload and a split or disconnection. The pain that cannot be integrated becomes stored tension, which manifests itself in neurotic

and psychosomatic symptomatology. The prototypic primal trauma (e.g. a birth trauma), establishes the characteristic mode of defence, where later events 'behave' as metaphorical representations of the 'primal scene'. In order to resolve the irrational physiological and psychological reactions the person has to relive (i.e. feel), the original prototypic anxiety situation (the major primal scene) which set the particular responses in motion.

The conclusions of Rank (1929), Fodor (1949) and Mott (1959) regarding the significance of perinatal experiences, were not reached by observing their patients, but solely through interpretations of dream material. On the other hand, an entirely different technique was employed by Frank Lake (1981) which involved the simulation of perinatal experiences. Lake used relaxation and 'guided' the patient through their conception and early prenatal life, encouraging them to "give vent to emotion with each prolonged outbreath". He claims that 'short inhalation - long exhalation' breathing produces a theta rhythm activity in the brain, which facilitates the retrieval of early memories 'stored' in the unconscious. Lake's major contribution has been to bring into focus the importance of the first few months of interuterine experience. He has arrived at similar conclusions to that of Mott (1959), and Peerbolte (1975) that the foetus, especially in the first three months after conception, can feel invaded by the emotional states of the mother. In a monograph, Studies in

Constricted Confusion (1981), Lake identifies the possible symptoms involved in the 'maternal-foetal-distress syndrome'. He hypothesizes that the origins of neuroses, paranoid-schizoid personality distortions, and psychosomatic disorders have their origin in the first trimester of pregnancy.

Lake draws freely on Stanislav Grof's concept of Basic Perinatal Matrices (BPM), outlined in his books, Realms of the Human Unconscious (1976) and LSD Psychotherapy (1980). The matrices refer to the various stages of intrauterine life and delivery. Each of these is associated with particular syndromes of psychopathology, as well as particular mythological, philosophical and religious references and phenomenology in LSD sessions. Grof's idea, based on his LSD researches, is that experiences of the various stages of birth form a memory substrate into which later experiences with similar affective themes are assimilated. The themes, or memory 'clusters', are referred to as COEX systems (systems of COdensed Experience). He defines a COEX system as "a specific constellation of condensed experiences (and related fantasies) from different life periods of the individual" (1976, p. 46).

These 'rebirthing' therapies are all essentially a form of primal therapy, the aim of which is to 'go back' and feel what was repressed at the time.

So far the major systems of psychotherapy with a

cathartic focus have been presented. However, before attempting to present and discuss the major issues concerning the role of catharsis in the therapeutic process, particularly with respect to the theories of Jackins (1975) and Heron (1977), a brief summary of a number of other approaches will be presented in order to provide a comprehensive review of emotive therapies.

Hypnotherapy

Pierre Janet (1925) developed a treatment for hysteria which was very similar to Freud and Breuer's cathartic method, but with a greater emphasis on strong emotional expression. According to Janet, when memories of traumatic events are dissociated from consciousness, they often lead to neuroses. Resolution of the neuroses requires that the traumatic memories be uncovered. Janet developed a cathartic method that he termed mental liquidation. He believed that when an event took place that required an emotional response, psychological tension occurred and unresolved tensions from similar experiences were restimulated. If these emotional action tendencies were blocked then neurosis was the result. Janet believed that hypnotizing patients and encouraging expression of the repressed feelings provides not only catharsis but liquidation of the repressed traumatic memory. Janet's work with hysterics led him to conclude that catharsis was

therapeutic to the extent that it reduced tension by 'activation, action, and discharge' of the aroused emotion. He observed that patients would often improve following convulsive cries in which they 'howled and struggled for hours'. It should also be noted at this juncture that Janet believed that discharge *per se* was therapeutic, even where a cognitive element was absent. However, Janet believed that cathartic treatment would often have to be repeated as symptoms would reoccur.

During World War 1, Freud's and Janet's ideas about repressed emotional memories were an important influence in the treatment of transient situational reactions (war neuroses). One prominent pioneer of hypnotic abreaction therapy was William Brown, whose theoretical orientation was demonstrably psychoanalytic, and who believed that the liberation of emotions associated with battlefield experiences was curative. He writes (1920), "Considered in a rough popular manner the facts seem to indicate that liberation of pent-up emotion.....produces a resolution of the functional symptom" (pp. 16-17). Brown hypnotized his patients and told them to visualize their traumatic experiences, and to ventilate their feelings. He wrote, ".....we bring up the repressed experience once more, we encourage him to work off the emotion involved in it. Just as a person who grieves for someone he has lost finds relief in tears, so we let these patients work off their fear. Abreaction of repressed emotion sweeps away the

repression and so frees energy which had been previously needed to hold the repressed memories apart from the rest of the mind and away from clear consciousness. This freed energy is thus put once more at the general disposal of the personality" (Brown, 1920, p. 63).

World War 11 brought a resurgence of abreactive therapy and numerous psychotherapists, using abreactions induced by hypnosis, parenteral barbiturates, and inhalational anaesthetics, pointed out its beneficial effects, particularly on the acute traumatic neuroses (Edkins, 1948; Sargent, 1948; Shrovon, 1947). It has been pointed out by various writers (Grinker & Spiegel, 1945; Rosen & Myers, 1947) that the beneficial effects for the patients were made more lasting by further therapy and the waking discussion of the abreacted material. Some investigators, including Edkins (1946), and Shrovon and Sargent (1948), noted that repeated abreactions may be necessary in order to effect a positive therapeutic change. Shrovon and Sargent state that as many as four or five abreactions of the same incident may be necessary before relief occurs. These authors postulate that the beneficial results of cathartic therapy occur chiefly as a result of the sudden state of emotional collapse which sometimes occurs at the termination of an emotional abreaction. They feel that this is equivalent to the Pavlovian phase of ultraparadoxical cortical inhibition and that during that phase there may be a break up of recently acquired conditioned behaviour.

usual theoretical framework adopted to account for the changes occurring during abreactive therapy was psychoanalytic. In general, the clinical work carried out within abreactive hypnotherapy, supported the contention that intellectualization of experiences has little therapeutic value, and that it is the affective re-experiencing that is beneficial.

Hypnotic and drug-induced abreaction procedures are still used today, in order to explore the genesis of the presenting symptomatology. Hypnoanalytic methods used to uncover unconscious material and to find the origin of a problem include the affect bridge (Watkins, 1971), ideomotor signalling (Cheek & LeCron, 1968; Cheek, 1974; Erickson & Rossi, 1981), and the 'pin-point' technique (Elman, 1964). Watkins describes the affect bridge as a ".....technique whereby a patient is moved experientially from the present to a past incident over an affect common to the two events rather than through an overlapping idea as is usual in psychoanalytic association" (p. 38). He further states, ".....when repressed experiences do emerge into consciousness they are usually accompanied by much vivid feeling and re-living. Under these conditions, the emergence of such experiences is more truly emotionally corrective" (p. 39).

Implosive Therapy

As we have seen, advocates of catharsis in psychotherapy generally adhere to a psychodynamic conception of human functioning. However, some behaviour therapy approaches, notably implosive therapy or 'flooding', utilize abreaction or catharsis. Wolpe (1982) defines abreaction as, ".....the reevocation with strong emotional accompaniment of a fearful past experience.....by which the neurotic anxiety was conditioned" (p. 236). According to Wolpe, "abreaction succeeds when anxiety is inhibited by emotional responses that the therapeutic situation induces in the patient" (1982, p. 237). The first account of a case that was successfully 'flooded' is recorded in Recent Experiments in Psychology (Crafts et al., 1938, p. 322). Recent interest in the approach started with the work of Malleon (1959) and Stampfl (1964).

Stampfl's strategy is called implosive therapy. In his early writings, quoted by London (1964), Stampfl expressed the view that if patients were consistently exposed to the conditioned anxiety-producing stimulus situations, and the anxiety was not reinforced (by an unconditioned stimulus), the anxiety response habit would extinguish. He would, accordingly, arrange for the frightening stimulus to be presented in circumstances from which the individual could not escape. The resulting continuous exposure to the stimulus was expected to cause it to lose all power to

elicit anxiety. Although in later accounts, implosion therapists (e.g. Stampfl & Levis, 1967; Levis, 1980), have continued to advocate maximal stimulation as a matter of principle, in practice they have often invoked weaker stimuli in the initial phases. They prescribe an 'avoidance serial cue hierarchy', and the hypothesized cues which are low on this hierarchy (i.e. cues with a low anxiety loading), are presented first. Although the clinical practice of Stampfl and Levis is essentially based upon Mowrer's learning theory (1950), they also assume the validity of psychoanalytic theorizing. They state that, "castration dangers and Oedipal time conflicts are not foreign to the implosive therapy approach in that they are hypothesized to be a product of primary or secondary aversive conditioning events" (1968, p. 112). Some of the imaginal scenes based upon psychoanalytic assumptions do evoke anxiety that diminishes in due course, and Stampfl and Lewis take this as evidence that such material has special therapeutic relevance.

Despite the peripheral role assigned to affect in implosive theory, in practice emotional discharge is prominent. Stampfl encourages patients to "lose themselves" and to "live" the past with genuine emotion. Hogan (1968) has noted that implosive therapy sessions are replete with emotional ventilation. He writes: "The therapist is trying to elicit maximum emotional response and will use any word or description that is effective in this endeavour"

(p. 215). Implosive therapy thus involves both cognitive- and somatic-emotional catharsis, although Nichols and Zax (1977) suggest that, "(it).....relies more on somatic discharge to achieve its result" (p. 164). Research studies demonstrating the effectiveness, or otherwise, of implosion methods will be presented in Chapter Three.

Bereavement Counselling

Throughout our lives, from birth to death, we encounter a series of losses and partings. The ways in which we encounter these have consequences for our self-esteem, our general well-being, our emotional integrity (Feinberg et al., 1978). Loss is a part of each life, and the ways in which it is managed can ameliorate the overwhelming trauma and provide a medium for positive adaptation and growth. In their excellent book, Leavetaking, Feinberg et al., (1978), identify the principal life events that most individuals encounter, all of which involve separation anxiety and object loss. These two concepts reflect intense anxiety, ambivalence, grief, sentimentality - a host of emotions accompanying loss and change.

"Object loss in the psychoanalytic sense means the forced abandonment of a desired and valued personal relationship. Grief at such a loss - whether real or fancied - usually affects one's image of oneself, sometimes pathologically" (Rochlin, 1965, p. 1). In more recent years

object loss has come to mean, "actual or threatened loss of any significant object, whether an intimate person, an aspect of self-concept, a limb, a valued possession, money, status in society, health, youth - any impoverishment of disengagement of bonding to a love object, whether tied by tendrils or by shackles" (Lipinski, 1980, p. 9).

Lipinski writes, "...death and object loss strike primordial, unconscious chords within us" (1980, p. 14), and Freud echoes a similar feeling when he says, "At a death the whole past stirs within one" (1954, p. 1). Freud (1957) saw the grief reaction as a hurtful dejection, withdrawal of the capacity to love, inhibition of all activity, a loss of interest in external events, and a loss of self-esteem. Following Heron (1978), the loss of a significant person results in the thwarting of the three basic personal needs (to be discussed later in the chapter), and consequent feelings of grief (sadness and longing), fear (separation anxiety), and anger. In order to overcome the loss this affect has to be discharged. Lindemann, in his famous study of bereavement following the Coconut Grove fire that claimed many lives, came to the conclusion that 'grief work' is necessary to overcome loss: "One of the big obstacles to this work seems to be the fact that many patients try to avoid the intense distress connected with the grief experience and to avoid the emotion necessary for it" (1944, p. 143). Parkes confirms this when he says, "if it is necessary for the bereaved

person to go through the pain of the grief in order to get the grief work done, then anything that continually allows the person to avoid or suppress this pain can be expected to prolong the course of mourning (Parkes, 1972, p. 173). If the pain is not acknowledged and worked through it will manifest itself through some symptom or other form of aberrant behaviour. John Bowlby has said, "Sooner or later, some of those who avoid all conscious grieving, break down - usually with some form of depression" (Bowlby, 1981, p. 158).

Bugen (1977) argues that in order to curtail a prolonged grief reaction a change in relationship between the deceased and the bereaved must occur. Individuals who believe that they now have no life of their own or who cling to symbolic vestiges of the deceased will perceive their world through 'grief coloured glasses'. The bereaved person needs to talk through the hurt and pain related to the loss, and to say "good-bye" to their loved one. Gestalt techniques are very effective in facilitating the latter.

One of the tasks of the grief therapist or counsellor, then, is to facilitate emotional discharge with respect to the deceased. In order to facilitate this process a vast range of 'techniques' are available, those that are used often depending on the therapist's theoretical persuasion, e.g. Gestalt techniques, psychodrama, literal description, neo-Reichian bodywork, 'flooding'.....

Volkan (1975) has developed a short-term psychotherapy

for 'established pathological mourners' referred to as re-grief work. He says, "re-grief therapy is designed to help the patient bring into consciousness some time after the death his memories of the one he has lost and the experiences he had with her, in order to test them against reality, to accept with affect - especially appropriate anger - what has happened, and to free himself from excessive bondage to the dead" (1975, p. 334). With the use of photographs of the dead person, as well as 'linking-objects', the patient is asked to review the circumstances of the death, their reaction to the news and to viewing the body, the events of the funeral etc. According to Volkan, anger often occurs at this point, at first diffused, then directed towards others, and finally to the dead person. He says, "Abreactions - what Bibring (1954) calls "emotional reliving" - may take place and demonstrate to the patient the actuality of his repressed impulses" (p. 338).

Nichols and Zax (1977) review some twenty-five original studies in their chapter on bereavement (Chapter 6, pp. 80-103), arguing that the relationship between grieving and catharsis is demonstrated in a way that supports the theory of catharsis. They state that these studies: ".....underscore the point that catharsis is particularly relevant in cases of recent emotional distress. We also found the widest agreement among experts of the importance

of experiencing and expressing the painful feelings accompanying the death of someone who was close. Most religious traditions and virtually all mental health experts encourage emotional catharsis during bereavement.catharsis is a helpful way to resolve any loss" (1977, p. 101).

Several researchers have referred to the possibility of a connection between loss, subsequent emotional suppression and psychosomatic disease (e.g. Booth, 1964; Grissom et al., 1975; Dattore et al., 1980; Kissen, 1967; Frederick, 1976; Schmale & Iker, 1966; Schmale, 1972). For example, Kissen studied the psycho-social factors that appeared to play a role in the development of lung cancer in men aged fifty-five to sixty-five. These factors involved childhood parental loss, especially parental death, and, to a lesser degree, prolonged separations from parents as well as adulthood marked by adverse events, especially interpersonal difficulties. Kissen states that, "this group of men seemed to have few effective outlets for emotional discharge ."

If suppressed emotional expression is a major contributing factor in psychosomatic illness, then patients with such problems may possibly be helped if they learn to express their feelings. Cathartic psychotherapy would, therefore, be a recommended form of treatment, perhaps as

an adjunct to orthodox medical approaches. Bastiaans (1969) advocates cathartic discharge of feelings and has noted improvements in psychosomatic symptomatology as soon as patients are able to discharge some of their inner tension through verbal and non-verbal expressions of feeling. He has suggested that hypnosis, narcoanalysis and LSD analysis may be useful in promoting therapeutic catharsis, pointing out that greater effort must be spent on encouraging affective expression to achieve a balance between intelligence and emotion in psychosomatic patients. Simonton (1978) and LeShan (1977) also stress the importance of emotional release as part of their holistic treatment of cancer patients. Simonton writes, "...and because cancer patients often have unresolved resentments.....helping our patients learn to release the past is often essential in getting them well" (1978, p. 164). However, there is, as yet, little available evidence to support this view, apart from a few clinical case studies.

At the heart of most of the psychotherapeutic systems examined so far is a belief that the emotional discharge of repressed traumatic material brings relief to emotional tension, thereby resulting in an alleviation of physical and psychological symptoms. It is also important to note at this juncture that **insight** is regarded as an important component of therapeutic change. In other words,

catharsis is believed to be a necessary, but not sufficient condition, for therapeutic change to occur. Indeed, many of the approaches discussed emphasize cognitive and behavioural strategies in addition to their original cathartic focus. In the last decade two further, and substantive theories of catharsis in human development and psychotherapy have been proposed (Jackins, 1965; Heron, 1977). Both these theories offer a more thorough and systematic analysis of cathartic processes than previously. These will be examined at this juncture so that a more explicit theory of catharsis can be developed, along with associated hypotheses that can be tested empirically and phenomenologically. Jackins' theory of Reevaluation Counselling will only be discussed briefly here, with a much fuller appraisal of Heron's theory.

Reevaluation Counselling - Harvey Jackins

Jackins' (1965) believes that human beings have the ability to create new, appropriate and rational responses. However, this special human capacity for rational responding is interrupted or suspended by an experience of physical or emotional distress. Immediately after the distress experience or as soon as possible thereafter, the distressed person seeks to discharge the accumulated distress, by crying or sobbing, trembling with cold perspiration, laughter, angry shouting and vigorous

movement, interested talking; and in a slightly different way, yawning, often with scratching and stretching. He further states that, "...rational evaluation and understanding of the information received during the distress experience occurs automatically following discharge and only following discharge" (p.3). However, as a result of long-term conditioning and neglect of affective education, such discharge is severely impeded, with a result that undischarged and unevaluated recordings of distress experiences become compulsive patterns of behaviour, feeling, and verbalizing when restimulated by later experiences which resemble them strongly enough.

Jackins believes that the effect of undischarged distress experiences and associated 'patterned behaviour' is an adequate explanation for all irrational behaviour in human beings. Jackins states (op.cit., p.4), ".....any human being, and human beings in general, can become free of the restrictions, inhibitions and aberrations of the accumulated distress experience recordings by reinstating a relationship with some other person's or persons' aware attention and allowing the discharge and reevaluation process to proceed to completion."

This theory provides, therefore, a detailed and explicit definition of catharsis. The discharge of the distressful emotions (catharsis) is defined as largely internal, involuntary processes, with invariant external indicators such as weeping, shivering, cold sweating, and so on. One

very important point to note is that emotional distress and discharge are two different, and in fact, opposite processes. For example, grief is experienced as sadness or longing (i.e. an emotional distress), whereas crying and sobbing are ways of discharging the grief.

In order for discharge to occur, Jackins stresses the importance of the client's being aware of the 'free attention' of the counsellor. If clients are totally enmeshed in the distressful material (i.e. underdistanced), they may merely relive the emotional experience and, just as in the original situation, discharge will not occur. On the other hand, if most of one's attention is in the safe present, the repressed emotion is not sufficiently felt, and, again, no discharge occurs (i.e. overdistancing). Overdistanced experience is totally cognitive. Thus a 'balance of attention' must be maintained between awareness of the painful incident and awareness of the safety and support of the therapeutic relationship (i.e. optimal distancing). When the balance of attention is achieved, the client is both participant in, and observer of, his own distress. Under these conditions the client becomes sufficiently aware of the repressed emotion to feel it and discharge it.

On the basis of the foregoing brief discussion of Jackins' cathartic theory a definition of catharsis may be formulated:

1. Distress (grief, fear, anger, and embarrassment), if not discharged spontaneously, accumulates and blocks the 'lovingness, zest, and rational intelligence that are basic to man's nature'.
2. Undischarged and unevaluated recordings of distress experiences become compulsive patterns of behaviour, feeling and verbalizing when re-stimulated by later experiences which resemble them strongly enough.
3. Discharge frees the core qualities of lovingness, zest, and rationality, dissolving the compulsive patterns.
4. In resolving such patterns insightful reevaluation is as essential as catharsis.
5. Such reevaluation follows cathartic discharge spontaneously.
6. Discharge is signaled externally by one or more of a precise set of physical processes, i.e. somatic-emotional catharsis (e.g. crying, shaking...).
7. During discharge, the residue of the distress experience(s) is being recalled and reviewed,

although not necessarily with awareness, i.e. cognitive-emotional catharsis (e.g. feeling sad, but without tears).

8. A 'balance of attention' (i.e. optimal distancing), signalled subjectively by feelings of control, pleasure, and relief, is required for discharge to occur.
9. Repeated discharge of the distress in relation to specific scenes is often required.

Catharsis in Human Development - John Heron

In England, John Heron has provided a very thorough conceptual model of catharsis (Heron, 1977), which in many respects is similar to that of Jackins', Reevaluation Counselling Theory. A review of Heron's model will allow an extension of the basic requirements for a theory of catharsis presented in the foregoing paragraph, and provide a basis for the development of hypotheses to be tested experientially (presented in Chapters Four and Five).

Heron believes that, as well as physical needs, human beings have three basic personal (or psychological) needs, each with an active and a passive form. These are: the need to love and be loved; the need to understand and be understood; and the need to choose and be chosen. He

further contends that the passive form precedes and indeed, facilitates the active form (i.e. before a person can 'love' they must first of all 'be loved'). When these personal needs are fulfilled satisfactorily then distinctively human behaviour results, which is characterized by three types of behaviour: playful (e.g. creative, improvisatory); conventional (accepting prevailing rational norms and values); and autonomous (self-directed and self-creating). On the other hand, when personal needs are interfered with, then ".....behaviour is distorted into half-conscious, quasi-mechanical, repetitive and maladaptive forms" (1977, p.7). This 'distorted behaviour' is similar to the chronic patterns described by Jackins in Reevaluation Counselling.

According to Heron, personal needs are frustrated and interfered with both by primary sources ("sources that are intrinsic to the human condition prior to human invention and intention", 1977, p.11), and by secondary sources. Secondary sources of frustration are basically those of the interfering actions of other 'distressed' persons. They include physical interference (e.g. a difficult birth; sexual interference) and its emotional concomitants; psychological interference (e.g. separation and loss, parental prescriptions as to how the child 'should' behave, rejection) both by individuals and by rigid organizations in which there is, ".....political oppression, economic exploitation, denial of human rights" (p. 14), and social

interference, where distorted human behaviour has become institutionalized and legitimated. Heron also proposes a third source of personal vulnerability inherent in many social structures because of the unavoidable tension between individual needs and the 'needs' of the organization in which the person seeks individual fulfillment.

What happens when these personal needs are frustrated and interfered with ? Heron's main contention is that anger, fear and grief occur, not only from the interference of physical needs, but also from the thwarting of personal needs, both in the infant and the adult. When love needs, both active and passive, are frustrated, through bereavement, say, then the resultant distress is experienced as grief, sadness, and sorrow, with a longing for the deceased person. Available evidence (e.g. Bowlby, 1951, 1979) suggests that a rich and sustained flow of love is necessary for the child to develop the capacity to develop healthy, intimate and loving relationships with others. When understanding needs are frustrated then the resultant distress is experienced as anxiety or fear. If not suppressed, such fear 'dissolves' by cold perspiration and involuntary trembling. When the need to be self-directing is blocked then the resultant distress is experienced as restlessness and tension, and in its more intense phases as anger or rage. If the expression of anger is not inhibited then it is discharged in violent physical

movements (e.g. kicking, hitting) and in loud sounds. It should be pointed out that, although the 'cause-effect' equations above have been presented as if they were discrete, they are obviously not mutually exclusive. Heron writes, ".....the primary frustration of any one involves secondary frustration of the other two. Primary grief at the sudden loss of a loved person may also involve secondary anger at the sudden permanent restriction on valued and pleasant choices and secondary fear at the prospect of unknowns and uncertainties thrown up by the loss" (1977, p. 20).

It should be noted at this point that Heron distinguishes between distress feelings and distorted feelings. Distress feelings are the original healthy responses of grief, fear and anger to frustration of personal needs. Distorted feelings occur when interrupted, frozen needs and distress feelings are denied expression and are repressed.

Having delineated the major distresses, it is now important to examine how they effect the individual both psychologically and somatically, when they are denied expression and result in distorted functioning. Heron postulates three types of distress. Enabling distress is positive in that it facilitates effective functioning, anger enabling appropriate assertive behaviour, for example. Neutral distress is, as its name implies, neither enabling or disabling, as long as it is fully available at the conscious level. Disabling distress, on the other hand,

produces maladaptive and unfulfilling behaviour. The extent to which a stressor is disabling depends upon a very complex interaction between the vulnerability of the person, the intensity of the stressor and its frequency, as well as to the ways in which the person cognitively appraises and copes with the situation. Heron suggests that, ".....the greater the person's insight into the reality of the interpersonal stress situation, the less the tendency of the stress situation, the less the tendency of the stress to have a disabling effect on behaviour" (p. 23). It will be realized that children are therefore highly vulnerable to personal stressors, with the result that, ".....any major suppression of this creative psychosomatic spontaneity of the young person is registered as psychosomatic distress, hence there will be a somatic component in the release and resolution of such distress" (1977, p. 24).

Heron suggests three ways in which frequent personal stressors effect the individual: (1) encysting: where the stress is occluded from consciousness, remaining latent within the system. Pre-natal trauma , birth, and early childhood experiences would seem to fall into this category (Janov, 1973., Lake, 1981., Laing, 1982., Grof, 1976). It may remain latent, never directly distorting behaviour, or it may erupt, particularly when current stressors are similar to the prototypical event, giving rise to distorted behaviour; (2) automatic distortion: again the distress is

occluded but is a weaker form of protective inhibition than encysting, and consequently some distortion of behaviour occurs. This may be intermittent or chronic; (3) induced distortion: the person discharges distress somatically, leading to emotional release, but persistent demands are made for the individual to 'control themselves'. This control of affective behaviour eventually becomes autogenic, with the consequence that behaviour becomes distorted.

Heron argues that distressed feelings of grief, fear, and anger can be resolved by the process of catharsis. He defines catharsis as follows: ".....a complex set of psychosomatic processes by means of which the human being becomes purged of an overload of distress due to the cumulative frustration of basic human needs" (Heron, 1977, p. 33). The cathartic part of the theory presented above holds that grief is purged from the system by tears and convulsive sobbing, fear by trembling and cold perspiration, anger by shouting and high-frequency storming movements. These somatic-emotional behaviours are, ".....regarded as processes that get rid of distress, that restore the person to non-distressed, flexible functioning again" (Heron, 1977, p.33). He states, ".....catharsis, when taken far enough, restructures awareness, liberates insight and reevaluation about the genesis and consequences of the original trauma. It discharges some of the underlying energy that disables

human behaviour, and gives scope for the re-emergence of flexible human responses" (Heron, 1982; p. 3). Heron also includes the discharge of embarrassment in laughter within the spectrum of cathartic behaviours. In his later writing (Heron, 1982), he states that, "both catharsis and transmutation are necessary for the resolution of disabling distress; neither should be used as a defence against the other; and catharsis has, perhaps, a certain precedence in any developmental programme" (p. 4).

Distorted feelings effect the mind-body giving rise to psychological and somatic rigidities. Heron argues that distorted behaviour (i.e. resulting from distorted feelings), is basically compulsive, and, moreover, is very widespread in our culture. Common forms of compulsive distorted behaviour are: invalidation, both of self, and of others; irrational claims, in which claims, demands and expectations of others are irrational; and rigid beliefs and attitudes. The physiological correlates of these psychological phenomena include muscular rigidities, the weakening of end-organ responsivity, and a decrease in immune system functioning, the possible long-term effects being psychosomatic 'illness'. Although Heron has little to say about this aspect it is very much an intrinsic component of his thesis. Other writers have developed this aspect much more fully (e.g. Janov, 1975; Lake, 1981; Lowen, 1976; Reich, 1961). The effects of catharsis on

psycho-somatic behaviour should logically, in terms of the conceptual map, lead to a break-up of the distorted body-mind functioning.

Heron (1977) argues that catharsis does not automatically regenerate behaviour, but that the liberated insight into the aetiology of the problem allows the person to choose new behaviour. Important here is the attention given to cognitive processes, and to the person choosing and developing new behavioral strategems. In other words, although affective release is emphasized, due attention is also given to cognitive, behavioural and somatic functioning, as part of the cathartic process.

Heron provides a comprehensive account of this cathartic process (Heron, 1977, p. 43). Such a process includes the following: balance of attention, where "attention is balanced.....between the distress and what is outside it, a psychodynamic leverage is maintained that tips the distress feeling into discharge". The techniques used to create a 'balance of attention' are described in Appendix Two; somatic-emotional release of the distressed feelings with a simultaneous cognitive-emotional catharsis; spontaneous insight occurs as a result of the release of distressed feelings. Heron says, "Discharge of distress has the effect of breaking up the distorted construct, liberating the mind to make a truly discriminating appraisal of what was really going on in the early critical incidents and in subsequent replays" (1977, p. 44);

celebration of human identity, of one's 'true self', in creativity, enjoyment of self and others, as well as in an intelligent appraisal of one's life (relationships, life style, activities, work etc.), leading to action planning and goal setting.

The presentation and discussion of Heron's theory of 'catharsis in human development' has been fairly extensive, because it seems to me to offer the most complete analysis of the processes of catharsis to date. His theory demonstrates a clear progression of thought from the earlier writings of Freud, Reich, and Jackins. The synopsis provided above does not really do justice to the richness of his writing, nor does it develop the social and political aspects of his theory. However, I believe it to be complete in terms of providing a basic understanding of his theoretical formulations in terms of the frame of reference adopted for this thesis. I will now attempt a summary of the theory with a view to clarifying the concept of catharsis, and the aim of developing a series of hypotheses that can be experientially explored.

1. Human beings have three personal needs (Basic Postulate).
- 1.a. When these are fulfilled, distinctively human behaviour flourishes.
- 1.b. When these are interfered with, distressed feelings

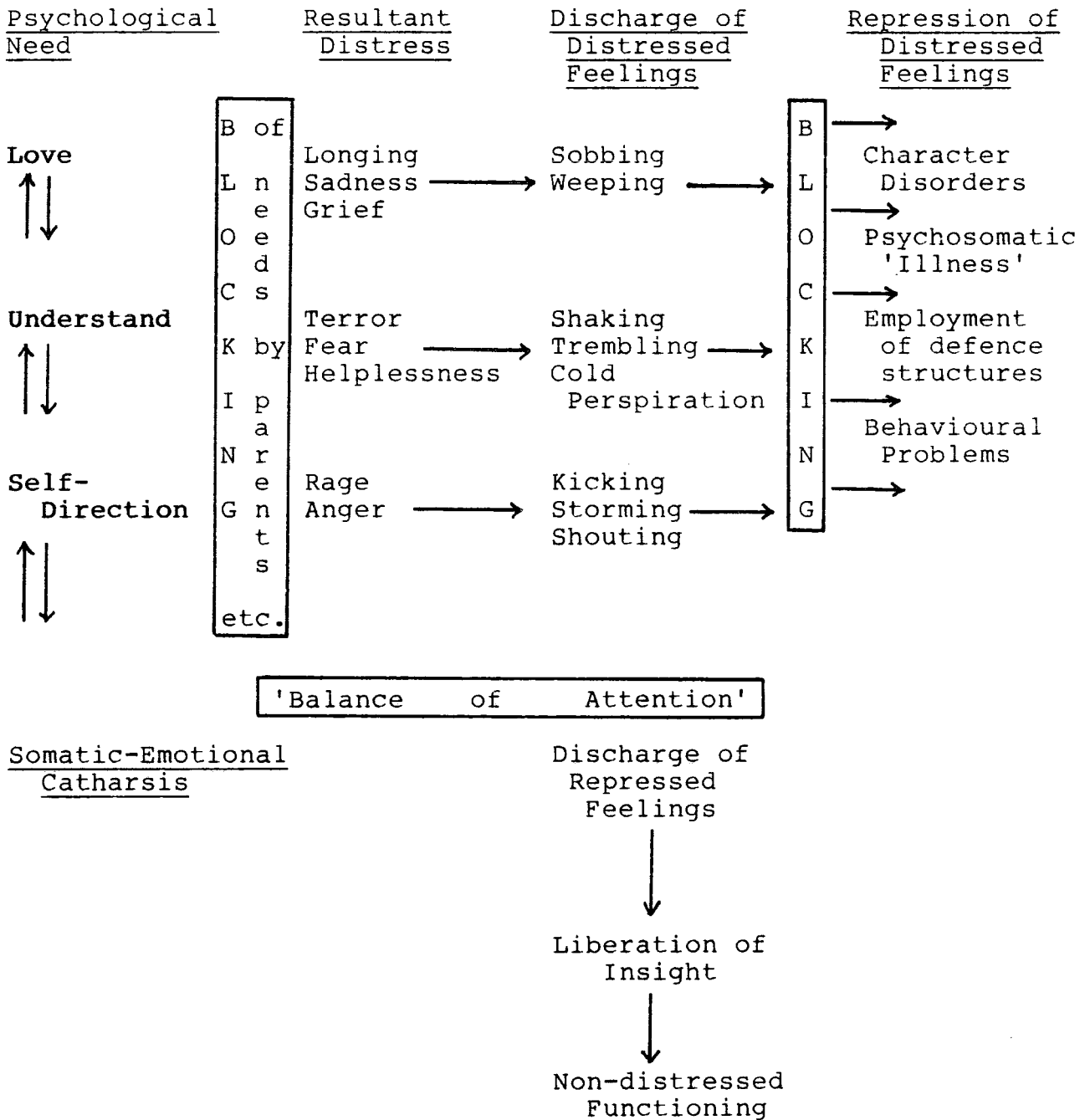
and/or distorted behaviour results.

- 2.a. Distressed feelings (grief, anger, fear) may be discharged leading to the relief of emotional tension.
- 2.b. Distressed feelings may be inhibited and repressed giving rise to distorted feelings.

- 3.a. Distorted feelings occur as a result of the direct interference of a personal need (encysting and automatic behaviour), or from the inhibition and repression of distressed feelings.
- 3.b. Distorted feelings effect the total mind-body giving rise to psychological and somatic rigidities.
- 3.c. Such rigidities may be (i) intermittent, (ii) chronic.

- 4.a. Distressed feelings can be resolved by the process of catharsis.
- 4.b. Catharsis occurs where there is a balance of attention.
- 4.c. Emotional discharge (catharsis) gets rid of distress, liberates insight and leads to a reevaluation of the original situation.
- 4.d. When distress is resolved the person is restored to non-distressed functioning again.

Figure 1. Summary Chart of Heron's Theory of Catharsis in Human Development



The above postulate and corollaries are presented in Figure One.

In Chapter Three reference will be made to a number of studies that have a direct bearing on the above proposals, and in Chapters Four and Five two experiential research inquiries will be reported that explore some aspects of Heron's theory, particularly in relation to 4.a., 4.c., and 4.d. (above).

SUMMARY

The various approaches to psychotherapy considered in this chapter all, to differing degrees, emphasize the process of catharsis within their respective systems. As we have seen, Freud abandoned catharsis and the traumatic theory in favour of free association and the conflict theory of neurosis. Ironically, many of the emotive therapies that were developed as a reaction against psychoanalysis rest on variations of Freud's early idea that neurosis results from repressed traumatic events and can be cured by remembering and expressing the associated affect (e.g. Janov, 1973; Jackins, 1975).

The pioneer and intellectual leader of modern cathartic therapy was undoubtedly Wilhelm Reich (1949, 1961). He was the first to emphasize sustained catharsis over a prolonged course of psychotherapy. Although Reich made the concept of catharsis central in vegetotherapy, he never treated

emotion as the only valid expression of one's humanity, and his theory emphasized understanding as well as catharsis. Reich's influence led to a shift away from rationality in psychotherapy, and to the notion that the mere surrender to feelings and the passive acceptance of impulses leads to fulfillment.

In the 1960's a variety of therapies with major emphasis on catharsis were popular including psychodrama (Moreno, 1946); encounter groups (Rogers, 1970); re-grief therapy (Volkan, 1975); primal therapy (Janov, 1973); bioenergetics (Lowen, 1969); Gestalt therapy (Perls, 1969); re-evaluation counselling (Jackins, 1965); feeling therapy (Hart et al., 1975), and new identity therapy (Casriel, 1972). Subsequently, some of these approaches as well as some related offshoots [e.g. feeling-expressive therapy (Pierce et al., 1983); primal integration (Swartley, 1976)] emphasized cognitive and behavioural strategies in addition to their original cathartic focus. Practitioners such as Harvey Jackins (1965), who had originally emphasized cathartic 'discharge' almost exclusively, began devoting more attention to the so-called 'chronic patterns' which seemed to require more than simple release. His writings (1975) included additional suggestions for acting and living in ways which forcibly contradict the neurotic programming, and he established co-counselling communities to provide a continuing social network. Thus, catharsis or discharge became a part of a larger, more complex

feeling-thinking-acting programme. Similar views are expressed in the theories presented by Heron (1977), Swartley (1976), Hart et al., (1975), and Pierce et al., (1983).

These therapeutic systems suggest that emotional-somatic catharsis of stored distress (grief, anger, and fear) leads to the relief of emotional tension, consequently restoring the person to a state of functioning representative of their 'real self'. The real self is the hypothesized 'inherent nature of human beings', which is considered to be basically good (loving and caring, altruistic), rational, and self-determining (free). This notion is a basic postulate of many of the essentially humanistically oriented theories of personality and psychotherapy (e.g. Rogers, 1942, 1961; Maslow, 1970, 1971; Jackins, 1965; Heron, 1977). In order to release the 'stored' emotional distress it is necessary for the individual to regress back to the 'point of origin' of the distress in order to 'feel' and ventilate the emotions that were not expressed at the time. It should be noted at this point that a simple hydraulic model of human emotion is not being suggested. Rather, catharsis is to be understood as a label for completing some or all of, a previously restrained or interrupted sequence of self-expression (e.g. crying, shaking, kicking.....) It is further argued that as well as engaging in this emotional-somatic catharsis, the individual, **because** of the emotional ventilation,

achieves cognitive insight into the aetiology of current and re-occurring presenting symptomatology, leading to a reevaluation of the original situation. Once the distress has been dealt with then the person is restored to 'truly human functioning' again, although some cognitive and behaviour restructuring may be necessary.

The psychotherapeutic systems that have been considered also emphasize the holistic aspect of human functioning, i.e. the intimate relationship between mind and body. Where feelings are repressed they become encapsulated with the body and give rise to various bodily rigidities, which generally 'stress' the system (e.g. Janov's primal pain). If the historic tension remains buried and unresolved then psychosomatic disorders are likely to develop. The necessity for 'grief work' is precisely to prevent this from happening.

However, as was mentioned earlier, these various abreactive-cathartic psychotherapies stay remarkably close, in terms of their central propositions, to the theory propounded by Breuer and Freud (1895): (i) neurosis is caused by "...psychical traumas. Any experience which calls up distressing affects - such as that of fright, anxiety, shame, or physical pain - may operate as a trauma if there has not been an energetic reaction to the event that provokes an affect sufficient to discharge it....." (pp. 6 & 8); (ii) Neurosis is cured by successfully ".....bringing clarity clearly to light the memory of the

event(s) by which it was provoked and in arousing its accompanying affect; the patient must describe the event(s) in the greatest possible detail and 'put the affect into words'" (p. 6); (iii) The task of the therapist ".....consists solely in inducing him (the patient) to reproduce the pathogenic impressions that caused it (the neurosis), giving utterance to them with an expression of affect.....;". "To do this the therapist must overcome the resistance or defense, a psychological force in the patients.....opposed to the pathogenic ideas becoming conscious." (Breuer & Freud, 1895, pp. 268, 278, & 283); (iv) Neurosis is essentially a 'splitting of consciousness' between memory and affect and the cure of neurosis is, therefore, the healing of this split - which "brings to an end the operative force of the idea which was not abreacted in the first instance....." (pp. 12 & 17).

All of the abreactive-cathartic therapies discussed in this Chapter, with the exception of implosion therapy, accept the basic ideas contained in the quotes from Studies on Hysteria. Additionally, they all, starting with Breuer and Freud, emphasize the striking intensity of abreactive events and the major psychological and physiological changes that follow successive abreactions. The major changes that have occurred with respect to psychotherapy concerns the recognition of the importance of cognitive and behavioural strategies as part of the total therapeutic endeavour. This is important since

psychotherapy is a process in which patients can claim greater responsibility for their actions, and can begin to control their own destiny, with consequent decreases in feelings of 'helplessness' (Seligman, 1975). Further discussion of the implications of this model for psychotherapy will be presented in Chapter Six.

In the next chapter an examination of the effectiveness of some of the major cathartic therapies will be undertaken. Because of the volume of material involved it was considered expedient to discuss this aspect separately from the strictly theoretical exposition which has been the focus of the current chapter.

CHAPTER THREE

THE EFFECTIVENESS OF CATHARSIS - RESEARCH EVIDENCE

Touch it; the marble eyelids are not wet,
If it could weep, it would arise and go.

Elizabeth Barrett Browning

Outcome Research in Psychotherapy - Problems

Before reviewing the evidence for the effectiveness of cathartic approaches in psychotherapy, it is necessary to briefly examine some of the problems inherent in therapy outcome research. Positive outcome, and *inter alia* effective treatment, is necessarily related to the values that society assigns to feelings, attitudes and actions. These values are inherent in conceptions of mental illness and health as well as in the clinical judgements based on one of these models.

One of the great stumbling blocks in psychotherapy research has been a failure to realize the importance of values (Garfield & Bergin, 1978). While researchers have made considerable gains in clarifying technical and methodological issues, objective assessments and measurements have remained imperfect and imprecise. For example, it is a common finding that outcome assessments by clinicians, patients, peers, and therapists correlate only moderately (Garfield, et al., 1971). Strupp (1978) writes, "One may attribute this to the imperfection of the instruments and the fallibility of raters, but.....raters bring different perspectives to bear,

and the relative lack of correlation partially results from legitimate divergences in their vantage points" (p. 8). Rachman and Wilson (1980) also argue that conventional outcome research "incorporates.....assumptions of doubtful validity, and as a result the research is bound to be of limited value."

Several reviewers of psychotherapy research have pointed out that change is multifactorial (Bergin & Strupp, 1972), and others have suggested various categories of therapeutic change. Knight (1941) postulated three major criteria for considering therapeutic change: (1) resolution of symptoms, or behavioural change; (2) real improvement in mental functioning; and (3) improved reality adjustment. Most therapists and researchers would concur that therapeutic success should be demonstrable in the person's feeling state (well-being, happiness, satisfaction), social functioning (actualization of behavioural goals), and personality organization.

The first type of change is, of course, most important from the point of view of the client. Unhappiness is usually the **real** reason for entering therapy, and without some measure of relief, therapy is not successful. Unhappiness may centre around a focal complaint (e.g. a specific psychosomatic symptom), but resolution of the symptom may occur **without** relieving the unhappiness. In other words, treatment may resolve the symptom while failing the client. However, increased happiness or satisfaction is difficult to evaluate and frequently is

transitory. Ventilating feelings usually, though not always, feels good; whether or not it leads to lasting increases in satisfaction with living is more difficult to determine.

An unfortunate side effect of Freud's concern with fundamental personality change is a tendency among some therapists to forget that, in addition to other goals, resolution of presenting problems is also important. This happens as therapists translate their client's goals into theoretical goals, and is exacerbated by a tendency to view therapy as a vague process without a clear rationale or purpose. At the end of the day clients usually want to change their way of functioning in the real world, and this means translating the insights or social skills gained in the consulting room into effective behaviours in everyday life.

The third aspect of successful therapy, personality change, is the most difficult to measure. Furthermore, although it ultimately may predict long-lasting satisfaction, it is often of more concern to the therapist than the client. In fact, it is quite common for a client to experience symptomatic improvement and increased satisfaction from brief supportive therapy while the therapist feels that not much has been accomplished.

Strupp (1978) points out that feelings of well-being are clearly part of the individual's subjective perspective; what constitutes effective behaviour in terms of social functioning constitutes a social perspective, including

prevailing standards of conduct and 'normality'. Personality change, on the other hand, is the perspective of mental health professionals whose "technical concepts (e.g. ego strength, impulse control) partake of information and standards derived from preceeding sources but which are ostensibly scientific, objective, and value free" (Strupp, 1978, p. 8). However, it may be argued that therapists and researchers have not taken the implications of these aspects seriously, consequently affecting the usefulness of outcome studies in therapeutic research (Strupp & Hadley, 1977). The full implications of Strupp's (1978) view will be considered when the outcome studies are evaluated later in the chapter. It should also be emphasized that virtually all research in psychotherapy has been 'orthodox', as opposed to 'new paradigm' which is "collaborative, experiential, heuristic, endogenous, and participatory" (Reason & Rowan, 1981, p. xx). The philosophical basis of the research methodology has considerable implications for outcome studies. This issue will be taken up in some detail in Chapter Four.

General Curative Factors in Psychotherapy

To date, although there is an extensive body of research about psychotherapy, it does not provide any 'real' evidence that one system of therapy is 'better' than any other. The view that all forms of psychotherapy are effective has gained some support (Luborsky et al., 1975;

Smith & Glass, 1977; Meltzoff & Kornreich, 1970). Analysing and synthesizing the data from 25 years of research on the efficacy of psychotherapy, Luborsky et al., (1975) have concluded that most forms of psychotherapy produce changes in a substantial proportion of patients - changes that are often, but not always, greater than those achieved by control patients who did not receive therapy. Smith and Glass (1977) demonstrated that across all types of therapy, patients, therapists, and outcome criteria, the average patient is better off than than 75 percent of untreated individuals. This evidence does not support Eysenck's (1952) view that psychotherapy produces no greater changes in emotionally disturbed individuals than naturally occurring life experiences.

In most psychotherapy research the features which all therapies share have been relatively neglected. Indeed, these common elements, which are not focussed on in the theory or practice of the particular therapeutic system, may be responsible for the view that "Everyone Has Won and All Must Have Prizes - the verdict of the Dodo bird in Alice in Wonderland" (Luborsky et al., 1975).

Frank (1971) writes, "The facts that the prevalent method of psychotherapy in any given era is strongly influenced by the prevailing cultural standards and values, that no one method has succeeded in eliminating its rivals and that many forms of contemporary treatment embody rediscoveries of age-old healing principles, all suggest

that features common to all forms of treatment contribute importantly to their effectiveness" (p. 355). He suggests that effective psychotherapies have the following six features in common: (i) An intense, emotionally charged, confiding relationship with a helping person, often with the participation of a group; (ii) A rationale, or myth, which includes an explanation of the patient's distress and a method for relieving it. To be effective this myth must be compatible with the cultural world-view shared by the therapist and patient. In Chapter One it was suggested that the 'effectiveness' of ritual, in the context of magic and religion, was intimately related to the prevailing socio-cultural climate within which 'understanding' occurred; (iii) Provision of new information concerning the nature and aetiology of the patient's problems, and possible alternative ways of dealing with them. This new information may occur as a result of either didactic teaching or through self-generated insight, as in the case of the therapies reviewed in Chapter Two; (iv) Giving the patient hope that symptom amelioration or self-discovery is possible. This is often implicit and is generated through the qualities of the therapist, and enhanced by their status in society and the setting in which they work; (v) Provision of success experiences which further encourage hope, and help develop a feeling of 'ego strength' in the patient; (vi) The facilitation of emotional arousal, which "seems to be a prerequisite to attitudinal and behavioural changes" (Frank, 1971, p. 357).

In other words, Frank argues that catharsis is an underlying curative factor in all therapies. Furthermore, all of the above conditions are present in the cathartic therapies that have been examined, although emotional expression is given a central position within them.

A similar conclusion is reached by Symonds (1954). Symonds researched the literature for reports on therapeutic treatment in which statements regarding changes in behaviour, attitude or feeling were linked to something that happened during the therapy session. Out of 68 such changes in adjustment related to events taking place in the session, 59 followed **abreactions**, 7 followed **interpretations** by the therapist, and 2 were related to **change in perception**. On the basis of this research, Symonds proposed the following hypothesis: "all changes in behaviour and adjustment occurring as a result of psychotherapy follow abreaction in the therapeutic situation" (p. 699). Of the 59 abreactions, the majority (35) were expressions of anger, from which Symonds concludes that, ".....the abreaction of aggression is the therapeutic factor in a large majority of cases" (p. 700). He evokes a similar explanation to the cathartic therapists as to why abreaction is effective, i.e. "there is a release of energies which comes from the freeing of repression and the relaxation of resistances" (p. 701). He further states that following abreaction other repressed feelings are more easily ventilated, and that positive aspects of the 'self' are actualized. This would appear to



support Heron's contention that the individual is restored to non-distressed functioning, and demonstrates "distinctively human behaviour" (Heron, 1978).

However, Symonds argues that abreaction alone, cannot constitute the therapeutic process; it must be accompanied by insight if the results of abreaction are to remain permanent. Moreover, insight is also necessary for abreaction to occur, i.e. the client has to see the prototypical emotional event as non-threatening. Within the co-counselling framework (Heron, 1974, 1977) 'paradoxical' techniques, such as relaxation, celebration, and validation are used to take the clients away from their distress and to 'free their attention'. As this process occurs there is a paradoxical 'pulling-up' of emotional distress making it more readily available for discharge. The therapist is also non-punitive, accepting, and supportive, thus helping clients to become less anxious. It was noted in Chapter Two that a reevaluation of the original situation occurs as a result of insight into the relationship between the early prototypical event and symptomatology, because of the emotional-somatic catharsis. This is the view inherent in most of the cathartic models of therapy.

Having reviewed, albeit briefly, the two papers on general curative factors in psychotherapy, we may turn our attention to the reports, both clinical and experimental, concerned with the effectiveness of specific therapeutic systems.

Freud and the Cathartic Method

After several years of using the cathartic method, Freud came to the conclusion that the results he had achieved were not permanent. Consequently he abandoned his emphasis on the use of hypnosis and cathartic therapy in favour of psychoanalysis. He writes, "Worse than this capriciousness of the technique was the lack of permanency of the results. After a short time, when the patient was again heard from, the old malady has reappeared, or it had been replaced by a new malady.....I have had it happen that an aggravated condition which I had succeeded in clearing up completely by a short hypnotic treatment returned unchanged when the patient became angry and arbitrarily developed ill-feeling against me. After a reconciliation I was able to remove the malady anew and with even greater thoroughness, yet when she became hostile to me a second time it returned again" (1920, P. 112).

As was mentioned in Chapter Two Anna O's cure was by no means as successful as Breuer himself had suggested in Studies on Hysteria (Jones, 1953). As long as five years after Breuer's contact with her had ceased, Anna O. was still liable - according to the testimony of Freud's wife, who encountered the patient then - to occasional hallucinations whenever evening approached (Sulloway, 1979). Although Jones testifies to Anna O. having many relapses and eventually being institutionalized, Ellenberger (1970, 1972) could find no evidence of this in

the medical archives. Ellenberger's research (1972) into the case of Anna O. uncovered a report written by Breuer in 1882. This contained many details missed out in Studies in Hysteria, and suggested that her illness was more severe than reported in the 1895 report. It should also be noted that nowhere was there any mention of 'catharsis'. Ellenberger also found a follow-up hospital report, dated 1882, which depicted her as ".....a neurological case of a rather unpleasant person showing some hysterical features" (Ellenberger, 1972, p. 379). He concludes that, ".....(these) newly discovered documents confirm what Freud, according to Jung, had told him: the patient had not been cured" (p. 379).

However, she did eventually 'recover', and as Bertha Pappenheim, became an important pioneer in the women's movement. Jones writes, ".....she became the first social worker in Germany, one of the first in the world. She founded a periodical and several institutes where she trained students. A major part of her life's work was given to women's causes and emancipation, but work for children also ranked highly. Among her exploits were several expeditions to Russia, Poland, and Roumania to rescue children whose parents had perished in pogroms. She never married, and she remained very devoted to God" (Jones, 1964, p. 204).

Freud, however, in his General Introduction to Psychoanalysis (1949), states that "she did not take up the normal career of a woman" (p. 102). Scheff infers from

this statement that Freud did not consider Anna O. to be fully recovered because "she didn't marry and have children" (Scheff, 1979, p. 43).

However, the veil of legend surrounding the foundation of psychoanalysis and the case of Anna O. has only partially been lifted by the critical historical research carried out by Ellenberger. Controversy about the true nature of her illness and the outcome of treatment still continues unabated (Thornton, 1983, 1985; Eysenck, 1985; Gibson, 1985; Freeman, 1972; Rosenbaum & Muroff, 1984).

The first patient with whom Freud used the cathartic method was Emmy von N. in 1889, although there is some evidence that the treatment began in 1888; (footnote, p. 103, Studies on Hysteria, Breuer & Freud, 1895). Freud attended this patient for about seven weeks in 1889 and then a year later, for about eight weeks. She was diagnosed as an hysteric "who could be put into a state of somnambulism with the greatest of ease." She had a large number of symptoms which caused impairment: phobias, hallucinations, pain, cramping, and facial and verbal tics.

Freud in writing about the therapeutic outcome of this case says: "I cannot say how much of the therapeutic success was due to my suggesting the symptom away in *statu nascendi* and how much to my resolving the affect by abreaction, since I combined both these therapeutic factors. Accordingly, this case cannot be strictly used as evidence for the therapeutic efficiency of the cathartic procedure; at the same time I must add that

only those symptoms of which I carried out a psychical analysis were really permanently removed. The therapeutic success on the whole was considerable; but it was not a lasting one" (op.cit. p. 163). Freud suggested that the reason for the cure being only partial was connected with her hereditary disposition. However, as already mentioned, Freud acknowledged that he was not yet able to use the cathartic method correctly.

At the end of 1892, Freud treated Miss Lucy R. who was suffering from mild hysteria with few symptoms, the major concern being her lost sense of smell. The treatment lasted for only nine weeks and seems to have been successful. Freud met her four months later and writes, "She was in good spirits and assured me that her recovery had been maintained" (op. cit., p.186). In the case of Fraulein Elizabeth von R., Freud writes, ".....this process of abreaction certainly did her much good" (op.cit., p.228). "Two months later (after the end of treatment, PJH) the colleague.....gave me the news that Elizabeth felt perfectly well and was behaving as though there was nothing wrong with her, though she still suffered occasionally from slight pain" (op.cit.,p.230).

Freud appears to have had varied success with the other cases which are only partially reported in Studies on Hysteria. With respect to Frau Cacilie, who suffered among other things from an extremely violent facial neuralgia, there seems to have been some initial remission of the

symptoms, followed by "a surprising wealth of hysterical attacks" (op. cit., p. 250). Eventually Freud helped her to trace the origin of her neuralgia back to events 15 years earlier. However, it is not at all clear from Studies as to whether this case was entirely successful. There is the same doubt about the cases of Katharina, and the 'highly gifted lady'. On the other hand, the case of Fraulein Mathilde H. seems to have reached a successful outcome. Fraulein Mathilde ".....had become depressed to a point of *taedium vitae*, utterly inconsiderate to her mother, irritable and inaccessible." Freud writes, "I continued to address her while she was in deep sonnambulism and saw her burst into tears each time without ever answering me; and one day.....her whole state of depression passed off - an event which brought me the credit of a great therapeutic success by hypnosis" (op. cit., p. 234). The other reported case in Studies on Hysteria, is that of Fraulein Rosalia H., a singer who developed feeling of choking and constrictions in her throat. Freud's treatment of this case ended prematurely and unsuccessfully because of interference arising from problems within the patient's household.

After several years of using the cathartic method Freud came to the conclusion that the results were not permanent. He presents a full discussion of the problems inherent in Breuer's method in the final chapter of Studies on Hysteria, and it was fairly evident that he was already using **psychoanalysis** at this time. However, of the

studies examined four were successful (this includes the case of Anna O.), three met with varied success, and only two (Rosalia H. and Emmy von M.) were failures.

It can be argued, as does Scheff (1979), that Freud and Breuer's technique of cathartic therapy was critically flawed, in that they believed that a single verbal description of a memory of a trauma constituted a sufficient abreaction. Studies have already been mentioned (Edkins, 1946; Shrovon and Sargent, 1947) that conclude that repeated abreactions may be necessary in order to effect a positive therapeutic change. Likewise, Janov argues that once clients have discovered key traumatic memories, they must continually reexperience the episodes, releasing more and more of the painful emotions connected to them. What is needed for effective cathartic discharge, according to Scheff, is "a repeated emotional discharge of fear, grief, anger, and so on, during a properly distanced reexperiencing of a traumatic scene" (Scheff, 1979, p. 79). This view is supported by the theoretical statements of both Jackins (1975), and Heron (1977).

In conclusion, I suggest that there is a strong possibility that the lack of consistency in 'cures' of Freud's cases treated by Breuer's method, is due to Freud's failure to have the patient engage in repeated abreactions, as well as the lack of attention given to the full range of emotions and the necessity for distancing or 'free attention'. It is also clear that Breuer and Freud emphasized the verbal content of therapy, as against the

non-verbal emotional processes, referring to their approach as 'the talking cure'. In their definition of catharsis, they give a prominent place to verbally expressed recollections of traumatic events: ".....when the patient has described that event in the greatest possible detail and put the **affect** into **words**" (Breuer and Freud, 1895). However, they are usually referring to a very low level of emotional arousal. It has already been pointed out in Chapter Two that somatic-emotional catharsis appears to be a necessary factor for positive therapeutic change.

Primal-Oriented Therapies

Quite a number of studies examining the effects of catharsis derive from primal-oriented approaches. The studies have been carried out within the context of primal therapy (Janov and Holden, 1975), feeling therapy (Hart, Corriere & Binder, 1975), and feeling-expressive therapy (Pierce, Nichols & DuBrin, 1983).

Karle et al. (1973), formulated the following general hypothesis: **perhaps abreaction-catharsis is the physiologically curative component of psychotherapy.** This was based on the clinical observations of Lowen (1969) and Janov (1973), as well as the controlled research studies of Luthe (1970) carried out in the context of autogenic therapy. Karle et al. (1973), suggested that marked subjective and behavioural changes should be paralleled by equally large physiological changes. Their study comprised

an experimental group (patients undergoing their first three weeks of intensive primal therapy), and two control groups, one active and the other passive. Measures of blood pressure, pulse, and rectal temperature were taken twice daily (pre- and post- session). In addition EEG's were taken at less frequent intervals. Results showed that the primal patients demonstrated significant decreases in pulse activity, rectal temperature, and brain-wave activity. No data is provided for blood pressure. Karle et al. write: "The temperature, pulse, and brain wave decreases indicate that tension is a total physiologic event, and due to its effect on the brain, must inevitably influence awareness" (p. 119). They conclude, "The results.....do lend support to our hypothesis. Primal patients did show reduced tension after three weeks of intensive abreactive therapy. If these levels can be maintained it would mean that post-primal patients are physiologically different from pre-primal patients. We expect that all abreactive therapies would show similar short-term physiological effects. And we do not believe that abreaction is the only component of therapeutic change. Even if abreaction is **the** physiological curative process other processes must operate to sustain physiological normalization and still other processes must convert tension reduction into changes in the way a person lives his life" (p. 121).

A second study dealing with the physiological effects of psychotherapy was carried out by Woldenberg et al. (1976). This study was carried out in the context of Feeling

Therapy, and was a development of the study described above (Karle et al., 1973). Their work was based on preliminary research (Corriere, 1975; Gold, 1975; Binder, 1975) showing that patients in feeling therapy underwent significant behavioural change. Results demonstrated that there were significant changes in physiological signs (rectal temperature, pulse, systolic B.P., diastolic B.P., pulse pressure) in the first three weeks of therapy. The 'going through the motions' type of session that control subjects underwent did not lead to any significant or consistent physiological changes. They concluded that "the full expression of any kind of feeling, past or present, may effect at least a temporary reduction in physiological tension" (Woldenberg et al., 1976, p. 1062).

A third study (Karle et al., 1976), compared experienced subjects in feeling therapy to less experienced ones (those who had been in therapy for a shorter time). Results indicated that the experienced clients maintained consistently lower levels on all the physiological parameters measured over an extended period of time. It was hypothesized that these physiological changes might be accompanied by measurable psychological changes as well.

This question was pursued in a study by Karle et al. (1978). Measures on the Personal Orientation Inventory (Shostrom, 1965) revealed significant increases on the Inner Directed, Feeling Reactivity, Spontaneity, Self-regard, and Acceptance of Aggression scales with increasing time in therapy. Karle et al. (1978),

lude that the pattern of scores obtained can be characterized as reflecting a trend towards increasing self-actualization with longer length of exposure to therapeutic intervention. With the Eysenck Personality Inventory no significant increase in Extraversion scores were found in relation to therapeutic time dimension. Neuroticism scores decreased non-significantly with increased exposure to therapy. Karle et al. come to a cautious conclusion that "measurable psychological changes seem to be associated with exposure to this therapeutic modality" (1978, p. 1333).

Although all the studies from the feeling therapy group are cross-sectional and make no definitive connection to catharsis, they do seem to show positive changes in clients who have had a great many cathartic experiences over a long period of time.

Periodically, at the Primal Institute, individuals undergoing Primal Therapy have completed a questionnaire regarding physical and physiological changes which occur during therapy. The responses to these questionnaires are reported in The Anatomy of Mental Illness (Janov, 1978), Primal Man (Janov & Holden, 1975), and Prisoners of Pain (Janov, 1982). In Anatomy of Mental Illness Janov sums up the findings as follows:

"So the composite primal patient is someone in his early thirties, married, with three and a half years of previous therapy. He entered therapy smoking two packs of cigarettes a day, taking tranquilizers and sleeping pills, and, in

addition to his mental anguish, suffering from stomach distress and headaches. His average time in therapy was eight months , by which time he felt practically cured. Primal therapy produces a calm and contentment in him; it eliminates his symptoms and his need for relief habits such as alcohol, drugs, and cigarettes. His sex life is less frequent but deeper and more fulfilling. He is a better husband and father simply because he is a better, less demanding human being. He does less than he did before, produces less, is less sociable and enjoys being alone more. He feels more alive and will not struggle with anything or anyone. He is healthy and does not abuse his body. He has no great aspirations, likes to eat and take walks. He is a simple human being" (1978, p. 214).

The sample consisted of twenty-five primal patients who had had five or more months of Primal Therapy.

Starting in March 1973, a second questionnaire was given to Primal patients, the results of which are reported and discussed in Primal Man (1975). The same general conclusions with regards to the patterns of physiological and psychological changes are reached to those of the first questionnaire study and the research described above (Karle et al., 1973). The phenomena which were experienced by a majority of the 83 men and women Primal patients in the second series included: straightening of posture; clearing of sinuses and nose; fuller, deeper respiration; normalization of appetite and food intake; decrease in sex urge with increased enjoyment of sex; decrease in muscle

tension; and, recognition of symptoms of illness and Primal Pain.

Holden (1977) reports that, ".....over many months in Primal Therapy there are progressive decreases in EEG voltage, pulse rate, blood pressure, and core body temperature, and psychosomatic ailments. The decrease in vital signs and EEG voltage in Primal patients over time offers evidence that Primals are capable of **resolving** childhood Pain" (p. 341). With respect to psychosomatic illnesses, Holden writes, ".....by resolving the feelings-of-origin of psychosomatic illnesses, we are addressing ourselves to causal mechanisms of neuroses, and no longer must resign ourselves to only treating these disorders symptomatically" (p. 350).

The Rochester Studies

Another series of four research studies, known as the Rochester Project, was carried out within the context of feeling-expressive therapy (Pierce et al., 1983). In this research actual psychotherapy sessions were recorded to determine what techniques therapists used to increase feeling, and to measure how much emotional expression occurs during feeling-expressive therapy.

In the first study (Nichols, 1974), the impact of catharsis on the outcome of brief psychotherapy was evaluated. Six relatively experienced therapists administered emotive therapy, based on Jackins'

reevaluation counselling, to every second patient assigned to him. The other clients were given traditional insight-oriented dynamic therapy. Each session was tape-recorded, and the therapist's interventions were scored in one of the following categories: i) emotive techniques; ii) reflection of feelings; iii) interpretation, and iv) advice or leading the patient to consider a concrete course of action. Measures of change were based on the Minnesota Multiphasic Personality Inventory (MMPI), scales D (depression), Pt (Psychasthenia), and Sc (Schizophrenia) being summed to provide a self-report index of distress and psychopathology. A test of emotional style (Allen, 1972) was also administered to assess specific changes in receptivity and expression of affect. Ratings of changes in personal satisfaction, and progress towards behavioural defined goals were also made. Results showed that the emotive group experienced significantly more catharsis, and high-catharsis patients changed significantly more on behavioural goals and showed a trend toward greater improvement in personal satisfaction. Nichols (1974) concludes that the findings ".....confirmed the effectiveness of emotive psychotherapy in producing catharsis and tended to validate the hypothesis that catharsis leads to therapeutic improvement" (p. 57).

In the second Rochester Study, Bierenbaum et al. (1976) examined three issues as they relate to brief emotive psychotherapy: (a) the effect of varying session length and

frequency relative to psychotherapy outcomes; (b) the impact of the different time frames in producing emotional catharsis; and (c) the role of emotional catharsis as an intervening variable in therapeutic change. Outcome was assessed in the same way as in the first study. The amount of emotional catharsis produced in each session was also measured. Results showed that patients in a one-hour group produced the most catharsis and improved the most on the personal satisfaction ratings and progression towards behavioural goals, with high-catharsis patients showing the greatest improvement. Patients in the half-hour group improved the most on the MMPI scales, irrespective of the amount of catharsis. On the other hand patients in the two-hour group showed, overall, less improvement than the other two, which may have been due to the two-week interval between sessions. The findings were seen as supporting the contention that within a specific time frame emotional catharsis can lead to certain positive outcomes in brief emotive psychotherapy. To make psychotherapy more effective they recommend as the best approach "to meet for at least an hour, probably once a week or more, and to engage the client actively in the direct expression of suppressed affects relevant to the present difficulty" (Bierenbaum et al., 1976, p. 116).

In a third study, Nichols and Bierenbaum (1978) examined the success of cathartic therapy as a function of patient variables, by combining data from the earlier two studies. Patients without mental disorders experienced more

emotional catharsis, whilst those with obsessive compulsive personality disorders improved more as a result of emotive treatment. It was also noted that, contrary to public stereotype, neither women nor hysterics experienced more catharsis or improved more in cathartic therapy. The authors conclude that catharsis appears to be beneficial by disrupting long-standing defences against emotional experience, rather than by releasing stored-up affects.

In the fourth study (Pierce et al., 1983) the results of long-term feeling-expressive therapy were examined. In the context of this study, long-term psychotherapy is defined as a process aimed at lasting character change, and involves resolving resistances; reducing mechanisms of defense; uncovering unconscious thoughts, feelings, and impulses; examining feelings about the therapist; and thoroughly reexamining material from the past. Results showed that long-term feeling-expressive therapy led to significant improvement in all three dimensions of personal change, symptoms, satisfaction, and character structure, across a wide variety of patients. It was found that women generated higher levels of catharsis than men over the course of long-term therapy, a reversal of the situation in short-term therapy (Study Three), and by termination began to show greater improvement than men. Significant improvements were also shown for obsessives, with particularly high change scores on the Feeling Scale, suggesting that they become more feelingful people. Depressives and psychotics also benefited significantly

from long-term reconstructive therapy.

Pierce et al. (1983), in drawing conclusions from all four studies, write, "Those of our clients who do not learn to express feelings tend not to improve, while those who do express feelings do change. But it is **not** true that those who show the most catharsis show the most change. More significant than the amount of catharsis **per se** are: (i) expressing feelings that were previously avoided, conflict-laden, or unconscious; (ii) having a cognitive connection to those feelings, and (iii) becoming more expressive than previously" (p. 271). Pierce et al. argue that the results support the contention that feelings are dispositions to action, and that cathartic therapy helps people to become more feelingful. "Our patients did not get rid of anything, they gained something - a fuller appreciation of themselves as feeling, thinking, and acting people" (Pierce et al., 1983, p. 273).

Co-Counselling Experiential Inquiries

Two systematic explorations of co-counselling using experiential and collaborative research methods (Reason & Rowan, 1981), have been reported (Heron & Reason, 1981; Heron & Reason, 1982). Co-counselling or reciprocal counselling (Heron, 1974), where client and counsellor alternate their roles, is based on the theoretical frameworks of reevaluation counselling (Jackins, 1965, Heron, 1977).

In the first co-counselling inquiry, two areas of investigation were proposed by Heron and Reason (1981). They identify these in the following way: "(i).....to map out the various mental spaces, intra-psychoic and interpersonal, which we journey through, both as clients in co-counselling and also - with the sort of awareness we derive from co-counselling - in everyday life; (ii) to identify and clarify the range of strategies we can use in moving from one space to another - again both as clients in co-counselling and in everyday life" (1981, p. 6). They continue, "All co-counsellors.....by virtue of participating in the common culture of co-counselling share certain informal maps and strategies. The purpose of this research is to clarify, refine and elaborate our grasp of these, and to correct and amend them where appropriate" (1981, p. 6). The research model adopted was one of collaborative enquiry, a detailed examination of which will be presented at the beginning of Chapter Four.

At the beginning of the inquiry a 'basic' map of states of attention, drawn from general co-counselling, was presented. Heron and Reason present this as follows: "....this 'basic' map consisted of four quadrants: (1) Attention out, away from distress - creative living, talking and thinking; (2) Attention balanced - in touch with distress and in touch with something safe/positive outside distress - for catharsis and re-evaluating; (3) Attention sucked in, swamped by, distress - disabling depression, emotional pain; (4) Attention conspiring to

dump / displace / act-out / dramatise distress-distorted behaviour afflicting others" (1981, p. 22). Over the course of the inquiry this 'basic' map was expanded and refined. The precise revisions of the map, however, will not be presented here.

From the point of view of catharsis, the mapping of states of attention is of considerable importance. The reason for this is that catharsis occurs when there is an optimal balance of attention between distress and 'something' outside of the distress. It follows that any research that can elucidate the conditions under which optimal catharsis will occur is helping to maximize the amount of discharge that will occur. However, it should be noted that this is not evidence that catharsis *per se* is effective in providing positive therapeutic outcomes.

The inquiry discussed above also helped to refine the process of experiential research, since it was one of the first systematic attempts to use this approach.

A second experiential co-counselling research inquiry commenced in 1982 (Heron & Reason, 1982). This inquiry was an investigation of the ways in which individuals manage restimulated distress. Findings (Heron & Reason, 1982, pp. 11-20) suggested that there is a hierarchy in the management of restimulated distress which ranges from tactics (practical methods in the actual situation); strategies (policies to adopt some regular practice(s); and belief systems (the conceptual framework that underlies a person's way of being and doing in the world). In terms of

therapeutic outcome or personal growth, the findings indicated that there were general increases in self-awareness, personal power, and belief. However, there is no direct evidence linking these positive changes with catharsis per se, although this is implied in the framework of the theoretical model (Jackins, 1965; Heron, 1977).

Behaviour Therapy

Another body of literature that bears on the effects of catharsis comes from the behaviour therapists. While behaviour therapists are more interested in the learning of new responses in social situations than emotive therapists, they have also been interested in cathartic expression and have amassed some tentative support for its power to change behaviour.

It has already been seen in Chapter Two that implosive therapy (Stampfl and Levis, 1973) is a highly evocative and expressive form of treatment. As clients are forcefully and repeatedly confronted with vivid descriptions of their fears and painful fantasies, they shake with fear, rage, and weep uncontrollably. The most successful sessions are presumed to be the ones with maximum emotional response (Fazio, 1970; Hogan, 1968; Stampfl & Levis, 1973).

Despite the consistency of research findings related to the presumed factors contributing to the effectiveness of implosive therapy (e.g. Edelman, 1972., May, 1977., Rabavilas & Boulougouris, 1974), research on the actual

effectiveness of implosive therapy has been quite mixed. Using the MMPI as a criterion for therapy effectiveness, Levis and Carerra (1967) found that out-patients treated by 8-hour-long sessions of implosive therapy had a larger number of T scores drop into the normal range than did patients who received conventional treatment or no treatment at all. A number of other carefully controlled clinical studies (e.g. Boulougous, Marks & Maset, 1971; Hogan, 1966; Hogan & Kirchner, 1967; Crowe et al., 1972) have also yielded positive results. However, a number of studies (e.g. Barrett, 1969; Borkovec, 1972; Willis, 1968) do not support the effectiveness of implosive therapy vis a vis other forms of behaviour therapy, usually systematic desensitization, except in the treatment of phobic disorders. However, it is difficult to draw any definite conclusions regarding the effectiveness of catharsis *per se*.

Studies that do provide some support for the effectiveness of implosive therapy do, of course, offer only indirect evidence of the effectiveness of catharsis. However, two studies support the contention that the effects of implosive treatment are due to non-specific emotional arousal and expression, rather than to extinction of specific phobic images (Hodgson & Rachman, 1970; Watson & Marks, 1971). More recently, though, a number of studies have provided evidence showing that patients' anxiety levels during implosion do not correlate with subsequent outcome (e.g. Hafner & Marks, 1976; Johnston et al., 1976;

Mathews, 1978).

The only behaviour therapist who has written of the direct therapeutic value of emotional release is Shoben (1960). He found that emotional release led to the re-examination and reintegration of formerly traumatic experiences, and that this was therapeutic for the patient.

Analogue Studies

When the complexity of psychotherapy seems to defy understanding, psychologists have built and tested laboratory models or analogues. Such experimental models or analogues permit the isolation of the various elements (e.g. patient, therapist, treatment, motivation, age, etc.) that interact in psychotherapy, under conditions of relatively greater control. These analogue studies of psychotherapy have provided suggestive evidence that emotional catharsis leads to tension-reduction, although few provide an adequate test.

Nichols and Zax (1977) examined eleven analogue studies of the effects of catharsis in therapy-like situations. Seven of these supported the effectiveness of cathartic interventions (Dittes, 1957; Goldman-Eisler, 1956; Gordon, 1957; Haggard & Murray, 1942; Levison, Zax & Cowen, 1961; Martin et al., 1960; Ruesch & Prestwood, 1949); one did not support the effect of catharsis (Keet, 1948); and three were ambiguous (Gordon, 1957; Grossman, 1952; Wiener, 1955). Nichols and Zax summarize their review of analogue

studies as follows: "Several of these studies discuss interventions regarded as cathartic. However, none of these interventions involve the intense emotional discharge advocated by contemporary emotive therapists. Moreover, none of these studies attempt to measure the occurrence of catharsis. For these reasons, we cannot say that they demonstrate the effectiveness of cathartic therapy" (p. 181).

Recently, Bohart has attempted to demonstrate the therapeutic effects of catharsis in laboratory analogues (Bohart, 1977, 1980; Bohart & Haskell, 1978). In the first study (Bohart, 1977) one of the purposes was to compare the effectiveness of role playing to both a discharge procedure and to an 'intellectual insight' procedure. Bohart assumed that role playing (as used in Gestalt therapy) is an example of a procedure that combines both insight and affect, and for this reason hypothesized that role playing would be more effective than either 'sheer discharge' or 'intellectual analysis'. The results supported the hypothesis that role playing can be effective in modifying feelings, attitudes and behaviours associated with interpersonal conflict. In addition role play consistently appeared to be better for this than either discharge, intellectual analysis, or no treatment. Bohart concludes, "The greater effectiveness of role play is in accord with the position that insight and emotion must go hand in hand for change to occur. Discharge alone did not seem to be effective, in fact,.....the discharge group appeared

to show increases in anger" (1977, p. 22). He further concluded that, ".....the current study suggests that the main attitudinal change involved a reevaluation of the provocateur's intentions" (1977, p. 23). However, Bohart acknowledges the problems inherent in the analogue procedure that he employed.

A second study (Bohart & Haskell, 1978) was conducted to take account of some of these problems. As in the previous study undergraduate subjects recalled a recent anger arousing incident. They then engaged in one of four counselling-analogue procedures: role play, catharsis, interpersonal, or 'situational analysis'. The results obtained confirmed the first study, i.e. that emotional expression, verbal or non-verbal, did not automatically lead to anger reduction and emotional relief" (Bohart, 1980, p. 194). However, one interesting aspect of the study suggested that practice with catharsis may be needed in order for it to become effective.

A third study, referred to by Bohart (1980), explored the hypothesis that the interpersonal condition may have been the condition most likely to facilitate catharsis. Results led to the following conclusions: (1) a rejection of the notion that interpersonal counselling is effective primarily because it facilitates catharsis; (2) that positive outcome is related to the counsellor's warmth, empathy and genuineness.

A fourth study referred to by Bohart (1980) demonstrated that even subjects' self-perception of emotional relief

gained through emotional expression was in part determined by cognitive factors. He concludes that, ".....cognitive, attentional factors are involved in the very self-perception of emotional relief gained through expression." Bohart also cites a number of studies (Lieberman, et al., 1973; Mallick & McCandless, 1966; Hokanson, 1970; Bach, 1974; Feshbach, 1956; Konecni, 1975), that generally support his conclusions.

Bohart (1980) proposes that the experience of being 'bottled-up' comes from the **interference** with an ongoing **action sequence**, rather than from the 'storing-up' of the undischarged emotion or motivation. It follows that it is the act of not expressing one's emotions, for whatever external reasons, that is frustrating. This is similar, in many ways, to Perl's 'unfinished business', and to Pierce's 'dispositions to action'. According to Bohart, the 'business' could be finished in a number of ways, and not necessarily by 'response sequence completion', thus emphasizing the planful, purposive nature of human behaviour. However, this view is essentially the same as that expressed by Nichols and Efran (1985) that, "catharsis (is) the completion of an emotional action sequence" (p. 55).

However, there are a number of reasons as to why the above studies cannot be considered an adequate test of the effectiveness of catharsis.

Experimental subjects lack the distress that motivates actual patients to change significant aspects of their

behaviour, and they may also lack the emotional blocks that make such changes difficult. In the studies reviewed above, only here-and-now situationally based emotions were involved, as opposed to the exploration of supposedly buried and 'deep' emotions. The notion that intense emotional discharge is a prerequisite for change has already been discussed in the previous chapter. None of the analogue studies of catharsis, with brief and time-limited counselling procedures, have produced the intense emotional discharge that occurs in contemporary emotive psychotherapies. Another weakness in Bohart's studies is that all the dependent variables were clients' self-reports, although he cites studies involving dependent measures other than self-report that support his general conclusions. Moreover none of the analogue studies attempt to measure the occurrence of catharsis. It could also be claimed that the findings from analogue research are not directly applicable to clinical, especially to psychiatric, problems. At best, the analogue studies provide suggestive evidence that emotional catharsis leads to tension-reduction.

Social Psychology of Aggression

Catharsis has also been studied in non-treatment contexts, the social psychology of aggression and attitude change.

Quarty (1976) in his excellent review of the aggression

catharsis literature concludes, "Results from the studies reviewed cast serious doubt on the traditional aggression catharsis hypothesis but lend support to a reformulation of that hypothesis in terms of social-learning theoryThe implications of the social learning model of aggression catharsis for educators and clinical practitioners should be obvious. Aggressive acts are not the only ones that can reduce tension caused by frustration; prosocial responses can prove just as effective" (pp. 125-126). Holt (1970) noted that, ".....there can be both constructive and destructive ways of expressing anger, and therapists should seek to discover nonviolent responses to anger that can serve both tension reduction and the maintenance of healthy interpersonal relationships" (p. 87).

However, a number of writers (e.g. Nichols & Zax, 1977; Pierce et al., 1983; Scheff, 1979) argue that the research on aggression catharsis is not directly relevant to cathartic psychotherapy because indulging in or observing aggressive behaviour is quite different from encouraging cognitive and somatic-emotional discharge of previous distressing experiences. Pierce et al. (1983) state, "Subjects in these social psychological experiments do not remember and cry about painful experiences in a therapeutic context. Instead, they punish, or watch others punish, real people who appear to be actually hurt. By contrast, the whole emphasis in cathartic therapy is that angry feelings may be recognized and expressed in a context quite removed

from any **direct** confrontation with the instigator of those feelings" (p.240). It is often necessary to emphasize to the client during an aggressive scene in therapy that "it is not for real", whilst at the same time giving them (the client) permission to 'kill off' the bad part of the protagonist whilst the 'good part' is being protected (as in Pessó's Psychomotor Therapy). The more clearly clients grasp the distinction between the therapeutic situation and real life, the freer they feel to express their feelings fully without their problems being compounded by guilt and remorse. Pierce et al. conclude by saying that, "Berkowitz's claim (1973) that 'ventilationists' reward unrestricted aggression is simply false" (1983, p. 241).

Scheff's (1979) view is similar, arguing that studies of aggression catharsis use aggression **behaviour**, rather than **emotional discharge**. In none of the studies is the amount and kind of emotional discharge measured. Until such studies are conducted, the large body of literature on aggression catharsis cannot be used to evaluate therapeutic catharsis.

Encounter Groups

It has already been noted that encounter groups can be valuable under some conditions and not so valuable under others. In his book Elements of Encounter (1973), William Schutz concluded that, ".....the results of encounter groups are overwhelmingly positive." Is there any evidence

for this statement, and if there is, is catharsis an important factor in promoting such positive changes?

Notwithstanding the fact that it is technically very difficult to evaluate the results of encounter (Schutz & Allen, 1966; Bebout & Gordon, 1972), several studies have been done. Gibb (1970) reviewed many of the research studies related to encounter groups, and concluded: "changes do occur in sensitivity, ability to manage feelings, directionality of motivation, attitudes toward the self, attitudes toward others, and interdependence." Although no direct reference is made to catharsis *per se*, it could be inferred that participants are more likely to express their emotions. Gibb understands sensitivity as implying "greater awareness of one's own feelings and the feelings and perceptions of others....It also involves openness, authenticity, and spontaneity" (1970, p. 77). Yalom et al. (1967) asked group therapy members which areas had been most helpful to them. The results showed that the most frequently selected areas were interpersonal input, catharsis, and cohesiveness. It should be noted that many of the items within the catharsis area referred to self-disclosure (i.e. verbal catharsis). Rohrbaugh and Bartels (1975) employing a similar procedure to that of Yalom et al., (1967) came to a similar conclusion. Sherry and Hurley (1976) also found interpersonal input and catharsis to be the two most frequently endorsed categories. The view that the encounter group function is largely cathartic is supported by Back (1972).

In a much quoted study, Lieberman et al. (1973) made independent measures of change. In this comparative evaluation of different encounter groups, the most endorsed sources of change were feedback from others, universality, receiving advice or suggestions, understanding previously unknown parts of oneself, and cohesiveness. According to this study, at least two of the mechanisms most frequently endorsed by members - feedback and self-disclosure (catharsis) - are not in themselves sufficient to sustain change. Lieberman et al. recognize the importance of emotional expression as an important component of encounter groups, but acknowledge that cognitive functioning is also necessary. This view is in accordance with many others that have been examined (e.g. Heron, 1977; Hart et al., 1975; Jackins, 1975). However, a number of writers (Smith, 1975; Schutz, 1975; Rowan, 1975) have argued that the Lieberman et al., study is so grievously flawed in conception and in research design as to be almost worthless as a contribution to understanding encounter.

A study by Meador, referred to by Rogers (1970), examined the developmental stages of a week-end encounter group, using post eventum analyses of film. Results indicated that over the time of the group, individuals showed a significant degree of process movement toward greater flexibility and expressiveness. They became closer to their feelings, were beginning to **express feelings** as they occurred, and were more willing to risk relationships on a feeling basis.

Heider (1974), writing largely on the basis of his personal experience in facilitating encounter groups, writes, "Following the massive emotional release of catharsis, a person typically, but not inevitably, experiences an ecstasy, then a depression, then a return to normal" (p. 39). According to Heider, the blissful state arises regardless of the manner in which the catharsis was produced. He writes: ".....a genitally induced catharsis as described by Reich (1968) has the same effect as an encounter group blow-out, a religious catharsis induced by fear of damnation, or the release accompanying ecstatic childbirth. As long as total organismic release occurs, a greater or lesser degree of ecstasy will follow" (p. 39). Heider describes the postcathartic individual as "radiant, even luminous, to others. The eyes are unusually clear; muscles are relaxed yet energized; physical movement and verbal expression are graceful, even beautiful, and very much to the point. Inner symptoms include a remarkable sensitization to colour and sound; an unusual perception of somatic events; a pervasive feeling of energy; and a feeling of profound well-being, ease, and familiarity within the ongoing, existential flow of life. The postcathartic person has an unusual number of coincidences and other intimations of paranormal perception or comprehension. Healings and other so-called miracles or gifts are manifested. Psychological, somatic, and spiritual pathology may be suddenly washed away as if disease were in some way antithetical to the radiant state" (p. 39).

Discussion

An examination of the foregoing 'evidence' reveals that little account has been taken of the problems discussed in the introduction to this chapter. Virtually none of the literature defined what was meant by positive outcome in terms of the three major criteria presented earlier, and in all the cases, except the co-counselling studies, outcome criteria were defined unilaterally (i.e. by the 'researcher').

It has been noted that Freud came to the conclusion that the results of cathartic therapy were not permanent, which could lead to a more general conclusion that emotional abreaction is not a necessary component of effective psychotherapy. However, an analysis of the cases in Studies on Hysteria reveal that out of the 9 presented, 4 could be considered as being successful, with only 2 being definite failures. There is not enough evidence available to make judgements about the other 2 cases. It appears from this evidence alone that the 'cathartic cure' was moderately successful. A related problem is that of the criteria that Freud used to formulate 'success'. Clinical judgements about the mental health of a patient were then as now, made in terms of current psychological theories and their attendant diagnostic assessments, as well as the 'hidden values' inherent in the socio-cultural perspective. In this respect the position of women in society, and Viennese society in particular, is relevant.

It is clear from Freud's writings that the overt criteria for mental health were seen as being different for women and men. Freud's reference to Anna O's not marrying is an illustration of this view. Given these reservations, it seems completely reasonable to accept Scheff's argument that Breuer and Freud's technique of eliciting and managing catharsis was critically flawed when examined in relation to the modern sophisticated theories of catharsis developed by Jackins and Heron, among others. An examination of the cases in Studies reveals that the level of somatic-emotional catharsis was low, the patient being encouraged to "put the affect into words", and the necessity for repeated abreactions was not realized. On the basis of the evidence presented it appears reasonable to suggest that Freud was premature in coming to the conclusion that the cathartic cure was not permanent, leading to the consequent abandonment of working with primary processes.

Much of the direct evidence for the effectiveness of catharsis comes from clinical, quasi-experimental, studies conducted within the context of the primal-oriented therapies. Studies from the feeling therapy group demonstrated that the somatic-emotional expression of a past or present feeling led to a reduction in physiological tension. These results lend some support to the idea of repressed pain or tension. These studies also tentatively demonstrated that individuals in feeling therapy showed some changes in their characterological structure. However,

none of these studies showed **conclusively** that individuals who engaged in somatic-emotional catharsis changed significantly in relation to the tripartite criteria for positive outcome.

Likewise, studies conducted at the Primal Institute by Janov and his co-researchers, demonstrated that individuals engaged in primal therapy, showed changes in physiological and psychological functioning, as a result of the somatic-emotional discharge of 'stored distress'. However, many of the statements made by Janov to indicate positive outcome, appear to reflect his own values as to what constitutes mental health.

The Rochester studies demonstrated, as did studies conducted within the context of other primal approaches, that the techniques employed do produce high levels of somatic-emotional catharsis. It was also concluded that the occurrence of catharsis was **directly** related to therapeutic change, and further, that feeling-expressive therapy was more favourable in terms of defined therapeutic outcome than traditional, dynamic psychotherapy. An important theoretical conclusion of the Rochester group was that feelings are **dispositions to action**, and that cathartic therapy helps people to become more feelingful.

Most of the studies referred to above confirm the view held by most primally-oriented cathartic therapists that emotional expression is most therapeutic when it involves discovery and insight. Insight into the relationship between the early prototypical event and symptomatology,

because of the emotional-somatic catharsis, allows the individual to reevaluate the original situation. Similar conclusions were reached by Symonds (1954). However, the necessity for intentional behavioural change, through, for example, action planning, contracting, or relaxation, seems to be relatively neglected in the research studies, although there is some emphasis on this strategem in the theoretical formulations. Whilst these studies see somatic-emotional catharsis as occurring predominantly in relation to historical events, the notion that feelings are "dispositions to action" does of course also apply to current events, such as bereavement.

Widespread indirect support for the efficacy of catharsis also exists in many of the approaches that use emotional discharge.

The effectiveness of implosive therapy, an intensely emotive approach, is supported by a number of clinical reports of success, as well as several controlled studies of outcome in clinical settings. However, the validation of implosive therapy is only indirect evidence of the effectiveness of cathartic therapy. Moreover, the criteria for successful outcome are necessarily different than those employed from within the primal-oriented therapies, as is the function of catharsis (i.e. the extinction of anxiety as opposed to the discharge of 'stored distress' or the 'completion of an action disposition').

The bulk of empirical research conducted by social psychologists on catharsis of aggression can be described

as refuting the catharsis hypothesis (i.e. that catharsis reduces aggression). Social learning explanations that individuals **learn** to be aggressive by imitating and modelling others are largely supported by the empirical research. However, it has been argued in this chapter that such research is not directly relevant to cathartic psychotherapy, because indulging in or observing aggressive behaviour is quite different from encouraging cognitive- and somatic-emotional discharge of previous distressful experiences.

It has also been argued that none of the analogue studies were an adequate test, in that the intense emotional discharge that occurs in emotive psychotherapy is not produced.

Finally, it should be noted that catharsis is generally included in lists of the underlying curative factors common to all forms of therapy (Frank, 1971; Symonds, 1954; Rosenzweig, 1936).

In summary, then, it does appear as though there is some empirical evidence linking emotional expressiveness to therapeutic gain. The research studies reported in Chapters Four and Five represent a furtherance of this work, and in particular that of Heron and Reason (1981, 1982).

CHAPTER FOUR
RESEARCH INQUIRY ONE

There is no substitute for experiential investigation of a theory concerned with possibilities for actualizing human potential. But the traditional research methods of the social sciences may be used to complement the experiential method.

Heron (1971)

Introduction to the Research Methodology

The methodology employed in the research to be presented later in this chapter and in Chapter Five, is an example of new paradigm research (Reason & Rowan, 1981; Heron, 1981; Reason & Heron, 1985). Reason and Rowan claim that the roots of the new paradigm lie widely within the behavioural sciences, and that "while we are critical of orthodox psychology, we are strongly influenced by humanistic psychology, which offers a thought-out stance towards human beings, their experience and their actions, their origins and their potential, as exemplified in the work of people like Maslow. We are also influenced by the idea of the person as scientist which was the basis of George Kelly's work.....We see as valuable the vast array of ideas and knowledge which has come from the clinical work of people like Rogers (1968), Laing (1960, 1967), Jung (1964), Sullivan (1953, 1964), and Bion (1968), indeed going right back to Freud. This tradition of clinical exploration is clearly one of the forebears of the new paradigm.

Particularly important for research method is the knowledge gained from the workings of the unconscious, and the way in which unconscious forces affect the investigator as well as the investigated" (1981, p. xvi).

Reason and Rowan also note how the development of new paradigm methodology has been influenced by 'applied' behavioural science (e.g. Benne et al., 1975), Marxism (Habermas, 1971), phenomenology (Filmer et al., 1973), existentialism, and Hegelian dialectics (Zelman, 1979). The philosophical basis of new paradigm research is clearly elaborated by Heron (1981, pp. 18-30).

Essentially, the new paradigm research method involves the collaborative participation of both experimenter and subjects. Indeed, the 'subjects' are co-researchers throughout, from initiating the area to be researched and formulating the hypotheses, through the action phase of the research, to the interpretation and reaching of conclusions, and the consequent revision of hypotheses. At all times the participatory researchers share the same 'information' regarding the basic philosophic and theoretical aspects of the research. In this sense the researchers are not alienated from the product (i.e. the data, the conclusions), the work (i.e. the 'experiment'), other people, or from themselves (Rowan, 1981).

In the traditional model the subjects make no contribution to the development of the hypotheses, and are usually naive as to the research propositions and the theoretical rationale from which the hypotheses have been

derived. On the other hand the researchers (experimenters) are not **personally** involved in the action phase of the research cycle. This has been summarized by Heron (1981) in the following way:

	<u>RESEARCHER</u>	<u>SUBJECT</u>
<u>CONTRIBUTION TO</u>	Strong	Zero
<u>RESEARCH PROPOSITIONS</u>		
<hr/>		
<u>CONTRIBUTION TO</u>	Zero	Strong
<u>RESEARCH ACTION</u>		
<hr/>		

Much of the psychotherapy research reviewed in Chapter Three is of this kind, where "the patient, passive and dependent, is the recipient of a therapeutic programme unilaterally designed and managed by the therapist" (Heron, 1981, p. 155). In psychotherapy evaluation studies patients are usually arbitrarily assigned to one of a number of treatment groups without consultation (and agreement). The patients' need to understand what is happening and why is considered to be irrelevant, as are the patients' rights to exercise intentional choices in determining their own

destiny.

The full experiential research model is summarized by Heron as follows:

	<u>RESEARCHER</u>	<u>SUBJECT</u>
<u>CONTRIBUTION TO</u> <u>RESEARCH PROPOSITIONS</u>	Strong	Strong
<hr/>		
<u>CONTRIBUTION TO</u> <u>RESEARCH ACTION</u>	Strong	Strong
<hr/>		

The essential elements of the full experiential model are succinctly stated by Heron and Reason: "In this approach to research, the co-researchers first of all develop a set of propositions, proposals, or hypotheses which are to be the basis of the research, and they also work out some ways of checking out these propositions against their own experience and action. They then engage in the activity which is being researched, systematically observing themselves and the other co-researchers using whatever means of doing this which have been previously agreed. And naturally, as they do this, they may well get fully absorbed into the activity. This provides the experiential bedrock of the enquiry; at times they may even lose sight temporarily of the enquiry element of their

project. Finally, having engaged in the activity as agreed, and recorded their action and experience, the co-researchers return to the propositions they started out with, and systematically review them in the light of their experience" (1981, p. 4). The implication here is that all members of the research group make a strong contribution to the research effort from the working hypothesis to the research conclusions and final dissemination.

Having outlined the full experiential research model, it is obvious that a number of intermediate models could be developed, falling somewhere between fully experiential research and orthodox research. The following intermediate model is the one adopted for the research presented later in this chapter.

	<u>RESEARCHER</u>	<u>SUBJECT</u>
<u>CONTRIBUTION TO RESEARCH</u>		
<u>PROPOSITIONS</u>	Strong	Weak
<hr/>		
<u>CONTRIBUTION TO RESEARCH</u>	Weak	Strong
<u>ACTION</u>		

after Heron(1981)

In this sort of research design the researcher

(facilitator) suggests the working hypotheses, based upon theoretical and experiential knowledge of the area to be researched. These are presented, along with the theoretical framework from which they are derived, and are fully discussed with the co-researchers. Before the research commences the co-researchers agree to test the hypotheses within a framework of specific procedural action strategies. Throughout the research, the facilitator engages the co-researchers in the agreed procedural action (e.g. a therapeutic strategem evoking catharsis). The co-researchers record the personal changes that occur in their behaviour and experiencing, and having discussed these in the group, decide whether the working hypotheses are accepted or not. The facilitator's contribution to the research action is not entirely absent, for they may engage in some, if not all, of the experiential 'exercises'. Indeed, the facilitator within a co-researched personal growth oriented group must, because of the action procedures used, develop a reasonably high level of reciprocal interaction which increases the probability of the group members knowing them as persons. In other words, the facilitators are also engaged in a process of personal change and growth as a result of being involved in the research process, but not to the degree of the co-researchers. Heron writes, with respect to the experiential model, "Because of its important elements of reciprocity between subject and researcher, this model is much more human, more a research on and with persons than

the traditional autocratic model" (1981, p. 11).

It can be seen from the above discussion of the experiential research method that there are four essential stages involved. Firstly, the facilitator and volunteer co-researchers agree the working research area or hypotheses based upon a shared knowledge of the theoretical framework. In the intermediate model the facilitator presents the working hypotheses or area(s) to be researched to the group for their agreement. In Stage 2, some intentional procedural action (e.g. a cathartic procedure) is engaged in, and is monitored by both the facilitator and the co-researchers. In Stage 3 each subject enters as fully as possible into their experiential knowledge of what is going on. This experiencing can of course be overtly and explicitly represented in many ways, e.g. painting, writing, drama, poetry etc. In the fourth stage, the facilitator and the co-researchers decide in the light of appropriate agreed criteria and the experiences of each co-researcher, whether or not the working hypothesis has been fulfilled. According to Heron this approach to research is experiential "because its empirical touchstone is the experiential knowledge of each co-researcher" (1981, p. 16).

Examples of 'new paradigm' research can be found in Reason & Rowan (1981), Heron & Reason (1981, 1982), and Heron (1984).

Issues of Validity in Experiential Research

Heron (1982) provides a comprehensive discussion of empirical validity in experiential research, and what follows is essentially a restatement of his views. One of the key concepts is that of **research cycling** (Heron, 1981; Reinharz, 1981; Rowan, 1981). Heron (1982) defines the research cycle as a process which ".....involves the inquirers moving from reflection to experience/action, and from experience/action to reflection, where these two poles are in repeated dialectical interplay with each other. In the reflection phase the inquirers generate conceptual models which identify some area of experience/action for further inquiry; what is encountered in the experience/action phase is taken back into the reflection phase to refine, amend, modify, enlarge the conceptual models; and so on" (p. 4).

It is clear that the research project can involve any number of research cycles, the number of cycles being related to accuracy and validity. Each research cycle involves a gradual correction, deepening, and clarification of the conceptual model.

A second key aspect effecting the validity issue is that of the management of counter-transference in the research project (Devereux, 1967). It has already been argued (Chapter Two) that individuals have a lot of unacknowledged distress, the origins of which are often in early life. With respect to how it may effect research issues, Heron

(1982) writes, "Such unresolved distress tends to interrupt and occlude rational understanding, and there is a high probability that it will interrupt and occlude attempts to understand and inquire into the nature of persons" (p. 8). "They are compulsively not inquiring into persons as persons.....Even researchers who use person-centered methods.....will still need, as a procedure to enhance validity, to watch for and to deal with the tendency of past unresolved distress to distort the research process" (p. 9). In other words, the very process of inquiring into the nature of human beings **may** stir up old hurts and pains, which could interfere with the research at any one of its stages (e.g. planning, choice of research area, cycling, the utilization of time and resources, collaboration, communication of results, writing-up.....). In order to avoid the effects of the historical distress, co-researchers need to be involved in their own personal-growth through, for example, regular co-counselling.

It has already been argued that experiential research involves **collaborative** inquiry. In the process of validation, the degree of authentic collaboration needs to be monitored, so that it is demonstrated that ".....any agreement that is reached can be based on a thorough grasp within each person of what is going on and how to monitor it. So that the agreement is genuine, sound, real" (Heron, 1982, p. 9).

A fourth, and very important aspect of ensuring

empirical validity, is to build-in methods of counteracting consensus collusion. Consensus collusion occurs, for example, when the co-researchers covertly agree not to inquire into certain aspects of their experience and behaviour, particularly where these do not support the theory being explored. Heron (1981) states, "Consensus gentium is no adequate criterion of truth; it may simply represent widespread collusion to ignore crucial and relevant variables. What is crucial in attaining.....consensual validation is the quality of critical awareness and discrimination in categorising and evaluating the experiential effects and referring them back to the original theory" (p. 9).

A fifth criterion of validity concerns the balance reached between the active, experiential phase of the research cycle and the reflection phase. However, the appropriate balance will depend upon the nature of the inquiry.

All of the above criteria of validity will be returned to later in the chapter when the research studies are discussed.

RESEARCH STUDIES

A note on Presentation

Before proceeding with a presentation of the research studies, the nature of the reporting requires some clarification. Having made decisions about the type of methodology to be used in the data collection phase of the research, similar decisions are also of relevance to the **reporting** phase. The laboratory report is, perhaps, the archetypal form for reporting positivist research. The impersonal, authoritative style may even be supportive of the positivist outlook. Some interesting work in this area has been carried out by Latour and Woolgar (1979) in their study of laboratory life. Giddens (1976) has suggested that scientific paradigms may be regarded as Wittgensteinian language games. If, therefore, a new-paradigm researcher leans towards a literary form which has close links with positivism, this may have unforeseen consequences: he or she may be drawn back into the positivist language game. In other words, the adoption of a positivist literary genre may be conducive to the adoption of a positivist language game.

In reporting the research presented below, I may at times slip back into the positivist style on account of habits instilled as a psychology undergraduate.

Methodology

It has already been indicated that the methodological strategem employed in the research is **new paradigm**, and follows closely the experiential model developed by Heron (1981). At this point, I feel that it is relevant to present the reasons why the new paradigm approach, as opposed to more orthodox experimental research methodology, was chosen, since I am personally involved. This personal involvement includes the reasons for deciding to do research in the first place, as well as the choice of research area, methodology, and style of presentation.

One of the strongest reasons for utilizing a new paradigm approach came from a **personal conviction**, a feeling that this was a good way to do research. It should be noted that this conviction was based partially on an intuitive judgement, arising from involvement in humanistic psychology and personal growth work during the past ten years, and in part a result of rational and intellectual debate within myself, and with colleagues, backed-up by reading the relevant literature.

My training in psychology was pervaded by orthodox experimental research methodology, where controlled studies, quantification, and statistical analysis were the order of the day. This approach to psychological research appeared to be the **only** acceptable approach to studying psychological phenomena, or so it seemed at the time, for no alternative methodology was actively presented.

Methodologies involving naturalistic and participant observation, and clinical case studies, for example, tended to be dismissed as being unscientific, and consequently not very useful to the psychologist. I accepted the traditional approach whole-heartedly, but was surprised to find that this approach, although later rejected both intuitively and intellectually, still influenced me in the various stages of carrying out the research presented here.

My involvement in humanistic psychology and the personal growth movement began in 1974, when a colleague introduced me to the 'new therapies'. At that time my major research interest was in behaviour therapy, whilst my colleague was primarily interested in humanistically oriented group work. However, the debate was purely intellectual, and I was **not** convinced, indeed my enthusiasm for behavioural approaches in clinical and educational psychology as well as the attendant positivist methodologies, actually increased. My views changed radically and rapidly, not because of a considered rational and intellectual evaluation of philosophical and theoretical-conceptual issues, but as a result of **personal involvement** in the personal growth movement. Towards the end of 1974 I attended two 'personal growth' groups, one in transactional analysis facilitated by Michael Reddy, and the other in co-counselling led by John Heron. Both these experiences had a profound effect upon me, not only personally but also intellectually. Since that time my involvement with humanistic psychology has increased, and for the past seven

years I have facilitated groups in co-counselling, primal integration, and stress management, as well as teaching courses in personality theory and counselling psychology with a humanistic emphasis. Throughout this time I felt that the new paradigm approach to carrying out research, particularly within the area of personal change and therapy, was right. These **feelings** have been supported by considered rational evaluation within the context of intellectual debate with colleagues, and by reading (e.g. Reason & Rowan, 1981).

It was mentioned above that my thorough, and extensive, training and involvement in traditional research methodology, although now incorporated within a new paradigm approach, was **still** active in a dogmatic form at various stages of the research. For example, at times I found myself being overly concerned about the **lack** of quantitative data and statistical analyses, or, more to the point, as to whether this would be **criticized** by my examiners. This is an example of counter-transference in research (Devereux, 1967). It will be more fully discussed at appropriate points in the research discussion.

Origins of the research

As indicated above, I have been involved in group/individual therapy and counselling for several years, both as facilitator and as client. It has already been shown in Chapter Two that somatic-emotional catharsis is the

corner-stone of many humanistically oriented therapeutic and personal growth approaches, including reevaluation co-counselling (Heron, 1977; Jackins, 1975; Evison & Horobin, 1983), and primal integration (Broder, 1976). Personal **experience** led me to believe that catharsis was beneficial with respect to my own mental and physical health, but I wanted to explore this in a more systematic and rigorous way with others who were prepared to be involved in an on-going, cathartically-oriented personal growth group.

Initially, I had strong reservations about registering for a Ph.D., although covert institutional pressures to do so were quite strong. Of course, such pressures may have been more imaginary than real. One of my reservations was concerned with a feeling that I might be coerced into adopting a traditional experimental methodology, something that I felt would be untenable. Other reactions, including a general uneasiness with establishment politics, the status accorded to research *vis a vis* teaching, and policies with regards to promotion were all against the idea of researching for a Ph.D. During the period 1978-1981, I spent a considerable amount of time working-through my feelings about doing research within the context of registering for a higher degree. This working-through was done within the framework of co-counselling, and proved invaluable in terms of coming to a definitive decision to pursue research leading to a Ph.D. Fortunately, I knew an academic psychologist,

sympathetic to the proposed research project, including the new paradigm methodology, who was prepared to supervise me, and who would be able to steer its path through the various committees required for University registration approval. This was completed in September, 1981. However, the reservations I had about doing the research within the Ph.D. context were restimulated from time to time during the course of the research, with some negative consequences. This will be returned to later in the chapter.

RESEARCH INQUIRY ONE

Initiating the research

Having decided to pursue a research project investigating the effects of catharsis, it was necessary to gather a group of committed co-researchers. I announced my intention of establishing a research group to approximately 150 psychology students, most of whom were in their first year of study for a Combined Arts Degree. I invited all those who were interested in finding out more about the research to attend a special meeting at a time to be arranged. Shortly after this I organized the preliminary meeting, making it explicit that no obligations would arise from attendance, the purpose being to find out what was involved.

Preliminary Meeting

The meeting took place early in November 1981, and thirty two students attended. At the meeting, I shared with those present something about my own background in psychology, relating this to the proposed research. I stressed that I was committed to the basic tenets of humanistic psychology and the attendant experiential/phenomenological methodology. This raised some interesting questions, and ensuing debate, about the nature of psychology, and the question of research. For all of those present, this way of doing psychological research, along with the humanistic view as to what psychology is, was something quite different to that which they had been exposed to in the short time they had been at college. In their formal psychology course they had been attending lectures in physiological psychology, as well as traditional laboratory classes, along with the emphasis on scientifically controlled experiments, statistical significance and the like. For a number of those present, the view that I was presenting was totally unacceptable, whilst others found it stimulating and relevant. A very subjective appraisal of this state of affairs suggested that the older students (i.e. those over 25 years of age) were more likely to find the humanistic viewpoint relevant, whilst those who had come straight from school favoured the orthodox view of psychology.

I then presented a brief outline of the content of the

research, and the ways in which it could be carried out. Their role in the research was very carefully explained in relation to the experiential method. Some of those present expressed a concern (with some anxiety and apprehension) about their ability to fulfil the role of co-researcher. I stressed the necessity for a personal commitment of both time and energy from potential participants. At the end of this meeting a further session was arranged for those who wished to be involved.

Second Preliminary Meeting

Fifteen people attended this second meeting, the aim of which was to present a more detailed exposition of the theoretical framework, from which the research inquiry would be generated. The theory that was outlined and discussed was essentially the one presented by Heron (1977) in Catharsis in Human Development. This was discussed fully in Chapter Two (pp. 78-88). Two copies of the monograph were placed in the library for further perusal. It was agreed that those persons who were committed to being involved in the research would attend the first research group session in one week's time. It was further agreed that meetings would occur weekly, for two hours on Tuesday afternoons, and that the research project would last until March 1982.

First Research Group Session

Eight people, who will henceforth be referred to as co-researchers, attended this meeting. We started with a round of introductions, in which the co-researchers said who they were, and the reasons why they had decided to be involved. The most frequently cited reason was that it seemed a good way of "doing psychology", and that it would be of personal benefit, both personally and academically.

I then presented a summary of Heron's theory, and suggested the following area to be researched:

what are the psychological and somatic consequences of emotionally discharging (through catharsis) my distressed feelings?

Throughout this session I was aware that I was 'in charge' of the proceedings, and contributed most to the discussion of the research area. Little authentic encounter occurred, a true person-to-person contact being diminished by the ascribed roles of lecturer and student. This was checked out in a group round, with 5 out of the 8 co-researchers saying that they were scared to say too much for fear of being "wrong", and that "they were only students, anyway." The group ended with a non-verbal validation milling exercise (i.e. an exercise where each person validates a personal quality of the other members of the group), followed by a round of celebration of personal

qualities (i.e. each person in turn shares something that they like about themselves).

I agreed to present a format for recording, 'states of physical and psychological functioning', at the next meeting.

Second Research Group Meeting

All of the co-researchers attended.

After a group round of "what makes life worth living right now", I introduced the Research Schedule (see Appendix One). I explained the purpose of this, and in particular clarified what was meant by **somatic catharsis** and **cognitive catharsis**, as well as the designation of an **event**. After some discussion the group agreed on working definitions of these terms:

Somatic catharsis: where a person shows an emotion (e.g. anger, sadness, fear) by storming, shouting, hitting, crying, shaking etc., in connection with a specific event. This **motoric** discharge of feeling is (usually) available to the witness of others.

Cognitive catharsis: where a person feels an emotion (e.g. feels angry, sad, or afraid) in connection with a specific event, but does not demonstrate any motoric discharge of the feelings.

Event: an event is considered to be an occurrence of either somatic catharsis or cognitive catharsis with respect to one particular life experience, past or current, regardless of the length of time involved.

Insight: making connections between current psychosomatic/psychological/behavioural symptoms and past events, i.e. understanding.

Some members of the group felt that it would be useful to give examples of physiological and behavioural symptoms representative of the various categories delineated in the Research Schedule. This was done, and the examples were included in the final version of the Research Schedule (see Appendix One).

I suggested to the group that a number of physiological functions (critical indices) e.g. blood pressure and pulse rate, should be monitored throughout the study. This was discussed, and the group agreed that each co-researcher should take their own measurements at the beginning and end of each session, the measurements to be taken after the person had been sitting quietly for approximately five minutes. Members of the group then learned how to use the instruments.

I then facilitated a group session using some of the techniques presented in Appendix Two. During this session

two of the co-researchers demonstrated a somatic-emotional catharsis, in relation to a current event, and four others reported that they experienced a cognitive-emotional catharsis (i.e. they felt sad, angry.....). At the end of the session each person (including myself) said how they were feeling, and whether they had learned anything about themselves (e.g. physical symptoms, behaviours, and dominant feelings).

Research Group Meetings 3-18

During these meetings a standard format was generally adhered to, with occasional exceptions, which are discussed separately below.

The standard format approximated the following:

(i) each co-researcher made the appropriate physiological measurements;

(ii) a group round of celebrations (for a description of this exercise see page 157), followed by 'minor distresses' (i.e. each person in turn shares a current minor distress/problem with the group);

(iii) each co-researcher briefly presented the contents of their Research Schedule, mentioning any particular changes in their psychosomatic and psychological functioning, as well as indicating any incidences of catharsis or insight during the previous week;

(iv) active phase (see Appendix Two), facilitated by myself. This phase was essentially unilateral group

therapy, the aim of which was to encourage somatic-emotional catharsis. After experiencing a somatic-emotional event(s) the co-researcher would measure and record blood pressure and pulse rate, as well as noting what they were experiencing (e.g. the emotion involved; the time and place at which the event occurred; the people involved). At the end of the active phase all the co-researchers took the physiological measures;

(v) reflective phase: each co-researcher said what they had experienced during the 'therapy' session, and what they were experiencing currently. The number of cathartic events was agreed by the group on the basis of what had happened, and on the reported statements. Statements made by any member of the group were open to challenge from the other co-researchers. This aspect will be discussed further under validity issues.

(vi) closing group round, e.g. person-person appreciation (non-verbal/verbal); "what are you looking forward to in the next few days?"; action planning and contracting

Sometimes smaller groups were established, e.g. two groups, with four co-researchers in each group, for action planning and contracting, each person in the group having 5 minutes to develop their action plans.

Session 6

One co-researcher (BS) raised a number of issues directly connected with the business of the group. This was raised as a 'minor distress', and was presented in the form

of a written statement which BS read out (printed in full in Appendix Seven). The views of BS were discussed, each person being given the opportunity to comment. Taking each of BS's points in turn:

(i) the group agreed that the length of time was too short and we agreed to start one hour earlier, although this meant that one person (KM) would be late in arriving. She felt that she might miss something important, or disrupt the group proceedings when she arrived. KM agreed to the group starting earlier, but wished it to be known that she was unhappy with the decision. Other times were discussed but none were mutually convenient.

(ii) BS's comment that "sessions were slow to get started", found some agreement with other group members, and as it was suggested that I was too lax in "calling the group to order". This raised the whole issue of my role in the group, and of course the issue of genuine collaborative research. After some discussion, and a short 5-minute each way co-counselling session (the counsellors were asked to listen without making any interventions), the group agreed that I was the primary researcher, was more knowledgeable than they were, and therefore should be "in charge". This had effectively been the case from the start, their contributions to the research propositions being weak compared with my own (i.e. Heron's intermediate experiential research model). The group approved my role as the primary facilitator, and whilst acknowledging BS's point that members should "try out bright ideas", they felt

that this was too premature given their experience in this type of group. We agreed that the active phase of the research should proceed as in the previous meetings, but that the monitoring of the physiological indices and any introductory group activity should take place as quickly as possible, so that more time could be spent reflecting on the weekly schedules;

(iii) in a group round each co-researcher said what they thought the aims and objectives of the research were, and how they felt about being part of the research project after 8 weeks. This was found to be a very useful exercise, and two of the group said that they were positively encouraged to proceed with the group (including BS).

Although this session was primarily concerned with issues of the group's management of time, and the relationship between myself and the other co-researchers, as opposed to the research per se, it was seen as being a very important positive meeting, enhancing group cohesiveness and purpose. Six members of the group experienced some cognitive catharsis (anger in the cases of 5 people, and sadness in the case of the other).

Session 7

This meeting was scheduled the week before the Xmas Vacation, and the group had earlier supported the view that we should not cancel it. However, in the event, only 3 people attended. We decided to work on our feelings about

the others not informing the group that they would be absent.

Session 13

I was ill on this occasion, and left a message with the group to proceed as normal, insofar as reviewing the weekly Schedule, and reflecting on the significance of any cathartic release for their own physiological and phenomenological functioning, could be dealt with in my absence. I found out the following week that they had abandoned the meeting feeling that they could use the time more profitably by working on last-minute assignment completion. I spent part of Session 14 working with my feelings about "being let down by people I thought I could trust."

Sessions 19 and 20

In these two sessions the time was spent in reflecting on the 'data' that had been collected over the previous 16 weeks. The group tried to make some sense of the data in relation to the area being researched, with each person being asked to present a conclusion with regards to the 'effects of catharsis on physical and psychological functioning'. The data was made available to the group on an ongoing basis. It was agreed that I should write up the results and conclusions and present them to the group early in the Summer Term (i.e. May 1982).

FINDINGS

All the co-researchers shared how they felt after a somatic-cathartic event, and at the conclusion of the active 'therapy' phase. When these events (both somatic- and cognitive- emotional catharsis) occurred during the week, between sessions, the immediate feelings were recorded in the Research Schedule (Item 18), and these were presented to the group at the beginning of the next session. The following conclusions resulted from the group discussions which took place in Sessions 19 and 20. At these meetings each co-researcher presented a summary statement with respect to their own post-cathartic experiences. These were written down on flip-charts, and then the group worked through them, removing redundant material, clarifying ambiguous statements, refining others and so on, until the statements remaining were seen to be representative of the group.

With respect to the physiological data it should be noted that in the majority of cases the size of the changes are at least double the standard error, and the changes between the pre- and post- measures are nearly all in the same direction. These two observations have been taken as an indication of 'reliable' change since two standard errors correspond approximately to a significant Z ($Z > 1.96$; $p < 0.05$), and the proportion of changes in the predicted direction is well above that regarded as significant by the Binomial test.

(N.B. For convenience all of the tables referred to in this chapter and in Chapter Five are located in Appendix Three).

Immediate Post-Cathartic State

(somatic-emotional catharsis)

a. feel calmer and more rational; release of tension and pressure; less anxious; feeling better - relieved; a feeling of being "set free";

b. life seems worth living; glad to be alive inspite of problems; decrease in significance of material possessions; sense of achievement/purpose;

c. sense of personal power, of confidence, of being in control of "my own destiny"; greater feeling/sense of self-worth; looking forward to the future with anticipation and hope; clearer about immediate goals - "I know what I have to do now in relation to X";

d. realization that to "let go" is valuable, and that it can happen in a caring, non-judgemental group; feeling of the strong support, love and caring in the group; wanting to be close to other group members, to be touched and held;

e. feeling of warmth and total relaxation; physical and emotional exhaustion - feeling 'drained', physical

stillness; a sense of lightness as if 'floating';

f. decreases in blood pressure and pulse rate, i.e. the difference between measures taken at the beginning of the session and after a somatic-emotional cathartic event (see Appendix Three, Tables 1 & 2).

Mean decrease in B.P. = 3.14 (S.D. 2.58; S.E. 0.26)

Mean Decrease in P.R. = 2.30 (S.D. 2.65; S.E. 0.26)

g. bright eyes; warm, open smile; muscular flaccidity; facial colour (noticed by others);

h. surprise at what happened, that the feelings were so strong; "learning about my feelings towards significant people in my life"; after anger release, feeling different (more positive) towards the protagonists;

i. recognition (intuitive) that "there's a lot more stuff where that came from";

j. confusion and chaos about the significance of the cathartic event; experience of negative feelings, e.g. guilt, "about feeling, and discharging, anger towards someone I love";

k. a greater understanding of the reasons why I am the way I am, in terms of relationships, attitudes,

behaviour.....i.e. insight.

Period following the Immediate Post-Cathartic State

There was a general group consensus that the positive post-cathartic states (above) carried over to life outside the group. This positive state seemed to last between 4 hours and 2 days, although one member of the group reported that it lasted for 6 days. As well as including some of the states mentioned above, the following states were also mentioned by a number of people in their Research Schedule (the number of people involved shown in brackets):

feel more rested after sleep; quality of sleep improved (4)

eating less frequently between meals (3)

smoking less (2)

getting things done that I've put off doing (4)

improved concentration; daydreaming about material that came up in the group (4)

feeling good with other people; sense of being as good as they are; less irritable than usual (5)

The positive state was almost invariably followed by a

period of depression, in which the person felt bad, but still retained a sense of being in control, of managing distress, of not being totally overwhelmed by it.

Immediate Post-Cathartic State

(cognitive-emotional catharsis)

a. feelings of tenseness, often aches and pains, particularly headaches; increased physiological tension; feeling "uptight"; a feeling of heaviness; "I feel worse than when I arrived";

b. increases in blood pressure and pulse rate i.e. the difference between measures taken at the beginning of the session and immediately after a cognitive-emotional cathartic event (see Appendix Three, Tables 1 & 2).

Mean increase in B.P. = 2.34 (S.D. = 2.72; S.E. 0.27)

Mean increase in P.R. = 3.06 (S.D. = 2.51; S.E. 0.25)

c. 'distant' feelings of anger and sadness;

d. agitated and restless movements; wanting to get away from the group; a desire to 'go home'; feeling close to the person(s) who were 'working';

e. increased understanding of feelings in relation to particular life situations; recognition that the feelings

will have to be worked through;

f. a sense of having accomplished something important; providing a direction for the next 'group therapy' session;

g. a "knowledge" that "I'm not the only one who is carrying this pain".

These feelings/behaviours tended to carry over into the next few days, followed by a return to 'normal'. Other states occurring in the time immediately after emotional-cognitive catharsis included: compulsive eating (2); feeling tired (5); disturbed sleep (7); poor concentration (3); dreams concerning childhood incidents/childhood surroundings and family (1).

Co-researchers who did not experience any catharsis (somatic or cognitive) in a session also demonstrated increases in subjective psychological tension, as well as increases in blood pressure (see Appendix Four). The days immediately following were characterised by feeling tired, disturbed sleep, poor concentration, and 'unusual amounts of vivid dreaming'.

Psychosomatic Symptomatology

(1) Physical Complaints(long-standing)

There was no evidence of any permanent disappearance of physical symptoms (e.g. stomach aches; migraines; etc.). However, 4 people in the group said that their symptoms had become less frequent, whilst 5 felt that their symptoms were less severe (2 felt that their symptoms were less frequent, as well as being less severe). This latter finding may be related to the greater number of somatic-emtional events that these two people experienced.

The symptoms that showed improvement in terms of being less severe were: pre-menstrual tension; tightness across the chest; and aches and pains. Symptoms decreasing in frequency were: headaches, migraines, abdominal disturbances (constipation, diarrhea, wind, nausea), feeling tired.

(2) Psychological/Behavioural Problems

As with physical complaints, there was no evidence of long-standing problems being resolved, regardless of the number of cathartic events, although some problems became less intense (e.g. a fear of speaking in front of a group of people).

However, the group sifted through all of the individual comments, and arrived at a group consensus with respect to

the following:

more positive and confident outlook on the future;

not being frightened to do what I want; more decisive;

able to live for the moment and enjoy those feelings at the time;

less shyness in stating my abilities and exercising them; generally less embarrassed with people;

an alertness about the "now";

more willing to trust people and get involved in relationships;

a greater awareness of the distresses of others;

an overall sense of well-being;

an understanding of my feelings which results in the ability to deal more positively and constructively with my own life, both present and future;

emotions, both negative and positive, felt with greater intensity;

DISCUSSION

Somatic-emotional catharsis

The consensus statements regarding the immediate post-cathartic state, with respect to somatic-emotional catharsis, suggest an enhancement of psychological well-being. In nearly all cases this is paralleled by **decreases** in blood pressure and pulse rate (Appendix Three, Tables 1 & 2). These results are similar to those presented by Karle et al., (1973); Woldenberg et al., (1976); and Holden (1977) with respect to vital signs (reviewed in Chapter 3). The study conducted here supports the view that the full expression of any kind of feeling, past or present, may effect at least a temporary reduction in physiological tension.

The subjective feelings of well-being of the person who has just completed an 'action sequence' through an emotional catharsis, is the same as that described by Heider (1974). The post-cathartic individual has 'a feeling of profound well-being, ease and familiarity within the on-going, existential flow of life', and has essentially attained a 'radiant state'. This positive state appeared to last for a varying amount of time after the group session.

Although the general effects of somatic-emotional catharsis confirm the earlier research, it should be noted that there was a lack of any (permanent) changes in psychosomatic symptomatology, and behavioural/psychological

problems. The reasons for this may be related to the following interrelated variables: (i) insight into the underlying dynamics of a person's psychosomatic symptomatology and existential condition only occurred occasionally (17 cases from a total of 80 somatic-emotional cathartic events); (ii) that the majority of the cathartic events concerned current situations rather than past ones (no attempt was made to distinguish between present and past episodes in this study); (iii) the number of somatic-emotional cathartic events was less than 50 per cent of cognitive-emotional ones (Appendix Three, Table 3); and (iv) reports from the co-researchers showed that there were few instances of the "re-experiencing of a key episode".

We have already discussed the relationship between catharsis and insight with respect to a number of systems of cathartic psychotherapy (e.g. primal integration; reevaluation counselling; feeling therapy). It was noted that **insight** was an important component of any therapeutic change, and further, that this **depends** on catharsis. Heron (1982) states: ".....catharsis, when taken far enough, restructures awareness, liberates insight and reevaluation about the genesis and consequences of the original trauma. It discharges some of the underlying energy that disables human behaviour, and gives scope for the reemergence of flexible human responses" (p. 3). In the present study the catharsis was probably not 'taken far enough' in order for insight into the aetiology of the

problem to be liberated, and for the consequent reevaluation of the original situation to occur.

The low incidence of insight may be related to the relative infrequency of somatic-emotional events occurring during a 'therapy' session, as well as to the high number of current events *vis a vis* prototypical and key early life experiences.

The low number of somatic-emotional events is probably related to two major factors: (i) the co-researchers were relatively unsophisticated in terms of 'working with their feelings', particularly at the beginning of the research when showing their feelings was avoided if at all possible; and (ii) the amount of time in each session devoted to working with feelings was relatively short, given the amount of time that was necessary for starting and finishing the session, as well as for reflecting upon what had happened during the active 'therapy' phase.

Although there was no evidence of any permanent disappearance of physical/behavioural/psychological symptoms, a number of the co-researchers had recorded in their Research Schedules that the symptoms were less severe. This was particularly the case with JP and AS. Inspection of the number of somatic-emotional cathartic events (Table 3) reveals that these two co-researchers experienced more of such events during research sessions than anyone else in the group, although the occurrence of insight was no higher than for the other members. The other three members of the group who said that their symptoms had

become less frequent/severe experienced considerably fewer somatic-emotional events, and in two cases less than the two co-researchers who said that the severity of their symptoms had not decreased.

Cognitive-emotional catharsis

If somatic-emotional catharsis is a necessary condition for getting rid of distress and liberating insight, then, when absent, there should not be any **permanent** and positive changes in the person's characterology. The current study suggests that experiencing a cognitive catharsis leads to an **increase** in tension, as indicated by objective physiological measures (Appendix Three, Tables 1 & 2). and by the subjective experiencing of the co-researchers. Perhaps it should be noted at this point that the individuals experiencing a 'feeling' (cognitive catharsis) were not encouraged to 'imagine themselves engaging in a motoric action', e.g. a 'silent abreaction' involving hitting someone.

Inspection of Tables 1 & 2 (Appendix Three) reveals that blood pressure and pulse rate both tended to rise after a cognitive-emotional cathartic event. One explanation for this is that memories in the person's unconscious are activated by the catharsis of others through identification (passive imagination). This usually occurred in the research group when one person was working with me 'out front'. In most cases, the passive co-researchers

who were experiencing a cognitive catharsis, did not ventilate their feelings because they thought it inappropriate "to interrupt what was going on". In other words, feelings were 'stirred-up' but not discharged. There was no evidence in this study for concluding that any vicarious discharge of feelings occurred. It seems likely that these 'controlled feelings' were responsible for the increases in blood pressure and pulse rate as well as the subjective states. These particular findings have an important relevance to clinical practice, an aspect that will be returned to in Chapter Six.

Longer-term changes

Although there was no evidence for the remission of any psychosomatic symptoms or psychological problems, there was considerable evidence for positive changes of a more general nature. Every co-researcher, without exception, said that they had gained something very positive from being involved in the group (three examples of the post-research 'reports' are provided in Appendix Seven, as being illustrative of the general positive effect). These more general changes do not appear to be related to the amount of catharsis, since every co-researcher experienced them. It seems more likely that these positive changes were a result of the group experience and 'general therapeutic strategems', as summed up by JP in her final report:

"The most valuable aspect of the therapy for me was the group setting. However, it wasn't just identification with other peoples feelings but the whole atmosphere generated within the group that I found most rewarding. I felt a warmth towards group members that seemed natural and good. However, I must add that this experience was confined to the therapy experience and did not "spill over" into everyday life.....To me the therapy seemed to offer a way forward to self-enhancement and in particular to improving interpersonal relationships."

SUMMARY

- (i) a temporary reduction in blood pressure and pulse rate following a somatic-emotional cathartic event;
- (ii) increased feelings of well-being following a somatic-emotional cathartic event, the enhanced feelings lasting for a varying amount of time after the session, and reflected in positive (if temporary) changes in behaviour, or intent to change behaviour (e.g. eating patterns; smoking etc.);
- (iii) a temporary increase in blood pressure and pulse rate following a cognitive-emotional cathartic event, where any motoric discharge (including 'talking through') was inhibited. The physiological changes accompanied by 'bad feelings', the recognition of

which were often recognized as being therapeutically valuable. These 'bad feelings' were often carried into everyday life and reflected in negative changes in behaviour.

- (v) A decrease in the severity and frequency of physical symptoms in both types of catharsis. This was more marked in those co-researchers who had experienced the greater number of somatic-emotional cathartic events. There were no cases of psychosomatic symptoms 'disappearing'.
- (vi) the 'research experience' seemed to be therapeutically valuable for everyone involved, with reports of enhanced psychological well-being. This was probably due to the effects of the group experience rather than catharsis *per se*. It should of course be recognized that the group experience provided an arena for 'educating the affect', allowing the participants to become more sophisticated in dealing with their emotions.
- (vii) the techniques used to evoke catharsis (see Appendix Two, particularly Section C) were successful, although the amount of somatic-emotional catharsis was fairly low. The reasons for this was probably related to the short amount of time available, as well as to the lack of prior 'emotional training' received by the

co-researchers.

(viii) the occurrence of insight was very low and it is suggested that this was due to a number of factors:

- a) much of the therapeutic work engaged in by members of the group was related to current events, rather than early **prototypical experiences**;
- b) traumatic experiences were usually only worked on for one session;
- c) the total number of cathartic events for any one person was low, with little, if any, catharsis occurring between group sessions (see Table 3).

These factors, taken together, may help to explain why improvements in psychosomatic functioning were limited.

CONCLUSIONS

The results do lend partial support to the basic abreactive-cathartic principle, namely, that energy must be discharged and not merely shifted within the system. Individuals who engaged in somatic-emotional catharsis did show reduced tension immediately, as well as experiencing positive subjective states. However, it is unlikely that abreaction is the physiologically curative process, and that other processes must operate to sustain physiological normalization, and still other processes must convert tension reduction into changes in the way individuals live

their lives. In this study the other processes operating included ego strengthening, relaxation, goal setting and action planning, behavioural contracting, and general stress management. All the co-researchers involved in the programme participated in these processes, and so it is no surprise that all participants achieved some therapeutic benefits. but it is not clear as to whether this was **dependent** upon somatic-emotional catharsis. All that can be said is that somatic-emotional catharsis has definite short-term benefits, particularly in relation to current, and probably transient, distresses. Whether it is valuable for characterological problems and psychosomatic disorders is not clear from this inquiry.

In general, the findings support those found by Heron and Reason (1981, 1982) in their inquiries into co-counselling.

Issues of validity arising from the study

The question of validity in experiential research has been fully discussed earlier in this chapter. The purpose here is to assess whether, and to what degree, this study met the the validity criteria proposed by Heron (1982).

The inquiry proceeded through a number of research cycles, moving from the active-experiential phase, back into the active phase, and so on. In all, nine co-researchers completed approximately 140 research cycles between them, with each reflection stage being a data gathering/understanding procedure. Little attempt was made

to "refine, amend, modify, or enlarge the conceptual model", until the final two sessions.

In terms of achieving a balance between the active experiential and reflective phases of the research, the research group felt that too much time was spent in the active phase. In some of the sessions little time was left for reflective activity, and consequently the possibility of consensus collusion was significantly increased. The quality of critical awareness with regards to noting feelings, subtle shifts in mood and the like, seemed to be lacking in at least half of the research group. Perhaps this is understandable given that, apart from myself, none of the co-researchers had had any previous experience of working with feelings. Often, when asked how they were feeling, they replied that they did not know. However, this was more likely at the beginning of the study, for it did seem that being involved in the research project provided for an 'affective education'. There was certainly evidence that towards the end of the study, all of the co-researchers were showing more critical awareness and discrimination of subtle affective states as a result of what had happened during the active experiential phase.

Throughout the research inquiry I remained the primary researcher and facilitator, and a number of issues, already discussed arose from this. However, the research was collaborative in that the co-researchers were kept fully informed of what was happening at every stage of the research process; they were fully involved in the

generation of the area of inquiry, and in 'drawing-up' the final conclusions. The co-researchers remarked that they appreciated being involved in a research project where they were treated as equals with that of the 'experimenter', and where their needs to understand and be self-directive were, at least partially, satisfied.

Another key aspect effecting the validity issue is that of the management of counter-transference in the research project (Devereux, 1967), already discussed earlier.

At various times in the research I felt considerable distress about various aspects of the research. These included some considerable anxiety (perseverating thoughts, worry, obsession) with regards to the chaotic data that was being produced in the form of statements being written by co-researchers on the Research Schedule. My need to make sense of this data, to give it some order, to 'collapse it' into a simple statement, was continually frustrated, as I realized that this was no easy task. I also felt that the research project **should** be producing a mass of quantitative data, 'ripe for statistical analysis', rather than the mass of chaotic qualitative statements. However, I co-counselled on this particular distress with my regular counselling partner (not a member of the experiential research group), and realized that "out of chaos comes order", and "from the darkness comes enlightenment." This realization helped me to deal with the distress, and the acknowledgement that "things would turn out alright, by just letting them happen, all by themselves." However,

there was still some distress, albeit at a distance, about whether a qualitative approach would satisfy the examiners.

Related to this was the occurrence of distress pertaining to "Am I utilizing the experiential model appropriately?", "Am I any good at doing research?", "Am I facilitating this group appropriately in order to evoke catharsis?" "Why did I ever start this?" What if, after 5 years of work, it goes down the drain?" At times, the distress associated with these thoughts drained my enthusiasm and energy, to the point where I felt considerable apprehension when looking ahead to a research group meeting. Indeed, my illness on Session 13, may well have been an 'excuse' to opt out on that particular occasion. Co-counselling sessions certainly helped me resolve some of the distress associated with the above.

The other co-researchers also experienced some distress in relation to the research project, although this was entirely different from my own. Four of the co-researchers acknowledged some distress about their being involved as collaborative researchers, given that "our knowledge of psychology and methodology is almost nil". They also experienced some distress in relation to the idea and partial actualization of 'authentic person-to-person encounter', particularly in relation to validation (both verbal and non-verbal). Their distress about physical touch was particularly evident with regards 'lecturer-student' contact. My position as a lecturer, rather than as a person, diminished only slightly over the course of the

research study. We did some work on this distress in the group, and also in co-counselling sessions.

Post-Research Group Meeting - Session 21

As agreed with the research group at the final research session (Session 20) in March, I arranged a meeting during the second week of May, 1982, in order to present the results and the conclusions of the study. Only five of the group were able to attend, although the other three presented their apologies, giving the immediacy of examinations as their reasons for not attending.

I presented the draft results and conclusions to the group, and invited comments. As a result of the following discussion a number of changes were made to the presentation and these have been incorporated into the final version.

I also suggested to the group that we generate ideas that could be considered with respect to a second inquiry planned to commence in October, 1982. And, further, that our experiences of being involved in the first inquiry could be the basis for generating these ideas. This was agreed, and I listed all of the ideas on a flip-chart. There was no time in this session to consider the suggested proposals, but they were considered at an early meeting of those individuals who were interested in being involved in a second cooperative research inquiry.

Suggestions

A basic co-counselling training course prior to the commencement of a research inquiry;

individual cathartic therapy;

evaluating catharsis within a co-counselling format rather than a group;

more sustained catharsis;

classification of feelings, e.g. anger, fear, disgust etc.,

work more on historical traumatic experiences;

measure personality changes as a result of catharsis;

retain Research Schedule, as well as measures of blood pressure and pulse rate;

have members of the research group more involved in the 'therapeutic' process;

record subjective experiences during the catharsis;

monitor physiological processes before, during, and after

catharsis;

record the actual time spent in a cathartic episode, rather than recording a cathartic event regardless of length of time;

note the conditions under which catharsis occurs; does not occur;

examining any outcome differences between men and women.

The meeting ended with a 'group round of celebration', followed by a relaxation session in which I provided a number of ego-strengthening suggestions. This ego strengthening exercise was related specifically to the students' forthcoming examinations. (For a description of John Hartland's Ego Strengthening Method see Appendix Two).

I thanked the students present for their continuing interest and invited the second year students to continue their involvement as co-researchers in the Second Research Inquiry to commence in the Autumn Term. The development of this second inquiry is presented in the following chapter.

CHAPTER FIVE
RESEARCH INQUIRY TWO

I cry a lot more,
I laugh a lot more,
I feel a lot more,
I am more aware
Of what is going on within me
And around me.

(S.B. Co-researcher, Second Research Inquiry)

Initial Thoughts

The experience of being involved as a co-researcher (primary facilitator) in the first research inquiry led me to consider a number of developments/changes with respect to the management of a second research inquiry. I recognized that in Research Inquiry One, my contributions to the research action were very weak in comparison to the other co-researchers (Heron's intermediate experiential model). I felt that in Research Inquiry Two, I would like to be more involved in the research *per se*, rather than being a primary facilitator almost adopting the role of a traditional experimenter. At the same time I felt that, for a number of reasons, it would not be possible to implement the full experiential model proposed by Heron. Another form of the intermediate experiential model (below), seemed to me to be appropriate.

	<u>RESEARCHER</u>	<u>SUBJECT</u>
<u>CONTRIBUTION TO</u> <u>RESEARCH PROPOSITIONS</u>	Strong	Weak

<u>CONTRIBUTION TO</u> <u>RESEARCH ACTION</u>	Strong	Strong
--	--------	--------

after Heron (1981)

In Inquiry One it was necessary for me to be the primary facilitator, i.e. managing the group 'therapy' sessions, since I was the only co-researcher with any experience. One obvious way to overcome this problem would be to take up the suggestion, made at the final session of the first group, to provide a basic co-counselling training course for all potential co-researchers. This seemed feasible since I was experienced at running such courses, and had attended a co-counselling teacher's training course run by John Heron in 1980. Such a course would provide the course participants with the basic skills necessary to facilitate and manage catharsis, as well as enabling them to work within a historical context (i.e. regression).

Researching catharsis within a co-counselling format (i.e. where two people counsel one another taking turns to be client/counsellor for a contracted amount of time) would not only allow myself to become more fully involved in the research action, but would also allow the research initiated in Inquiry One to be systematically developed. I

envisaged at this point (during the Summer, 1982) that Research Inquiry Two would involve the following developments:

- (i) more sustained catharsis in relation to a specific emotional experience;
- (ii) an increase in the overall levels of somatic-emotional catharsis;
- (iii) an increase in cathartic work in relation to key prototypical experiences;
- (iv) recording the 'type' of emotion experienced during a cathartic session.

I made a decision in early September, 1982, to invite psychology students, who were following courses that I taught, to be involved as co-researchers in the second research inquiry. The students concerned had opted to study courses in Personality Theory (2nd. Year), and Counselling Psychology (3rd. Yr.). As most of the students following the second year course would eventually choose to study the 3rd. year option in Counselling Psychology, it seemed reasonable to assume that involvement in a 'counselling' research project would be of considerable interest to the students concerned, and further that such an involvement would complement the essentially theoretical courses that they were taking as part of their degree programme.

Initiating the Research

During the early part of October I met both of the groups concerned (approximately 60 students in all) on separate occasions. During these meetings I outlined the research that had been done as part of Inquiry One, putting particular emphasis on the methodological aspects, as the new paradigm approach would be a totally different perspective on research activities for most of them. Mention was also made at this stage of the possibility of running a basic co-counselling course for those interested in the research inquiry, stating, of course, that no fee would be payable for this. Interested students were invited to attend a preliminary meeting during the following week, at a time and place to be posted on the student notice board.

Preliminary Meeting

26 students attended this meeting. Although this was quite a large number I decided to ask everyone to say who they were, and to very briefly state why they had come along. Responses included, "I wanted something practical from the course, and this seems to be the only way to get it"; "The chance of doing a co-counselling training course for nothing"; "Being involved in a research inquiry"; "I know someone who was a member of the first research group, and they seemed to enjoy it and to get something from it";

"Just to find out what is involved"; "To help me sort out some of my own personal problems". In other words, those present were there for a whole range of individual reasons. I also introduced myself, and declared my interest in the research inquiry. I also declared my 'ideological bias' towards humanistic psychology and its attendant strategems for change, and experientially-oriented methodology.

Having completed the introductions, I briefly described the first research inquiry, including the theoretical rationale, the methodological procedures, the results, and tentative conclusions. Before proceeding to introduce the proposed second research inquiry, a short discussion occurred in relation to issues raised by my short introductory talk. In particular, I was asked to elaborate, and justify, the new paradigm experiential method. There was at this stage a certain atmosphere of 'suspiciousness' of such approaches, vis a vis orthodox 'scientific' psychological experimentation, amongst many of the students present.

I then presented my general thoughts about a second research inquiry, emphasizing that they were not definitive, and those who chose to participate would be fully involved in early discussions about the content of the research. It was agreed however, that a co-counselling training course would be run on two consecutive weekends, and that attendance at these would be necessary for any further involvement in the research project. It was also agreed that attendance at the co-counselling training

course did not obligate individuals to continue their involvement with the project. The first two weekends in November were the most suitable, since the pressure on students' workloads was less than it would be later on. I informed those present that I would place a notice on the board, stating times and venue, and asking them to "sign up" if they were interested. Before leaving I suggested that they read Heron's Catharsis in Human Development (1977), two copies of which were on short-term reference in the Polytechnic library.

Co-Counselling Training Workshops

Eighteen students (including 4 who had participated in the first research inquiry) attended both the co-counselling training workshops, and three students attended the first one only. Approximately 40 hours of training was provided over the two weekends, thus meeting the minimum informal requirements considered necessary (Heron, 1978). The specific details of the workshops will not be presented here, but the content and format approximated that detailed by Heron in his Co-counselling Teachers Manual (1978). The techniques utilized in the training workshops were adopted from those presented in Appendix Two.

In general, I felt that these workshops were very successful, the participants finding them worthwhile, but emotionally demanding. All those taking part were

encouraged to continue co-counselling with each other, and were invited to continue with their involvement in the research inquiry. I explained how co-counselling, with its emphasis on somatic-emotional catharsis, could be an integral part of the research. I invited all those who wished to continue their involvement to attend the first meeting of the research group in the following week, having first established that Tuesday afternoon was a suitable time.

First Research Group Session

Thirteen people attended this meeting, and thus constituted the Second Research Group. We started the session with a round of "News and Goods", followed by a "milling" exercise where each person said "who they were", as well as "celebrating a personal quality".

I then presented the suggestions that had been made by the first research group in their final meeting (Session 21), as detailed on p. 185. There was, of course, an assumption on my part that the focus of the project would be the same as in the first inquiry, namely an investigation into the **effects** of catharsis. We considered each proposal in turn, and initially made a decision to either retain it or eliminate it (in retrospect I was aware of the strong influence that I had on this decision-making process). However, there was one particular suggestion that I was not in favour of, but which the group

as a whole supported, namely that we "measure personality changes as a result of catharsis". The group felt that it would be interesting and relevant to do this, whilst my reservations concerned questions of "which personality tests could be used, and would this be legitimate within the context of a new paradigm experiential inquiry". After some discussion we agreed to research the following area (the same as in the Inquiry One):

what are the psychological and somatic consequences of emotionally discharging (through catharsis) my distressed feelings?

We also agreed to the following:

to utilize a co-counselling format so as to maximize the opportunity for catharsis;

to record the experience as either **current** or **historical**, with an attempt to work more on 'historical traumatic experiences';

to keep the Research Schedule as it is, but to monitor its usefulness as the research proceeds;

to continue to monitor blood pressure and pulse rate in the same way as in the first study; although the physiological recording apparatus would not be available

outside of the weekly meetings;

to measure personality changes over the length of the inquiry. I said that I would have to consult the literature on personality testing before making any firm decisions as to how this would be undertaken;

to classify the feelings involved in the cathartic experience;

The session ended with a group round of "what are you looking forward to doing in the next few days?", followed by a reminder that we would meet at the same time the following week. Before leaving I distributed copies of the Research Schedule.

In the days following the first meeting I researched the literature on personality tests, as well as that on catharsis research. I found that the most common instrument that had been used in catharsis research was the Minnesota Multiphasic Personality Inventory, MMPI, (Nichols, 1974; Bierenbaum, Nichols, & Schwartz, 1976). However, the various scales of the MMPI seemed to be related to the morbid and pathological aspects of personality rather than the favourable and positive aspects, and as such would be more useful in psychiatric settings (Dahlstrom & Dahlstrom, 1980). A better instrument for the catharsis research inquiry seemed to be the California Personality Inventory

(CPI). In the CPI Manual (Gough, 1975) it is stated that "The inventory is intended primarily for use with 'normal' (non-psychiatrically disturbed) subjects. Its scales are addressed to personality characteristics important for social living and social interaction, i.e. to variables that are woven into the fabric of everyday life" (p. 5). The Scale Descriptions are provided in Appendix Six. I decided to use the CPI, and since immediate access was available to copies of the British Edition of the test, it could be administered at the next meeting of the research group.

Second Session

Physiological Monitoring After a group round of 'news and goods', each person measured and recorded their blood pressure and pulse rate, in the same way as in the first inquiry.

Research Schedules Each co-researcher shared the contents of their Research Schedule. 3 people had failed to complete the schedule; 2 of these because they could not find the time, whilst the other said that she found it "too personal and private to reveal". However, having listened to the personal disclosures of the others she felt less reticent about completing it in the future.

CPI administration The California Personality Inventory was completed as per the administration guidelines provided in the Manual (Gough, 1975, p. 6). The hand-scorable answer sheets were used, from which a colleague later obtained the raw scores and standard scores (Appendix Six). These were later transferred to the profile sheets (Figs. 1-10, Appendix Six). None of the co-researchers, including myself, were given any feedback regarding their CPI profiles until the research inquiry had been completed.

Mini co-counselling session Each person then did a mini co-counselling on 'filling in forms', since the completion of the CPI had restimulated some distress in several of the group members.

Scanning Exercise Working in pairs, each person scanned their life for "times I've been put down", for 5 minutes each way.

Loosening Exercise The group did some active body work, i.e. shaking, deep breathing, contradicting normal posture, ways of walking, talkingetc.

Co-counselling session (30 minutes each way) It was suggested by me that each person work with "what's on top", and that the counsellors encourage clients, where appropriate, to "shift level" and to express their feelings

somatically (e.g. by hitting or kicking a cushion; shouting.....). Immediately after the session each person recorded the following information: how they were feeling; what had happened during the session in terms of catharsis (i.e. cognitive-emotional catharsis; somatic-emotional catharsis, as defined on p. 157); the nature of the emotion that was felt/expressed; their blood pressure and pulse rate; the occurrence of any spontaneous insight.

Relaxation Session I facilitated a guided fantasy, which included some ego strengthening and goal setting.

This was a long session lasting over three hours. Some of the group felt that it was too long, and we agreed to restrict the sessions to a maximum of three hours on future occasions. I encouraged them to have at least one co-counselling session during the week, and that it would be a good idea if they organized that before leaving.

Third Session

The format of this session provided a general approach for all of the ensuing research meetings, with the exception of Sessions 4, 5, 8, and 11, and the final three meetings (Sessions 16,17 & 18).

Group Round of 'news and goods', followed by 'minor

distresses'.

Research Schedules Each co-researcher shared the content of their Research Schedule. Their statements were open to comment (challenge, questions etc.) from other group members.

Co-counselling Session (half-an-hour each way; i.e. half-an-hour as client, half-an-hour as counsellor). Each person monitored their blood pressure and pulse rate before and after their counselling session. They also recorded information regarding the cathartic event (with the help of the counsellor), and the post-session feelings. This information was recorded on a special form (Report on Co-Counselling Session; Appendix One) which I had suggested to the group as a way of keeping the data 'orderly'. The group had accepted this idea, and most of them commented that the Report Form helped them to organize their experiential data.

Reflection During this phase, which lasted about 45 minutes, each co-researcher shared feelings and thoughts regarding the co-counselling session. As a result of doing this, aspects of their records were clarified and elaborated, often consequent upon someone else commenting on non-verbal behaviour. As well as helping to provide more accurate and refined experiential data, this procedure also functioned as an important validity check against consensus

collusion.

Relaxation I facilitated a relaxation session which included ego strengthening, using the scrap-book method. In this method the recall and experiencing of past success events is encouraged (see Appendix Two).

Sessions 4-15

The format of these sessions approximated that of Session Three (above). However, there were some exceptions.

In Sessions 5, 8, and 11, the group round on minor distresses lasted for nearly one hour on each occasion. Distress about the research activity itself was restimulated in a number of the co-researchers. This was partly concerned with lack of time to do the recording, i.e. to complete the research schedules, and also to a feeling of being alienated from the both the process of the research and the experiential data that was accumulating (it should be noted at this point that I collected the schedules and co-counselling reports each week). Some of the group, notably AB, felt that they were being used by me "as guinea pigs for **your** research". This 'accusation' caused some restimulated distress in myself, which will be discussed later in the chapter. However, as a result of 'working through' the resentments, and considering a number of alternative strategies, the group decided to

proceed with the research format as previously.

Due to this extended group round on 'minor distresses', the sharing of information from the Research Schedules was omitted on these three occasions.

As a result of the feedback received in the reflection phase about what had happened during the co-counselling sessions, the group decided, upon my suggestion, to work more explicitly on somatic-emotional catharsis in relation to a personal-historical event. The main problem preventing this from happening seemed to be the co-researchers lack of experience in shifting level (i.e. to remember/experience an earlier event in one's life) in a self-directed manner, as well as the counsellor's lack of confidence in providing the necessary interventions (the contract between counsellor and client was 'intensive' with respect to facilitating historical - somatic - emotional catharsis, i.e. the counsellor picks up **every** cue in the client's behaviour and feeds it back as a suggestion about what the client may say or do.

The final activity of each meeting was usually a relaxation session. However, the 'therapeutic communication' during the relaxation varied from week-to-week, and included ego-strengthening, visualization for healing, goal setting and action planning. I facilitated the first six relaxation sessions, and then encouraged the other group members to take a turn,

although there was considerable reluctance to be involved. I provided them with printed relaxation instructions so as to help build up confidence.

During the course of the research meetings three of the co-researchers withdrew. Two presented their reasons to the group (Session 4) and each co-researcher shared how they felt about their wanting to leave. The major reason for wishing to withdraw was the amount of time involved (including attendance at the research meeting, completion of Research Schedules), which competed for time designated for the writing of course-work assignments, reading, and library work in connection with their degree course. Neither of these two co-researchers completed the Research Schedules during the first four weeks of the research project, and consequently no data is provided for them. RB also left in the fourth week, although she was expecting to return at a later time. However, because of certain distressing events at home she was forced to leave college.

Session 16

After a group round of 'news and goods', each co-researcher completed the CPI, in the same manner as in Session 2. This activity took approximately 1 hour.

We then discussed how we should collate and make sense of the vast amount of material that had been generated during the nineteen weeks (including 3-week Xmas vacation,

during which 7 out of the 11 co-researchers had continued to complete their research schedules). A number of the group said that they would like to make some sense of their own 'data' initially before beginning to work on the 'group data'. This was agreed, and consequently I redistributed the Research Schedules and the Co-Counselling Report Forms, which I had, fortunately, kept separately for each person. We also decided that our usual two-and-a-half hour session would not be long enough to complete the task of refining the data. We, therefore, agreed to meet for a whole day early in the Summer Term, thus allowing time to be spent researching the data during the Easter vacation. We also agreed to continue completing the Research Schedules.

Session 17

Opening Round Each person said how they were feeling. Five people said that they felt good about being in the group again after four weeks, but at the same time recognized that this was probably the last meeting. Another two felt that they should really be revising for the forthcoming final examinations, and felt some conflict between doing this and loyalty to the group. One of the co-researchers (SB) was not present.

Research Schedules Of the 9 people present only two had not completed the Research Schedules during the Easter vacation. The other two (JS & AB) said that they did not

have time to 'get round to it' since they had been busy completing their final year dissertations. This aroused considerable feelings of resentment and anger in JH, since he had been presented with the same situation, but "I felt that it was important to complete the research schedule so as to make the research project worthwhile. It would have been pointless to have given up at this stage, and anyhow it only takes about 10 minutes to complete." A short interpersonal session involving JS & AB, and JH, was facilitated by myself, using mainly Gestalt dialogue. I made no attempt to 'shift level' during this 'therapeutic encounter', although this would probably have been appropriate had this been 'on the agenda'.

Inspection of data Before examining the findings of individual co-researchers, I distributed copies of the CPI profiles to the group. Whilst acknowledging that it would be difficult to digest the full implications of these without a more in-depth perusal, I suggested that it might be possible to begin to make some sense of the personality profiles.

Each person, in turn, then presented their personal data with respect to the research inquiry. All those present, with the exception of JS and AB, had summarised their phenomenological experiences and somatic functioning (including blood pressure and pulse rate) in relation to historical and current somatic/cognitive catharsis.

During these personal presentations, I took on the role

of devil's advocate, as a way of challenging any implicit, or indeed explicit, attempts to 'come up with' findings supporting 'hypotheses' that were covertly part of the research inquiry. It should be noted here that this 'validity' aspect of the research was included in all the research meetings, i.e. during the Research Schedule round, in the completion of the Co-Counselling Report Form, and in the reflection phase following the co-counselling sessions.

This aspect of the proceedings lasted approximately three-and-a-half hours, and since we had agreed to terminate the session at 4.00 p.m., little time was left to formulate the general findings of the whole group.

Group Round on 'what to do next?' There was a division of opinion in response to this question. Four of the group felt that it would be appropriate if I took away all the information, collated it, and prepared summary statements with respect to the group findings. The other five members (including myself), on the other hand, felt that this was unacceptable given the methodological premises of the research project. We felt that it would be more appropriate for us to have another group meeting where we would sift through all of the individual summary statements in order to generate a "summary of the findings of the group, with respect to the experiential, somatic, and personality changes consequent upon somatic/cognitive catharsis". The major problem seemed to be one of finding the time to do this given that examinations were imminent. However, it was

agreed to meet for half-a-day to produce a 'group statement' immediately after the examinations (i.e. during the last week of May).

Session 18

Prior to the meeting I sent reminder notes to all members of the group stressing its importance. Consequently, all of the ten co-researchers attended this final session.

Opening Round Each person said "what had been good during the past week". This was followed by a round of "minor distresses".

Co-counselling (15 mins. each way) Each person co-counselled on their minor distresses, ending-up with a celebration around the theme of "what makes life worth living right now".

Generation of Group Findings Each person read out their summary statement with respect to their own experiential and somatic data. On this occasion they were able to include the CPI personality data. Their findings were written down on a flip pad, and then an attempt was made to collate the data in a systematic way. The findings were delineated into a number of headings representing the major aspects of the research (these are shown below, under

Findings). All the statements were worked through, removing redundant material, clarifying ambiguous statements, refining others and so on, until the statements remaining were seen to be representative of the whole group.

Writing-up the Findings It was agreed that this should be done by myself since this seemed most appropriate given the context in which the research was being prosecuted. However, they all felt that they would like copies of the write-up. I said that I had no objection to that, and would like their comments on the report, with regard to its accuracy, when it was completed.

Closing Session I invited each person to say what they had got from the research group, as well as what they had given to it. Statements made during this session are provided under Findings. During this closing session two people in the group (EN & JS) said that they would like to do some re-birthing, since this was something that I had mentioned on a number of occasions. They felt that the members of the group were now very close, and trusting of one another, so as to facilitate the re-birthing process. After some discussion where each person shared their views, it was decided that I would facilitate a one-day re-birthing session, and that they would write a short account of their experiences to be included as a post-script to the second research inquiry. The date was

agreed.

I thanked the group for their participation, and the enthusiasm which they had shown throughout, and looked forward to seeing them again at the re-birthing session. However, for a number of reasons this session did not take place.

RESEARCH FINDINGS

Many of the findings in this second research inquiry 'confirm' those of Research Inquiry One, but are re-stated here for completeness.

Immediate Post-Cathartic State

(somatic-emotional catharsis)

- i) feeling more positive about life; glad to be alive;
- 11) a greater sense and appreciation of self-worth, attributes, and achievements;
- 111) mind clearer about what needs to be done in relation to current interpersonal problems and somatic symptomatology; motivation to "go and do it"; a sense of hope and of "being in charge of my own destiny"; awareness of present-time realities;
- iv) decreases in blood pressure and pulse rate (see

Appendix Three, Tables 4 & 5):

B.P. Mean decrease = 3.88 (S.D. 3.27; S.E. 0.34)

P.R. Mean decrease = 4.37 (S.D. 2.83; S.E. 0.24)

- v) feelings of warmth & heaviness, and total relaxation; tingling feeling in hands and feet;
- vi) a feeling of 'psychological' lightness, "as if a heavy load had been got rid of"; feeling better - relieved;
- vii) increase in self-awareness and self-knowledge;
- viii) feelings of being emotionally drained, and wanting to lie still;
- ix) relief from the symptom (e.g. stomach ache, head ache, nausea, etc.) that was present before the beginning of the session;
- x) not bothered by what others think and feel about me;
- xi) a greater understanding of the reasons why I am the way I am, in terms of relationships, emotional reactions, attitudes, behaviour, and somatic functioning, i.e. insight;

All of the above statements regarding the post-cathartic

emotional state, with the exception of (xi), applied to both historical and current somatic-emotional catharsis. The occurrence of insight appeared to be generated by working on a historical event, and where a somatic-emotional catharsis (as opposed to a cognitive-emotional catharsis) occurred (Appendix Three, Tables 6 & 7).

Period following the Immediate Post-Cathartic State
(somatic-emotional catharsis)

Similar findings to those of Inquiry One were obtained, namely that the positive post-cathartic states carried over to everyday life. This was evidenced by the entries made in the Research Schedules.

- i) attempts to complete 'unfinished business", where this was worked on during the co-counselling session;
- ii) increased energy and vitality to engage in those tasks that need doing;
- iii) increase in intentionality in relation to eating, drinking, work, relaxation, relationships etc.;
- iv) thinking about the events worked on during the co-counselling session, causing some distraction and lack of concentration;

- v) general feeling of 'well-being';
- vi) decrease in the severity and frequency of psychosomatic symptoms (including aches and pains, colitis, and sinus problems);
- vii) more effective in handling my distressed emotions; of using them constructively;

Immediate Post-Cathartic State
(cognitive-emotional catharsis)

- i) sense of relief, of unburdening; feeling calmer;
- ii) more confidence about myself as a person;
- iii) a greater understanding of the significance of the personal problem worked on during the co-counselling session;
- iv) changes in blood pressure and pulse rate in both upward and downward directions;

B.P. Mean decrease = 0.69 (S.D. 4.4; S.E. 0.28)

P.R. Mean decrease = 1.00 (S.D. 3.7; S.E. 0.34)

- v) general sense of well-being;

vi) increase in the number of remembered dreams; dreams more vivid; disturbed sleep with frequent waking-up.

These feelings tended to carry-over to the following days. Little, if any, noticeable change in somatic and psychological functioning was discernable in the period following the cognitive-catharsis, except for an increase in the number and vividness of dreams, as evidenced by the entries in the Research Schedule.

Psychological and Physical Functioning

(over the time of the research inquiry)

- i) a decrease in the severity and frequency of physical symptoms (6 co-researchers);
- ii) complete amelioration of a long-standing complaint (1 co-researcher);
- iii) feeling less depressed; more positive outlook on life;
- iv) more confident and outgoing (9 co-researchers);
- v) more tolerant of others; able to listen to others points of view; increase in patience; increased understanding and empathy with others;

- vi) greater awareness of my distressed behaviour; increased understanding of my irrational behaviours, and the ways in which these are 'triggered';
- vii) greater choice and flexibility in what I do; the relationships I'm involved in; what I eat; spending time in effective relaxation etc.; more spontaneous and lively;
- viii) more efficient and resourceful in terms of the tasks that I tackle; more conscientious, responsible, thoughtful, and intentional in action; engage in action planning of both short-term and long-term goals; more purposive;
- ix) better able to cope emotionally with difficult situations; able to manage stress using relaxation, emotional discharge etc; more effective in dealing with restimulation; more emotionally competent;
- x) has made life (interpersonal relationships in particular) more difficult in some respects, e.g. not willing to play the 'games' that are expected; problems involved in challenging the rules and sanctions, of being honest and emotionally open; greater emotional competence;

xi) decreases in blood pressure and pulse rate (this 'finding' was included by me at a later date);

Other aspects of being involved in the research inquiry

Apart from the benefits listed above, a number of others were felt by the co-researchers to be significant:

provided a rewarding 'education' into the experiential method;

the practical sessions complemented the more formal didactic input in the college psychology course;

enabled me to get to know other students intimately;

introduced me to a new way of doing research, of assessment, that I probably wouldn't have had the opportunity of doing on other courses;

recognition of the value of the support of others, and of the importance of sharing a value system;

the opportunity to get to know and appreciate a member of 'staff' who is able to be 'himself', rather than hiding behind the 'lecturer mask';

Measures of Personality Change (on the California Personality Inventory)

The standard scores were obtained from the raw scores by using the Equivalents Table presented in the CPI Manual (Gough, 1975, p. 30). The standard scores are presented in Appendix Six, and the differences between pre- and post- research inquiry measures of personality are presented in Appendix Three (Table 8).

Inspection of the CPI profiles (Figs. 1-10, Appendix Six) show that there is a general elevation of scores over the course of the study. This increase occurs for all co-researchers, and applies to all four major clusters of scales (see Table 8, Appendix Three). However, some co-researchers show greater score elevations than others, and possible reasons for this will be presented in the discussion.

DISCUSSION

Immediate Post-Cathartic State (somatic - emotional catharsis)

Similar findings to those of the first inquiry are demonstrated. Essentially the group consensus statements (pp. 208-209) reflect an enhanced state of well-being, e.g. feelings of relaxation, of being more positive about oneself and about life in general, a greater awareness of

present-time reality, as well as perceived decreases in psychosomatic symptomatology. Heron (1977) puts it very succinctly when he writes, "The beaming human person, as distinct from the shadowy distressed person, emerges through the cathartic release" (p. 45).

Decreases in blood pressure ($M = -3.88$; S.E. 0.34), and in pulse rate ($M = -4.37$; S.E. 0.24) are similar in the amount of directional change to those found in the first inquiry. The individual differences with respect to pre- and post- cathartic measures of diastolic blood pressure and pulse rate are shown in Tables 4 and 5 (Appendix Three). Inspection of the data presented in Appendix Five suggests that the decreases in blood pressure and pulse rate occur with respect to both historical and current events. In other words, any somatic-emotional discharge of feelings relating to 'unfinished business' seems to be tension reducing, at least with respects to the two vital signs that were monitored.

These findings are similar to those presented by Karle et al. (1973); Woldenberg et al. (1976); Holden (1977); and Luthe (1970), and supports Heron's contention that when distressed feelings are discharged emotional tension is alleviated.

The reduction in physiologic tension would be an explanation of the general feeling of relaxation, of warmth and muscular heaviness, as well as the immediate, although, maybe temporary, relief of physical symptoms, such as headaches, stomach aches, and feelings of nausea. An

inspection of all the Co-counselling Report Forms further revealed that the category of emotion expressed during the cathartic event was of little significance in relation to the general decrease in physiologic tension.

The number of somatic-emotional episodes was much greater for historical events than for current events, the opposite of that in Inquiry One. The reasons for this can be related to the specific encouragement given to co-researchers to "switch level and work on historical material", rather than to some other explanatory factor. This, in itself, demonstrates the effectiveness of the 'switching techniques' used in co-counselling (examples of these techniques are provided in Appendix Two).

However, the main significance of engaging in historical somatic-emotional catharsis as opposed to current somatic-emotional catharsis seems to be the frequency of occurrence of insight. Reference to Table 6 (Appendix Three), shows that insight occurred very infrequently following somatic catharsis (current), the reverse being the case for historical events. The frequency of occurrence of insight in the first inquiry was probably very low because most of the somatic catharsis occurred in relation to current events.

One of the consequences of developing insight is an increase in the understanding of personal functioning. Having insight into the *minutae* of the past traumatic event, together with an understanding of its aetiological relationship to the dynamics of subsequent/current

functioning, liberates intentionality (i.e. having conscious and rational control of one's life). Heron (1977) argues that emotional discharge gets rid of distress, liberates insight and leads to a reevaluation of the original situation. More importantly, perhaps, is his conviction that the resolution of distress leads to non-distressed functioning (refer to discussion in Chapter Three). There was certainly some confirmation of this view in terms of how the co-researchers felt immediately after the cathartic event. Further discussion of the significance of insight will be presented in later sections.

The records that the co-researchers kept as part of the Research Schedule indicated that the positive psychological and physical states that occurred immediately after a co-counselling session, with a somatic-catharsis component, continued for some time after the session. The amount of time for which this happened gradually increased over the course of the study. The positive effects of this 'carry-over' are listed under Findings on p. 210. In general terms the most important changes seem to be in respect of: increases in motivation to engage in tasks that are personally significant (e.g. contacting someone by letter or telephone, making out an application for a post-graduate course, completing an assignment, taking time out to relax); increases in intentionality, that is having a conscious and rational choice about what to do, whether this is in relation to eating, working, relaxing, relationships, or sex; temporary decreases in the frequency

and severity of psychosomatic symptomatology, which is probably related to the general decrease in physiologic tension; and the feeling of 'well-being'.

An important aspect of the 'enhanced state of being' is that the person is more proactive, more telic, rather than reacting compulsively, and without choice in restimulative situations. Heron (1977) sums this up in the following way, ".....as soon as discharge of distress liberates enough insight into the dynamic of the distorted behaviour, then a person can start to live intentionally. The old distortions may still have some energy in them, may still tend to leap out of the bushes when the situation that provokes them occurs, but now that the person understands what makes them leap, she can choose to replace them with alternative and more adaptive, effective behaviours" (p. 45).

However, this is not a suggestion that somatic emotional discharge and the liberation of insight, **in themselves**, are responsible for changes in behaviour. Although there has been a liberation of intentionality, the rigidities of somatic and psychological functioning do not always dissolve as a consequence, and more direct therapeutic interventions are often required, e.g. relaxation training, cognitive restructuring, ego-strengthening, goal setting and action planning. Interventions, which included those mentioned, were provided in the final experiential session of each research group meeting, and must, therefore, be considered as part of the total therapeutic strategem with

respect to longer term changes.

It should be noted here that no discernable relationship was apparent between the dominant feelings occurring in the co-counselling session and subsequent functioning. This would suggest that the discharge of **any** feeling is tension reducing.

Changes in Psychological and Somatic Functioning (over the time of the research inquiry)

The results are detailed on pp. 212-214, and indicate a general reduction in physiologic tension, as well as increases in both personal and interpersonal functioning.

With respect to somatic functioning, a decrease in baseline measures of blood pressure and pulse rate are evident (diastolic B.P. Mean decrease 5.5; S.D. 10.84; S.E. 0.32; P.R. Mean decrease 2.2; S.D. 7.5; S.E. 0.32; see Tables 8 & 9, Appendix Three).

In the case of one co-researcher (AB) the decrease in blood pressure over the time of the inquiry was 23 points. At the beginning of the inquiry her blood pressure was diagnostically high at 159, but by the end of the inquiry could be considered normal at 136. Inspection of Table 7 (Appendix Three) shows that she (AB) experienced a high number of somatic cathartic events (24) of which a high proportion were related to historical material. The number of instances of insight was also high, relative to the other co-researchers. It could be postulated here that, in the case of AB, repressed psychological distress,

represented as physiologic tension, effected the heart as the specific end-organ. With a measure of sustained catharsis and accompanying insight the physiologic tension gradually decreased over the time of the inquiry. However, as intimated earlier, this decrease in blood pressure **may not** have occurred without the therapeutic sessions concerned with counteraction, e.g. relaxation, action planning etc. It could be argued that the somatic emotional catharsis with accompanying insight is a necessary factor, but not a sufficient condition of therapeutic change. It may be relevant to note here that AB lost approximately two stone in weight over the course of the inquiry. She reported that this was a result of having increased control over her eating behaviour. The reduction in weight may have mediated the decrease in blood pressure.

In the case of MW there is an increase in diastolic blood pressure from 120 to 136. However, MW experienced relatively few somatic emotional abreactions with respect to historical events, and there were no instances of insight (see Table 7, Appendix Three). The incidence of cognitive catharsis, however, was much higher, and may account for the increase in physiologic tension as represented by measures of blood pressure. The reasons for this have already been postulated, namely, that feelings may be restimulated in connection with a past or present event but are not motorically discharged by completing the action sequence.

With respect to psychosomatic symptomatology there was a decrease in the severity and frequency of the symptoms in the cases of six of the co-researchers. The co-researchers concerned were PH, FI, SB, JH, NW, & EN. Inspection of Table 7 (Appendix Three) shows very clearly that these six people demonstrated the highest number of somatic emotional abreactions in relation to historical events, as well as the highest number of instances of insight. In the case of SB, a long standing problem of irritable colon completely disappeared. The symptoms that showed some reduction in severity and frequency included headaches, migraine, general muscle tension, sinus problems along with upper respiratory tract problems in general, skin disorders, stomach and intestinal complaints. The incidence of "feeling low and depressed" also decreased in these people, but this could have been because they were feeling physically better. The other co-researchers who had similar problems said that they had noticed little difference over the course of the study, but as I have already intimated, they were low on somatic catharsis and insight.

Other longer-term effects seem to be related to increases in reported intentionality, confidence, resourcefulness, and emotional competence. These positive changes were effected in all the co-researchers irrespective of the total number of cathartic events and associated insights. Statements made in the Research Schedule as well as verbally in the reflection stage of the

weekly session suggested little difference between the researchers.

The California Personality Inventory

Inspection of Table 11 (Appendix Three) and Figures 2 and 3 (pp. 224, 225), show clearly that those co-researchers with the lowest incidence of somatic-emotional catharsis and insight, showed the smallest change across the CPI scales (co-researchers JS, MW, & AS). Greater 'positive' changes occurred in those people who had experienced a higher number of somatic-emotional cathartic events. Greatest changes were shown in relation to Scales Cs (more resourceful, insightful, effective in communication etc.); Sy (more confident, enterprising, ingenious etc.); Sa (more self-confident & self-assured); Wb (increases in sense of well-being); and Ai (increases in autonomy and independence). A full description of the Scales is provided in Appendix Six. However, there was a general increase in scores on most of the scales for all of the co-researchers. The reasons for some positive changes occurring in individuals who demonstrated minimal catharsis could be explained by the fact that they were exposed to the same general therapeutic 'programme' as the co-researchers showing maximal catharsis.

According to Heron (1977) the resolution of distress restores the person to non-distressed functioning, both at

FIG 2. Relationship between Insight and Mean Changes on the CPI Scale

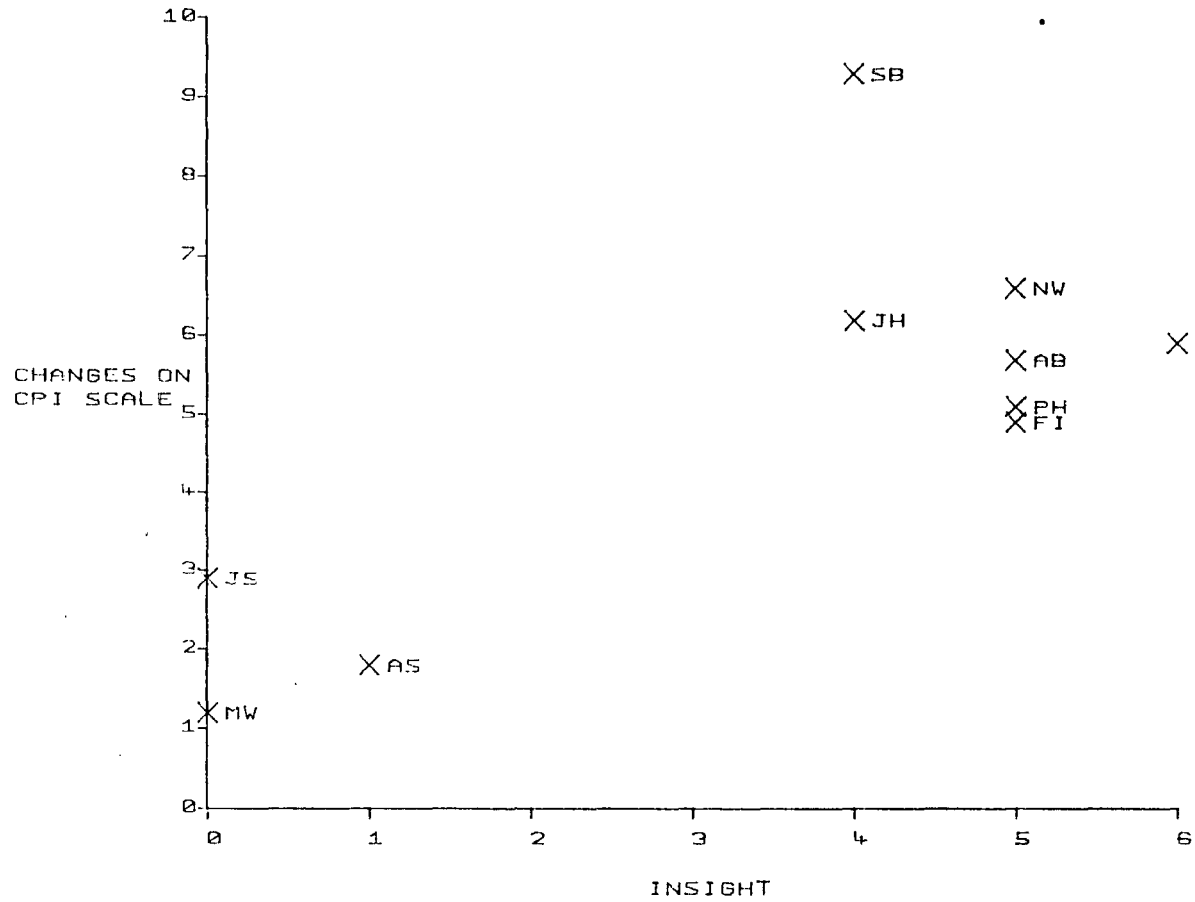
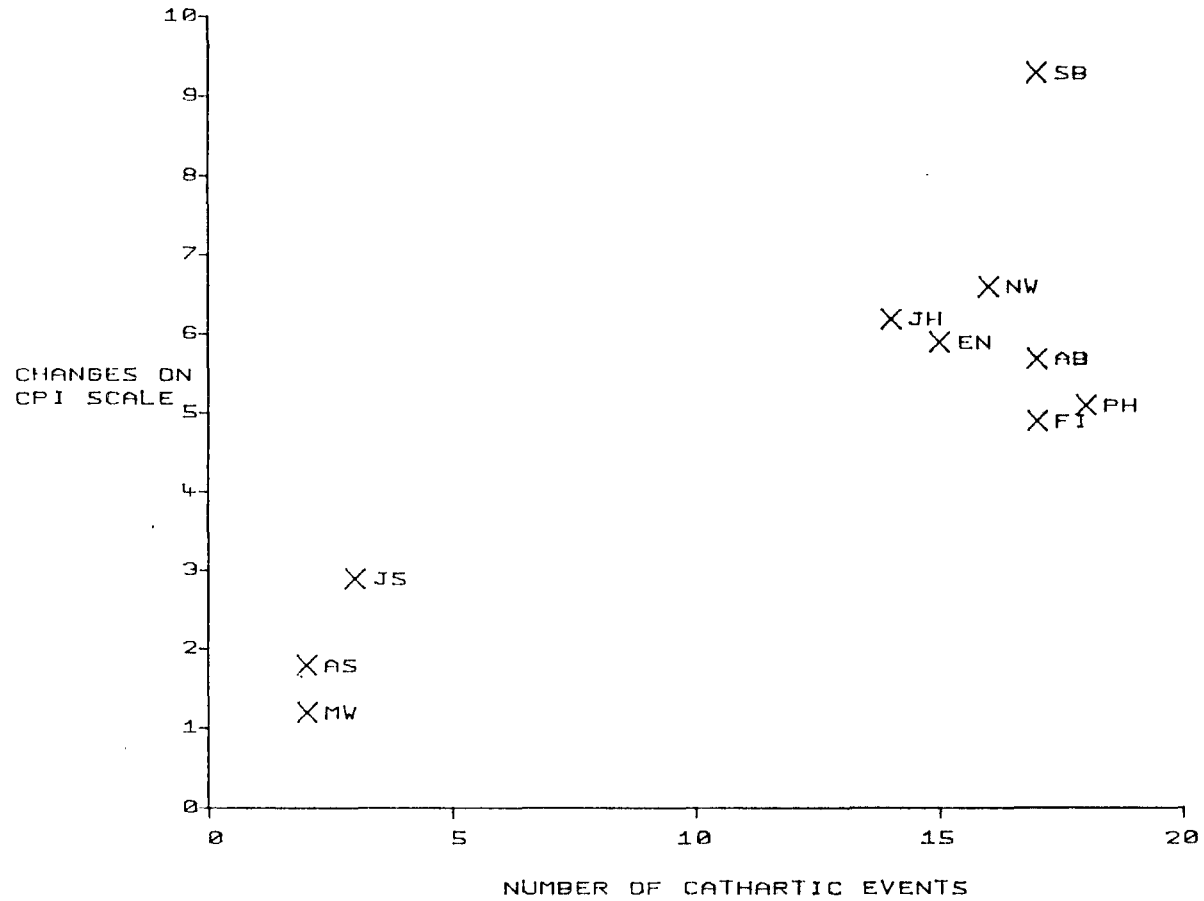


FIG3. Relationship between NUMBER of Somatic Emotional Cathartic Events and Mean Changes on the CPI Scale



the somatic and psychological levels. I have already argued that somatic functioning is enhanced as a result of sustained somatic emotional discharge and spontaneous insight into what was really going on in the early prototypical incidents and subsequent replays. With the discharge of early repressed feelings, it is no longer necessary for the person to defend against such powerful negative affect. The person does not have to be 'false' to their 'true inner self' which has been liberated from the shackles of the socialised persona (the 'false self' concerned with game-playing, with collusion and reasonable insanity). As a result the individual has the capacity to be 'who they really are', that is to demonstrate distinctively human behaviour, with the possibility of ".....(being) playful (spontaneous, improvisatory, joyful, fun-filled, creative); conventional (accepting prevailing rational norms and values); and engaging in self-directed and self-creating autonomous behaviour (e.g. purposive, intentional, innovative, decisive, caring, insightful.....)" (Heron, 1977, p. 7). The scores obtained on the CPI suggest that all the co-researchers showed evidence of more 'distinctively human behaviour' over the course of the inquiry. These changes were also demonstrated in their Schedule entries, as well as being evidenced in the reflection phases of the research sessions. Furthermore, the differences between the pre- and post- inquiry CPI measures suggest that the greater the amount of somatic catharsis (indicated by the number of

cathartic events, and irrespective of time and intensity), and liberated insight, the greater the increase in 'distinctively human behaviour'. Of course, this is not evidence that 'distinctively human behaviour' actually occurred more frequently.

Unfortunately, no post-inquiry follow-up measures of CPI or of psychological and somatic functioning were made.

Immediate Post-Cathartic State (cognitive catharsis)

Examination of the findings on p. 211 suggests that cognitive catharsis tends to result in positive states. With respect to somatic functioning there is a mean decrease in diastolic blood pressure of 0.69 and for pulse rate a similar decrease of 1.00. In the first inquiry post-cathartic measures of blood pressure showed increases of 2.34, and for pulse rate 3.06. This difference could be explained with reference to the 'talking out' that occurred during the co-counselling sessions. Even though no motoric discharge occurred, the 'client' was able to discharge some distress by talking about what was happening, and how she was feeling in connection with a particular historical or current event. In contrast, the cognitive catharsis occurring in the first inquiry did not involve any 'talking out' since it occurred when someone else was working 'out front'. This explanation would also help to account for the positive psychological changes that occurred (p. 211).

Summary

- 1) a temporary reduction in blood pressure and pulse rate following a somatic-emotional event, accompanied by decreases in psychosomatic symptomatology, along with an enhancement of reported psychological well-being.
- 2) insight is more likely to occur following historical somatic emotional catharsis.
- 3) having insight into the past traumatic event, together with an understanding of its aetiological relationship to the dynamics of subsequent/current somatic and psychological functioning, liberates intentionality.
- 4) longer-term changes with respect to psychological and somatic functioning seem to be related to the amount of somatic catharsis and consequent insight.
- 5) the resolution of distress through somatic catharsis and cognitive insight leads to increases in non-distressed functioning. This was supported by increased scores on the California Personality Inventory.
- 6) when cognitive catharsis occurs, 'talking-out' the distress appears to be moderately therapeutic, but not as fully effective as somatic catharsis.

Issues of Validity arising from the study

The criteria used for the assessment of validity in the current inquiry are those adopted by Heron and Reason (1982, pp.23-25), and they will be addressed in a similar manner.

1) Rigour through a cyclic process The same line of inquiry was prosecuted in each of the cycles, but with little clarification and elaboration during the cyclic process. Although each cycle comprised an action phase and a reflection phase within each session, the 'data' that emerged during the reflection phase was not systematized in any profound manner, and consequently did not result in any major change to the following cycle. Each cycle generated data relevant to one line of inquiry only, and no attempt was made to 'refine, amend, modify, or enlarge the conceptual model'. The earlier tentative findings arising out of the reflection phase were of course noted, but at the end of each cycle it was decided by the group that the cycle should be repeated, as a way of checking the 'data' over a repeated number of cycles.

2) The management of counter-transference In three of the research sessions, referred to on pages 200-201, a number of the co-researchers felt some distress about the research activity itself, and in particular about their involvement in it. This related to the issue of "who was

doing the research?", "who was it for?", and "what do we get out of it?" The individuals concerned were able to work through their feelings in a co-counselling session.

The 'accusation' that I was "using them as guinea pigs for my research", caused some restimulated distress in myself, particularly about 'not being liked'; 'not being as good as others'; and, 'the need to be approved of'. I dealt with this within a co-counselling contract, and this proved satisfactorily therapeutic. It should be made clear, of course, that my personal distress relating to the reactions of the other co-researchers was not specific to the research *per se*.

As in the case of the first inquiry, I felt, at various times during the research, some anxiety about the mass of chaotic data that was continually being generated. Such apprehensions and anxieties were related to "negative fantasies" with regards to the outcome of the research as "examinable material". Feelings and reactions arose which were similar to those occurring in the first inquiry.

Also during the time of this second research inquiry I was in some conflict between pressing ahead with the research or developing a facilitator styles course under the auspices of the IDHP (Institute for the Development of Human Potential). For a time I pursued the idea of the IDHP course quite vigorously, but then, having directly confronted the issue in a counselling session, I decided to complete the research first.

Any counter-transference was dealt with as it arose,

rather than planning for its eventuality within the programme. However, I felt that it was dealt with reasonably adequately.

3) Counteracting Consensus Collusion This was primarily dealt with during the reflection phase of the research. Individual co-researchers were open to challenge with respect to their statements about post-catharsis feelings, schedule entries etc. from any other member in the group. However, the number of challenges was very small, there being a general acceptance of the 'truth' of the statements. No one was formally appointed as a devil's advocate, and in retrospect, it seems quite probable that some consensus collusion occurred during the inquiry. However, all the co-researchers were encouraged to supportively confront other group members particularly during the reflective phase, when each co-researcher occupied the 'hot seat'.

4) Check on the degree of authentic collaboration As with the first inquiry I initiated the project and was largely responsible for 'determining' its direction. However, all the co-researchers were involved in the decision making from the time of initiating the research to deciding on the precise area of inquiry, to being fully involved in the research action and reflection, and finally to the collation and systematization of the data and the drawing-up of the conclusions. It could be argued though,

that the research was not fully collaborative, in the sense that I remained very influential throughout the project in terms of sustaining the research effort, of making suggestions regards necessary action, and of course in writing-up the results. The other co-researchers 'knew' this but felt that I should retain the role of primary facilitator since "I was better informed about psychological research in general, and about this research in particular". At times, I was aware of deciding what to do, and then getting the groups approval to do it. However, I do not feel that there was anything oppressive about this. In general, each member of the group was given the opportunity to be fully involved in decisions being made about the research.

5) Balance between inquiry/reflection & experience/growth

In this inquiry the time spent on experience and growth was about the same as that spent on reflection, whereas in the first inquiry more time was spent on experience/growth. When I checked this balance out with the other co-researchers there was a general feeling that the research group was primarily a growth/therapy group, and that the "research issue" was of secondary importance. My cognizance of the project was exactly the opposite, the emphasis being on the collection and systematization of 'data', with the personal growth aspects being of secondary significance. It seems that the balance achieved between inquiry and experience was about right.

Directions for Future Research

1. Although the two reported inquiries suggested that there were positive changes in psychological and somatic functioning over the time of the studies, further research is required in order to clarify the conditions that give rise to optimal change. Longer term follow-up studies of individual functioning are also necessary. It would also be useful to study individuals in greater depth using a case-study approach.

2. In relation to (1) it would be important to establish whether the use of imagery to discharge distressed feelings would be as effective as motor discharge. Some therapeutic strategems involve asking the client to "imagine that you are killing-off X", and "see yourself doing this as if you were watching a film". The metaphorical expression of distressed feelings is also used, e.g. "clench the anger in your fists and then throw it away". These 'silent abreaction' approaches are used substantially within the context of hypnotherapy.

3. For research and clinical purposes it would be useful to develop a scale which provided a reliable measure of the amount of emotional distress and discharge characterizing individuals. Developing profiles of distress levels (physiological measures, frequency of nightmares, phobias, compulsions, psychosomatic functioning.....), as well as

discharge profiles (amount of crying, laughing, shouting.....) for individuals. It would be valuable to develop these in relation to the persons 'emotional life history'. This could then be used to investigate aspects of, for example, Heron's theory of catharsis in human development. Areas of inquiry could include:

looking at the relationship between the distress/discharge profile and psychosomatic illness;

more specifically, exploring the relationship between particular distressed feelings and psychosomatic symptoms (e.g. is it the case that individuals who have skin disorders such as psoriasis are emotionally repressed, particularly with respect to anger?).

from a therapeutic point of view more information is required about the value of emotional discharge in the 'treatment' of psychosomatic malfunctioning. For example, is it therapeutically valuable, both psychologically and somatically, for (some) cancer patients to express their anger and resentment in relation to past and current protagonists?

The above suggestions are certainly not exhaustive, and indicate that outcome research is still in its infancy.

Significance of the two Research Inquiries

Both inquiries were conducted within the frame-work of the new paradigm experiential approach, and therefore

continue the work of Heron and Reason (1981, 1982). However, an attempt was also made to obtain 'objective' measures of change (i.e. blood pressure, pulse rate, and personality functioning) contingent upon catharsis, and to correlate these with changes in phenomenological experiencing and behavioural functioning. It thus extends the work of Heron and Reason to include the physiological and psychosomatic areas of functioning, and in a similar way extends the work of, for example, Karle et al. (1973) to include the phenomenological/experiential domain.

In both inquiries catharsis was defined as a strong motoric expression of feeling about repressed (historic) or conflictual (current) material. It is therefore understood as both a cognitive and a somatic experience, involving the recall of forgotten or discordant material, along with the physical expression of emotion in, for example, shouting, sobbing, and hitting. In somatic-emotional catharsis both the cognitive (i.e. the contents of consciousness), and the somatic (motoric expression of emotion) are present, whereas cognitive catharsis involves the reliving of a traumatic experience without any motoric expression. Research into the effects of catharsis has paid relatively little attention to cognitive catharsis, the emphasis being on physical expression.

In general, the findings with respect to somatic-emotional catharsis support the research of Heron and Reason (1981, 1982), that individuals demonstrate an

increase in their subjective feeling of 'well-being'. The inquiries also confirm the work of, for example, Karle et al. (1973), showing a reduction in physiologic tension following somatic-emotional catharsis. More importantly the two inquiries reported here demonstrate that positive changes in a persons's subjective state are accompanied by reductions in physiologic tension.

Unlike most of the earlier studies a distinction was made between cognitive catharsis and somatic catharsis. The results indicate that when a person experiences a cognitive catharsis (i.e. remembering a painful experience) and is prevented from ventilating their feelings, or when expression is discouraged, there is an increase in physiologic tension accompanied by a deterioration in the individual's subjective feeling state. However, allowing the person to 'talk through' their problems/feelings appeared to have some therapeutic benefit. In Inquiry Two where this process was enabled, this was shown to be the case, whereas in Inquiry One a cognitive catharsis without 'talking through' led to increases in physiologic tension and a lowering of subjective 'well-being'. This finding has considerable implications for the practising psychotherapist, a point that will be further discussed in the next chapter.

The finding that somatic catharsis leads to greater reductions in physiologic tension than cognitive catharsis, should be considered in relation to whether such events are historical or current. The second inquiry suggests that

somatic catharsis in relation to a historical event is more likely to lead to the person making connections (i.e. insight) between a (traumatic) event(s) and a 'symptom', and further that the number of 'insights' seems to relate to improvements in general psycho-somatic functioning. This would suggest that although strong expressions of feeling may decrease tension and relax defenses, they do not significantly enhance the work of dynamic psychotherapy unless the 'patient' becomes cognizant of their original source. However, both inquiries also show that the 'working through' of current conflicts and unresolved tensions in the individual's current life leads to a reduction in physiologic tension.

In the previous studies (discussed in Chapter Three) no attempt was made to differentiate between historical and current events in relation to catharsis, nor to the generation, or otherwise, of 'insight into the genesis of the symptomatology'.

In the context of Heron's theory of catharsis in human development the two research inquiries lend considerable support to his view that: (i) distressed feelings can be resolved by the process of catharsis; (ii) emotional discharge gets rid of distress, liberates insight and leads to the reevaluation of the original situation; (iii) when distress is resolved the person is restored to non-distressed functioning again.

Data collected as part of the research inquiries partially demonstrates that individuals who engaged in

'sustained' somatic catharsis in relation to 'key events' (both historical and current) evidenced reductions in physiologic tension, with some amelioration in the intensity and frequency of psychosomatic symptomatology, as well as increases in their subjective state of well-being (paralleled by increases in their CPI scores).

It should also be borne in mind that all the co-researchers showed 'improvements' in their subjective states over the course of the inquiries, with an indication that greater improvements were manifested by individuals who demonstrated a larger number of catharsis (motoric) - insight events. The fact that all co-researchers showed some improvements was probably due to their being exposed to the same therapeutic strategems and group processes.

The implications of the 'data' with respect to the cathartic process and psychotherapeutic intervention will be explored in Chapter Six.

CHAPTER SIX

CATHARSIS: CLINICAL APPLICATION

'When we see how neurosis is generated we see more clearly how to treat it. Fortunately, we have within us at all times the means with which to cure ourselves. The antidote is the very feelings which, repressed, makes us sick.'

(Janov, 1982)

The Process of Therapeutic Catharsis

It has been continually emphasised that the cathartic process does not simply refer to emotional abreaction or discharge of negative feelings. This could, of course, be a very narrow definition of catharsis per se. However, the cathartic process consists of a number of 'consecutive elements', all of which appear to be essential to the therapeutic efficacy of the approach. The cathartic 'elements' include emotional distancing (balance of attention), somatic-emotional catharsis and cognitive-emotional catharsis in relation to occluded past events, as well as to current situations; the development of insight (i.e. understanding) into the origin of current symptomatology (physical, psychological, & behavioural); the consequent 'release' of intentionality; and finally the effective and purposive utilization of such intentionality in everyday life, through goal setting, action planning, cognitive restructuring and other complementary processes.

On a broader level still, the process of catharsis would have to include the function of catharsis in human development with particular reference to its significance in the aetiology of psychopathologic symptomatology. Detailed exposition of the developmental aspects of catharsis, as well as the components and effects of cathartic release are provided by Heron in Catharsis in Human Development (1977). This paper is discussed in Chapter Three.

Although Heron's exposition of the cathartic process is probably the most clearly and thoroughly articulated work available, the processes of catharsis are described in a wide variety of disciplines: not only in psychiatry and psychology, but in anthropology, physiology, the history of religion, psychosomatic medicine, and many other fields.

We have seen in Chapter Two that catharsis is a technique now in wide use in a number of discreet psychotherapeutic systems. The differences between the various proponents of catharsis are pronounced. For some, it is the major or only source of cure (Janov, 1973; Casriel, 1972); for others, it is one tool among many (behaviour therapists); for yet others it is a central concept supported by other procedures (Kelley, 1972; Lowen, 1975; Heron, 1977).

The rationale most clearly evident in the cathartically oriented psychotherapies is based on the hydraulic metaphor, and rooted in the psychoanalytic metaphors of inner space (Riebel, 1984). This rationale sees the person

in distress as "damming up feelings and responses, upsetting the natural flow of energy and preventing full response to new stimuli" (Riebel, op. cit., p. 32). Inherent in this view is the recognition of the role that incomplete past events play in creating psychological difficulties, but it concentrates on the person as a material entity, or energy system, rather than on consciousness. This rationale is most clearly expressed by people like Janov (1973) and Casriel (1972), who assert that discharging past pain is sufficient in itself to create change, but is opposed by Perls (1972, p. 36), Nichols and Zax (1977, p. 201), Szasz (1959, pp. 90-91), and by Heron (1977, p. 45). Heron writes: ".....Nor should.....a crude hydraulic model be used. Such a model might argue that first of all you have to drain off the total pool of distress in which paralytic distorted behaviour lurks, before that behaviour is rendered impotent and new behaviour can be begin. A preferable model is that as soon as discharge of distress liberates enough insight into the dynamic of the distorted behaviour, then a person can start to live intentionally" (1977, p. 45).

According to this latter view, it is 'directed actions' that are blocked and not 'feelings'. Thus, catharsis is to be understood as a label for completing (some or all of) a previously restrained or interrupted sequence of self-expression. The expression is that which would have occurred as a natural reaction to some experience had that expression not been thwarted. This is similar to Heron's

(1977) view that distressed feelings result from the blocking of one or more of three psychological needs. It is accompanied by 'recovery manifestations' of some sort, for example, tears or angry shouting. As was clearly indicated by Reich (1942) and more recently by Heron (1977), most cultures place substantial prohibitions on emotional (recovery phase) displays. What is sometimes permitted in children is forbidden to adults. Boys learn the value of inhibiting signs of weakness and fear, and develop techniques for 'holding themselves together' or withdrawing before losing face. Girls, on the other hand, who are often expected to play more supportive and subsidiary roles, are chastened for displays of protest and anger, and may learn early on to refrain not only from fighting but also from verbal expressions of aggression as well. By the time individuals reach psychotherapy or counselling, they have learned well to avoid expressing their feelings. They do this because of chronic defenses against experiencing and expressing feelings.

It is unfortunate that people in general, as well as many mental health professionals, have been confused about the relationship between manifestations of recovery (e.g. tears and angry displays), and the first - stage activating events or blockages. Some professionals interfere with the manifestations of recovery as though the manifestations were the problem itself. They want the person to stop crying or shouting as though that would end the distress. In other words they treat the emotional display as if it

was the distress, rather than viewing it as a natural way of dealing with distressed feelings (e.g. feeling sad or angry). However, such emotional displays often make people feel uncomfortable, as they probably did Breuer and Freud.

While it seems to be therapeutic to allow people to discharge their distressed feelings, it is equally unwise to worship these manifestations, as some of the early emotivists seem to have done. Eliciting tears, laughter, or screams should not become an end in itself. There is no need to regard the quantity of tears or the loudness of screams as a measure of the success of treatment.

Describing catharsis as the completion of an emotional action sequence has practical consequences which bear on therapeutic technique. These will be examined in the next section.

It should be reiterated at this point, that although catharsis may well liberate insight and consequent intentionality, other specific goal-directed behaviour-change strategies are often required for individuals to behave in more adaptive and satisfying ways. Cathartically-oriented therapists vary in the degree to which they say behaviour change will automatically follow catharsis. Heron writes: ".....it would be absurd to argue that catharsis is in and by itself a sufficient condition of human development. I do not for a moment believe that it is anything more than a necessary condition, needing to be complemented by other necessary conditions before anything like a sufficient account of human development comes into

view" (1977, p. 46). These other necessary conditions will be discussed in the next section.

The Cathartic Process: Implications for Clinical Practice in Psychotherapy and Personal Growth

In the light of the above, and previous discussions, a number of general therapeutic strategies for cathartic psychotherapy may be formulated which take into account the conclusions drawn from the two research inquiries presented in Chapters Four and Five.

Essentially, the 'therapist's' task is to help the 'client' express feelings as fully as possible in a way that leads to insight, the liberation of intentionality and behaviour change. In general, the therapist pursues this goal by (i) continuing to work effectively against defences as feeling-expression unfolds, (ii) being in intimate contact with the client, (iii) choosing appropriate methods, and (iv) not being afraid or upset by strong feelings.

One of the first conditions necessary for effective cathartic discharge is an optimum 'balance of attention', or 'distancing'. Deviation from the point of 'balance' usually keeps discharge from occurring or stops discharge if it has started. If most of one's attention is absorbed by the distress, the distressful event is simply relived, as if it were happening again. On the other hand, if most of a person's attention is in the safe present, the

repressed emotion is not sufficiently felt, and no discharge occurs. At the balance point, the person is both reliving the event, and therefore feeling the emotions associated with it, and at the same time, observing the distressful events from the safety of the present. Heron (1977) writes: "When attention is balanced in this way between the distress and what is outside it, a psychodynamic leverage is maintained that tips the distress feelings into discharge.....If I go away from distress feelings but remain open to them, then by the play of opposites they are ineluctably drawn upwards from their buried place toward discharge.....The person needs consciously to disidentify a little from the taut system - then liberating discharge can commence.....There are actually two complementary principles involved in this disidentification: the initial loosening of the system, and the drawing power of the contradictory assertions - that is, thoughts and words that contradict or are quite outside the gloom generated by the hidden distress have the effect of drawing that distress out into discharge" (p. 43).

Greenson (1967) speaks of an "experiencing ego" and an "observing ego", and states that the successful patient is one who can move back and forth between these two types of experiencing. When the person is carried away by painful feelings and memories, the experiencing ego is in the foreground. Little understanding of the meaning of the emotions and memories occurs at this moment. Later, when

the affect has been thoroughly expressed, the person is amenable to rational analysis of the experience.

In general, present-time events, fiction or fantasy, rapid review (e.g. scanning), positive emotions and building the human centre (through confirming and actualising the capacities of rational healthy human beings by celebrating and validating their true human capacities and resources) are distancing, whereas past-time events, real events, detailed recollection (i.e. literal description), and negative or unpleasant events remove distance. Each of these dimensions is indicative, therefore, of a tactic in managing the distancing of emotions and consequent emotional discharge. Examples of 'attention-switching' techniques are provided in Appendix Two.

Secondly, attention must be given to the specific techniques that facilitate somatic-emotional catharsis. The research described in Chapters Four and Five suggest that the motoric discharge of distressed feelings is of greater psychophysiologic consequence than cognitive emotional catharsis. Indeed, the 'data' generated in the two research inquiries suggest that therapists should be careful not to evoke cognitive catharsis where there is no outlet provided in either somatic motoric discharge or 'talking through'.

Heron classifies elicitation techniques into "four basic ways into discharge" (1978, pp. 16-17; 1977, pp. 53-54), namely: active imagination (internal ideation); passive imagination (external ideation); active body work

(self-directed mobilisation of body energy), and passive body work (external mobilisation of body energy). These four basic ways of facilitating and maintaining somatic-emotional catharsis are summarized in Appendix Two. As a result of the motoric discharge of repressed affect spontaneous insight into the genesis of subsequent symptomatology may occur, either immediately or at a later time. Such insights occur quite naturally and spontaneously, where the client is totally self-directed. Interpretations and speculative analyses are not required from the therapist. On this point Heron (1977) argues that "interpreting to the client is a repressive process for both client and counsellor.....For the counsellor, systematic interpretation applied to others is a form of double treason: it manipulates the client in order to keep at bay post-cathartic insight in the counsellor herself" (p. 44). The therapist or counsellor needs to give the client space for the post-cathartic insights to flow. Indeed, these insights can occur long after the cathartic event that generated them. The client should be alerted to 'catching the insights' which may appear in dreams or sudden unexpected thoughts and feelings.

Similarly, asking analytic questions when a person is in the throes of a strong affective experience only diverts the person from finishing the experience. Reassurance is easy and tempting to give. Nevertheless, it often blocks emotional experiencing, and, moreover, it may be false.

In addition to these procedures, there are a variety of

techniques that therapists can use to increase further the intensity of a session. Choosing them depends upon the therapist's comfort level and purpose at the moment. Sitting closer to the client increases the intimacy of the therapeutic relationship, raises the client's anxiety, and brings the client's emotions closer to the surface. Discouraging various tension-reducing rituals such as smoking or fidgeting also raises the affective intensity. Eye contact and tracking and reflecting the client's feelings intensify the affective tone. In general, client's will express their feelings spontaneously whenever the press of environmental experience is affectively intense, their own defenses are relaxed (or weakened), and the therapeutic milieu is appropriately safe.

We have already seen that when feelings are expressed fully, they lead to new ways of viewing both self and the universe; these new cognitive constructions then lead to changed, more satisfying behaviours. However, it has already been postulated that adaptive behavioural change does not automatically follow catharsis ; that catharsis is in and of itself not a sufficient condition of human development; that other necessary and complementary conditions are required.

Some of the necessary complementary processes include: values clarification, goal setting and action planning, life-style analysis, cognitive restructuring, ego-strengthening, relaxation (autogenic training,

auto-hypnosis, sensuous massage, sensory awareness), reaching and maintaining a healthy state of bodily functioning (exercise, diet, healthy living), transmutation of consciousness (Heron, 1974, 1982; Heider, 1974), and art (Heron, 1977). By providing some basic structure in terms of goals, allows both clients and therapists to evaluate (together) the progress and direction of the therapy.

It should also be emphasized that therapists who limit themselves to manifest content are not dealing with the unconscious. Similarly, therapists who limit their attention to emotions that are spontaneously expressed or readily uncovered are severely limiting the potential inroad into the unconscious that catharsis makes possible. This deep and intense work involves more than a momentary affective eruption. Intense cathartic probing of the unconscious requires opening avoided areas of content, vigorously opposing resistance, and intensifying and prolonging subsequent affective expression. In general, the inquiries reported in Chapters Four and Five suggest that moving toward the past (i.e. engaging in historical somatic emotional catharsis) leads to more effective therapeutic catharsis.

It is interesting to note here that catharsis and regression are also important elements in the creation of transference and countertransference. When the client is crying, he or she has dropped the pseudoadult pretense of not needing anything from anybody. This is consistent with

Winnicott's (1958) concept of giving up the 'false self system' and Guntrip's (1969) notion that to become fully adult, one must let go of the 'pseudoadult self'. These and other writers recognized that most of us expend much of our energies denying and suppressing basic needs and feelings. Catharsis and regression in the client also make very specific demands on the therapist. Unless comfortable with a wide range of emotions, the therapist is likely to inhibit the client's exploration of self. An overly rigid therapist" tends to hinder the client's 'regression in the service of the ego' (Kris, 1952) by conveying discomfort with raw feelings and primitive experience" (Nichols & Paolino, 1986, p. 94).

In my opinion, therapists should allow catharsis as a means of helping a person discover their 'real self', but should recognize this as a preliminary step. After blocked aspects of the self have been discovered, then the person must begin to claim responsibility for choosing more congruent actions and appropriate social expressions, thereby defining a richer, more satisfying experience.

If catharsis were a process of expelling pathogenic affect, it would not need to be repeated more than once. However, as I have argued earlier, catharsis is not an expulsive, but an expressive, means of helping clients overcome resistances to become more feelingful. It is not therefore the 'one-shot' process originally described by Freud (Breuer & Freud, 1895). Effective therapy often requires repeated confrontations of the emotional defences,

and repeated abreaction. Such cathartic 'working-through' includes both continued cathartic uncovering and encouragement of behaviour change.

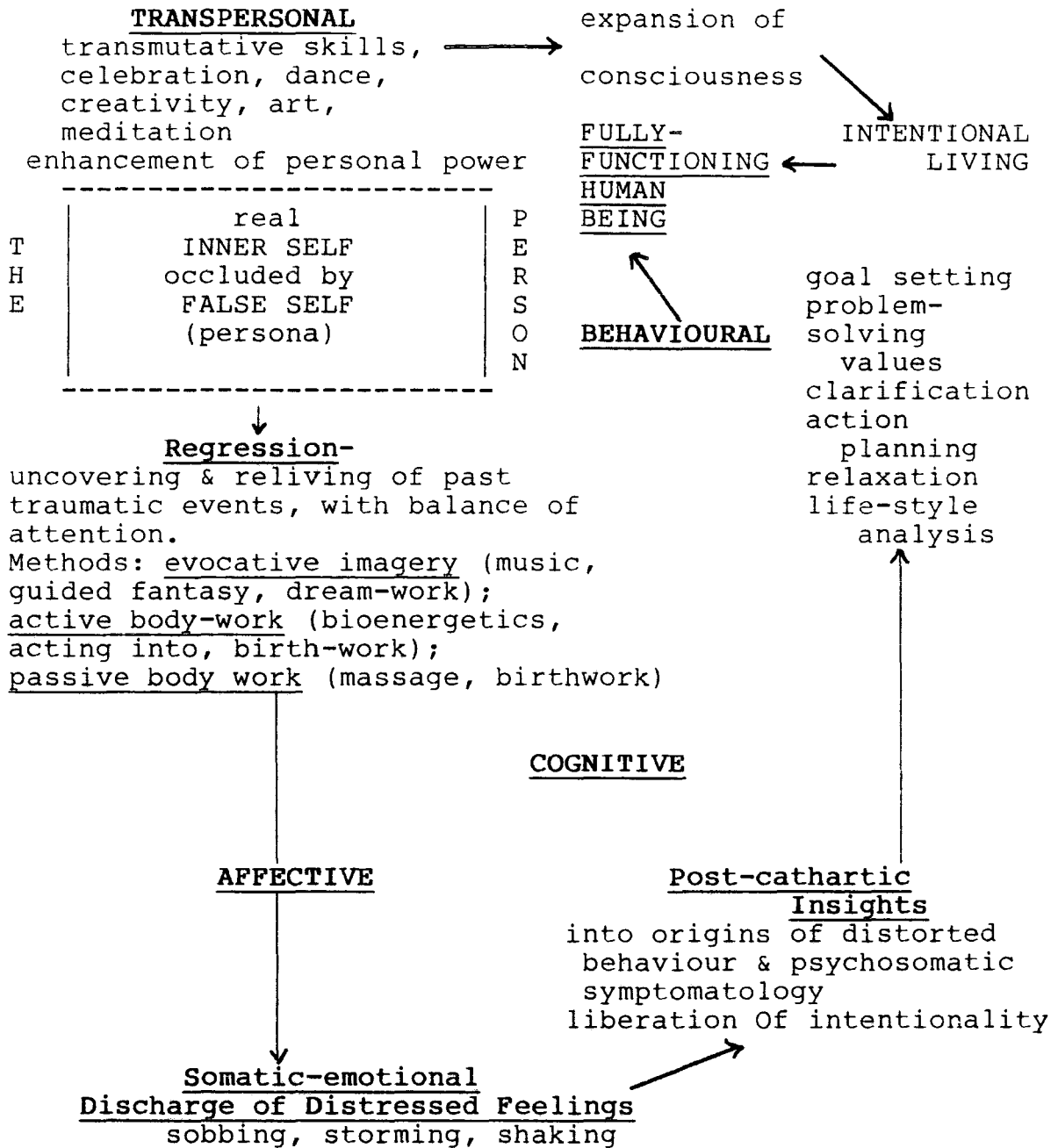
However, it is important that therapists do not attempt to demand feelings. Demanding feelings is intrusive and ineffective, but helping the client breach resistances may be sufficient to permit cathartic expression of feelings previously warded off. In helping the client to overcome resistances, the therapist has available a large range of 'therapeutic interventions', including passive body work, active body work, and active imagination (Heron, 1977, 1978).

A summary chart of a basic model for personal growth and change, based on the above discussion, is presented on page 252.

As well as discussing what therapists and counsellors actually do in cathartically-oriented psychotherapy, some attention must be given to the personal qualities of the therapists themselves, and the relationship that they have with clients.

A basic category of therapist response required to support and encourage emotional expression is characterological and dispositional. The therapist must be comfortable in the face of emotional display and have the capacity to tolerate a wide range of 'material'. Furthermore, the therapist must consciously and unconsciously accept the notion that affective expression

Figure 4. A Model for Change



is important and should usually be encouraged. This inherent tolerance for an interest in emotional experience will be felt by clients and will enhance their level of experiencing, even without any deliberate use of technique.

If clients are to share deep feelings from childhood, with their attendant sense of vulnerability, considerable warmth and support are required from the therapist. Such a warm and active relationship forms a good basis for the vigorous confrontation of defenses. Clients can only hear and use interruptions of their defensive ways after a basic sense of personal respect and warmth has been established (Rogers, 1942, 1951, 1961). Rogers (1951) stated as a basic hypothesis that "the individual has a sufficient capacity to deal constructively with all those aspects of his life which can potentially come into conscious awareness", and refers to "the counsellor's acceptance of the client as a person who is competent to direct himself" (p. 24).

Rogers (1942) called therapy a "structured permissive relationship that allows the client to move toward understanding" (p. 18). He writes, ".....the counselling relationship is one in which warmth of acceptance and absence of any coercion or personal pressure on the part of the counsellor permits maximum expression of feelings, attitudes, and problems by the counsellee" (pp. 113-114). Later the quality of the acceptance became, along with therapist congruence and accurate empathy, a cardinal condition in a successful therapeutic partnership (Rogers, 1961).

Rogers (1967) explained how acceptance works: "When someone understands how it feels and seems to be me, without wanting to analyse or judge me, then I can blossom and grow in that climate. When the therapist can grasp that moment-to-moment experiencing occurring in the inner world of the client as the client sees it and feels it, without losing the separateness of his own identity in this empathic process, then change is likely to occur" (p. 54).

Finally, Rogers stated that the very essence of therapy is an attitude of acceptance whereby the therapist relates to the whole potential person in the client (1970, p. 57).

To be engaged in effective cathartically-oriented psychotherapy, the therapist must be able to demonstrate the personal qualities alluded to by Rogers, namely non-possessive warmth, accurate empathy, and non-judgemental acceptance.

Such nonintrusive techniques and a respect for the client's processes, both essential aspects of a truly humanistic psychotherapy, bespeak a therapy in which the therapist is not the socially sanctioned representative of a 'right' way of living, but rather a more experienced traveller and guide in realms the client will have to travel in person (see Laing's The Politics of Experience, 1967, in which he suggests a similar 'arrangement' for helping potential schizophrenics undertake "a voyage towards madness"). Of course, this involves therapists exploring their own personal 'psychological maps', of

engaging in a continuing process of personal growth and discovery, and of 'working on' their own presently unidentified pathology. This valuing of experience embraces the humanistic value of authenticity expressed by Rogers (1942), Bugental (1978), Perls (1972), and Heider (1974). Seaborn Jones (1978) believes that the **example** of the therapist is important when he writes: "Far from adopting the pose of someone 'cured', 'normal', 'analysed', 'clear', or 'enlightened'.....he will be seen to be travelling on the same path of progressive bodymind liberation as the people he is guiding and helping" (p. 82).

Heron (1978) summarizes the primary qualities of the effective therapist or counsellor (p.44). These include deftness, non-attachment, 'midwifery', caring, empathy, acceptance, transcendence, and firmness. A similar position is held by Seaborn Jones (1978) who writes: "the therapist needs to be able to change direction, to challenge, to surprise, to be unpredictable while keeping his own sense of direction.....At the highest level, technique is transformed into art" (p. 82).

There are three basic rationales inherent in the above approaches: (i) a trust in natural processes with minimal interference by the therapist. Faith in this natural growth process is explicitly stated by Rogers (1949) and Heron (1977); (ii) the role of the imaginative leap or realization mentioned by Watts (1961) and Perls (1972) endorses the value of higher-order mental and spiritual

aspirations. Heider (1974) describes catharsis as the route to transcendent experience, and this view is also explicit in the work of Heron; and (iii) the notion that the native feeling or impulse will, with the therapist's help, complete itself, unfolding its full cycle, which had been interrupted or arrested by fearful inhibitions. This latter view is evident in all of the cathartically-oriented approaches to psychotherapy.

Finally, it is important to recognize the importance of hope and expectation as factors influencing outcomes in psychotherapy (Frank, 1961). Sharing the philosophic/theoretical rationale (or 'map') with the client increases expectation and hope. If a therapist communicates acceptance and a trust that the client is acceptable now and has the capacity for self-regulation in the future, the factor of expectation may produce a self-fulfilling prophecy. Building up conditions of hope in the client can reverse the feelings of helplessness that are often present (Seligman, 1975; Garber & Seligman, 1980), thereby increasing motivation and the personal power of the individual. This principle is as important in the cathartically-oriented psychotherapies as in any other. Because it is so tangible, emotional expression clearly indicates to the client that "something is happening". If this something has been extolled as therapeutic, the client may take it as a sign that therapy is progressing.

Any therapy that focusses on private experience and on

uncovering and expressing feelings runs the risk of becoming self-absorbed. It is therefore important that as well as individual therapy, a variety of interpersonal methods are used in order to foster an awareness of others and a sense of community. In group therapy, family therapy, peer counselling (co-counselling), and workshops, clients interact with others whose needs and pain they must somehow recognize and respond to. This interaction not only counteracts the tendency toward self-absorption but also teaches clients about themselves and how to give as well as to receive help. When one person is 'working' in front of the group, her distress and pain often triggers off the occluded pain of others. This process has already been referred to as passive imagination or external ideation (Heron, 1977, 1978), and it can be an important and potent aspect of group psychotherapy where catharsis is valued. Often there is a contagion of catharsis that creates an evocative and permissive climate for the expression of feelings.

Co-counselling is a process of exchanging therapeutic help in which two people take turns as each other's counsellor/therapist. In a narrow sense it refers to the use of the above methods with respect to reevaluation counselling (Jackins, 1962; Heron, 1973, 1978), but such reciprocal helping can obviously apply to any therapeutic system (e.g. primal therapy, bioenergetics, relaxation therapy, systematic desensitization, etc.). Co-counselling emphasizes the adult, coping, responsible aspects of

clients. It supplements and extends the therapy process in many ways. It gives clients extra time to examine their thoughts, express their feelings, and try out new behaviour in a safe environment. It is also a reminder to clients of their ability, competence, and capacity to give to others. Finally, it is a demystifying experience that shows clients that the process is useful rather than that the therapist is magical. Liss (1974) writes: "The remarkable success of co-counselling proves incontrovertibly that all human beings have the capacity, given the right opportunity, to undo the psychological warping of unresolved emotional pain and help other human beings do the same thing.....Courage and trust are needed to pour out your heart to another person who, like yourself, also suffers. Patience, skill, and compassion, as disclosed through silent attentiveness, will offer another human being the same opportunity, so he too re-experiences and clears the hurt from the past. Everyone must become a psychiatrist in order to learn what is not conventionally taught in family life, in schools, and in friendship. Opening the mysteries that heal hurt to happiness is a new skill" (pp. 198-199). Heron develops this view even further when he writes, "Personal and political liberation through peer self-help, mutual aid, is a potent ideology and a potent practice. It generates its own destiny" (1980, p. 106).

Like individual therapy, group therapy, and co-counselling, workshops provide an opportunity to look at oneself, to express feelings, and to plan personal change.

Pierce et al (1983, p. 195) claim that workshops have the following unique characteristics: (i) the extensive and intensive character of workshops helps to break down defences against feeling and allows thematic work; (ii) workshops are interpersonal laboratories permitting the diagnosis of, and prescription for, interpersonal difficulties; and (iii) workshops build a sense of community and provide a good starting point for co-counselling and group participation.

There are diverse opinions among clinicians as to how safe it is for clients to lose control, i.e. to ventilate their feelings in somatic-emotional discharge. It is probably useful if all clients increase their ego-strength as a prelude to dissolving the defences and exploring their repressed feelings. However, some clinicians (e.g. Lowy, 1970) believe that it is dangerous to tamper with the defences of a psychotic patient, for fear that he will lose, and be unable to regain, control. Thus, psychotic patients are most often treated with supportive therapy and with drugs. On the other hand, there are those who believe that cathartic therapy is valuable for **everyone**, in that the basic healing process is the same for all human beings (Jackins, 1962; Janov, 1973; Laing, 1960). Jackins believes that psychotics are people with more stored-up pain, who are in more need of opportunities to discharge than 'normals'. However, with 'heavily distressed persons' Jackins makes more effort to draw their attention to the present time than to the past

distressful experiences. Nevertheless, this effort is still directed at encouraging the client to lose control and discharge feelings.

Nichols and Zax (1977) conclude that ".....if a skilled clinician, in a protective environment, can spend a great deal of time with patients, there may be no contraindication for the use of emotive techniques" (p. 219). But as discussed earlier, catharsis and insight need to be complemented by other processes in order for the individual to function in healthy and adaptive ways (psychological and somatic). In the view of Heron (1982), both catharsis and transmutation are necessary for the resolution of disabling distress.

In general. I feel that therapists ought to accept cathartic emotional expression in almost any therapeutic context. In this way clients learn to recognize, accept, and express their feelings. Even if catharsis is not the major focus of the therapy, it is generally a good idea to permit clients to cry or say angry things whenever these feelings emerge. However, if the therapeutic situation encourages feelings to be unblocked, either intentionally or otherwise, then permission and encouragement should be given to the client to motorically discharge those feelings. If this does not happen then the clients may show an increase in physiological tension, as well as a decrease in their subjective state of well-being (as indicated by the research reported in Chapters Four & Five).

Like other avant garde forms of therapy that have come

into vogue, cathartic therapy has both zealous adherents and harsh critics. Perhaps the most serious of the criticisms about intense cathartic therapy is that it is dangerous and destructive. There is no question but that emotional abreaction can be a powerful and frightening experience. In fact, it is the powerful nature of the experience that makes change possible. Changes will alter situations, or the subjective experience of them, that clients encounter following 'treatment'. The outcome of cathartic therapy effects the future, not the past. Above all, the person who engages in the cathartic process will ultimately enjoy the increased freedom of expressivity and action as they become liberated from the shackles of their past. However, it may be that some individuals, and some psychological and somatic 'conditions', will respond to intense cathartic therapy more optimally than others. There is a need for more research into this area.

However, there is little doubt that the advocates of cathartically oriented approaches have made an impact on the field of psychotherapy in general, and that future research, experimental, clinical, and experiential will continue apace. This can only be to the long-term benefit of individual well-being. But ultimately society has to recognize the necessity of educating people to manage their own distress feelings through catharsis and transmutation. This will involve major changes in parenting, educational, and medical practices, whose current institutions legitimate many rigid and maladaptive behaviours which

result from repressing distressed feelings.

APPENDIX ONE

CATHARSIS RESEARCH SCHEDULE

CATHARSIS RESEARCH SCHEDULE (Inquiries One & Two)

Week beginning _____

Events

Current/Historical

before/after

Cognitive Catharsis

B.P.

Somatic Catharsis

P.R.

Insight

Major Feelings e.g. anger

Heavy type refers to Research Study 2 only

1. Nervous System

e.g.,

headache

migraine

blackouts

tremors

2. Musculo-Skeletal

e.g.,

muscle tension

muscle spasms

cramps

3. Abdomen

e.g.,

nausea

bloating

wind

cramps

constipation

diarrhea

4. Reproductive

e.g.,

pre-menstrual tension

period pains

5. Urinary Tract

e.g.,

frequency

discomfort

infections

6. Skin

e.g.,

lesions

rashes

marks

moles

warmth

hair

7. Senses

e.g.,

vision

hearing

smell

sinuses

8. Mouth

e.g.,

ulcers

sores

lips

taste

throat

9. Chest

e.g.,

breathing

chest cold

pain

palpitations

10. Illnesses/Symptoms

e.g.,

tiredness

11. Diet

e.g.,

eating between meals

lack of appetite

change in habits

alcohol

12. Sleep

e.g.,

quality

dreams

length

13. Sexuality

e.g.,

desire

frequency

enjoyment

problems

14. Mood

e.g.,

depressed

irritable

happy

hopeful

15. Behaviour

e.g.,

phobias

compulsions

concentration

T.V. viewing

smoking

getting things done

16. Stress

e.g.,

work

relationships

money

illness

17. Catharsis

e.g.,

current

primal

18. Feelings

19. Other Comments

CO-RESEARCHER

REPORT ON CO-COUNSELLING SESSION

Date:

Events

	<u>Current / Historical</u>	<u>before/after</u>
<u>Cognitive Catharsis</u>		<u>B. P.</u>
<u>Somatic Catharsis</u>		<u>P. R.</u>

Major Feelings recognized/expressed:

Spontaneous Insights:

Feelings immediately after session:

Other Comments:

APPENDIX TWO
TECHNIQUES

Techniques used during the Active Phase of the Research

The techniques used are based primarily on those found in co-counselling (Heron, 1975, 1977, 1978; Evison & Horobin, 1983; Jackins, 1970), primal integration (Broder, 1976), Six Category Intervention Analysis (Heron, 1975), and feeling-expressive psychotherapy (Pierce et al., 1983), as well as books by Ernst & Goodison (1981), and Southgate & Randall (1976). My experience in these techniques was gained initially by attending courses in co-counselling (fundamentals, advanced & teacher training) with John Heron, and primal integration with Frank Lake, as well as a number of workshops in Gestalt therapy, Reichian bodywork, psychosynthesis, transpersonal psychology, and transactional analysis. Recently I have undertaken considerable training in hypnosis and neurolinguistic programming. Since 1978 I have been actively involved in running workshops/groups, utilizing the methods learned in the above courses, whilst evolving my own personal style.

The methods used in the research studies may be classified as follows. The examples provided in each category are not exhaustive.

A. Techniques to facilitate the person's resources.

Unqualified celebration and appreciation of personal qualities to other group member(s);

Celebration of worth as a human being (the "real self"), both verbally and non-verbally (e.g. in dance, painting, movement etc.);

Celebration of "what makes life worth living right now" (the "News and Goods");

Validation of the personal qualities of other group members, using both verbal and non-verbal means of communicating;

Validation of other members of the group as human beings. A recognition that every person is loving, self-directive, and understanding, whilst appreciating that such human qualities are often occluded. Validation may be verbal or non-verbal (as in touch, gentle & relaxing massage, sensory relaxation, holding);

Recognition of personal resources, achievements, joyful & creative past experiences through the use of hypnosis, e.g. John Hartland's ego strengthening technique; neurolinguistic programming (Bandler & Grinder, 1979; Grinder & Bandler, 1981), including the use of metaphor and story telling (Erickson & Rossi, 1981; Erickson et al., 1976), and guided fantasy (Assagioli, 1975).

These celebratory and validatory 'statements' were

made by the individual to the group as a whole, in smaller groups, in pairs, and to themselves. There were a number of reasons for using these methods: (i) to increase ego strength, both in the short-term so as to enable the individual to "go into" areas of distress, and in the longer term to counteract the self-negating tendency that is epidemic in our society, and consequently enabling the person to engage in realistic goal setting and implementation; (ii) to make the occluded distress more available for discharge, on the principle of the 'play of opposites' (essentially a paradoxical intervention, based on Hegelian dialectics, and part of an attention switching strategy); (iii) to enable profound human-to-human encounter, through authentic communication and self-disclosure, consequently helping in the development of a warm, trusting, non-judgemental and permissive environment, where sharing and intimate contact become a group norm. These techniques were used at the beginning and the end of the group counselling sessions, as well as after 'working in an area of distress'.

B. Attention Switching or Present Time techniques

Describing something good that happened in the past few days;

Celebrating an aspect of oneself (see under (A) above);

Getting attention out to the environment - describing the room, the scene through the window, the colours, shapes, and sounds in the room, journey to the session etc.;

Description of some minor, trivial distress (e.g., the weather, the late bus);

Physical actions demanding some attention;

Simple mental tasks;

Remembering positive events, and associated affect, with or without induced relaxation;

Relaxation, sensory awareness, massage;

There are two major uses of attention switching techniques: (i) to achieve a balance of attention in order to facilitate somatic-emotional discharge, and (ii) to return to an undistressed frame of mind at the end of a discharge session.

C. Methods to facilitate Emotional Discharge

The organization of techniques used in the facilitation of catharsis follows Heron's classification of "the four basic ways into discharge" (1978, p. 16-17). It should also be remembered that individuals will often "slip into

discharge" when they go **away** from the distress, as in the two categories above.

(i) Active Imagination

Focussing on a specific traumatic event, either recent or past, and talking it through;

Literal description - Talking through the event using the present tense (as if the event was happening currently;

Concrete literal description of all aspects of the scene - searching through the sensory modalities i.e. colours, smells, textures, temperature, sounds.....

Repetition of key phrases, words, movements, facial expressions, and sounds, which appear to have an emotive content e.g. change in tone of voice; swallowing; diversion of eye-contact; finger tapping; hair pulling; scratching, rapid changes in posture, etc. The client may be encouraged to say words louder or softer, to exaggerate movements or to stop them (i.e. contradiction);

Completion of unfinished business - "what's left unsaid?". This may be done using the 'empty chair' technique, as used in Gestalt therapy;

Putting words to actions, and actions to words, e.g. "what is your left leg saying, if it could talk?" ;

Roleplay - talking directly, using the present tense, to key people in a current or an earlier scene. Members of the group role-play the significant others. May involve role-reversal. Role-play can be acted out in the imagination, e.g. "imagine that you are telling your father how much you hate him"; "see yourself being angry with your mother"; "what do you want to do to your teacher, right now? See yourself doing it, allowing the feelings to come up, just as it happens all by itself." It can be useful to do this in the hypnotic state.

Exploring pattern connections:

scanning: reviewing past experiences, maybe in relation to specific themes, e.g. times I've been rejected; food; sexual experiences; losses; times I've felt afraid, etc.,

following associations: essentially 'catching the thought'. Can be elicited from the client by asking, "What's the thought?" "What's going on in your mind right now?" "What's on top?" "What does this event remind you of? First thought."

earliest or strongest memory associations: this is where there is an attempt to shift the client to the prototypical event. This involves a 'time shift' from something that is happening in the present to something

that happened in the past. Some examples of interventions include: "Who are you really saying that to?"; "Who are you really doing that to?.....first thought"; "When did you first feel like this"; "What's your earliest memory of a situation like this?" Another method is to track back using the affect or somatic bridge (Watkins, 1971), the 'dreaming arm' (Grinder & Bandler, 1981, p. 71-72); regression with reverie, perhaps involving progressive gentle-deep massage (Heron, 1977b, p. 42); hypnotic ideomotor signalling (Erickson & Rossi, 1981; Cheek & LeCron, 1968); finding the answer in a special place such as a garden or a castle, within a guided fantasy exercise; or "imagine yourself getting smaller and smaller, until you are the age at when.....(the symptom).....first occurred" (Desoille, 1965; Shorr, 1972).

(ii) Passive Imagination

This occurs when a group member identifies (generally an unconscious process) with the overt distress of another member. The consequence of this passive identification with another's distress evokes a catharsis in the identifier. It is not uncommon in groupwork for several members to be emotionally discharging (i.e. somatic-emotional discharge) at the same time, as a result of passive identification. It is also possible for individuals to identify with a client who is discharging, and as a result experience a cognitive-emotional catharsis.

(iii) Active body work

The aim of active body work is to begin to loosen-up the occluded affect held within the body, i.e. body armour (see Chapter Three for a detailed explanation, particularly the theories of Reich and Lowen), making it available for discharge;

Various vigorous and sustained physical movements, e.g. shaking, hyperventilation, kicking, thrashing on a mattress, dynamic meditation (Rajneesh), trembling, loud sounds, running on the spot,.....

Contradicting normal body movements, e.g. moving in 'silly' ways, exaggerating bodily movements, holding arms open wide.....

Bioenergetic stress positions (Lowen);

Acting into discharge - pounding cushions whilst making loud sounds (very effective when combined with deep breathing); trembling whilst pressing fingers into counsellor's back; reaching out with arms outstretched for the parent who is not there; killing-off the 'bad' parent;

Birth work - there is always a very strong active component

in birth work;

Regression positions - on the potty, at the breast, thumb-sucking, lying, curled-up on the counsellor's lap.....

(iv) Passive body work

This is where the counsellor (group facilitator) does something to the client;

Deep tissue massage - working on the tense musculature, the client being encouraged to let the discharge come through, to catch the thoughts and associations, to add a sound to the out-breath;

Working on acupressure points;

Long leverages on spinal joints, encouraging the client to "keep their breathing going and allow the sound to come through";

Gentle, relaxing massage (often leads to copious discharge);

Birth work;

Physical interventions that symbolize a client's statement,

e.g. get off my back; I don't feel part of this group.....

Holding the person whilst she is working;

After the client has discharged, she is encouraged to "catch the thoughts", and to make the connections between the earlier prototypical experiences and later adult behaviour, feelings, and psychosomatic symptomatology. She is then encouraged to action plan for more rational living.

D. Action planning for rational living

Working with post-cathartic insights;

Goal setting: using hypnosis [e.g. Spiegel's split-screen technique (Spiegel & Spiegel, 1978); neurolinguistic programming; reframing]; each member of the group spends equal amounts of time developing action plans for the next few days/months;

Behavioural contracting;

As was stated previously, the list of possible interventions listed above is not exhaustive, and during the course of the research other approaches were used. Of course, some of the techniques listed above were not used.

The range of interventions in which the counsellor needs

to be skilled are described by Heron in his manual, Six
Category Intervention Analysis (1975).

HARTLAND'S EGO STRENGTHENING TECHNIQUE

(Hartland, 1971, pp. 197 - 202)

You have now become so deeply relaxed.....so deeply asleep...that your mind has become so sensitive....so receptive to what I say.....that everything that I put into your mind.....will sink so deeply into the unconscious part of your mind.....and will cause so deep and lasting impression there.....that nothing will eradicate it.

Consequently.....these things that I put into your unconscious mind.....will begin to exercise a greater and greater influence over the way you think.....over the way you feel.....over the way you behave.

And.....because these things will remain.....firmly embedded in the unconscious part of your mind.....after you have left here.....when you are no longer with me....they will continue to exercise that same great influence....over your thoughts.....your feelings.....and your actions....just as strongly.....just as surely.....just as powerfully.....when you are back home.....or at work....as when you are with me in this room.

You are now so very deeply asleep.....that everything that I tell you that is going to happen to you.....for your own good....will happen....exactly as I tell you.

And every feeling.....that I tell you that you will experience....every day.....and you will continue to experience these same feelings.....every day.....just as strongly just as surely.....just as powerfully,,,,,,when you are back home.....or at work.....as when you are with me in this room.

During this deep sleep.....you are going to feel physically stronger and fitter in every way.

You will feel more alert.....more wide-awake....more energetic.

You will become much less easily tired.....much less easily fatigued.....much less easily discouraged.....much less easily depressed.

Every day.....you will become so deeply interested in whatever you are doing....in whatever is going on around you....that your mind will become completely distracted away from yourself.

you will no longer think nearly so much about yourself.

You will no longer think nearly so much about yourself.....you will no longer dwell nearly so much upon yourself and your difficulties.....and you will become much less conscious of yourself.....much less preoccupied with yourself.....and with your own feelings.

Every day.....your nerves will become stronger and steadier.....your mind calmer and clearer.....more composed.....more placid.....more tranquil. You will become much less easily worried.....much less easily

agitated.....much less easily fearful and
apprehensive....much less easily upset.

You will be able to think more clearly.....you will be able
to concentrate more easily.

You will be able to give up your whole undivided attention
to whatever you are doing....to the complete exclusion of
everything else.

Consequently.....your memory will rapidly improve....and
you will be able to see things in their true
perspective....without magnifying your difficulties.....
without ever allowing them to get out of proportion.

Every day.....you will become emotionally much
calmer.....much more settled.....much less easily
disturbed.

Every day.....you will become.....and you will
remain....more and more completely relaxed.....and less
tense each day.....both mentally and physically.....even
when you are no longer with me.

And as you become.....and as you remain.....more
relaxed....and less tense each day.....so.....you will
develop much more confidence in yourself.....more
confidence in your ability to do.....not only what you
have.....to do each day.....but more confidence in your
ability to do whatever you ought to be able to
do....without fear of failure.....without fear of
consequences.....without unnecessary anxiety.....without

uneasiness.

Because of this.....every day.....you will feel more and more independent.....more able to stick up for yourself.....to stand upon your own feet.....to hold your own.....no matter how difficult or trying things may be

Every day.....you will feel a greater feeling of personal well-being.....a greater feeling of personal safety..and security.....than you have felt for a long time.

And because all these things will begin to happen....exactly as I tell you they will happen.....more and more rapidly.....powerfully....and completely.....with every treatment I give you.....you will feel much happier.....much more contented.....much more optimistic in every way.

You will consequently become much more able to rely upon....to depend upon.....yourself.....your own efforts.....your own judgements.....your own opinions. You will have much less need.....to have to rely upon.....or to depend upon.....other people.

APPENDIX THREE

TABLES

TABLE 1

Changes in Blood Pressure (diastolic)
following emotional catharsis

<u>Session</u>	<u>JH</u>	<u>JP</u>	<u>FI</u>	<u>SB</u>	<u>BG</u>	<u>AW</u>	<u>BS</u>	<u>AS</u>
3	-4	2	4	2	-2	-8	-8	5
4	0	-2	2	-3	-4	1	4	8
5		-2	-6	2	2	-2		
6	5	-5	6	5		3	-8	-6
7		-2				-2	-6	
8	-4			-4			-2	1
9	4	4	5	3	-4	-2		-6
10			-5	1	-2	3	2	2
11	-2	0	-8	-3		3	-6	-1
12	2	1	6	3	2	5	3	
13								
14	-2		4	2	5		3	1
15	2	-2	-6		-2	-1	-6	-2
16			2		0	-2	-2	
17	-2	-3		-4		3	2	-6
18	5	2	2		2	2	2	

Somatic Catharsis

M	-1.74	-2.25	-5.74	-1.83	-2.41	-2.83	-6.00	-3.17
SD	1.71	1.83	0.55	2.44	1.56	2.31	2.00	3.08
SE	0.61	0.73	0.34	1.04	0.72	0.95	0.82	1.26

Cognitive Catharsis

M	2.34	1.26	2.54	3.01	1.85	2.86	2.00	3.75
SD	3.10	2.04	4.13	1.12	2.23	1.12	1.77	2.95
SE	1.71	0.94	1.38	0.56	1.04	0.43	0.67	1.47

Mean change for somatic catharsis = -3.14 (S.E. = 0.26)
 Mean change for cognitive catharsis = +2.34 (S.E. = 0.27)

Figures referring to Cognitive Catharsis are in **bold type**

TABLE 2

Changes in Pulse Rate following Emotional Catharsis

Session	JH	JP	FI	SB	BG	AW	BS	AS
3	-2	2	8	3	0	-2	-7	3
4	-1	-2	8	-2	-4	1	2	6
5		-2	-8	4	2	-1		
6	4	-4	6	6		6	-6	-6
7		-4				-2	-5	
8	-2			-2			0	0
9	4	3	5	4	-4	-1		-2
10			-4	2	-1	2	5	4
11	-2	4	-4	-4		2	-6	-1
12	3	1	4	6	2	2	0	
13								
14	-3		6	5	3		5	2
15	3	-2	-4		-2	-1	-6	-4
16			3		-1	0	-2	
17	-1	-1		-2		4	2	-4
18	5	2	1		6	3	1	

Somatic Catharsis

M	-1.83	-2.00	-5.33	-0.67	-2.40	-0.67	-3.86	-3.40
SD	0.69	1.73	1.89	2.75	1.36	0.94	3.91	1.74
SE	0.28	0.71	1.09	1.12	0.61	0.38	1.48	0.78

Cognitive Catharsis

M	3.81	1.80	4.11	4.80	2.60	2.43	1.67	3.00
SD	0.75	2.04	3.57	1.17	1.96	2.26	1.70	2.00
SE	0.33	0.91	1.19	0.52	0.88	0.85	0.69	0.89

Mean change for somatic catharsis = -2.3 (S.E. = 0.26)

Mean change for cognitive catharsis = +3.06 (S.E. = 0.25)

Figures referring to cognitive catharsis are in bold type

TABLE 3

Total Number of Cathartic Events

<u>C-R</u>	<u>Cathartic Events-</u> <u>Research Sessions</u>			<u>Cathartic Events-</u> <u>between Sessions</u>			<u>Total</u> <u>Cathartic Events</u>		
	<u>SC</u>	<u>CC</u>	<u>I</u>	<u>SC</u>	<u>CC</u>	<u>I</u>	<u>SC</u>	<u>CC</u>	<u>I</u>
JH	11	25	3	18	20	2	29	45	5
JP	14	23	2	12	14	0	26	37	2
FI	9	19	2	2	8	0	11	27	2
SB	7	15	1	4	6	1	8	21	2
BG	6	18	2	3	8	0	8	26	3
AW	9	26	2	5	21	0	14	47	2
BS	11	20	3	6	15	0	17	35	3
AS	13	20	1	4	12	0	17	32	1

SC = somatic-emotional catharsis
CC = cognitive-emotional catharsis
I = insight

TABLE 4

Changes in Blood Pressure (diastolic)
following emotional catharsis

Session	PH	FI	SB	JH	AS	JS	AB	MW	NW	EN	RB
1	-8	-5	-3	-4	-4	-5	-5	6	-1	2	2
2	-7	-6	-4	-4	-2	-4	-4	0	-5	4	-4
3	-8	-6	-8	-8	-6	1	-10	1	-3	-1	0
4	-4	-4	-5	-4	-2	-8	-6		-10	-4	-3
5		-2	-2	-3	-2	-9	-2		-10	-9	
6			1		-4	-5	-8			3	
7	1	4			-10	6	-5	-2		-5	
8	-7	-5	-2		-8	-1	4	-4	-1		
9	-2	-4	-3				-8		-9		
10	2	-3	-1		-2			-4		9	
11	-2						-7	1	-6	-1	
12	-3			-6	1		-5	-3	-6	-2	
13	-4	-4	-5	-1	-1		-5	2	-8		
14		2	-7	-3	3		-1	-1	-6		
15	-7	-5		-3	-2		-3		-3	-7	

Somatic Catharsis

M	-4.4	-4.4	-3.5	-3.3	-5.3	-5.5	-5.7	-2.4	-5.7	-2.0	-0.3
SD	2.87	1.20	2.24	1.39	2.98	4.00	2.17	1.62	3.07	4.07	1.19
SE	0.91	0.38	0.79	0.49	1.22	2.83	0.63	0.73	0.88	1.29	1.19

Cognitive Catharsis

M	2.50	3.00	-3.67	-8.00	-1.00	-2.50	1.50	1.60	0.00	-9.00	-4.00
SD	4.50	1.00	3.09	0.00	2.14	4.65	2.50	2.58	0.00	0.00	0.00
SE	3.18	0.71	1.78	0.00	0.80	1.90	1.77	1.15	0.00	0.00	0.00

Mean change for somatic catharsis = -3.88 (S.D. 3.27; S.E. 0.34)
Mean change for cognitive catharsis = **-0.69** (S.D. 4.4; S.E. 0.88)

Figures referring to cognitive catharsis are in bold type

TABLE 5

Changes in Pulse Rate
following emotional catharsis

<u>Session</u>	<u>PH</u>	<u>FI</u>	<u>SB</u>	<u>JH</u>	<u>AS</u>	<u>JS</u>	<u>AB</u>	<u>MW</u>	<u>NW</u>	<u>EN</u>	<u>RB</u>
1	-5	-12	-4	-2		-6	-3	3		-4	
2	-8	-8	-2	-3	-3	-4	-3	-2	-3		
3	-9	-6	-2	-7	-6	-2	-2	4	-6		
4	-5	-7	-4	-5	-2	-4	-5		-9	-3	2
5		-7	-4	-5	-4	-6	-4		-7	-2	-2
6			1		-4	-1	2			8	
7	3	2			-7	5	-6	-3		-3	
8	-4	-5	-4		-7	-5	4	-2	-3	-7	
9	-3	-6	-4				-7		-4		
10	1	-6	-6		-8			-2		5	
11	-3						-1	-1		-1	
12	-3		-6	-7	-1		-5	-3	-5	-8	
13	-4	-8	-6	-3	-5		-5	-1	-4		
14		2		-5	1		-6	-5	-3		
15	-4	-5		-6	3		-4		-2		

Somatic Catharsis

M	-4.5	-7.0	-2.5	-4.4	-6.4	-5.5	-4.0	-2.8	-4.6	-2.5	0.0
SD	2.42	1.95	2.94	1.61	1.36	0.50	2.32	1.17	2.06	4.56	2.00
SE	0.76	0.62	0.93	0.48	0.61	0.35	0.67	0.24	0.65	1.16	1.41

Cognitive Catharsis

M	2.0	2.0	-4.0	-7.0	-1.6	-3.3	-1.0	0.4	0.0	5.0	0.0
SD	1.00	0.00	1.63	0.00	2.61	3.40	5.00	2.65	0.00	0.00	0.00
SE	0.71	0.00	0.94	0.00	0.99	1.29	3.53	1.19	0.00	0.00	0.00

Mean change for S.C. = -4.37 (S.D. 2.83; S.E. 0.24)

Mean change for C.C. = -1.0 (S.D. 3.68); S.E. 0.34)

Figures referring to cognitive catharsis are in **bold type**

TABLE 6

Catharsis - Summary

C-R	Co-counselling Cathartic Events (no.)									Between Sessions Cathartic Events								
	Sc			Cc			I			Sc			Cc			I		
	H	I	C	H	I	C	H	C		H	I	C	H	I	C	H	I	C
PH	8	4	4	3		4	4	0		10	1	2	0		2	1		0
FI	12	3	3	3	N	3	3	0		5	2	6	2	N	4	2		0
SB	11	3	3	3		2	3	0		6	1	3	2		4	1		0
JH	10	3	2	2		2	3	0		4	1	4	0		6	1		0
AS	2	1	5	7	I	9	1	0		0	0	3	1	I	2	0		0
JS	3	0	0	8		3	0	0		0	0	3	0		4	0		0
AB	13	4	3	2		4	4	1		4	1	4	2		6	1		0
MW	2	0	2	7	L	5	0	0		0	0	2	0	L	3	0		0
NW	10	4	4	1		2	4	0		6	1	8	2		5	1		0
EN	10	4	2	2		2	4	0		5	2	5	0		3	2		0
RB	0	1	4	1		0	0	1		5	0	10	2		6	0		0

TABLE 7

Total Cathartic Events

C-R	Sc			Cc			I		
	H	C	(H+C)	H	C	(H+C)	H	C	(H+C)
PH	18	6	24	3	6	9	5	0	5
FI	17	9	26	5	7	12	5	0	5
SB	17	6	23	5	6	11	4	0	4
JH	14	6	20	2	8	10	4	0	4
AS	2	8	10	8	11	19	1	0	1
JS	3	3	6	8	7	15	0	0	0
AB	17	7	24	4	10	14	5	1	6
MW	2	4	6	7	8	15	0	0	0
NW	16	12	28	3	7	10	5	0	5
EN	15	7	22	2	5	7	6	0	6
RB	5	14	19	3	6	9	0	1	1

Sc = somatic catharsis
H = historical
I = insight

Cc = cognitive catharsis
C = current
C-R = co-researcher

TABLE 8

Changes in Baseline Blood Pressure (diastolic)

<u>Session</u>	<u>PH</u>	<u>FI</u>	<u>SB</u>	<u>JH</u>	<u>AS</u>	<u>JS</u>	<u>AB</u>	<u>MW</u>	<u>NW</u>	<u>EN</u>	<u>RB</u>
1	121	128	134	132	140	146	159	120	134	144	---
15	125	118	129	125	142	140	136	136	123	129	---
d	4	-10	-5	-7	2	-6	-23	16	-11	-15	---

Mean Change in Blood Pressure (diastolic) = -5.5
 S.D. 10.28 S.E. 0.32

TABLE 9

Changes in Baseline Pulse Rate

<u>Session</u>	<u>PH</u>	<u>FI</u>	<u>SB</u>	<u>JH</u>	<u>AS</u>	<u>JS</u>	<u>AB</u>	<u>MW</u>	<u>NW</u>	<u>EN</u>	<u>RB</u>
1	81	88	74	72	82	96	87	81	86	90	--
15	83	76	80	78	87	88	78	86	77	81	--
d	2	-8	6	5	5	-8	-9	5	-9	-9	--

Mean Change in Pulse Rate = -2.00
 S.D. 6.68
 S.E. 0.32

TABLE 10

Differences in Standard Scores between pre- and post-
inquiry measures of the CPI

<u>Scale</u>	<u>PH</u>	<u>FI</u>	<u>SB</u>	<u>JH</u>	<u>AS</u>	<u>JS</u>	<u>AB</u>	<u>MW</u>	<u>NW</u>	<u>EN</u>
Do	1	2	14	-1	2	3	1	0	5	6
Cs	12	8	16	-1	-3	-1	9	1	4	7
Sy	11	6	9	1	1	0	9	-1	6	4
Sp	5	3	13	3	-3	7	4	-4	1	-2
Sa	6	7	16	7	2	2	10	2	12	5
Wb	10	8	27	15	3	5	17	4	15	16
Re	4	6	2	4	0	-1	2	1	4	1
So	5	7	8	13	1	3	10	3	9	11
Sc	-2	2	1	4	1	2	-3	-2	6	-1
To	1	4	4	6	2	3	10	2	4	2
Gi	7	9	6	9	2	4	11	4	7	9
Cm	4	2	0	2	2	2	2	3	2	1
Ac	2	2	3	3	1	4	2	3	0	2
Ai	10	9	20	16	7	2	-2	-4	14	10
Ie	-1	1	4	-4	-5	1	5	1	6	5
Py	7	5	5	2	9	11	4	6	5	9
Fx	3	1	4	2	7	3	5	1	6	9
Fe	6	7	15	1	3	2	6	1	13	12
M	5.1	4.9	9.3	6.2	1.8	2.9	5.7	1.2	6.6	5.9
S.D.	4.0	2.8	7.5	5.9	3.5	2.8	5.2	2.7	4.4	4.9
S.E.	0.9	0.7	1.8	1.4	0.8	0.7	1.2	0.6	1.0	1.2

TABLE 11

Incidence of Somatic Emotional Catharsis (Historical), Insight,
and Mean Changes on CPI Scales

	<u>Sc (Historical)</u>	<u>I</u>	<u>CPI</u>
PH	18	5	5.1
FI	17	5	4.9
SB	17	4	9.3
JH	14	4	6.2
AS	2	1	1.8
JS	3	0	2.9
AB	17	5	5.7
MW	2	0	1.2
NW	16	5	6.6
EN	15	6	5.9

APPENDIX FOUR

PHYSIOLOGICAL DATA - INQUIRY ONE

CO-RESEARCHER FI

Session	Cathartic Event (no) - Insight	Blood Pressure				Pulse Rate				
		pre-C		post-C		pre-C		post-C		
		D	S	D	S	di		dii		
2	SC(1)									
3	CC(2)	120	78	124	82	4	72	80	8	
4	CC(1)	128	79	130	84	2	64	72	8	
5	CC(2) SC(3) I	124	84	118	78	-6	72	64	-8	
6	CC(3)	128	81	134	86	6	68	74	6	
7	absent									
8	-	130	82	132	84		70	71		
9	CC(1)	121	79	126	86	5	70	75	5	
10	SC(2) CC(1)	120	84	115	78	-5	72	68	-4	
11	CC(1)	130	86	122	80	-8	76	72	-4	
12	CC(2)	123	79	129	84	6	68	72	4	
13	absent									
14	CC(3)	126	82	130	86	4	68	74	6	
15	SC(3) I	124	79	118	74	-6	70	66	-4	
16	CC(2)	118	76	120	78	2	69	72	3	
17	absent									
18	CC(1)	124	82	126	82	2	70	71	1	

pre-C = before catharsis SC = somatic catharsis
post-C = after catharsis CC = cognitive catharsis
D = diastolic B.P. S = systolic B.P.
I = insight
di = diff. between pre- & post- cathartic measures of BP(D)
dii = diff. between pre- & post- cathartic measures of PR
figures referring to cognitive catharsis are in **bold type**

Total No. SC=9; CC=19; I=2;

CO-RESEARCHER SB

Session	Cathartic Event (no) - Insight	Blood Pressure					Pulse Rate		
		pre-C		post-C		pre-C	post-C		
		D	S	D	S	di	dii		
2	CC(1)								
3	CC(2)	125	74	127	76	2	69	72	3
4	CC(1) SC(1) I	123	71	120	68	-3	70	68	-2
5	SC(2)	127	78	129	80	2	70	74	4
6	CC(2)	129	79	134	84	5	68	74	6
7	absent								
8	SC(1) CC(1)	132	84	128	82	-4	71	69	-2
9	CC(2)	128	82	131	86	3	72	76	4
10	SC(1) I CC(1)	134	85	135	86	1	74	76	2
11	CC(1) SC(1)	134	83	131	82	-3	74	70	-4
12	CC(2)	137	89	140	92	3	72	78	6
13	absent								
14	CC(2)	132	82	134	84	2	71	76	5
15	absent								
16	-	128	78	135	84		69	74	
17	SC(1)	137	82	133	80	-4	74	72	-2
18	absent								

pre-C = before catharsis SC = somatic catharsis
post-C = after catharsis CC = cognitive catharsis
D = diastolic B.P. S = systolic B.P.
I = insight
di = diff. between pre- & post- cathartic measures of BP(D)
dii = diff. between pre- & post- cathartic measures of PR
figures referring to cognitive catharsis are in **bold type**

Total No. SC=7; CC=15; I=1;

CO-RESEARCHER JH

Session	Cathartic Event (no) - Insight		Blood Pressure				Pulse Rate			
			pre-C		post-C		pre-C	post-C		
			D	S	D	S	di	dii		
2		-								
3	CC(2)	SC(2)	132	80	128	76	-4	72	70	-2
4	SC(3)	I CC(1)	126	76	126	75	0	74	73	-1
5		-	130	82	134	84		70	74	
6	CC(4)		129	76	134	78	5	72	76	4
7		absent								
8	SC(2)	I	134	78	130	74	-4	69	67	-2
9	CC(3)		130	76	134	83	4	70	74	4
10		absent								
11	CC(2)	SC(1)	128	74	126	73	-2	74	72	-2
12	CC(3)		132	76	134	77	2	72	75	3
13		absent								
14	SC(2)	I CC(1)	125	84	123	83	-2	77	74	-3
15	CC(3)		133	87	135	90	2	71	74	3
16		absent								
17	SC(1)	CC(2)	132	84	130	83	-2	69	68	-1
18	CC(4)		129	82	134	87	5	71	76	5

pre-C = before catharsis SC = somatic catharsis
post-C = after catharsis CC = cognitive catharsis
D = diastolic B.P. S = systolic B.P.
I = insight
di = diff. between pre- & post- cathartic measures of BP(D)
dii = diff. between pre- post- cathartic measures of PR
figures referring to cognitive catharsis are in **bold type**

Total No. SC = 11 ; CC = 25; I = 3

CO-RESEARCHER AS

<u>Session</u>	Cathartic Event (no) - Insight	Blood Pressure					Pulse Rate			
		pre-C		post-C		pre-C	post-C			
		D	S	D	S	di	dii			
2	SC(2)									
3	CC(2)	134	84	139	87	5	73	76	3	
4	CC(2)	128	82	136	89	8	70	76	6	
5	absent									
6	CC(2) SC(3) I	136	84	130	80	-6	76	70	-6	
7	absent									
8	CC(3)	135	82	136	82	1	74	74	0	
9	CC(2) SC(2) I	128	80	122	78	-6	72	70	-2	
10	CC(4)	130	84	132	85	2	70	74	4	
11	SC(2) CC(2)	139	85	138	84	-1	69	68	-1	
12	absent									
13	absent									
14	CC(1)	131	84	132	84	1	70	72	2	
15	CC(1) SC(2)	138	89	136	87	-2	74	70	-4	
16	-	140	94	144	95		74	76		
17	CC(1) SC(2)	136	88	130	83	-6	78	74	-4	
18	absent									

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 I = insight
 di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to cognitive catharsis are in **bold type**

Total No. SC=13; CC=20; I=1;

CO-RESEARCHER JP

Session	Cathartic Event (no) - Insight	Blood Pressure					Pulse Rate		
		pre-C		post-C			pre-C	post-C	
		D	S	D	S	di	dii		
2	SC(2)								
3	CC(2)	120	90	122	90	2	70	72	2
4	CC(2) SC(2)	116	88	114	84	-2	70	68	-2
5	CC(3)	124	94	122	90	-2	74	72	-2
6	CC(1) SC(2) I	122	91	117	88	-5	72	68	-4
7	SC(2)	119	90	117	87	-2	74	70	-4
8	absent								
9	CC(4)	120	90	124	91	4	71	74	3
10	absent								
11	CC(2)	124	89	124	92	0	70	74	4
12	SC(2) CC(2)	120	88	121	94	1	71	72	1
13	absent								
14	-	124	90	129	92		68	74	
15	CC(2) SC(1)	126	88	124	84	-2	70	68	-2
16	absent								
17	CC(2) SC(3) I	129	84	126	90	-3	74	73	-1
18	CC(3)	125	89	126	92	1	72	74	2

pre-C = before catharsis SC = somatic catharsis
post-C = after catharsis CC = cognitive catharsis
D = diastolic B.P. S = systolic B.P.
I = insight
di = diff. between pre- & post- cathartic measures of BP(D)
dii = diff. between pre- & post- cathartic measures of PR
figures referring to cognitive catharsis are in **bold type**

Total No. SC=14; CC=23; I=2;

CO-RESEARCHER BG

Session	Cathartic Event (no) - Insight	Blood Pressure				Pulse Rate				
		pre-C		post-C		pre-C	post-C			
		D	S	D	S	di	dii			
2	-									
3	CC(3)	146	97	144	96	-2	88	88	0	
4	CC(1) SC(1) I	140	92	136	90	-4	84	80	-4	
5	CC(2) I	138	93	140	94	2	82	84	2	
6	absent									
7	absent									
8	absent									
9	CC(1) SC(1)	134	88	130	85	-4	84	80	-4	
10	SC(1) CC(1)	136	89	134	87	-2	87	86	-1	
11	absent									
12	CC(2)	138	92	140	94	2	86	88	2	
13	absent									
14	CC(3)	137	89	142	93	5	84	87	3	
15	CC(2) SC(2)	139	89	137	87	-2	84	82	-2	
16	SC(1) CC(1)	134	87	134	88	0	82	81	-1	
17	absent									
18	CC(2)	139	92	141	94	2	80	86	6	

pre-C = before catharsis SC = somatic catharsis
post-C = after catharsis CC = cognitive catharsis
D = diastolic B.P. S = systolic B.P.
I = insight
di = diff. between pre- & post- catharsis measures of BP(D)
dii = diff. between pre- & post- cathartic measures of PR
figures referring to cognitive catharsis are in bold type

Total No. SC=6; CC=18; I=2;

CO-RESEARCHER AW

Session	Cathartic Event (no) - Insight	Blood Pressure				Pulse Rate		di	dii
		pre-C		post-C		pre-C	post-C		
		D	S	D	S				
2	CC(1)								
3	CC(2) SC(1)	118	93	110	89	-8	66	64	-2
4	CC(2)	105	84	106	86	1	62	63	1
5	CC(1) SC(1) I	106	83	104	81	-2	60	59	-1
6	CC(3)	109	82	112	86	3	60	66	6
7	SC(2) I	105	82	103	80	-2	62	60	-2
8	-	108	84	110	89		64	66	
9	SC(2) CC(2)	104	82	102	81	-2	62	61	-1
10	CC(2)	111	89	114	91	3	67	69	2
11	CC(1)	107	84	110	87	3	64	66	2
12	CC(3)	112	82	117	87	5	62	64	2
13	absent								
14	absent								
15	CC(2) SC(1)	103	81	102	80	-1	60	59	-1
16	SC(2) CC(2)	106	84	104	83	-2	66	66	0
17	CC(4)	105	82	108	89	3	62	66	4
18	CC(1)	103	80	105	84	2	62	65	3

pre-C = before catharsis SC = somatic catharsis
post-C = after catharsis CC = cognitive catharsis
D = diastolic B.P. S = systolic B.P.
I = insight
di = diff. between pre- & post- cathartic measures of BP(D)
dii = diff. between pre- & post-- cathartic measures of PR
figures referring to cognitive catharsis are in **bold type**

Total No. SC=9; CC=26; I=2;

CO-RESEARCHER BS

Session	Cathartic Event (no) - Insight	Blood Pressure				Pulse Rate			
		pre-C		post-C		pre-C	post-C		
		D	S	D	S	di	dii		
2	CC(1)								
3	SC(3) I	140	88	132	79	-8	79	72	-7
4	CC(2)	138	88	142	89	4	74	76	2
5	absent								
6	SC(2) CC(1)	144	90	136	82	-8	76	70	-6
7	SC(2) I	138	86	132	84	-6	79	74	-5
8	CC(2)	142	86	140	88	-2	78	78	0
9	-	136	84	139	86		74	76	
10	CC(2)	142	89	144	94	2	73	78	5
11	SC(1) CC(2)	148	88	142	83	-6	79	73	-6
12	CC(2)	141	89	144	92	3	76	76	0
13	absent								
14	CC(3)	136	84	139	88	3	74	79	5
15	SC(2) I	136	86	130	78	-6	74	68	-6
16	SC(1) CC(1)	142	92	140	88	-2	72	70	-2
17	CC(3)	138	90	140	94	2	72	74	2
18	CC(1)	140	87	142	88	2	74	75	1

pre-C = before catharsis SC = somatic catharsis
post-C = after catharsis CC = cognitive catharsis
D = diastolic B.P. S = systolic B.P.
I = insight
di = diff. between pre- & post- cathartic measures of BP(D)
dii = diff. between pre- & post- cathartic measures of PR
figures referring to cognitive catharsis are in **bold type**

Total No. SC=11; CC=20; I=3;

APPENDIX FIVE

PHYSIOLOGICAL DATA - INQUIRY TWO

CO-RESEARCHER PH

Co-counselling

Session	Cathartic Event		Blood Pressure					Pulse Rate		
			pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S	di		dii	
1	SC.	SC	121	87	113	82	-8	81	76	-5
2	SC.I.		122	89	115	89	-7	82	74	-8
3	CC	SC	125	92	117	87	-8	85	76	-9
4	SC.I		120	93	116	90	-4	82	77	-5
5		ABSENT								
6		ABSENT								
7	CC	CC	120	89	121	92	1	79	82	3
8	SC	SC	122	91	115	83	-7	76	72	-4
9	SC	CC	127	94	125	90	-2	81	78	-3
10	CC	CC	123	92	125	93	2	79	80	1
11	SC.I.		119	94	121	90	-2	79	76	-3
12	SC		119	89	116	85	-3	77	74	-3
13		SC	123	93	119	89	-4	82	78	-4
14		ABSENT								
15	SC.I.		125	94	118	88	-7	83	79	-4

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

Total No. SC (H) 8 SC (C) 4
 CC (C) 3 CC (H) 3
 I (H) 4 I (C) 0

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC re in **bold type**

CO-RESEARCHER FI

Co-counselling

Session	Cathartic		Blood Pressure				Pulse Rate			
	Event		pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S	di	dii		
1	SC	SC	128	79	123	72	-5	88	76	-12
2	SC I	CC	128	81	122	75	-6	85	77	-8
3	SC (2)	SC	127	80	121	78	-6	85	79	-6
4	SC 1		124	80	120	77	-4	83	76	-7
5	SC	CC	121	79	119	78	-2	82	75	-7
6			ABSENT							
7	CC		120	78	124	85	4	80	82	2
8	SC (2) I		122	78	117	76	-5	79	74	-5
9	SC	SC	120	79	116	77	-4	79	73	-6
10	SC		118	78	115	75	-3	78	72	-6
11			ABSENT							
12			ABSENT							
13	SC I		119	77	115	74	-4	77	69	-8
14	CC (2)	CC	117	76	119	78	2	77	79	2
15	SC		118	77	113	73	-5	76	71	-5

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

Total No. SC (H) 12 SC (C) 3
 CC (H) 3 CC (C) 3
 I (H) 3 I (C) 0

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC are in **bold type**

CO-RESEARCHER SB

Co-counselling Session	Cathartic		Blood Pressure				Pulse Rate			
	Event		pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S	di	dii		
1	SC	SC	134	85	131	82	-3	74	70	-4
2	SC(2) I		132	82	128	80	-4	74	72	-2
3	CC		134	84	126	87	-8	76	74	-2
4	SC I		133	85	127	88	-5	77	73	-4
5		CC	131	83	129	82	-2	79	75	-4
6	SC	SC	130	88	131	88	1	78	79	1
7		ABSENT								
8	SC	SC	129	87	127	83	-2	77	73	-4
9	SC(2)		128	84	125	80	-3	76	72	-4
10	CC(2)	CC	130	88	129	85	-1	82	76	-6
11		ABSENT								
12	SC I		130	86	125	80	-5	83	77	-6
13	SC(2)		129	84	122	69	-7	80	74	-6
14		ABSENT								
15		ABSENT								

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

Total No.	SC (H)	11	SC(C)	3
	CC (H)	3	CC(C)	2
	I (H)	3	I(C)	0

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC are in **bold type**

CO-RESEARCHER JH

Co-counselling		Blood Pressure				Pulse Rate				
Session	Cathartic		pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S	di	dii		
1	SC (2)		132	80	128	76	-4	72	70	-2
2	SC I	CC	132	77	128	75	-4	77	74	-3
3	CC (2)		137	86	129	77	-8	82	75	-7
4	SC		128	81	124	76	-4	78	73	-5
5	SC (2)	I	129	80	126	75	-3	76	71	-5
6			ABSENT							
7			ABSENT							
8			ABSENT							
9			ABSENT							
10			ABSENT							
11			ABSENT							
12		SC (2)	133	88	127	77	-6	81	74	-7
13	SC I		129	86	128	87	-1	76	73	-3
14	SC (2)	CC	128	87	125	83	-3	77	72	-5
15	SC		125	80	122	77	-3	78	71	-6

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

Total No. SC (H) 10 SC (C) 2
 CC (H) 2 CC (C) 2
 I (H) 3 I (C) 0

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC are in **bold type**

CO-RESEARCHER AS

Co-counselling

Session	Cathartic Event		Blood Pressure				Pulse Rate		di	dii
			pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S				
1		SC (2)	140	92	136	90	-4	-	-	
2	CC	CC	138	90	136	88	-2	82	79 -3	
3		SC	139	91	133	87	-6	80	74 -6	
4	CC	CC	138	90	136	85	-2	79	77 -2	
5		SC	136	88	134	84	-2	76	72 -4	
6	CC	CC	144	93	140	87	-4	83	79 -4	
7	SC	CC	146	94	136	86	-10	85	78 -7	
8	SC I	CC	143	94	135	87	-8	88	81 -7	
9		ABSENT								
10	CC	SC	141	95	139	88	-2	91	83 -8	
11		ABSENT								
12	CC	CC	143	94	144	97	1	88	87 -1	
13		CC	145	92	144	95	-1	89	84 -5	
14	CC	CC	138	93	141	98	3	87	88 1	
15	CC	CC	142	93	140	92	-2	87	90 3	

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

Total No. SC (H) 2 SC (C) 5
 CC (H) 7 CC (C) 9
 I (H) 1 I (C) 0

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC are in **bold type**

CO-RESEARCHER JS

Co-counselling Session	Cathartic		Blood Pressure				Pulse Rate			
	Event		pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S	di	pre-C	post-C	
										dii
1	CC(2)		146	99	141	87	-5	96	90	-6
2	CC	CC	144	98	140	88	-4	92	88	-4
3	CC		143	98	144	89	1	90	88	-2
4	CC(2)	CC	148	103	140	99	-8	90	86	-4
5	SC		149	100	140	93	-9	94	88	-6
6	CC	CC	146	97	141	94	-5	90	89	-1
7	CC		143	99	149	104	6	86	91	5
8	SC(2)		140	97	139	94	-1	88	83	-5
9		absent								
10		absent								
11		absent								
12		absent								
13		absent								
14		absent								
15		absent								

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

Total No.	SC (H) 3	SC(C) 0
	CC (H) 8	CC(C) 3
	I (H) 0	I(C) 0

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC are in **bold type**

CO-RESEARCHER AB

Co-counselling

Session	Cathartic		Blood Pressure				Pulse Rate			
	Event		pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S	di	dii		
1		SC	159	109	154	105	-5	87	84	-3
2	SC	CC	157	105	153	102	-4	84	81	-3
3	SC (2)		154	107	144	100	-10	81	79	-2
4	SC I	CC	155	107	149	102	-6	87	82	-5
5	SC		149	103	147	99	-2	84	80	-4
6	SC (2)	I	148	100	140	94	-8	83	85	2
7		SC	144	99	139	95	-5	84	78	-6
8	CC	CC	146	100	150	106	4	88	92	4
9	SC I		148	102	140	93	-8	84	77	-7
10		ABSENT								
11	SC (2)		143	96	136	91	-7	80	79	-1
12	SC	SC	136	97	131	90	-5	83	78	-5
13	SC I	CC	135	95	130	90	-5	80	75	-5
14	CC I		135	96	134	88	-1	79	73	-6
15	SC		136	95	133	88	-3	78	74	-4

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC are in **bold type**

Total No.	SC (H)	13	SC (C)	3
	CC (H)	2	CC (C)	4
	I (H)	4	I (C)	1

CO-RESEARCHER MW

Co-counselling Session	Cathartic Event		Blood Pressure				Pulse Rate			
	H	C	pre-C		post-C		pre-C		post-C	
			D	S	D	S	di	dii		
1	CC	CC	120	71	126	77	6	81	84	3
2	SC	CC	123	76	123	77	0	82	80	-2
3	CC		127	79	128	80	1	84	88	4
4		ABSENT								
5		ABSENT								
6		ABSENT								
7	CC	CC	122	81	120	81	-2	89	86	-3
8	CC	SC	125	84	121	80	-4	87	85	-2
9		ABSENT								
10	SC		124	83	120	81	-4	79	77	-2
11	CC	CC	129	76	130	80	1	81	80	-1
12	CC	SC	130	77	127	74	-3	75	72	-3
13		CC	127	74	129	76	2	78	77	-1
14	CC		136	81	135	74	-1	86	81	-5
15		ABSENT								

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff, between pre- & post- cathartic measures of PR
 figures referring to CC are in **bold type**

Total No.	SC (H) 2	SC (C) 2
	CC (H) 7	CC (C) 5
	I (H) 0	I (C) 0

CO-RESEARCHER NW

Co-counselling			Blood Pressure				Pulse Rate			
Session	Cathartic Event		pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S	di	dii		
1		SC	134	94	133	92	-1	-	-	
2		SC	135	96	130	89	-5	86	83	-3
3	CC	SC	134	95	131	87	-3	90	84	-6
4	SC	CC	139	98	129	81	-10	90	81	-9
5	SC (2)	I	136	97	126	80	-10	87	80	-7
6		ABSENT								
7		ABSENT								
8	SC	SC	139	96	138	90	-1	86	83	-3
9	SC	I	135	97	126	84	-9	85	81	-4
10		ABSENT								
11	SC		131	94	125	84	-6	-	-	
12	SC	I	130	92	124	84	-6	84	79	-5
13	SC		130	89	122	85	-8	79	75	-4
14	SC	I	128	88	122	84	-6	78	75	-3
15	SC		123	85	120	79	-3	77	75	-2

pre-C = before catharsis SC = somatic catharsis
post-C = after catharsis CC = cognitive catharsis
D = diastolic B.P. S = systolic B.P.
C = current H = historical
I = insight

di = diff. between pre- & post- cathartic measures of BP(D)
dii = diff. between pre- & post- cathartic measures of PR
figures referring to CC are in **bold type**

Total No.	SC (H)	10	SC (C)	4
	CC (H)	1	CC (C)	2
	I (H)	4	I (C)	0

CO-RESEARCHER EN

Co-counselling Session	Cathartic		Blood Pressure				Pulse Rate			
	Event		pre-C		post-C		pre-C	post-C		
	H	C	D	S	D	S	di	dii		
1		SC	144	98	146	99	2	90	86	-4
2	CC	SC	145	96	149	101	4	-	-	
3	SC		141	95	140	94	-1	-	-	
4	SC (2)		142	97	138	93	-4	87	84	-3
5	SC I		139	96	130	90	-9	88	86	-2
6	SC		138	97	141	99	3	87	95	8
7	SC I		136	95	131	90	-5	80	77	-3
8	SC	CC	-	-	-	-		82	75	-7
9		ABSENT								
10	CC	CC	139	96	148	101	9	76	81	5
11	SC I		138	96	137	97	-1	79	78	-1
12	SC		134	90	132	88	-2	81	73	-8
13		ABSENT								
14		ABSENT								
15	SC I		129	89	122	87	-7	-	-	

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC are in bold type

Total No.	SC (H)	10	SC (C)	2
	CC (H)	2	CC (C)	2
	I (H)	4	I (C)	0

CO-RESEARCHER RB

Co-counselling		Blood Pressure						Pulse Rate	
Session	Cathartic Event		pre-C		post-C		pre-C	post-C	
	H	C	D	S	D	S	di	dii	
1		SC	121	87	123	92	2	-	-
2	CC I	SC	124	88	120	90	-4	-	-
3		SC	126	89	126	92	0	89	91 2
4		SC	125	92	122	90	-3	91	89 -2
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

left the
research group for
personal
reasons

pre-C = before catharsis SC = somatic catharsis
 post-C = after catharsis CC = cognitive catharsis
 D = diastolic B.P. S = systolic B.P.
 C = current H = historical
 I = insight

di = diff. between pre- & post- cathartic measures of BP(D)
 dii = diff. between pre- & post- cathartic measures of PR
 figures referring to CC are in **bold type**

Total No.	SC (H)	0	SC(C)	4
	CC (H)	1	CC(C)	0
	I (H)	0	I(C)	0

APPENDIX SIX

CALIFORNIA PERSONALITY INVENTORY

SCALE DESCRIPTIONS, PROFILE SHEETS & RESULTS

CALIFORNIA PERSONALITY INVENTORY - SCALE DESCRIPTIONS

Class 1. Measures of Poise, Ascendency, & Self-Assurance

1. **Dominance**
Do To assess factors of leadership ability, dominance, persistence, and social initiative. HIGH SCORERS: aggressive, confident, out-going, planful, having initiative; verbally fluent, self-reliant. LOW SCORERS: retiring, inhibited, commonplace, indifferent, silent; lacking in self-confidence.
2. **Capacity for Status**
Cs To serve as an individual's capacity for status. The scale attempts to measure the personality qualities and attributes which underlie and lead to status. HIGH SCORERS: active, ambitious, forceful, insightful; effective in communication; LOW SCORERS: apathetic, shy, dull, simple; restricted in outlook and interests.
3. **Sociability**
Sy To identify persons of outgoing, social, participative temperament. HIGH SCORERS: confident, enterprising, outgoing, original & fluent in thought; LOW SCORERS: awkward, conventional, quiet, submissive; suggestible.
4. **Social Presence**
Sp To assess factors such as poise, spontaneity, & self-confidence in personal & social interaction. HIGH SCORERS: clever, enthusiastic, imaginative, quick, informed, expressive; LOW SCORERS: deliberate, moderate, patient, self-restrained; unoriginal in thinking.
5. **Self-Acceptance**
Sa To assess factors such as a sense of personal worth, self-acceptance, and capacity for independent thinking and action
6. **Sense of Well-Being**
Wb To identify persons who minimize their worries & complaints, & who are relatively free from self-doubt & disillusionment.

CLASS 11. Measures of Socialization, Maturity & Responsibility

7. Responsibility To identify persons of conscientious, responsible, & dependable temperament & disposition
Re
8. Socialization To indicate the degree of social maturity, probity, & rectitude which the individual has attained.
So
9. Self-Control To assess the degree & adequacy of self-regulation & self-control & freedom from impulsivity & self-centredness,
Sc
10. Tolerance To identify persons with permissive, accepting, and non-judgemental social beliefs & attitudes.
To
11. Good Impression To identify persons capable of creating a favourable impression, & are concerned about how others react to them.
Gi
12. Commonality To indicate the degree to which an individual's reactions & responses correspond to the modal ("common") pattern established for the inventory
Cm

CLASS 111. Measures of Achievement Potential & Intellectual Efficiency

13. Achievement via conformance To identify those factors of interest & motivation which facilitate achievement in any setting where conformance is a positive behaviour. HIGH SCORERS: capable, cooperative, organized, responsible, stable, & sincere; persistent & industrious; valuing intellectual activity & achievement. LOW SCORERS: coarse, stubborn, awkward insecure, & opinionated; easily disorganized under stress or pressures to conform; pessimistic about their occupational futures.
Ac
14. Achievement via independence To identify those factors of interest & motivation which facilitate achievement in any setting where autonomy & independence are positive behaviours. HIGH SCORERS: mature, forceful, dominant, demanding, & foresighted; independent & self-reliant; having superior intellectual ability & judgment. LOW SCORERS: inhibited, anxious, cautious, dissatisfied, dull; submissive &
Ai

compliant before authority; lacking in self-insight & self-understanding.

15. **Intellectual efficiency**
Ie
- To indicate the degree of personal & intellectual efficiency which the individual has attained. HIGH SCORERS: efficient, clear-thinking, intelligent, progressive, thorough & resourceful; alert & well-informed; placing a high value on intellectual matters. LOW SCORERS: confused, cautious, easygoing, defensive, shallow & unambitious; conventional & stereotyped in thinking; lacking in self-direction & self-discipline.

CLASS IV. Measures of Intellectual & Interest Modes

16. **Psychological mindedness**
Py
- To measure the degree to which the person is interested in, and responsive to, the inner needs, motives, & experiences of others. HIGH SCORERS: outgoing, spontaneous, quick, resourceful, changeable; verbally fluent & socially ascendant; rebellious towards rules, restrictions & constraints. LOW SCORERS: apathetic, serious & unassuming; slow & deliberate in tempo; overly conforming & conventional.

17. **Flexibility**
Fx
- To indicate the degree of flexibility & adaptability of a person's thinking & social behaviour. HIGH SCORERS: insightful, informal, adventurous, humorous, rebellious, idealistic, assertive, & egotistic; sarcastic & cynical; concerned with personal pleasure & diversion. LOW SCORERS: deliberate, worrying, industrious, guarded, mannerly, methodical, & rigid; formal & pedantic in thought; differential to authority, custom & tradition.

18. **Femininity**
Fe
- To assess the masculinity or femininity of interests. (High scores indicate more feminine interests, low scores more masculine). HIGH SCORERS: appreciative, patient, helpful, gentle, moderate, persevering, & sincere; respectful & accepting of others; behaving in a conscientious & sympathetic way. LOW SCORERS: hard-headed, ambitious, masculine, active, robust, & restless; manipulative & opportunistic in dealing with others; blunt & direct in thinking &

Femininity
Fe
(cont.)

action; impatient with delay, indecision
& reflection.

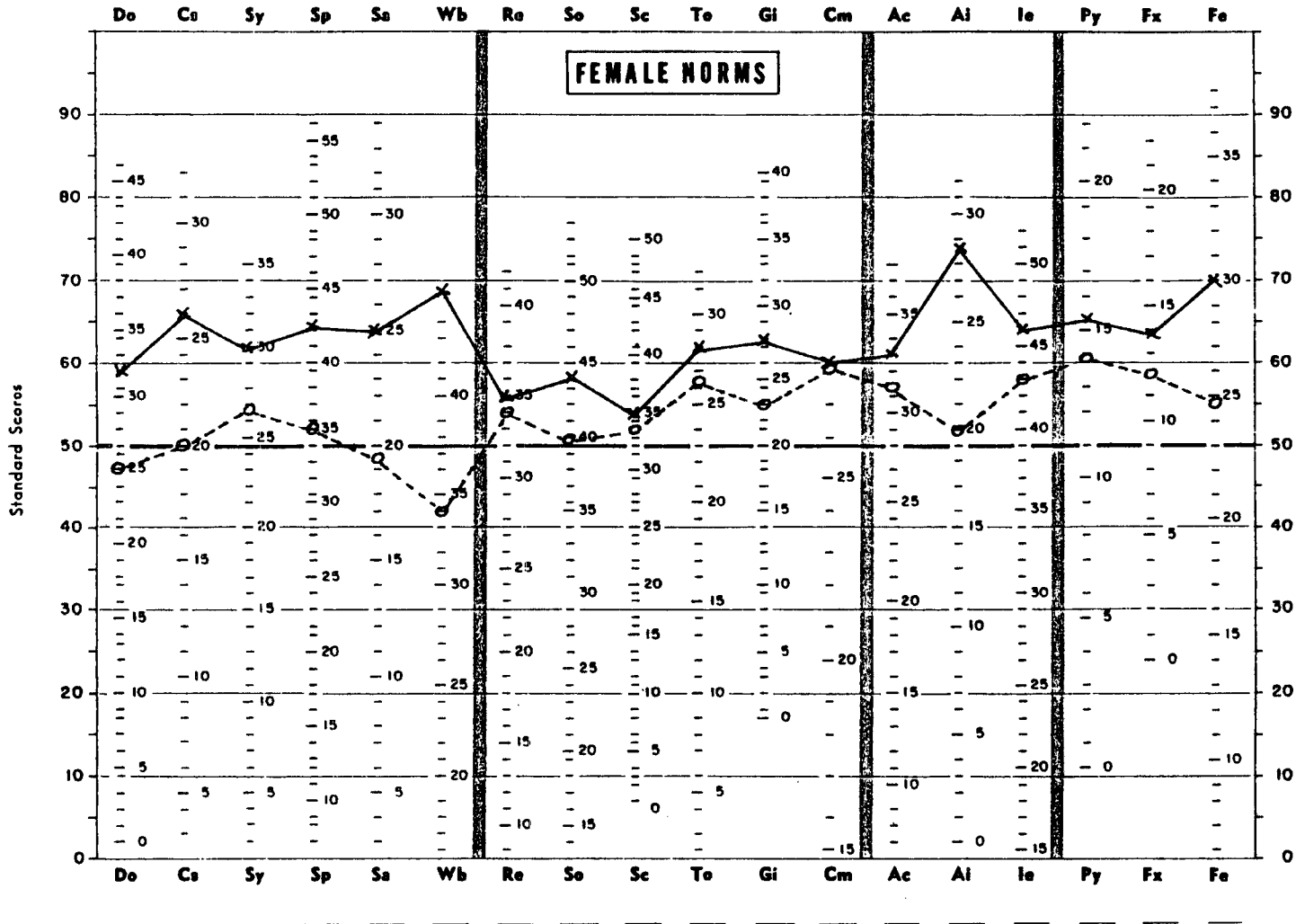
PROFILE SHEET FOR THE *California Psychological Inventory*: FEMALE

Name SB

Age _____ Date Tested _____

Other Information _____

Notes:



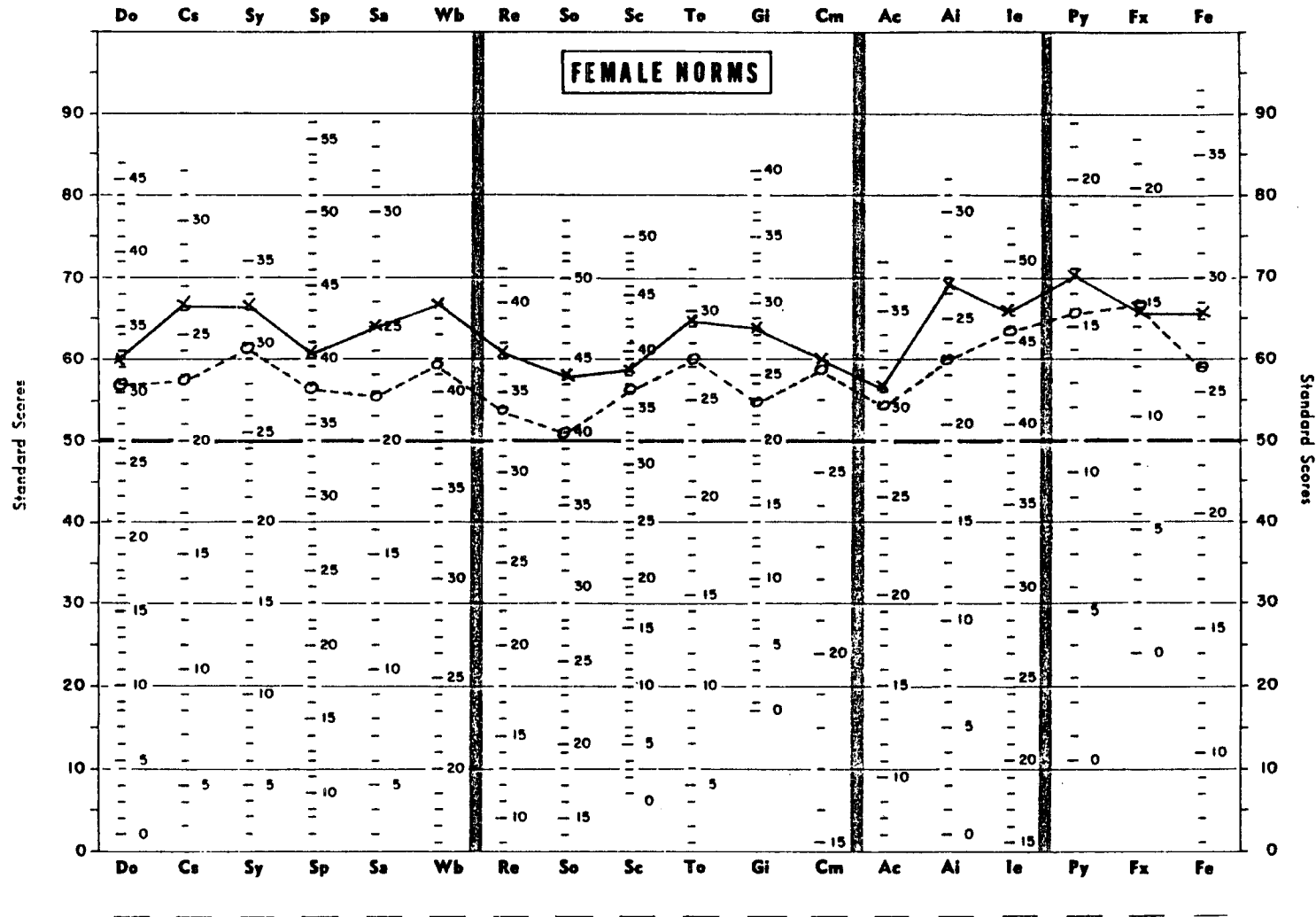
Female Norms

PROFILE SHEET FOR THE *California Psychological Inventory*: FEMALE

Name F1 Age _____ Date Tested _____

Other Information _____

Notes:



x — x post-
o - - o pre-

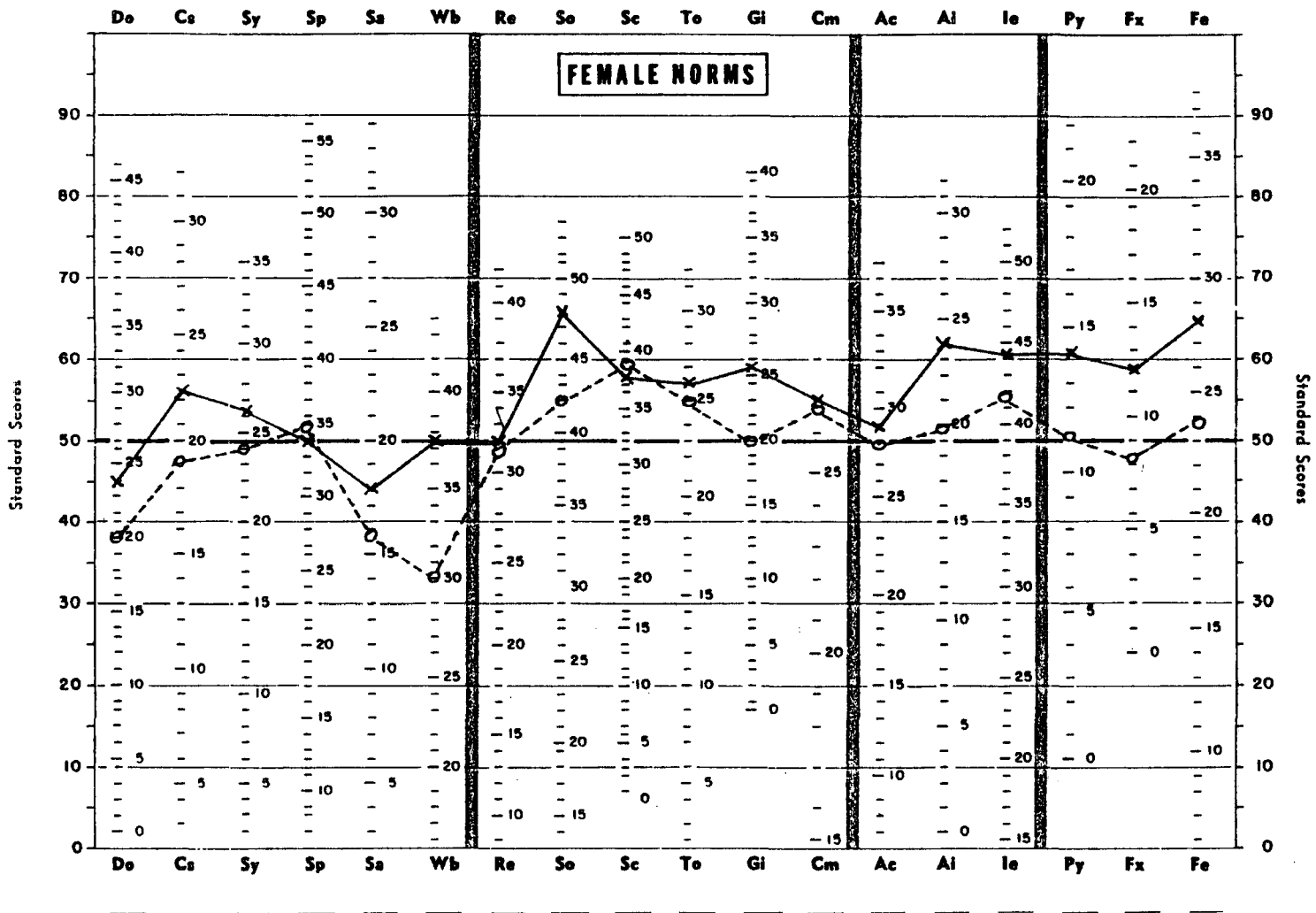
Female Norms

PROFILE SHEET FOR THE *California Psychological Inventory*: FEMALE

Name EN Age _____ Date Tested _____

Other Information _____

Notes:



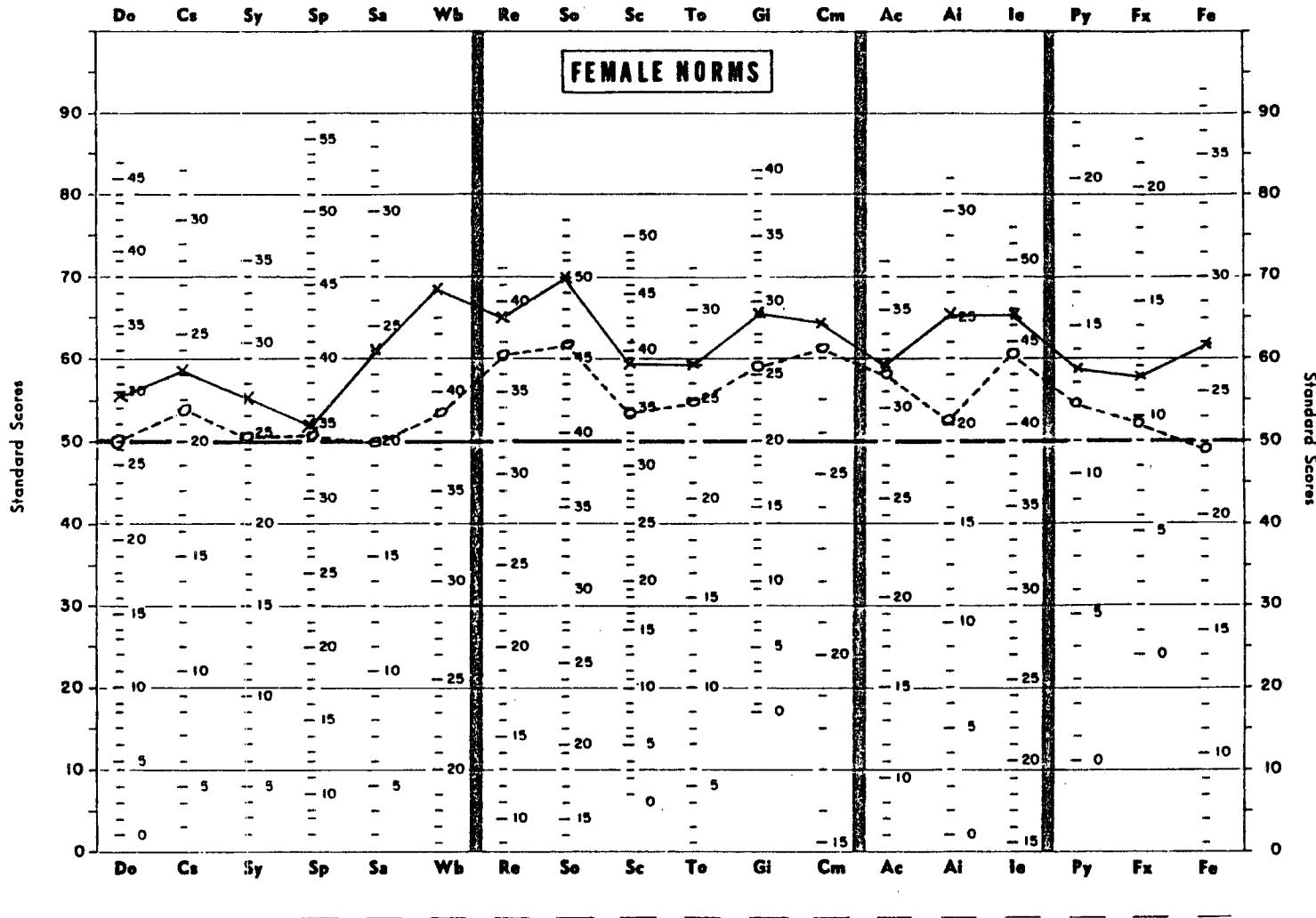
x — x post-
o - - - o pre-

PROFILE SHEET FOR THE *California Psychological Inventory*: FEMALE

Name NW Age _____ Date Tested _____

Other Information _____

Notes:



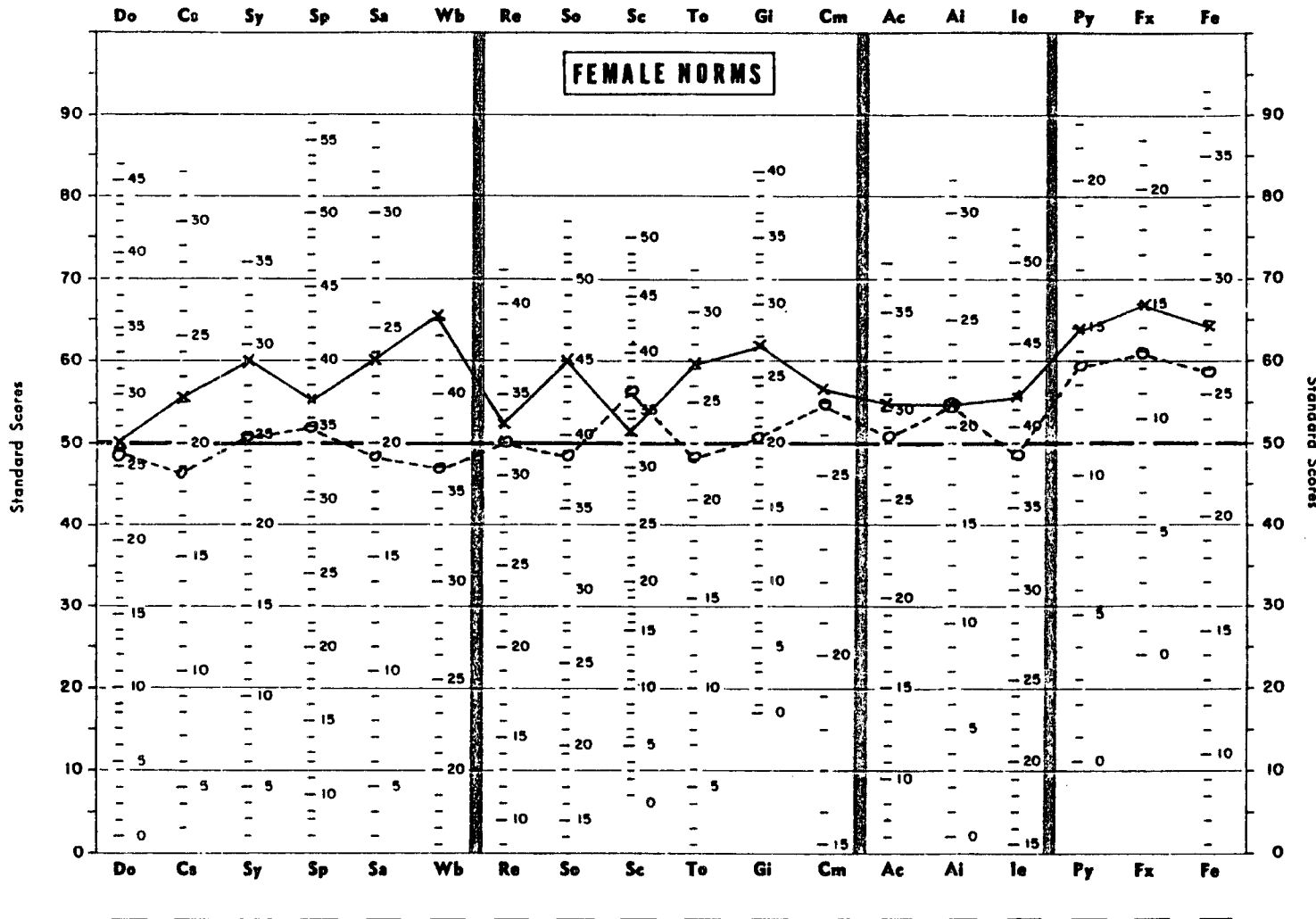
x — x post-
o - - o pre-

PROFILE SHEET FOR THE *California Psychological Inventory*: FEMALE

Name AB Age _____ Date Tested _____

Other Information _____

Notes:



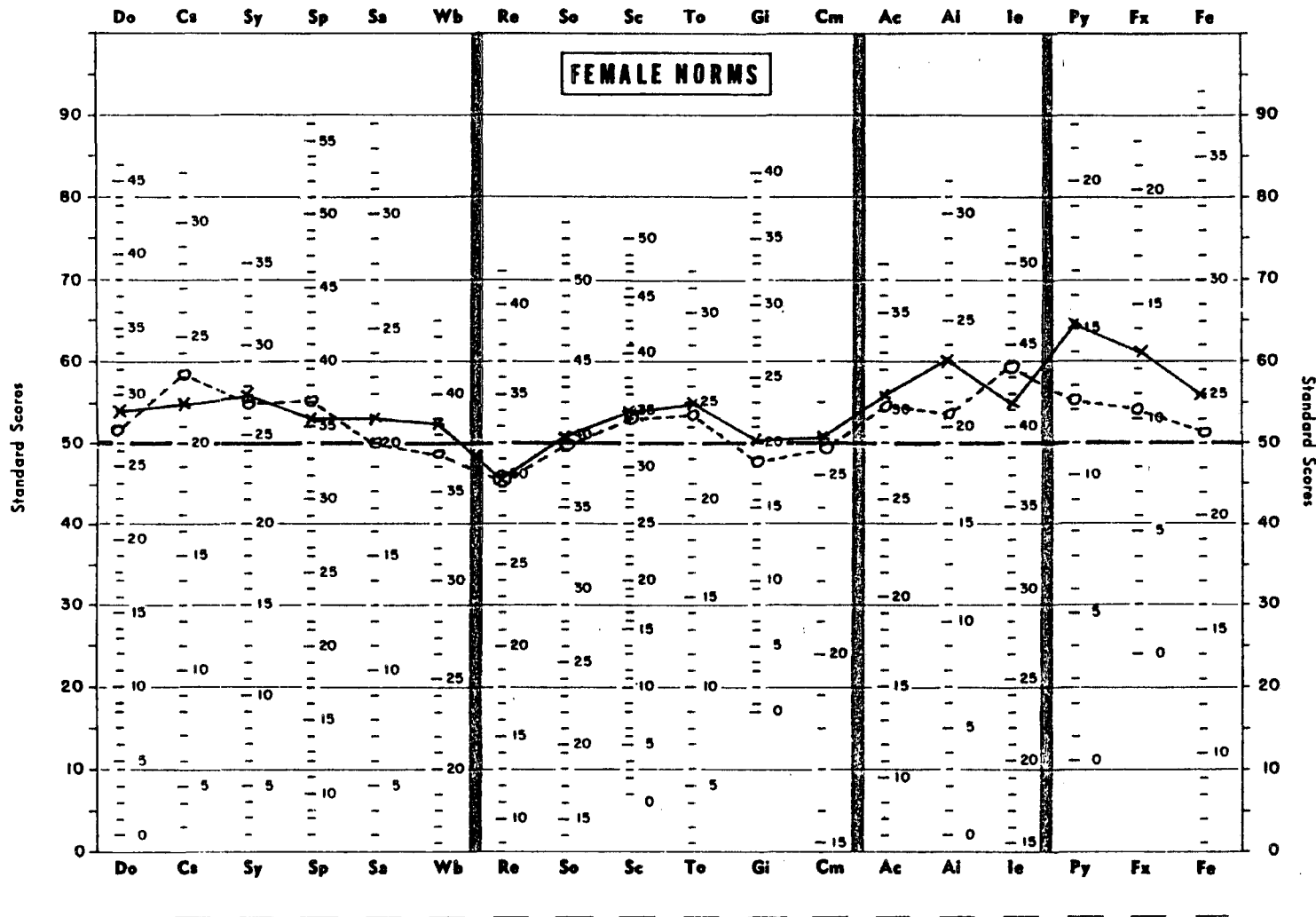
Female Norms

PROFILE SHEET FOR THE *California Psychological Inventory*: FEMALE

Name AS Age _____ Date Tested _____

Other Information _____

Notes:



x — post-
o - - - pre-

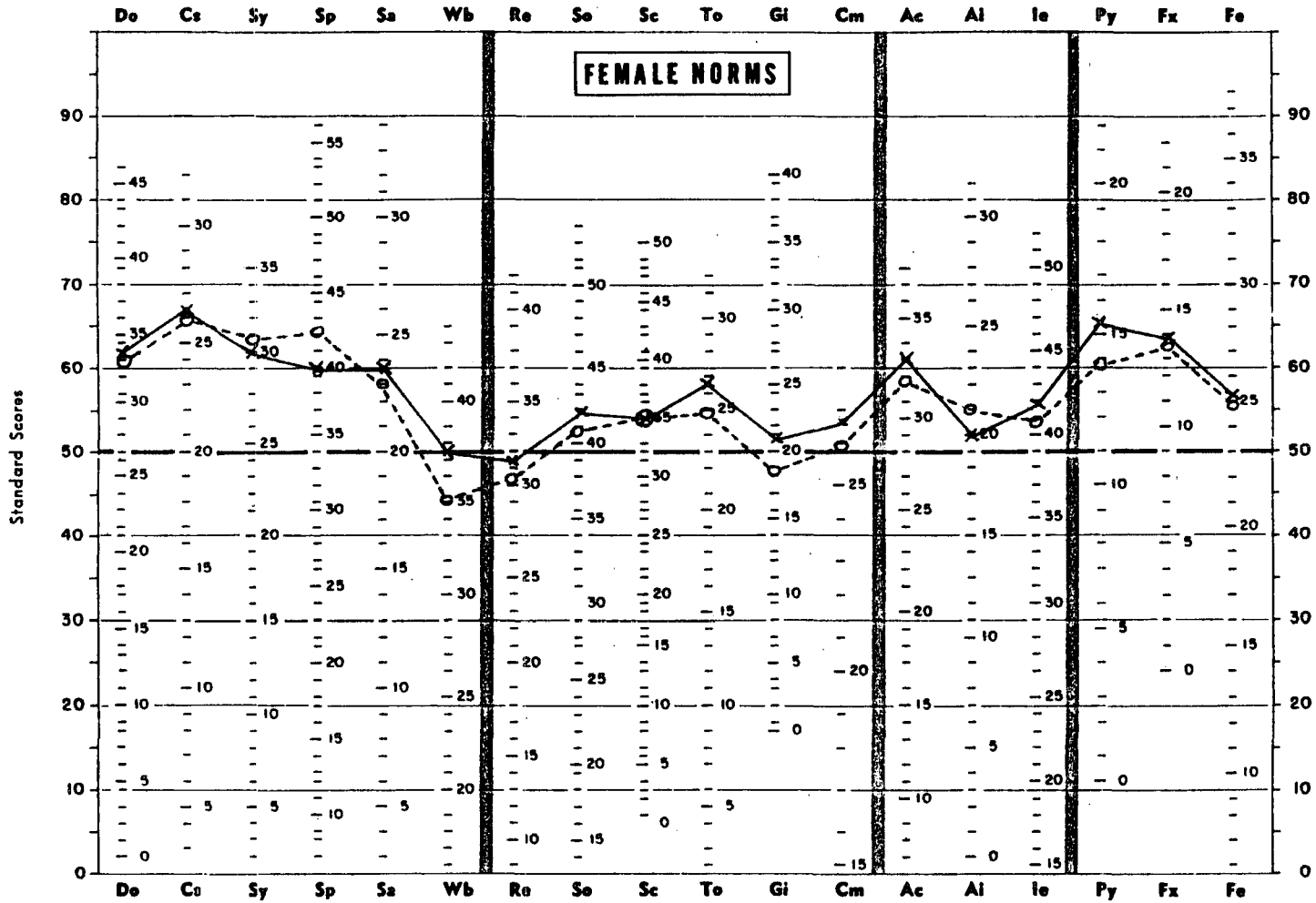
Female Norms

PROFILE SHEET FOR THE *California Psychological Inventory*: FEMALE

Name MW Age _____ Date Tested _____

Other Information _____

Notes:



x — post-
o — pre-

PROFILE SHEET FOR THE *California Psychological Inventory*: MALE

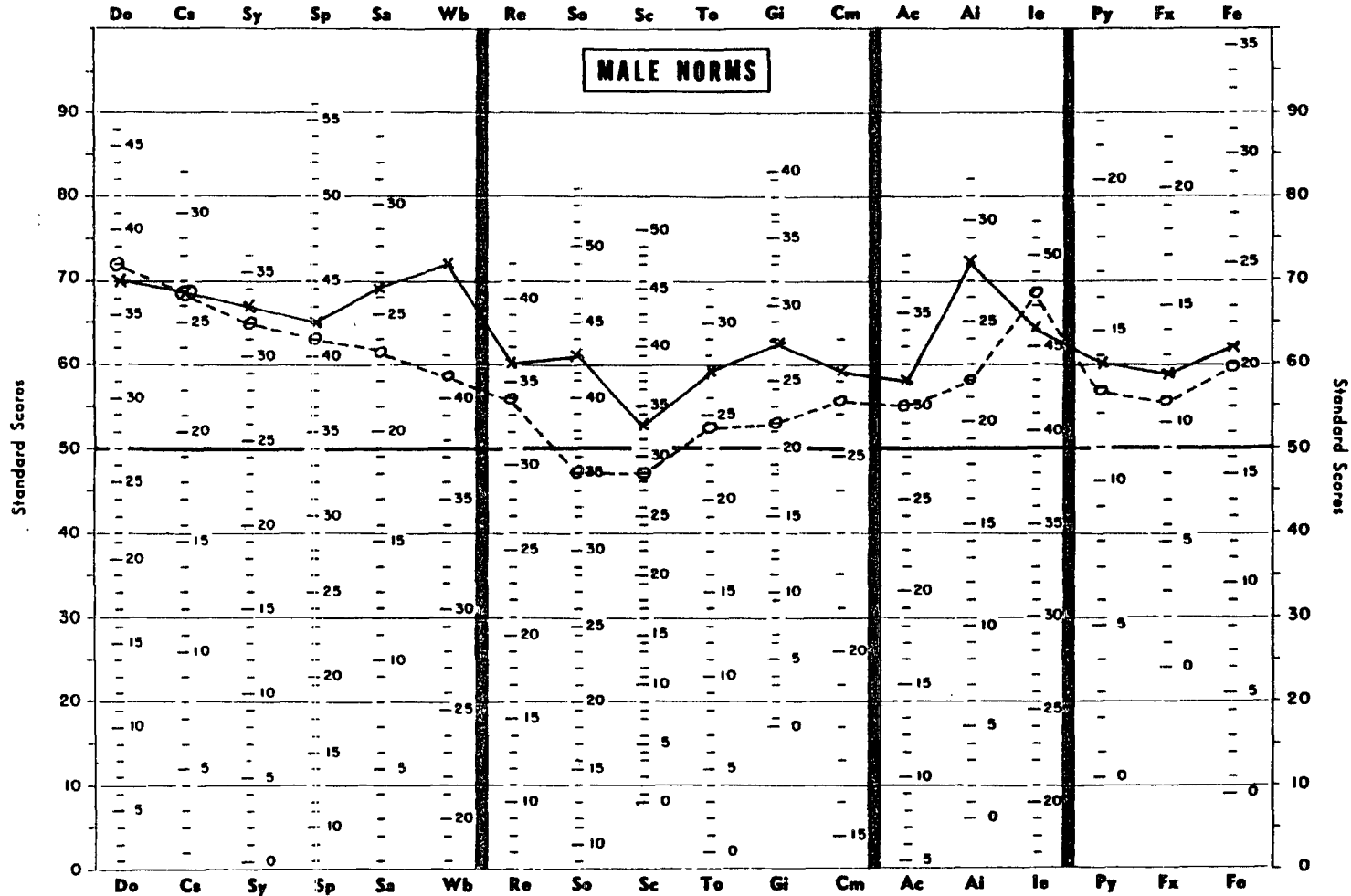
Name JH

Age _____

Date Tested _____

Other Information _____

Notes:



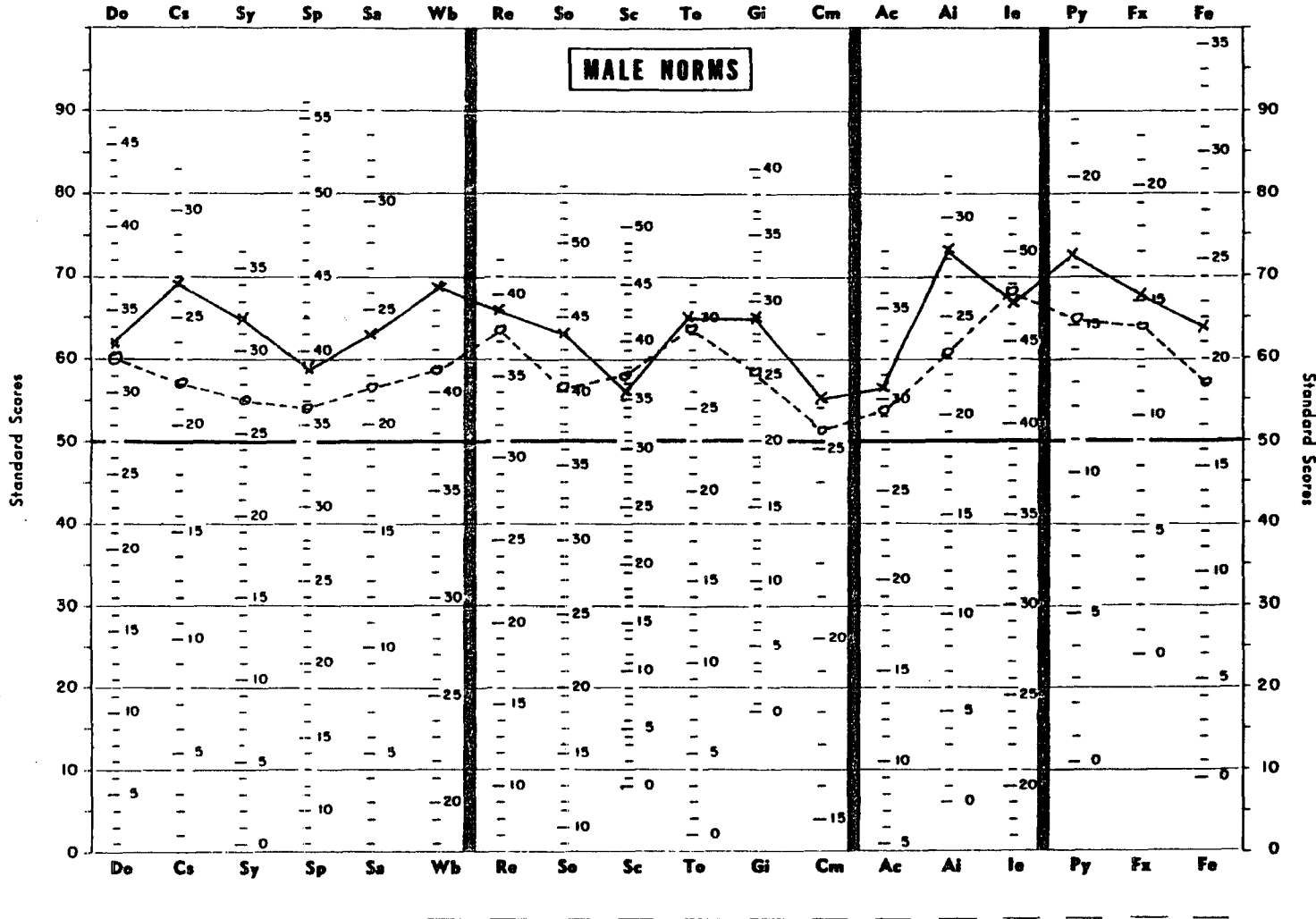
x — x post-
o - - o pre-

PROFILE SHEET FOR THE *California Psychological Inventory: MALE*

Name PH Age _____ Date Tested _____

Other Information _____

Notes:



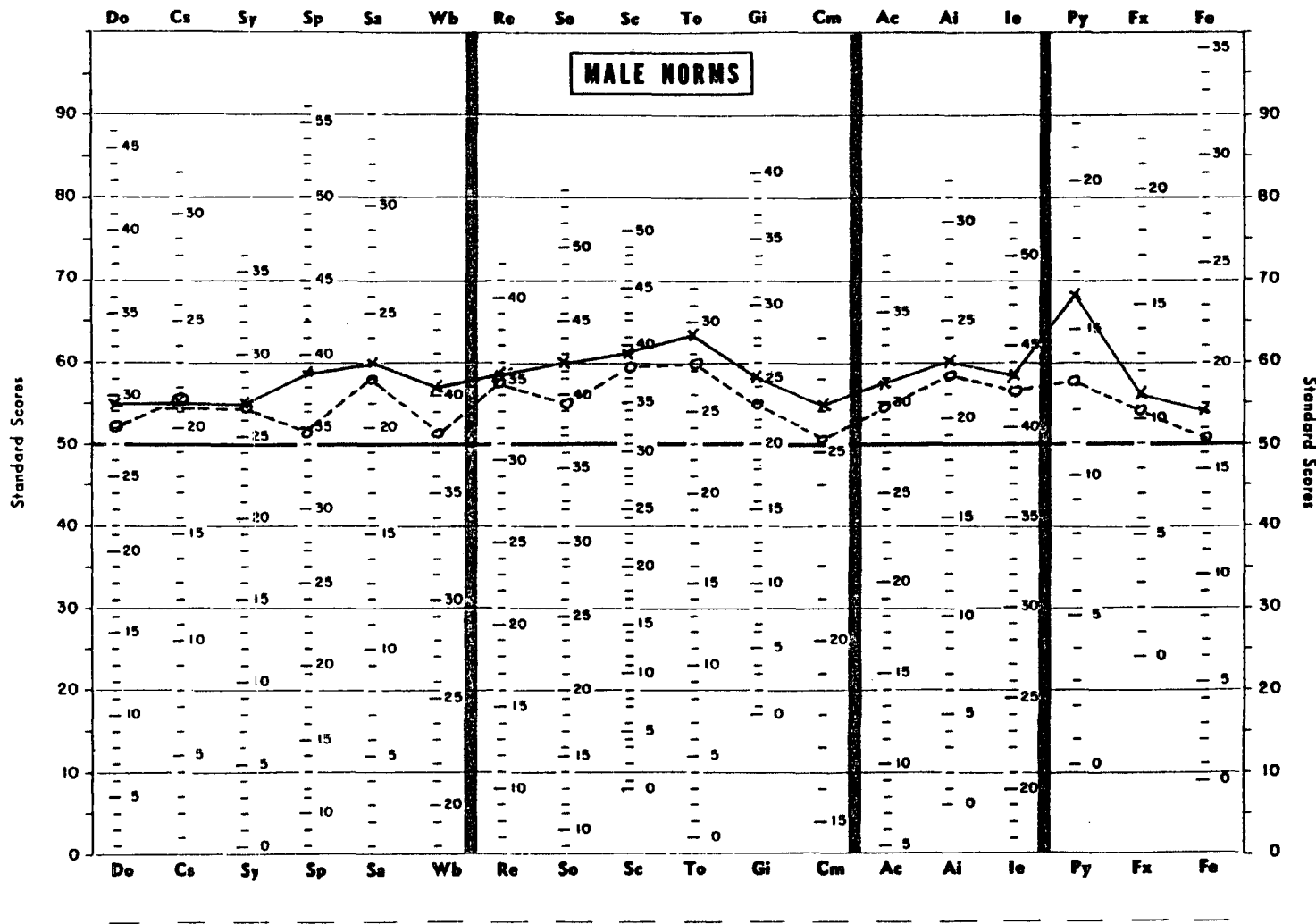
x — x post-
o - - - o pre-

PROFILE SHEET FOR THE *California Psychological Inventory: MALE*

Name JS Age _____ Date Tested _____

Other Information _____

Notes:



x — x post -
o - - - o pre -

Standard Scores obtained on the CPI with respect to
Pre- & Post- Inquiry Measures

<u>Scale</u>	<u>PH</u>	<u>FI</u>	<u>SB</u>	<u>JH</u>	<u>AS</u>	<u>JS</u>	<u>AB</u>	<u>MW</u>	<u>NW</u>	<u>EN</u>	<u>RB</u>
Do	60	58	45	71	52	52	49	61	50	39	48
Cs	58	58	50	69	58	56	47	65	53	48	54
Sy	55	61	53	66	55	54	51	63	50	49	52
Sp	54	57	52	63	55	51	52	64	51	52	53
Sa	56	56	49	62	50	57	49	58	50	38	49
Wb	58	59	42	58	49	52	48	45	54	34	48
Re	63	55	54	56	46	58	50	48	60	49	55
So	57	51	50	48	51	56	49	52	61	55	57
Sc	58	56	52	48	53	59	55	56	53	59	52
To	63	60	58	53	53	60	49	56	55	55	49
Gi	58	56	56	53	48	54	51	48	59	50	53
Cm	51	58	59	57	49	51	56	50	62	55	54
Ac	54	54	58	55	55	53	52	58	59	49	50
Ai	61	60	52	58	53	57	56	56	52	52	60
Ie	68	63	58	69	59	56	49	53	60	56	60
Py	66	65	61	58	55	57	59	60	54	52	58
Fx	65	66	59	56	54	53	61	62	52	49	57
Fe	58	59	55	60	52	51	58	55	49	52	54

<u>Scale</u>	<u>PH</u>	<u>FI</u>	<u>SB</u>	<u>JH</u>	<u>AS</u>	<u>JS</u>	<u>AB</u>	<u>MW</u>	<u>NW</u>	<u>EN</u>
Do	61	60	59	70	54	55	50	61	55	45
Cs	70	66	66	68	55	55	56	66	57	55
Sy	66	67	62	67	56	54	60	62	56	53
Sp	59	60	65	66	52	58	56	60	52	50
Sa	62	63	65	69	52	59	59	60	62	43
Wb	68	67	69	73	52	57	65	49	69	50
Re	67	61	56	60	46	57	52	49	64	50
So	62	58	59	61	52	59	59	55	70	66
Sc	56	58	53	52	54	61	52	54	59	58
To	64	64	62	59	55	63	59	58	59	57
Gi	65	65	62	62	50	58	62	52	66	59
Cm	55	60	59	59	51	53	57	53	64	56
Ac	56	56	61	58	56	57	54	61	59	51
Ai	73	69	72	72	60	59	54	52	66	62
Ie	67	64	62	65	54	57	54	54	66	61
Py	73	70	66	60	64	68	63	66	59	61
Fx	68	67	63	58	61	56	66	63	58	58
Fe	64	66	70	61	55	53	64	56	56	64

APPENDIX SEVEN
PERSONAL REPORTS

Report on Catharsis Research Group - B.L.

Concerning benefits, I have found that through participation in the group I have more of an idea of my emotional problems. What I have found particularly encouraging is that the practice of some of the techniques adopted by the group has given me some hope and confidence with regards confronting unpleasant situations in the future.

I have a few criticisms of what has gone on so far. Firstly, the amount of time, two hours or so, once a week seems inadequate for making real progress. Secondly, the sessions are slow to get started. Perhaps too much time is spent on preamble. Thirdly, the group has not taken full advantage of the flexible nature of the sessions (see suggestions). Fourthly, the aims and purpose of the group have not been made all that clear.

There are a few suggestions I have to make:

(i) more use could be made of our weekly records, concerning what's been going on with our bodies and minds. Perhaps we could discuss a particular thing that has suddenly cropped up or elaborate on an insight into a particular problem;

(ii) incorporating *ad hoc* techniques into the group may work well. By this I mean, if one of us gets a bright idea we should try it out straight away;

(iii) using our imaginations in a creative sense. For instance, using painting as a form of expression of a

cerain emotion. Also we could do plays, that is little scenes, reenacting a past unpleasant time in our lives;

(iv) using non-verbal communication more. Perhaps spending a whole session communicating wholly by signs and gestures.

In short I feel that if it is possible, we should increase the length of the sessions, say, by an hour per week, that the sessions should make use of the flexibility available, and that the aims of the research should be clearly stated.

B.S. 13/12/81

Report on Group - Co-Researcher JP

Given the limited number of sessions the group met it was inevitable that the therapy did not help me come to terms with deep rooted problems and fears, which would have required a more substantial "working through". Nevertheless, I recognized the potential of this particular therapeutic environment for personal and social growth.

The most valuable aspect of the therapy for me was the group setting. Instead of being self-absorbed with my own problems I began to focus on other peoples. This was difficult at first because I needed to vent my problems - they were the most important, yet, listening to others express their particular experiences, both verbally and emotionally, I found I was able to relate to them, despite the different nature of their conflicts. This helped me see my own problems in a wider perspective and it "brought it home" to me how we are all screwed up about something. I suppose in an egoistic way I derived some comfort from this insight. I wasn't so odd after all.

However, it wasn't just identification with other peoples feelings but the whole atmosphere generated within the group that I found most rewarding. The therapy practiced encouraged people to be open and spontaneous, to express their deepest feelings and fears, this in turn helped me, not just to listen, but to share those feelings - to feel closer. I felt a warmth towards the group members which seemed natural and good. However, I must add that

this experience was confined to the therapy experience and did not "spill over" into everyday life. Nor did it appear to with the rest of the group, though they too spoke of the warmth conveyed. I suppose this indicates how repressed our true nature is. Nevertheless I did experience a more positive attitude to certain group members to whom I had previously been somewhat negative or indifferent.

It is my opinion that had the therapy sessions continued members of the group could have helped and learned from each others experience - we could all have been "therapist". Instead, Peter had to take a dominant role in guiding the sessions. As a woman, thoroughly socialised in gender norms, I liked the presence of a male leader and would have felt uneasy relating to a woman. This, however, is where the therapy, with its emphasis on co-counselling rather than an authoritative figure-head (usually male) has a great relevance in breaking down gender role barriers and dependencies. Certainly, I feel a closer relationship with my peers which could have provided the opportunity to develop a more positive attitude towards women in particular.

With regard to the physical contact encouraged during the sessions I felt a certain unease. This was not due to fear or dislike of being touched by members of either sex - quite the reverse, I found this pleasureable. My unease arose because the physical contact appeared as a technique directed by the "therapist" rather than a genuine spontaneous act expressed by the group. However, since

physical contact in a non-sexual way is not encouraged in society I couldn't really expect spontaneity at first. Again this aspect of the therapy has the potential for breaking down inhibitions. Personally it has helped me to demonstrate my feelings towards those close to me, and one can only assume that this could have been enhanced further.

In sum, after overcoming the initial anxiety (I felt apprehensive speaking in front of the group). I have enjoyed the therapy sessions, despite the uncomfortable emotions that were aroused. To me the therapy seemed to offer a way forward to self-enhancement and in particular to improving interpersonal relationships. Yet, in many ways because the behaviour in the therapy is different to our "normal" behaviour in society, and because disturbing emotions are raised problems seem to arise - Firstly, in retaining the group's commitment and support; secondly in overcoming the novelty and developing the experiences in the therapy into life experiences.

Report on Group - Co-Researcher AS

I feel that I have become more emotionally aware and better able to look at aspects of my personality & emotional life which were, in the past, shrouded in guilt, fear, and confusion. Emotions buried long ago, repressed feelings and hurts have been relived in a way that produces a sense of immediacy & has enabled me to things now that I didn't in the past, and to lay ghosts to rest - an utterly liberating if exhausting experience! The effectiveness of the techniques used amazed, and at times appalled me - being a well-defended person with the ability to use intellect and verbal ability to protect myself the application of non-verbal techniques had a profound and stunning effect. Insights about myself and my relationships with others, the exploration of my relationship with my parents & the effect on me of their expectations and interpersonal relationship was a revealing experience. I have discovered a new access to my emotions and new acceptance of myself with greater emotional space and courage to look at previously taboo or hidden areas. The therapy has enabled me to grow as a person, to be more effective in my relationships & more aware of my own needs. It has enabled me to give myself permission to work towards self-fulfilment. It has been a revelation just how much was going on in me that I wasn't aware of & how much of my negative feeling was inappropriate and carried over. Curiously my defence mechanisms in the past have been used

to maintain the status quo - the effect of the therapy techniques was at first very frightening, the experience is now very rewarding.

The Journey To ME (SB)

I cry a lot more,
I laugh a lot more,
I feel a lot more,
I am more aware
Of what is going on within me
And around me.

I know more about why I do some things
And perhaps more importantly
Why i don't do some things.
I am a different person to who I was one year ago
And to who I was two years ago.
Primal therapy has directed and shaped and
Influenced that change.
No longer can I accept what happens
To be what it appears.

I am more caring
I am more understanding
I am more tolerant
I am less well defended
I get hurt more often
I get loved more often
A can touch and be touched
I can hold and be held.

I know more about why but

Not all about why.

I will learn until i die.

i now feel closer to being

ME as I was conceived than

I have ever felt in my entire life.

(SB)

Co-Researcher - BS

The group was beneficial as a whole. It helped me to gain insight into my problems by listening to other people's similar experiences. The relaxed atmosphere helped to break down inhibitions by the help and support of others who I came to trust by the nature of the honest and open approach adopted.

No one was coerced to do anything within the group but on the other hand they did not have complete control over themselves, as in observing others, it may often result in the triggering of spontaneous emotional activity.

As I have regular contact with some members of the group I have noted some definite changes in attitude following the sessions, but I don't feel that they are all positive changes, and thus I suggest that it may be better to leave some people unaware.

Overall, the group facilitated a greater self-awareness by allowing greater self-knowledge which in turn encourages a deeper understanding of others. The group provided warmth and support and allowed free expression of many things that would normally be repressed, and thus enhanced growth.

Report on Group - Co-Researcher AW

More assertive, not frightened of the future, enjoy being alone, identify my feelings and enjoy them at the time. Ability to change bad feelings into good feelings. More confident. Willing to take risks. A deeper knowledge of myself. An enjoyment of the way I am. I live in this society but I don't have to conform to it. An overall sense of well-being. An understanding of my feelings which results in the ability to deal positively and constructively with my own life, both present and future.

Able to live for the moment and enjoy those feelings at the time.

Positive and confident outlook on the future.

Not being frightened to do what I want. More decisive.

Less shyness in stating my abilities and exercising them.

Generally less embarrassed with people.

A sort of feeling of being "set free".

The choice of doing my own thing and putting it into practice.

A new appreciation of things around me.

An alertness about the "now".

Less anxious.

More willing to trust people and get involved in relationships.

An awareness of the distresses of others.

REFERENCES

- Adzema, M. V. (1985). A primal perspective on spirituality. *Journal of Humanistic Psychology*, 25, 3, 83-116.
- Albery, N. (1985). *How to feel reborn?* London: Regeneration Press.
- Albery, N. (1985). Rebirthing: The Primal Context. *Self & Society*, XIII, 1, 14-29.
- Albery, N. (1985). An interview with Janov. *Self & Society, The European Journal of Humanistic Psychology*. Vol. XIII, No. 4. pp. 168-183.
- Alexander, F. (1950). *Psychosomatic medicine: Its principles and applications*. N.Y.: W.W. Norton & Co.
- Alexander, F. M. (1969). *Resurrection of the body*. University Books.
- Alexander, F. & French, T. (1946). *Psychoanalytic Therapy: Principles and Applications*. N.Y.: Ronald Press.
- Allen, J. A. (1972). Adaptive function of affect in interpersonal interactions. Unpublished Doctoral Thesis. University of Rochester. Referred to in Nichols, M. P. (1974). op cit.
- Aristotle. (1968). *Poetics*. D.W. Lucas (ed.). Oxford: Clarendon Press.
- Assagioli, R. (1975). *Psychosynthesis*. London: Turnstone Press.
- Atkins, A., Hilton, J., Neigher, W. & Bahr, A. (1972). Anger, fight, fantasy, and catharsis. Referred to in M. B. Quanty, 1976, (op cit).
- Back, K. W. (1972). *Beyond words: The story of sensitivity training and the encounter movement*. N.Y.: Russell Sage.
- Bach, G. R. (1974). Constructive aggression in growth groups. In A. Jacobs & W. W. Spraden (Eds.) *The group as agent of change*. N.Y., Behavioural Publications.
- Baker, E. (1967). *Man in a Trap*. N.Y.: Macmillan.
- Balint, M. (1968). *The basic fault: therapeutic aspects of regression*. Tavistock.
- Bandura, A. (1973). *Aggression: A social learning analysis*. Prentice-Hall.
- Bandler, R. & Grinder, J. (1979). *Frogs into Princes: Neuro Linguistic Programming*. Real People Press.

- Barnes, B. (1983). Doubts and certainties in practising psychotherapy. In D. Pilgrim (ed.), *Psychology and psychotherapy*. Routledge & Kegan Paul. 1983.
- Barrett, C. L. (1969). Systematic desensitization versus implosive therapy. *Journal of Abnormal Psychology*, 74, 587-592.
- Bastiaans, J. (1969). The role of aggression in the genesis of psychosomatic disease. *Journal of Psychosomatic Research*, 13, 307-314.
- Bauer, G.P. & Kobos, J.C. (1984). Short-term psychodynamic psychotherapy: reflections on the past and current practice. *Psychotherapy*, 21, 2.
- Bean, D. (1971). *Me and the orgone*. N.Y.: St. Martin's Press.
- Beattie, J. (1963). "Sorcery in Bunyoro." in J. Middleton & E. H. Winter (eds). *Witchcraft and Sorcery in East Africa*. N. Y.: Frederick A. Praeger. pp. 27-55.
- Bebout, J., & Gordon, B. (1972). The value of encounter. In L. N. Solomon & B. Berzon (Eds.) *New perspectives on encounter groups*. Jossey-Bass.
- Benne, K. D. et al., (Eds.). (1975) *The laboratory method of changing and learning: theory and application*. Calif: Science & Behaviour Books.
- Bergin, A.E. & Strupp, H.H. (1972). *Changing frontiers in the science of psychotherapy*. Chicago: Aldine-Atherton.
- Berkowitz, L. (1966). On not being able to aggress. *British Journal of Personality and Social Psychology*, 5, 130-139.
- Berkowitz, L. (1970). Aggressive humor as a stimulus to aggressive responses. *Journal of Personality and Social Psychology*, 16, 710-719.
- Berkowitz, L. (1973). The case for bottling up rage. *Psychology Today*, 7, 2, 24-31.
- Bibring, E. (1954). Psychoanalysis and the dynamic psychotherapies. *Journal of the American Psychoanalytic Association*, 2, 745-770.
- Bierenbaum, H., Nichols, M.P. & Schwartz, A. (1976). Effects of varying session length & frequency in brief emotive psychotherapy. *Journal of Consulting & Clinical Psychology*, 44, 790-798.

- Binder, J. (1975). **The discovery of personness: the assessment of feeling-expressiveness.** Doctoral dissertation, University of California, Irvine.
- Binstock, W.A. (1973). Purgation through pity and terror. *International Journal of Psychoanalysis*, 54, 483-504.
- Bion, W. R. (1961). **Experience in groups.** London: Tavistock.
- Bion, W. R. (1968). **Experiences in groups, and other papers.** London: Tavistock Publications.
- Blumberg, E. M. (1954). Results of psychological testing of cancer patients. In J. A. Gengerelli, & F. J. Kirkner (Eds.), **Psychological variables in human cancer.** University of California Press.
- Blumberg, E. M., West, P. M., & Ellis, F. W. (1954). A possible relationship between psychological factors and human cancer. *Psychosomatic Medicine*, 16, (4), 276-286.
- Bohart, A. (1977). Roleplaying and interpersonal conflict resolution. *Journal of Counselling Psychology*, 24, 15-24.
- Bohart, A., & Haskell, R. (1978). The ineffectiveness of a cathartic procedure for anger reduction. Referred to in A. Bohart (1980). op cit.
- Bohart, A. (1980). Toward a cognitive theory of catharsis. *Psychotherapy: Theory, Research and Practice*, 17, (2), 192-201.
- Booth, G. (1964). Cancer and culture: Psychological disposition and environment (A Rorschach study). Unpublished. Reported in Cooper, G. (Ed.) **Stress Research: Issues for the Eighties.** John Wiley. 1983.
- Borkovec, T. D. (1972). Effects of expectancy on the outcome of systematic desensitization and implosive treatments of analogue anxiety. *Behaviour Therapy*, 3, 29-40.
- Boulougouris, J. C., Marks, I. M., & Maset, P. (1971). Superiority of flooding (implosion) to desensitization for reducing pathological fear. *Behaviour Research and Therapy*, 9, 7-16.
- Bowlby, J. (1951). **Maternal care and mental health.** Geneva: WHO; London, HMSO. Abridged version, **Child care and the growth of love.** Harmondsworth, Middx.: Penguin Books, (2nd. Ed.), 1965.

- Bowlby, J. (1979). **The making and breaking of affectional bonds.** London: Tavistock.
- Bowlby, J. (1981). **Attachment and loss, Vol. 111.** Harmondsworth, Penguin.
- Breuer, J. & Freud, S. (1895, 1974). **Studies on hysteria.** Penguin Books.
- Broder, M.S. (1976). An eclectic approach to primal integration. **Primal Integration Monographs, Vol. 1, No. 1.**
- Brown, W. (1920). The revival of emotional memories and its therapeutic value. **British Journal of Medical Psychology, 1, 16-19.**
- Bugen, L. A. (1977). Human grief: A model for prediction and intervention. **American Journal of Orthopsychiatry, 47, 196-206.**
- Bugental, J.F.T. (1978). **Psychotherapy and process: The fundamentals of an existential-humanistic approach.** Reading, MA: Addison-Wesley.
- Cartwright, D. & Zander, A. (1953). **Group dynamics: Research and theory.** Row, Peterson.
- Casriel, D. (1972). **A scream away from happiness.** Grosset & Dunlap.
- Charcot, J. M. (1882). "Sur les divers etats nerveux determines par l'hypnotisation chez les hysteriques." **Comptes Rendus Hebdomadaires des Seances de l'Academie des Sciences, 94: 403-405.**
- Cheek, D. (1974). Sequential head and shoulder movements appearing with age regression in hypnosis to birth. **American Journal of Clinical Hypnosis, 16, 261-266.**
- Cheek, D. & LeCron, L. (1968). **Clinical hypnotherapy.** N.Y.: Grune & Stratton.
- Cooper, G. L. (Ed.) (1983). **Stress research: Issues for the Eighties.** John Wiley & Sons.
- Corriere, R. **The transformation of dreams.** Unpublished Doctoral Dissertation, University of California, Irvine.
- Crafts, L.W., Schneirla, T.C., Robinson, E.E. et al., (1938). **Recent experiments in psychology.** N.Y.: McGraw-Hill.
- Crowe, M. J., Marks, I. M., Agras, W. S., & Leitenberg, H.

- (1972). Time-limited desensitization, implosion and shaping for phobic patients: A crossover study. *Behaviour Research & Therapy*, 10, 319-328.
- Dahlstrom, W. G. & Dahlstrom, L. E. (1980). *Basic readings on the MMPI: a new selection on personality measurement*. Minneapolis: Univ. of Minnesota Press.
- Dattore, P., Shontz, F., & Coyne, L. (1980). Premorbid personality differentiation of cancer and non-cancer groups. *Journal of Consulting and Clinical Psychology*, 48, (3), 388-394.
- Davanloo, H. (1978). *Basic principles and techniques in short-term psychodynamic psychotherapy*. N.Y.: Spectrum.
- Davanloo, H. (1980). A method of short-term psychodynamic therapy. In H. Davanloo (Ed.), *Short-term dynamic psychotherapy*. N.Y.: Jason Aronson.
- Denes-Radomslis. (1971). quoted in J. B. Shaffer & M. D. Galinsky. *Models of group therapy and sensitivity training*. Prentice-Hall Inc., 1974.
- Desoille, R. (1965). *Directed daydreams*. N.Y.: Psychosynthesis Research Foundation.
- Devereux, G. (1967). *From anxiety to method in the behavioural sciences*. The Hague: Mouton.
- Dittes, J. E. (1957). Extinction during psychotherapy of GSR accompanying "embarrassing" statements. *Journal of Abnormal & Social Psychology*, 54, 187-191.
- Dodds, E. (1966). *The Greeks and the irrational*. Berkeley: University of California Press.
- Dollard, J., Doob, L., Miller, N. E., Mowrer, O. H., & Sears, R. R. (1939). *Frustration and aggression*. Yale University Press.
- Doob, A. N., & Wood, L. E. (1972). Catharsis and aggression: Effects of annoyance and retaliation on aggressive behaviour. *Journal of Personality and Social Psychology*, 22, 156-162.
- Douglas, M. (1970). *Natural symbols*. London: Barrie & Jenkins.
- Dworkin, E. S. & Efran, J. S. (1967). The angered: Their susceptibility to varieties of humor. *Journal of Personality and Social Psychology*, 5, 368-371.

- Edelman, R. I. (1972). Vicarious fear induction and avowed autonomic stereotypy. *Behaviour Research and Therapy*, 10, 105-110.
- Edkins, J.R.P. (1946). Further developments in abreaction. In N.G. Harris (ed). *Modern trends in psychological medicine*. N.Y. Hoeber.
- Ellenberger, H.F. (1970). *The discovery of the unconscious*. N.Y. Basic Books.
- Ellenberger, H. F. (1972). "The story of 'Anna O': A critical review with new data". *History of the Behavioural Sciences*. 8, p. 279.
- Ellenberger, H. F. (1977). "L'Histoire d'Emmy von N'". *L'Evolution Psychiatrique*, 42: 519-40.
- Elman, D. (1964). *Hypnotherapy*. Glendale, Calif: Westwood Publishing Co.
- Emerson, W. (1978). Life, Birth, and rebirth: The hazy mirrors. *Self & Society*, 6, No. 7, 233-238.
- Erickson, M., Rossi, E. L., & Rossi, S. I. (1976). *Hypnotic realities*. N.Y.: Irvington.
- Erickson, M. H. & Rossi, E. (1981). *Experiencing hypnosis*. N.Y.: Irvington Publishers.
- Ernst, S. & Goodison, L. (1981). *In our own hands: A book of self-help therapy*. London: The Women's Press.
- Evans-Pritchard, E.E. (1965). *Theories of primitive religion*. Oxford University Press.
- Evison, R. & Horobin, R. (1983). *How to change yourself & your world: A manual of co-counselling theory and practice*. Sheffield: Co-Counselling Phoenix.
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319-324.
- Eysenck, H. J. (1985). Letter to the *British Psychological Society Bulletin*, 38.
- Fazio, A. F. (1970). Implosive therapy in the treatment of a phobic disorder. *Psychotherapy: Theory, Research and Practice*, 7, 228-232.
- Feinberg, M.R., Feinberg, G., & Tarrant, J.J. (1978). *Leavetaking: When and how to say goodbye*. N.Y.: Simon & Schuster.

- Feldenkrais, M. (1972). *Awareness through movement*. N.Y.: Harper & Row.
- Fenichel, O. (1945). *The psychoanalytic theory of neurosis*. N.Y.: W.W. Norton & Co.
- Ferenczi, S. (1930). The principle of relaxation and neocatharsis. *The International Journal of Psychoanalysis*, 11, 428-443.
- Ferenczi, S. (1920). The further development of an active theory in psychoanalysis. In J. Suttie (ed. & trans.), *Further contributions to the theory and techniques of psychoanalysis*. London: Hogarth. 1950.
- Feshbach, S. (1955). The drive-reducing function of fantasy behaviour. *Journal of Abnormal and Social Psychology*, 50, 3-11.
- Feshbach, S. (1956). The catharsis hypothesis and some consequences of interaction with aggressive and neutral play objects. *Journal of Personality*, 24, 449-462.
- Feshbach, S. (1961). The stimulating versus cathartic effects of vicarious aggressive activity. *Journal of Abnormal and Social Psychology*, 63, 381-385.
- Filmer, P. et al., (1973). *New directions in sociological theory*. MIT Press.
- Fodor, N. (1949). *The search for the beloved*. Hermitage Press.
- Foxe, A.N. (1941). The therapeutic effect of crying. *Medical Record*, March 5th., 167-168.
- Frank, J.D. (1961). *Persuasion and healing*. Baltimore: John Hopkins Press.
- Frank, J.D. (1971). Therapeutic factors in psychotherapy. *Journal of Psychotherapy*, 25, 350-361.
- Frankl, V.E. (1975). Paradoxical intention and dereflection. *Psychotherapy: Theory, Research & Practice*, 12, 226.
- Frankl, V. (1960). Paradoxical intention: A logotherapeutic technique. *American Journal of Psychotherapy*, 14, 520.
- Frazier, S.H. (1965). Psychosomatic illness: A body language form of acting-out. In L.E. Abt & S.L. Weissman (Eds.). *Acting Out: Theoretical and clinical aspects*. N.Y.: Grune & Stratton.

- Freeman, L. (1972). **The story of Anna O.** N.Y. Walker.
- Frederick, J.F. (1976). Grief as a disease process. **Omega: Journal of Death and Dying**, 7, 297-305.
- Freud, S. (1908). Character and anal eroticism. In Richards, A. (ed). **The Pelican Freud Library**, Vol. 7. **On Sexuality**. Penguin Books. 1977.
- Freud, S. (1910). **Five lectures on psychoanalysis**. London: Hogarth.
- Freud, S. (1917). **"Mourning and melancholy"**. Standard Edition, 19, p. 243. London: Hogarth Press.
- Freud, S. (1920). **Beyond the pleasure principle**. Standard Edition, 18, 3-64. London: Hogarth Press.
- Freud, S. (1925). An autobiographical study. In **Standard Edition**, 20, 3-70. London: Hogarth Press.
- Freud, S. (1949). **A general introduction to psychoanalysis**. N.Y.: Perma Giants.
- Freud, S. (1957). Mourning and melancholia. In J. Strachey (ed). **The Standard Edition of the Complete Works of Sigmund Freud**. Vol. 14, pp. 274-300. London: Hogarth Press.
- Freud, S. (1954). **The origins of psychoanalysis**. Vol. 6. pp. 1-6. N.Y.: Basic Books.
- Freundlich, D. (1973). **What is a primal?** N.Y.: Center for the Whole Person.
- Garber, J. & Seligman, M. E. P. (1980). **Human helplessness: Theory and applications**. N. Y.: Academic Press.
- Garfield, S. L. & Bergin, A. E. (1978). **Handbook of psychotherapy and behaviour change: An empirical analysis** (2nd. Edn.). John Wiley & Sons.
- Garfield, S. L., Prager, R. A. & Bergin, A. E. (1971). Evaluating outcome in psychotherapy: A hardy perennial. **Journal of Consulting & Clinical Psychology**, 37, 320-322.
- Gerz, H.D. (1966). Experience with the logotherapeutic technique of paradoxical intention in the treatment of phobic and obsessive-compulsive patients. **American Journal of Psychiatry**, 123, 548.
- Gibb, J. R. (1970). The effect of human relations training. In A. E. Bergin & S. L. Garfield (Eds.) **Handbook of**

- psychotherapy and behaviour change. N.Y.: John Wiley & Sons.
- Gibson, H. B. (1985). Letter to British Psychological Society Bulletin, 38, 229-230.
- Giddens, A. (1976). New rules of sociological method. Hutchinson.
- Gold, S. (1975). Experience and expression: A new approach. Unpublished Doctoral Dissertation, University of California, Irvine.
- Goldman-Eisler, F. A. (1956). A contribution to the objective measurement of the cathartic process. *Journal of Mental Science*, 102, 165-178.
- Gordon, J. E. (1957). Leading and following psychotherapeutic techniques with hypnotically induced repression and hostility. *Journal of Abnormal & Social Psychology*, 54, 405-410.
- Gough, H. G. (1975). Manual for the California Psychological Inventory. Palo Alto, Calif.: Consulting Psychologists Press.
- Grinder, J. & Bandler, R. (1981). Trance-formations. Real People Press.
- Grinker, R.R. & Spiegel, J.P. (1945). Men under stress. Blakiston.
- Greenson, R.R. (1967). The technique and practice of psychoanalysis. N.Y.: International Universities Press.
- Grissom, J., Weiner, B., & Weiner, E. (1975). Psychological correlates of cancer. *Journal of Consulting & Clinical Psychology*, 43, 113.
- Groen, J. (1957). Psychosomatic disturbances as a form of substituted behaviour. *Journal of Psychosomatic Research*, 2, 85-96.
- Grof, S. (1976). Realms of the human unconscious. Dutton.
- Grof, S. (1980). LSD Psychotherapy. Calif: Hunter House.
- Grossman, D. (1952). An experimental investigation of a psychotherapeutic technique. *Journal of Consulting Psychology*, 16, 325-331.
- Grotowski, J. (1963). Toward a poor theatre. N.Y.: Clarion.
- Guntrip, H. (1969). Schizoid phenomena, object relations

- and the self. N.Y.: International Universities Press.
- Guntrip, H. (1977). **Personality structure & human interaction.** Hogarth Press & The Institute of Psychoanalysis.
- Habermas, J. (1971). **Knowledge and human interests.** Boston: Beacon.
- Hafner, J., & Marks, I. (1976). Exposure in vivo of agoraphobics: Contributions of diazepam, group exposure and anxiety evocation. **Psychological Medicine**, 6, 71-88.
- Haggard, E. A., & Murray, H. A. (1942). The relative effectiveness of three "therapy" procedures on the reduction of experimentally induced anxiety. **Psychological Bulletin**, 39, 441.
- Hart, J., Corriere, R., & Binder, J. (1975). **Going sane.** N.Y.: Jason Aronson
- Hartland, J. (1971). **Medical & Dental Hypnosis & its Clinical Applications** (2nd. Ed.). Eastbourne, England: Bailliere Tindall.
- Heilbrunn, G. (1955). On weeping. **Psychiatric Quarterly**, 24, 245-255.
- Heider, J. (1974). Catharsis in human potential encounter. **Journal of Humanistic Psychology**, 14, 4, 27-47.
- Heron, J. (1971). **Experience and method.** Univ. of Surrey: Human Potential Research Project.
- Heron, J. (1974). **Reciprocal counselling.** University of Surrey, Human Potential Research Project.
- Heron, J. (1973). **Re-evaluation counselling: A theoretical review.** Human Potential Research Project, University of Surrey.
- Heron, J. (1975). **Practical methods in transpersonal psychology.** Human Potential Research Project, University of Surrey.
- Heron, J. (1975). **Six category intervention analysis.** Human Potential Research Project, University of Surrey.
- Heron, J. (1977). **Dimensions of facilitator style.** British Postgraduate Medical Federation, University of London, and Human Potential Research Project, University of Surrey.
- Heron, J. (1977). **Catharsis in human development.** British

Postgraduate Medical Federation & Human Potential Research Project.

- Heron, J. (1978). **Co-counselling teachers' manual**. British Postgraduate Medical Federation, University of London, and Human Potential Research Project, University of Surrey.
- Heron, J. (1980). History and development of co-counselling. **Self & Society**, V111, 4, 99-106.
- Heron, J. (1981). **Experiential research**. British Postgraduate Medical Federation, University of London & Human Potential Research Project, University of Surrey.
- Heron, J. (1982). **Education of the affect**. British Postgraduate Medical Federation & Human Potential Research Project.
- Heron, J. (1984). **Co-operative inquiry into Altered States of Consciousness**. Human Potential Research Project, University of Surrey.
- Heron, J. & Reason, P. (1981). **Co-Counselling: An experiential inquiry**. British Postgraduate Medical Federation, University of London, and Centre for the Study of Organizational Change & Development, University of Bath.
- Heron, J. & Reason, P. (1982). **Co-counselling: An experiential inquiry (2)**. Human Potential Research Project, University of Surrey.
- Hodgson, R. J., & Rachman, S. (1970). An experimental investigation of the implosion technique. **Behaviour Research and Therapy**, 8, 21-27.
- Hogan, R. A. (1966). Implosive therapy in the short-term treatment of psychotics. **Psychotherapy: Theory, Research and Practice**, 3, 25-31.
- Hogan, R.A. (1968). The implosive technique. **Behaviour Research & Therapy**, 7, 177-183.
- Hogan, R. A., & Kirchner, J. H. (1967). Preliminary report of the extinction of learned fears via short-term implosive therapy. **Journal of Abnormal Psychology**, 72, 106-109.
- Hokanson, J.E. (1970). Psychophysiological evaluation of the catharsis hypothesis. In E.I. Megargee & J.E. Hokanson (eds). **The dynamics of aggression**. Harper & Row.
- Hokanson, J. E. (1961). The effects of frustration and

- anxiety on overt aggression. *Journal of Abnormal and Social Psychology*, 62, 346-351.
- Hokanson, J. E., & Burgess, M. (1962). The effects of three types of aggression on vascular processes. *Journal of Abnormal and Social Psychology*, 64, 446-449.
- Hokanson, J. E., & Edelman, R. (1966). Effects of three social responses on vascular processes. *Journal of Personality and Social Psychology*, 3, 442-447.
- Hokanson, J. E., & Shetler, S. (1961). The effects of overt aggression on physiological arousal. *Journal of Abnormal and Social Psychology*, 63, 446-448.
- Hokanson, J. E., Burgess, M. M., & Cohen, M. (1963). The effects of displaced aggression on systolic blood pressure. *Journal of Abnormal and Social Psychology*, 67, 214-218.
- Hokanson, J. E., Williers, K. R., & Koropsak, E. (1968). The modification of autonomic responses during aggressive interchanges. *Journal of Personality*, 36, 386-404.
- Holden, M.E. (1977). Primal pathophysiology. *Journal of Psychosomatic Research*, 21, 341-350.
- Holt, R. R. (1970). On the interpersonal and intrapersonal consequences of expressing or not expressing anger. *Journal of Consulting and Clinical Psychology*, 35, 8-12.
- Jackins, H. (1962). *Elementary Counsellor's Manual*. Seattle: Rational Island Publishers.
- Jackins, H. (1965). *The human side of human beings*. Seattle: Rational Island Publishers.
- Jackins, H. (1970). *Fundamentals of co-counselling manual* (Rev. Ed.). Seattle: Rational Island Publishers.
- Jackins, H. (1973). *The human situation*. Seattle: Rational Island Publishers.
- Jackins, H. (1975). *Guidebook to re-evaluation counselling*. Seattle: Rational Island Publishers.
- James, W. (1914). *The varieties of religious experience*. Longmans, Green & Co.
- Janet, P. (1925). *Psychological healing: A historical clinical study*. Vols. 1. & 11. N.Y.: Macmillan.
- Janov, A. (1973). *The primal scream*. London: Sphere.

- Janov, A. (1977). *The feeling child*. London: Sphere.
- Janov, A. (1978). *The anatomy of mental illness*. London: Sphere.
- Janov, A. (1982). *Prisoners of pain*. London: Sphere.
- Janov, A. (1985). *Imprints*. London: Sphere.
- Janov, A. & Holden, E.M. (1975). *Primal man: the new consciousness*. Crowell.
- Johnston, D. W., et al., (1976). Imaginal flooding and exposure to real phobic situations: Changes during treatment. *British Journal of Psychiatry*, 129, 372-377.
- Jones, E. (1953). *The life and work of Sigmund Freud*. Penguin Books.
- Jung, C. G. (1964). *Man and his symbols*. London: W. H. Allen.
- Kamiya, J., Barber, T. X., Di Cara, L., Miller, N., Shapiro, D., & Stoyva, J. (Eds.) 1971. *Biofeedback and self control*. Aldine-Atherton.
- Karle, W., Corriere, R., & Hart, J. (1973). Psychophysiological changes in abreactive therapy - Study 1. Primal Therapy. *Psychotherapy: Theory, Research & Practice*, 10, 117-122.
- Karle, W., Gold, S., Maple, C., Corriere, R., Hart, J., & Hopper, M. (1976). The maintenance of psychophysiological changes in feeling therapy. *Psychological Reports*, 39, 1143-1147.
- Karle, W., Hart, J., Corriere, R., Gold, S., & Maple, C. (1978). Preliminary study of psychological changes in feeling therapy. *Psychological Reports*, 43, 1327-1334.
- Karle, W., Corriere, R., Hart, J., & Klein, J. (1981). The Personal Orientation Inventory & the Eysenck Personality Inventory as outcome measures in a private outpatient clinic. *Psychotherapy: Theory, Research & Practice*, 18, 117-122.
- Kaufman, W. (1974). An anatomy of the primal revolution. *Journal of Humanistic Psychology*, 14, 4, 49-69.
- Kaufman, G.B. & Aronoff, G.M. (1983). The use of psychomotor therapy in the treatment of chronic pain. *Psychotherapy: Theory, Research and Practice*, 20, 4, 449-456.

- Keet, C. D. (1948). Two verbal techniques in a miniature counselling situation. *Psychological Monographs*, 62, No. 294.
- Keleman, S. (1970). Bio-energetic concepts of grounding. In Boadella, D. (ed), *In the wake of Reich*, Coventure, 1976, pp. 192-209.
- Keleman, S. (1973). We do have bodies. *Psychology Today*, 7, 64-70.
- Kelley, C. (1972). Post-primal and genital character: A critique of Janov and Reich. *Journal of Humanistic Psychology*, 12, 4.
- Kirsch, C. (1973). The role of affective expression and defense in the character. In D. Boadella (ed). *In the wake of Reich*. Coventure. 1976.
- Klopfer, B. (1957). Psychological variables in human cancer. *Journal of Projective Techniques*, 21, 331-340.
- Kissen, D. M. (1967). Psychosocial factors, personality, and lung cancer in men aged 55-66. *British Journal of Medical Psychology*, 40, 29.
- Knight, R. P. (1941). Evaluation of the results of psychoanalytic therapy. *American Journal of Psychiatry*, 98, 434-446.
- Konecni, V. J. (1975). Annoyance, type and duration of post-annoyance activity, and aggression. The "cathartic effect." *Journal of Experimental Psychology: general*, 104, 76-102.
- Knox, R.A. (1961). *Enthusiasm*. N.Y.: Oxford University Press.
- Kris, E. (1952). *Psychoanalytic explorations in art*. N.Y.: International Universities Press.
- Lake, F. (1976). *Clinical theology*. Dartman, Longman, & Todd.
- Lake, F. (1978). The significance of perinatal experiences. *Self & Society*, 6, 7, 224-232.
- Lake, F. (1981). *Tight corners in pastoral counselling*. Dartman, Longman, & Todd.
- Lake, F. (1981). *Studies in constricted confusion: Exploration of a pre- and peri-natal paradigm*. Nottingham: The Clinical Theology Association.

- Laing, R.D. (1960). **The Divided Self**. Penguin.
- Laing, R.D. (1967). **The politics of experience and The bird of paradise**. Harmondsworth: Penguin.
- Laing, R.D. (1976). **The facts of life**. Allen Lane.
- Laing, R.D. (1982). **The voice of experience**. Penguin.
- Langs, R. (1973). **The technique of psychoanalytic psychotherapy**, vol. 1. N.Y.; Jason Aronson.
- Latour, B. & Woolgar, S. (1979). **The social construction of scientific facts**. Sage Publications.
- LeBoyer, F. (1977). **Birth without violence**. Fontana.
- Leak, G. K. (1974). Effects of hostility arousal and aggressive humor on catharsis and humor preference. **Journal of Personality and Social Psychology**, 30, 736-740.
- LeShan, L.L. (1977). **You can fight for your life**. N.Y.: M. Evans & Co.
- Levine, R. A. (1963). Witchcraft and socery in a Guisii community. In J. Middleton & E.H. Winter (eds). **Witchcraft and sorcery in East Africa**. N.Y.:Frederick A. Praenger.
- Levis, D. J. (1980). Implementing the technique of implosive therapy. In A. Goldstein & E. B. Foa (eds). **Handbook of behavioural interevntions**. N.Y.: Wiley.
- Levis, D.J. & Carrera, R. (1967). Effects of 10 hours of implosive therapy in the treatment of outpatients. **Journal of Abnormal Psychology**, 72, 504-508.
- Levison, P. K., Zax, M. & Cowen, E. L. (1961). An experimental analogue of psychotherapy for anxiety reduction. **Psychological Reports**, 8, 171-178.
- Lewin, K. (1948). **Resolving social conflicts: Selected papers on group dynamics**. G. W. Lewin (Ed.). N.Y.: Harper & Row.
- Lieberman, M. A., Yalom, I. D. & Miles, M. B. (1973). **Encounter groups: First facts**. N.Y.: Basic Books.
- Lindemann, E. (1944). Symptomatology and management of acute grief. **American Journal of Psychiatry**, 101, 141-148.
- Lipinski, B. G. (1980). Separation anxiety and object loss.

In B. Mark Schoenberg. **Bereavement Counselling.** Westport, Conn.: Greenwood Press.

- Lipowski, Z. J. (1977). Psychosomatic medicine in the seventies: An overview. **American Journal of Psychiatry**, 134, 233-244.
- Lipshitz, K. & Blair, J. H. (1960). The polygraphic recording of a repeated hypnotic abreaction with comments on abreactive psychotherapy. **Journal of Nervous and Mental Diseases**.
- Liss, J. (1974). **Free to feel.** London: Wildwood House.
- London, P. (1964). **The modes and morals of psychotherapy.** N.Y.: Holt, Rinehart & Winston.
- Lonsbury, J. (1978). Inside primal therapy. **Journal of Humanistic Psychology**, 18, 4, 19-28.
- Loud, G.C. (1928). **Evangelized America.** N. Y.: Dial Press.
- Lowen, A. (1969). **The betrayal of the body.** N.Y.: Macmillan.
- Lowen, A. & Lowen, L. (1977). **The way to vibrant health: A manual of bioenergetic exercises.** N.Y.: Harper & Row.
- Lowen, A. (1975). **Bioenergetics.** Coventure.
- Lowen, A. (1972). Bioenergetic analysis: a development of Reichian therapy. In G. Goldman & D. Milman (eds). **Innovations in psychotherapy.** Springfield, Ill.: Charles C. Thomas.
- Lowy, F.H. (1970). The abuse of abreaction: An unhappy legacy of Freud's cathartic method. **Canadian Psychiatric Journal**, 15, 557-565.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that everyone has won and all must have prizes? **Archives General Psychiatry**, 32, 995-1008.
- Luthe, W. (1970). Autogenic therapy. Vol V. **Dynamics of autogenic neutralization.** N.Y.: Grune & Stratton.
- Luthe, W. A. (1970). Autogenic therapy. Vol. 1V. **Research & Theory.** N.Y.: Grune & Stratton.
- McLoughlin, W. G. (1959). **Modern revivalism.** N.Y.: Ronald Press.
- Malan, D. (1976). **Frontier of brief psychotherapy.** N.Y.:

Addenda

Mesmer, F. (1779). **Memoirs sur la decouverte du magnetisme animal**. Paris: Didot.

Mesmer, F. (1948). **Mesmerism**. London: Macdonald.

Plenum Medical Book Co.

- Malan, D. (1963). *A study of brief psychotherapy*. N.Y.: Plenum Medical Book Co.
- Mallesson, N. (1959). Panic and phobia. *Lancet*, 1, 225.
- Malinowski, B. (1955). Magic, Science & Religion. In J. Needham (ed). *Science, religion & reality*. N.Y.: George Braziller.
- Malinowski, B. (1945). *Magic, science and religion*. Glencoe Ill. The Free Press.
- Mallick, S. K. & McCandless, B. R. (1966). A study of catharsis of aggression. *Journal of Personality & Social Psychology*, 4, 591-596.
- Martin, B., Lundy, R. M. & Lewin, M. H. (1960). Verbal and GSR responses in experimental interviews as a function of three degrees of "therapist" communication. *Journal of Abnormal & Social Psychology*, 60, 234-240.
- Maslow, A. H. (1970). *Motivation and personality*. Harper & Row.
- Maslow, A.H. (1971). *The farther reaches of human nature*. Harmondsworth: Penguin.
- May, J. R. (1977). Psychophysiology of self-regulated phobic thoughts. *Behaviour Therapy*, 8, 150-159.
- Mathews, A. (1978). Fear-reduction research and clinical phobias. *Psychological Bulletin*, 85, 390-406.
- Meltzoff, J. & Kornreich, M. (1970). *Research in psychotherapy*. N.Y.: Atherton Press, Inc.
- Moreno, J. L. (1946). *Psychodrama*. Vol.1. N.Y.: Beacon House Inc.
- Morganstern, K. P. (1973). Implosive therapy and flooding procedures: A critical review. *Psychological Bulletin*, 79, 318-334.
- Mott, F. (1959). *The nature of the self*. Integration Publishing Co.
- Mott, F. (1964). *The universal design of creation*. Mark Beech.
- Mowrer, O. H. (1950). *Learning theory and personality dynamics*. New York: Ronald Press.

- Newhouse, M. & Furda, Mary Ann H. (1978). Primal-oriented psychotherapy. In H. H. Grayson & C. Loew (eds). *Changing approaches to the psychotherapies*. Halstead.
- Nichols, M. P. (1974). Outcome of brief cathartic psychotherapy. *Journal of Consulting and Clinical Psychology*, 42, 403-410.
- Nichols, M. P. & Bierenbaum, H. (1978). Success of cathartic therapy as a function of patient variables. *Journal of Clinical Psychology*, 34, 726-728.
- Nichols, M. P. & Zax, M. (1977). *Catharsis in psychotherapy*. N.Y.: Gardner Press.
- Nichols, M. P. & Efran, J.S. (1985). Catharsis in psychotherapy: a new perspective. *Psychotherapy: Theory, Research & Practice*, 22, 1, pp. 46-58.
- Nichols, M.P. & Paolino, T.J. (Eds.). (1986). *Basic techniques of psychodynamic psychotherapy*. N.Y.: Gardner Press.
- Orr, L. & Ray, S. (1977). *Rebirthing in the new age*. Berkeley, Calif.: Celestial Arts.
- Paolino, T.J. (1981). *Psychoanalytic psychotherapy: Theory, technique, therapeutic relationship, and treatability*. N.Y.: Brunner/Mazel.
- Parkes, C. M. (1972). *Bereavement: Studies of grief in adult life*. London: Tavistock.
- Peerbolte, L. (1975). *Psychic energy in prenatal dynamics*. Service Publications.
- Pelletier, K. R. (1977). *Mind as healer, Mind as slayer*. N.Y.: Dell.
- Perls, F. (1969). *Gestalt therapy verbatim*. Real People Press.
- Perls F. (1947). *Ego, hunger, and aggression*. N.Y.: Random House.
- Perls, F. (1972). Four lectures. In J. Fagan & I.L. Shepherd (Eds). *Gestalt therapy now*. Penguin.
- Perls, F., Hefferline, R. F., & Goodman, P. (1973). *Gestalt Therapy*. London: Penguin Books.
- Pierce, R. A., Nichols, M. P., & DuBrin, J. R. (1983). *Emotional expression in psychotherapy*. Gardner Press.

- Pilgrim, D. (ed.) 1983. **Psychology and psychotherapy. Current trends and issues.** Routledge & Kegan Paul.
- Quanty, M. B. (1976). Aggression catharsis: Experimental investigations and implications. In Russell G. Green & E. O'Neal (eds). **Perspectives on aggression.** N.Y.: Academic.
- Rabavilas, A. & Boulougouris, J. (1974). Physiological accompaniments of ruminations, flooding and thought-stopping in obsessive patients. **Behav. Res. Ther**, 12, 239-244.
- Rachman, S. J. & Wilson, G. T. (1980). **The effects of psychological therapy** (2nd. Edn). Pergamon Press.
- Radcliffe-Brown, (1952). **Structure and function in primitive society.** Glencoe Ill.: The Free Press.
- Rank, O. (1929). **The trauma of birth.** Harper and Row.
- Rank, O., & Ferenczi, S. (1925). **The development of psychoanalysis.** N.Y.: Nervous & Mental Disease Publishing Co.
- Reason, P. & Heron, J. (1985). **Research with People: the paradigm of co-operative research inquiry.** Centre for the Study of Organizational Change & Development, University of Bath, & British Postgraduate Medical Federation, University of London.
- Reason, P. & Rowan, J. (eds). (1981). **Human inquiry.** Wiley.
- Reich, W. (1949). **Character analysis.** N.Y.: Orgone Institute.
- Reich, W. (1942). **The function of the orgasm.** N.Y.: Orgone Institute.
- Reich, W. (1961). **The function of the orgasm.** N.Y.: Farrar, Straus, & Giroux.
- Reich, W. (1948). **The discovery of the orgone. The function of the orgasm.** Vol.1. N.Y.: Orgone Institute Press.
- Reich, W. (1968). **Wilhelm Reich: Selected writings.** N.Y.: Farrar, Straus, Cudahy.
- Reik, T. (1948). **Listening with the third ear.** N.Y.: Farrar, Straus.
- Reinharz, S. (1981). Implementing new paradigm research: A model for training and practice. In Reason, P. & Rowan, J. (Eds.), **Human Inquiry,** Wiley, 1981.

- Riebel, L. (1984). A homeopathic model of psychotherapy. *Journal of Humanistic Psychology*. Vol. 24, No. 1, 9-48.
- Rochlin, G. (1965). *Griefs and discontents: The forces of change*. Boston: Little, Brown.
- Rogers, C. (1942). *Counselling and psychotherapy*. Houghton Mifflin.
- Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. Boston: Houghton Mifflin.
- Rogers, C. (1961). *On becoming a person*. Constable.
- Rogers, C. (1967). Learning to be free. In C.R. Rogers & B. Stevens (Eds.), *Person to person: The problem of being human*. Moab, UT: Real People Press.
- Rogers, C. (1968). Some thoughts concerning the pre-suppositions of the behavioural sciences. In W.R. Coulson and C. R. Rogers (eds.) *Man and the science of man*. Ohio: Charles E. Merrill.
- Rogers, C. R. (1970). *Carl Rogers on encounter groups*. Penguin.
- Rohrbaugh, M. & Bartels, B. D. (1975). 'Participants' perceptions of 'curative factors' in therapy and growth groups. *Small Group Behaviour*, 6, 430-456.
- Rolf, I. (1975). *Structural integration*. N.Y.: Viking Press.
- Rosen, H. & Myers, H. J. (1947). Abreaction in the military setting. *Archives of Neurology & Psychiatry*, 57, 161-172.
- Rosenbaum, M. & Muroff, M. (eds.). (1984). *Anna O. Fourteen Contemporary Reinterpretations*. N.Y.: Free Press.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6, 412-415.
- Rowan, J. (1975). "Encounter group research: No joy?" *Journal of Humanistic Psychology*, 15, (2), Spring, 1975.
- Rowan, J. (1981). A dialectical paradigm for research. In P. Reason & J. Rowan (eds.). *Human inquiry*. John Wiley.
- Ruesch, J. & Prestwood, A. R. (1949). *Anxiety: Its initiation, communication and interpersonal management*.

- Archives of Neurology & Psychiatry, 62, 527-550.
- Sadoff, R. L. (1966). On the nature of crying and weeping. *Psychiatric Quarterly*, 40, 490-503.
- Sargent, W. (1948). Some observations on abreaction with drugs. *Digest Neurology & Psychiatry*, 16, 206.
- Sargent, W. (1957). *Battle for the mind*. Heinemann.
- Scheff, T. J. (1979). *Catharsis in healing, ritual, and drama*. University of California Press.
- Schmale, A. H. J., & Iker, H. P. (1966). The effect of hopelessness & the development of cancer: 1. Identification of uterine cervical cancer in women with atypical cytology. *Psychosomatic Medicine*, 28, 714.
- Schmale, A. H. J. (1972). Giving up as a final common pathway to changes in health. In Z. J. Lipowski (ed). *Psychological aspects of physical illness*. Basel: S. Karger.
- Schutz, W. C. (1973). *Elements of encounter*. Joy Press.
- Schutz, W. C. (1975). "Not encounter and certainly not facts." *Journal of Humanistic Psychology*, 15, (2), Spring.
- Schutz, W. C. & Allen, V. (1966). "The effects of a T-group laboratory on interpersonal behaviour." *Journal of Applied Behavioural Science*, 11, 265-286.
- Seaborn Jones, G. (1978). Fear-raising and fear-draining - Part One. *Energy and Character*, 9, 1, 72-83.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development and death*. San Francisco: W. H. Freeman.
- Sherry, P. & Hurley, J. R. (1976). Curative factors in psychotherapeutic and growth groups. *Journal of Clinical Psychology*, 32, 835-837.
- Shoben, E. J. (1960). Psychotherapy as a problem in learning theory. In H. J. Eysenck (ed). *Behaviour therapy and the neuroses*. N.Y.: Pergamon Press.
- Shorr, J. E. (1972). *Psycho-imagination therapy*. Intercontinental Medical Book Corporation.
- Shrovon, H. J. & Sargent, W. (1947). Excitatory abreaction: With special reference to its mechanism and the use of ether. *Journal of Mental Science*, 93, 709-732.

- Shostrom, E. L. (1965). A test for the measurement of self-actualization. **Educational and Psychological Measurement**, 24, 207-218.
- Sifneos, P.E. (1979). **Short-term Dynamic Psychotherapy**. N.Y.: Plenum.
- Simmel, E. (1944). War neuroses. In S. Lorand (Ed.). **Psychoanalysis today**. N.Y.: International University Press. 227-248.
- Simonton, O. C., Matthews-Simonton, S., & Creighton, J. (1978). **Getting well again**. Los Angeles: Tarcher.
- Singer, D. (1968). Aggression arousal, hostile humor, catharsis. **Journal of Personality and Social Psychology Monograph Supplement**, 8, (1, Pt. 2).
- Smail, D. (1983). Psychotherapy and psychology. In D. Pilgrim (ed.), **Psychology and psychotherapy**. Routledge & Kegan Paul. 1983.
- Smith, M. L. & Glass, C. V. (1977). Meta-analysis of psychotherapy outcome studies. **Am. Psychol**, 32, 752-760.
- Smith, P. B. (1975). "Are there adverse effects of sensitivity training?" **Journal of Humanistic Psychology**, 15, (2), Spring.
- Smith, W. R. & Sebastian, H. (1976). Emotional history and pathogenesis of cancer. **Journal of Clinical Psychology**, 32, (4), 863-866.
- Southgate, J. & Randall, R. (1976). **The barefoot psychoanalyst**. Association of Karen Horney Psychoanalytic Counsellors.
- Spiegel, S. B., & Zelin, M. (1973). Fantasy aggression and the catharsis phenomenon. **Journal of Social Psychology**, 91, 97-107.
- Spiegel, H. & Spiegel, D. (1978). **Trance & Treatment**. N.Y.: Basic Books.
- Stampfl, T. G. (1964). quoted by London (1964), op cit.
- Stampfl, T.G. & Levis, D. J. (1967). Essentials of implosive therapy: A learning-theory-based psychodynamic behavioural therapy. **Journal of Abnormal Psychology**, 72, 496-503.
- Stampfl, T. G. & Levis, D. J. (1968). Implosive therapy, A behavioural therapy. **Behaviour Research & Therapy**, 6, 31.

- Stampfl, T. G. & Levis, D. J. (1973). **Implosive therapy: Theory & technique**. New Jersey: General Learning Corporation.
- Stanislavski, K. (1924). **My life in art**. Newton: Little Brown.
- Stone, L. J., & Hokanson, J. E. (1969). Arousal reduction via self-punitive behaviour. **Journal of Personality and Social Psychology**, 12, 72-79.
- Strachey, J. (1934). The nature of the therapeutic action of psychoanalysis. **International Journal of Psychoanalysis**, 15, 117-126,
- Stroebel, C.F. (1978). **Quieting Response Training**. N.Y.: BMA Publications.
- Strupp, H. H. (1978). Psychotherapy research and practice: An overview. In S. L. Garfield & A. E. Bergin (Eds.), **Handbook of psychotherapy & behaviour change: An empirical analysis**. John Wiley & Sons, 1978.
- Strupp, H. H. & Hadley, S. W. (1977). A tripartite model of mental health and therapeutic outcomes. **American Psychologist**, 32, 187-196.
- Strupp, H.H. & Binder, J. L. (1984). **Psychotherapy in a new key**. N.Y.: Basic Books Inc.
- Sullivan, H. S. (1953). **The interpersonal theory of psychiatry**. N.Y. : Norton & Co.
- Sullivan, H. S. (1964). The fusion of psychiatry and social science. N. Y.: Norton & Co.
- Sulloway, F. J. (1979). **Freud, Biologist of the mind**. Fontana.
- Swartley, W. (1976). **Primal integration**. N.Y.: Center for the Whole Person.
- Symonds, P. H. (1954). A comprehensive theory of psychotherapy. **American Journal of Psychotherapy**, 25, 350-361.
- Szasz, T. (1959). **The myth of mental illness**. N.Y.: Harper & Row.
- Tannenbaum, R., Weschler, I. & Massarik, F. (1961). **Leadership and organization**. N.Y.: McGraw-Hill.
- Thayer, R. E. (1970). Activation states as assessed by verbal report and four psychophysiological variables.

Psychophysiology, 7, 86-94.

- Thibaut, J. W., & Coules, J. (1952). The role of communication in the reduction of interpersonal hostility. *Journal of Abnormal and Social Psychology*, 47, 770-777.
- Thornton, E. E. (1983). *Freud and cocaine*. London: Blond and Briggs.
- Thornton, E. E. (1985). Letter to *British Psychological Society Bulletin*, 38, 264.
- Thornton, N. (1949). What is the therapeutic value of abreaction? *Psychoanalytic Review*, 36, 411-415.
- Treacher, A. (1983). On the utility or otherwise of psychotherapy research. In D. Pilgrim (ed.), *Psychology and psychotherapy*. Routledge & Kegan Paul. 1983.
- Verny, T. (1982). *The secret life of the unborn child*. London: Sphere.
- Vishnudevananda, Swami. (1960). *The complete illustrated book of Yoga*. N.Y.: Bell.
- Volkan, V. D. (1975). Re-grief therapy. In B. Schoenberg et al., (eds). *Bereavement: Its psychosocial aspects*. N.Y.: Columbia University Press.
- Waal, N., Grieg, A., & Rasmussen, M. (1956). The psycho-dynamics of the body. In Boadella, D. (ed). *In the wake of Reich*. Coventure, 1976.
- Watkins, J.G. (1949). *Hypnotherapy of war neuroses*. N.Y.: Ronald Press.
- Watkins, J. G. (1971). The affect bridge: A hypnoanalytic technique. *International Journal of Clinical & Experimental Hypnosis*, 19, 21-27.
- Watson, J. P. & Marks, I. M. (1971). Relevant and irrelevant fear fear in flooding - A crossover study of phobic patients. *Behaviour Therapy*, 2, 275-293.
- Watts, A.W. (1961). *Psychotherapy East and West*. N.Y.: Random House.
- Wiener, M. (1955). The effects of two experimental counselling techniques on performance impaired by induced stress. *Journal of Abnormal & Social Psychology*, 51, 565-572.
- Willis, R. W. (1968). A study of the comparative

effectiveness of systematic desensitization and implosive therapy. Unpublished Doctoral dissertation, University of Tennessee.

- Willis, R. W. & Edwards, J. A. (1969). A study of the comparative effectiveness of systematic desensitization and implosive therapy. *Behav. Res. Ther.* 7, 387-395.
- Wimsatt, W. K. & Brooks, C. (1957). *Literary criticism*. N.Y.: Random House.
- Winnicott, D. W. (1949). Birth memories, birth trauma, and anxiety. In D. W. Winnicott, *Through paediatrics to psychoanalysis*, Karnac Books, 1975.
- Winnicott, D.W. (1958). Metapsychological and clinical aspects of regression within the psychoanalytical set-up. In: *Collected Papers*. N.Y.: Basic Books.
- Winnicott, D. W. (1972). *The maturational process and the facilitating environment*. Hogarth Press.
- Winnicott, D. W. (1975). *Through paediatrics to psychoanalysis*. Karnac Books.
- Woldenberg, L. et al., (1976). Psychophysiological changes in feeling therapy. *Psychological Reports*, 39, 1059-1062.
- Wolff, H. H. (1969). The role of aggression in the psychopathology of illness. *Journal of Psychosomatic Research*, 13, 315-320.
- Wolpe, J. (1982). *The practice of behaviour therapy*. Pergamon Press.
- Yalom, I. D., Tinklenberg, J., & Gilula, M. (1967). Curative factors in group therapy. Unpublished study, cited by Yalom, 1975.
- Yalom, I. D. (1975). *The theory and practice of group psychotherapy* (2nd. edition). N.Y.: Basic Books.
- Zelman, R. (1979). The mystical roots of Hegel's philosophy. *The Humanistic Psychology Institute Review*, 1, (2), 43-70.

