Innovations in Practice Section

Editorial Note: This section of the Journal is devoted to reports by traumatologists who have developed innovative practice methods. Although these approaches are still considered experimental it is our opinion that they deserve attention. It is hoped that investigators, particularly traumatologists who are skilled at clinical trials and outcome research generally, will read these articles and want to invest the time and money to investigate the efficacy of the approach. As with all articles published in this Journal, the Editorial Board encourages responses from the readership.

The Phoenix Club: A Programme for Adults Who Were Traumatized in Childhood*

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THE PHOENIX MYTH

The phoenix is a mythical bird, about the size of an eagle. Its plumage is magnificent, red, gold, and blue. When it is near to death, it builds a pyre of the sweetest spices and sits on it, singing a beautiful song. The sun's rays ignite the pyre and it and the phoenix bird are burned to ashes. From the ashes there arises a worm, which eventually grows into a new phoenix. The bird's first task is to gather the ashes of its parent and, accompanied by a throng of other birds, fly to Heliopolis (the City of the Sun) on the Nile. There the bird is received with great ceremony by the priests of the sun, and the ashes buried in the temple. (Encyclopedia of World Mythology, 1975.

The name of the Phoenix Club thus resonates with the myth; the idea of personal rebirth from the ashes of a tragedy, images of a fiery ordeal on a hot-seat, and support from a flock of other birds. The club operates on the Gold Coast of Queensland, Australia, a modern Heliopolis or City of the Sun. The word 'club' conveys equal membership, empowerment, and belonging. It connotes the possibility of political as well as therapeutic activities.

HISTORY OF CATHARTIC PSYCHOTHERAPIES

The history of catharsis, like the myth of the Phoenix, goes back to the temples of ancient Egypt and to classical Greece. Aristotle discussed it in his 'Poetics', and it undoubtedly played an important part in many different religious rituals throughout the ages. Its use in modern psychotherapy can be traced to 1775, the time that Ellenberger (Ellenberger 1970) cites as the birth of dynamic psychiatry.

Gassner

Ellenberger described Father Johann Gassner (1727-79) as one of the most famous healers of all time. A priest, he was a skilled exorcist who attracted huge numbers of people to Ellwangen, a small town in southern Germany. He would command the demon possessing an afflicted person to produce the symptoms of the disease. In suitable cases this would happen, and Gassner would then further instruct the demon to produce convulsions and emotional manifestations. Once fully tamed, the demon would be cast out in a 'crisis'.

A controversy erupted, possibly because the Enlightenment movement was at the same time trying to replace blind faith and superstition with Reason. Demons, possession and exorcism were unfashionable. In 1775, several inquiries were held into Gassner's activities. As a result they were severely restricted. The inquiry in Munich featured an expert witness called Dr Franz Mesmer.

Mesmer

Mesmer (1734-1815) was able to reproduce Gassner's cures, but he claimed it was through 'animal magnetism', not exorcism. He was a doctor from Vienna who had married a wealthy noble widow with a magnificent estate. Mozart's first opera was performed in a private theatre in their garden. Mesmer's dissertation had been on the influence of planets on disease, and he attempted initially to reproduce tidal forces by the use of magnets attached to his patients. Later he developed a wide variety of techniques for 'shifting fluids' in the body, some of which were similar to Gassner's. One technique was to sit in front of his patient with his knees touching their knees, press on their thumbs, stare into their eyes, and press on their hypochondrium. When successful, a 'crisis' would occur. If provoked repeatedly, the crises would become less severe and eventually disappear. This meant recovery.

Mesmer was no stranger to controversy. In 1777 he left Vienna after a scandal involving a young female patient. He moved to Paris and established a lucrative practice. It was so busy he began treating groups of up to 200 people at a time. A society was founded to spread his ideas. Some of these were somewhat grandiose, for instance he once claimed that running water was magnetized because he, Mesmer, had magnetized the sun!

In 1784, the agitation around Mesmer led King Louis XVI to establish an inquiry into his activities. The commission included Lavoisier, the famous chemist, and Benjamin Franklin, who first proved the electrical nature of lightning, who was at

that time the American ambassador in Paris. The report stated that no evidence could be found of a 'magnetic field'. A supplementary report warned of the dangers of a magnetized female patient developing an erotic attraction for her male magnetizer.

Marquis de Puysegur

It was one of Mesmer's disciples, the Marquis de Puysegur (1751-1825), who made a discovery that changed the direction of Magnetism, and foreshadowed the verbal/action split that has been a recurring theme in psychotherapy since. He discovered a particular type of crisis, the 'perfect crisis', characterized by somnambulism, the ability to talk lucidly about delicate matters, and subsequent amnesia. Convulsions did not occur. De Puysegur rejected the magnetic fluid theory, believing that magnetic sleep was the result of a psychological force between magnetizer and patient. From 1785, a rift developed between the followers of Mesmer, who believed that magnetic sleep was only one of many forms of crisis, and de Puysegur's school. The latter group prevailed after the French Revolution, though the distinction between them was obscured by the use of the term 'mesmerizing' by de Puysegur's followers. Much later, in 1843, it became known as hypnosis.

Charcot

The next significant development occurred near the end of the nineteenth century. After a time when hypnosis had been shunned by the medical establishment, the eminent neurologist Charcot (1825-1893) succeeded in making it once more a respectable subject for study.

Breuer

Among those stimulated to use it were Breuer and Freud. Their book 'Studies on Hysteria', published in 1895, includes the celebrated case of 'Anna O.' as well as Freud's views on the cathartic method (Freud 1955). This involved hypnotizing the patient, encouraging them to concentrate on the symptom and then recount the experiences that had produced it. Much has been written about Breuer and Anna O. (Szasz 1963, Jones 1953, Ellenberger 1970, Hollender 1980, Sulloway 1979). 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. What is known is that the treatment involved Breuer at times visiting his attractive patient's bedside twice daily to close her eyes at night and open them in the morning, his identity being confirmed by her feeling his hands. It

is also said that when he terminated the therapy on account of his wife's jealousy, Anna O. developed an hysterical childbirth which she claimed was a pregnancy from Breuer (Hollender 1980). He panicked, put her into a trance, and fled the house. This event led him to delay publication of the case for 13 years, and eventually played a part in him abandoning his work with Freud (Freud 1955).

Freud

Freud continued to believe in the cathartic method, although he found hypnosis difficult (Freud 1955). He experimented with other approaches, including suggestion, massage (Freud 1955), pressure on the head, and free association. He finally stopped using hypnosis in 1896 (Freud 1955), after a female patient threw her arms around his neck on awaking from a trance. A servant walked in at the same moment (Freud 1955).

Freud's shift from cathartic therapy to free association and psychoanalysis was complicated, and the record contains sufficient information to support a number of different interpretations. The mid 1890s saw several important changes and events in his life, including his dream of Irma's injection in July 1895 (with its implication of emerging doubts about his friend Fliess), the writing of his 'Project for a Scientific Psychology' in September 1895, and a general loss of interest in therapy in favour of psychology and philosophy (Gay 1988). His subsequent emphasis on the method of free association and the analysis of dreams and resistances may also have been influenced by the death of his father in 1896, and his own neurosis and self-analysis (Ellenberger 1970).

From the point of view of a cathartic therapist, Freud's apostasy occurred at exactly the time in his life when he really needed a dose of his own medicine. Probably his personality was such that it would have been hard for him to accept it. It is interesting to speculate about the history of psychotherapy in the last century if Freud had been able to trust Breuer or Fliess to support him through a catharsis of the things that were troubling him, rather than retreat from emotions into intellectualization. He became estranged from Breuer in 1896 (Sulloway 1979), and Fliess, who was not a psychotherapist, lived in Berlin. Freud had to find a more controlled method, one that he could use on himself. The outcome of this was recorded in 'The Interpretation of Dreams' which he later described as being 'my reaction to my father's death' (Gay 1988).

Psychoanalysis was a triumph for intellectual understanding, but has been less of a success as a change-inducing therapy. Although in 1895 Freud had discussed the value and limitations of the cathartic method in balanced, sympathetic terms

(Freud 1955), from this time on he and most of his followers have held that catharsis produces only transient change.

Another notion discarded at the time of Freud's split with Breuer was the latter's belief that ideas or experiences were pathogenic if they occurred during a 'special state of mind', such as hypnosis, a hypnoid state, emotional shock or exhaustion. Freud thought the primary factor was defence against an incompatible idea (Freud 1955). 'Special states' will be mentioned later in the discussion on the 'holographic model'.

An important concept that did survive from this period was 'transference'. Szasz (Szasz 1963) has argued that, whatever the logical status of the idea, it serves an important function in protecting the analyst from disturbing feelings in the patient. According to Freud, these played 'an undesirably large part in.... cathartic analyses' (Freud 1955).

Janet.

Although Freud and his followers stopped using hypnosis and catharsis, others did not. Janet, who had also worked with Charcot and became Freud's main rival in France, claimed to have discovered the cathartic technique before Breuer. In 1891, he introduced 'automatic talking' and incidentally also devised a technique for modifying visual images under hypnosis which bears a striking resemblance to what is known today as Neuro-Linguistic Programming (N.L.P.) (Ellenberger 1970). Other aspects of Janet's approach remind the modern reader of Milton Erickson (Ellenberger 1970) and Ida Rolf (Ellenberger 1970).

Janet also studied the feelings that patients developed towards their therapist. Quoting the old magnetizers, he developed the idea of 'somnambule influence' which extended beyond the hypnotic session. He advocated controlling the undue development of this influence by spacing sessions (Ellenberger 1970). Unlike Freud, he regarded the influence as being more a function of the psychotherapy than the psychopathology.

In the early part of the twentieth century there were several other psychotherapists using approaches that are familiar today. Adler pre-empted Bandler and Grinder in assessing patients' primary representational system; visual, auditory, or motor. He also emphasized the importance of understanding a person's 'hidden goal' several decades before Transactional Analysis developed script theory or Redecision Therapy (Ellenberger 1970).

First World War.

Even Freud spoke favourably of Simmel who used catharsis as a treatment for war neuroses during the First World War. 'The practical results of the cathartic treatment were excellent. Its defects were those of all forms of hypnotic treatment' (Freud 1955). He may have been referring to disturbing feelings in the patient of an unanalysable kind (Freud 1955).

Inefficacy of treatment.

The war and its aftermath produced an epidemic of psychological trauma which focussed the attention of psychotherapists on the efficacy of their techniques. Free psychoanalytic clinics were established in Berlin and Vienna. These also demonstrated the poor results then being achieved (Reich 1973). In response to this, at the International Psychoanalytic Congress in Berlin in 1922, Freud proposed a competition with a cash prize to study the correlation between theory and effectiveness of therapy (Reich 1973). Dissatisfaction with the lack of therapeutic success led to several important developments.

Death instinct.

Firstly, the elaboration of theory to explain failures. The death instinct, described by Freud in 'Beyond the Pleasure Principle' in 1920, had complex origins (Sulloway 1979, Gay 1988) and was his most controversial theory. It led to a rift with analysts who regarded masochism and the desire for punishment or death as secondary consequences of libido repression. According to Wilhelm Reich, the death instinct was used to explain 'negative therapeutic reactions' and rationalize technical failures (Reich 1973). Later in his life, Freud explicitly expressed pessimism about psychoanalysis as a therapy, linking his conservatism to his death instinct theory (Sulloway 1979).

Reich.

A second outcome was the setting up of a seminar on therapeutic technique. Reich was the chairman of this from 1924 to 1930. During this time he was in the mainstream of the analytic movement. He developed his orgasm theory and the technique of character analysis.

Child analysis.

A third development came later with child analysis and the work of Anna Freud, Melanie Klein, and Winnicott in devising theories and therapeutic techniques relating to issues earlier in life, before the Oedipus complex.

Moreno.

Fourthly, psychodrama, the first group psychotherapy, was developed by Moreno in Vienna in the early 1920s. This was a fringe activity at the time, but it can be seen to have been important in retrospect (Moreno 1946).

It is Reich and Moreno who are the fathers of modern experiential psychotherapies. Reich had an unshakeable conviction that satisfactory genital orgasm was essential for the cure of neurosis. This belief led him to investigate obstacles to its achievement, not only in the neurotic symptom, but also in the character and later in the body. His theory of character included an explanation of the mass psychology of fascism, and his biological studies covered sexual problems, psychosomatic disorders and cancer. Most important, however, was his development of 'vegetotherapy' or bodywork, with a variety of physical techniques for treating affect block (Reich 1950, Reich 1973). These included physical pressure on 'blocked' parts of the body, especially over the solar plexus or hypochondrium. Patients were told to exaggerate characteristic gestures or movements. The physical and emotional abreactions he produced by these means are likely to have resembled Mesmer's magnetic crises.

They were probably rather more intense than the hypnotic catharses produced by Freud and Breuer. Reich's patients also developed strong feelings for him, but as a proselytizing sexual radical, he did not panic. Rumours spread that he was sexually abusing his female patients. This was almost certainly a factor in his ostracism from the psychoanalytic association. He was eventually expelled in 1933, ostensibly because of his writings on fascism (Reich 1973).

Reich's reputation suffered even more in the late 1930s, when he claimed the discovery of 'cosmic orgone energy'. In ways that evoke other parallels with Mesmer, he became grandiose and messianic. This was one reason why his earlier and more valuable work was ignored for many years.

Perls.

Many of his ideas survived, however, and resurfaced in the work of two of his analysands; Fritz Perls (Gestalt Therapy) and Alexander Lowen (Bioenergetics). Primal Therapy has some similarity to Reichian bodywork, but Janov denies being influenced by anyone.

The influences on Perls came from several sources. As well as Reich, he was analysed by Karen Horney and Helene Deutsch. He also worked with Kurt

Goldstein, the celebrated holistic neurologist at the Frankfurt Neurological Institute. Next door was the Sociological Institute, where Kurt Lewin's Gestalt Psychology was frequently discussed. Perls also visited Moreno in Vienna (Shepard 1975).

Catharsis in a group setting.

Early individual experiential therapies involving catharsis were curtailed because of social or official disapproval. Gassner, Mesmer and Reich were each the object of investigations or sanctions. Breuer and Freud abandoned their experiments out of fear of scandal, failure of nerve or both. They covered their retreat with assertions that 'catharsis produces only transient change'. Such a judgment from Freud had the effect of placing a taboo on the topic for several decades.

It was the development of experiential therapy in a group setting that created conditions in which the potential of these methods could be taken seriously. In a publicly chaperoned situation, when a patient underwent a major catharsis with the enactment of unconscious issues, a Breuer could not flee in panic, nor could a Reich abuse post-cathartic vulnerability.

Human Potential Movement.

Yalom (Yalom 1975) has described the evolution of the encounter group from Kurt Lewin's first T-group in 1946 in the United States. Initially concerned with group process and techniques of education, the T-group moved in the direction of greater self-disclosure and 'therapy for normals'. By 1960, the Esalen Institute was running encounter groups. It was one of a large number of Growth Centres which promoted the 'Human Potential movement'. Among the people who worked at Esalen were Fritz Perls, Virginia Satir, Ida Rolf, and William Schutz, each pioneers in different forms of experiential therapy.

Many other schools and styles flourished, especially in California. Transactional analysis (T.A.), Gestalt therapy, Primal therapy, Bioenergetics, Psychodrama, Encounter, Neuro-Linguistic Programming (N.L.P.), Neo-Reichian bodywork, Rebirthing, and many others contributed to the baroque flowering of experiential techniques. As they competed for custom, they pushed further into the territory claimed by psychiatrists and psychoanalysts. Attempts to minimize conflict by demarcating 'patients' from 'normals' and 'psychotherapy' from 'growth' failed to obscure significant overlap between the goals and clientele of both systems. On the other hand, the non-medical framework liberated many experiential group leaders from fear of criticism on ethical grounds, particularly in the social climate of

California in the 1960s and 1970s. The slogan 'I am not responsible for your feelings' came to serve a protective function for experiential therapists in a way similar to the use of transference by psychoanalysts, as described by Szasz (Szasz 1963). It has been used to its limits too.

Initially, the attitude of psychiatrists and psychotherapists to the resurgence of experiential therapies was one of suspicious antagonism. Conventional wisdom about the ineffectiveness of cathartic methods was recycled without its origins being re-examined. Dangers were exaggerated. Yalom wrote: 'The casualty research findings have resonated with so many preconceptions that encounter groups per se are now, as a result of the study, described as more dangerous than I, the principal investigator of the casualty research, believe them to be.' (Yalom 1975).

THE BACKGROUND OF THE PHOENIX CLUB

The Human Potential movement spread its influences around the world in the 1970s. I first became aware of it in New Zealand in 1975. At the time I was a young doctor, working as a G. P. (general practitioner). I had become convinced that I needed more skills to help my patients with psycho-social problems, and had been looking for alternatives to the drugs and psychoanalytically based therapies that I had been taught about at medical school. Reading of Gestalt and Primal therapy led me to attend a 5 day encounter group in Wellington. I was profoundly impressed with what I saw and experienced.

I decided to train in these therapeutic approaches, and got a job as a psychiatric registrar. I discovered there was a world of difference between a psychiatric training and the human potential movement, and the next few years were spent trying to reconcile the two perspectives. In 1977 I became a lecturer in psychological medicine at the new Wellington Clinical School of Medicine. This enabled me to attend workshops at weekends while establishing some experimental programmes in the psychiatric unit of the hospital.

The fore-runner of the Phoenix Club was a programme called the Change and Support Programme. I had seen that many patients were referred to the Psychiatric Unit in a crisis, or seeking help changing some feature of their lives. In the process they became outpatients or day-patients, usually receiving individual counselling for about 12 weeks. Often some level of dependency on the counsellor was generated. Symptoms were addressed; rarely were deeper issues tackled in the time available. I believed that a combination of group therapy and experiential

techniques might produce a better outcome with some of these patients, while needing no more total professional time per patient than was already being used.

It was a complex job trying to win the confidence of my superiors for such a programme. The first step was to extend a weekly psychotherapy from one hour to a whole afternoon of three hours. Role play, modest psychodrama, and the use of a 'Hot-Seat' were tried. The room had a one-way screen, and other staff could watch. As time passed and no disasters occurred, the sessions were extended. The workshops were extended to one day and later two days. These showed that deeper levels of trust amongst the members could lead to deeper therapeutic work being achieved. The venue was moved to a room away from the hospital. There were two leaders, two staff observers, and 12 patients. Feedback from staff and patients was good.

By 1979 the workshops had grown to 5 days, Mon-Fri, 8 am - 5 pm. The outcomes were being evaluated using questionnaires and repertory grids. The findings were very positive at the end of the workshop, but showed some fading at the 3-month mark, and more by 6 months. 'I told you so' was heard more than once. 'The old analysts tried catharsis in the early days and found it didn't produce lasting change.' I decided to try and find ways to improve the maintenance of therapeutic change, and also to research what the old analysts had really found. What was the quality of their conclusions?

During a 5 day workshop, considerable bonding develops between the members of the group. It seemed to me that this could be used to help in the change consolidation process, and also replace some of the support being provided by professionals.

The Change and Support Programme thus developed four stages:

- 1) A screening group of one afternoon. Patients referred to the programme would attend, and various exercises would be used. The intention was to try and identify people who might find the Intensive workshop too stressful.
- 2) A 5-day intensive workshop, in which a range of experiential techniques were used. Psychodrama, Gestalt, neo-Reichian, etc. These workshops were videotaped.
- 3) A 6 week support group, with the two leaders attending. These groups took place in the evening in the clients' homes (note how they have changed from being 'patients' to 'clients'). The leaders took a much lower profile, emphasizing the competence of the group membership.

4) An ongoing weekly support group, without the professional leaders. Several of these groups continued to meet for more than 6 months, with two lasting for more than 2 years. The best survival times occurred when the members had been originally recruited from restricted geographical areas, so that 'members' (note the name at this stage) didn't have to travel too far to attend meetings.

This 'Change and Support Programme' worked well in general, and produced better long term benefits than the intense workshops alone. It convinced me that changes produced by cathartic therapies could be long-lasting, under the right circumstances. It also impressed on me the value of re-empowering people and re-tribalizing them by putting them in a group. Ivan Illich's book 'The Disabling Professions' (Illich 1977) was having an influence at about that time, and I was keen to find approaches to helping people that didn't have the effect of locking them into long term dependency on professionals. I wasn't able to demonstrate it conclusively, but many of the people who attended the programme appeared to do significantly better than those patients who went through the routine out-patient experience at the psychiatric unit.

Some years passed, and by the mid 1980s I was working as a psychiatrist in private practice on the Gold Coast of Queensland, Australia. I returned to running weekend personal growth workshops, and from time to time would introduce a patient from my psychiatric practice into them. The patients who seemed to benefit most were those who had suffered some significant trauma in their earlier life, for whom gentle verbal psychotherapy never really seemed to 'hit the spot'. Remembering the value of the follow-up group in the 'Change and Support Programme', I began running a weekly therapy group to serve as a preparation for weekend workshops, and to provide support and reaffirmation opportunities for people who had attended the workshops.

This was the origin of the 'Phoenix Club'.

THE PHOENIX CLUB

Elements of the programme

Referral. Under the Australian Medicare system, all people attending a psychiatrist must have been referred by another doctor if they are to receive benefits. In practice this means everyone who takes part in the Phoenix Club has been medically referred for a psychiatric condition.

The Assessment involves at least two sessions, at the second of which a letter is dictated to the referring doctor. This occurs in front of the patient, who is invited to correct errors, and also 'interrupt me if I say anything you don't want your doctor to know.' This option is very rarely used. The patient is offered a copy of the letter.

Individual therapy. Often there will now begin some individual sessions on a weekly basis. Sessions last 30 mins. If the patients symptoms include depression, or panic attacks, I commonly prescribe medication or initiate treatments aimed at biological issues, such as withdrawal from alcohol or benzodiazepines. Before Specific Serotonin Reuptake Inhibitors (SSRIs) became available in Australia, the drug I used most commonly for panic or depression was dothiepin (Prothiaden; Boots) in a dose of about 150 mg at night. Since SSRIs became available, the most common drugs are fluoxetine (Prozac) 20 mg, sertraline (Zoloft) 50 mg, or paroxetine (Aropax, Paxil) 20 mg. If panic or insomnia is prominent, I find Aropax best of the three. If sleep is good, and the patient is overweight or easily oversedated, I find Prozac the best. Zoloft seems intermediate. If sexual dysfunction with low libido is a presenting symptom, moclobemide (Aurorix; Roche) 300 mg b.d. is superior to the SSRIs.

After a time when I used to try and avoid medication when using a predominantly psychotherapeutic approach, I have come to the conclusion that antidepressants interfere with psychotherapy much less than untreated depression or panic does. On the other hand, benzodiazepines provide a major obstacle to making use of psychotherapy, particularly cathartic approaches. It is very difficult to produce a catharsis in a patient taking benzodiazepines. Various questions are addressed in the individual sessions prior to someone joining the group. The most important is whether an intense cathartic programme would be safe for them. Influenced by the research showing relapse rates in schizophrenia to be higher in families with high levels of 'Expressed Emotion' (Brown, Birley, & Wing 1972, Leff 1978), I assume that people who have ever been psychotic might be at risk if they participated in an intense experiential workshop. Similarly, since many people become a bit hypomanic after a workshop, I also exclude people with a significant history of Bipolar Disorder.

Once I have confidence that the person would be suitable for the programme, and once we have established some rapport together, I have told them of the Phoenix Club and invited them to join.

Individual sessions continue by negotiation, once a week maximum, and once a month minimum. The general tone is gentle, relaxed and informal. The sessions have the quality of a tutorial to discuss the progress of a student with their study.

Bibliotherapy. In my waiting room I have a small bookstall, and several titles are stocked of relevance to the healing of childhood trauma. 'Courage to Heal' for victims of sexual abuse, and 'Struggle for Intimacy' for children of alcoholics are particular favourites.

Phoenix Club archive. This is a file that is kept in a cupboard. Members and prospective members of the club are able to read the file in the waiting room. It contains written contributions from past and present members; stories of abuse and recovery, letters written to perpetrators and parents, and poems. Members choose the level of anonymity they want. Most use their own names. It is understood to be a public document.

Both the books and the archive contribute to the reduction of shame. Many people who were abused sexually or otherwise in childhood feel ashamed at some level. It is a major concern to people considering joining a psychotherapy group. I regard the alleviation of shame as a central goal in the early stages of introducing someone into the Phoenix Club.

Weekly group. This contains a maximum of 9 members (Medicare rules) and meets at 5 pm every Thursday evening for about 1½ hours. The sessions begin with a 'Round'. If no new members are present, I will invite the person sitting beside me to start. They will tell the group of how they are feeling, and anything important that happened since the previous meeting. Each person in the group does the same. Sometimes someone will indicated they want to 'claim some time' after the round to go into something in more depth.

If a new member is present, I explain to them the rules and suggestions, and then a longer 'Round' occurs, with each person introducing themselves, saying why they joined the club, and what they have got out of it. The new member also introduces themselves, although it is made clear to them 'only say as much as you want to at this stage'. The weekly group is fairly gentle, supportive and non-confrontational. No 'Hot-seat' is used. Experiential techniques are not used. Tissues are needed only rarely. Sometimes the content of the sessions is mundane and trivial. Sometimes it focuses on the dynamics of the group. There is talk of current life dilemmas, relationship problems, and issues between members of the group.

After an Intensive workshop has taken place, which several members have attended, there is much talk of what happened, and who did what. Members are encouraged to reaffirm new life decisions made on the workshop. When one reports the application of a change in their lives, such as an event when they were more assertive than usual, the other members of the group tend to offer support and encouragement.

I regard the principle functions of the weekly group to be as follows:

1. Preparation for workshops.

New members of the club meet more experienced members, and gain encouragement and modelling of the various processes involved in healing the effects of childhood trauma. An analogy might be the marinating of a steak before putting it on the barbecue. Rarely the group serves as an opportunity to screen out an unsuitable person; I decide someone is suitable for the programme, put them in the weekly group, and later decide that I was wrong.

2. Shame reduction.

I perceive shame as a 'group' and 'visual' emotion. The shamed person visualizes a group of people whose judgement matters to them, looking at them with disgust or contempt if some secret fact becomes known. It is typical for the eyes to be downcast or covered. Group therapy offers a unique opportunity to provide an antidote. In a caring, supportive group, the person may disclose their painful secret, and watch the faces of the other members and see (usually) that the feared contempt is not shown.

3. Retribalisation.

Margaret Mead once said that for 99% of human history, mankind has lived in tribes. Our culture has been progressively dismantling them, first to extended families, then nuclear families, and for increasing numbers of people, living alone. People who are depressed, panicky, or ashamed, are particularly prone to being peripheralised from social groups. They are more likely to experience relationship breakdown, and unemployment. The weekly group provides an opportunity to belong to something and feel valued by others. This helps in the lifting of self-esteem.

4. Post-workshop consolidation.

As described before in the section on the 'Change and Support Programme', the main challenge with cathartic therapies is the consolidation of the changes that are made. In the language of cognitive therapy, a catharsis makes possible the development of a new 'schema', in an area where it was previously hindered by

some negatively cathected idea. It is not enough for a novel schema to be possible; it must also be practised and reinforced. The group provides support and reinforcement for the novel schemas. It represents a 'transitional context' between the intensity of the workshops and normal day-to-day life.

Chrysalis workshops. These occur over a weekend every two months or so. They run from 7.30 pm on a Friday until 5 pm on the Sunday. Occasionally longer ones are held that finish on the Monday or Tuesday. There are a maximum of 16 participants. The workshops will be discussed at greater length below.

Meeting for partners of members. From time to time I have held a meeting for partners of club members. Some husbands (in particular) found the changes their wives went through threatening. These meetings aimed to reduce the alienation they felt from the therapeutic process, and diminish the likelihood of sabotage occurring at home.

Miscellaneous projects. Members of the club once organized a 'Purple Ribbon Project' march in remembrance of abused children. Several of them who had been raped or assaulted joined a self-defence course together. Five of the members came with me to help present a training course for social work students at the University of Queensland.

MEMBERSHIP

Between 1991 and 1995, there were 43 people who took part in the Phoenix Club. Of these, 8 left early. The 43 had the following characteristics:

44% married, 14% de facto, 42% single or separated.

- Average age on joining: 35.7 years.
- Age range 20-29: 26%
- Age range 30-39: 37%
- Age range 40-49: 32%
- Age range 50-59: 5%

Gender: Female 88%, Male 12%.

Diagnosis

- Depression 70%
- Panic disorder 23%

- Sexual dysfunction 28%
- Eating disorder 28%

Type of Trauma

- Total sexual trauma 70% (Sexual abuse or incest 49%) (Rape 21%)
- Physical abuse 30%
- Alcoholic parent(s) 49%
- Others (wartime trauma, iatrogenic trauma) 4.5%
- Mixed Physical abuse and alcoholic parent 16%
- Sexual trauma and alcoholic parent 25%

Treatments

Average no. of weeks attending group:	30 weeks
Average for those attending > 4 meetings:	36 weeks
Those attending workshops	53%
Average no. of workshops attended by them	5
Antidepressants	60%

Stages of Healing

1. Recognition of problem.
2. Decision that problem is intolerable. 'Patient stage'
3. Decision to seek help.
4. Linkage of problem to childhood trauma.
5. Admission to self of childhood trauma. 'Shame stage'
6. Admission to another (friend or therapist).
of childhood trauma
7. Experiences that reduce the myth of uniqueness. 'Victim stage'.
Reading. Archive. Group.
8. Experiences that reduce shame.
Self-disclosure in supportive group.
9. Experiences that re-empower. 'Survivor stage'.
Cathartic work and redecisions. Assertiveness.
Self-defence training
10. Experiences that re-tribalize.
Phoenix Club. New job. New relationships.
11. Exit from the patient role. 'Thrivers stage'.
Help others. Political action. Join non-problem groups.

12. Consolidation of new personal system.

CHRYSLIS WORKSHOPS

The Chrysalis Personal Growth Workshops are the centrepiece of the Phoenix Club programme, although they are not exclusively for members of the club. Others attend as well, including other patients from my practice, and also people who are not patients. They take place in my home, in the foothills of some mountains in the Gold Coast Hinterland. The fact that they occur in my own home introduces another selection factor into membership of the Phoenix Club. I need to feel comfortable about a prospective member spending a weekend in my home. They run from 7.30 pm on the Friday to 5 pm on the Sunday.

Principles

The purpose of the weekend workshops is to provide a context in which people can make use of therapeutic approaches that may be noisy, intensely emotional, and require more time than can be scheduled in a conventional psychiatric practice.

Various principles are applied:

All activities are voluntary and only occur with the active consent of the person attending. 'Therapy' is only done with people who have chosen to sit in the centre of the room on a 'Hot-seat'. They may leave it at any time without explanation. They may not be questioned by other group members. There is no pressure from me or the group to sit on the Hot seat. If the work involves physical contact, such as pressure on the back of the shoulders for someone who is trying to deal with guilt, or some re-enactment of a traumatic incident, the person is instructed that they may stop what is happening at any time. They are coached in the procedure for doing this: they may either say 'Stop!' and use my name, or they may hit on the floor twice, like a wrestler surrendering.

No violence against people or breakables.

The normal social pressures to minimize emotions are reversed. Thus people who are sad are commonly encouraged to cheer up, the angry are told to calm down, and the scared are advised to relax. During the workshop, people are encouraged to exaggerate their feelings.

The 'Round'.

The Round in the workshop is similar to that in the weekly group. At the beginning, after some introductory exercises, relaxation, and one-to-one introductions, each person in the group introduces themselves as fully as they wish. They are encouraged to tell 'the story so far.' People who have attended previous workshops are asked to report what they did at the last workshop, and how they had made use of the work they had done then. This acts as an opportunity for reaffirmation, and also raises the level of expectation in newcomers. There are further 'Rounds' throughout the workshop. They occur at the beginning and end of each session, and also after any particularly emotional piece of work. As the workshop develops, much of the talk occurs either in Rounds or when someone is working on the hot seat. In other words, the workshop is highly structured, although not particularly highly directed by me.

When a Round occurs after a person has done a piece of work on the Hot-seat, the group is explicitly asked not to give advice or ask questions of them. This is to reduce the chance that the person's focus on their new decision will be distracted.

Pronouns and Ego-boundaries

I was influenced in the early years of my training by the ideas of Gestalt Therapy. Fritz Perls described (Perls, Hefferline & Goodman 1973) the ego-boundary disturbances of projection, introjection, pathological confluence and retroflection. I have found them very useful concepts when working with adults who were traumatized in childhood, and also when working in groups.

Projection occurs when a person attributes to something outside the self, a quality that is truly inside the self. An example is 'Pot calling kettle black'. Pronouns are the words used to denote the location of phenomena with respect to the ego-boundary, thus projection usually involves the misuse of the word 'you'. The speaker says 'you are/think/feel...' when the truth is 'I am/think/feel...'

Introjection is the opposite error. The person identifies as belonging to 'self' something that is truly 'non-self'. They misuse pronouns in the opposite direction, and may say 'I am/think/feel...' when the truth is 'You/he/she/they are/think/feel...'. Characteristically the introjector swallows indiscriminately other peoples feelings, thoughts and emotions. They tend to take other peoples problems on themselves. Commonly they show other features, such as eating disorders, substance abuse, and an 'all-or-nothing' attitude to sex in women or receptive male homosexuals. The mouth, vagina, and anus are three places where the abstract process of introjection is made concrete in eating or sex. They also commonly have episodes of unresolved grief, and difficulties with assertion and anger. (See Footnote) Pathological confluence. Such people can't distinguish between 'I' and 'we'. The

pattern is particularly clearly visible in groups, when they claim to speak for everyone. 'We' really understand/care/disagree etc. The truth is 'I really understand/care/disagree'. Such people are often 'oceanic' in their relationship to the world and tend to minimize differences.

Retroflection. This is where an outgoing emotion gets turned back onto the self. The classic example is anger retroflected as guilt, but others exist. Narcissism is retroflected love, and suicide may be retroflected murder or hate.

I have found that distorted ego-boundaries are common in victims of childhood trauma and abuse who present to my practice. The commonest ones are introjection and retroflection. There are two possible interpretations; firstly that childhood trauma leads to distorted ego-boundaries, and secondly that people with distorted ego-boundaries who suffer from childhood trauma are more likely to develop problems that lead them into psychiatric treatment than people with intact ego-boundaries who experience childhood trauma. I haven't found a way of clearly resolving these possibilities, and I suspect both play a part. Where is the ego-boundary? It is not in a physical space, like the skin. It can't be simply sewn up, if it is leaky. Instead it exists in a cognitive space, in the mind and perceptions of the person. Thus when it is distorted, the changing of it requires a cognitive strategy. This is why I pay close attention to the correct use of pronouns. As noted above, pronouns are the words used to locate phenomena and their relationship to the ego-boundary. They can be used correctly or incorrectly, in a variety of ways. By insisting on their correct use, it is possible to cognitively modify a persons thinking about their 'self' and its boundary. The point of the exercise is not to do with communication. Language is, of course, used for two purposes, to communicate with others, and also as a tool for thinking. It is the latter purpose that is primarily being modified, although groups in which projection is inhibited by the word 'you' being carefully controlled suffer from much less chaotic hostility than those in which projective processes have a free rein. I think this contributes to the groups being supportive and caring.

In practice this means that when someone misuses a pronoun I will correct them. If someone uses the word 'you' in a generalization, such as 'you just feel so scared', I will suggest 'I just felt so scared'. Or in projection 'you look really angry', I might enquire 'are you feeling angry yourself?'. Someone who announces that 'we think..' will be invited to say 'I think..'

A metaphor explains the point of the exercise. If a dinghy has capsized and is full of water, it is impossible to bale it out if any part of the gunwale is under water. A bucketful thrown out is immediately replaced by seawater flowing in over the

edge. But if the gunwale can be got clear of the water, it becomes possible to successfully bale the water out. A boundary with some integrity is essential.

Traumatized children often carry with them into adulthood toxic introjects in the form of negative injunctions such as 'you don't unconditionally have the right to exist', or 'you have no right to say no'. From experience I have come to believe that the long-term benefits of cathartic therapies are greater if the person has cognitively achieved an ego-boundary with some integrity.

Work on the 'Hot-Seat'

The workshops begin on the Friday night, with instructions, a relaxation/guided fantasy exercise, one-to-one introductions, followed by an introductory round. On the Saturday morning, after an opening round, there is an exercise designed to promote trust and risk-taking. Each person is asked to identify a part of themselves that is normally concealed that they would like to be able to share with someone else. They have to find an object to symbolize this, and in the morning exercise, choose one person they are prepared to entrust it to. They are then asked to explain across the group what the object represented, and why they chose the particular recipient.

This has the effect of moving the group beyond the amorphous soup that had been developing, and towards differentiation and self-disclosure.

After the discussion this evokes, I stop leading exercises, and wait for someone to volunteer to sit on the cushion in the centre of the room; the 'Hot-Seat'. There I work with them on whatever issue they want to bring up. The right to stop things at any time is emphasized.

Gestalt therapy

Gestalt therapy is reasonably well known (Perls 1969), so I won't elaborate at length. I particularly use the 'Two-chair' technique; getting the person to choose a cushion for the significant other person involved in the story, such as a parent, partner, or abuse perpetrator, etc. They are encouraged to speak to the other, then reverse roles and speak back. As the dialogue develops, non-verbal clues of emotions that are not appearing in language may be noted. I may then encourage them to intensify them. For example, if the dialogue involves the expression of sadness towards a dead father imagined on the cushion, yet the person's right hand is clenched, I may suggest 'say that again, and clench your fist tighter.' Or even 'Say it again, and try hitting the cushion at the same time.' Often this leads to a

shift in emotion, some anger being expressed, and then a movement towards resolution of the grief.

Another gestalt technique is to ask the person to go around the group and look each member in the eye and say something. I might suggest the first part of a sentence, and ask them to finish it with whatever seems right. For example, 'I was really scared that if I told anyone what was being done to me that...' As each fear is described, emotions are intensified. The emotional expression is encouraged.

As tears appear, I notice the physical level that is responding. Some people just cry with their eyes, and a snivel. I encourage them to move it down to their throat, 'Make a sound'. When it is audible, 'Let it go deep down into your tummy'. 'Breathe more deeply and let it all come out'.

If a catharsis is evoked by these sorts of methods, I and the group will provide support and encouragement while it is going on. After it is over, I will ask the person to go around some or all of the group and tell them their new decision. 'I do have the right to exist, be angry, feel sad, ask for help, etc'.

For reasons that I will discuss shortly, I believe it is important to focus the person's attention in the post-cathartic state on their new decision, and not on ideas like 'He is a wonderful therapist', or even 'this is the most caring group of people in the world.' Cathartic therapies may create the opportunity for novel cathexes; it is important that the opportunity is not wasted on something that is not useful, or is dependency-generating.

Psychodrama

Psychodrama is also well known in the therapeutic community (Moreno 1946) and I have no doubt there are practitioners more expert than me. I regard it as occupying a similar role to Gestalt Therapy, with some advantages and disadvantages. The advantages apply for people whose capacity for visualization is inadequate to make use of the 'Two-chair' technique. Such people say 'but how can I talk to a cushion?'. They find it easier to talk to an actor. Another situation where psychodrama has some advantage is where there was a specific event that occurred and was never satisfactorily completed. A third advantage is that psychodrama involves other group members actively, even though they are helping with someone else's story. This can serve to desensitize them to going onto the 'Hot-seat' for themselves.

The main disadvantage of psychodrama is that it often takes longer. I thus tend to use it with discretion in only those situations where it seems likely to have a clear advantage.

Some examples. A 26 year old student whom I shall call Jenny, with several years of depressions, suicide attempts, and compulsive washing behaviours. She would shower more than 6 times a day; a fact which only came to light because she was draining all the limited hot-water on the (residential) workshop. She had been hospitalized several times, and had been on most antidepressants with limited benefit. She was quiet in the weekly group, but volunteered that she had been sexually abused between the ages of 8 and 12 by a step-father. She read 'Courage to Heal' conscientiously, became depressed again, and improved after a few months to the point where I considered it safe to invite her to attend workshops. She watched quietly on the first one, but at the second she came out onto the 'Hot-seat'. She told her story, of how her stepfather would hold her back to miss the school bus, then sexually molest her and leave her with semen on her face and clothes before taking her to school. He would not allow her to wash, and her big terror was that other kids would smell her and tease her.

I suggested that she do a psychodrama of the class-room, and she agreed. With my help she arranged the room with blackboard, seats, and doorway, and asked most of the group to play various roles, such as the stepfather, the teacher, the main class bully 'George', a special friend 'Anna', and the other kids sitting in rows. She then introduced the characters by playing their roles, watched by the actors. Eg. 'I'm George, I like hooning around, and teasing Jenny. If I think it will make people laugh I will call out 'Jenny stinks!'. The teacher was basically kind, but frustrated that Jenny was always late and wouldn't explain why. After enrolling everyone, the action was played through, from the step-father driving her to the school, and her entering the classroom late, and feeling very embarrassed. At each step in the plot, she reversed roles with the person about to speak, and delivered their lines, which were then repeated by the actor. George teased her, the whole class laughed. The teacher called her up and asked why she was late. She cried and couldn't say.

Once the scenario was completed, I asked how she would like it to have been different. She couldn't say. I asked her to 'be' her friend Anna, and asked Anna. Anna didn't know what was happening to Jenny, but thought Jenny should try and tell the teacher the truth. 'Reverse roles'. Jenny didn't think she could tell the teacher. 'Be the teacher'. The teacher was worried about Jenny and thought he would be able to be more help if he really knew what was going on. I asked Jenny if she would be prepared to try telling him if I helped her. She agreed.

So the action was played through again from the beginning, with stepfather, late entry, George yelling out 'Jenny stinks!', the teacher's enquiry, etc. Jenny went up to the teacher at the front of the class. Very nervously she started to tell him. 'I'm sorry I'm late. I couldn't help it. My step-father is doing bad things to me.' Then with increasing vehemence, and turning to the class, 'and I know I smell, George, I can't help that either. He shouldn't be doing those things to me. He's got no right!'. Visibly the shame in her face diminished, and she started to look indignant, angry and defiant.

Two years later, she is going well, has instituted legal proceedings against the stepfather, and is tentatively dating for the first time.

A second case. A woman of 40 whom I shall call Kate.

She came into therapy with her husband after a marital crisis. In the course of exploring issues it emerged that she had been gang-raped by 5 youths when she was 15, while jogging home across a park at dusk. She had been warned about jogging alone by her parents, and feared she would be blamed if she told them, so never did. I invited her to join the Phoenix Club, and she attended several weekly groups, before coming on a workshop together with her husband.

When she volunteered for the 'Hot-seat' I offered her a few alternatives, including an attempt to unblock feelings at the time of the rape. She agreed to do that. My major concern on this occasion was to ensure that she retained the ability to stop the proceedings. She had told me that her memory was not of the sexual aspects of the rape, but rather that she was held down and had a hand over her face to stop her screaming. Her principle fear had been that she would suffocate and die. I therefore asked her to choose one person to come and help her by holding her right hand, with particular responsibility for noticing if Kate tapped twice to abort the re-enactment. We rehearsed this; 'show me how you would stop us'. I then asked her to choose five others (not including her husband) to come and help her, by holding her down. She did.

She then re-enacted what had happened, running on the spot for a while to recreate the breathing, and describing the car pulling up and the youths dragging her into it. I asked to lie down on a mattress, close her eyes, and the 6 helpers to hold her firmly but gently. 'Tell me what is happening'. She reported the youths holding her down and became very distressed. 'Don't suffocate me!' I put my hand over her mouth firmly, leaving her nose free. She screamed and fought. Ensuring she was free to breathe, I kept my hand touching her mouth. 'Scream louder!' 'No-one can hear you, scream louder!' She did.

Once the catharsis was established, we just provided encouragement and support. Afterwards I suggested she go and sit with her husband, and let him hold her. He was very supportive. Later she went round the group and affirmed 'they had no right to rape me, I have every right to protest and scream, and to tell my parents, and expect their support'. 'I have the right to say 'No!'

She attended a second workshop a few months later, and again relived the rape experience using psychodrama. On this occasion, however, she was able to access some of the rage that had not emerged on the first occasion. The result was a spectacular scene in which she 'killed' each of the five rapists by attacking five cushions with her fists, roaring vengeance, and emerging triumphant and reempowered.

A year later, she was much happier, more assertive, and the marriage had a new lease of life.

Reichian therapy

In the 1920s Wilhelm Reich developed a number of therapy techniques for shifting blocks of what he called 'orgone energy'. I am personally sceptical about the existence of any such energy, but I have found some of his approaches useful. His daughter Eva Reich was one of many travelling workshop leaders, mostly from America, who visited New Zealand in the 1970s teaching their methods.

From her I learned the 'Radix Technique'. It is one of the most powerful of the cathartic methods I know, although it is something of a 'lucky dip', in that one does not necessarily know the scene whose re-enactment will be provoked by it. Because it is so powerful, and can elicit material of such intensity, I tend not to use it with people coming on a workshop for the first time. I believe a better outcome is more likely if the person has already seen others go through similar experiences and emerge feeling helped.

The method involves inviting the person who has claimed the 'Hot-seat' to lie on their back on a mattress in the middle of the group. I remind them of their ability to stop things at any time. I then invite them to breathe deeply down into their abdomen. I sit beside them, talking gently. After a little while, I put a hand on their solar plexus, and gently push down as they expire. The push becomes firmer at the end of their expiration, effectively emptying their lungs more than normal. When this pattern is well established, I may leave their solar plexus and move around their body, lifting each limb in turn, and testing it for tension. The intent is to mobilize the other parts of the body. The hyperventilation continues. Maybe 5

minutes have passed by now. I return to the solar plexus, and continue to push on expiration. I then suggest they close their eyes, and open their mouth. 'As you breathe out, make a little sound... Ahhh'. Quite commonly, from this time on signs of some feeling become apparent. It may be noticeable in the voice, or a tear may trickle from the corner of an eye. Or the face may change, with tension around the eyes, mouth or jaw. Sometimes the legs will move.

Whatever I notice, I encourage to be intensified and exaggerated. (Recall Gassner and Mesmer who did similar things). I pay attention to where in the body there appears to be activity and where there is not. Often it seems to fit a pattern such that there is tension or movement above a certain level in the body, and none below that level. Eg. tension around the eyes and mouth, but little sound, and resistance to freely deep-breathing. This suggests a block in the area of the throat. If I notice this, I encourage them to make more noise, and actively massage the throat. If the mouth is closed, I may test the ease with which I can push the jaw open; if it is difficult I suspect issues to do with anger, or alternatively resistance to screaming. Throughout I will encourage, 'it's OK, let the feelings come up.'

Often they will. A cathartic regression will be provoked, with outpourings of emotion and movement, suggestive of a young child reliving some experience for which the feelings were somehow blocked or buried. They will flow for a while, and then another resistance may become apparent. The art of this therapy is in the noticing of the blocks, and being intuitive and inventive enough to come up with things to say, or physically do, that will help the person move on to a resolution.

The power of the method is its ability to move someone into quite primitive early emotional experience, often before the stage of language. The corresponding challenge is to help the person integrate the regression afterwards. At one stage I used to videotape people working on the hot-seat. People using Reichian methods found it particularly valuable to review afterwards.

I have many times seen births being re-enacted, with curling into a foetal position, followed by pushing forwards against an obstruction. Sometimes it is possible that the person was deliberately acting out some plan, but many times I am certain they were quite innocent of the appearance they were giving. On one occasion a woman

suddenly went into a spasm with her head arched back, and crying in pain. I was worried, thinking that some dangerous problem might be developing. I asked one of the members of the group, an anaesthetist, if he had

ever seen such a thing arising from hyperventilation. He hadn't. Another member of the group was a midwifery tutor. She suggested it might be a face presentation rebirth. When it was all over, we asked the woman about her birth. She didn't know. Neither did her mother, who had had to have a general anaesthetic. Face presentations only happen once in 900 births. If it could be confirmed from obstetric records it would be strong evidence that it was a genuine re-enactment. Unfortunately the records have proved hard to trace so far.

Hyperventilation depletes the body of CO_2 , which is acidic, thus the body becomes more alkaline. This affects calcium ionisation which in turn affects some nerves. People may develop tingling of the fingers or mouth, or even tetany, (spasm of the fingers). Some rebirthers regard tetany as insignificant and 'push through' that stage with more vigorous hyperventilation. I think it is at least a distraction, and possibly dangerous, so my practice is to have a paper bag nearby, and hold it over the mouth to make the person rebreathe their own CO_2 , thus reducing the effects.

The hyperventilation technique may regress people to other experiences as well as birth. Another memorable case early in my experience with this method concerned a man I shall call John, in his late 30's. He was depressed and anxious, and had a variety of obsessional symptoms focussing on his concern that he might have bowel cancer. All physical tests had been entirely normal. In his history there was a traumatic incident, when, at the age of 8, he had gone off to school waving to his mother. While he was away his mother suddenly died. Following this he was put into foster homes and had various bad experiences in his early teens and later. After a number of other approaches had been tried with him I used the Reichian approach described above, except that instead of getting him to say 'ahh', at that moment I asked him to imagine his mother and call for her. A similar technique is described by Janov in 'The Primal Scream' (Janov 1970). He became increasingly tense and then let out a huge scream of pain and distress. The catharsis continued for about an hour. It was as if his life between the death of his mother and his early twenties unfolded before my eyes, with the emotions emerging one at a time. He went through sadness, anger, laughter, and periods of stillness. When it ended he was smiling and happy and describing a deep joy that he had never experienced before. I followed him over 12 years, and the event remained extremely significant to him, representing a turning point in his life.

THEORETICAL SPECULATIONS

The Phoenix programme, and the various components of it, have essentially evolved in a pragmatic fashion. Few parts of it are genuinely original, rather it is that the different components have been combined into an integrated programme

and applied to a population of people who were traumatized in childhood. It would be tempting to try and justify it by overstating theoretical explanations. Instead, I regard any theory as essentially speculative.

There are 4 principal models for understanding the changes that occur in cathartic therapies:

1) The Hydraulic Model is usually described as such by its detractors. It essentially holds that a 'fluid' or 'energy' in the body and mind may become blocked or obstructed in some way, and that successful therapy manages to 'unblock' it. This is by far the most popular view of emotions, and is reflected in ideas such as 'letting your feelings out'. Exorcists such as Gassner thought in terms of getting spirits out of an afflicted person. Mesmer's 'magnetic fluid' and Reich's 'orgone energy' also clearly fit this pattern.

A similar metaphor that illuminates some of the issues at stake is the idea of an abscess. It is possible to have a cut or wound which is clean and allowed to bleed freely. When sewn up, after a while one is left with a scar which is not particularly painful. Another cut, in other respects similar, which is dirty and infected, yet sewn up, may later produce a similar looking scar, but underneath it, an abscess. A bump in the vicinity produces more pain than can easily be explained by the bump itself. The person erects various defences against people touching them in that area. The treatment requires that the patients trust be acquired, that bandages and other protective devices be removed, and then that the patient submit to having a scalpel or needle inserted.

Some parallels can be seen in the treatment of childhood trauma. A traumatic experience for which the emotions at the time cannot be freely processed may become walled off; a dissociated memory with associated life decisions which are unamenable to conscious change. The treatment may require a period of confidence building before an attempt is made to release the painful pus.

Any attempt to evaluate the efficacy of a treatment like this should usefully bear in mind this analogy. Sticking needles into people who have no abscess, or sticking needles into recent wounds which are not infected, may produce no significant benefit. On the other hand, sticking a needle into an abscess, and following it up with a suitable drainage system may well make a very considerable difference.

2) The Pavlovian Model has been used by Sargant (Sargant 1957) to explain a range of phenomena including shell-shock (and its treatment by sodium amytal or ether abreaction), religious conversion, and political brainwashing. Pavlov was

particularly interested in the effects that the Leningrad flood of 1924 had on the dogs that he had been conditioning. Some of the dogs were trapped in their cages by the rising flood-water. A number were terrified beyond a point at which they could respond normally, and switched to a state of 'transmarginal protective inhibition'. In addition their recently implanted conditioned reflexes had disappeared.

Sargant draws on this to suggest that severe mental stresses, such as occur in battle, religious conversion rituals, or political interrogation, may create a physiological disturbance of the brain as a result of which old patterns of thought may be discarded and new beliefs instilled. He describes how many conversion rituals have certain features in common, typically involving arousal, hyperventilation and subsequent abreaction. These are then followed by the adoption of a new belief about the self, the world or a religious figure.

Sargant describes similar patterns in a variety of different settings. Some Christian sects in the U.S.A. pass rattlesnakes around the congregation to facilitate arousal, Egyptian priests use a shower or hose squirted repeatedly at the face to produce both arousal and hyperventilation. Voodoo sects use chanting, drumming and exhaustive dancing, together with the appearance of frightening spirits, to provoke an abreactive collapse. Many religions use lengthy singing by congregations, some use fear inducing threats of hell, fire and damnation.

Cathartic therapies may act in a similar way by raising levels of arousal. Examples include the re-enactment of traumatic experiences in psychodrama, or the deliberate use of hyperventilation in Reichian therapy to create a catharsis or abreaction. After this the person is more open to accepting a new belief.

The Pavlovian model can be compared with the rubbing out of a blackboard, onto which new things may be written.

3) The Cathexis model utilises the concept of bonding. Usually this is conceived as being the emotional attachment between one person and another, however it can be broadened to include emotional attachment to a belief, or view of the self or the world. Phobic objects are negatively cathected, while beliefs and attached objects are positively cathected. In contrast to the 'hydraulic model', this could be described as the 'electrostatic model'.

A central idea in this model is that such cathexes develop at times of changing arousal. Thus if an organism is in a high state of arousal, and that arousal diminishes, an object in the vicinity may become positively cathected. Examples

of this phenomenon include childbirth, when a mother might be in some pain, hyperventilating, and very aroused. At delivery, there is a sudden drop in arousal and bonding onto the new infant may occur. Obviously other processes are also involved, but it maybe that this particular example lies behind the evolution of the mechanism. Sexual intercourse similarly features high arousal with a drop after orgasm and consolidation of bonding between partners. Other things can be thought of in these terms, for example when Pavlov's hungry dogs are fed, they positively cathect the sound of the bell that preceded the arousal drop. Skinner's hungry pigeons are fed, they positively cathect the pecking behaviour. A lion in pain has the thorn removed from its paw; it bonds onto Androcles. Someone with panic disorder rushes out of a supermarket, arriving home as the panic passes off; they over-positively cathect their home, developing agoraphobia. An anxious person smokes a cigarette or takes a tranquillizer; they become addicted. Even hijack or rape victims sometimes bond onto their captors, especially if the situation is prolonged to a point where the initial arousal and fear has time to reduce while the victim is still in the vicinity of the persecutor. This is known as the 'Stockholm Effect', or 'trauma bond'.

The phenomenon may have played a part in the formation of the 'unanalysable transferences' that Mesmer, Breuer, Freud and Reich discovered when using catharsis. It probably contributes to the intense group bonding and cohesion that one sees in experiential groups, and the adulation of certain group leaders. An understanding of it is crucial to the assessment of the benefits and risks of cathartic methods.

4) The Holographic Model. Karl Pribram was born in Vienna and qualified as a neurosurgeon in the U.S.A. (Ferguson 1982). He studied under Karl Lashley, whose major area of research was the location of memory in the brain. Lashley trained experimental animals, then selectively damaged portions of their brains, expecting to remove the memory of what they had been taught, and thereby identify the location of the memory. Instead he found that the memories remained, regardless of the position of the damage. Performance dropped off in relation to the mass of brain removed. Lashley's 'Law of Mass Action' states that the loss of memory is proportional to the mass of brain tissue removed not its location. (Lishman 1987) It represents a major puzzle in neurology. Pribram helped write

up Lashley's research, and began to search for an explanation. In the mid 1960's he heard about the first hologram, and in 1966 he published his first paper suggesting a connection. This was later elaborated in his book 'Languages of the Brain' (Pribram 1971).

A hologram is a three-dimensional picture that is created using a type of lensless photography. A tuned light from a laser is split into two beams. One beam is projected onto an object, such as a face, from where it reflects towards a photographic plate. The other beam hits a mirror, and is also reflected towards the film. As the two beams intersect, they form an interference pattern, similar to that formed when several pebbles are thrown into a pool. This interference pattern is recorded on the film. The developed film is the hologram.

If tuned light, with the same frequency, is shone through the hologram, a three-dimensional image of the face appears beyond it.

Three remarkable features of holography have contributed to the analogy with brain processes:

a) Whole-part relationship. If the hologram is cut into pieces, any part of it can be used to recreate the whole image. The smaller the fragment of film used, the worse the picture definition, but even the smallest bits generate the whole face. This phenomenon parallels the feature of memory that so puzzled Lashley and Pribram.

b) Frequency specific record. A double exposure can be made using two different frequency light sources. For example, a hologram of a face could be made using red light, then a hologram of a hand using blue light, on the same photographic plate. When the red light is shone through the hologram, only the face is seen; with the blue light, only the hand. c) Pattern recognition. If a hologram is made of a shape, such as the letter 'e', then the light projected through the hologram onto a page of print, every incident of that shape, whatever the size, will be lit up. This phenomenon is particularly intriguing to workers trying to enable computers to recognize shapes. Conventional computing techniques of scanning and analysis cannot achieve a speed of recognition even remotely approaching the ability of a baby when it looks up and says 'Mum!'. It suggests that the human brain may use a different approach entirely, possibly utilizing a mechanism analogous to holography.

DISCUSSION

It is the second phenomenon, the frequency specific record, which is particularly relevant to this paper, and other aspects of psychiatry. It suggests the hypothesis that memories, emotions, and life decisions may be recorded in ways that are somehow 'frequency-specific' to the state the brain was in at the time the experience occurred. This idea parallels Breuer's position in the disagreement he had with Freud over the origin of pathogenic ideas or experiences. It is also

comparable to the concept of 'state-dependent learning'. It suggests the possibility that there is not just one 'unconscious', but many.

It is an idea that raises a number of questions. What, for example, is the analog of 'frequency'? Is it simply some physiological component of arousal? Or does it include multiple factors such as pH (under the influence of hyperventilation), drugs, alcohol, hormones and sensory context?

The therapeutic implication of the holographic model is this: insofar as the relationship between a life event and subsequent psychopathology is mediated by memory, cathexis, or a life decision, efforts to change any of these will gain greater purchase if the brain is 'tuned' to the same 'frequency' as when the memory, cathexis or decision was 'recorded'. In practical terms, this means reduplicating, as far as practical, the psychophysiological state the person was in at the time the restrictive life decision was made and then facilitating the making of a new, and more life-enhancing 'rededecision' (Goulding & Goulding 1979).

Psychodrama achieves this by re-enacting events or relationships with live actors. Gestalt therapy uses empty chairs and role-play. Reichian therapy uses physical methods, such as forced hyperventilation or emotionally arousing confrontations. The behavioural treatment of phobias involves 'exposure' to the feared situation (Marks 1978).

Therapies that elicit certain 'frequencies' of arousal in the course of decathecting traumatic events may inadvertently 'tune' to nearby 'frequencies' with comparable features of hyperventilation and arousal, thus accessing experiences to do with sexuality and birth. This may explain why schools of thought have arisen that attribute primary significance to either the orgasm (eg. Reich) or birth (eg. Rank). It may also help to account for the sexual nature of the complications that arose for therapists working with cathartic methods, such as Mesmer, Breuer, Freud, and Reich. Grof, whose theory of experiential therapy also draws on the holographic model, links horrifying war-time or concentration camp scenes to perinatal experiences (Grof 1985).

Notice that the holographic model is significantly different from the 'hydraulic model' with which catharsis is usually associated. The latter equates emotions with a fluid which the person must 'get out'. It implies that the heightened arousal and catharsis is both necessary and sufficient for change. The holographic model, on the other hand, regards the achievement of original (not maximal) levels of arousal as being necessary, but not sufficient. The key element is the 'rededecision' which may or may not also occur. This is similar to the idea of 'insight' in analytic

therapies. If the 'holographic' model's ideas of arousal level and redecision are linked with the 'cathexis' model's concept of arousal reduction, they suggest that the period immediately after a catharsis may be critical in determining outcome. As arousal is diminishing, ideas or people in the immediate environment may be positively cathected. If the person's attention is focused on their new life-affirming decision during this period, they may be helped to positively cathect it. If their attention is on the group their decision may be diluted with the belief that these are the most wonderful, caring people in the world. Similarly, attention on the therapist may produce 'unanalysable transference'. Clearly a group leader who was unaware of these issues, or whose agenda was ego gratification, could produce some of the effects that have made many responsible clinicians suspicious of cathartic therapies, intensive encounter groups and their ilk.

It is interesting to compare these ideas with developments in behaviour therapy. A phobia can be thought of as a cathected belief or 'decision' that the phobic object is dangerous. The favoured treatment for a time was systematic desensitization, in which deep muscle relaxation is combined with the slow, progressive exposure to the phobic stimulus. Then flooding came into favour, with maximum levels of arousal being provoked until the arousal begins to extinguish. The current approved approach (Marks 1976) involves 'exposure' without either relaxation or an attempt to maximize arousal. Group support assists by providing modelling and aiding compliance. The patient is helped to 'redecide' that the phobic object is not dangerous after all.

From the perspective of the ideas in this paper, an analogous developmental path has occurred in the field of psychodynamic psychotherapy. Early successful cathartic therapies fell into disrepute because the practitioners ran into social or sexual taboos. Freud changed direction towards the couch, relaxation, free association and secondary process. Cathected ideas and experiences were approached slowly and verbally. After a number of false starts, experiential therapists rediscovered catharsis and for a while aimed to maximize levels of arousal. The 'holographic-redecision' model now suggests that optimum, not maximum arousal, is needed to facilitate change, and that the critical issue is the new decision. This may be most efficaciously consolidated in the post-cathartic state. This state is also critical for other possible outcomes of the therapy, including some undesirable ones.

SUMMARY

The Phoenix Club has now been running successfully for about 6 years. It has been the crucible in which many people have successfully healed the effects of

childhood trauma, without, as far as I'm aware, any casualties eventuating. It is not a treatment approach that is suitable for people who have ever been psychotic, nor hypomanic to a serious degree, and because the treatment is experimental and to some extent unconventional, I think it would be unwise to use it with people who have recently been actively suicidal.

The variables that appear to me to affect the outcome include the following:

- 1) The presence of a depression that appears not to respond to antidepressants makes progress difficult.
- 2) The quality of current relationships is clearly important. Members have fallen into three broad groups: those with a supportive partner, those with a hostile and critical partner, and those without a partner. The therapy of people with hostile partners has been intermittently interrupted by current relationship conflicts, separations, etc.
- 3) The process of making use of the workshops is one that each person has to take at their own speed. I believe that the safety record of the Phoenix Club is in part because of the policy of there being no coercion, and no pressure to perform. I think it's also very important that a person has the right to get 'cold feet', and back out of a cathartic therapy. Some people seem to have a natural ability to make use of these approaches and quickly learn how to regress and re-experience blocked emotional memories. Others find it much more difficult, and spend some time observing others before they are prepared to try it. Similarly some people seem more able to link a new decision to their cathartic work, whereas others produce much noise and drama, and yet little seems to really change in their lives. These are clearly variables that would need to be considered in any evaluation programme.

APPENDICES

A Rules and Suggestions.

- 1) Confidentiality. Nothing said in the group must be repeated outside it.
- 2) Anonymity. Do not disclose the identity of other members.
- 3) Punctuality and regular attendance.
- 4) Be as honest as you can.
- 5) No violence.
- 6) Procedure for resigning. Attend at least one meeting after giving notice of quitting.

7) Use 'I' statements, not 'you' statements or questions. (See the section on Pronouns and Ego-boundaries).

B Footnote on Introjection. I think the reason introjectors have problems with grief is that they 'swallow' the people they love, rather than merely get close to them. When a person gets close to someone else, and the other dies or leaves, the survivor is left with a patch of 'cold skin'. But an introjector holds the other in some sense 'inside' them so that when they die or leave they are left with an emptiness inside. Introjectors often make 'perfect' patients, in that they do everything I tell them to do, read every book I suggest, and hang off every word I say. The danger of this is that they may become pseudo-cured. An important issue with them is too be able to rebel and emancipate themselves. I find humour an asset. For example, if one of these 'acolyte' patients asks my permission to do something, I will routinely say 'No'. The humour accompanying this makes it clear that I am declining to be the recipient of power they are trying to give me.

In a sense, I think introjection represents a failure to achieve the psychological task of 'teething'. Teeth serve a dual function; they enable us to chew and break down 'non-self' food to permit it to be digested to become 'self' in the form of flesh. Teeth also are an agent of anger.

I believe that anorexia nervosa is not primarily an eating disorder. Instead it is an ego boundary disorder characterised by prepubertal introjection (the good girl phase of the indiscriminate 'Yes'), the development of introjection phobia (particularly in relation to vaginal introjection), and then displacement from vagina to mouth (the stage of the indiscriminate oral 'No'.) The eating disorder is secondary to the ego-boundary disturbance.

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