Mainstream psychiatry and psychotherapy have held for many years that cathartic psychotherapies involving powerful emotional expression have limited value. The conventional wisdom is that they are either dangerous, or ineffective, or that their effectiveness is short-lived. This paper reviews the origins of this conventional wisdom and makes two findings. Firstly, that there is remarkably little serious research into cathartic psychotherapies, but what there is tends to support catharsis. Secondly, that the periods in the last 200 years when cathartic methods have fallen into disrepute have often coincided with threatened or actual scandals involving prominent practitioners of cathartic psychotherapy. Four models of catharsis are described; the “Hydraulic”, the “Pavlovian”, the “Cathexis”, and the “Holographic”. The discussion suggests situations in which catharsis would be likely to prove useful, and indicates potential risks.

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The field of cathartic psychotherapy has been thoroughly reviewed in two books by Nichols and his associates, “Catharsis in Psychotherapy” [1] and “Emotional Expression in Psychotherapy” [2]. Another review by Kellerman [3] covers its place in psychodrama. As one of these [2] wrote, “If the expression of powerful feelings is therapeutic, then one should be able to demonstrate it empirically and explain it with an adequate theoretical rationale. Unfortunately, neither the evidence nor the rationale is yet available.” They went on to describe the evidence available as “meagre”, yet that which exists tends “to support the utility of catharsis as a vehicle for behavior change”.

In the last two or three decades there has been a resurgence of cathartic methods of therapy or “personal growth” in the context of the “Human Potential” movement. These alternative therapies have arisen in competition to conventional psychiatric treatments such as psychopharmacology and behavioural or psychoanalytic psychotherapy. A common reaction from psychiatrists and conventional psychotherapists has been that “catharsis was tried by the grand old pioneers of psychotherapy and found wanting.” In the absence of a significant literature of empirical evaluation to support such a guilty verdict, it is interesting to know how such a conclusion arose.

History

The history of catharsis goes back to the temples in 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 [4] cites as the birth of dynamic psychiatry. He 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".

The controversy which erupted may have occurred because of the emergence of the Enlightenment, which was attempting to replace blind faith and superstition with Reason. Demons, possession and exorcism were shunned. In 1775 several inquiries were held into Gassner, as a result of which his activities were severely restricted. The inquiry in Munich featured an expert witness called Dr Franz 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 the patient with his knees touching the patient's knees, press her thumbs, stare into her eyes, and then press on her hypochondrium. When successful, a "crisis" would occur. If repeatedly provoked, the crises would become less severe and eventually disappear. This he interpreted as recovery.

Mesmer was no stranger to controversy. In 1777 he left Vienna after a scandal involving a young woman patient. He moved to Paris and established a lucrative practice. It was so busy he began treating groups of about 200 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 XV1 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, at that time the American ambassador in Paris. The report stated that no evidence could be found of a "magnetic fluid". A supplementary report warned of the dangers of a magnetized female patient developing an erotic attraction for her male magnetizer.

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 issue 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. 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 Puysegur's school. The latter group prevailed, though the distinction was obscured by the use of the term "mesmerizing" by Puysegur's followers. Much later, in 1843, it became known as hypnosis.

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. Amongst 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 [5]. This involved hypnotizing the patient, encouraging her to concentrate on the symptom and then recount the experiences that had produced it. Much has been written about Breuer and Anna O. [6-10]. 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 treatment on account of his wife's jealousy, Anna O. developed an hysterical childbirth which she claimed was a pregnancy from Breuer [9]. 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 his abandoning his work with Freud [11].

Freud continued to believe in the cathartic method, although he found hypnosis difficult [12]. He experimented with other approaches, including suggestion, massage [13], pressure on the head, and free association. He finally stopped using hypnosis in 1896 [14], after a female patient threw her arms around his neck.
on awaking from a trance. A servant walked in at the same moment [15].

Freud’s shift from cathartic therapy to free association and psychoanalysis was complicated, and the record contains enough diverse 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 [16]. 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 [17].

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 95 years 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 [10] and Fliess, who was not a psychotherapist, was in Berlin. He 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" [16]. 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 [18], 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 hypnotic state, emotional shock, or exhaustion. Freud thought the primary factor was defense against an incompatible idea [19]. “Special states” will be mentioned again in the discussion of the “holographic model”. An important concept that did survive from this period was “transference”. Szasz [6] 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” [20].

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 currently called Neuro-Linguistic Programming [21]. Other aspects of Janet’s approach remind the modern reader of Milton Erickson [22] and Ida Rolf [23].

Janet also studied the feelings that patients developed towards their therapist. Quoting the old magnetizers, he developed the idea of “somnambulic influence” which extended beyond the hypnotic session. He advocated controlling the undue development of this influence by spacing sessions [24]. Unlike Freud, he regarded the influence as being a function more 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 preempted 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 [25].

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.” [26]. He may have been referring to disturbing feelings in the patient of an unanalysable kind [15].

The war and its aftermath produced an epidemic of psychic 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 [27]. 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 the effectiveness of therapy [28]. Dissatisfaction with the lack
of therapeutic success led to several important developments.

Firstly, the elaboration of theory to explain failures. The death instinct, described by Freud in "Beyond the Pleasure Principle" in 1920, had complex origins [10,16] 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 [29].

Later in his life, Freud explicitly expressed pessimism about psychoanalysis as a therapy, linking his conservatism to his death instinct theory [101].

A second outcome was the setting up of a seminar on therapeutic technique. Reich was 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.

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.

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 [30].

It is Reich and Moreno who are the fathers of modern experiential psychotherapies. Reich had an unshakable 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 [31, 32]. 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 abreacts 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 [33].

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 years.

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 analyzed by Horney and 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 [34].

Interestingly, Foulkes, a key figure in establishing group psychotherapy in Britain, also worked with Kurt Goldstein. He claimed his Group Analysis approach was stimulated by both Moreno and Kurt Lewin [35]. British group therapy lacks the Reichian ingredient.

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 only produces transient change". Such a judgement 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 uncon-
conscious issues, a Breuer could not flee in panic, nor could a Reich abuse post-cathartic vulnerability.

Yalom [36] 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, Gestalt Therapy, Primal Therapy, Bioenergetics, Psychodrama, Encounter, Neuro-Linguistic Programming (N.L.P.), Neo-Reichian bodywork, Rebirthing and hypnosis each 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 concern about 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 similar way to the use of transference by psychoanalysts, as described by Szasz [6]. 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." [37].

Models of catharsis

There are four 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 easily 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.

2) The Pavlovian model has been used by Sargant [38] 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 USA pass rattlesnakes round 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 to the rubbing out of a blackboard, onto which new things may be written.

3) The Cathexis model utilizes 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 may be 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. A woman with panic disorder rushes out of a supermarket, arriving home as the panic passes off; she over-positively cathects her home, developing agoraphobia. An anxious person smokes a cigarette or takes a tranquilizer; 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”.

This 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 an 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 US [39]. 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 [40]. It represents a major puzzle in neurology. Pribram helped write up Lashley’s research, and began to search for an explanation. In the mid 1960s 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” [41].

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, that 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 “redecision” [42].

Psychodrama achieves this by reenacting events or relationships with live actors. Gestalt therapy uses empty chairs and roleplay. Reichian therapy uses physical methods, such as forced hyperventilation or emotionally arousing confrontations. The behavioural treatment of phobias involves “exposure” to the feared situation [43].

Therapies that elicit certain “frequencies” of arousal in the course of decathcting 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 [44].

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 “redecision” which may or 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 "un-analysable 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 maximal levels of arousal being provoked until the arousal begins to extinguish. The current approved approach [45] 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.

Conclusion

It is not the contention of this paper that cathartic therapies are proven effective and safe. Rather it is that they were condemned on inadequate evidence, and that the verdict entered the collective consciousness of mainstream psychiatry and psychotherapy. From a review of the history of the last two hundred years, it seems at least possible that the reputation of catharsis derives more from the controversial activities of its proponents than any intrinsic properties of the therapies as such. In the absence of good empirical research on questions of efficacy and safety, the verdict should be left open. Any treatment for psychological distress which has been used over thousands of years by many different cultures merits serious investigation.

So, what are the implications for practice and research?

a) Cathartic therapies are better carried out in a group setting rather than one-to-one, especially between a male therapist and a female client/patient. Allegations of professional misconduct have been associated with too many of the occasions when catharsis has fallen into disrepute for the issue to be ignored. It may be that a therapy which encourages "acting-out" carries particular risks of irresponsibility. In any case, the group setting has advantages, in that one member's catharsis may help trigger useful emotions in another.

b) The Pavlovian model, as well as other evidence, suggests that people whose problems stem from highly arousing traumatic events are more likely to benefit from highly arousing therapies. Thus research would be more likely to demonstrate benefit with populations of sufferers of post traumatic stress disorder or bereavement reactions than, for example, personality disorders.

c) The Cathexis model focuses attention on the post-cathartic state. Responsible therapists should keep the client's attention on their newly affirmed life decision rather than drawing the opportunity for forming a new cathexis onto themselves, by, for example, giving their client a hug. A good technique is to instruct the client to go around the group and tell each member their new decision. Groups in which blunt feed-back is the rule should be encouraged to be gentle with people who have just had a cathartic experience.

d) The Holographic model suggests that the arousal level in therapy should approximate to the arousal level at the time of the original trauma. Research should record arousal level in some way, yet not equate higher with better. Precisely how to measure arousal without disrupting the therapy remains a problem.

e) Research data should include evidence of new beliefs or attitudes following a catharsis, and not merely whether an experience was relived. Events in the immediate aftermath may be important in determining the outcome, as well as efforts to help the person consolidate their changes in the succeeding weeks and months.
f) Cathartic techniques are unlikely to be effective with people on medications that may restrict their ability to achieve high states of arousal or previous brain-states (in the holographic sense). Benzodiazepines are particularly obstructive.

g) Research should be undertaken with real patient populations, and not with volunteers. Telling psychology students to get angry and punch cushions is unlikely to shed much light on the therapeutic issues at stake.

References

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