Catharsis in Groups

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Jack has always been the "Good Boy." Raised by an authoritarian, angry, alcoholic, and distant father, his role has always been to excel in everything to make mom and dad proud. After many decades of being an "angry nice-guy," Jack reluctantly seeks therapy for problems confronting and working with his authoritarian boss at work. After several days of preparatory group work, Jack designs a role-played confrontation with his father where, instead of being the quiet accepting son, he gives voice to all the things he has always wanted to say to his dad. With intense affect, Jack expresses the sadness and hurt he feels about never being hugged or told he was loved his father. This gradually shifts into an intense expression of his anger for never feeling good enough and never having his own voice. He symbolically silences his father. When Jack says he is finished, he is exhausted but reports feeling elated, free, strong, and peaceful – and shouts several affirmations of these feelings to the group. Jack is laid down with eyes closed and asked to fully describe his feelings, any connections he has made with his past behaviors, and how he sees and feels them differently now. From this vantage point, he is invited to say what is true about little Jack – the things that little Jack would have loved to hear from a nurturing adult. He is asked to describe in detail how this new, nurturing voice feels, how he might anchor it, and how he might use this voice in his work and personal relationships.

This vignette is a typical example of the process work with which I am involved. We have found client-directed cathartic processes to be a very effective tool for healing and changing behavior in a group setting. Catharsis as a therapeutic tool has been a highly controversial topic throughout the history of psychology and continues to be so today. This debate not withstanding, catharsis has been identified by several contemporary authors as one of the major factors in group therapy that make change possible (Lieberman, Yalom, and Miles 1973; Yalom 1985; Bloch and Crouch 1985; MacKenzie 1997). The question is: under what circumstances is catharsis and effective factor in change? Is it simply the expression of strong emotion that is healing or changing? Are other conditions necessary?

The cathartic techniques we use have been developed empirically over several years, but the purpose of this paper is to examine the theoretical underpinnings of catharsis and, based on this foundation, begin to build a model of therapeutic catharsis that could explain our success and enable the development of improved techniques.

Some Definitions

While today catharsis is commonly interpreted to mean any expression of "pent up" emotion, it actually has had several very specific definitions over the years. Even today, at least three formal definitions can be found:

1. **Medical** – Purgation of the excrements of the body, especially the evacuation of the bowels. In its first uses, the term was applied to all medicines that cleansed or purified the body of disease. Later this term was restricted to purgative agents.

2. **Spiritual** - A purifying or figurative cleansing of the emotions by vicarious experience or ritual.

3. **Psychological** – The relief of tension and anxiety by bringing repressed feelings and fears to consciousness. (Houghton Mifflin Company 1993)

A related term that is frequently used as a synonym for the third, or psychological definition of catharsis is *abreaction*. As it is used today, abreaction is more specific form of catharsis and is defined in the American Heritage College Dictionary as "the release of repressed emotions by acting out, as in behavior or the imagination, the situation causing the conflict" (Houghton Mifflin Company 1993). Another definition by Chefetz (1997) is "The verbal or non-verbal expression of intense affect associated with a coherent narrative of experience that provides relief of chronic anxiety states." Both of these definitions describe an emotional release from the reliving of past experiences thought to cause distress and/or dysfunction. For the purposes of this paper, most of our discussion will focus on the psychological definition of catharsis and its more specific cousin, abreaction.

A Brief History of Catharsis

The use of catharsis in modern group psychotherapy perhaps can be traced, according to Ellenberger (1970), to Father Johann Gassner (1727-79). A priest, Gassner was a skilled exorcist who attracted huge numbers of people. Under his instruction, the demons in people would produce convulsions and other highly emotional manifestations ending in his taming and casting out the demons.

Gassner's activities generated much debate in a Europe emerging into the Enlightenment – an era attempting to replace blind faith and superstition with Reason. As a part of an inquiry to restrict Gassner's activities, Franz Mesmer (1734-1815) was called as an expert witness. Using a variety of techniques (one of which would later be developed into hypnosis), Mesmer was able to reproduce Gassner's results, but claimed it was through "animal magnetism" and the "shifting of fluids", not exorcism.

A few years later, Mesmer also became the center of controversy. After leaving Vienna for Paris amidst a scandal involving a young woman patient, he began treating about 200 patients at a time that demonstrated many of the same affects as did the patients of Gassner. In a report commissioned by King Louis XVI, a group of scientists (including Benjamin Franklin) concluded there was no evidence for the existence of the fluids or magnetisms referred to by Mesmer.

Several decades followed where hypnotism and the intense emotional affects associated with it were shunned by the medical establishment (Straton 1990). Then, in 1857, Jacob Bernays (1824 – 1881) published a paper arguing that the notion of a medical purgation and healing was a significant element in Aristotle's catharsis. In addition to being one of many in a trend towards more secular and scientific interpretations of catharsis, Bernays was the uncle of Sigmund Freud's wife and his views are likely to have influenced Josef Breuer and Freud in the selection of the term *catharsis* for the mode of psychological healing that set the stage for most modern interpretations and usages of catharsis (Jackson 1994).

While there were some others experimenting with cathartic methods in the mid 19th century (e.g. Pierre Janet in France and Andries Hoek in Denmark), Breuer and Freud are certainly the most famous. After Bernays' work was republished in 1880, Breuer and Freud applied the term *catharsis* to a method first used by Breuer in 1881 and then taken up by Freud. This term became associated with both men through their joint publication, *Studies on Hysteria*, in 1895. The book includes the celebrated case of "Anna O." as well as Freud's views on the cathartic method (Freud 1955). This technique involved hypnotizing the patient, encouraging her to concentrate on the symptom, and then recount the experiences that produced it. It is not clear from the case history precisely how he induced the hypnotic state, nor the extent to which the "catharsis" was an emotional abreaction or a more gentle verbal report (Straton 1990).

Freud continued to believe in the cathartic method although he found hypnosis difficult. He experimented with other approaches, including suggestion, massage, pressure on the head, and free association. He finally stopped using hypnosis in 1896 after a female patient threw her arms around his neck as a servant walked into the room (Freud 1955). Becoming estranged from Breuer in that same year, Freud and most of his followers gradually shifted their emphasis to free association and psychoanalysis and held that catharsis produced only transient change. By this time, however, several other doctors and psychologists had become strong supporters of the psychotherapeutic uses of catharsis (e.g. Delboeuf, Binet, Bourru, and Burot).

World War I and II provided much in the way of funding, research, training, and, unfortunately, a large number of psychologically damaged people. Many of these people suffered from what was called "shellshock" – a general term that included symptoms of PTSD and other dissociative disorders. Two clinicians especially typified the approaches used to treat "shellshock" patients in both wars. William Brown (1881-1952) explicitly drew upon Freud's earlier catharsis work with Breuer and used hypnosis to revive emotional memories associated with traumatic events. His emphasis was on releasing "dammed up" emotions. Ernst Simmel, a medical officer in the German army, took an approach similar to Brown, but included post-cathartic discussions and dream interpretations in the interest of understanding and resolving underlying conflict and undoing dissociation. By the Second World War, hypnotic states were being induced by a variety of drugs, especially sodium amytal, sodium pentothal, chloroform, ether, and nitrous oxide (Jackson 1994).

These efforts as well as those between the wars led to several post-war therapies that utilized cathartic methods to one extent of another – some emphasizing the integration of traumatic memories with the rest of a patient's experiences, and others emphasizing the emotionally charged recall and release. Several examples are:

Psychodrama – Jacob Moreno (1889 – 1974) developed a therapeutic technique for groups that helped clients release internal conflict through role-playing, which facilitated a cathartic experience.

Reichian Therapy – Wilhelm Reich (1897 – 1957) developed several approaches that sought to free up psychic energy through the use of breathing, massage, and other physical work. Emotional release was a central aspect of the "freeing up" of energy.

Bioenergetics – A student of Riech, Alexander Lowen, developed a broader therapeutic approach that sought to release bound-up energies and facilitate the expressive use of those energies. His approach also included the process of self-discovery and resolution of long-standing conflicts and traumatic memories.

Gestalt Therapy – Fritz Perls (1893 – 1970) drew upon Gestalt psychology, Reichian Therapy, and psychoanalysis, while emphasizing the here-and-now to create Gestalt Therapy for both groups and individuals. His approach sought to resolve "unfinished business" and catalyze underdeveloped or unrealized human potential. While emotional release was a prominent theme, this approach also emphasized the importance of identifying and working through conflicts.

Primal Therapy – This therapy is a good example of an approach where cathartic/abreactive experiences are at the heart of the therapeutic work. Arthur Janov developed this approach that emphasized reliving core experiences from client's early past. He believed that "the disease… is the denial of feeling, and the remedy is to feel" (Janov 1970).

Current directions in catharsis

In a comprehensive meta-survey of contemporary research on the efficacy of catharsis in group psychotherapy, Bemak and Young (1998) sought to answer the questions (a) Is catharsis effective in producing therapeutic change? (b) How does catharsis cause change to occur? and, (c) What counselor interventions activate emotional arousal and enhance expression?

Their conclusions are that, in general, *catharsis is effective for producing attitudinal and behavior change*. Far beyond the simple hydraulic or ventilation ("letting off steam" or releasing pent up emotions) models of Freud and others, they found a significant body of research supporting catharsis as a method for insight, attitude change, creation of cognitive dissonance, and completion of unfinished actions. They also concluded that producing arousal and *maximizing expression is not sufficient for therapeutic change*. Specifically, their survey shows that cognitive insight, reframing, and education (both before and especially after abreaction) is necessary for maximum therapeutic effect. Blatner (1985), a contemporary psychodramatist, reiterated this finding, stating that clients should first heighten their awareness, then abreact, and finally learn how to integrate these feelings through learning new skills and cognitions. The work of Pennebaker (1990), Kraus (1997), Kismicki and Glickauf-Hughes (1997), Chefetz (1997), Straton (1990), and Bohart (1980) support the notion that the release of emotions is not as significant as the new insights and new learning experiences that <u>result</u> from emotional expression and confession. Based on these findings, it is not surprising that Busman et al. (1999) did not find a therapeutic effect in a study of how simple physical exertion (pounding a bag) effects laboratory induced aggression.

Essentially, the current research supports the hypothesis that therapeutically significant change is possible when powerful emotional connections are combined with cognitive reframing and re-education. This hypothesis is also supported by recent neurobiological work reported by Rolfe (2000). New models of emotions and development suggest that emotions play an important "binding "role in memory. Rolfe posits that experiential enactments may be a way of binding out of awareness emotions into conscious awareness. Rolfe further states,

"…the orbitofrontal cortex seems to orchestrate changes in engrained states of mind through the process of response flexibility. Emotional change does indeed appear to be mediated by cognitive facilitation as the orbitofrontal region, through the process of response flexibility, integrates new information and emotional experiences with older enduring states of mind through the working memory platform. The result is the creation of new and more flexible states of mind."

Two Therapeutic Examples

Several contemporary group therapies explicitly utilize the combination of cathartic release and cognitive insight. One example is Depth Oriented Brief Therapy (DOBT) that combines many different Gestalt and Psychodramatic techniques to bring into awareness the "emotional truths" that logically and rationally drive undesired behaviors and thoughts (Ecker and Hulley 1996). The model assumes and expects cathartic release of emotions when these truths are brought into awareness and further assumes that most therapeutic change will take place when these truths are combined explicitly with the cognitive assessment of the consequences of the undesired behaviors or thoughts. An example from the group I lead is a woman who complained during several meetings how alone she was and that the few relationships she did have were all with emotionally unavailable men. When she agreed to work, I had her visualize and describe in detail the qualities of her perfect mate. When this vision was complete, I had her imagine this perfect mate reaching to embrace her and immediately asked her what she was feeling. She was feeling great fear and wanted to run. While she was feeling this fear, I asked her to think of a scene from her past. The scene she chose was one where her alcoholic father was physically abusing her (the scene later expanded to include and uncle and a brother who also abused her). Using other group members as role players, she expressed a great deal of fear and anger towards these men. She eventually exactly described the emotional truth that these scenes created for her and still operated in her choices of men: "If I am vulnerable with a man, I will die." I helped her craft the exact phrase that combined this emotional truth with the already conscious behaviors and consequences of her choices to form the phrase: "If I am vulnerable with a man, I will die, and I am willing to be alone or choose emotionally unavailable men in order to be safe." Ecker (1996) stresses the importance of "pitching a tent in the emotional truth" by writing it down on a 3 by 5 card, reviewing the card daily, observing the expression of the truth in day-to-day life in a journal. Ecker (1996) contends, and my experience with the techniques supports, that after a week or so of making the complete emotional truth conscious, the client spontaneously decides to change their behavior.

Another example of a group therapy that is based on connecting the client with the emotional decisions made in childhood that effect present-day behavior is Redecision Therapy (RT). Similar to DOBT, RT helps clients find early decisions that are effecting there-and-now thoughts and actions. Through the use of Gestalt techniques, clients visit early scenes that represent the emotional, child-based decisions about self. This therapeutic approach utilizes the Parent-Adult-Child model of Eric Berne's Transactional Analysis. Goulding and Goulding (1997), the developers of RT, contended that therapeutic change takes place when the client "redecides" early decisions driving current unwanted behavior or thoughts. The Gouldings further contend that accessing the client's "Free Child", the seat of emotion and passion, is a necessary step in the redecision process. An example from the group I run is a gentleman that complains that his normal reaction to professional or personal success is depression and anxiety. I asked him to examine current examples of this behavior and describe his feelings,

what he was saying about himself, and what he imagined others were saying about him. With these feelings and thoughts still in mind, I asked him to choose an early scene where he thought and felt the same way (seeking to establish contact with the Free Child). He picked a scene with his mother where she was admonishing him to settle down, grow up, and not be so excited. He described her as "depressive" and constantly looking for what could go wrong. She did not allow any feelings of happiness or pride for accomplishment because she believed that would just create more disappointment when thing inevitably did not work out. Using the "empty chair" technique, I invited him to alternate between being himself as a child and his mother in the scene. The client expressed intense anxiousness, fear, and sadness as the scene played out. His "mother" did not change and his early self felt frustrated and stuck (this is called an "impasse" in RT). While still in the scene, I suggested he say to his mother, "I am going to stay anxious and depressed like you so you won't be angry at me or afraid for me." He said the statement while he nodded and shrank down in his chair. After a few moments, he sat up in his chair and in a strong voice said, "No, mom, I am NOT willing to stay anxious and depressed for you!" (A redecision.) He then declared his independence and commitment to allowing happiness into his life. He easily withstood the protestations and threats from his mother (played by himself). The scene ended with the client feeling very powerful, happy, and excited. He stood in front of the group and declared that he was a joyous man and the group joined him in a long period of laughing. He ended his work by planning the things he would do during the coming week where he could express his joy and happiness (this is called "anchoring" in RT).

Both of these therapies, DOBT and RT, assume that early emotional decisions are the crux of unwanted behaviors and thoughts. Finding and making conscious these decisions can involve substantial cathartic affect. When combined with cognitive and emotional reframing and "redecision," cathartic expression can lead to significant shifts in client behavior and thinking. These results are not surprising given the empirical and neurobiological research presented above.

Limitations and restrictions

Bemak and Young (1998) also concluded that cathartic methods were not for everybody. They report that individuals who have difficulty expressing emotions may actually be helped more from emotional arousal-expression than those who are already expressive or over-expressive.

In our expressive and experiential therapy, we have found that clients with challenges in emotional dyscontrol (clients that may have behaviors associated with Borderline Personality Disorder, dissociation disorders, some mood disorders, etc.) are not appropriate for cathartic therapy without individual work on ego strength, emotional control skills, and strong support networks.

Several authors have written about the potential harm done by inappropriate use of cathartic methods. The negative outcomes in early encounter groups noted by Lieberman, Yalom, & Miles (1973), the ethical issues considered by Corey & Corey (1992), and the potential damage to clients with PTSD suggested by Peebles (1989) all point to uses of catharsis directed, and in some cases demanded, by the therapist or leader. Blather (1985) and others (including this author) have suggested several guidelines for the efficacy and safety of the client using cathartic methods:

- The control over the content, form, and intensity of cathartic experiences should rest with the client.

- Cathartic experiences should be preceded and followed with emotional and cognitive support designed for insight, integration, reframing, and re-education.

- Clinicians must especially assess their clients' ego strength and emotional control mechanisms before cathartic experiences and monitor them during and after such experiences.

- The goal of cathartic experiences should not be to maximize emotional intensity, but rather to encourage expression in the form and intensity set by the client.

- Special care should be given to the physical safety of the client and other participants in the cathartic activities.

- Clients must be fully informed of the methods and potential benefits and hazards of the cathartic methods before they are used.

Directions for future research

Based on this review of catharsis in group psychotherapy, I would suggest the following directions for future research in the field:

- While the conclusions of Bemak and Young (1998) are compelling and confirm our own experiences with cathartic processes, additional research is needed to confirm, modify, or refute the guidelines outlined above.

- It would appear that the simple ventilation or "hydraulic" models of cathartic expression are inadequate to explain therapeutic efficacy. Therefore, more sophisticated models of cathartic expression must be developed, perhaps along the lines suggested by Straton (1990).

- There is little mention in the literature about the developmental issues associated with catharsis. Are cathartic methods appropriate for children? Ginsberg (1993) examines some of these issues in relation to play therapy, but much more research must be done.

- Lastly, I would suggest investigation of specific methods of catharsis and their efficacy as well as measuring the efficacy of various combinations of cognitive and cathartic methods.

Conclusions

While historically controversial and, at times, therapeutically questionable, it is now clear why many of our clients, like Jack mentioned at the beginning of this paper, experience very positive therapeutic effects from methods that include a substantial abreactive component. It would appear, assuming appropriate cautions are taken, that the combination of emotional and cognitive preparation, client-directed cathartic experiences, and significant reframing and cognitive learning after such experiences can create a powerful and lasting therapeutic effect. Much more research is required to validate this conclusion and create models that might direct more effective therapeutic interventions in the future.

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