COMMON FACTORS IN THE FACILITATION OF THE RELIVING PROCESS ACROSS THREE CATHARTIC THERAPIES

By

JOANNE S. GILBERT

B.A. University of British Columbia, 1983

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES
(Department of Counselling Psychology)

We accept this thesis as conforming to the required standard.

THE UNIVERSITY OF BRITISH COLUMBIA

1992

© Joanne S. Gilbert, 1992
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

(Signature)

Department of Counselling Psychology

The University of British Columbia
Vancouver, Canada

Date April 1, 1992
ABSTRACT

The purpose of this study was to determine what common factors/behaviours/conditions were involved, in the facilitation of the reliving process, across three different types of cathartic therapy: Cathartic Hypnotherapy, Primal Therapy and Bioenergetics. In this study, the reliving process was found to be a key element, across three cathartic therapies, in the resolution of emotional pain. Reliving is defined as the re-enactment of repressed trauma.

A total of 15 qualified psychotherapists were interviewed for this study: 5 Primal therapists, 5 Bioenergetic therapists and 5 Cathartic Hypnotherapists. The selected methodology was the Critical Incident Technique. The 15 psychotherapists were interviewed about their experiences in therapy regarding which factors/behaviours/conditions facilitate the reliving process.

The 15 interviews were transcribed and 3 independent raters selected all critical events from the transcriptions. All the selected observations were then transcribed onto index cards and categorized by the researcher and one of the independent raters. These categories provided descriptions of the factors/behaviours/conditions which facilitate the reliving process. Percentage of agreement, across the three raters, was used as an index of reliability. Seventeen common and four crucial factors/behaviours/conditions were identified.

As a result of this research, recommendations for further study into cathartic therapy are offered. As well, guidelines are presented for both counsellors and clients who want to become involved in cathartic therapy. Also, this study provides a more comprehensive understanding of the reliving process.
# TABLE OF CONTENTS

| Abstract | .................................................. | .ii |
| Table of Contents | .................................................. | .iii |
| List of Tables | .................................................. | .vi |
| **Chapter I - Introduction** | 1 | |
| Objective of Study | .................................................. | 5 |
| Significance of Study | .................................................. | 6 |
| **CHAPTER I - Review of the Literature** | 7 | |
| Definition of Catharsis | .................................................. | 7 |
| Definition of Cathartic Method | .................................................. | 12 |
| Definition of Psychological Catharsis | .................................................. | 15 |
| Neo-Catharsis | .................................................. | 16 |
| Summary | .................................................. | 20 |
| Orgone Therapy | .................................................. | 21 |
| Summary | .................................................. | 28 |
| Cathartic Hypnotherapy | .................................................. | 29 |
| Summary | .................................................. | 34 |
| Primal Therapy | .................................................. | 34 |
| Summary | .................................................. | 40 |
| Bioenergetics | .................................................. | 40 |
| Summary | .................................................. | 45 |
| Final Definition of Psychological Catharsis | .................................................. | 45 |
| The Reliving process | .................................................. | 46 |
| Pattern | .................................................. | 46 |
| Regression | .................................................. | 48 |
| Symptomology | .................................................. | 50 |
| Recollection/Expression | .................................................. | 55 |
| Definition of Recollection/Expression Stage of Reliving Process | .................................................. | 60 |
| Factors/Behaviours/Conditions which Facilitate the Reliving Process | .................................................. | 61 |
| Position | .................................................. | 61 |
| Time | .................................................. | 62 |
| Setting | .................................................. | 62 |
| People involved in the Session | .................................................. | 63 |
| Client | .................................................. | 64 |
| Staging | .................................................. | 64 |
| Therapist | .................................................. | 65 |
| Therapeutic Techniques | .................................................. | 66 |
| Summary | .................................................. | 79 |
| Review of Critical Incident Technique | .................................................. | 80 |
| History & Development of Critical Incident Technique | .................................................. | 81 |
| Critical Incidents Procedure & Data Collection | .................................................. | 84 |
| General Aims | .................................................. | 84 |
| Plans & Specifications | .................................................. | 85 |
| Data Collection | .................................................. | 85 |
| Data Analysis | .................................................. | 87 |
| Frame of Reference | .................................................. | 87 |
| Category Formulation | .................................................. | 87 |
| General Behaviours | .................................................. | 88 |
Procedural Review .............................................. 88
Purpose of Study .................................................. 89
Assumptions of Study ............................................. 89
Limitations of Study .............................................. 89

CHAPTER III - Methodology ........................................ 91
Critical Incident Interview ........................................ 91
Sample ..................................................................... 91
Bioenergetic Therapist-subjects .................................... 91
Hypnotherapist-subjects ............................................ 92
Primal Therapist-subjects ......................................... 92
Interview Preparation ............................................. 93
Data Collection ...................................................... 94
Data Analysis ......................................................... 95
Training Independent Interview Raters ......................... 97
Categorization ....................................................... 98
Training Independent Card Raters ................................ 100
Analysis of Data of First Set of Factors/Behaviours/Conditions ................................................. 102
Analysis of Data of Second Set of Factors/Behaviours/Conditions .................................................. 103

CHAPTER IV - The Results .......................................... 105
Common Factors/Behaviours/Conditions ......................... 105
Common Factors/Behaviours/Conditions with No Statistical Difference in Frequency of Use .......... 106
Common Factors/Behaviours/Conditions with Statistical Difference in Frequency of Use .......... 106
Uncommon Factors/Behaviours/Conditions .................... 107
Other Factors/Behaviours/Conditions ........................... 107
Crucial Factors/Behaviours/Conditions ......................... 107
Client Information ................................................... 108
The Data .................................................................. 108
Uncommon Factors/Behaviours/Conditions .................... 132
Uncommon Factors/Behaviours/Conditions & Frequency of Use .................................................. 137
Crucial & Common Factors/Behaviours/Conditions .......... 142

CHAPTER V - Discussion ............................................ 147
Common Factors/Behaviours/Conditions ......................... 147
Staging .................................................................... 147
Client/Therapist-subject Relationship-- Time Element .... 147
Client is Lying Down/Reclining; Therapist-subject is Beside or Behind Client .............................. 147
Therapist-subject Monitors Client's Body-- Movements/Reactions .............................................. 148
Therapist-subject Directs Client's Body-- Position/Movements .................................................. 149
Therapist-subject has Client wear Appropriate Clothing ...................................................... 149
Therapist Monitors/Directs Client's Breathing ......... 149
Emotional Safety-Time Element ................................. 150
Therapist-subject's Tone of Voice ................................. 150
List of Tables

Table 1. Number & Type of Therapist-Subjects who have Soundproof Reliving Rooms......................109

Table 2. Number & Type of Therapist-Subjects who have Reliving Rooms with Mat/Recliner/Pillows...........110

Table 3. Number & Type of Therapist-Subjects who have seen Client 2 Months or More.....................111

Table 4. Number & Type of Therapist-Subjects who See Client 1 to 2 times Weekly.........................112

Table 5. Number & Type of Clients who Recline on Back........113

Table 6. Number & Type of Therapist-Subjects who Monitor Client's Body--Position/Movements/Reactions......114

Table 6A. Frequency with which Therapist-Subjects Monitor Client's Body--Position/Movements/Reactions......115

Table 7. Number & Type of Therapist-Subjects who Direct Client's Body--Position/Movements...............116

Table 7A. Frequency with which Therapist-Subjects Direct the Client's Body--Position/Movements.............117

Table 8. Number & Type of Therapist-Subjects who Direct Client To Wear Appropriate Clothes..............118

Table 9. Number & Type of Therapist-Subjects who Monitor & Direct Client's Breathing.......................119

Table 9A. Frequency with which Therapist-Subjects Direct and Monitor Client's Breathing..................120

Table 10. Number & Type of Therapist-Subjects who Extend Session if Required.............................121

Table 11. Number & Type of Therapist-Subjects the Client Can Call After Session..........................122

Table 12. Number & Type of Therapist-Subjects who Use a Calm, Relaxed, Gentle Tone of Voice............123

Table 13. Number & Type of Therapist-Subjects who Talk with Client for 10-30..............................124

Table 14. Number & Type of Therapist-Subjects who Monitor Client Talking About Symptom/ Issue/Past scene in Past Tense..............................125

Table 14A. Frequency with which Therapist-Subjects Monitor Client Talking about Symptom/Issue/Past Scene....126
Table 15. Number & Type of Therapist-Subjects who Direct Client Speak/Behave in Present Tense......127
Table 15A. Frequency with which Therapist-Subjects Direct Client Speak/Behave in the Present Tense......128
Table 16. Number & Type of Therapist-Subjects who Monitor Client Speaking/Behaving in Present Tense..........................129
Table 16A. Frequency with which Therapist-Subjects Monitor Client Speaking/Behaving in the Present Tense.....130
Table 17. Number & Type of Therapist-Subjects who Monitor Client’s Emotions.................................131
Table 17A. Frequency with which Therapist-Subjects Monitor Client’s Emotions ......................132
Table 18. Number & Type of Therapist-Subject who use Subdued Lighting in the Reliving Room..............133
Table 19. Number & Type of Therapist-Subjects Who Extend Therapy Session Beyond 1 Hour...............134
Table 20. Number & Type of Therapist-Subjects who Direct Client about Scheduling After Session......135
Table 21. Number & Type of Therapist-Subjects who Sit Opposite/Beside the Client..........................136
Table 22. Number & Type of Therapist-Subjects Who do Nothing During the Reliving Process...........137
Table 23. Frequency with which Therapist-Subjects Touch Client...............................................138
Table 24. Frequency with which Therapist-Subjects Direct Client to Relax......................................139
Table 25. Frequency with which Therapist-Subjects Direct Client to do Guided Imagery, Auto-suggestion and Desensitization..............140
Table 26. Frequency with which Therapist-Subjects Direct Client to Focus on Feelings......................141
Table 27. Frequency with which Therapist-Subjects Comfort and Reassure Client..........................142
Table 28. Number & Type of Therapist-Subjects who Think Qualifications of Therapist are Crucial.....143
Table 29. Number & Type of Therapist-Subjects who Think Qualities of Therapist are Crucial.........144
Table 30. Number & Type of Therapist-Subjects who Think Trust in Therapist/Client Relationship is Crucial ............................. 145

Table 31. Number & Type of Therapist-Subjects who Think Emotional Safety of Client is Crucial ..................... 146

Table 32. Time Chart of the 15 Cathartic Therapy Sessions .............................. 168

Table 33. Crucial & Common Factors/Behaviours/Conditions ............. 205
Chapter I
Introduction

Catharsis is a challenging topic for academic study. For example, the term has yet to be clearly defined. Indeed, the word is used differently by the artistic field and psychological field. Thus, for clarification, this paper divides catharsis into two categories: "artistic catharsis" and "psychological catharsis". The latter will be the focus of this particular work.

The definition of catharsis in the field of psychology is unclear and obscure. "It is generally understood to mean a process that relieves tension and anxiety by expressing emotions,--emotions that have been hidden, restrained, or unconscious" (Nichols, 1977, p. 1). Corsini’s (1984) definition is just as general:

In contemporary psychotherapy outside the psychoanalytic tradition, "catharsis" often refers in a general way to the therapeutic release of emotions or tensions, including some which might be conscious or related to conscious experiences. (p. 188)

Kellermann, a psychodramatist, defines catharsis "as an experience of release that occurs when a longstanding state of inner immobilization finds its outlet in action" (1984, p.1). Zerka Moreno (1971) refers to catharsis as the expression of feelings that were never allowed so that a person can "begin to be what [he/she] might have become" (p.43).

People who have experienced catharsis have a different perspective. One individual stated, "It is a moment of growth, a moment of opening up to experience" (Kellerman, 1984, p.6). Another person said, "I lose myself, let go of consciousness, of control, of memory. I become a little child" (Kellerman, 1984,
p.6). Still another client describes catharsis in this way, "It is like an orgasm! If you had it, it is blessed, it is a miracle!" (Kellerman, 1984, p. 5-6).

Although descriptive, these above definitions of catharsis are too subjective to be used for this work. In order to do precise research, terminology must be clearly defined.

Catharsis was first defined, within the field of psychology, by Freud and Breuer in 1894. Based upon an intellectual understanding of catharsis, as the purging of emotions, they developed a therapeutic technique called the "cathartic method" which consisted of five important elements (outlined on p. 15 this paper). Thus, the term catharsis had been operationalized for the first time.

Next, several therapeutic models that were founded upon these five elements of the cathartic method were studied: Neo-catharsis, Orgone therapy, Cathartic Hypnotherapy, Primal therapy and Bioenergetics. In studying these different models even more information was uncovered about catharsis so that a full and more concise definition of the term emerged than the one originally honed from the research of Freud and Breuer. This final version (p.45 of this paper) is an operationalized definition of catharsis; describing more specifically the five elements that make up the process of catharsis; and identifying the main component of catharsis as the "reliving process".

Cathartic therapists such as Ferenczi (1955), Watkins (1949), etc. have an exact view of the integral nature of deep emotional pain. They postulate that there are two types of trauma; one that occurs in childhood and the other that occurs to the adult due to
some cultural or sociological aberration, e.g., a car accident or war. For many reasons, these primal experiences can be forgotten by both child or adult and the emotions become repressed. Yet, these buried traumas continue to exert an effect upon the individual on an emotional, physiological and behavioural level.

One of the basic tenets of cathartic therapy (Watkins, 1949; Reich, 1951; Ferenczi, 1955; Baker, 1967; Janov, 1970) is that an individual can be purged of his trauma by reliving it. This is not to suggest that cathartic therapists do not use other processes because they do, e.g., recall. Also, although other types of therapists may use different methods for the resolution of early trauma, the reliving process is the main procedure that is used in cathartic therapy.

Therefore, once the extreme significance of the reliving process in catharsis was recognized, the next step was to define the procedure. The same therapeutic models of the cathartic method, studied previously, were reviewed again but this time in relation to the reliving process. After this examination, a definition of the reliving process (p. 60 of this paper) was outlined; a list of factors that went into facilitating this procedure was compiled and described and a hypothesis was formed. This hypothesis was that factors, which facilitate the reliving process, may exist in common across different models of cathartic therapy. However, to substantiate such a supposition further research was needed.

Three models of the cathartic method were used for the purpose of this research: Cathartic Hypnotherapy, Primal therapy and Bioenergetics. These are the current surviving models of the cathar-
tic method. Bioenergetics grew out of Reich's Orgone therapy (Lowen, 1975). The roots of Primal therapy can be found in Ferenczi's Neo-cathartic therapy (Ferenczi, 1955; Janov, 1970). Cathartic Hypnotherapy has not changed significantly since Freud's original work (Udolf, 1981 & Waxman et al., 1985).

A number of therapeutic processes were not included in the research for this paper because they do not embody the five basic requirements of psychological catharsis. For example, Psychodrama was dropped from the research because of its limitations.

According to Freud and Breuer (1947), during catharsis a patient's memory of a traumatic experience must possess hallucinatory vividness. But this clarity of memory was often not obtained in psychodrama. Moreno (1969) writes:

The inability to recall perfectly indicates that such recall is a practical impossibility, absolute recall does not exist and correct reproduction is a hardly attainable ideal. Furthermore, spontaneity and "presentness" are subjugated to correct reproduction and thus disappears...(p. 234)

Also, trauma that is not consciously remembered is rarely accessed through psychodrama. For, a client would not be able to consciously act out an experience of which he/she had no memory.

Biosynthesis (Boadella, 1987), an off-shoot of Bioenergetics, was not researched because it is not different enough from the latter to be included separately. Rolfing (Rolf, 1977) and the Alexander Technique (Barlow, 1973) are basically concerned with the adjustment and the realignment of the body's posture. Rebirthing (Orr & Ray, 1977), a therapeutic process in which an individual is encouraged to relive his/her birth, does not embrace two important requirements of psychological catharsis. For example, it was difficult to discern from the rebirthing literature (Orr & Ray,
1977) whether the memory of the experience was recollected which is an extremely important element of catharsis. Also, it was not clear if any analysis of the re-enactment is ever done by the therapist; another important step in catharsis.

Holotropic therapy, developed by Stanislav Grof (1982, 1985 & 1988), will not be studied in this work either. The reason for this decision is that individuals undergoing this therapy not only relive early trauma but, supposedly, relive experiences from previous lives; an added and complex dimension which cannot be incorporated into the framework of this study.

Objective of the Study

There are several models of the cathartic method in which the reliving process is induced: Cathartic Hypnotherapy, Primal therapy and Bioenergetics. Therefore, it was hypothesized that all three models must contain common elements in regard to the facilitation of the reliving process. In other words, in spite of the apparent differences within three types of cathartic therapy, commonalities in the facilitation of the reliving process should exist across all three. Therefore, the question becomes:

1) What common factors/behaviours/conditions are involved, which facilitate the reliving process to occur in a given therapy session, using Cathartic Hypnotherapy, Primal therapy and Bioenergetics as therapeutic models?

Also,

2) Which factors are considered, by the therapist, the most necessary or critical in the facilitation of the reliving process?
Significance of the Study

The importance of this study was to shed light upon the subject of catharsis. For example, psychological catharsis was operationally defined.

Secondly, the reliving process was identified as a key element of psychological catharsis and operationally defined as well.

Thirdly, across three models of cathartic therapy, common and crucial factors/behaviours/conditions, involved in the facilitation of the reliving process, were identified.

In summary, psychological catharsis is a therapeutic process for the resolution of traumatic experiences and the research from this study provided a more comprehensive understanding of this process than has hitherto been available.
Chapter 2

Review of the Literature

In a review of the literature on the nature of catharsis, it was concluded that re-enactment was a significant part of the process in the resolution of trauma. Therefore, due to the importance of the "reliving process" in relation to this aspect of psychological health, it became the focus of this study. However, before research began, the connection between re-enactment and catharsis needed to be understood.

In reviewing the literature on catharsis it became apparent that there was no set definition of the term. Yet, in order to research a subject it is imperative that the terminology pertaining to the topic be defined. Although the focus of this work was in the area of psychology, in pursuing the etymological roots of catharsis many different fields of interest had to be examined as they all contribute to the final psychological meaning of the term.

Definition of Catharsis

"Katharsis/catharsis" is a term first used in ancient Greece (Srivastava, 1982). Hippocrates, the father of medicine, used katharsis to describe the expulsion of diseased humours from the body's system. According to his theory of medicine, health depended upon the balance and proportion of four vital fluids called humours within the body. These four humours were blood, phlegm, yellow bile and black bile. Disease was caused by their defective accumulation or excess in the human system. The more disordered these fluids, the more they accumulated; the more they accumulated, the more disease would grow within the body. Thus, it became the physician's task to help the body discharge the morbid
humour and this process was called "katharsis" or purgation (Srivastava, 1982).

In the Odyssey, Homer used "katharos" as an adjective to refer to clean clothes, "thou shouldst have clean (kathara) raiment upon thee" (Srivastava, 1982, p.143). In two later passages, Homer uses the verb "katharein" to mean "to cleanse":

"Begin now to bear forth the dead bodies and bid the women help you, and thereafter cleanse (kathairein) the beautiful chairs"... (Srivastava, 1982, p. 143)

and

Then they cleansed (kathairon) the beautiful high seats and the tables with water and porous sponges. (Srivastava, 1982, p. 143)

Further on in the Odyssey Homer uses katharsis as an adjective to mean honourable:

"Let it be no clean (kathro) death that I take the lives of these women who on my own head have poured reproaches and on my mother, and were wont to lie with the wooers." (Srivastava, 1982, p. 144).

Plato also used many inflections of the term katharsis. In Phaedo 66D-E he writes:

...if we are ever to know anything absolutely (katharos) we must be free from the body. (Srivastava, 1982, p. 146)

and

For if pure (katharos) knowledge is impossible while the body is with us, one of the two things must follow. (Srivastava, 1982, p. 146)

In Phaedo 67C Plato refers to katharsis as the soul freeing itself from the body-prison:
And does not the purification (katharsis) consist in this which has been mentioned long ago in our discourse, in separating, so far as possible, the soul from the body and teaching the soul the habit of collecting and bringing itself together from all parts of the body, and living, so far as it can, both now and hereafter, alone by itself freed from the body as from fetters. (Srivastava, 1982, p. 147)

In Phaedo 69B-D Plato writes:

...but truth is in fact a purification (katharsis) from all these things(1) and self-restraint and justice and courage and wisdom itself are a kind of purification (katharsis)...  
(Srivastava, 1982, p. 147)

Also, in Phaedo 108C he writes:

But the soul that passed through life in purity (katharos) and righteousness, finds gods for companions and guides, and goes to dwell in its proper dwelling...  
(Srivastava, 1982, p. 148)

and still later in the same work he states:

Would not that man do this most perfectly (katharotata) who approaches each thing, so far as possible with the reason alone... (Srivastava, 1982, p. 148)

Aristotle, a pupil of Plato, also used the term katharsis. He used the word in his work Virtues and Vices as an adjective to describe cleanliness, "the liberal man is cleanly (katharios) in his dress and dwelling" (Srivastava, 1982, p.148). Then, in another critique, Aristotle uses katharsis to refer to genealogical purity, "those who were not of pure (katharai) descent" (Srivastava, 1982, p. 148).

---

1 Things refers to non-virtuous behaviour.
However, what is more important than these two references is the fact that it was Aristotle who first defined catharsis within a deep emotional framework. In his work *Poetics* he states:

A tragedy, then, is the imitation of an action that is serious and also, as having magnitude, complete in itself; in language with pleasurable accessories, each kind brought in separately in the parts of the work; in a dramatic, not in a narrative form, with incidents arousing pity and fear, wherewith to accomplish its catharsis of such emotions. (McKeon, 1941, p. 1460)

What Aristotle meant in this above passage, by the term catharsis, has been the subject of numerous interpretations. One major theory, put forth by Henri Weil and Jacob Bernays (Srivastava, 1982, p. 39), is based upon the Hippocratic definition of catharsis that tragedy arouses and purges the morbid passions of pity and fear, thereby causing pleasurable relief. This theory is strongly based upon the passage in *Politics* in which Aristotle writes of music:

We accept the division of melodies proposed by certain philosophers into ethical melodies, melodies of action, and passionate or inspiring melodies, each having, as they say, mode corresponding to it. But we maintain further that music should be studied not for the sake of one, but of many benefits, that is to say, with a view to 1) education, 2) purgation (the word "purgation" we use at present without explanation, but when here-after we speak of poetry, we will treat the subject with more precision); music may also serve 3) for intellectual enjoyment, for relaxation and for recreation after exertion. It is clear, therefore, that all modes must be employed by us, but not all of them in the same manner. In education, the most ethical modes are to be preferred but in listening to the performance of others we may admit the modes of action and passion also. For feelings, such as pity and fear or, again, enthusiasm, exist very strongly in some souls, and have more or less influence over all. Some persons fall into a religious frenzy, whom we see as a result of the sacred melodies--when they have used the melodies that excite the soul to mystic frenzy--restored as though they had found healing and purgation. Those who are influenced by pity and fear, and every emotional nature, must have a like experience, and others in so far as each is susceptible to such emotions, and all are in a manner purged and their souls lightened and delighted. The purgative
melodies likewise give an innocent pleasure to mankind. 
(McKeon, 1941, p. 1315)

In summary, the term catharsis was used in two different areas: medicine and art. In the former, catharsis meant purgation or evacuation of bodily fluids and in the latter it came to mean purification or purgation of emotions through art. For, even though some critics (Srivastava, 1982) questioned Aristotle's theory of catharsis through art, his definition of the term was universally accepted by people. Thus, catharsis became etymologically grounded. Later the term would be applied to newer areas of study, such as, psychology. However, before proceeding, further clarification was required.

As stated previously, the word catharsis is used somewhat differently depending upon the field of study. When using catharsis in relation to art the term will be classified as artistic catharsis; when applied to the field of psychology it will be classified as psychological catharsis.

In their joint work, Studies in Hysteria, Freud and Breuer (1947) were the first to establish a definition of catharsis in the field of psychology/psychiatry. They accepted the purgative definition of the word and used it to mean "the elimination of a complex by bringing it to consciousness and affording it expression" (Webster, 1959, p. 131). But this definition was too general. In order to do proper empirical research, a more precise meaning of the word had to be honed.

In their psychological research, Freud and Breuer developed the "cathartic method" which was based upon their purgative definition of catharsis. Because of this work, they succeeded in
operationalizing the term. Therefore, in order to obtain an operational definition of catharsis it became essential for this researcher to define the "cathartic method".

**Definition of the Cathartic Method (1894-1897)**

Freud and Breuer (1947) devised the cathartic method in 1894. Three years later Freud stopped using this therapeutic procedure because he claimed it was not effective. He arrived at this conclusion shortly after he had discovered the prevalence of sexual abuse in many of his clients. At this time, neither Freud nor society, in general, would accept these research findings. Freud abandoned the cathartic method and went on to develop psychoanalysis. The reasons for this reversal can only be surmised and do not pertain to the focus of this work. What is of importance is the fact that Freud, for a brief period of 3 years, ventured forth into an area of psychotherapy that involved the catharsis of deep traumatic emotions.

In the late 1800s, the neurologist, Jean Martin Charcot, had observed that forgotten memories could be retrieved with hypnosis. Based upon this discovery, Freud and Breuer began to investigate the cause of hysteria using the technique of hypnosis and later (Freud) free association. At that time, hysteria was defined as a type of neurosis characterized by emotional excitability and various physiological symptoms such as anorexia, paralysis, epileptiform convulsions, contractures, anesthesias, neuralgias, tic-like affections, persistent vomiting, visual disturbances and hallucinations.

Freud and Breuer (1947) concluded that hysteria was a form of defense in which the unconscious converts an emotionally painful
experience into physiological symptoms. Whether an experience is traumatic or not depends upon the person involved, e.g., how sensitive he/she is and the conditions under which the experience occurs. An experience remains psychologically traumatic because the associated response to the incident is not expressed. Freud and Breuer isolated four separate and/or combined factors as to why a traumatic event may be initially repressed.

First, the nature of a trauma can preclude a reaction. Secondly, the social environment in which a severely painful incident occurs can render a reaction impossible. Thirdly, the trauma may involve issues which the individual wishes to forget and he/she intentionally banishes the memory from consciousness. Fourthly, the psychic state of the individual can make a response impossible, e.g., paralyzing fright or day dreaming.

What the two researchers then found "was that hysterical symptoms immediately disappeared without returning if [the therapists] succeeded in thoroughly awakening the memories of the causal process with its accompanying affect, and if the patient circumstentially discussed the process in the most detailed manner and gave verbal expression to the affect" (Freud and Breuer, 1947, p. 4). In other words, not only did the clients have to relive or recall (it is not possible to discern which process from the above passage) the traumatic incident that was causing the particular hysterical symptom but they had to be allowed to express the feelings accompanying the memory. For, according to Freud and Breuer, recollection without emotion was utterly useless. They write:

The psychic process, which originally elapsed, must be reproduced as vividly as possible so as to bring it back into the statum nascendi, and then thoroughly "talked out". If it
concerns such irritating manifestations as convulsions, neuralgias, and hallucinations, they are once more brought to the surface with their full intensity, and they then vanish forever. Functional attacks like paralyses and anesthesias like-wise disappear, but naturally without any appreciable distinctness of their momentary aggravation. (1947, p.4)

Freud and Breuer referred to this entire process as the cathartic method and they reported some important observations in the use of this therapeutic process.

First, it was noticed that the traumatic experiences were either completely lacking from the conscious memory of their patients or else they existed in a greatly abridged form.

Secondly, when the experiences were remembered, during the cathartic process, it was as if they had occurred the day before, the memory and emotions were so fresh, accurate and vivid. Therefore, they concluded, that their patients "suffered mostly from reminiscences" (Freud & Breuer, 1947, p. 4).

Thus, Freud and Breuer (1947) developed the first operational definition of psychological catharsis. It was based on 5 important elements which are summarized below.

1. Specific traumatic events can be repressed so that they are completely lacking from the conscious memory or else exist in an abridged form. The unconscious converts the repressed trauma into physiological symptoms which may effect the individuals emotions and/or behaviour. The repression and conversion are a form of defense.

2. The repressed traumatic event "must be reproduced as vividly as possible"; reproduction means: a) the experience must be recollected  b) the emotions that accompany the memory of the experience must be expressed.

3. When these experiences are reproduced in the present, hysteric and/or physiological symptoms can surface during the process.

4. The whole process of reproduction must also be talked out.

5. Once these experiences have been reproduced and talked out the symptoms they cause disappear and the patient is purged of his/her symptoms--catharsis
Yet, given these 5 psychological components, the definition of psychological catharsis still remains unclear. First, it is uncertain whether the repressed experiences are recalled or relived; two very different processes.

Secondly, it is vague as to what Freud and Breuer meant when they stated that the process of reproduction must be talked out. This lack of a precise description indicated the need for further research. For, although in 1897 Freud stopped using the cathartic method, because he claimed it was ineffective, his model did not remain abandoned. Many therapists would return to Freud's original theories thus generating more data on the subject.

Definition of Psychological Catharsis

The definition of psychological catharsis originates from the five components that make up Freud's cathartic method. Freud provided the first basic theoretical and therapeutic foundation from which other cathartic therapists could work (1). But Freud's definition was not concise. For more precise data the later works of other cathartic therapists (Ferenczi, Reich, etc.) must be explored.

There are basically three therapeutic models that developed from Freud's and Breuer's cathartic method: 1) Neo-catharsis which was founded by Ferenczi, a psychiatrist. 2) Orgone Therapy which was founded by Reich, a psychiatrist. 3) Cathartic Hypnotherapy which was founded by Freud but fully developed by Brown, Simmel,

---

1 The work of Pierre Janet, a contemporary of Freud's, will not be reviewed. Even though he discovered a similar and effective cathartic method called mental liquidation, he was unable to provide any new information or clarification on the subject of psychological catharsis (See Appendix VI).
Watkins and Brenman, all psychiatrists.

Although many of their techniques and beliefs were very different, all of the above clinicians used the same theoretical base which was composed of the five components of the cathartic method. Later these clinicians were able to further clarify and enhance, by their separate research, these five important elements.

Neo-Catharsis (1928-1933)

The first clinician to further define psychological catharsis was Ferenczi, a student of Freud. When first practicing psychotherapy, Ferenczi applied the cathartic method but, like Freud, he found that it was not enough to provide lasting change in his patients. True, many hysterical symptoms would immediately disappear but only to return, in some cases, the next day. Instead, Ferenczi became a psychoanalyst. However, after twenty-five years, Ferenczi returned to catharsis or, as he termed it, "Neo-catharsis".

Neo-Catharsis did not consist of any elaborate theoretical or technical procedures. Quite simply, Ferenczi was able to reach his clients' deepest pain based, almost solely, upon his humanistic ability to build an honest, supportive and trusting relationship between himself and his patients. Indeed, his personal warmth was eventually reflected in his entire belief system which led him to originate Neo-catharsis.

Ferenczi (1955) not only agreed with Freud and Breuer that repressed traumatic experiences caused physiological symptoms in the present. He believed that trauma deeply affected the individual on an emotional, behavioural and physical level and actually described the genesis of trauma.
Ferenczi claimed that the first reaction to an emotional trauma is "transitory psychosis, e.g., a turning away from reality" (Ferenczi, 1955, p. 121). He felt that during an emotional shock there occurred a "psychotic splitting off of a part of the personality" (p. 121). He wrote about one of his neo-cathartic sessions:

This process gives us an opportunity of observing something of the mechanism of the genesis of a trauma. First, there is the entire paralysis of all spontaneity, including all thinking activity and, on the physical side, this may even be accompanied by a condition resembling shock or coma. Then there comes the formation of a new—displaced—situation of equilibrium. If we succeed in making contact with the patient even in these phases, we shall find that, when a child feels himself abandoned, he loses, as it were, all desire for life or, as we should have to say with Freud, he turns his aggressive impulses against himself. Sometimes this process goes so far that the patient begins to have the sensation of sinking and dying. He will turn deadly pale, or fall into a condition like fainting, or there may be a general increase in muscular tension, which may be carried to the point of opisthotonos. What we here see taking place is the reproduction of the mental and physical agony which follows upon incomprehensible and intolerable woe. I will just remark in passing that these "dying" patients also sometimes tell me interesting things about the next world and the nature of existence after death... (1955, p. 138)

Ferenczi (1955) referred to this coma-like condition as the trance state. He also observed that not only was this reaction the first response to trauma but later it could emerge, during catharsis, as a form of conversion.

Ferenczi (1955) concluded that when individuals split off from a trauma the dissociated part "lives on hidden, ceaselessly endeavouring to make itself felt, without finding any outlet except in neurotic symptoms" (p. 121). The trauma is then converted into physiological, behavioural and emotional symptoms which could include the trance-like state. He discovered this phenomenon when his patients would relive their trauma in therapy sessions.
Just like Freud, Ferenczi (1955) found that if his patients' traumatic experiences were reproduced and the accompanying emotions were discharged, neurotic symptomology would disappear. However, he clarified the whole process by indicating that the experiences must be relived—not merely recalled. He (1955) writes about a patient in his office:

Sure enough, his memory pictures soon grouped themselves round a trauma in his early childhood. The episode was an operation for hydrocele. He saw and felt with objective vividness how he was seized by the hospital attendants, how the chloroform-mask was put over his face, and how he tried with all his might to escape from the anaesthetic. He repeated the straining muscles, the sweat of anxiety, and the interrupted breathing which he must have experienced on this traumatic occasion. (p. 111)

Yet, as Ferenczi brought his clients to the edge of their trauma their symptomology would surface. The reason for this was clear. Instead of reliving their trauma, his clients were reliving how they originally protected themselves from their emotional agony, i.e., repression, conversion, displacement, etc. Ferenczi (1955) describes such responses:

...hysterical physical symptoms would suddenly make their appearance, often for the first time in an analysis extending over years. These symptoms included paraesthesia and spasms, definitely localized, violent emotional movements, like miniature hysterical attacks, sudden alternations of the state of consciousness, slight vertigo and a clouding of consciousness often with subsequent amnesia for what had taken place. (p. 118)

What is extremely important to note here is that when the client is reliving his/her symptomology he/she is not purging him/herself of his/her pain. He/she is not experiencing psychological catharsis. The individual must be taken deeper into the event. He/she must remember the experience; relive the actual trauma and express the emotions he/she did not communicate at the
time. If the client merely relives his/she defensive response then his/her symptoms will keep returning and he/she will be destined to symbolically act out his/her pain over and over again in life and in therapy:

...just like a conversation in half-sleep which has to be guided with extraordinary tact and the greatest possible economy and adaptation, it may happen that the patient is suddenly overpowered by an extremely strong hysterical pain or spasm, not infrequently by a true hallucinatory nightmare, in which he acts out in word and gesture some inner or external experience. There is always present the tendency to awake immediately afterwards, to look round for some seconds as if dazed, and then to reject all that has happened as a stupid and senseless fantasy. With some skill we can succeed, however, in restoring contact with the patient who is still in the fit. This must be done rather forcefully. Without actually giving him direct hints, the patient can be brought to tell us about the causes of his pain, the meaning of his defensive struggle, still apparent in his muscles. We may thus succeed in getting from him details of his emotional and sensory processes and of the exogenic causes of those traumas and sensations, and the defenses against them... when we then put all these formulations to the patient and urge him to combine them into a whole, we may experience the re-emergence of a traumatic scene with distinct indications of the time and place at which it occurred. Not infrequently we then succeed in differentiating the auto-symbolic representation of the mental processes after the trauma (e.g. fragmentation as falling to bits, atomization as explosion) from the real external traumatic events, and in this way reconstruct the total picture of both the subjective and objective history. There often follows, then, a state of calm relaxation, with a feeling of relief. It is as if the patient had with out help succeeded in climbing a hitherto unscaleable wall which awakes in him a feeling of increased internal power, with the help of which he has now succeeded in conquering certain dark forces whose victim he had been until now.

(Ferenczi, 1955, p. 233-234)

According to Freud and Breuer (1947), for catharsis to occur the whole process of reproduction must be talked out. However, they do not clarify reproduction or what they mean by the term talked out. Ferenczi, on the other hand, is very clear. Reproduction refers to the reliving process in which the client recollects the traumatic memory and expresses the accompanying
emotions. Naturally, the patient is encouraged to communicate throughout this procedure. However, for Ferenczi, there is a second phase to this communication. The session must be analyzed as well. Thus, Ferenczi elaborates and clarifies the term talked out. Communication throughout the reliving phase is a given. However, once the client has gone through and expressed his/her pain, the process must be talked out or analyzed. Ferenczi (1955) writes:

The material re-enacted in play or repeated in any other way has to be thoroughly worked through analytically. (p. 131)

Ferenczi interpreted analysis to mean that the patient be given the opportunity to intellectually understand the significance of his pain. He (1955) writes:

But I never let an analytic hour pass without thoroughly analyzing the material provided by the acting out, of course making full use of all that we know (and have to bring to the patient’s consciousness) about transference and resistance and the metapsychology of symptom-formation. (p. 132)

Summary

Like Freud, when Ferenczi first began to use the cathartic method he found the client’s symptoms returned so he abandoned the model. Later, when he developed Neo-catharsis, he discovered that, for psychological catharsis to occur, the client had to go beyond his/her original defense during the reliving process. He also noted that often the client had to relive a traumatic event several times at a deeper and deeper level for the symptoms to be eradicated. Unfortunately, because of his early death his research ended abruptly without further elaboration on the results of Neo-cathartic therapy. However, one of his last entries regarding the outcome of catharsis indicated that neurotic symptoms disappeared
and "the level of the patient's personality" appeared to be "considerably raised" (1955, p. 159).

After reviewing Ferenczi's research, the definition of psychological catharsis could be further defined. More specific information could now be added to all five elements.

1. Specific traumatic events can be repressed so that they are completely lacking from the conscious memory or else exist in an abridged form. The first reaction to a specific emotional trauma is a transitory psychotic splitting off often manifested by a trance-like state. The trauma is then converted into physiological, emotional and/or behavioural symptomology which can include the trance state.

2. The trauma must be relived as vividly as possible; to relive means: a) the experience must be remembered b) the emotions that accompany the memory of the experience must be expressed.

3. When trauma is reproduced in the present the client may relive his/her defensive response to the trauma. The individual must go beyond this point; to relive the actual trauma and express the emotions he/she did not communicate at the time it occurred.

4. The whole process of reliving a trauma must be analyzed so the client intellectually comprehends the meaning of the event as it relates to his/her symptomology.

5. Once repressed primal pain has been relived (possibly several times) and analyzed the symptoms it caused disappear and the patient is purged of his/her pain--psychological catharsis.

Orgone Therapy (1939-1967)

Wilhelm Reich originated Orgone Therapy, a cathartic therapy, which is based on a complex and "highly idiosyncratic set of theories" (Nichols, 1977, p. 105) that are difficult to comprehend. In order to understand Reich's theories, the therapeutic findings of E. Baker will be included in this synopsis on Orgone therapy. The reason for this joint approach is because Baker and Reich were colleagues. They shared the same psychological constructs. Baker was also an Orgone therapist and was able to illustrate, on a
practical level, many of Reich's theories. For example, one of the
most concise explanations ever written on Reich's philosophy
appears in a book written by Orson Bean (1971) called *Me and the
Orgone*. Bean underwent Orgone therapy with Baker. Bean (1971)
writes:

It took me a long time to understand, even intellectually,
the orgasm theory but I finally did and here, in over
simplified, but basically accurate form, is what it is:

Human beings, like all living things from the amoeba on up
have within them an energy, hithertofore undetected. Reich
discovered it and called it orgone energy (from the root of
the word organism). This energy is, in effect, the life
force, not in any mystical sense, but physically. The energy
is built up by intake of food, fluid and air and is also
absorbed directly through the skin.

Orgone energy streams rhythmically and continuously through
the body from the top of the head to the bottom of the feet
and back again and in the ideally healthy and natural person,
it can be felt as a pleasurable, glowing sensation of health
and well-being. It is discharged by activity, excretion,
emotional expression, the process of thinking and by
conversion into body heat, which radiates to the environment.
It is also used up in growth. In the normal course of things,
more energy is built up than is discharged. This extra energy
is stored for emergency situations such as battle or
exhausting work. But when no emergency exists, the energy
keeps piling up so that the organism would have to grow
continuously or would eventually burst unless there were some
mechanism to discharge the accumulated excess energy after it
had reached a certain level. In healthy individuals, this
level is felt as sexual excitation. The build-up of energy
creates a tension and the method that nature has created for
relieving this tension and regulating the build-up is the
sexual orgasm. The deep feeling of relaxation which follows
a truly satisfying sexual climax is indicative of this release
from tension. But the tension is relieved and the energy
regulated only when the individual is capable of full,
healthy, loving, sexual fulfillment. An unrewarding or
compulsive sexual experience doesn't work. The orgasm must be
deeply pleasurable and it must be followed spontaneously by
complete relaxation or the orgone energy has not been
discharged. This lack of discharge is felt as tension or
restlessness. In healthy individuals, the need for sexual
surrender and release is based entirely on this ebb and flow
of orgone energy.

For untold centuries, man, alone among the other animals,
has interfered with his own natural functioning by preventing
the flow build-up and release of his orgone energy. He has done this by making himself incapable of full, natural, healthy, sexual gratification through a process that Reich calls armoring. (p. 7-8)

Armoring is a term Reich (1951) used to described the way individuals learn to repress feelings. He believed that when children suppress their emotions they do so, "not on an intellectual level, but by deadening the feeling in the muscles involved" (Bean, 1971, p. 9). He writes:

One deadens feeling by tightening muscles. Over the years, this tightening and deadening becomes chronic until the musculature of one's own body becomes a veritable armor against unacceptable feelings. Reich found that the muscles which tend to get armored are the ones that go crosswise in the body, across the eyes, mouth, chest, solar plexus, etc. As they become chronically hardened, they interfere with the pleasurable up and down, head-to-toe streamings of the orgone... (Bean, 1971, p. 9 & 10)

Reich observed that neurotic and psychotic people are physically armoured, e.g., hold their body rigid or tense their neck, shoulder, facial, abdominal, pelvic muscles, etc. They also hold their breath and inhibit exhalation. This "muscular armor is arranged in segments" (Reich, 1951, p. 151) of which there are seven. They are: 1) ocular: forehead, eyes and the region of the cheekbone 2) oral: lips, chin and jaws 3) cervical: neck, platysma, sternocleidomastoid muscles 4) thoracic: the chest 5) diaphragmatic 6) abdominal 7) pelvic.

As each segment of armor is dissolved, usually by the physical manipulation of the client's body by the therapist, repressed traumatic emotions are discharged. Thus, it is because of this primary belief, that deep emotional pain is remembered through the body, that Reich developed a more physiological approach to cathartic therapy than did Freud or Ferenczi. Yet, he did not
stand completely alone because theoretically, at least, Ferenczi did agree with him. Ferenczi (1955) writes,

Children in the (? 3-4) first years of life have not many conscious memories of events, but only of sensations (pleasurable and unpleasurable tones) and consequent bodily reactions. The "memory" remains fixed in the body and only there can it be awakened. (p. 261).

Also, in spite of the many technical differences between Reich's approach to catharsis and the methods used by Ferenczi and Freud, the model for Orgone therapy was founded upon the five basic elements of the cathartic method.

Like Ferenczi, Reich (1951) discovered that when the expression of impulses or feelings are repressed it creates a "split" in the organism which produces a state of paralysis or rigidity called "contactlessness". This is the trance-like state Ferenczi observed. Baker (1967) writes,

Contactlessness may also occur where excitation is avoided by withdrawal in the eyes. This occurs naturally in sleep. Also, it is a major factor in schizophrenia. But it is more important in all the neuroses and more prevalent in the general population than is realized. The eyes, ears, smell and touch are all important factors in excitation. I believe the eyes are by far the most important, and contactlessness can be produced by dulling the eyes regardless of whether the origin of the stimulus was sound, smell, touch or even pain. With withdrawal of energy also results in contactlessness--as in anorgonia and shock. (p. 70)

Reich also believed, along with Freud and Ferenczi, that repressed trauma could affect an individual on a behavioural, emotional and physiological level. This trauma could be forgotten or remembered in an edited form. Reich also thought that the goal of therapy was to access these feelings by having clients remember and relive their traumatic experiences. A patient describes a session with Reich:

...I relived the experience as if it were occurring in the
present. I was a baby about nine months of age, lying in a carriage outside the door of my home. I have been crying loudly for my mother. She was obviously busy in the house, and my persistent crying had upset her. She came out, furious at me. Lying there on Reich's bed at the age of thirty-three, I looked at her image and, using the words I could not have known as a baby, I said, "Why are you so angry with me? I am only crying because I want you." (Lowen, 1975, p. 21)

Indeed, Reich truly expanded the definition of psychological catharsis in the whole area of re-enactment. However, in order to explain Reich's constructs, it is important to use terminology that Ferenczi originated in referring to childhood trauma—primal pain. For in Orgone therapy, not only did patients relive specific traumatic scenes, they also relived deep, but general, emotional pain.

Up until Reich's and Baker's research, psychological catharsis had been defined as the reliving of a single repressed traumatic scene. Reich (1951) and Baker (1967) expanded this definition to include the reliving of general pain. For example, a mother's death may be relived as a specific scene but years of living with an emotionally dead mother produces trauma as well. Although this general pain can be relived it is very difficult to access. Baker (1967) states:

... single traumatic events are contained in memory in the body's armor and reappear as the organism is mobilized. But no memory is present if the armor is the result of attitudes in the parents. The most malignant to overcome are the implied, unspoken prohibitions imposed gradually at each stage of development. (p. 41)

Also, it must be noted that Reich (1951) and Baker (1967) discovered, as did Ferenczi, that for symptoms to be eradicated the client often had to relive his/her pain more than once. Baker (1967, p. 38-41) describes a patient reliving an episode of her parents trying to kill her when she was a baby. She relived this
incident over and over again at a deeper and deeper level.

As well, Reich (1949) observed that the client's behavioural, emotional and physiological symptomology, including contactlessness, could surface during re-enactment as Ferenczi had discovered. The symptomology was directly related to how the patient defended him/herself against his/her original pain. Therefore, Reich believed that it was the therapist's task to help the individual go beyond this point to the expression of the repressed feelings and the recollection of the accompanying memory. Reich (1949) describes a session:

I encouraged her to exhale fully and helped by softly pressing down on her chest. She gave in to expiration suddenly but went into a state of trance immediately afterwards. She did not respond to my calling her; her eyes were turned toward a corner of the ceiling in a staring manner; she seemed to be hallucinated. Her legs trembled severely and she had fascicular convulsions in the muscles of her shoulders for about 30 minutes....

...I succeeded in bringing her out of her trance by pinching her hard enough to make her aware of the sensation of pain. Slowly she began to return to full consciousness. (p. 411)

Physiological symptoms not only appeared during individual Orgone sessions but they could also develop during the whole process of therapy and could be life threatening. Baker (1967) writes of one of his patients undergoing therapy:

Her throat continued blocked and she swallowed back her emotions. She continued hanging on to her husband and making a mother out of him. She admitted sexual feelings for me, which she would hold back by clamping in her pelvis. At this point, she developed acute appendicitis and was operated on. During the operation, an ovarian cyst the size of an orange was found; it had not been present 3 months previously when she had been thoroughly examined by a gynecologist. (p. 264)

Baker attributed the development of this cyst as a defensive response. However, to counteract any trepidation such an account could inspire, it must be mentioned that Reich also claimed that
Orgone therapy could prevent and reverse such maladies as cancer, allergies, arthritis, etc. Indeed, he believed that such illnesses were the direct result of the toll repressed emotions took upon the body. Orgone therapy, by purging the patient of his/her pain, removed the origin of many health problems.

Another element that Freud (1947), Ferenczi (1955) and Reich (1949) agreed upon in relation to the nature of catharsis, was the importance of analysis. Reich believed that emotional discharge was not enough; analysis was also a vital component in the patient's understanding and resolution of his/her problems. In fact, Reich developed his own type of analysis called "character analysis" which involved "the development of insight via confrontation, clarification, interpretation and working through" (Nichols, 1977, p. 107). It also involved categorizing people into specific types, e.g., anal, phallic, ocular, etc. which would determine how Orgone therapy was applied. Baker (1967) writes:

Individual character development depends on the degree of fixation or armoring at the various erogenous levels where the major part of the energy is concentrated. Symptoms characteristic of these levels are present whenever there is an increase in energy concentration or block at that level. The great majority of persons fall into one of the specific character types although most of them have elements of other character types. (p. 99)

Indeed, Reich stated that "character analysis" was "an indispensable auxiliary technique in biophysical Orgone therapy" (1949, xviii). Unfortunately, Reich gradually used this therapeutic intervention less and less. Baker, on the other hand, never stopped using analysis. He considered the process vital for psychological catharsis.

The type of character analysis that Baker used in his sessions
involved categorizing, analyzing, explaining, confronting, comforting, clarifying, interpreting, challenging and discussing. This type of free-flowing analysis could occur before, during and after the catharsis. He followed no rigid time patterns. For example, he (1967) writes about a session:

I then proceeded to her abdomen, thighs and pelvis. Immediately the wheezing started but was mild, and I continued. Her thighs began to tremble, she became anxious and restless, finally sat up and said that she wanted to go home; that she couldn't stand the treatment after all and doubted that I knew what I was doing. She was going crazy and I could not stop her; besides I had not cured her asthma after all; perhaps I was crazy myself. I again pointed out her stiff-necked attitude--she must be prim and proper at all costs [italics added]. She burst into tears and felt considerable relief, apologizing profusely for her attitude, begging me not to be angry or to throw her out because I was the only one who could help her. All that she wanted was to remain near so that she could feel safe.

.... I returned to her chest, bringing out more anger and sobbing which relieved her asthma. Then I concentrated on her eyes inducing her to express anxiety and to look at me [italics added]. She was never able to do this and when I insisted [italics added] she became very alarmed and sat up, saying that she would stand no more. I accused her of having thoughts about me [italics added] and she confessed that she had an intense desire to throw her arms about me and to kiss me.

Reassuring her that such impulses were natural enough [italics added]. I asked her if she trusted me [italics added]. Was she afraid that I would take advantage of her? She was sure that she had no fears in that respect but she was afraid of her own impulses. Finally, she became more comfortable, could look at me, and talked more freely. I continued pointing out her haughty attitude [italics added], her virgin purity as contrasted to her promiscuous dreams, and worked on her neck. (p. 241 & 242)

Summary

Through the discoveries of Reich and Baker in relation to Orgone therapy, it was possible to add to the definition of psychological catharsis. For the purpose of this study, the first element now included general trauma and not just specific primal scenes.
1. **Specific** or **general** primal pain can be repressed so that it is completely lacking from the conscious memory or else exists in an abridged form. The first reaction to primal pain is a splitting off process often manifested by a trance-like or contactlessness state. Repressed primal pain is converted into physiological, emotional and/or behavioural symptomology which can include the trance state.

The second and fifth elements that were based upon Ferenczi’s data remained the same. The third and fourth elements based upon the information provided by Reich and Baker were expanded.

2. The trauma must be **relived** as vividly as possible; to relive means: a) the experience must be remembered b) the emotions that accompany the memory of the experience must be expressed.

3. When primal pain is experienced in the present the client may relive his/her defensive response to the trauma, i.e., psychological, physiological, and/or emotional symptomology. The individual must go beyond this point, to relive the actual trauma and express the emotions he/she did not communicate at the time it occurred.

4. The whole process of reliving a primal pain must be analyzed. Analysis means: a) to categorize, to discuss, analyze, clarify, interpret, explain, confront, comfort, challenge, discuss before, during and after the reliving process; b) to aid the patient to understand and comprehend the meaning of his/her pain and how it relates to his/her symptomology; c) to help the client gain emotional and intellectual integration of what he/she is going through and of what he/she has gone through in his/her sessions.

5. Once repressed primal pain has been relived (possibly several times) and analyzed the symptoms it caused disappear and the patient is purged of his/her pain--psychological catharsis.

**Cathartic Hypnotherapy (1916–1959)**

About the same time Reich was developing his theories a number of psychiatrists were exploring (separately) catharsis or abreaction while working with soldiers in World War I and World War II.

These psychiatrists were W. Brown (1921), Simmel (1944) and Watkins (1949) and, like Freud, they used hypnosis to achieve catharsis. Others, Hordern (1952), Grinker and Spiegel (1945), Shorvon and Sargent (1947) used drugs to elicit catharsis:
"depressants such as sodium pentothal, nitrous oxide, hydrobromide, alcohol, sodium amytal and ether—as well as one stimulant, scopolamine" (Nichols, 1977, p. 57). However, before exploring the work of these above clinicians it must be noted that the subject of drug-induced-catharsis will not be explored in this paper.

Even though there are many similarities between catharsis-induced without-chemicals and catharsis-induced-with-chemicals, there are too many independent biochemical variables involved in the latter to make a comparison. Each drug works on each individual in a different way. Secondly, it is impossible to know where the individual personality begins and the drug's effects end. Thirdly, it is impossible to know where the therapy begins and the drug's effects end.

Technically, Cathartic Hypnotherapy is the cathartic method. Freud used hypnosis to induce catharsis. However, Cathartic Hypnotherapy is being studied as a separate model because Freud very quickly abandoned the technique of hypnosis as unreliable. He used free association instead. Indeed, Cathartic Hypnotherapy was only really established as a cathartic model by these later clinicians.

Using hypnosis, Brown (1944), Simmel (1921) and Watkins (1949) worked separately with soldiers who, due to war trauma, suffered from symptoms such as hysteria (mutism, paralysis, deafness, blindness and contractures), phobia, tension, depression, paranoia, fatigue, nightmares and insomnia.

All of the above psychotherapists believed in the first, most important component defining psychological catharsis. They understood that when an individual is faced with an overwhelming
traumatic experience to which he/she cannot respond—that person splits off from the incident. He/she forgets or edits the memory and converts the emotion into behavioural, emotional or physiological symptomology. Brown (1944) writes:

...we have given him an outlet for an emotion which was originally experienced by him with too great intensity—with so great an intensity that he could not keep it consciously within bounds, and his mind split in the attempt. (p. 17)

However, it must be noted that the Cathartic Hypnotherapists did not refer to a trance or contactlessness state as the first reaction to trauma. As they made no observations at all in this particular area no critical or supportive conclusions can be drawn on this subject. Yet, they (Brown (1944), Watkins (1949), Brenman and Gill (1947)) refer frequently to the patient’s hypnotic state as a trance. Ferenczi observed the same similarity. He (1955) writes:

Where this takes a quasi-hallucinatory form, people can call it auto-hypnosis if they like; my patients often call it a trance-state. (p. 134)

Also, Watkins (1949), Gill and Brenman (1959) observed that clients under hypnosis could also experience contactlessness (p. 54 this paper). Thus, as in Orgone and Neo-cathartic therapy, the trance state could emerge as part of the client’s symptomology. Cathartic Hypnotherapists also believed that if the client was allowed to consciously remember and emotionally relive his traumatic experiences his symptomology disappeared.

Yet, it is important to note that the clients of Brown, Simmel and Watkins differed from those of Freud, Ferenczi, Reich, etc., for, their patients were predominantly adults when their trauma occurred. However, it was observed by Brown that for some
traumatized soldiers their wartime symptomology was emotionally connected to their childhood. In other words, their symptoms originated from traumatic events of childhood and were triggered by their recent war experiences.

Brown (1944) writes about a signaller who was blown up by a bomb. After the explosion, the solider felt that everything was twisted at right angles to its ordinary position and this feeling of disorientation persisted:

I hypnotized this patient and put him through his experiences again......but the disorientation continued to occur from time to time. He was better, but by no means cured.

(p. 17)

The signaller then learned from his mother that he had had the same symptom of disorientation at the age six due to a fall. Brown hypnotized him and had him relive this experience. But still the patient was not cured. Finally, Brown suggested to him, under hypnosis, that he return to his very first experience of disorientation. At this time, the patient relived a scene in which, at the age of three, he upset a pot full of hot coffee on top of himself.

This above experience was rare for Brown (1944) because he normally only needed one session to eradicate such wartime symptomology. However, patients whose war experiences triggered repressed trauma from childhood needed more treatment. Thus, it was experiences such as these, of traumatized soldiers not improving, that convinced Brown "that the emotions of early life, even those of the first two years, can persist and be recalled under hypnosis" (Brown, 1944, p. 82).

Cathartic Hypnotherapists also observed that physiological,
emotional and/or behavioural symptomology emerged during their sessions. Hadfield, a Cathartic Hypnotherapist stated that:

...the immediate effect of recalling the traumatic experience may be an exacerbation of the symptom or the appearance of substitute-symptoms: "The headache disappears but gives place to acute anxiety; or in addition to the pain in the back, the patient begins to vomit. (Brennen & Gill, 1947, p. 71)

However, like Ferenczi, these clinicians also discovered that re-enactment had to be followed by or accompanied with analysis before symptomology disappeared for good. Analysis or "autognosis" (Brown, 1944, p. 67) or "hypnoanalysis" (Brenman & Gill, 1947, p. 79) was defined as discussion, support, interpretation, understanding and intellectual integration. It was a necessary and crucial step in the final cathartic outcome; the soldier had to remember and understand consciously what had occurred under hypnosis. Brenman (Brenman & Gill, 1947), a civilian psychiatrist, writes:

A combination of analytic-cathartic hypnosis with analytical conversations during the waking state, and dream interpretation carried out both in the waking state and in deep hypnosis, has given me a method which on an average of two or three sittings brought about relief of the symptoms. (p. 81)

Watkins (1949) writes:

In this abreaction or reliving of the original trauma episode the corrective emotional experience is administered which enables the patient to close off or complete the incomplete Gestalt of the neurosis. By a return to the emotion of the moment, followed by a more beneficial interpretation [italics added] the guilt can be released, and what has been referred to by Kubie (1943) as the "repetitive core" need no longer compulsively plague the patient in a never-ending search for fulfillment which never comes. (p. 247)

Thus, it was the combination of the reliving process and analysis, induced by hypnosis, that resulted in psychological catharsis. Indeed, as with all cathartic therapists, this
intellectual and emotional combination was deemed vital to the whole process of catharsis.

Summary

The research from these clinicians supports the changes and the additions made to the definition of psychological catharsis from the information provided by Ferenczi (1955), Reich (1951) and Baker (1967). However, due to this new data the fifth element has been further enhanced.

5. Once repressed traumatic experiences have been relived (possibly more than once) and analyzed the symptoms they cause disappear and the patient is purged of his/her pain—psychological catharsis.

a) However, symptoms that originate from childhood trauma, but are triggered by a recent trauma, will not be eradicated by reliving the latter. The original trauma must be relived and analyzed.

b) Symptoms of an original trauma will resurface during the therapeutic reliving of childhood traumas that emotionally parallel the first. This symptomology will not be eradicated until the first original trauma is relived and analyzed.

After reviewing the three basic models of the cathartic method, it is now necessary to substantiate the five points, defining psychological catharsis, in relation to more current models. Cathartic Hypnotherapy has not altered much in theory or method—the five elements stand. Although Neo-catharsis has disappeared, the roots of Primal therapy can be found within Ferenczi’s model, while Orgone therapy has evolved into Bioenergetics.

Primal Therapy (1970—)

Primal therapy was originated in 1970 by Arthur Janov, a psychologist, and its entire structure is based upon the reliving process. Technically and theoretically, it closely parallels Ferenczi’s Neo-cathartic model.
Janov, like Ferenczi, was able to reach his clients' deepest pain based, almost solely, upon his humanistic ability to build a supportive, trusting and honest relationship between himself and his patients. Yet, unlike Neo-catharsis, Primal therapy enveloped an entire theoretical structure which consisted of many unique ideas.

Primal pain is defined as:

The pain resulting when the child cannot be himself. Primal Pain is the result of parental denial of basic need and natural development.

Primal Scenes - Key early traumas representative of many other events when the child could not be himself.

The Split - The disengagement of feelings from thoughts. To be split is to be disconnected from one's feelings.

Major Primal Scene - The early critical event which sets neurosis on its course. It is the signal occurrence which makes the child predominantly unreal.

A Primal - Reliving key Primal Scenes and their painful feelings in a totally encompassing way, mind and body. (Janov, 1972, p. 9-10)

According to Janov, there are three different levels of pain within each individual that correspond to three levels of approximate consciousness: viscera (from fetus to 6 months), emotional (from 6 months to 6 years) and intellectual (from 6 years and up).

In Primal therapy, pain is thought to begin in the womb. If the mother is under stress it will be transmitted to the fetus. These traumas to the unborn are stored in its rudimentary nervous system and affect the physiology and consciousness of the individual throughout life. Any great emotional pain that occurs in gestation, birth and infancy is imprinted upon the visceral level. Thus, many diseases and physical symptoms, e.g., colitis, asthma,
stomach problems and migraines find their origin in the time period from conception to birth and up to 6 months after birth. Janov (1980) writes:

The vulnerability and malleability of the nervous system during the first weeks of life means that events can be stamped with a permanence which is greater than that of events occurring later in childhood. The fact that first line traumas are often life-and-death matters means that the valence or charge value of the stored memory will be high, and that the force it exerts on later behaviour and symptom formation will be considerable. This is precisely why prenatal and perinatal care of infants is crucial.

All emotional experiences that happen to us after we differentiate ourselves from our surroundings and develop emotional relationships to our parents are second-level or feeling events. Criticisms, humiliations, rejections, scoldings, and punishments are "remembered" on this emotional level.

Later, the development of the symbolic intellect or third level will not only integrate the lower two levels, but also keep them apart. If ideas and concepts can quell pain, they can also shield against consciousness rather than act as a force for it. Ideas can be developed to keep us from knowing what is going on below the level of conscious awareness. Because the third level is quite plastic, it can deceive, manipulate, and condition itself. It can misrepresent feelings to distract the self from recognition of feelings.

Third level consciousness begins its formations between the ages of five and seven and becomes solidified after the age of thirteen (when there is a qualitative shift in the brain wave pattern). Simultaneous with this shift is an increase in the ability to inhibit, reflect, and block emotional responses. It is then that one can shift from emotionality to intellectuality and respond in terms of rules, regulations, and mores...

He elucidates further:

First-level consciousness is body consciousness. The second has to do with relating to others.

The second level of consciousness is also where images lie and therefore, creativity. It is the level that conjures up dragons, demons, dreams, and artistic perception. It is the level that bridges the first and third levels, adding emotional content to experience. The images of the second level have a clarity that is lost when filtered through the third level. In dreams, however, that sharpness of image is recaptured. A person reliving something in his childhood sees, hears, and smells exactly as if he were there. And,
indeed, with access to the second level he literally and neurologically is there.

The third level is the last to develop. This is the integrating consciousness, responsible for bringing together first- and second-line events, for rationalizing, intellectualizing, and symbolizing those happenings. It is the system of logic, of problem solving, and of storing facts and figures. It is the system of "figuring out". It philosophizes, makes mathematical symbols, fixes machines. It is the system that internalizes religion and mystical ideation. It is the part of us that tries to make sense of the world. It is the last acquired system of consciousness both in terms of the history of the species (phylogeny) and in terms of the development of the infant (ontogeny).

It is the third level which perceives symbolically and reflects through language. It has insights— an awareness of feeling and of awareness itself, while the second level has a feeling of awareness. (p.102-103)

According to Janov the memory of an emotional trauma can exist on an unconscious level or in an abridged form. The repressed emotions that accompany these memories cause behavioural, emotional and physiological symptomology. Also, like Ferenczi, Reich and the Cathartic Hypnotherapists, Janov refers to the initial moment of repression as a splitting process. He (1970) writes:

Since the infant cannot himself overcome the sensation of hunger (that is, he cannot go to the refrigerator) or find substitute affection, he must separate his sensations (hunger; wanting to be held) from consciousness. This separation of oneself from one's needs and feelings is an instinctive maneuver in order to shut off excessive pain. We call it the split.

The organism splits in order to protect its continuity. This does not mean that unfulfilled needs disappear, however. On the contrary, they continue throughout life exerting a force, channeling interests, and producing motivation toward the satisfaction of those needs. But because of their pain, the needs have been suppressed in the consciousness, and so the individual must pursue substitute gratifications. He must, in short, pursue the satisfactions of his needs symbolically. Because he was not allowed to express himself, he may be compelled to try to get others to listen and understand later in life. (p. 18-29)

That event I call the major Primal Scene. It is a time in the young child’s life when all past humiliations, negations, and
deprivations accumulate into an inchoate realization: "There is no hope of being loved for what I am." It is then that the child defends himself against that catastrophic realization by becoming split from his feelings and slips quietly into neurosis. (p. 21-22)

However, in regard to the trance state as being the first reaction to trauma, Janov made no reference. Thus, no critical or supportive conclusions can be made on this subject. However, withdrawal or a state like contactlessness could emerge during Primal therapy, as part of the client's symptomology. As well, Janov mentions that a state of trance exists in all neurotics. He (1970) writes:

Every neurotic is really in a hypnotic state for all of his life. He is a victim of unconscious forces which drive him relentlessly and for which he has no explanation. (p. 105)

According to Janov neurotics spend their entire lives in a trance state which is dispelled with cathartic therapy. He (1970) writes:

Many neurotics who have finished their therapy explain that their lives previously were like being in a trance. Because they were dominated by the past, they were scarcely aware of what was going on in their lives. One patient described it as being in a perpetual daze. (p. 247)

As a person gains access to his early Pain, he restores the connection between his body, his feelings, and his intellect which were lost due to repression....He begins to regain consciousness--not just awareness but an organic fluidity of levels and structures of the brain which have been strangers to each other for many years. (p. 110)

The next major construct of Primal Therapy, which coincides with the second element defining psychological catharsis, is that an individual can only become free of his/her neurosis by remembering and reliving his repressed primal pain:

The feeling in a Primal that is associated with a childhood experience any time after the split is a piece of the real self, a real self that cannot be totally experienced unless you go back before the split. That is why reliving childhood
experiences or scenes in Primal Therapy is so important. They help you feel pieces of your real self by associating the pain with specific incidents, until you can be the essence of your real self... (Janov, 1970, p. 98)

To surface the emotional pain one must be able to access the first and second level of consciousness. Janov (1980) writes:

First-level consciousness is body consciousness. The second has to do with relating to others.

...A person reliving something in his childhood sees, hears, and smells exactly as if he were there. And, indeed, with access to the second level he literally and neurologically is there. (p. 102-103)

Janov also stated that the original trauma may have to be relived many times over. He (1970) writes:

If the split is early and the Pain great, the patient may relive one scene many times over. (p. 97)

Yet, like Reich and Baker, Janov determined that general primal pain could be relived as well—not just specific scenes. He (1970) writes about a patient:

After this, however, she continued to have Primal experiences earlier and earlier in her life until she reached the age of three, when she came to feel the "pure need" of wanting her parents' love. She later said that this was her most painful Primal—to feel that physical need meant to feel the continuous Pain of something that was never fulfilled. There were no words during this Primal, just a completely internal experience with a bunching up of the body, writhing and groaning, clenching of the fists, and grinding the teeth. (p. 97)

Janov noted that during primal sessions the original defense of his patients would surface. These defenses were psychological, behavioural and certainly physiological. Like Baker, he observed that many of the physiological symptoms appeared, not just in specific sessions, but over the course of therapy, i.e., diarrhea, headaches, backaches, asthma attacks etc. Also, what is apparent is that Janov confirms what many of the cathartic therapists have concluded before him. In order to be purged of the emotional
influence of a repressed trauma, the actual experience must be relived not the original defense. He writes:

Psychosomatic afflictions trouble almost every Primal patient early in his therapy...

Because excessive pain seems to be shut off automatically by our systems, what seems to happen in the first few days of therapy is what I would call the Symbolic Primal...The physical part of the Pain may be galvanized at first, but the patient cannot make a mental connection. He may, instead, feel a terrible pain in his back (symbolic of someone's being "on his back"), or he will become partially paralyzed (symbolic of his helplessness)...

...physical pains are the result of early mental pain, and when those hurts are felt, the physical afflictions drop away [italics added]. (p. 93 & 94)

Analysis or integration also occurs in Primal therapy. First, after clients go through catharsis it is Janov's experience that they are often flooded with insights or connections which explain many of their neurotic behaviours. It is the classic Gestalt "aha" experience taken to its deepest level. Ironically, the patient invariably ends up explaining to the therapist the origins and causes of his/her own neurosis. This discussion or integration can take place whenever the patient comes out of his/her pain and wants to share his/her experience with the therapist. As well, throughout the Primal sessions, the therapist is comforting, confronting, challenging, blocking, etc.

Summary

The structure of Primal therapy is based upon the 5 elements defining psychological catharsis. In researching Primal therapy, no changes or additions to the definition were indicated.

Bioenergetics (1975---)

Bioenergetics, developed by Alexander Lowen in 1975, is derived from Orgone therapy and embraces the five elements that make up
psychological catharsis. Lowen was Reich's patient and student. The major difference in their theories is that Lowen placed less emphasis on flow of sexual energy in his clients. Instead, he was interested in the overall flow of energy within the body. Also, he placed more emphasis on analysis: the client's intellectual integration and understanding of his feelings. Reich eventually dropped analysis from his therapy.

According to Lowen, the core of pain is the inability to be open and to love fully which is included in Reich's definition of orgastic functioning. People develop defenses during childhood to protect themselves from emotional pain. There are three major defensive layers and it is the job of the therapist to work through all three layers.

1. The ego layer is the outer level of the personality and contains the psychic defenses, e.g., projection, distrust, denial, rationalization, blaming, etc.

2. The muscular layer is the "chronic muscular tensions that support and justify the ego defenses and at the same time protect the person against the underlying layer of suppressed feelings that he dare not express."

3. The emotional layer contains all the suppressed feelings of panic, despair, pain, sadness, rage and terror. And the "feeling to love and be loved" is found at the "core or heart" of the individual. (Lowen, 1975, p. 120)

Like all cathartic therapists, Lowen believed that emotional, behavioural and physiological problems were "determined by traumatic experiences in the early life of the individual" (Lowen, 1971, p. 161). These traumatic experiences existed in the unconscious or in abridged form in the conscious mind and caused physiological, behavioural and emotional symptomology. The splitting off, noted by the other cathartic therapists, was also isolated by Lowen. He (1975) writes:
...when the natural playfulness of the child is not allowed its full and free expression. The suppression of a child's sexual curiosity and fun-loving proclivities does not eliminate these tendencies. They are buried and removed from consciousness but remain alive in the subterranean layers of the personality, emerging when the person lets down as perversions of the natural tendencies. The qualities of the child have not been integrated into the personality but are split off and encapsulated as foreign bodies alien to the ego. (p. 57)

In relation to contactlessness, Lowen obviously observed the symptomology pertaining to this state but referred to it as contraction instead. He, like Reich and Baker, also recognized this symptomology as a reaction to suppressed pain:

A dulling of the eyes indicates the withdrawal of feeling from them. A cold, white skin is due to the constriction of capillaries and arterioles and indicates that the blood is being held back from the body surface. Rigidity and a lack of spontaneity suggest that the energetic charge is not flowing freely into the muscular system. This picture adds up to a state of contraction in the organism which is the somatic aspect of pain. (Lowen, 1975, p. 138)

In regards to the second element of psychological catharsis, Lowen placed extreme importance upon accessing primal pain through the reliving process. But, as in Orgone therapy, the trauma was accessed through the body. He also concluded that the cathartic effect is short lived if the underlying traumatic memory is not consciously remembered. For Lowen, as with other cathartic therapists, to discharge feelings without connecting them to a memory was futile. For example, he writes of a patient who had "many strong emotional breakthroughs" or "affective discharges" (1971, p. 127). Although she felt better for them there was no real change occurring within her. Lowen (1971) states:

...The strong affective discharges had led nowhere. They had begun during her previous therapy with me. At that time they took the form of crying with choking sensations which were mixed with anger. As I observed these outbursts, I realized that they were ineffectual to promote the therapy. She did
not cry or become angry because of the awareness of a past trauma. Her reaction was one of frustration without any direction. I interpreted it as a resistance in the sense that the patient was "blowing off steam." This "blowing off steam" made her feel better temporarily, but at the same time it had the effect of preventing the build-up of sufficient inner tension to bring her into better contact with her character armor. (p. 127)

Thus, the patient not only had to relive his/her feelings but he/she had to be able to recollect the traumatic event. However, according to Lowen, not all primal pain was linked to a specific event. As Baker had first observed, the pain could be connected to a general attitude projected upon the child. Still, conscious awareness even of attitude was of prime importance in Lowen's therapeutic approach. Lowen (1975) writes about a session in which two Bioenergetic therapists worked on him:

One worked with some tension in my throat. The other was working on my feet. Suddenly I felt a sharp pain as if someone had taken a knife and cut my throat. I had the immediate feeling that this was something my mother had done, psychologically, not literally. I realized the effect was to stop me from speaking out or crying out...

When I felt the pain, I threw the therapists off me and cried out in anger. Then I experienced a deep relief. (p. 109-110)

Lowen also observed, during his sessions, that the clients behavioural, emotional and/or physiological symptomology, including contraction or contactlessness, could surface. He stresses that the client must be urged beyond his/her symptomology; to recollect his/her trauma and express the feelings surrounding it. For example, he refers to some emotional outbursts as the way the patient defends him/herself against feeling his/her pain. Lowen (1971) writes:

...this kind of emotional release has the function in many impulsive individuals of preventing too great a strain upon the character and muscular tensions. In reality, then, these
releases are part of the neurotic mechanism. This is the problem of acting out in the therapy. The analyst who permits the patient to function neurotically in the analysis blocks himself from an effective attack upon the neurosis. The acting out of the neurotic character is the fundamental resistance. (p. 128)

He further states that a patient can,

...continue to scream, cry and rage with little change in his overall personality. He will have substituted a cathartic process for an inhibiting one, but he will not significantly change in the direction of growth. He will remain caught between inhibiting forces he has not understood and worked through and the desire to obtain a momentary cathartic release. (p. 121)

Like all cathartic therapists, Lowen also believed in the need for analysis before, during and following cathartic therapy. He (1975) writes:

As an analyst Reich had emphasized the importance of character analysis. In his treatment of me this aspect of the therapy was somewhat minimized. It was further diminished when character-analytic vegetotherapy became orgone therapy. Though character-analytic work takes much time and patience, it seemed to me that it was indispensable to a solid result. I decided then that no matter how much importance we placed on the work with muscular tensions, the careful analysis of a person's habitual mode of being and behavior merited equal attention. I made an intensive study of character types, correlating the psychological and the physical dynamics of behaviour patterns. (p. 41-42)

As did Reich, Lowen believed that the body corresponded to the psychology of the person. Lowen divided neurotics into personality types, e.g., masochistic, hysterical, phallic-narcissistic, passive feminine, schizophrenic, schizoid and oral. He saw each type as possessing certain psychological as well as physical characteristics. He (1971) writes about the oral character:

The oral character tires rapidly when engaged in a continuous physical activity such as striking the couch. Many of these individuals feel that they lack energy. The abandonment of the effort is only partly due to muscular fatigue. When they resume it is not for long. This assumption of a lack of energy finds support in the fact that this structure is frequently associated with low blood pressure and a low normal
basal metabolism. While tiredness and lack of energy are not pathognomonic for this structure, their presence always indicates a strong oral element in the personality.

The chest is generally deflated, the belly is without turgor and feels soft and empty to palpation. The deflation in the chest may produce the depressed sternum which is found in some oral structures. (p. 173-174)

Thus, for Lowen, emotional release resulting from working with the body had to be integrated and understood.

**Summary**

Lowen's findings correspond to the other cathartic therapists. Thus, the definition of psychological catharsis does not alter.

**Final Definition of Psychological Catharsis**

1. **Specific** or **general** primal pain can be repressed so that it is completely lacking from the conscious memory or else exists in an abridged form. The first reaction to primal pain is a splitting off process often manifested by a trance-like or contactlessness state. Repressed primal pain is converted into physiological, emotional and/or behavioural symptomology which can include the trance state.

2. The trauma must be **relived** as vividly as possible; to relive means: a) the experience must be remembered; b) the emotions that accompany the memory of the experience must be expressed.

3. When primal pain is experienced in the present the client may relive his/her defensive response to the trauma, i.e., psychological, physiological, and/or emotional symptomology. The individual must go beyond this point; to relive the actual trauma and express the emotions he/she did not communicate at the time it occurred.

4. The whole process of reliving a primal pain must be analyzed. Analysis means: a) to categorize, to discuss, analyze, clarify, interpret, explain, confront, comfort, challenge, discuss before, during and after the reliving process; b) to aid the patient to understand and comprehend the meaning of his/her pain and how it relates to his/her symptomology; c) to help the client gain emotional and intellectual integration of the what he/she is going through and of what he/she has gone through in his/her sessions.

5. Once repressed traumatic experiences have been relived (possibly more than once) and analyzed the symptoms they cause disappear and the patient is purged of his/her pain—psychological catharsis.
a) However, symptoms that originate from childhood trauma, but are triggered by a recent trauma, will not be eradicated by reliving the latter. The original trauma must be relived and analyzed.

b) Symptoms of an original trauma will resurface during the therapeutic reliving of childhood traumas that emotionally parallel the first. This symptomology will not be eradicated until the first original trauma is relived and analyzed.

The Reliving Process

Once psychological catharsis was defined, it became apparent that the reliving process was a key element of the definition. Because of this significance, re-enactment was explored in more detail. All models of Freud’s cathartic method were examined; Neocatharsis, Orgone therapy, Cathartic Hypnotherapy, Primal therapy and Bioenergetics. Following this review, a more comprehensive description and definition of the reliving process was formed.

Pattern

Some cathartic therapists observed that there was a pattern to the reliving process. For example, Reich (1951) and Baker (1967), who referred to the reliving process as unlayering or breakthrough, recognized a sequence.

In Orgone therapy there are 7 segments of armor in the body and each segment has 3 layers. Baker (1967) writes:

1. The superficial veneer or social facade.

2. The secondary or great middle layer where the sum of all the repressions has built up, resulting in destructive forces such as rage, spite, hate, contempt, etc. There are usually many subsidiary layers here.

3. The healthy core...(p. 61)

As each layer of armor is removed, three things appear in sequence:

First, anxiety occurs. Then, emotion is released—rage, contempt, spite, crying etc. After the emotion is expressed,
there is a sense of relief. Third, contactlessness appears. There is no desire to move and the patient is temporarily stuck. A stage where the repressed and repressing forces are equal has been reached. (Baker, 1967, p. 70)

Actually when the above passage is carefully reviewed it appears that Baker is describing a four step sequence of: anxiety---emotion---relief---contactlessness. Also, the goal of the reliving process or unlayering in Orgone therapy is not contactlessness which refers to physical and emotional withdrawal. As Baker states, contactlessness is only a temporary stage.

Reich (1951) and Baker (1967) constantly urged patients, who entered contactlessness to go beyond this stage; to remember the traumatic experience and express the accompanying feelings. Indeed, after research (Reich, 1951 & Baker, 1967), it becomes apparent that the sequential pattern of the reliving process in Orgone therapy is: anxiety--emotion--relief--contactlessness--anxiety--emotion--relief. Also, according to Baker (1967) this emotional sequence could occur, entirely or partially, within one therapy session or over an extended period of time.

The other clinician who also observed a pattern occurring in the reliving process was Ferenczi. According to Ferenczi (1955), the reliving process occurred in three stages during a therapeutic session. The following is a summary of his research:

1. Regression: the client goes back to the time at which his trauma occurred.

   Symptomology: many physiological and emotional symptoms would surface as the client approached his/her trauma.

3. Expression/recollection: the client remembers his/her trauma and expresses the accompanying feelings.

   Although none of the other cathartic therapists under study made any specific reference to a sequence occurring in the reliving
process, they all observed, partially and on various levels, a certain flow to the process. In order to understand this movement, Ferenczi’s model will be used as a reference as it can incorporate all observed phenomena pertaining to the reliving process including the Orgone pattern.

Regression

No matter what model of the cathartic method is being applied, in order for the reliving process to occur, the individual must be regressed. Whether the trauma occurred recently or in the far past, the patient has to be taken back to the time it happened.

According to Ferenczi (1955), when his patients regressed, they would descend into an infant-like state; becoming playful, talking in a baby voice and playing childish games. For example, Ferenczi (1955) writes of patient who was in this state:

Suddenly, in the midst of what he was saying, he threw his arms round my neck and whispered in my ear, "I say, Grandpapa, I am afraid I am going to have a baby!" (p. 129)

Ferenczi believed that such playful behaviour was a necessary stage of the reliving process. He writes:

I was soon forced to admit to myself and to the patient that many of the serious realities of childhood were concealed beneath this play. I had proof of this when certain patients began to sink out of this half-playful behaviour into a kind of hallucinatory abstraction, in which they enacted before me traumatic occurrences, the unconscious memory of which lay, in fact, behind the dialogue of the game. (1955, p. 130)

Reich and Baker did not refer to their patients becoming child-like; however, during regression childish behaviour was certainly evident. Baker (1967) writes:

...during therapy a forty year old woman repeatedly saw a mental image of a woman and man. She hated the woman but did not know why, She saw herself with them at three years of age. She got into bed with the man but was convinced they were not her parents. At times, she would see the man and
woman on a porch at a party and thought they might be neighbors she had been left with. Gradually the woman became clearer and she experienced great hatred for her, wanting to kill her. At this point she became very excited, lying on her back and kicking, pounding, and screaming in a typical childish temper tantrum. (p. 39)

When Watkins, the Cathartic Hypnotherapist, regressed his patients he also observed that the client spoke and acted the age at which he/she was regressed. He (1949) writes:

The patient may also be regressed under reasonably deep trance to an early age level. He not only remembers what happened then, but he acts in every way like an individual of that age (Spiegel, Shor and Fishman, 1945). For example, when regressed to the age of seven he will read, write, and play games like a seven-year-old. (p. 48)

In Primal therapy, Janov (1980) noted that the client not only regressed during the reliving process but, as therapy progressed, the individual was able to access earlier and earlier pain. Janov(1980) describes a client's regression:

In a session a patient began crying about her boyfriend, who was beginning to feel distant and to talk about possibly breaking up. She was in considerable pain, feeling that he might go....The patient began rocking back and forth as she cried out for her boyfriend not to leave. As time went on, the rocking continued and she began crying in greater agony, "I don't want to die. Don't let me die!" She started to relive being sent away to her stepfather's house when her mother remarried and could no longer take care of her. She had to rock herself to sleep every night for years. Back then she wasn't aware of the terror that she was going to die. She only felt terrified and the rocking eased her tension...

The patient traveled from the present to the early source of her neurosis via feeling, which connected the present to past. (p. 64 & 65)

The above individual regressed slowly into the reliving process. Just how quickly and how far back a client regresses depends upon the individual. For example, one of Janov's patients began therapy with the reliving of her birth. Others never go that far:
Some patients are able to go directly to the major scene in which they felt the split; others take months to get there. (Janov, 1970, p. 96)

Lowen (1975) also considered the facilitation of regression in his patients one of the most important aspects of therapy. He believed that there is, within each patient, a suppressed child who has never been allowed to express him/herself. Lowen (1975) writes about an adult client:

...As I look softly into his or her eyes, I often see a little child looking out at me from behind a wall or through an opening, wanting to come out but not daring to. This is the child kept hidden from the world. I may say to him, "Come out and play with me. It's all right." It is fascinating to watch the response as the eyes relax and feeling flows into and through them to me. That little child wants desperately to come out and play but is scared to death it will be hurt, rejected or laughed at. It needs my reassurance to venture forth, especially my loving touch. And how good it feels to come out and find oneself accepted!

An experience such as the above may be the first time in a very long while that the patient has revealed and acknowledged the hidden child in him. But once the acknowledgment is consciously made, the way is open to analyze and work through all the anxieties and fears that have forced the child to hide and bury his love. (p. 296)

According to Lowen (1975), regression is necessary because the reliving process involves a time distortion in which the client relives the "there and then" in the "here and now". However, he also discovered that the patient is always conscious of the present no matter how far back he/she has been regressed. Lowen (1975) writes:

...Regardless of how much a patient regresses in the course of a session to an infantile state, he or she is still an adult and fully conscious of that fact. (p. 297)

Symptomology

As individuals regress and approach their trauma, often physiological, emotional and behavioural symptomology would
surface. All of the cathartic therapists observed this phenomena. Indeed, according to Janov (1970), each person has a specific pattern as to how they enter the reliving process or primal:

Some patients need to talk their way into feeling; others will start with a bodily feeling which is momentarily inexplicable and later hook it up with a memory. (p. 89)

Thus, their symptomology is manifested in many different ways; through intellectualization, compulsive talking, physical complaints such as headaches and backaches. Janov (1970) writes that some clients:

...will grasp the couch, others will clutch their stomachs, and still others will begin to roll their heads, teeth chattering and perspiring profusely. Some patients will double up with the Pain, others will curl in a corner of the couch and some will fall off the couch onto the floor convulsing. (p. 89)

One form of symptomology which surfaced repeatedly was the trance-state. So frequently did this state emerge that Ferenczi, Reich and Baker appeared to believe that it could be a necessary step in the reliving process (p. 17 & 24 this paper). Although no other cathartic therapist made similar observations, they all witnessed the state in one form or another in their therapy sessions. This trance state is such a complex phenomena that further exploration is warranted.

Ferenczi (1955) describes the state:

The other extreme is abstraction (trance) with total or partial loss of reality of time and place and with very vivid, often hallucinatory, reproduction of experienced or imagined scenes. On "waking up" the feeling of conviction with regard to the (probably really experienced) events mostly disappears. This argues the suggestive nature of the hallucination. Repeated reproduction leads then later to a) exactly the same scene, or b) modifications of it. (p. 259)

In Orgone therapy, contactlessness or trance was believed to be a general phenomenon of neurosis. However, both Reich (1951)
and Baker (1967) concluded that there were varying levels of 
contactlessness; some levels more severe than others. For 
instance, some clients would appear close to death while others 
were merely withdrawn. In the case of severe contactlessness the 
origin could be three-fold: 1) reliving a life/death experience 2) 
using dying as a defensive reaction and 3) orgasm anxiety.

First, contactlessness can be a very real physical reaction to 
a life and death incident. For example, one of Baker's patients 
was strangled as a baby by her parents. When she relives the scene 
in Baker's office she is back in her crib being strangled. Hence, 
she goes through the same physical reaction. Baker (1967) writes:

When she came in she looked very bad. Her colour was gray 
and her expression could be described only by saying that she 
gave me an uneasy feeling of death. Soon after she lay on the 
couch I became aware of the smell of death....I saw that her 
chest was moving very little. I mobilized it somewhat and 
then grabbed her throat. The picture of the hands came into 
her mind and she panicked and began to choke (I had touched 
her throat only momentarily). She could not get her breath 
and was becoming cyanotic, so I pried her jaw open and gently 
massaged her neck....

This event, she said, went back much earlier in her life. 
She was in her crib and a woman was choking her until her 
tongue was hanging out....Shortly, she screamed, "The hands 
again," and choked once more. After this was relieved she 
choked again with her tongue out. She became cyanotic and it 
was with difficulty that I got her to breathe; her eyes were 
sunken in her head and she looked as though she were dying. 
(p. 39-40)

Secondly, severe contactlessness or trance can manifest itself 
as a conscious defensive reaction to pain. Reich (1951) provides 
an example in which a patient repressed her feelings as a child by 
actually playing at dying:

The following day, I received a telephone call from the 
relatives: the patient was in fact dying; her respiration was 
poor, there was a severe rattle in the throat, and she was 
unable to defecate. I went to her at once. At first glance, 
she seemed actually on the point of death. Her face had a hue
color and was sunken; rattling sounds came from her throat, and there was a forlorn look in her eyes as she whispered to me, "This is the beginning of the end". Her pulse was rapid but strong.

...She told me, without any resistance, that as a child she had often rolled up her eyes and played "dying". The groaning and rattling sounds were also familiar to her from childhood. She had been in the habit of making them whenever she felt a constriction in her throat or, as she put it, when she felt "something tightening in her throat". (p. 252)

Thirdly, Reich (1951) also interpreted the state of severe contactlessness as orgasm anxiety. As the analyst works to release the tension in the pelvis—the last segment—the patient’s anxiety level increases dramatically. This is because the pelvic area is an extremely emotionally, physically and sexually charged area. So, as the patient’s pelvic armor is being dissolved, orgasm anxiety occurs. The client fears losing control; letting go of his/her defenses; being vulnerable emotionally, etc. He/she can experience a fear of bursting; of going insane; "a feeling of falling apart"; disorientation; "feelings of emptiness and exhaustion" and "a fear of dying" (Baker, 1967, p.230). As this anxiety mounts, old symptoms may reappear, e.g., Organic symptoms, "suicide, psychosis, murder or criminal behaviour can occur" (Baker, 1967, p. 230). Or contactlessness can occur. Reich (1949) explains:

The next day her respiration was normal and I attempted to relieve the paralysis in the legs by inducing a clonus in the musculature of the legs. I succeeded to a certain extent by moving her legs, which were bent at the knees, slowly apart, then together again. I had not forewarned the patient about the preorgastic sensations in the genitals that usually appear when the contractions in the leg musculature are relaxed. All at once, the patient inhibited her breathing, locked her jaw, paled, and assumed an expression in her face that I can only describe with one word: "dying". The reaction was so violent that it frightened me....From my clinical experiences, I knew that all this was the patient’s reaction to plasmatic currents in the genitals. Vegetotherapy (Orgone
therapy) has taught us that under the pressure of orgasm anxiety orgastic sensation manifest themselves as a fear of dying—"dying" in the sense of total disintegration, dissolving, losing consciousness, "not being". (p. 409)

In relation to Cathartic Hypnotherapy, three clinicians, Brown (1944), Watkins (1949) and Brenman and Gill (1947) refer directly to hypnosis as a trance-like state. Hypnosis is, therefore, a form of contactlessness or vice versa. However, clients under hypnosis could also experience an even deeper contactlessness. In other words, a trance within a trance. Brenman and Gill (1959) write of this phenomena:

A married woman, among whose presenting symptoms were fainting spells, spontaneously announced during a hypnotic session that a "...complete blackness is closing in on me...little waves of white light are striking against my eyelids, rising to a peak and then beginning again...I am falling...I'm getting awfully tense...I'm falling fast into a dark nothingness...want to go to the bathroom...need to urinate." (The patient was now extremely disturbed, began to tremble and to grab the side of the couch.) "...This is different from anything I have felt before in hypnosis.... My head feels closed in...constricted...this is how it usually feels just before I faint..." (p. 46)

Watkins (1949) also writes of the symptomology of a trance occurring within the hypnotic trance:

The patient then regressed back to the age of five. At this point he developed a twisting of the head and a jerking and quivering of the whole body. There was very heavy breathing. He would hardly talk at all. (p. 195-196)

In Primal therapy, the trance state is never identified by Janov, as such. However, he does describe similar types of behaviour which surfaced as clients go through the reliving process. A patient describes a session:

I was little again and felt the need for Mommy and Daddy. I was afraid and terribly cold. I lay there paralysed, freezing my fear that they wouldn't take care of me, hold me. I couldn't call out, because I still couldn't bear to look at them. (Janov, 1970, p. 110)
Also, like Baker (1967), Reich (1951) and Ferenczi (1955), Janov (1983) observed the same death-like behaviour in his clients but specifically when they were reliving their births:

In observing these birth experiences we watched (often with great trepidation) as anoxia (oxygen deprivation) overwhelmed patients lying unharmed on the floor: we watched as patients struggled to catch their breath, turning red and blue as the early imprint engrossed them-- (Janov, 1983, p. 19)

Lowen (1967) also observed symptomology similar to the trance state but referred to it instead as contraction. As well, like Reich (1951), he had the experience of a patient who consciously used "dying" as a means of defense during childhood. Lowen (1967) writes about a patient:

He was lying on the couch in a relaxed position when I noticed that his eyes were rolling up in his head, with the whites of the lower part showing. His breathing diminished; he lay there motionless; and he looked as if he was dying. When I pointed out to him the meaning of his bodily expression, he told me that he used to adopt this pose or attitude when he was a small boy and was threatened by his parents. They became frightened when they saw his death look, and their behavior changed from threats to solicitude. (p. 105)

Recollection/Expression

According to all the cathartic therapists under study in this work, after regression, recollection/expression is the most important element of the reliving process. This is the climax of the procedure when the patient remembers his/her trauma and expresses the accompanying feeling.

Ferenczi (1955) states that when the patient is in this expressive stage--when he/she is feeling his/her pain on a conscious level--he/she becomes impossible to deceive. He/she and the analyst are connected via an invisible umbilical cord. The patient is so sensitive and so aware he/she feels everything the
therapist is feeling. Also, Ferenczi (1955) states that, "In the moment of trauma the world of objects disappears partially or completely: everything becomes objectless sensation" (p. 261).

The Cathartic Hypnotherapists, Watkins (1949), Brown (1944), did much research on this stage of the reliving process. They discovered that when a patient is emotionally reliving a traumatic event he/she switches from past to present tense. Often the material is recited in the past tense but when the emotion becomes very intense he begins to speak in the present while, with hallucinatory vividness, reliving the experience. For example, Watkins (1949) writes about a soldier with hysterical paralysis; his right hand had three fingers clenched. Watkins hypnotized him and the man relived a war time tragedy in which his friend was killed:

Barkley began to breathe rapidly. Tremors swept over his body. He squirmed and twisted about. Occasionally tears would come into his eyes, and he would grind his teeth. He lay on the bed a quivering mass of silent agitation, biting his lips to keep from speaking...

Barkley’s lips parted, and he began to murmur, "My buddy--my buddy--they killed him." This was followed by more thrashing about on the cot. Tears began to flow copiously. Continually the therapist reassured and prodded. Higher and higher mounted the anxiety.

Finally in gasping breaths, snatches of almost incoherent speech began to emerge. "I was in front of him--I couldn’t help him. The sons of bitches killed him. I couldn’t help him. They would have killed me. Keep going--keep going--keep going."

"That’s right, Barkley, keep going."

"Where am I? What’s happening? The damn Jerries, the damn Jerries are coming. The patrol--I’m point man. I’m supposed to spot ’em. I don’t see nothing. Where are the Jerries? There aren’t any Jerries."

"Who is behind you, Barkley?"
"My buddy--the best soldier in the Army. My buddy, he is right behind me--about twenty feet. A lot of Jerries here. Oh, damn," and in a tidal wave of agony, Barkley began to paw his face.

"Kill the sons of bitches. Too late--too late." Rivers of tears now streamed down his cheeks.

"What’s too late?"

"Too late--my buddy is dead...."

Barkley began to kick his feet about. He turned over and pounded with his fists on the wall--weeping, wailing, crying, bawling, shouting, "I didn’t see them. I didn’t see them. I couldn’t help it. It wasn’t my fault. If I could have saved him--I wanted to save him so much?" ...This scene continued for another fifteen to twenty minutes. The sweating, writhing, crying man on the cot poured out every last ounce of energy--screaming with his whole body that he was not guilty for the death of his buddy. Like a warehouse full of fireworks, he was exploding. The abreaction would have to continue until Barkley was exhausted--until this vast reservoir of pent-up emotion had been released. All this time he was in deep hypnotic trance.

Gradually the heaving tide of anxiety began to subside. Minutes passed, and from pure exhaustion alone the legs and arms ceased their thrashing. The blanket was so wet that it seemed impossible his eyes could have manufactured another single tear. (p. 244 & 245)

Not only does the patient switch from past to present but he is often fully oriented to the fact that the therapist is there. He will answer the doctor’s questions and will often direct his remarks to him as well. Frequently, at the peak of the abreaction, his connection with the environment can get lost and the doctor becomes part of the past scene, e.g., co-pilot or gunner. However, Brenman offers an interesting example which is an exception to this. She (Brenmen & Gill, 1947) writes:

....her fear of falling which disappeared soon after the beginning of the treatment, immediately after her recall and reliving in hypnosis with intense affect two childhood falling experiences. In one she fell from a high chair and in the second, she fell from a hammock at the age of seven. It is difficult to describe the vividness with which she cried out in terror: "Save me, Dr. B., save me--I’m falling!" (p. 126)
What is fascinating about this above passage is that the patient incorporates the therapist into her past experience. Dr. Brenman (Brenmen & Gill, 1947), explains this phenomena:

That this reliving in hypnosis is not simply reliving of the original experience but rather a reliving that takes place in the frame of the present personality structure is clearly shown by her calling on the doctor to save her—and indeed it is likely that it is this very difference that permits the resolution of the conversion mechanisms.

...We think that in the hypnotic state the ego and the resistances can be temporarily suspended to gain repressed material and that then, within the hypnotic state, this material can be re-integrated into the ego. The patient's spontaneous shifting from past to present tense, which we previously described can be viewed as a switching, first out of and then back into the current ego orientation.

(p. 126-7 & 132-3)

Although Janov has never acknowledged steps to the reliving process, the recollection/expression stage (primaling) did occur during his sessions. The reliving process or primal was seen as an indescribably intense experience. Indeed, when Janov (1970) first observed his clients primaling he was convinced that his patients were in agony. However, this was not the case. One of his patients stated:

...During a Primal you don't even think about whether it hurts. You are just feeling a miserable feeling everywhere. But it doesn't hurt. If anything, you could say that it hurts nice because it's such a relief to finally be able to feel."
(Janov, 1970, p. 98)

Janov (1970) elaborates on this point:

...during a Primal there is no reflecting on what you are doing, no processing of the happening, no reasoning the need, so to speak. There is only a self totally engaged in something for the first time since childhood. The person is the feeling. (p. 98-99)

Another patient describes the reliving experience:

"...I was not conscious of the feeling and its connections, I don't really think I was conscious of anything. I simply was my pain, and there was no connection needed (nothing separate
that says, "You hurt"). The only thing that was needed was for my being to accept the experience and not split away from it as I did once before when I finally went neurotic. This was being my real self." (Janov, 1970, p. 99)

Janov made a number of conclusions from these experiences. Janov (1970) states:

What is significant about the Primal Pain experience is that it indicates that feelings, in and of themselves, do not hurt. Tensing up against the feeling is what seems to hurt. This does not mean that there are no unpleasant feelings, but when they are felt for what they are, they will not become transmuted into Pains. Sadness doesn't hurt. But if one is deprived of his sadness, if he isn't permitted his misery then he will hurt. Feeling, then is the antithesis of Pain. The dialectic of the Primal method is that the more Pains one feels, the less pain one suffers. You cannot really hurt the feelings of a normal person, but you can hurt a neurotic by triggering off denied feelings. (p. 99)

Each individual acts differently when primaling or when immersed in the recollection/expression stage of the reliving process. "There are angry and violent ones, fearful ones, and quiet, sad Primals" (Janov, 1970, p. 89). There are also very physical primals. For example:

... One patient near the end of his therapy went into a Primal in which his body began twisting from right to left in strange and bizarre postures. He was lying on his abdomen and his legs were drawn up toward his back while his head was raised off the floor, neck thrown back. This went on for almost an hour in involuntary fashion. He then stood up straight and said that he felt that his hunched back, which had plagued him for most of his life, was gone... (Janov, 1970, p.96)

In terms of the time dimension Janov describes the reliving process or primals "as a conscious coma" (1970, p.90):

...[the patient] can come out of them any time they want, they prefer not to do so. They know where they are and what is going on, yet when inside the Primal, they are reliving past history and are engulfed by it. They have always been engulfed by this past, but they acted it out, rather than felt it. (p.90

When the patient comes out of the reliving experience he usually "opens his eyes and blinks as though he has come out of
some kind of coma" (Janov, 1970, p. 96). Janov continues:

Sometimes it isn’t as dramatic as that; there will be a shift in the tone of the voice back to the adult voice, and we know that the person is out of the early feeling. What is continuously surprising is the way tension often sets in when the organism has had enough Pain for one day. After feeling a great Pain, the person will inexplicably feel tension and say that he cannot remember any more. Or if he has felt the entirety of one experience, he will feel completely relaxed. We know there is more feeling to be resolved if the person ends up tense after a Primal. Residual tension after a Primal is dramatic evidence that neurosis was our early friend and benefactor. It took over and kept us safe when life became too painful to bear, and it takes over and makes the patient tense when he has had enough Pain for one day. (p. 96)

In Bioenergetic therapy sessions, Lowen (1975) observed that feelings could emerge without the accompanying memory surfacing at the same time which would result in an incomplete catharsis. Without specifically isolating the recollection/expression stage, Lowen emphasized that, in the reliving process, the underlying traumatic memory must be consciously remembered and the accompanying feelings expressed.

Lowen (1975) writes:

As long as a patient fails to confront his fear and understand the reasons for it, he will continue to scream, cry and rage with little change in his overall personality. He will have substituted a cathartic process for an inhibiting one, but he will not significantly change in the direction of growth. He will remain caught between inhibiting forces he has not understood and worked through and the desire to obtain a momentary cathartic release. (p. 121)

Thus, it is clear that the memory must surface during the recollection/expression stage. The fact of whether the memory emerges before, during or after the feelings have been expressed has not been isolated.

**Definition of the Recollection/Expression Stage of the Reliving Process**

1. When an individual re-experiences deep, repressed emotional
pain as vividly as possible.

2. The original memory causing the repressed emotional pain must be remembered consciously.

3. The emotions that accompany the memory of the experience must be expressed.

4. The individual regresses to the age he/she was at the time of the painful experience.

5. The individual speaks and acts in the present.

**Factors/Behaviours/Conditions which Facilitate the Reliving Process**

Once all the data on the reliving process had been accumulated, a list was compiled of all the factors/behaviours/conditions that went into facilitating the procedure. It was discovered that, no matter what model of the cathartic method was examined, there were common elements throughout.

**Position**

The position most favoured by cathartic therapists is for the patient to lie on his/her back; often with his/her eyes closed.

Freud (1912) would ask his patients to lie down on a couch, on their backs, and to close their eyes. This process was followed in order to avoid distraction and muscular exertion so that the individual could concentrate all of his/her attention onto his/her own psyche. Freud would sit behind the couch out of sight of his patient so that his patient would remain free of all external impressions and influences. However, Ferenczi stated that Freud "involved himself passionately and selflessly in the therapy of neurotics (lying on the floor for hours, if necessary, next to a patient in the throes of a hysterical crisis)" (In J.M. Masson, 1988, p.89).

For Ferenczi (1955), the position was flexible for both client
and analyst. However, ideally the client lay prone upon a sofa and the analyst did not face him/her. However, Ferenczi allowed freedom of movement for the patient and the analyst.

In Orgone Therapy the favoured position for the client is lying down on a bed or sofa or a softened floor. This is also true for Bioenergetics, although Lowen (1975) developed a number of breathing positions as well.

In Cathartic Hypnotherapy the position varies but often the client is lying down. In Primal therapy the client usually lies prone (spread eagle) but any position or movement is acceptable if it helps the patient to feel his/her pain.

Time

Except in Orgone therapy and Bioenergetics, time was not limited and a cathartic session could last 2-3 hours if not longer. In Orgone therapy and Bioenergetics no time limit was specified. The general impression received from reading the literature is that the sessions lasted until the client had completed whatever process he/she was involved in.

Setting

Sometimes when involved in cathartic therapy the client had to suspend his/her normal life's schedule. To avoid the "disturbing intrusion of new psychic impressions" [Freud] "made it a practice of applying cathartic psychotherapy in conjunction with a rest cure, which when required "was changed to a full Weir-Mitchell treatment" (In Brill, 1912, p.83).

The Mitchell (1875) treatment was simple. The patients resided in an institution under the supervision of a physician. They had to stay in bed as motionless as possible and not even get up for
meals or the toilet. Everything was done for the patients by the nurses, who were to speak to the individual as little as possible. The latter was fed, washed and cared for like a little child. A general daily massage was performed so that atrophy from muscular inaction would not occur. The diet was rigidly set and consisted mostly of large quantities of milk. Indeed, in some cases, a patient could gain as much as from 50 to 70 lbs in six weeks.

In Neo-catharsis normal life often had to be suspended. In severe cases Ferenczi (1955) allowed the patients to rest in bed for "days and weeks and relieve them of the effort of coming to" (p. 114) his house.

For Reich (1951) and Baker (1967) normal life was best. This was usually the case in Cathartic Hypnotherapy although some military clinicians (Watkins 1949, W. Brown 1944), etc.) conducted therapy with soldier/clients who were institutionalized. In Bioenergetics the setting is not specified.

Janov requires his clients to stop taking pills (tranquilizers or painkillers) and to stop smoking and drinking. The client ceases employment for the first three weeks of intensive therapy. Also, twenty-four hours before starting therapy the patient is isolated in a hotel room. During this time, he/she cannot watch television, make phone calls or read. He/she is allowed to write. Sometimes he/she is asked to stay up all night.

People Involved in the Sessions

In the therapy sessions the only people involved were the counsellor and the client. In a few cases the spouse of the client may be included and/or another therapist.
Client

No specifications surfaced.

Freud's clients were usually female and often suffering from hysteria. The only point Ferenczi (1955) made was that the client had to trust the therapist implicitly. Neither Baker nor Reich specified in any detail what kind of clients were best suited for cathartic therapy, although both treated schizophrenic as well as neurotic individuals. However, Baker (1967) did stress that the client's motivation to change was an important factor in the success of the therapy.

In Cathartic Hypnotherapy (Watkins, 1949) it was stressed that the client must be motivated to change or to get well. In Bioenergetics no specifications were stated. However, in Primal therapy, Janov stated, "Perhaps the ideal Primal patient is unmarried and fairly young without a vested interest in unreality" (Janov, 1970, p. 157). However, clients of all ages, class, sex, etc. are accepted into Primal therapy. If the patient "is older and has a family, he is going to be more difficult to treat" (Janov, 1970, p. 157) because he has more to give up.

Staging

Freud used his office but did not specify what kind of lighting he used when applying the cathartic method. Ferenczi did not specify what kind of room or lighting he used.

In Orgone therapy Baker (1967) used a dark brown office with carpets on the walls. The lighting was not specified. In Bioenergetics nothing was really specified. This was also true for Cathartic Hypnotherapy.

In Primal therapy the room is padded, sound-proof, carpeted,
no furniture, soft cushions about and the lighting is semi-darkened.

Therapist

All the cathartic therapists under study in this work, except for Freud and the Cathartic Hypnotherapists, stated that the clinician must undergo the therapy him/herself.

Ferenczi's (1955) expectations of the therapist were complex. Not only was the therapist expected to be indulgent towards the client but he/she had to be completely honest as well. Also, while at the same time the therapist was expected to be in complete control of the session, at no point was he/she to act parental.

Reich (1951) and Baker (1967) both stressed the absolute necessity that the therapist must have gone through therapy him/herself and be well trained. Baker (1967) states that:

...no therapist should attempt to treat patients who have problems he has not been able to handle in himself nor should he expect a patient to do things he cannot do and has not been able to do. (p. 223)

Also, the Orgone therapist was expected to be trustworthy and honest, both qualities that Watkins (1949), a Cathartic Hypnotherapist, believed the analyst should possess as well.

According to Janov, therapists should not practice Primal therapy unless they have undergone the therapy themselves and have been thoroughly trained. For, the therapist is an essential part of the reliving process. If he/she is neurotic, him/herself, he/she will block the feeling rising up in his patient. If he/she is free of unresolved pain then he/she will be sensitive enough to know the patient’s needs: to be confronted, comforted, etc.

In Bioenergetics, the therapist not only has to be honest, warm
and trustworthy, he/she also has to have undergone his/her own therapy. Lowen (1975) writes:

...It was out of this joint work on my own body that bioenergetics was conceived. The basic exercises we used were first tried and tested on me, so I knew from personal experience how they work and what they can do. In all the years since I have made it a practice to try out on myself everything I ask my patients to do, since I do not believe one has a right to demand of others what one is unprepared to ask of one's self. Conversely, I don't believe one can do for others what one cannot do for one's self. (p. 39)

...A therapist's touch has to be warm, friendly, dependable and free of any personal interest to inspire confidence in touching. But since a therapist is a human being, too, his personal feelings may get in the way at times. When this happens, he shouldn't touch the patient. Therefore, a therapist has to know himself, to be in touch with himself before he can be in touch with his patient. Going through one's own therapy is the basic condition for doing therapy with others. (p. 91)

Also,

...Much depends of course, on the sensitivity of the therapist and on his freedom to make contact, to touch and be touched, particularly on his ability to stay free of any emotional involvement with the patient. A (deeply emotional) situation of this kind can easily lead a therapist to unloading on the patient his own need for contact. If this happens, it is a tragic error. Every patient has all he can do to accept and cope with his own needs and feelings. To have to handle the personal feelings of a therapist adds an impossible obstacle to the recovery of his self-possession. He will respond to the therapist's feelings to escape his own; he will see the therapist's need as greater than his own, and in the end, he will lose the sense of his own self as he did when a child and was caught in the conflict between his needs and rights and those of his parents. (p. 297)

Therapeutic Techniques

Although many different techniques are used to induce the reliving process, two common elements surfaced across all four models of cathartic therapy: relaxation and the therapist/patient relationship. However, a brief and general overview of all the techniques used in cathartic therapy will be included in this work.

For relaxation, Freud (1947) had his clients lie down and
breathe deeply while at the same time relaxing their muscles.

Another technique that Freud used was hypnosis. However, he discovered that some clients could not be hypnotized. So, he moved onto to another technique. He would ask them to remember events that were disturbing them. If they could not remember he would proceed as follows:

I placed my hand on the patient's forehead or took her head between my hands and said, "Through the pressure of my hands it will come into your mind, the moment that I stop the pressure you will see something before you, or something will flash through your mind which you must note, it is that which we are seeking." (Freud and Breuer, 1947, p.79)

In time, however, he even stopped using the pressure procedure as he found that it was needless. Instead, he began to apply the "free association" method. In this procedure, the patient is asked to give a detailed account of his/her problems after being informed that he/she must repeat everything that comes to his/her mind, even those thoughts which cause shame and embarrassment.

The client was also required to relate all of his/her thoughts in the order they occurred no matter how irrelevant they may seem to him/her. If Freud noticed any sign of self-editing, e.g., hesitation, he would urge the patient to repeat all unintentional thoughts that came to mind on whatever subject was in question. If his patients insisted they did not remember Freud would insist that they did and that they "had not yet learned to let their criticism rest" (1947, p.79).

Ferenczi (1955) used a technique which he called "relaxation" to induce catharsis. The patient was to lie slack upon a sofa, the analyst not facing him. Then he/she was encouraged to breathe deeply and to loosen his/her muscles, i.e., to uncross his/her
legs. Although this position was encouraged, Ferenczi was flexible, allowing the patient freedom of movement, e.g., to get up and walk about.

Ferenczi also used the Freudian technique of free-association to ease his patients into their pain. The difficulty with this technique was how and when the therapist decided to intervene. Ferenczi (1955) writes:

The patient felt disturbed and irritated by the often repeated "signs of understanding" ("Hm"--"yes"--"of course", etc.) on the part of the analyst; had the feeling that something was being interrupted by them. Interpretations prematurely given were particularly disturbing ... The greatest possible economy of interpretation is an important rule.

...she literally shouted at me: "Do not talk so much, do not interrupt me; now everything has been spoiled again." Frequently interrupted free associations tend to remain more on the surface.

Any communication or talk brings the patient back into the present situation (analysis) and may hinder him from sinking deeper. (p. 259)

The therapist's ability to understand the therapeutic needs of his client was based upon how real the analyst was as a person. For example, how honest and aware he/she was.

For Ferenczi (1955), the analyst must be truthful at all times and very much "with" the client, as the patient knows intuitively if the analyst is preoccupied or not. Indeed, if the therapist is experiencing any misgiving, trepidation, hostility, etc. the patient is immediately aware of it and withdraws. If the analyst is not there for the individual, the therapeutic session has merely become a duplication of what happened to the patient in his/her childhood. Ferenczi (1955) writes:

The analytical situation--i.e. the restrained coolness, the professional hypocrisy and--hidden behind it but never revealed--a dislike of the patient which, nevertheless, he
felt in all his being--such a situation was not essentially different from that which in his childhood had led to the illness. When, in addition to the strain caused by this analytical situation, we imposed on the patient the further burden of reproducing the original trauma, we created a situation that was indeed unbearable. Small wonder that our effort produced no better results than the original trauma. The setting free of his critical feelings, the willingness on our part to admit our mistakes and the honest endeavour to avoid them in future, all these go to create in the patient a confidence in the analyst. It is this confidence that establishes the contrast between the present and the unbearable traumatogenic past, the contrast which is absolutely necessary for the patient in order to enable him to reexperience the past no longer as hallucinatory reproduction but as on objective memory. (p. 160)

Also, on this note, Ferenczi refers to one of his patients:

So long as she identified me with her hard-hearted parents, she incessantly repeated the reactions of defiance. But when I deprived her of all occasion for this attitude, she began to discriminate the present from the past and, after some hysterical outbreaks of emotions, to remember the psychic shocks of her childhood. We see then that, while the similarity of the analytical to the infantile situation impels patients to repetition, the contrast between the two encourages recollection. (p. 124)

Thus, it can be seen that the inter-relationship between patient and therapist was the most important therapeutic technique of the reliving process in Neo-catharsis. For example, in the regressive stage, when the patient is child-like, the therapist must respond with the utmost sensitivity or the patient will stop and go no further. The therapist must "be able to meet the patient as far as possible with almost inexhaustible patience, understanding, goodwill, and kindliness" (Ferenczi, 1955, p. 132). He/she must behave like a benevolent parent towards the client. Ferenczi (1955) called this the "principle of indulgence" (p. 115).

However, even though the therapist is indulgent he/she cannot allow the patient to "act out" to the point where it is dangerous or detrimental to the individual. Ferenczi (1955) writes:
Adult patients, too, should be free to behave in analysis like naughty (i.e. uncontrolled) children, but if the adult himself falls into the mistake with which he sometimes charges us, that is to say, if he drops his role in the game and sets himself to act out in infantile reality in terms of adult behaviour, it must be shown to him it is he who is spoiling the game. And we must manage, though it is often hard work, to make him confine the kind and extent of his behaviour within the limits of that of a child. (p. 132)

But at the same time that Ferenczi set limitations on his patients he would also try to enter into the child-like games of his patients as much as possible. He called this "play-analysis" (1955, p. 131).

Ferenczi believed that "many serious realities of childhood were concealed beneath this play" (1955, p. 130). Indeed, the themes of these infant games and dialogue often symbolized the core of the patient's pain. For example Ferenczi (1955) writes:

I have been told little tales like the one about the wicked animal which tries to destroy a jelly-fish by means of its teeth and claws, but cannot get at it because the jellyfish with its subtleness eludes each jab and bite and then returns to its round shape. This story may be interpreted in two ways: on the one hand it expresses the passive resistance with which the patient meets the attacks of his environment, and on the other it represents the splitting of the self into a suffering, brutally destroyed part and a part which, as it were knows everything but feels nothing. (p. 135)

Thus, when the client is in the regressive stage the therapist practices the principle of indulgence and play analysis. However, during the symptomological stage the therapist becomes more active. He/she encourages the client asking him/her what is happening and gently (or not so gently) pushing him to go deeper. The therapist is the client's only link to reality and he/she must maintain contact throughout. Ferenczi (1955) writes:

Once, when a patient was talking to me, he suddenly fell into a kind of hysterical "twilight state" and began to enact a scene. On that occasion I shook the man vigorously and shouted to him that he was to finish what he had just been
saying to me. Thus encouraged, he succeeded, though only to a limited extent, in making contact, through me, with the world again and was able to communicate something of his hidden conflicts to me in intelligible sentences instead of in the gesture-language of his hysteria. (p. 130)

Throughout the symptomological and recollection/expression stage Ferenczi may hold the patient’s hand, gently stroke the person’s head, talk to the individual, ask questions, urge the client to describe what is happening to him, question him, encourage him and support him. He will also push the client further into the trauma so that the patient can be made conscious of what he is reliving; so that he faces as an adult what he could not face as a child. Ferenczi writes (the quote is on page 19 of this paper) about the transition from trance symptomology to expression/recollection. From this passage, it can be seen that the ultimate goal of Neo-catharsis was the resolution of an individual’s deepest pain. This was also true of Orgone therapy.

The entire concept of Orgone therapy was to release emotional pain by the physical relaxation of the client’s musculature. The muscular armor of the body is divided up into seven segments (p. 23 this paper) and each segment of armor has three layers (p. 41 this paper). As each of the 7 segments are dissolved the patient goes through the 3 layers. This process is referred to as unlayering and often equals the reliving process. The secondary layer may contain a great number of subsidiary layers. When a subsidiary layer yields, it is also called a breakthrough. This may or may not be a dramatic event, but it is felt as a temporary relief.

Normally the therapist does not move on until each previous segment is relaxed. Sometimes a layer involving one segment cannot
be removed or even discovered until other segments are freed. For example, some crying may come out with the loosening of the first two segments, but deep sobbing comes only after the freeing of the first four segments. In unlayering, one works from the outside in and from the head down to the pelvis. But even this practice cannot be held too rigidly. One must watch the needs of the organism (Baker, 1967, p.63). Indeed, usually one of the most important things is to mobilize and allow expression of hate. Bean (1971) writes about the whole process:

Reich’s treatment consisted, in a nutshell, of breaking down the armoring and thereby restoring the natural self regulative process. Using his physician’s knowledge of musculature, he discovered exactly which muscles controlled which functions. He found that by kneading, pressing or jabbing at certain muscles used to inhibit crying, he could make the patient spontaneously start to sob and he found that other muscles, when jabbed at or pressed, would cause rage-filled screaming. He encouraged his patients to give in to these natural functions. At first, the patients felt embarrassed to rant and rave and sob but in a short time they felt overwhelming relief at being able to express their feelings fully. Reich discovered that as his patients found themselves able to cry and rage again, the old feelings from the old days when they originally armored themselves came to the surface and could be analyzed. The armoring, it seemed, was not symptomatic of neurosis but was, in fact, the actual physical counterpart of the neurosis. As it was broken down vivid dreams occurred which the patient was often spontaneously able to analyze himself. Reich found that in his armored patients breathing was shallow, and he worked with them to get them to breathe more freely and deeply. The holding in of the chest and diminishing of the breathing function was in itself, it turned out, a defense mechanism against feelings in the area. When this defense was broken down, all kinds of deep feelings flooded out, which under classical psychiatry would have taken years to reach, if they could be reached at all. (p. 9-12)

In Orgone therapy the techniques that the analyst used to dissolve the individual’s armor in order to discharge repressed primal emotions, were varied. However, before proceeding with his therapy Baker made sure his patients understood and were comfortable with his concept of therapy. Once they agreed to body work
the patient was asked to change into a swim suit or underclothes and lie down. Then, the therapist proceeded with several different techniques: 1) deep breathing 2) jabbing, poking, massaging, pressing, kneading and general manipulating of the muscles 3) having the client gag, pound the bed with his/her fists, do bicycle movements with his/her legs, pound the bed with his/her pelvis, make faces, scream and sob.

Combined with these very physical techniques, the analyst also employed character analysis. The Orgone therapist talks about what is occurring during the session; he/she interprets, analyzes, confronts, supports and comforts. Indeed, it is imperative that the therapist maintain contact with the patient and maintain control throughout the session. Reich (1951) states:

Accordingly, I encouraged her crying which blocked the rage and after some tearful release of sorrow I let her develop her rage by encouraging her to hit the couch. This is a dangerous procedure if the patient, especially the schizophrenic, is not in perfect contact with the physician [italics added]. In order to secure this contact, one must explain to the patient that he must stop his reaction instantly when asked to do so. It is the task of the physician to decide when the point in emotional release is reached where the patient is in danger of getting out of control. (p. 251)

In Cathartic Hypnotherapy the relaxation techniques they used were the loosening of the muscles, eyes closed, deep breathing and having the patient concentrate on various stimuli (e.g., voice).

The methods for inducing hypnosis were varied: postural swaying method, eye fixation method, use of a metronome, etc. "However, they all involve the limitation of distracting stimuli or, ...the restricting of the patient’s environmental field and the inducing of relaxation through the repetition of monotonous suggestions" (Watkins, 1949, p.47).
Also, in Cathartic Hypnotherapy, the role of the therapist was of the utmost importance in spite of the three compliant relationships of: 1) soldier to army doctor as established by the military (Brown 1944, Simmel 1921, Watkins 1949) 2) patient to doctor as established by the medical system and 3) submissive child to controlling parent as established by hypnosis.

According to Brown, "the personal influence of the physician" (1944, p. 86) was of the utmost importance because it was the determining factor in the success of the hypnoanalysis. Simmel (1921) agreed with him and stated:

Experiences taught me that it depended very much on my personal attitude during the hypnotic situation to what extent and in what way the patient under hypnosis was able to remember and to relive traumatic experiences in his hallucinations. I had to give him reassurance by suggestion that he was perfectly safe and did not need to fear physical annihilation or personal defamation. I assured him, in particular, that he would lose nothing in my esteem no matter what he might reveal.

The function which I assumed in this way--as is clear to me now--was the function of a super-ego, of a benevolent one, a representative of a good father, who guaranteed him security and protection against his evil father. In this way, in the capacity of the hypnotized soldier's superego I could remove the intra-mental censorship which during the condition of sleep sustains the barriers of repression and inhibits the full uncovering of forgotten traumatic experiences and their adequate emotional abreacts. (p. 244)

Brenman (Breman & Gill, 1947) noticed that this transference to therapist could be both positive and negative. She writes:

In our patient, the ease of hypnotizability varied with the state of transference. When she was in an angry, rebellious mood, the hypnosis was somewhat more difficult to induce and was not as deep. When she was in a state of positive transference, she went quickly to sleep, with a deep sigh of unmistakably erotic significance. (p. 128)

It was also essential that the therapist maintained contact with the patient throughout the reliving process. Watkins (1949)
writes:

Abreactive sessions will be most valuable if the therapist will prod by dramatic and emotional suggestions the most thorough participation of the entire patient psychologically and physiologically. (p. 105).

In Primal therapy relaxation techniques are also used. The patient is encouraged to wear loose, comfortable clothing. He/ she usually lies in a spread eagle position on the carpeted floor or sofa and is asked to breathe deeply with his/her mouth open.

In Primal therapy, the therapist also uses a number of other techniques to induce re-enactment. Indeed, the whole process is a delicate balance of: 1) being patient 2) encouraging the client to sink into early situations that evoke feeling in him/her 3) being insightful enough to recognize defenses 4) knowing when to confront or block a defense 5) realizing when to comfort the client 6) and, most importantly, of knowing when to urge the patient into talking of past pain in the present tense. An example of these various techniques being used is the following description of a Primal session. It begins with a client speaking about his fear of his father.

"I was sitting there, letting him beat up my brother and--Gee, I feel tense....I don't know what it is..." He is again encouraged to sink into the feeling [italics added]. He may not discover what the feeling is, or he may say, "I think I began to feel that this thing could happen to me if I spoke back like my brother did.....Oooh, I've got a knot in my stomach. Was I afraid?" The patient begins to twitch a bit. He moves his legs and hands. His eyelids flutter, and his brow is furrowed. He sighs or grinds his teeth. I urge him to "Feel that! Stay with it!" [italics added].

Sometimes he will say, "It's gone. The feeling has passed." This sparring may go on for hours or days [italics added]. "I feel tight all over. Yeah, I think I was really afraid of the old man" may be the patient's next statement. At this point, when I see that he is into the feeling and is holding on tight, I will ask him to breathe deeply and hard from the belly. I will say, "Open your mouth as wide as possible and
keep it that way! Now pull, pull that feeling from your belly!" The patient will begin to breathe deeply, writhing and then shaking. When the breathing seems to be happening automatically, I will urge, "Tell Daddy you’re afraid!" [italics added] "I’m not going to tell that son of a bitch anything!" he may answer. I urge him on. "Say it! Say it!" Usually, during the first hour, as simple as that task seems, the patient will not be able to say it. If he does scream it out, it will usually bring a stream of tears and stomach-wrenching gasps. He may immediately begin talking afterward about the kind of person his father was. Chances are good that he will also have several insights as he speaks.

...After possibly fifteen minutes the patient is calm again and may start "rapping," his usual style of non-communication: his talk, devoid of feeling. Again, he is led into a particularly painful situation from his past. The therapist is also challenging every display of the patient’s defense. For example, if the patient is talking softly, he is made to speak up. If he is intellectual, his intellectualization is called at every turn [italics added].

...If the patient is being bright, humble, polite, obsequious, hostile, dramatic--whatever the front he presents--it is forbidden in an effort to get him beyond the defense and into the feeling. If the patient raises his knees or turn his head, he is made to lie straight. He may giggle or yawn as feelings rise, and this is immediately pointed out with impatience. He may try to change the subject, and that is stopped. Or he may literally swallow the feeling, as is true with many patients who swallow each time a feeling starts to come up. This is one reason we keep the mouth open.

... I start the pulling and breathing process [italics added]. The patient swears that he doesn’t know what the feeling is. His throat becomes tight, and his chest feels as though there were a band around it. He begins gagging and retching. He says, "I’m going to throw up!" I inform him that it is a feeling and that he won’t throw up. I urge him to say the feeling even though the patient doesn’t know what he is feeling. He will start to form a word only to begin thrashing about and writhing in Pain. I urge him to let it out, and he will continue to try to say something. Finally, out it will come: a scream--"Daddy, be nice!" "Mommy, help!" --or just the word "hate": "I hate you, I hate you!"

.During the first hour I will sometimes have the patient talk only to his parents [italics added]. To tell me about them automatically removes the patient one step from his feelings, very much like two grown-ups having a discussion. So the patient may say something like, "Dad, I remember when you were teaching me how to swim and you yelled at me because I was afraid to put my head underwater. Finally, you dunked me under." At this point, the patient might turn to me with anger and say, "Can you imagine that stupid son of a bitch
dunking a six-year-old under the water?" I say, "Tell him what you feel!" [italics added] and he does, unloosing a tirade and screaming his fear as that of six-year-old. This will lead to other associations, and he is now into some feeling.

The second day,

...Again, we are stabbing at the defense system [italics added]. He is not allowed to wander off the subject if we suspect he is avoiding something. Nor is he allowed to sit up and "rap". We again hook into a painful memory: "Once Mother took me shopping with her and two women friends, and she put a bow in my hair and said to her friends, "Don’t you think he’d be a beautiful girl?" "I’m a boy, you dummy!" he’ll scream. And then he’ll discuss the ways that his mother tried to make him feminine. More memories, insights, and feelings aimed at her. ...Then, another memory. "I was going off to the Army, and she was kissing my goodbye. She stuck her tongue in my mouth. Can you imagine? My own mother. My God! She always wanted me instead of Father. Mother! Leave me alone! Leave me alone! I’m your son!" .... Ooh, you bitch! you bitch!" Now the patient may be rolling on the floor, writhing and gasping, "Hate, hate, hate, hate. Ooh, ooh!" He screams how he wants to kill her. "Tell her." I say [italics added]. He begins pounding the floor, out of control with rage which may go on for fifteen or twenty minutes. (Janov, 1970, p. 82-86)

It is obvious from the above passage that the success of the session rests almost entirely upon the ability of the therapist. Janov, like Ferenczi, contends that the therapist has to be extremely sensitive to understand the therapeutic needs of his/her client. The more real, honest and aware the analyst is as a person; the better he/she is as a therapist. He/she has to know, almost intuitively, how and when to intervene. For example, it is imperative the therapist does not interject inappropriately during the reliving process as this will halt the process. Janov (1970) writes:

After a while, there is little for the therapist to do except remain silent. When the patient is into a feeling, he is "back there" reliving it--smelling the aromas, hearing the sounds, and going through the bodily processes which occurred and were blocked in that early time... It must be remembered that the patient is totally into that past scene, and any talk
by the therapist in the present may bring him out of it. Left alone, the feeling will transport the patient back to its beginnings, which cannot happen when the feeling is being discussed by the therapist and the patient. (p. 90-91)

In Bioenergetic therapy a number of therapeutic techniques are used. First, as in Orgone therapy, the primary goal of Lowen’s therapy is musculature relaxation. Towards this endeavour, he uses many procedures.

They are:

a) Body positions: an entire repertory of positions have been created to allow for open breathing; to give the person a sense of being grounded; to help the person feel the flow of energy from feet to head; and to enable the therapist to diagnose where central muscular tension lies.

b) Physical manipulation of the body by the therapist such as massage, prodding, jabbing and kneading to release tension or stored feelings.

c) Body mobilization for the patient such as beating a couch with a tennis racket, bicycle leg movements, beating the bed or sofa with his/her legs, pounding the bed with his/her pelvis, falling down, etc. to also release tension or stored feelings.

Touching is an important factor in Bioenergetics as it was in Orgone therapy. For instance, Lowen (1975) devised certain techniques to achieve regression or the child-like state in his patients:

There are a number of other procedures which can be used to mobilize feeling in the eyes. One is important to describe—an attempt to bring the patient out through his eyes by having him contact mine. In this procedure the patient is also lying on the couch in the same position. I lean over and ask him to reach up and touch my face with his hands. I place my thumbs on his brows and with a gentle, soothing movement try to remove any expression of anxiety or concern that would cause
a knitting of the brows. As I look softly into his or her eyes, I often see a little child looking out at me from behind a wall or through an opening, wanting to come out but not daring to. This is the child kept hidden from the world. (p. 296)

Another standard technique, Lowen used, was screaming. It is an explosion "that momentarily shatters the rigidity created by chronic muscular tension and undermines the ego created by chronic muscular tension and undermines the ego defenses in the first layer" (Lowen, 1975, p. 120). He continues:

[If the therapist applies pressure]...to the anterior scalene muscles along the side of the neck while the person is making a loud sound, that sound will often turn into a scream. Following the screaming, one moves into the first layer to determine what the screaming was about and why it was necessary to suppress it. (p. 122)

As well, Lowen used the relationship between patient and therapist as a therapeutic technique. For Lowen believed that the reliving process could only be achieved once the patient is regressed to the point where he trusts the therapist as a child might trust a parent. Thus, the role of the therapist is extremely significant. Lowen (1972) states:

...A therapist will often function as a substitute mother or father. He will offer love and approval and he may encourage a patient to regress to an infantile state. This is not done, however, with the idea that it will make up for the patient's earlier loss but to help him re-experience that loss and express the grief associated with it. (p. 86-87)

Summary

Within this chapter, the reliving process was recognized as a key element of psychological catharsis. Also, a certain pattern was identified regarding the reliving process. This pattern consisted of three parts: 1) Regression 2) Symptomology 3) Expression/Recollection. All three sections were described and defined. Then a list of all the factors/behaviours/conditions that
facilitate the reliving process in a therapy session was complied
and described. These factors/behaviours/conditions were:
1) Client Position  2) Time Length of Session  3) Setting
4) Number of People Involved in Session  5) Staging  6) Client
Characteristics, e.g., motivation  7) Therapist Characteristics
8) Therapeutic Techniques:  a) Relaxation  b) Therapist/Client
Relationship  c) Directing & Monitoring Client's Body/Position/
Movements  d) Directing & Monitoring Client's Breathing  e) Play-
analysis  f) Principle of Indulgence  g) Therapeutic techniques of
Challenge/Support/Encouragement/Comfort  h) Touching the Client
i) Hypnotic Techniques of concentration/autosuggestion/imagination
j) Screaming  k) Free Association  l) Clothing

Review of the Critical Incident Technique

The critical incident technique developed by John Flanagan
(1954) was the research method used for this study. It is a
procedure which generates data based on actual behaviour. Flanagan
(1954) writes:

The critical incident technique consists of procedures for
collecting direct observations of human behaviour in such a
way as to facilitate their potential usefulness in solving
practical problems and developing broad psychological
principles. The critical incident technique outlines
procedures for collecting observed incidents having special
significance and meeting systematically defined criteria.
(p. 327)

It is a technique which is flexible and can be adapted to many
different situations.

According to Flanagan (1954) an "incident" is "any observable
human activity that is sufficiently complete in itself to permit
inferences and predictions" (p. 327) regarding the person doing the
act.
In order to be critical:

...an incident must occur in a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects. (Flanagan, 1954, p. 327)

The purpose of this study is to gather information about which factors facilitate the reliving process in specific therapy sessions by asking subjects questions from an interview protocol which is based upon Flanagan’s structured set of principles called the Critical Incident Technique. This technique provides a process in which subjects are able to provide important information regarding the facilitation of the reliving process in a therapeutic session.

History and Development of the Critical Incident Technique

The Critical Incident Technique developed from studies made by the Aviation Psychology Program of the United States Army Air Forces in World War II. This program was established (1941) to "develop procedures for the selection and classification of air crews" (Flanagan, 1954, p. 328).

One of the first studies (1941) to use this technique concerned the analysis of the reasons pilot candidates failed to learn how to fly. The proceedings of the elimination boards were analyzed. It was discovered that "a number of specific observations of particular behaviors were reported" (Flanagan, 1954, p. 328) which provided a basis for the selection of pilots. The study also indicated the need for better procedures for obtaining factual incidents relating to pilot performance.

A second study was done (1943-1944) by competent observers in the Air Force who wrote factual reports on performance regarding
why certain bombing missions had failed. The information collected "was found to be of considerable value" (Flanagan, 1954, p. 328). Important changes in the selection and training procedures of the Air Force were implemented due to this study.

Then a series of studies were done (1944) on combat leadership problems. Combat veterans were asked to report incidents they had observed of helpful or inadequate behaviour during specific missions. Thousands of incidents were collected and analyzed. Once reviewed, the information provided a factual and objective definition of effective combat leadership. "The resulting set of descriptive categories was called the "critical requirements of combat leadership" (Flanagan, 1954, p. 328).

Over the next few years other studies were conducted using the same observation and recording techniques. These studies provided data that led to a number of changes in: 1) cockpit and instrument panel design  2) training to prevent and overcome vertigo while flying  3) the design of instruments and controls and their arrangement in the cockpit 4) the theoretical basis of procedures for obtaining critical requirements of any activity.

At the end of World War II a number of the psychologists who had participated in the Air force studies established the American Institute for Research. It was in connection with this institution that the critical incident technique was formally developed and named. Although the projects conducted by this institution varied, the same methodology was applied.

In one study they interviewed officers for the Air Force; collected 3,029 critical incidents; obtained 58 critical requirements; and 6 major areas were classified regarding the
requirements for the work of an officer. Then in other projects they determined (among other factors such as performance and aptitude) the critical requirements of a commercial airline pilots; science researchers; air traffic controllers; and General Motors workers.

As the procedure developed and proved valid and reliable, it became more widely used. The University of Pittsburgh used the technique to identify the critical requirements for specific occupational groups, e.g., dentists. The method was also applied in the study of personality which produced a "functional description of emotional immaturity" (Flanagan, 1954, p. 334).

In its present form, the Critical Incident Technique is a method for gathering significant facts concerning behaviour in a defined situation. Rather than "a single rigid set of rules" governing data collection, it is a "flexible set of principles" which can be adapted and modified "to meet the specific situation at hand" (Flanagan, 1954, p. 335). In essence the technique consists of judgements made by qualified observers who understand that all observations are evaluated "in terms of an agreed upon statement of the purpose of the activity" (Flanagan, 1954, p. 335). The extent to which a reported observation is accepted as fact depends upon the number of independent observers who concur with the report. Thus, the accuracy and objectivity of the judgements depends upon how well the characteristic has been defined and the competence of the observer's interpretation of the definition in relation to the incident observed.

The next important step consists of the classification of the critical incidents. This is a subjective and inductive process.
But once a classification system has been developed, objectivity can be achieved by placing the incidents in the defined categories.

The second essential step refers to inferences that are made based upon the observed incidents. These predictions or deductions cannot stand alone. For, these "incidents must be studied in light of relevant established principles of human behavior and of the known facts regarding background factors and conditions operating in the specific situation. From this total picture hypotheses are formulated" (Flanagan, 1954, p. 335).

Critical Incidents Procedure and Data Collection

The Critical Incident Technique consists of data collection based upon a "flexible set of principles" which can be adapted and modified "to meet the specific situation at hand" (Flanagan, 1954, p. 335). Flanagan (1954) has outlined 5 essential principles: General Aims, Plans and Specifications, Collecting the Data, Analyzing the Data and Interpreting and Reporting.

General Aims

In order to complete a functional description of an activity, it is necessary to know the general aims of the activity. Flanagan (1954) writes:

In its simplest form, the functional description of an activity specifies precisely what it is necessary to do and not to do if participation in the activity is to be judged successful or effective. The principal criterion in formulating procedures for establishing the general aim of the activity should be the proposed use of the functional description of the activity which is being formulated. Unless the general aim used is acceptable to the potential users of the detailed statement of requirements, the whole effort in formulating this statement will have been wasted. (p. 336 & 337)

The general aim of an activity is obtained from the authorities in the field under study. They are asked to express in simple
terms the objectives of a given activity. All statements are pooled and a brief, simple statement describing the purpose of a given activity is developed.

**Plans and Specifications**

Precise and specific instructions must be given to observers so that they pay close attention to aspects of behavior that are believed crucial in formulating a functional description of the activity. Also, specifications "need to be established and made explicit prior to collecting the data" (Flanagan, 1954, p. 338). For example, details regarding the situation observed must include information about the place, the conditions, the people, and the activities.

The next step is to decide if a specific observed behavior is relevant to the general aim of the activity. Then the extent of the effect on the general aim must be weighed. For instance, "an incident is critical if it makes a "significant" contribution, either positively or negatively, to the general aim of the activity" (Flanagan, 1954, p. 338). Finally, the observers should be selected from people who are familiar with the activity being studied, i.e. supervisors. They should also receive training which "should include a review of the nature of the general aim of the activity and a study of the specifications and definitions for the judgements they will be required to make" (Flanagan, 1954, p. 339).

**Data Collection**

It is important that the behaviors to be observed have occurred recently and are still fresh in the mind of the observer so that the details rendered are precise and comprehensive. It is even better if the observer is aware of the need to remember before the
events take place. Flanagan (1954) writes:

Evidence regarding the accuracy of reporting is usually contained in the incidents themselves. If full and precise details are given, it can usually be assumed that this information is accurate. Vague reports suggest that the incident is not well remembered and that some of the data may be incorrect. (p. 340)

There are four procedures that are used in collecting recalled data in the form of critical incidents: Interviews, Group Interviews, Questionnaires and Record Forms. The data for this study was collected by single interviews.

In the interview method trained personnel explain to the observers what data to record. If a stranger to the observer is collecting the data he/she should indicate on what authority the interview is being held. The purpose of the study should be explained informally, e.g., "We wish to find out how a therapist facilitates the reliving process." The special qualifications of the observer may be mentioned if the individual is doubting his/her capabilities to report. Also, it should be mentioned that the data is confidential and will not be harmful to other people.

"The most crucial aspect of the data collection procedure is the questions asked the observers" (Flanagan, 1954, p. 341). The questions should refer to the general aim of the activity and clearly indicate that actual behavior, or an incident or what the person did is desired. The question should also specify the type of most recent behavior which is relevant and important enough to be reported. Once the main question has been stated the asking of leading questions should be avoided.

According to Flanagan (1954), there is definite criteria the interviewer should apply:
Some of the more important criteria are: a) is the actual behavior reported; b) was it observed by the reporter; c) were all relevant factors in the situation given; d) has the observer made a definite judgement regarding the criticalness of the behavior; e) has the observer made it clear just why he believes the behavior was critical. (p. 342)

Data Analysis

The aim of data analysis is to obtain as much useful material from the information provided without compromising the validity, specificity or comprehensiveness of the data. There are three problems involved in this process: a) frame of reference  b) category formulation  c) general behaviors.

Frame of Reference

There are a number of ways a specific set of incidents can be classified. In the selection of a classification one must consider what uses will be made of the data. "The preferred categories will be those believed to be most valuable in using the statement of requirements" (Flanagan, 1954, p. 344).

Category Formulation

This procedure is often subjective. Few rules are available. Indeed, much depends upon the skill of the formulator.

The steps are as follows:

1. Sort a small sample of incidents into categories that relate to the frame of reference selected.

2. Define these categories and classify any additional incidents. It is possible during this process that new categories may have to be developed and previous categories redefined.

3. Classify all incidents.

4. Subdivide the large categories into smaller groups and place all similar incidents together.

5. Re-examine all definitions and major headings in terms of the incidents classified in each group.
General Behaviours

The last step in the process of analysis is the determination of the "most appropriate level of specificity-generality" to be used in the reporting of the data (Flanagan, 1954, p. 345). In other words, the advantages of being able to obtain detailed information from specific incidents must be weighed against the simplicity and practicality of using a relatively small number of headings.

Flanagan (1954) provides a number of guidelines to be followed "in establishing headings for major areas and in stating critical requirements at the selected level of generality" (p. 345). These are:

1. The requirements and headings should be logical and clearly organized with a "discernible and easily remembered structure". (p. 345).
2. The titles, alone, should be meaningful.
3. "The list of statements should be homogeneous" and the headings should be neutral and "parallel in content and structure" (p. 345).
4. The headings of a particular type should be of the same level of importance.
5. The headings used for reporting and classification of the data "should be such that findings in terms of them will be easily applied and maximally useful" (p. 345).
6. The headings "should be comprehensible and cover all incidents having significant frequencies (p. 345).

Procedural Review

All four steps of the critical incident technique must be studied to see what biases have occurred. The four procedures to be reviewed are:

a) the determination of the general aim
b) the specification of observers, groups to be observed and observations to be made
c) the data collection, and
d) the data analysis

(Flanagan, 1954, p. 345)

This review must be done before continuing on with the interpretation of the results.

Purpose of Study

The purpose of this study is to determine what common factors/behaviours/conditions are involved in the facilitation of the reliving process, across three different types of cathartic therapy: Cathartic Hypnotherapy, Primal therapy and Bioenergetics.

Assumptions of Study

1. The reliving process is a major element of psychological catharsis.
2. Fifteen therapist-subjects would accurately recall a cathartic therapy session because they are trained to analyze and observe.
3. Even though no time frame was set, fifteen therapist-subjects would accurately remember the cathartic therapy session they chose for this study.

Limitations of the Study

1. The sample size of fifteen therapist-subjects is small.
2. The interviews were conducted over the phone which can be impersonal and inhibiting.
3. The data was collected using an interview method of self report; a technique which relies on the accurate recall of past events.
4. The self report interview method cannot account for individual differences in the reporting of incidents.
5. There is a lack of validation of the data, e.g., the
therapist-subjects may conclude that a particular technique facilitated the reliving process when in fact the clients may not agree.
Chapter 3

Methodology

The Critical Incident Interview

The Critical Incident technique (Flanagan 1954) was selected to help participants identify from their own experience which factors, behaviours and conditions are involved in the facilitation of the reliving process in a therapy session.

Sample

A total of 85 qualified therapists were asked to participate in this study; 29 Bioenergetic therapists, 43 Hypnotherapists and 13 Primal therapists. Only twenty-eight of these therapists responded; ten declined to participate for a variety of reasons, e.g. illness in the family, no time, etc. Although eighteen qualified therapists were interviewed, three interviews had to be discarded because it was impossible for the researcher, using the definition of the relive process as criteria, to discern if the relive process had occurred in the three therapy sessions.

Thus, a total of 15 qualified therapists participated in this study; five Bioenergetic therapists, five Hypnotherapists and five Primal therapists. For the sake of clarity, all fifteen will be referred to in this study as therapist-subjects.

Bioenergetic Therapist-subjects

The 5 Bioenergetic therapist-subjects were selected from a list of qualified Bioenergetic therapists registered with the International Institute for Bioenergetic Analysis, 114 E 36th St. New York, NY 10016. Three therapist-subjects had their Masters in psychology; one had a B.A. and the last was an occupational therapist with a B.Sc.
Hypnotherapist-subjects

Two of the five certified Hypnotherapist-subjects were selected from a list of qualified Hypnotherapists registered with the Canadian Society of Clinical Hypnotherapists, 2095 W 45th Ave., Vancouver, B.C. V6M 2H8. The other three were selected from a list from the American Association of Professional Hypnotherapists, P.O. Box 731, McLean, VA. 22101, USA. One therapist-subject had a Ph.D and three others had their Masters in psychology. The last had no degree.

Up until this point, in order to distinguish therapists who use hypnosis for catharsis and those who apply it for other reasons, the former were referred to as Cathartic Hypnotherapists. However, the five cathartic counsellors interviewed for this study, who use hypnosis, call themselves Hypnotherapists. Thus, in accordance to their own standards, they will be referred to as Hypnotherapist-subjects with the understanding that all five apply hypnosis primarily to induce catharsis.

Primal Therapist-subjects

The five Primal therapist-subjects were difficult to locate. No one from the Primal Institute, (1950 Cotner Ave. Los Angeles, California 90025-5602) which trains and certifies Primal therapists, responded to a request for subjects because the Institute had misplaced the initial contact letter. An address of a primal therapist was obtained from a psychology book and a letter was sent. This psychologist was able to provide the names and addresses of several other counsellors trained in Primal therapy.

Two of the 5 therapist-subjects interviewed were certified Primal therapists. Another had her certification revoked upon
leaving the Primal Institute which she stated was the policy of the institute at that time. The fourth therapist-subject was taught by a Primal therapist who had also had his certification revoked upon leaving the Primal Institute. The fifth one had been trained by the fourth.

One Primal therapist-subject was a Ph.D. candidate and four had their Masters Degree in Psychology.

Interview Preparation

It had been decided that data would be collected through interviews. However, before proceeding a student of cathartic therapy was interviewed (Appendix II). The intention of this interview was twofold:

- to provide the necessary opportunity to test the quality of the interview questions in eliciting information pertaining to the objective of the study.
- to ensure that the definition of the reliving process was clear and comprehensible.

The criteria for establishing a definition and setting up questions had been determined by the extensive literature review. This being one of the first instances that psychological catharsis had been operationally defined and the reliving process recognized as a major element in the phenomenon.

The findings from this interview were:

- the definition of the reliving process was clear and comprehensible
- the questions were found to be unclear

As a result of this preparatory interview the original questions (Appendix VI) were simplified.

Data Collection

All eighteen therapist-subjects were contacted by letter
(Appendix III) that provided:

- an explanation of the study
- a description of the reliving process
- a general outline of the questions to be asked
- and an invitation asking them to participate in the research

Enclosed with the letter, was a consent form (Appendix IV) to be completed and sent back to the researcher in a stamped and addressed envelope. The letter was then followed by a phone call to set up a time that was convenient for the therapist-subject to be interviewed. At this time, following a set protocol (Appendix V), each therapist-subject was asked two questions:

1. "Is the reliving process a regular occurrence in your therapy?"

2. (If their credentials had not been verified) "Are you a certified Bioenergetic therapist, Hypnotherapist or Primal Therapist?" Or, "Have you been trained in Primal therapy?"

If they replied in the affirmative, to both, they were included in the study.

A time was then arranged for the interview to be held. The interview was conducted over the phone because most of the therapists lived long distances from the researcher. Each interview was tape recorded and a typed transcript was made of each interview. No interview was longer than one hour. Each therapist-subject had the right to refuse to participate in the project or to withdraw at any time without any consequences.

After a set protocol (Appendix VI), the researcher went over the definition of the relive process and asked the therapist-subject if the process that occurred in their session--the one they would be referring to for the interview--corresponded to the definition (Appendix III). If they answered in the affirmative the interview continued.
However, to make sure the therapist-subject was correct in his interpretation the researcher also asked several questions about the scene itself:

- "To what age did your client regress?"
- "Where did the scene take place?"
- "Who was present (father, mother)?"
- "What took place?"

In spite of these precautions, three taped interviews were discarded because it was impossible for the researcher, using the definition as criteria, to discern if the relive process had occurred in the sessions.

The last question (Appendix VI) was designed to obtain non-identifying information regarding the client such as age and gender.

The factual background information supplied by the last questions were not included in any categorization process. The information was merely recorded and then reported in Chapter 4.

From this point on, the interview proceeded with open-ended questions (Appendix VI) designed to elicit specific criteria from the therapist-subjects. For example, Question four:

"Could you describe the session from the beginning to the end; telling me exactly what was said and done by you and the client?"

Throughout the interview, as the therapist-subjects described their sessions, the researcher kept asking them to be more specific in their description, for example (Thp refers to therapist-subject):

Thp: "I had the client relax."
Researcher: "What did you do to get the client to relax?"
Thp: "I told him to close his eyes and breathe deeply."
Researcher: "Anything else?"

Thp: "I told him to let the tension out of his muscles."

Another example:

Thp: "The client came into my office and lay down and began to talk to me about his feelings of anger."

Researcher: "What did he lie on?"

Thp: "A mat."

Researcher: "What position did he lie in?"

Thp: "On his back; not facing me. I was sitting in a chair behind him."

By asking the therapist-subjects to be more specific, in their descriptions, additional data was obtained.

The last question posed was to ask the therapist-subjects what factors they considered to be crucial in the facilitation of the reliving process.

Data Analysis

All 15 interviews were tape recorded. To preserve confidentiality, the tapes were number coded and eventually erased. Any identifying information was deleted from event descriptions. No one had access to the tapes except the researcher and Dr. Bob Tolsma (thesis supervisor).

The 15 tapes were then transcribed. In two separate interviews the relive process occurred twice during a session. As this frequency could influence the results only the first relive process was included in the transcript. Also, all the factors/behaviours/conditions the therapist-subjects considered crucial in the facilitation of the reliving process were separated from the transcript. These factors were isolated from the main body because they
were not critical incidents, but instead statements of personal theory and philosophy.

Three independent raters were then assigned, separately, to select all significant or critical events from the transcriptions. The percent of accurate selections provided the measure of reliability and a minimum of 85% agreement (Woolsey, 1986), between the three raters and the researcher, as to what should be defined as a significant event, was set.

Training of Independent Interview Raters

One of the three interview raters was a Ph.D. candidate in counselling psychology. The other two were MA candidates in counselling psychology.

The researcher met with each interview rater separately. A set protocol (Appendix VII) was provided and the researcher read through the first two sections of this form with each of the raters.

In the first section of the protocol, the "critical incident" was defined (Appendix VII). In the second section, 12 examples (Appendix VII)--of what was and what was not a critical incident--were given.

The third section contained a sample transcript (Janov, 1970, p. 82-86) of a client reliving an early trauma. To train the raters each was asked to highlight the critical incidents within the sample. The same sample was given to all 3 raters and none had any difficulty identifying the critical incidents within the transcript.

After each training session was over, the researcher gave each rater the transcripts of the interviews and asked each to highlight
any critical incidents. The researcher remained with each rater until they had finished all 15 transcripts. At various times all three raters asked for direction and the researcher would refer the individual rater back to the example sheet. One of the raters achieved a score of 96% agreement with the researcher; the second had a score of 97%; and the third achieved a score of 94%. A critical incident was accepted as such only if there was a majority agreement between the raters and the researcher (3 out of 4). Twenty-six statements or incidents from the 15 interviews were discarded (Appendix VIII) because no majority agreement was reached.

Categorization

Many of the critical events, identified by the interview raters, were edited for clarity. The purpose of the editing was to make the context of the incident clear, e.g., who was talking or who was performing the activity. A critical incident such as, "I told him to lie spread eagle on the mat," was changed to, "I (thp) told him (clt) to lie spread eagle on the mat."

Once edited all the critical incidents were entered on index cards. Each index card was number coded on the back in order to recognize the therapist and therapeutic model from which it originated. When all the incidents were recorded, the researcher sorted the set of cards into tentative categories. These categories had a common meaning in relation to factors/behaviours/conditions which facilitate the reliving process in a given therapy session. All incidents were represented by a category.

The tentative categories were then reviewed by a research assistant who was chosen from the independent interview raters
because of her now familiarity with the material.

The research assistant reviewed the set of tentative categories and provided valuable feedback on the classification process so that some of the categories were combined and/or re-defined. Eventually each category was made distinct and clearly different from the other categories. Thus, each incident would only fit into one category, with minimal overlays.

A heading title was chosen for each category. The headings were simple, clear and logical and were chosen to convey the meaning of the incidents of the given category.

This exact same procedure of categorization was followed (separately) for the second set of statements. These were the factors/behaviours/conditions identified by the therapist-subjects as being crucial in the facilitation of the reliving process. The only difference between the two sets of factors/behaviours/conditions is that those recognized by the therapist-subjects as being crucial were not rated as critical incidents because they were, instead, personal and theoretical conclusions.

From the 718 critical incidents, 32 categories were recognized (Appendix 1X) to include factors/behaviours/conditions involved in the facilitation of the reliving process across three different models of cathartic therapy. For clarity these were then divided under 7 General Headings by the researcher.

From the total of the 127 factors/behaviours/conditions, the 15 therapist-subjects reported as being crucial in the facilitation of the reliving process, 8 categories (Appendix X) were identified.

When the categorization process was completed, for the first set of cards, then three different independent raters were
assigned, separately, to sort them under the categories established by the researcher and the research assistant. This same procedure was followed for the second set of index cards. The percent of accurate placements provided the measure of reliability and a minimum of 85% agreement (Woolsey, 1986), between the three raters and the researcher was set (3 out of 4)—as to which category a particular critical incident belonged.

**Training Independent Card Raters**

Two of the three card raters were Ph.D. candidates in counselling psychology. The other had a Masters degrees in counselling psychology.

A set protocol was given to the card raters (Appendix IX and X) and each one was trained separately. The first set of cards to be categorized were the 718 incidents taken from the interviews.

The raters were told that the cards described factors/behaviours/conditions which facilitate the reliving process and that each card had been sorted and categorized by the researcher and an assistant. Then, reading from the protocol (Appendix IX), the assignment was explained. Each card represented a category and each rater was expected to sort these cards into the appropriate group. Every category was represented by a heading and, as these title cards were lined up, the meaning of each heading was read from the protocol.

The raters were then asked to place 10 sample cards in the appropriate categories. None of the incidents on the sample cards were included in the 718 critical incidents. The same sample cards were given to each rater and none had any difficulty identifying the appropriate category for each card.
The card raters were then asked to place the real cards in the appropriate categories. The researcher remained with each rater until they were finished. At various times all three raters asked for direction and the researcher would refer the individual rater back to the example sheet (Appendix IX). Also, when the meaning seemed ambiguous, all three raters asked for certain incidents to be put into context which the researcher did.

Once the individual rater had completed filing the first set of cards, the categorization process was explained for the second set of cards (Appendix X). The same format was followed as with the first set except the categories were different. Also, the raters were only asked to place 5 sample cards in the appropriate categories. None of the raters had any difficulty identifying the appropriate category.

The level of agreement for the first set of index cards, identifying the common factors/behaviours/conditions which are involved in the facilitation of the reliving process across three different types of cathartic therapy, was above the required 85% mark. Twenty-five incidents were discarded (Appendix XI) because no majority agreement (3 out of 4) was reached leaving a total of 693 incidents. The first rater achieved a score of 91% agreement with the researcher, the second achieved a score 93% and the third had a score of 92% agreement.

The level of agreement for the second set of index cards, identifying the factors/behaviours/conditions which the 15 therapist-subjects considered to be crucial in the facilitation of the reliving process, was also above the required 85% mark. From the 127 incidents, 9 were discarded (Appendix XII) because no
majority agreement (3 out of 4) was reached leaving a total of 118 incidents.

The first rater achieved a score of 89% agreement with the researcher; the second had a score of 93%; and the third achieved a score of 91% agreement.

Once agreement, regarding the categorization of each set of cards, had been established between each of the three card raters and the researcher, the data could then be analyzed. The sorted incidents defined categories of factors/behaviours/conditions which are involved in the facilitation of the reliving process across three different cathartic therapies.

**Analysis of Data of First Set of Factors/Behaviours/Conditions**

First, it had to be determined if a factor/behaviour/condition, involved in the facilitation of the reliving process, was common within a single therapeutic model. Therefore, it was decided that if three or more therapist-subjects, within a single model of therapy, used a particular factor/behaviour/condition then this element would be considered common within that therapeutic model.

The second element involved in the analysis of the data was to determine if a particular factor/behaviour/condition was common across the three different therapeutic modalities. Chi Square was used to determine the Goodness of Fit.

The third step, involved in the analysis of the data, was to determine if there was a difference, among the individual therapist-subjects, in the frequency with which they used a common factor/behaviour and/or condition. Once a factor/behaviour/condition was found to be common across the three therapy models,
Analysis of Variance was applied to the data. Both parametric and non-parametric numbers were used and the results were similar in both tests. The results recorded in this study were based upon the Kruskal-Wallis One-way Analysis of Variance. This statistical test was used to discover whether the frequency at which a common factor/behaviour/condition was applied by all 15 therapist-subjects was significantly different across the three therapies.

Finally, the fourth element involved in the analysis of the data was to determine statistical differences between two therapeutic models. Factors/behaviours/conditions emerged from the data that occurred more than once in the session and were found to be common within two therapeutic models but not common across the 3 therapeutic models. The Analysis of Variance, Mann-Whitney U Test was applied to the data to determine whether the frequency at which a factor/behaviour/condition was applied by the therapist-subjects was significantly different between two therapies.

Analysis of Data of Second Set of Factors/Behaviours/Conditions

To determine, what factors/behaviours/conditions were considered crucial by the majority of therapist-subjects interviewed, the same above procedure was followed. If three or more therapist-subjects within a single model of therapy identified a particular factor/behaviour/condition as crucial then this element would be considered common within that therapeutic model. Then the Chi Square was used as a Goodness of Fit test to determine if a particular factor/behaviour/condition was common across the three therapies.

The frequency of use was not accounted for in the analysis of this second set of data. For example, if a particular therapist-
subject identified a specific factor/behaviour/condition more than once, albeit within a different context, his/her two responses were categorized under the same heading and counted as one. The reason the frequency of response was not recorded was because this data was not relevant. The fact that a therapist-subject may have identified a particular factor as being crucial more than once neither increases or decreases the importance of this factor. It is either viewed as crucial to the process or it is not.

Critical Value of the Chi Square and Analysis of Variance distribution was placed at .05 for all data.
Chapter 4

The Results

In this critical incident study, 15 therapist-subjects were asked to describe one of their therapy sessions. From this process it was hoped that the common factors/behaviours/conditions involved in the facilitation of the reliving process, across three different types of cathartic therapy, could be identified. Consequently, a total of 718 incidents were reported and of these 693 were rated as being critical incidents.

A second question was posed to the 15 therapist-subjects, regarding what factors they considered crucial in the facilitation of the reliving process. They reported a total of 127 factors, behaviours/conditions and of these 118 were rated as being crucial.

Common Factors/Behaviours/Conditions

From the 693 critical incidents, 17 common factors, behaviours and/or conditions were identified:

A. Staging
   1) Soundproof Reliving Room
   2) Rm has Mats/Recliner/Pillows

B. Client/Therapist-Subject Relationship--Time Element
   3) Therapist-Subject Seeing Client 2 months & up
   4) Therapist-Subject Seeing Client 1 to 2 times weekly

C. Therapist-Subject Directs and Monitors the Client’s Body/Position/Movement/Reactions
   5) Body Position "B": Clt is Lying Down/Reclines and Therapist-Subject Sits Beside or Behind
   6) Therapist-Subject Monitors Client’s Body--Position/Movements/Reactions
   7) Therapist-Subject Directs Client’s Body--Position/Movements
D. Relaxation

8) Therapist-Subject has Client wear Loose/Comfortable Clothes
9) Therapist-Subject Monitors & Directs Client’s Breathing

E. Emotional Safety

10) Therapist-Subject Will Extend Session Time
11) Client May Call Therapist-Subject After Session

F. General Therapeutic Techniques

12) Therapist-Subject Tone of Voice is Calm/Gentle/Relaxed
13) Therapist-Subject & Client Talk for 10-30 minutes
14) Therapist-Subject Monitors Client Talking About Symptom/Issue/Past scene in Past Tense
15) Therapist-Subject Directs Client Speak/Behave in Present Tense
16) Therapist-Subject Monitors Client Speaking/Behaving in Present Tense
17) Therapist-Subject Monitors Client’s Emotions

Common Factors/Behaviours/Conditions with No Statistical Difference in Frequency of Use

No significant statistical difference was found (across the three models) in the frequency of use in the following common factors:

D. Relaxation

9) Therapist-Subject Monitors/Directs Client’s Breathing

F. General Therapeutic Techniques

14) Therapist-Subject Monitors Client Talking About Symptom/Issue/Past scene in Past Tense
15) Therapist-Subject Directs Client Speak/Behave in Present Tense
16) Therapist-Subject Monitors Client Speaking/Behaving in Present Tense
17) Therapist-Subject Monitors Client’s Emotions

Common Factors/Behaviours/Conditions with Statistical Difference in Frequency of Use

Significant statistical difference was found (across the three models) in the frequency of use in the following 2 common
behaviours:

6) Therapist-Subject Monitors Client’s Body--Position/Movements/Reactions
7) Therapist-Subject Directs Client’s Body--Position/Movements

**Uncommon Factors/Behaviours/Conditions**

Many factors/behaviours/conditions emerged that were applied only within one or two therapy models--not all three--and therefore did not qualify for comparison for commonality. These uncommon factors/behaviours/conditions were:

18) Subdued Lighting in the Reliving Room
19) Body Position "A": Therapist-Subject & Client Sitting Opposite or Beside Each Other
20) Session is Extended to 1 1/4 to 1 1/2 hours
21) Scheduling After Session
22) Therapist-Subject Touches Client
23) Therapist-Subject Directs Client to Relax
24) Therapist-Subject Directs Client do Guided Imagery/Autosuggestion/Desensitization
25) Therapist-Subject Directs Client to Focus on Feeling
26) Therapist-Subject Comforts and Reassures Client
27) Therapist-Subject does Nothing During Relive Process

All of the results of the above data are illustrated by Tables 1 through 31.

**Other Factors/Behaviours/Conditions**

The following categories were minimally represented.

28) Therapist-Subject Uses Music
29) Therapist-Subject Directs Clt to Recall Past Scene
30) Therapist-Subject Directs Clt to Focus on Body Feeling
31) Time factor
32) Miscellaneous

None of the above factors/behaviours/conditions were represented by a majority of therapist-subjects within any model of therapy and are not illustrated by tables except for the Time Factor category in Chapter Six.
Crucial Factors/Conditions/Behaviours

From the total of the 118 factors/behaviours/conditions, the 15 therapist-subjects reported as being crucial in the facilitation of the reliving process, only 4 were identified as being in common.

A. Qualifications of Therapist
B. Qualities of the Therapist
C. Trust/Rapport within Therapist/Client Relationship
D. Therapist Provides Emotional Safety

These results are illustrated by Tables 27 to 31.

Client Information

Before proceeding with the data, certain information elicited by interview Question Two and Three (Appendix VI) should be recorded here. This data is included here because it provides general background knowledge of the clients and the therapeutic processes involved in this study.

Eleven (73%) of the clients were female and 8 (53%) clients were between the age of 35 to 45. Two clients were 25 to 35 years old and 5 were between 45 and 65 years old.

Thirteen (87%) of the clients regressed to the age of 10 years and under and 8 (53%) clients relived sexual abuse trauma. Three relived emotional abuse, two relived a near death experience, one relived physical abuse and the last relived a birthing experience.

The Data

Tables 1 through 17A represent two types of data. The Chi Square tables record the common factors/behaviours/conditions involved in the facilitation of the reliving process across the three types of cathartic therapy; Primal therapy, Hypnotherapy and Bioenergetics.

The other tables record the frequency with which the 15
individual therapist-subjects applied or used the common factors/behaviours conditions within a given therapy session.

Table 1 represents one common condition (soundproofing) found in all the rooms used by the therapist-subjects for the reliving process.

Table 1

### Soundproof Reliving Room

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Soundproof Reliving Room</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>5</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

**Expected Counts**: 5 5 5

**Observed Counts**: 5 5 5

**Note**: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject.

\[ X^2 (2, N = 15) = 0, \ p > .05 \]

No significant statistical difference was found, across the three models of therapy, regarding soundproofing. Fifteen (100%) of the therapist-subjects reported having soundproof reliving rooms.
Table 2 represents another common condition—the contents—found in the rooms used by the therapist-subjects for the reliving process.

Table 2

<table>
<thead>
<tr>
<th>Reliving Room has Mat/Recliner/Pillows</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Counts</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>4.67</td>
<td>4.67</td>
<td>4.67</td>
<td></td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject.

\[ X^2 (2, N = 15) = .14, \ p > .05 \]

No significant statistical difference was found, across the three models of therapy, regarding certain contents of the reliving room. Fourteen (93%) of the therapist-subjects had their reliving room setup with pillows and either a mat or a recliner for the client to lie down on.
Table 3 represents a common time element involved in the relationship between the client and the therapist-subject.

Table 3

**Therapist-Subject Seeing Client 2 Months or More**

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Thp Seeing Clt 6 Months or More</td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

**Note**: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = .50, p > .05 \]

No significant statistical difference was found, across the three models of therapy, regarding the time element in the client/therapist relationship. Twelve (80%) therapist-subjects had been seeing their clients for 2 months or more. Two Hypnotherapist-subjects were seeing their clients for the first time and another therapist-subject (Bio) was seeing the client every two weeks.
Table 4 represents another common time element involved in the relationship between the client and the therapist-subject.

Table 4

Therapist-Subject Seeing Client 1 to 2 Times Weekly

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Thp Seeing Clt 1-2x Weekly</td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = .50, p > .05 \]

No significant statistical difference was found, across the three models of therapy, regarding this time element in the client/therapist relationship. Twelve (80%) therapist-subjects had been seeing their clients 1 to 2 times a week. Two Hypnotherapist-subjects were seeing their clients for the first time and 1 Bioenergetic therapist-subject saw his client every 2 weeks.
Table 5 represents the number of clients who lay on their back during the reliving process.

Table 5

**Body Position "B": Client Reclining on Back and Therapist-Subject Sits Beside or Behind**

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Clt Reclining On Back</td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ x^2 (2, N = 15) = .14, \ p > .05 \]

No significant statistical difference was found, across the three models of therapy, regarding the client's reclining body position. In fourteen (93%) of the therapeutic sessions the client lay down on his/her back. This was the only client position to be found in common across the three different therapy models. Only the client of one Hypnotherapist-subject remained in a seated position throughout the session.
In Table 6 is recorded the number of therapist-subjects who monitored the client's body position, movements and bodily reactions.

Table 6

<table>
<thead>
<tr>
<th>Therapist-Subject Monitors Client’s Body—Position/Movements/Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number &amp; Type of Therapist-Subject (N = 15)</td>
</tr>
<tr>
<td>6. Thp Monitors Clt's Body</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

**Note:** Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = 0, p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to monitoring the client's body. All (100%) the therapist-subjects monitored the client’s position, movements and bodily reactions during the therapy session.
Table 6A represents the frequency with which 15 therapist-subjects monitored their clients' body position, movements and bodily reactions.

Table 6A

Frequency with which Therapist-Subject Monitors the Client's Body--Position/Movements/Reactions

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter refers to the identity code for that particular therapist.

Kruskal-Wallis test statistic = 10.581 (2, N = 3) Probability = 0.005. Significant statistical difference was found in the frequency with which the 15 therapist-subjects monitored the client's body, position, movements and bodily reactions.

No statistical difference was found [Mann-Whitney U Test Statistic = 4.0 (2, N = 2) Probability = 0.065] between the two models of therapy, Primal and Hypnotherapy, in the frequency with which the therapist-subjects monitored the client's body, movements and bodily reactions. However, Bioenergetic therapist-subjects monitored the client's body, movements and bodily reactions more
frequently than therapist-subjects from the other two models.

Table 7 represents the number of therapist-subjects who directed the client's body position and movements.

Table 7

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist-Subject Directs Client's Body--Position/Movements</td>
</tr>
<tr>
<td>--------------------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Thp Directs Clt's Body</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Counts</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>4.33</td>
<td>4.33</td>
<td>4.33</td>
<td></td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = .62, \ p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to directing the client physically. During their session, thirteen (87%) of the therapist-subjects directed their clients to change body position and/or move their bodies in a certain way, e.g., kick.
Table 7A represents the frequency with which 13 therapist-subjects directed the client's body position and movements.

Table 7A

Frequency with which Therapist-Subject Directs the Client's Body--Position/Movements

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>3</td>
<td>2</td>
<td>--</td>
<td>1</td>
<td>--</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter refers to the identity code for that particular therapist.

Kruskal-Wallis test statistic = 7.108 (2, N = 3) Probability = 0.029. Significant statistical difference was found in the frequency with which the 15 therapist-subjects directed the client's body, position and movements.

No statistical difference was found [Mann-Whitney U Test Statistic = 9.5 (2, N = 2) Probability = 0.511 ] between the two models of therapy, Primal and Hypnotherapy in the frequency with which the therapist-subjects directed the client's body, position and movements. However, Bioenergetic therapist-subjects directed the client's body, position and movements more frequently than therapist-subjects from the other two models.
Table 8 represents the number of therapist-subjects who directed their clients to wear loose, comfortable clothes in which they could lie down and/or move around.

Table 8
Therapist-Subject Directs Client’s To Wear Appropriate Clothes

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Thp Directs Clt Wear Appropriate Clothes</td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 \ (2, \ N = 15) = .20, \ p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to clothing. Ten (67%) of the therapist-subjects asked their clients to wear clothes that promoted relaxation (comfortable/loose) and allowed movement, e.g., sweat pants, leotards, baggy tops.
Table 9 represents the number of therapist-subjects who directed and monitored their clients' breathing--to make sure their breathing was deep, regular, slow and/or not blocked.

Table 9
Therapist-Subject Monitors & Directs Client's Breathing

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Thp Directs &amp; Monitors Clt’s Breathing</td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

$X^2 (2, N = 15) = .18, p > .05$

No significant statistical difference was found, across the three models of therapy, in regard to breathing. Eleven (73%) of the therapist-subjects monitored the client's breathing and directed the client to breathe or breathe in a certain way, e.g., "Any time her (clt) breathing got shallow I told her to breathe deeply and slowly."
Table 9A represents the frequency with which 11 therapist-subjects monitored and directed the client's breathing in the therapy session.

Table 9A

Frequency with which the Therapist-Subject Monitors and Directs Client's Breathing

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>--</td>
<td>3</td>
<td>--</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>--</td>
<td>3</td>
<td>8</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>--</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter refers to the identity code for that particular therapist-subject.

Kruskal-Wallis test statistic = 2.450 (2, N = 3) Probability = 0.294. No significant statistical difference was found in the frequency with which eleven (73%) of the therapist-subjects monitored and directed their clients' breathing.
Table 10 illustrates how many therapist-subjects extend the length of their session if it is required by their clients.

Table 10

Therapist-Subject Extends Session if Required

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Counts</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>3.67</td>
<td>3.67</td>
<td>3.67</td>
<td></td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = .73 \]  \( p > .05 \)

No significant statistical difference was found, across the three models of therapy, in regard to session extension. Eleven (73%) of the therapist-subjects will extend the time of the session if the client requires it.
Table 11 illustrates how many therapist-subjects gave their clients permission to call them after the session was over.

Table 11

**Client Can Call Therapist-Subject After Session**

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject</th>
<th>(N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Clt can Call Thp After Session</td>
<td></td>
</tr>
<tr>
<td>Primal</td>
<td></td>
</tr>
<tr>
<td>Hypno</td>
<td></td>
</tr>
<tr>
<td>Bio</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Observed Counts</td>
<td>4</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>4.67</td>
</tr>
</tbody>
</table>

**Note:** Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 \ (2, \ N = 15) = .14, \ p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to emotional safety. Fourteen (93%) therapist-subjects told their clients that they could call the therapist after the session if they needed to, e.g., if the client was feeling upset.
Table 12 represents how many therapist-subjects used a calm, gentle and relaxed tone of voice during the therapy session.

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thp Tone of Voice</td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
<tr>
<td>12. Calm/Gentle/Relaxed</td>
</tr>
</tbody>
</table>

Observed Counts

Expected Counts 3.67 3.67 3.67

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = .18 \quad p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to tone of voice. Eleven (73%) therapist-subjects used a calm, gentle and relaxed tone of voice throughout most of the session.
Table 13 represents how many therapist-subjects talked with the client for 10-30 minutes during the therapy session.

Table 13
Therapist-Subject and Client Talk for 10-30 Minutes

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Thp/Clt Talk For 10-30 Minutes</td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

$X^2 (2, N = 15) = .18, p > .05$

No significant statistical difference was found across the three types of therapies in regard to talking. Eleven (73%) therapist-subjects stated that their clients talked with them for approximately 10-30 minutes. This particular factor taken out of context loses much of its meaning and is discussed further in Chapter Six.
Table 14 represents the number of therapist-subjects whose client talked about a symptom, issue or past incident in the past tense.

Table 14

**Therapist-Subject Monitors Client Talking About Symptom/Issue/Past scene in Past Tense**

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14. Clt Talks/Recalls in Past Tense</strong></td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

**Note**: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = .18, \ p > .05. \]

No significant statistical difference was found, across the three models of therapy, in regard to talking. Eleven (73%) therapist-subjects monitored their clients talking to them about an issue or incident--past or present--in the past tense. This particular factor, as well, taken out of context loses much of its meaning and is discussed further in Chapter Six.
Table 14A represents the frequency with which 11 therapist-subjects monitored their clients talking about a symptom, issue or past scene in the past tense.

Table 14A

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>--</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>--</td>
<td>1</td>
<td>2</td>
<td>--</td>
<td>2</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>1</td>
<td>--</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter refers to the identity code for that particular therapist-subject.

Kruskal-Wallis test statistic = 0.040 (2, N = 3) Probability = 0.980. Throughout the eleven therapy sessions, no significant statistical difference was found in the frequency in which clients talked about a symptom, issue, past scene in the past tense.
Table 15 represents the number of therapist-subjects who directed their clients to speak/behave in the present tense regarding a past experience.

Table 15
Therapist-Subject Directs Client Speak/Behave in Present Tense

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Thp Directs Clt Speak/Behave in Present Tense</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, \ N = 15) = 0, \ p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to directing clients to speak and behave in the present tense. Nine (60%) of the therapist-subjects directed their clients to speak in the present tense regarding a past event, e.g., "Tell him (a parent) you are angry." They directed their clients to describe an old experience in the present tense, e.g., "Where are you walking?" Also, they directed their clients to behave in the present tense, "Are you ready to walk into the room?"
Table 15A represents the frequency with which 9 therapist-subjects directed their clients to talk or behave in the present tense regarding a past experience.

Table 15A

**Frequency with which Therapist-Subject Directs Client Speak/Behave in the Present Tense**

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>--</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>--</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>2</td>
<td>--</td>
<td>--</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>--</td>
<td>3</td>
<td>--</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

**Note:** "T" = therapist-subjects; the number following the letter refers to the identity code for that particular therapist.

Kruskal-Wallis test statistic = 0.799 (2, N = 3) Probability = 0.671. No significant statistical difference was found in the frequency with which 9 therapist-subjects directed their clients to talk or behave in the present tense regarding a past experience.
Table 16 represents the number of therapist-subjects who monitored their clients speaking/behaving in the present tense regarding a past event.

Table 16
Therapist-Subject Monitors Client Speaking/Behaving in Present Tense

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>16. Thp Monitors Clt Speak/Behave in Present Tense</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Counts</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

$X^2 (2, N = 15) = 0, p > .05$

No significant statistical difference was found, across the three models of therapy, in regard to monitoring clients who speak and behave in the present tense. Fifteen (100%) of the therapist-subjects monitored their clients speaking and behaving in the present tense regarding a past event.
Table 16A represents the frequency with which 15 therapist-subjects monitored their clients talking/behaving in the present tense regarding a past experience.

Table 16A

Frequency with which Therapist-Subject Monitors Client Speaking/Behaving in the Present Tense

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>7</td>
<td>10</td>
<td>10</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter refers to the identity code for that particular therapist.

Kruskal-Wallis test statistic = 2.446 (2, N = 3) Probability = 0.294. No significant statistical difference was found in the frequency with which 15 therapist-subjects monitored their clients talking/behaving in the present tense regarding a past experience.
Table 17 represents the number of therapist-subjects who monitored their clients’ emotions.

Table 17
Therapist-Subject Monitors Client’s Emotions

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Counts</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

χ² (2, N = 15) = .50, p > .05

No significant statistical difference was found across the three types of therapies in regard to monitoring emotions. Twelve (80%) therapist-subjects were aware and monitored their clients’ emotional state during their therapy sessions.
Table 17A represents the frequency with which 12 therapist-subjects monitored their clients' emotions.

Table 17A

<table>
<thead>
<tr>
<th>Frequency Therapist-Subjects Monitors Client’s Emotions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapies</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>Hypnotherapy</td>
</tr>
<tr>
<td>Bioenergetics</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter refers to the identity code for that particular therapist.

Kruskal-Wallis test statistic = 0.814 (2, N = 3) Probability = 0.666. No significant statistical difference was found in the frequency with which 12 therapist-subjects monitored their clients emotions.

**Uncommon Factors/Behaviours/Conditions**

Many factors/behaviours/conditions emerged that were applied only within one or two therapy models--not all three--and therefore did not qualify for comparison for commonality. These uncommon factors/behaviours/conditions were:

18) Subdued Lighting in the Reliving Room
19) Body Position "A": Therapist & Client Sitting Opposite or Beside Each Other
20) Session is Extended to 1 1/4 to 1 1/2 hours
21) Scheduling After Session
27) Therapist-Subject does nothing During the Reliving Process

Table 18 illustrates the number of therapist-subjects who used subdued lighting in the reliving room.

Table 18
Subdued Lighting in the Reliving Room

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N - 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Subdued Lighting in Reliving Room

| Subdued Lighting in Reliving Room | 4 | 4 | 1 | 9 |

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

Four Hypnotherapist-subjects and 4 Primal therapist-subjects used subdued lighting in the reliving room. This was a common factor only within these two therapies. Just one Bioenergetic therapist-subject used subdued lighting, the other four conducted their sessions in ordinary lighting. As one Bioenergetic therapist-subject stated, "I hate sitting in the dark."
Table 19 illustrates the number of therapist-subjects who extended their therapy session beyond 1 hour to 1 1/4 hours or 1 1/2 hours.

Table 19

Therapy Session Extended Beyond 1 Hour

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N - 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Session Extended</td>
</tr>
<tr>
<td>1 1/4 hr to 1 1/2 hr</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

Three Hypnotherapist-subjects and four Bioenergetic therapist-subjects extended their therapy session from 1 1/4 hr to 1 1/2 hr. This was a common factor only within these two therapies. Just 2 Primal therapist-subjects extended their therapy session beyond one hour.
Table 20 illustrates the number of therapist-subjects who directed their clients not to schedule anything for after their therapy session but, instead, to go home or to some place restful and take it easy.

Table 20

Therapist-Subject Directs Client about Scheduling After Session

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N - 15)</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thp Directs Scheduling After Session</td>
<td>--</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

Three Hypnotherapist-subjects and 3 Bioenergetic therapist-subjects directed their clients not to schedule anything after their session and to take it easy. This was a common behaviour only within these two models.
Tables 21 and 22 represent uncommon behaviours which are obscure in meaning if taken out of the context. They both illustrate behaviours that took place at a particular time in the therapeutic session and will be discussed further in the posthoc analysis.

Table 21 illustrates the number of therapist-subjects who sat opposite or beside their client during the therapy session.

Table 21

**Body Position "A": Therapist-Subject & Client Sitting**

**Opposite/Beside Each Other**

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Note:** Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

Five Hypnotherapist-subjects and four Bioenergetic therapist-subjects sat opposite or beside their clients during the therapy session. This was a common behaviour only within these two models. Just 2 Primal therapist-subjects used this position.
Table 22 represents another behaviour which is obscure in meaning if taken out of the context of time. It illustrates the number of therapist-subjects who did nothing during the reliving process. This factor will be discussed further in the posthoc analysis.

Table 22

<table>
<thead>
<tr>
<th>Therapist-Subjects Who did Nothing During the Reliving Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number &amp; Type of Therapist-Subject (N - 15)</td>
</tr>
<tr>
<td>Primal</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Thp Did Nothing During Reliving</td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client.

Three Primal therapist-subjects, one Hypnotherapist-subject and two Bioenergetic therapist-subjects chose to do nothing during the reliving process. This behaviour was only common within Primal therapy.

Uncommon Factors/Behaviours/Conditions and Frequency of Use

Many uncommon factors/behaviours/conditions (ones that occurred only within one or two therapy models) were applied more than once in the individual therapy sessions. These uncommon factors/behaviours/conditions were:

22) Therapist-Subject Touches Client
23) Therapist-Subject Directs Client to Relax
24) Therapist-Subject directs Client do Guided Imagery/Autosuggestion/Desensitization
25) Therapist-Subject Directs Client to Focus on Feeling
26) Therapist-Subject Comforts and Reassures Client

Table 23 represents the number of therapist-subjects who touched their clients during the session and the frequency with which this technique was applied.

Table 23

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>1</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>2</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>--</td>
<td>6</td>
<td>5</td>
<td>--</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter is the identity code for that particular therapist-subject.

Three Bioenergetic therapist-subjects touched their clients 3 times or more during the therapy session while the other therapists rarely applied this technique. This was only a common behaviour within Bioenergetics.
Table 24 represents the number of therapist-subjects who directed their clients to relax during the session and the frequency with which this technique was applied.

Table 24

Frequency with which the Therapist-Subject Directed the Client to Relax

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>--</td>
<td>--</td>
<td>2</td>
<td>--</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter is the identity code for that particular therapist-subject.

Five Hypnotherapist-subjects applied this behaviour almost to the exclusion of the other two models. This was a common behaviour within Hypnotherapy.
Table 25 represents the number of therapist-subjects who used guided imagery, auto-suggestion and desensitization and the frequency with which these techniques were applied.

Table 25

**Frequency with which the Therapist-Subjects Directed Client to do Guided Imagery, Auto-suggestion and Desensitization**

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>--</td>
<td>--</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

**Note:** "T" = therapist-subjects; the number following the letter is the identity code for that particular therapist-subject.

Guided Imagery, Auto-suggestion and Desensitization was used only by 3 Hypnotherapist-subjects making these common behaviours only within this model.
Table 26 represents the number of therapist-subjects who directed their clients to focus on their feelings; stay with their feelings; identify their feelings and the frequency with which this behaviour was applied.

Table 26

Frequency with which the Therapist-Subject Directed the Client to Focus on their Feelings

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>1</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>1</td>
<td>--</td>
<td>1</td>
<td>--</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter is the identity code for that particular therapist-subject.

Nine therapist-subjects directed their clients to focus on their feelings. However, this behaviour was only common within Primal therapy and Bioenergetics.

However, significant statistical difference was found [Mann-Whitney U test statistic = 24.00 (1, N = 2) probability = 0.014] between the two therapies (Primal and Bioenergetics) in the frequency of use.
Table 27 represents the number of therapist-subjects who comforted and reassured their clients and the frequency with which this technique was applied during the therapy session.

Table 27

Frequency with which the Therapist-Subject Comforted and Reassured the Client

<table>
<thead>
<tr>
<th>Therapies</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primal</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Bioenergetics</td>
<td>--</td>
<td>3</td>
<td>6</td>
<td>--</td>
<td>6</td>
</tr>
</tbody>
</table>

Note: "T" = therapist-subjects; the number following the letter is the identity code for that particular therapist-subject. Five Hypnotherapist-subject and 3 Bioenergetic therapist-subjects comforted and reassured their clients. This behaviour was only common within these two therapeutic models.

Also, no significant statistical difference [Mann-Whitney U test statistic = 21.000 (1, N = 2) probability = 0.072] was found in the frequency with which the therapist-subjects from the two models comforted and reassured their clients.

Crucial and Common Factors/Behaviours/Conditions

Table 28 through 31 represent the four common factors/behaviours/conditions considered crucial, by the 15 therapist-subjects, in the facilitation of the reliving process. All other
factors/behaviours/conditions considered crucial by the therapist-subjects—but found not to be in common across the three therapies—are illustrated in Appendix XIV.

Table 28 represents the number of therapist-subjects who considered the qualifications of the therapist to be critical in the facilitation of the reliving process.

Table 28
Qualifications of Therapist

<table>
<thead>
<tr>
<th>Thp Qualifications</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Counts</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Note: Bio = Bioenergetic therapist-subject. Hypno = Cathartic Hypnotherapist-subject; Thp = therapist-client; Clt = client.

\[ \chi^2 (2, N = 15) = 0 \quad p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to the therapist's qualifications. According to fifteen (100%) therapist-subjects, in order to do cathartic therapy the counsellor must be well trained.
Table 29 represents the number of therapist-subjects who felt that the cathartic therapist must possess certain qualities of honesty, empathy, etc. in order to be able to facilitate the reliving process.

Table 29
Qualities of the Therapist

<table>
<thead>
<tr>
<th>Thp Qualities</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Counts</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Note: Bio = Bioenergetic therapist-subject. Hypno = Cathartic Hypnotherapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = .50, p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to the qualities of the therapist. According to twelve (80%) therapist-subjects a cathartic counsellor should be empathetic, supportive, accepting, caring and have unconditional positive regard for his/her client; that the therapist should be honest, warm and share his/her feelings with the client; and that the therapist must have his/her own life in order and be in tuned with him/herself and his/her own feelings.
Table 30 represents the number of therapist-subjects who believed that trust and rapport must exist between therapist and client as an essential factor in the facilitation of the reliving process.

Table 30

**Trust & Rapport in Therapist/Client Relationship**

<table>
<thead>
<tr>
<th>Trust in Thp/Clt Relationship</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed Counts</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Expected Counts</td>
<td>4.33</td>
<td>4.33</td>
<td>4.33</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Bio = Bioenergetic therapist-subject. Hypno = Cathartic Hypnotherapist-subject; Thp = therapist-client; Clt = client.

\[ X^2 (2, N = 15) = .62, p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to the therapist/client relationship. Thirteen (87%) of the therapist-subjects believed that trust and rapport must exist between therapist and client as an essential factor in the facilitation of the reliving process.
Table 31 represents the number of therapist-subjects who believed the therapist must respect the client's boundaries and provide emotional safety for the client.

Table 31

Therapist-Subject Should Provide Emotional Safety

<table>
<thead>
<tr>
<th>Number &amp; Type of Therapist-Subject (N - 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thp Provides Emotional Safety</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Observed Counts</td>
</tr>
<tr>
<td>Expected Counts</td>
</tr>
</tbody>
</table>

Note: Bio = Bioenergetic therapist-subject. Hypno = Cathartic Hypnotherapist-subject; Thp = therapist-client.

\[ X^2 (2, N = 15) = .18, \ p > .05 \]

No significant statistical difference was found, across the three models of therapy, in regard to emotional safety. Eleven (73%) of the therapist-subjects believed that the therapist must respect the client's boundaries and provide emotional safety for the client, e.g., by not touching the client without permission; by informing the client about the cathartic process and the therapist's methods and by providing a debriefing, re-integration and proper closure at the end of the session.
Chapter 5

Discussion

Seventeen (out of 32) factors/behaviours/conditions, involved in the facilitation of the reliving process, were found to be in common across the three models of cathartic therapy.

Common Factors/Behaviours/Conditions

Staging

Except for the literature on Primal and Bioenergetic (Orgone) therapy, little specific information was obtained describing the offices therapists used for cathartic therapy. However, one of the results of this research is that it specified what common conditions existed in 15 reliving rooms representing 3 types of cathartic therapy. It was discovered that all the offices were soundproof and appropriate furniture included mats, recliners and/or pillows.

Client/Therapist-Subject Relationship--Time Element

Twelve of the therapist-subjects had been seeing their clients for 2 months and up--1 to 2 times weekly. This time factor suggests that clients were familiar with the therapeutic process of catharsis. Also, 3 therapist-subjects (2 Primal/1 Hypno) mentioned that time is important in the build up of trust between therapist and client. So, a possible outcome as a result of the time factor could have been the establishment of trust between client and therapist.

Client is Lying Down/Reclining; Therapist-subject is Beside or Behind Client

In the literature the position most favoured by all the
cathartic therapists was for the patient to be lying on his/her back and the counsellor to be usually sitting beside or behind the client. This position promoted relaxation, open breathing and helped the client to concentrate and stay focussed on him/herself.

The research from this study supports the literature. Fourteen therapist-subjects had their clients in a reclining position while the therapist-subjects sat either beside or behind them.

**Therapist-subject Monitors Client’s Body--Movements/Reactions**

The literature indicated that cathartic therapists, no matter what their orientation, monitor the client’s body—movements and reactions. In this study, fifteen (100%) of the therapist-subjects applied this behaviour, thus, confirming the findings from the literature. Still, it must be noted that in this research there were 4 reasons for this monitoring. These 4 objectives were also to be found in the literature.

First, the therapist is watching to see if the client is in a position where he or she can breathe openly, regularly and/or deeply, e.g., if the client’s mouth is open.

Secondly, the therapist wants to be aware if the client is relaxed or tense.

Thirdly, the therapist watches to see how the client is moving his or her body in relation to feelings. For example, one Bioenergetic therapist-subject stated: "His (clt) body continued the movement of rocking side to side as if his whole body was saying, "No!"

Fourthly, the therapist-subject is observing if the client is being distracted or not, e.g., if the client’s eyes are shut.

However, it must be remembered that the eventual goal for
monitoring the body was always the same—to access emotional pain.  

**Therapist-subject Directs Client’s Body Position/Movements**

It was found in the literature that therapists, from the three different cathartic models, would ask their clients to change their body positions or move their bodies in a certain way during their sessions. In this study, thirteen of the therapist-subjects (87%) applied this direction thus confirming the findings from the literature.

Again, there were 4 reasons for the therapist-subject to direct the client’s body. Also, these 4 objectives correspond to the conclusions drawn from the literature. The therapist-subject directed the client’s body so that: 1) the client could breathe openly 2) be relaxed 3) concentrate and/or 4) re-create a past experience or feeling.

**Therapist-subject has Client wear Appropriate Clothing**

Only the literature on Primal and Bioenergetic therapy specified that the client should wear loose, comfortable clothes in which he or she could be relaxed, lie down and or/move around. This conclusion was substantiated by the research. What was unexpected is that 3 out 5 Hypnotherapist-subjects also told their clients to wear such clothing.

**Therapist Monitors/Directs Client’s Breathing**

In the literature, all the cathartic therapists emphasized the importance of breathing in the facilitation of the reliving process. It helped the client relax and concentrate which, in turn, allowed the client to access repressed pain.

The findings from this research support the literature, eleven (73%) of the therapist-subjects monitored and directed the client’s
breathing 3 times or more times per session. They did this with one objective in mind—to make sure it was either regular, deep, slow and/or calm. If the clients’ breathing was blocked in any way the therapist-subjects would give them directions, e.g., "Breathe!" Or "Take three deep breaths." "Focus on your breathing." Or "Keep breathing." etc.

**Emotional Safety-Time Element**

The general impression received from the literature is that the cathartic session was extended beyond the hour and usually lasted until the client had completed the reliving process.

In this research, only 9 therapist-subjects (2 Primal, 3 Hypno & 4 Bio) had extended sessions. However, to compensate for this difference, eleven (73%) therapist-subjects were willing to extend the therapy session if the client required the time. Three (1 Bio & 2 Primal) leave 15 minutes between sessions and 1 Hypnotherapist-subject booked his client at the end of the day for just such an occurrence.

The fact that 6 sessions were not extended beyond an hour may be due to the time element in the therapist/client relationship. Twelve therapist-subjects had been seeing their clients 2 months and up, 1 to 2 times weekly which suggests an established relationship and procedure. Indeed, it must be noted that only new clients in Primal therapy start with extended (2-3 hours) sessions and then, after three weeks, the time is tapered down.

**Therapist-subject’s Tone of Voice**

Eleven therapist-subjects described their tone of voice, overall, as gentle, relaxed and calm. Although this factor was not mentioned in the literature it must be assumed that tone of voice
is such an integral part of a therapy session it was, for the most part, overlooked.

**Therapist-subject Directs Client to Speak/Behave in the Present Tense and Monitors the Behaviour**

From the literature it was concluded that the client speaking and behaving in the present tense regarding a past event was an essential part of the reliving process. Indeed, it is a key element in the definition (Appendix VI) of the reliving process: b) When an individual is reliving repressed emotional pain it was observed that he/she speaks and acts in the present tense.

Therefore, it becomes essential that the therapist focuses the client on the past as if it were the present. Consequently, 9 therapist-subjects directed their clients to speak/behave in the present tense about a past event and all 15 monitored their clients speaking and behaving in the present tense.

**Therapist-subject Monitors the Client’s Emotions**

A major objective in most therapies is the monitoring of emotions and, according to the literature, this is certainly true of cathartic therapy. In this research 12 therapist-subjects monitored the client’s emotions 2 or more times per session.

**Crucial Factors/Conditions/Behaviours**

Four (out of 8) factors/behaviours/conditions were identified, by the 15 therapist-subjects, as being crucial or necessary in the facilitation of the reliving process.

**Therapist**

The literature on catharsis stresses the importance of the therapist. The success of a session was his/her responsibility.
He/she had to have certain qualifications and qualities.

_**Qualifications:**_

In this research, 15 therapist-subjects stated that a necessary factor in the facilitation of reliving is that the therapist must be well trained and 14 stated (one Hypnotherapist disagreeing) that as part of his/her training the therapist must have undergone his/her own therapy.

This data indicates a major change in the evolution of cathartic therapy. In the literature, all the cathartic therapists believed that such counsellors should be well trained. However, not all believed they should have to undergo therapy as well. The Cathartic Hypnotherapists, for example, never required such a prerequisite. Yet, in this research, 4 of the Hypnotherapists specified that the therapist must have had therapy. Indeed, this requirement cannot be stressed enough. For example:

Therapist-subject (Hypno): "The reason I am calm and do not panic is because I have gone through similar experiences."

Therapist-subject (Primal): "You have to go through Primal therapy in order to do the therapy."

Therapist-subject (Bio): "Part of the training is you have to go through the Bioenergetic therapy yourself. You can not lead someone where you have not been yourself. I, myself, have experienced reliving. It is why I am not frightened when clients go into cathartic experiences."

Therapist-subject (Primal): "My own personal experience as a client in primal therapy is vital! I would not know what to do. I would block or take him out of the feeling. I know what is going on as they regress. They intuitively feel it. They are very in
tune. They pick up if the therapist is uptight they can feel it."

In other words, no counsellor should do this type of therapy unless they have undergone it themselves. As one Bioenergetic therapist-subject stated: "I would never do this therapy with a therapist who had not gone through his own abreactive therapy."

**Qualities:**

In the literature a number of cathartic therapists (Ferenczi, Baker, Lowen, etc.) specified that the counsellor must be honest, trustworthy and indulgent yet firm. Janov, in particular, stressed that the therapist must be relatively free of unresolved pain.

In this research, 12 therapist-subjects stated that the counsellor must possess certain basic qualities. These are: honesty, warmth, caring and unconditional positive regard.

These same 12 also stated that therapists must also take care of their own needs and be in tune with themselves. For example:

Therapist-subject (Bio): "It is very important to be true to myself. I have to know myself."

Therapist-subject (Primal): "A therapist must have her own life in good order. A lot of Primal therapists burn out. A therapist must be fed emotionally themselves from a deep source. They must be stable and strong for the clients’ needs. You have to take care of your life. My emotional and personal life is the most important thing in my life."

**Trust/Rapport within the Therapist/Client Relationship**

The literature on catharsis emphasizes that trust must exist between therapist and client. Twelve of the therapist-subjects specified that trust and rapport between the therapist and client is a necessary factor in the facilitation of reliving. Also, three
therapists (2 Primal/1 Hypno) mentioned that one of the key elements in establishing trust is time; time in which to work together.

Therapist-subject (Hypno): "Relive cannot work without trust, building up trust--that is why you need time."

It is possible that this criteria of time was present in most of the cathartic therapy sessions. For, twelve of the therapist-subjects had been seeing their client's for 2 months and up--1 to 2 times weekly.

Emotional Safety-Boundaries

In the literature, the emotional safety of the client was important but, depending on the model of therapy, different aspects of this factor were stressed. For example, before doing any body work, Baker made sure his patients understood and were comfortable with his concept of therapy. However, in Primal therapy, Janov stresses how imperative it is that the counsellor does not interject inappropriately in the therapeutic process.

In this research, eleven (73%) therapist-subjects stated that emotional safety was a critical factor in the facilitation of the reliving process. Emotional safety was defined by two basic elements. Basically, the therapist respects the client's boundaries; providing an environment in which the client feels in control, supported and protected. For example, one therapist-subject (Bio) stated: "I always ask permission before and sometimes during--if they can respond--in regards to touching them."

Another therapist-subject (Hypno) said: "I tell my clients, "You are not going to do anything you do not want to do."
Still another therapist-subject (Primal) said: "The therapist should be unobtrusive. Don’t push clients around!"

Secondly, the therapist must inform the clients’ about his or her methods and processes. For example, as one therapist-subject (Hypno) reported: "There must be common understanding of the problem and the methods. ...I try to keep the people I am working with fully informed about what I am doing and what I am concluding and what I am about to do."

The Differences

In doing this research, not only did the commonalities emerge, across the three therapeutic models, but the differences surfaced as well.

Subdued Lighting in the Reliving Room

In the literature, subdued lighting was identified as a common condition only in Primal therapy. However, in this research, this type of lighting was used by 9 therapist-subjects (4 Hypno, 4 Primal & 1 Bio). This difference remains unexplained.

Scheduling after the Session

There is little or no information in the literature on this subject. So, no comparison can be made. Only six therapist-subjects (3 Hypno & 3 Bio) gave directions to their clients regarding the time following their sessions, such as, telling them to take it easy or not to schedule any appointments afterwards. The other 9 gave no instructions. As one Primal therapist-subject stated, "As a client I used to go from work during my lunch hours--primal--and return to work right after." Whether the 9 clients in question did this was not ascertained.

However, it must be noted that 12 of the clients had been
seeing their therapists regularly for 2 months or more which suggests a certain familiarity with and an adaptation to the emotional demands of this therapeutic process. What form this adjustment took, in the way of scheduling, is open to speculation.

**Therapist-Subject Comforts and Reassures Client**

The literature does state that cathartic therapists comfort and reassure their clients. For example, both Ferenczi and Baker speak of holding the client's hand for reassurance. In this research, 5 Hypnotherapist-subjects comforted their clients 3 or more times on average per session while 3 Bioenergetic therapist-subjects reassured their clients 5 or more times on average.

However, no Primal therapist-subjects comforted their clients even though it is also part of the therapeutic repertoire of this model. Unfortunately, the literature does not identify or offer any explanations regarding this difference.

**Therapist-Subject Monitors Client's Body--Position/Movements/Reactions**

Even though this was a common behaviour (100%), significant statistical difference was found in the frequency with which the therapist-subjects monitored the client's body, movements and bodily reactions. The Primal therapist-subjects and the Hypnotherapist-subjects monitored the client's body approximately 2 to 3 times on average per session. On the other hand, Bioenergetic therapist-subjects monitored the client's body approximately 6 times on average per session.

According to the literature, such differences were to be expected. Bioenergetics is a therapeutic model which focuses primarily on the client's body in order to access deep pain.
Therapist-Subject Directs Client's Body--Position/Movements

Even though this was also a common behaviour (87%), significant statistical difference was found in the frequency with which the therapist-subjects directed the client's body position and movements. The Hypnotherapist-subjects and the Primal therapist-subjects directed the client's body approximately two times on average per session. On the other hand, Bioenergetic therapist-subjects directed the client's body approximately 4 times on average per session.

Again, according to the literature such differences were to be expected. Bioenergetics is a therapeutic model which focuses primarily on the client's body in order to access deep pain.

Therapist-Subject Touches Client

Bioenergetic (3) therapist-subjects touched their clients 3 times on average per session while the other therapist-subjects (1 Primal & 1 Hypno) rarely did. Again, this difference was expected as the literature identifies Bioenergetics as a therapeutic model which focuses primarily on the client's body in order to access deep pain.

Therapist-Subject Directs Client to Relax

All the Hypnotherapist-subjects directed their clients to relax and 4 of them applied this direction 3 or more times per session. Only 2 other therapist-subjects (Bio) directed their clients to relax and not more than 2 times per session.

According to the literature, it is not surprising that the Hypnotherapist-subjects dominated in this area. Hypnosis, the main technique for facilitating reliving in Hypnotherapy, is often referred to (synonymously) as relaxation. However, the results
were unexpected as the other models of therapy appeared to be under represented.

According to the literature, relaxation was stressed by all the cathartic therapists (Freud, Ferenczi, Reich, Baker, Janov, etc.). Indeed, the entire concept of Orgone therapy and Bioenergetics was to release emotional pain by the physical relaxation of the client’s musculature. Yet, only two Bioenergetic therapist-subjects directed their clients to relax and Primal therapist-subjects were not even represented.

**Therapist-Subject Directs Client to do Guided Imagery, Autosuggestion and Desensitization**

Three Hypnotherapist-subjects used guided imagery, autosuggestion and desensitization 3 or more times during the therapeutic session. No other therapist-subjects applied these techniques. However, according to the literature, this difference can be explained for guided imagery, autosuggestion and desensitization techniques are important hypnotic procedures.

**Therapist-Subject Directs Client to Focus on Feelings**

All the Primal therapist-subjects directed their clients to focus on their feelings two times or more during the therapy session. Whereas only one Hypnotherapist-subject applied this technique once and 3 Bioenergetic therapist-subject used it once on average during their sessions.

The fact that Primal therapy dominates in this area is not surprising. In the literature, the focus of Primal therapy is feelings. Janov (1970) believed that feeling equalled healing. He writes, "To become whole again, it is necessary to feel... (p. 41) Feeling, then, is the antithesis of Pain. The dialectic of the
Primal method is that the more Pains one feels, the less pain one suffers (p. 99)."

Summary

In this chapter, the common and uncommon factors/behaviours/conditions, involved in the facilitation of the reliving process, were discussed. As well, the common factors/behaviours/conditions identified by the therapist-subjects, as being the most crucial in the facilitation of the reliving process, were also examined.

Many of the research findings corresponded to the literature. The reclining body position, the monitoring and directing of the client’s breathing, of the client’s body, of the client speaking/behaving in present tense and the monitoring of the client’s emotions were all found to be common factors/behaviours/conditions in the research. This conclusion was supported by the literature.

However, the research did shed light on some aspects of cathartic therapy that were not clear in the literature. First, a clear description of the offices used for cathartic therapy was identified.

Secondly, the research clarified that all three models of cathartic therapy dictate to the client what clothing to wear for the session.

Thirdly, the research explained how cathartic therapists who do not schedule extended sessions are able to accommodate their clients and provide for their emotional safety afterwards.

Fourthly, the research identified the general tone of voice used by cathartic therapists as gentle, relaxed and calm. This was a factor that was overlooked in the literature. Thus, the research
discovered and examined certain factors/behaviours/conditions which were omitted or neglected by the literature.

Also, in the research, 4 common factors/behaviours/conditions were identified by the therapist-subjects, as being crucial in the facilitation of the reliving process. These four were the therapist’s qualifications and qualities, trust and rapport in the client/therapist relationship and emotional safety for the client. These 4 conclusions were supported by the literature (p. 65 this paper).

However, it must be noted that the research did indicate one major change in the evolution of cathartic therapy in that Hypnotherapists now consider therapy a necessary requirement for cathartic counsellors.

One aspect considered crucial by some therapists (Baker, 1967 & Watkins, 1949) in the facilitation of catharsis was not uncovered by the research. This factor was client motivation. In the research, (Appendix XIV) only 6 therapist-subjects (3 Primal & 3 Bio) considered this an important component.

Also, this investigation emphasized many of the differences across the three models of therapy: the subdued lighting, the scheduling after the session and the comforting of the client.

Four other major areas of difference were also uncovered. First, the fact that Bioenergetic therapist-subjects monitored and directed the client’s body more frequently than counsellors from the other two models.

Secondly, the therapist-subjects who predominantly directed their clients to do guided imagery, autosuggestion and desensitization were the Hypnotherapists.
Thirdly, Primal therapist-subjects directed their clients to focus on feelings more frequently than counsellors from the other two models.

There may be many reasons for these differences. Yet, perhaps it is possible that each therapy uses at least one specific technique, which is basically unique to that model, in order to facilitate the reliving process. Bioenergetics concentrates on the body. Hypnotherapy centers upon general techniques of imagination and relaxation. Primal therapy focuses on feelings. Each technique is the galvanizing factor which triggers reliving and each technique defines the core difference between the three therapies. Such a hypothesis would be supported by much of the literature and by this research.

In conclusion, the data collected from this research was clear and comprehensible. For the most part it supported many of the conclusions drawn from the literature. Also, this research clarified and identified certain aspects of catharsis which had changed, were omitted or were unclear in the literature.

This discussion also explored many of the differences across the three models of therapy and further enhanced our knowledge of catharsis. Perhaps, as much if not more, can be learned about catharsis by exploring the differences as well as the commonalities. However, the data still needed a more thorough exploration which was not possible given the methodology outlined in this study. Therefore, in Chapter Six the data is viewed from a more holistic perspective.
Chapter 6

Posthoc Analysis

The Time Flow and Rhythm of the Cathartic Therapy Session

During the categorization process the time flow of the cathartic therapy session was identified but could not be exposed using the methodology established for this study. Therefore, the data had to be analyzed from a different perspective; using a time frame as an overlay. In other words, the common and uncommon factors/behaviours/conditions were to be examined in the context of time.

Each therapy session was divided into 3 sections: 1) First Section/Beginning of the Session  2) Second Section/Before the Reliving Process  3) Third Section/During the Reliving Process.

First Section/Beginning of the Session

At the start of 11 therapy sessions, the client entered and sat down opposite or beside the therapist-subject. The other four (3 Primal & 1 Bio) clients lay down on a mat. The lighting is subdued in all the rooms except those of the 4 Bioenergetic therapist-subjects.

It is at this point that the two common factors represented in Chapter 4 by Tables 13 and 14 must be discussed. Eleven therapist-subjects monitored their clients talking (in the past tense) to them about an issue/symptom or past scene and eleven reported that their clients talked with them for approximately 10-30 minutes. Taken out of context, these two factors make little sense. However, when it is understood that these two factors occurred simultaneously and at the beginning of the therapy session then their essential meaning becomes clear.
Thus, once the client was seated, 11 of the therapist-subjects described their sessions as beginning with their clients talking (in the past tense) about a symptom/issue or past scene for about 10-30 minutes. As their clients are talking the Primal therapist-subjects are waiting for "something old"--a feeling--to come up. The Hypnotherapist-subjects usually are searching for an incident they can trace back. The Bioenergetic therapist-subjects watch the body for signs of repressed emotions.

When the therapist-subject has discovered what he/she is searching for the session changes. At this point, if the client is not already lying on his/her back, he or she lays down or is asked to recline. Some examples of this shift in the session are (any identifying information has been edited):

**Primal:**

Thp: "Where do you feel that these feelings are really coming from?"

Clt: (Crying) "When I was a little girl I almost drown."

Therapist had client lay down on the mat.

**Hypnotherapy:**

The client stated that if he let loose his anger the therapist would be reduced to a shrivelling mass, the room would be a disaster.

Thp: "I am not afraid of your anger. In the group room we have cushions, a thick mat, we do this (have clients express feelings) routinely."

The client agreed to do some anger work and moved into the group room.

**Bioenergetics:**

As the client was talking she began to move and squirm and pull her legs up in the chair.

Thp: "It looks like we should go to the mat."
Second Section/Before the Reliving Process

Fourteen of the clients are now lying on their backs. Only one therapist-subject (Hypno) left his client sitting throughout the session.

During this second section all the therapist-subjects are applying a number of factors/behaviours/conditions designed to facilitate the reliving process. All the therapist-subjects are monitoring their clients' breathing, emotions and their bodies. They are making sure their clients' bodies are relaxed and their breathing is regular, deep and unblocked. At the same time, they are watching for signs of emotion.

It is also at this time that each therapist-subject applies the techniques which are basically unique to his/her particular therapeutic model. In general, the Hypnotherapist-subjects direct their clients to relax and direct them into guided imagery, autosuggestion and/or desensitization. The Primal therapist-subjects direct their clients to focus on their feelings. While the Bioenergetic therapist-subject is monitoring, directing and touching the client's body. At this point, if there is trust between the therapist-subject and the client; and if the therapist-subject is well trained--the client begins to relive. Some examples (any identifying information has been edited) of this shift in the session are:

Primal:

Clt: "I don't believe it. I'm seeing this. I'm seeing this but I don't believe it."

Thp: "Stay with it! Tell me what's happening. What is the feeling?"

Clt: "She's lying down beside me and she's touching me..."
Hypnotherapy:

Thp: (Guided Imagery) "You will see a little boy coming towards you." He went into reliving.

His (clt) body tensed, he looked extremely distressed. He started to cry and scream and started to push someone away.

Bioenergetics:

I (thp) asked him to straighten his legs and start kicking and saying "no". He did this for 20 seconds when he abreacted.

He started screaming. "No! Don’t! Leave me alone!"

During Reliving Process

Thus, this section was marked by the client suddenly speaking/behaving in the present tense regarding a past scene or from the point the therapist-subjects stated their client abreacted.

The reclining body position can change during reliving. The majority of the therapist-subjects monitored their clients squirming, tensing, moving about in extreme agitation; flailing their arms and holding themselves rigid in terror.

As far as directing and touching their clients bodies, essentially only the Bioenergetic therapist-subjects did this during the reliving. For example, one Bioenergetic client was moved into a number of different breathing positions—requiring kneeling and standing; while another massaged her client and still another directed her client to kick during the reliving.

During the reliving all the therapist-subjects are monitoring and/or directing the client to speak and behave in the present tense. As one Bioenergetic therapist-subject stated: "...Once she is in the grip of the memory she is very direct but once in a
while, especially on the really tough stuff, she slips into a
description about it. At that point, I will say, "No, say it to
them. Or, what would you say? Or, what are you feeling now?" I
coach her to be as immediate as she can be."

It was also only during the reliving that the (8) therapist-
subjects (5 Hypno & 3 Bio) comforted and reassured their clients.
The major exception were the five Primal therapist-subjects who did
no comforting at all. This difference was not unexpected.
Although Janov does state that clients sometimes need comforting
during catharsis, Primal therapy is an unobtrusive model. For
example, of the 6 (1 Hypno & 2 Bio) therapist-subjects who reported
they did nothing during the reliving process, 3 were Primal
therapist-subjects; making this a common factor within this
therapy. This means that, during the reliving process, these
therapist-subjects did not touch their clients, they did not direct
and/or reassure them—they merely monitored. As one of the
Bioenergetic therapist-subjects stated, "I think it is possible to
mechanically take people back. And if people trust you they can
abreact on their own. You just really have to stay out of the
way."

Finally, using all the time elements supplied by the
therapist-subjects in the 15 interviews, the cathartic therapy
session began to take a certain form. These time incidents
were taken from three categories and were pieced together so that
a complete view of each therapy session could be represented.
These three categories (Appendix XIII) are: #13 Therapist/Client
Talk for 10-30 minutes; #20 Session is Extended to 1 1/4 to 1 1/2
hours; #31 General Time Factor.
Table 32 illustrates an approximate time frame for all 15 interviews.

Table 32

<table>
<thead>
<tr>
<th>Thps</th>
<th>1st Section Clt/thp</th>
<th>2nd Section Before Talk</th>
<th>2nd Section Relive</th>
<th>3rd Section During Relive</th>
<th>End Section After Relive</th>
<th>Total Time Length of Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>15 m</td>
<td>None</td>
<td>30 m</td>
<td>15 m</td>
<td>1 hr</td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>15 m</td>
<td>None</td>
<td>15 m</td>
<td>15 m</td>
<td>45 m</td>
<td></td>
</tr>
<tr>
<td>P3</td>
<td>18 m</td>
<td>3 m</td>
<td>15 m</td>
<td>54 m</td>
<td>1 1/2 hr</td>
<td></td>
</tr>
<tr>
<td>P4</td>
<td>10 m</td>
<td>U/N</td>
<td>1-5 m</td>
<td>U/N</td>
<td>45 m</td>
<td></td>
</tr>
<tr>
<td>P5</td>
<td>None</td>
<td>45 m</td>
<td>1-5 m</td>
<td>40 m</td>
<td>1 1/2 hr</td>
<td></td>
</tr>
<tr>
<td>H6</td>
<td>None</td>
<td>U/N</td>
<td>30 m</td>
<td>U/N</td>
<td>1 hr</td>
<td></td>
</tr>
<tr>
<td>H7</td>
<td>10 m</td>
<td>2-5 m</td>
<td>20 m</td>
<td>25 m</td>
<td>1 hr</td>
<td></td>
</tr>
<tr>
<td>H8</td>
<td>30 m</td>
<td>10-20 m</td>
<td>1-5 m</td>
<td>35 m</td>
<td>1 1/2 hr</td>
<td></td>
</tr>
<tr>
<td>H9</td>
<td>None</td>
<td>10-15 m</td>
<td>1-5 m</td>
<td>1:10 hr</td>
<td>1 1/2 hr</td>
<td></td>
</tr>
<tr>
<td>H10</td>
<td>15 m</td>
<td>53 m</td>
<td>1-5 m</td>
<td>17 m</td>
<td>1 1/2 hr</td>
<td></td>
</tr>
<tr>
<td>B11</td>
<td>15 m</td>
<td>None</td>
<td>20 m</td>
<td>40 m</td>
<td>1 1/4 hr</td>
<td></td>
</tr>
<tr>
<td>B12</td>
<td>None</td>
<td>None</td>
<td>30 m</td>
<td>40 m</td>
<td>1:10 hr</td>
<td></td>
</tr>
<tr>
<td>B13</td>
<td>20 m</td>
<td>2-3 m</td>
<td>10-15 m</td>
<td>52 m</td>
<td>1 1/2 hr</td>
<td></td>
</tr>
<tr>
<td>B14</td>
<td>10 m</td>
<td>2 m</td>
<td>1-5 m</td>
<td>37 m</td>
<td>55 m</td>
<td></td>
</tr>
<tr>
<td>B15</td>
<td>18 m</td>
<td>45 m</td>
<td>1-5 m</td>
<td>22 m</td>
<td>1 1/2 hr</td>
<td></td>
</tr>
</tbody>
</table>

Note: Hypno = Hypnotherapist-subject; Bio = Bioenergetic therapist-subject; Thp = therapist-client; Clt = client; None = means that the client did not participate in this part of the session; U/N = means that the information is unavailable; and m = minutes.

The time length for the reliving process does not indicate continuous reliving. Two Primal therapist-subjects and two Bioenergetic therapist-subjects stated that during reliving their clients went in and out--coming out of reliving into the present and then back into reliving. Also, it must be noted that Therapist H10 and B14 had two relives during their session. Only the first
relive is represented. Therefore, the end of the session would have to include time for the second relive.

What is most interesting about Table 32 is the length of time left over in many of the sessions once the reliving process is over, e.g., 54 min, 40 min, 25 min, 35 min, 1:10 hr, 40 min, 40 min, 52 min and 22 min (H10 and B14 excluded). Perhaps this time was set aside so that the reliving process could be analyzed. This hypothesis could certainly be supported by the literature. For, one of the important elements of psychological catharsis is that the reliving process must be discussed with the client; clarified and interpreted and the client must be helped to understand the experience intellectually and emotionally.

Summary

In conclusion, the common and uncommon factors/behaviours/conditions were also studied in the context of a time frame. Almost every session could be divided into 3 sections: The Beginning, Before the Reliving Process and During the Reliving Process.

The Beginning section was marked by the therapist-subject and client talking about an issue in the past tense for 10-30 minutes. Once the therapist-subject discovered an old feeling (Primal), an emotionally charged incident (Hypno) or emotions expressed by the body (Bio) the client moves or was moved into the reclining body position. Although, in some cases, the client is already lying down.

Before the reliving process, the therapist-subjects applied a number of factors, behaviours and conditions. Depending upon the model of cathartic therapy, some of these factors were applied
exclusively in the second section while others were used equally, before and during the reliving process. This was true for the third section as well.

Also, a Table (32) was constructed representing a time frame for all 15 interviews. Using this table as a reference, it was speculated that once the reliving process was completed a number of therapist-subjects may have analyzed, clarified and discussed the session with their clients.

Finally, this exploration of the data in relation to time illustrated that there exists a common rhythm in the cathartic therapy session. By analyzing the factors/behaviours/conditions involved in the facilitation of the reliving process within the context of time gave the original data additional meaning.
Chapter 7

Summary

The significance of this study was to shed light upon the subject of catharsis. First, psychological catharsis was operationally defined and it was discovered that reliving was a key element in this process.

Subsequently, the reliving process was then defined.

Thirdly, using several models of cathartic therapy as a database, factors/behaviours/conditions, involved in the facilitation of the reliving process, were identified.

Then it was hypothesized that in spite of the apparent differences within three types of cathartic therapy, commonalities in the facilitation of the reliving process, would exist. Therefore, the question became:

1) What common factors/behaviours/conditions are involved, which facilitate the reliving process to occur in a given therapy session, using Cathartic Hypnotherapy, Primal therapy and Bioenergetics as therapeutic models?

Also,

2) Which factors are considered crucial, by the therapist, in the facilitation of the reliving process?

Once the questions had been formulated, then 15 cathartic psychotherapists were interviewed; 5 therapist-subjects from each therapeutic model: Primal Therapy, Hypnotherapy and Bioenergetics. Using the critical incident technique as a methodology, 17 common factors/behaviours/conditions involved in the facilitation of the reliving process, across three models of cathartic therapy, were identified.
Also, 4 common factors/behaviours/conditions were identified by the 15 therapist-subjects as being crucial in the facilitation of the reliving process across the three models of therapy.

However, in searching for commonalities, the differences that existed across the three therapies also emerged and these were explored as well.

A posthoc analysis was then done in the context of a time frame. In other words, a factor/behaviour/condition was analyzed in relation to when it occurred during the therapeutic session. This investigation exposed the time frame of the cathartic therapy session, thereby, giving the original data additional meaning.

In conclusion, this study furthers our understanding of the reliving process; a most significant element of psychological catharsis. This understanding is important the reliving process is a useful therapeutic procedure in the resolution of traumatic experiences and this study provides a more comprehensive understanding of this process than has hitherto been available.

Implications and Recommendations of this Study

One potential value of this study is the provision of information that can be used to help counsellors interested in doing cathartic therapy. The 17 common factors and 4 crucial factors identified in the facilitation of the reliving process could be viewed as criteria necessary for effective catharsis to occur. Therefore, it is recommended that therapists take these guidelines into account when deciding to do cathartic therapy. Some suggested strategies for counsellors interested in doing cathartic therapy are:
1. All counsellors doing cathartic therapy must be well trained and, as part of this training, the therapist must have undergone his/her own cathartic therapy and have his/her own life in order.

2. Trust and rapport are elements that must exist in the client/therapist relationship for catharsis to occur. However, this trust may take time to build.

3. The offices of a cathartic therapist must be soundproof and provide an area in which clients can lie down and move around.

4. In order for the client to relax and feel free to move, the cathartic therapist should recommend they wear comfortable, loose clothes, e.g., sweat pants and sweat shirts.

5. The therapist’s tone of voice should be calm, gentle and relaxed in session.

6. The therapist must be willing to provide emotional safety for the client by: a) extending the time of the session if needed b) giving the client permission to call after the session c) respecting the clients’ boundaries and providing an environment of support d) informing clients of the methods and processes involved in the therapy.

7. In order to understand what factors/behaviours/conditions to use to facilitate the reliving process, it is recommended that cathartic therapists be qualified in either Primal therapy, Bioenergetics or Cathartic Hypnotherapy. One important reason for choosing one of these models is because all 3 have evolved over a long period of time. The theoretical and technical foundations of all 3 are based upon nearly 90 years of
clinical research conducted by extremely qualified and reputable psychotherapists. Due to this evolution all 3 are comprehensive and holistic models of cathartic therapy.

8. There is a certain flow to the cathartic therapy session and it is recommended that the cathartic therapist be familiar with this rhythm.

There are also other recommendations and implications that emerge from this study. Cathartic therapy is a form of counselling which delves deep into the emotional psyche of a client. For this reason, clients who are seeking such counselling should choose their therapy and therapist carefully. In terms of which model of cathartic therapy to choose, it is recommended that clients also choose one of the three used in this study.

Also, in terms of which therapist to choose, it is recommended that clients follow the guidelines set by the cathartic therapists, themselves; that the counsellor has gone through his/her own abreactive therapy and be well trained in one of the three cathartic models used for this study.

It is also recommended that further research be conducted into the reliving process. There are parts of this process that are fascinating and are in need of more exploration, e.g., what occurs in the time that follows the reliving process. As one Bioenergetic therapist-subject stated: "But it is not just about having catharsis. It is about making sense of it. It is about somehow finding a way to make the past make sense today; to integrate the past into the person today so there is a change of behaviour."

It is recommended that further study be conducted into the time
flow of the cathartic therapy session. As this was not the primary focus of this study it is possible that with further research more could be learn on this subject.

It is recommended that the clients of catharsis be studied. Perhaps a comparison could be made between what the therapists consider crucial and what the clients, themselves, deem critical in the facilitation of the reliving process. With such an investigation it could be determined how clients adapt their everyday life to such an emotionally demanding therapy. As well, it could be discovered if the clients, themselves, view the reliving process as a therapeutic method for change.

Also, it is recommended that research be done on beginner clients; clients who are reliving for the first time in session. Perhaps the data would be different from the facts presented in this study which focussed on the more experienced client.

Lastly, it is recommended that the many differences across the three models of therapy be investigated, e.g., the subdued lighting, the scheduling after the session, the comforting of the client and the directing of the client to relax. Many of these differences remained unexplained. Indeed, much can be learned about catharsis by exploring the differences as well as the commonalities.
References


Ferenczi, S. (1955). *Final contributions to the problems and methods of psycho-analysis* (E. Mosbacher and others Trans.). In M. Balint (Ed.)


Gardner Press.


Appendix I

Pierre Janet

The research of Pierre Janet, a contemporary of Freud’s, was reviewed. Unfortunately, he discovered no new information that could be used for further clarification of the term psychological catharsis. Because his data provides corroboration, confirmation and verification of Freud’s theories it is included here.

Mental Liquidation

At the same time that Freud and Breuer were applying their cathartic method, Pierre Janet, a pupil of Charcot, was using synopsis and the study of dreams in a treatment he considered similar and just as effective called "mental liquidation" (Janet, 1925). Indeed, many of Janet observations resembled the findings of Freud and Breuer.

Janet (1925) asserted that traumatic memories became "dissociated" or "split" from the patient’s consciousness and induced neuropathic disorders, such as, hysteria. Secondly, he believed, in the most part, that these suppressed memories should be remembered and the accompanying emotions discharged. However, as with Freud and Breuer, it is difficult to discern if Janet’s patients recall or relive their trauma. Thirdly, as Freud had observed in his sessions, physiological symptoms surfaced during Janet’s therapy as well. Janet (1925) writes:

While her phrases are being formed with great difficulty, the patient has laughing fits, twitching and contortions, and in the end she weeps copiously. She then feels bewildered and extremely tired, but is incredibly happy....The transformation is a very rapid one, and (this being rare) it is durable. (p. 695)

Fourthly, Janet also emphasized the therapeutic importance of confession and recital which may parallel the observation made by Freud and Breuer of the necessity to talk out traumatic memories. Janet (1925) refers to a patient who has a dread of syphilis:

It is plain that, in his absurd and distressing confession the patient must have expended the energetic charge of the morbid tendency, must have canalized the energy. This immediately relieved him of his distress. (p. 685)

He continues:

A situation has not been satisfactorily liquidated, has not been fully assimilated, until we have achieved, not merely an outward reaction through our movements, but also an inward reaction through the recital of the event to others and to ourselves, and through the putting of this recital in its place as one of the chapters in our personal history. (p. 662)
Original interview questions which were revived after the preparatory interview:

1. Could you describe a recent experience within the past three months in which one of your clients relived a past emotional event during one of your therapy sessions?

2. Could you tell me exactly what was said and done during this experience?

3. What factors, conditions and/or behaviours facilitated the reliving process in your therapy session? I am interested in concrete examples rather than opinions or theories?

4. Which of these factors is the most critical or important in facilitating the reliving process? Again, I am interested in concrete examples rather than opinions or theories?
Appendix III
Letter of Initial Contact

Dear _______________________

I am an M.A. student working on a thesis about cathartic therapy. I got your name through ______________________ and I am writing to you in the hope that you would let me interview you over the phone regarding this topic.

My research project is called, Factors which Facilitate the Reliving Process in Cathartic Therapy, under the supervision of Dr. Bob Tolsma, University of British Columbia (228-5259).

The conclusions I have drawn, from my reading of the research, is that emotional pain resulting from trauma can be resolved through cathartic therapy. I call this phenomena the reliving process (description enclosed).

My research is intended to identify what the most important factors are that facilitate the reliving process in cathartic therapy.

If you participate, you will be asked to describe a reliving process that occurred in one of your therapy sessions and the factors you considered most important in facilitating this experience for your client (questions enclosed). To preserve confidentiality, no names of clients or identifying information would be used.

The interviews will be conducted over the phone at a time that is convenient for you. It will take no longer than an hour and will be tape recorded. Any identifying information will be deleted to preserve confidentiality. No one will have access to the tapes except the researcher or Dr. Bob Tolsma (thesis supervisor). Once the study is completed all tapes will be erased. You have the right to refuse to participate in the project or to withdraw at any time without any consequences.

If you would agree to being interviewed I have enclosed a written consent form and self-addressed envelope to be mailed back to me. Upon receipt of the consent form I will telephone you within a few weeks to set up a convenient time for you to be interviewed. At this time I would be more than willing to answer any questions you may have. Also, please do not hesitate to phone me collect if you have any further questions.

Yours truly.

Joanne Gilbert
(604) 732-0283
Definition of the Reliving Process

1. When an individual re-experiences a deep, repressed emotional event as vividly as possible; the individual does not merely recall the event he re-enacts the incident right in front of the therapist.

2. The original memory causing the repressed emotional pain must be remembered consciously.

3. The emotions that accompany the memory of the experience must be expressed.

4. When an individual is reliving repressed emotional pain it was observed that he speaks and acts in the present tense.

The Interview Questions:

I am interested in a therapeutic session in which one of your clients relived a painful emotional experience they had repressed. I will be asking you questions about:

- the scene that was relived, e.g., how old client was, where it took place, who was present?

- what exactly was said and done by therapist and client during this therapeutic experience from the beginning of the session to the end.

- what conditions caused the reliving process to occur and which ones you considered the most important.
Appendix IV

Consent Form

Research Project: Factors, behaviours and/or conditions which facilitate the reliving process to occur in a given cathartic therapy session.

Project Supervisor: Dr. Bob Tolsma, (604) 228-5259

Researcher: Joanne Gilbert, University of British Columbia, (604) 732-0283.

This project is intended to identify what are the most important factors involved in order to facilitate the reliving process in cathartic therapy.

Interviews will be tape recorded and, from each tape, significant events will be extracted in written form. A set of categories will then be developed that indicate what the most important factors are that facilitate the reliving process.

To preserve confidentiality, the tapes will be number coded and will be erased upon completion of the analysis. Any identifying information will be deleted from event descriptions. No one will have access to the tapes except the researcher. The respondent’s identity will remain confidential. The total amount of time required by you, the participant, is approximately one hour. If there are any questions concerning the procedures, the investigator is available to answer them.

You, the respondent will have the right to refuse to participate in the project or to withdraw at any time without any consequences. Participation is voluntary. I, the respondent, confirm that I have received a copy of this consent form.

Phone # _______________________

Date ________________________ Signed ________________________
Appendix V

Protocol for First Phone Contact

Hello ____________, my name is Joanne Gilbert. I am doing my MA at the University of B.C. I sent you a letter 2 weeks ago describing the subject of my thesis and asking if you would be so kind as to be interviewed by me over the phone for my thesis. The time would be set up for your convenience.

Before I set up the time, I have to ask you one question.

1. Is the reliving process a regular occurrence in your therapy?

2. (If their credentials have not been verified) Are you a certified Bioenergetic therapist/Hypnotherapist or Primal Therapist? Or, Have you been trained in Primal therapy?
Appendix VI

Protocol for Second Phone Contact

1. Introduce myself again

2. Thank them for taking the time out of their schedule to do the interview.

3. Remind them that my research is intended to identify what the factors facilitate the reliving process in cathartic therapy.

4. Tell them that the interview will take no longer than one hour and consists of 6 questions.

Ask them if we might now proceed.

The Interview Questions:

I am interested in a therapeutic session in which one of your clients relived a painful emotional experience they had repressed.

1. Does the reliving event you are referring to for this interview correspond to the definition, in that:

   - The individual did not merely recall a past event he re-enacted in front of you as vividly as possible

   - The original memory causing the repressed emotional pain was remembered consciously

   - The emotions that accompany the memory of the experience were expressed.

   - The individual speaks and acts in the present tense.

2. I would like you to provide me with non-identifying information regarding your client. I need to know a few characteristics about your client such as: age, gender?

3. Now I'd like to ask you some questions about the scene itself.

   - How old was your client at the time of the scene?
   - Where did the scene take place?
   - Who was present (father, mother)?
   - What took place?
   - How long was the reliving?

4. Could you describe the session from the beginning to the end; telling me exactly what was said and done by you and the client?

5. What were the conditions that caused this reliving process to
occur? Please as specific as possible and give me concrete examples?

6. Are there any other factors or behaviours you think caused the reliving process to occur? Can you give me concrete examples?

7. Of all the factors involved which ones do you consider the most critical or important in facilitation of the reliving process? Why?
Appendix VII

Protocol for Interview Raters

I want you to read the following interviews. Fifteen therapists were interviewed about one of their therapy sessions. I would like you to highlight every critical incident that occurs in the interview.

A critical incident is:

A. A fact or factual statement: e.g. The client had never met me before this session.

B. An actual behaviour that is observed or established or proven: e.g.: I asked the client to close her eyes.

The following are examples:

1. I (thp) knew the client was motivated to work during the session.
   - This is NOT a critical incident because it is not a fact -- how does the therapist know the client is motivated -- there is also no observed behaviour involved. DO NOT HIGHLIGHT.

2. The client said: "I really want to work on this problem."
   - This is a critical incident -- the client has stated that she is motivated to work on an issue -- this is an observed behaviour -- a behaviour that proves the client was motivated. Please highlight this.

3. The client moved to the mat and lay down.
   - This is a critical incident -- because this is an observed behaviour -- please highlight this.

4. I (thp) use the word trance instead of hypnosis in my sessions.
   - This is a critical incident -- because this is a factual statement -- please highlight this.

5. I (thp) felt the client was suppressing her rage at her mother.
   - This is NOT a critical incident because it is not a fact -- the therapist is interpreting -- it is not observed behaviour. DO NOT HIGHLIGHT.

6. Client states: "I don't know how I am feeling. There is
something that is bothering me but I don’t know what it is.”
Thp: “I think you know what is bothering you.”

- These are both critical incidents because it is observed behaviour--both the client and the therapist are speaking. It does not matter what they are saying--they are interacting--please highlight both statements.

7. - The client spoke with a lot of emotion.
- The client was agitated.
- The client was upset.
- The client was very frightened.

Because these phrases are used so often to indicate certain behavioural patterns -- they will be interpreted in this study as observed behaviour. Please highlight these.

8. Client always thinks someone is watching him.
- This is an interpretative statement--no observed behaviour to accompany this observation. DO NOT HIGHLIGHT.

9. The client appeared to be on track.
- Interpretive. DO NOT HIGHLIGHT.

10. I guided the client into the feeling.
I validated the client’s feelings.
- No observed behaviour. Interpretive. How did the therapist do this? DO NOT HIGHLIGHT.

11. It was clear she was regressing.
The client was aware of his feelings.
- Interpretative! How did he know? DO NOT HIGHLIGHT.

12. The therapist did not do anything.
The client said nothing.
- Observed behaviour. Please highlight.

The following is a sample from a therapeutic session--please highlight the critical incidents.

The client is obviously feeling a lot.

Thp (to client): "Sink into the feeling Jake."

Clt: "I was sitting there, letting him beat up my brother and--Gee, I feel tense....I don’t know what it is..." I think
I began to feel that this thing could happen to me if I spoke back like my brother did. . . . Oooh, I've got a knot in my stomach."

Thp: Were you afraid?

Clt: Was I afraid?"

The patient begins to twitch a bit. He moves his legs and hands. His eyelids flutter, and his brow is furrowed. He sighs or grinds his teeth. He does not know whether to express his feelings or not.

Thp: Feel that! Stay with it!

Clt: "It's gone. The feeling has passed."

This sparring goes on for 1 hour.

Clt: "I feel tight all over. Yeah, I think I was really afraid of the old man"

I see that he is into the feeling and is holding on tight.

Thp: "Breathe deeply Jake hard from the belly. Open your mouth as wide as possible and keep it that way! Now pull, pull that feeling from your belly!"

Jake begins to breathe deeply, writhing and then shaking.

When the breathing is happening automatically, I said: "Tell Daddy you're afraid!"

Clt: "I'm not going to tell that son of a bitch anything!"

Thp: "Say it! Say it!"

Jake cannot do it.

If he could scream it out, it would probably bring a stream of tears and stomach-wrenching gasps. He might immediately begin talking afterward about the kind of person his father was. Chances are good that he will also have several insights as he speaks.

Clt: I don't know what the feeling is. My throat is tight and my chest feels as though there's a band around it.

He begins gagging and retching.

Clt: "I'm going to throw up!"

This is a feeling he will not throw up. I inform him that it is a feeling and that he won't throw up. I urge him to say the feeling even though the he doesn't know what it is.
He started to form a word and then began to thrash and writhe.

I urge him to let it out.

Clt screams: "Daddy, be nice!"

If you have any problem during this rating procedure please talk to me and I will help you to understand or clarify the situation.
Appendix VIII

Discarded Statements or Incidents From Interviews

The following 26 statements or incidents are from the 15 interviews and were discarded because no agreement was reached among the raters. Some statements have been kept in context and it is only the underlined portion of these statements that was discarded. To preserve confidentiality any information identifying either therapist or client has been deleted.

1. At that point, clt went right back into the scene.
2. This was an ongoing theme (of the clt’s).
3. Just a general avoidance of him (the clt felt for her father).
4. Therapist just listened waiting until the clt gets to something that is old.
5. Thp said nothing during the reliving process because thp wanted her to be totally in the feeling.
6. After the scene became very vivid...
7. Once clt was relaxed, she regressed.
8. I use the word relaxation, not hypnosis, if people are uptight with the word.
9. I was reassuring her...
10. She would go into a trance state; experience it; to know what it feels like and what to expect.
11. We began to work from there so she was very prepared.
12. When she is in that state I do preparatory work.
13. If she said she did not feel good I would say, "If you are not comfortable, you are in control you can stop it any time."
14. I never push a client beyond the point they do not want to go.
15. She wanted to relive the entire situation.
16. And allowing her to experience it.
17. ...he comes back into consciousness, into his body more and more.
18. Her head starts to go back and forth as it comes from the sacrum.
19. When she suddenly stopped breathing like that I knew that we were dealing with a shock or trauma.
20. I go through a process to make sure they are back in the current reality.
21. If I know something is coming up I often book an hour an half and the client would be aware of this and that the therapist would be trying to facilitate the reliving process.
22. Thp: Thp feels very supportive of the work this counsellor is doing because it is a very difficult relationship.
23. Thp is always quite thrilled to hear what is happening.
24. He really has their trust.
25. Thp is always amazed that it is going so well and that they are hanging in there with him.
26. Client is aware that the thp is supportive of the marital counselling.
APPENDIX IX

Categories of First Set of Index Cards
Protocol for the Card Raters

Fifteen therapists were interviewed about one of their therapeutic sessions. All significant statements the therapists made about behaviour observed during their sessions were placed on cards.

There are two sets of categories. The first set has 7 general headings and 28 categories. I will ask you to categorize these cards first and then we will have a short break and then proceed to the second set of categories. Once I have explained the meaning of the categories I will show you 10 sample cards and ask you to place them under the appropriate heading.

I will now explain what each category means. Most are self-explanatory while some categories may need more explanation. While I go through this procedure please feel free to ask me any questions.

The First Set of Categories

A. Staging

1) Lighting in the Relive Room
   -therapist lowers light
   -therapist lighting is described in the room as subdued/bright/normal

2) Description of Office
   -therapist describes his office/office equipment, e.g., such as mats, recliners, sofas, bats, etc.
   i) -Soundproof

B. Client/Therapist Relationship

3i) How Long Therapist Seeing Client
   -therapist seeing client how many months or years

ii) How Often Therapist Seeing Client
    -therapist seeing client how many times a week or month

iii) How Long was the Session
     -the time length of the session

C. Client’s Body Position and Therapist Directs and Monitors the Client’s Body/Position/Movement/Reactions

4) Body Position A
   -therapist & client sitting opposite/beside each other either on sofas, chairs, etc.

5) Body Position B
   -client is lying down/reclining on his back with therapist beside or behind

6) Therapist Monitors Clt’s Body/Movements/Reactions
   -therapist monitors the client’s posture, body position & movements
   -therapist monitors the client’s bodily reactions
7) Therapist Directs Client’s Body Position/Movements
   - therapist directs the client to change body position
   - therapist directs the client to move his body in a
certain way, e.g. kick
8) Therapist Touches Client
   - therapist touches the client’s body

D. Relaxation

9) Clothing
   - therapist directs client to wear certain type of
clothing
   - therapist directs client to change his clothes
10) Therapist Monitors/Directs Client’s Breathing
    - therapist monitors client’s breathing
    - therapist describes client’s breathing
    - therapist directs client to breathe or breathe
      in a certain way
11) Therapist Directs Client to Relax
    - therapist directs client to relax
    - therapist directs client to relax his muscles
    - therapist directs client to be calm, peaceful, restful,
      less tense
12) Therapist Uses Music
    - therapist puts music on or off
    - therapist has music playing in his session

E. Emotional Safety

13) Session Time Extension
    - therapist is willing or not willing to extend
      the time of the session if it is needed
14) Calling Therapist After Session
    - therapist does or does not allow client to call
      him after their session
15) Scheduling After Session
    - therapist does or does not give directions to client
16) Therapist Comforts and Reassures Client
    - therapist offers protection/support
    - therapist is respectful of boundaries

F. Therapeutic Techniques

17) Therapist Tone of Voice
    - therapist’s tone of voice is firm/loud/calm etc.
18) Time factor
    - therapist states that a particular event took
      a certain amount of time
      i) - Therapist/client talk for certain time
19) Therapist Does Nothing
    - therapist just sits back; watching & listening
20) Client Talks to Therapist About Symptom/Issue/Past scene
    - client talks to therapist about a problem--past or
      present
    - client recalls/talks to therapist about a past
21) Therapist Directs Client to Recall Past Scene
   -therapist directs client to remember a past scene
   -therapist directs client to recall a past scene

22) Therapist Directs Client Speak/Behave in Present Tense
   -therapist directs client to speak to a person as
     if he is there
   -therapist asks questions about an event as
     if the client is really there
   -therapist directs client to behave as if a
     past event is really occurring

23) Therapist Monitors Client Speaking/Behaving in Present Tense
   -client speaks in present tense about past event
   -client behaves as if a past event is really occurring

24) Therapist Directs Client Focus on Feeling
   -therapist directs client focus on a feeling
   -therapist directs client to "stay" with the feeling
   -therapist directs client to express the feeling

25) Therapist Directs Client to Focus on Body Feeling
   -therapist directs client to focus on a feeling in his

26) Therapist Monitors Clients' Emotions
   -therapist describes client’s emotional state
   -therapist is aware and monitors client’s emotional state

27) Therapist has Client do Guided Imagery/Autosuggestion/Desensitization
   -therapist has client imagine

G. Other

28) Miscellaneous
   -any incident that does not fit into any category

1 In fact, there are 32 categories, however, not all were numbered individually.
APPENDIX X

Categories of Second Set of Index Cards
Protocol for the Card Raters

The second set of index cards has only 8 categories and once I have explained the meaning of the categories I will show you 5 sample cards and ask you to place them under the appropriate heading.

I will now explain what each category means. Most are self-explanatory while some categories may need more explanation. While I go through this procedure please feel free to ask any questions.

1. Client Motivation
   - cathartic therapy is painful and takes time and the client must be prepared to invest time, energy, money in order to do long term therapy

2. Qualifications of Therapist
   - therapist must be well trained and must have gone through cathartic therapy as a client as part of his training; in order to understand and not to panic or block the process

3. Qualities of the Therapist
   - therapist is empathetic, supportive, accepting, caring and has has unconditional positive regard for client & faith in the client
   - therapist is honest, warm and shares his feelings (self-disclosure) with the client
   - the therapist must have his own life; take care of himself and be in tuned with himself and his feelings

4. Therapist and Client Relationship
   - rapport must exist between therapist and client which often takes time
   - client must trust the therapist which also takes time

5. Therapist Provides Emotional Safety
   - therapist respects client's boundaries and does not push him to go further emotionally than the client wants to go nor does he touch him without permission
   - therapist informs client about his methods and about the process of therapy
   - provides a debriefing, re-integration and proper closure
at the end of the session

6. **Therapist Focuses on Body/Breathing**

   - physical manipulation of the body
   - deep breathing
   - body position

7. **General Therapeutic Techniques**

   - challenging
   - modelling
   - have client exaggerate
   - pacing
   - have client talk directly to source of pain

8. **Other**

   - miscellaneous
APPENDIX XI

Discarded Incidents After Independent Rating of First Set of Cards

These incidents were discarded because no agreement could be reached among the independent raters (any identifying information has been edited).

1. Thp: "Notice the feel of your clothing against your skin; the pressure of your body on the cushions."
2. I gage my delivery to her breathing, extending the vowels to deliver the message to relax.
3. Thp: "Focus on your feet; the neck, the throat, the legs, the eyes, nose mouth chest."
4. Clt is still throbbing.
5. Clt got on his knees and started beating the walls.
6. I (thp) took my hands away from her chest and went up to her head and held it.
7. At this time the clt reached out and grabbed my arm.
8. I asked the clt to blow out any kind of tensions she was experiencing.
9. I told her to relax her chest muscles.
10. Thp: "Think the word completely and think the word calm as you breathe in and out."
11. Thp: "Start talking about it (clt’s anger)."
12. Clt: "There is a numbness below my waist."
13. Thp: "Stay focussed on that."
14. Clt: "This can’t be true."
   Thp: "Well that may be but obviously there is stuff going on in your body so let’s follow that."
15. Thp: "You may find different feelings throughout your body; feelings of lightness, warmth, tingling, whatever.
16. Thp: "what is it that makes your body tremble and shake?"
17. Thp: "A calm mind is a controlled mind; a controlled mind is a controlled body and a controlled mind allows you to achieve those thing you want to achieve in your life time."
18. Before doing relaxation the thp explains the use of relaxation and how it can help anxiety.
19. Thp: "Are you alright?"
20. As the clt’s breathing slows down I (thp) slow down my delivery.
21. I (thp) also model relaxation, relax my body, voice etc.
22. I (thp) explain that it (relaxation) is a skill that people need to learn.
23. Before doing relaxation, thp talked about relaxation technique and guided imagery.
24. I (thp) am always in vision with him and it does not matter where he is, I will move so he can see me.
25. Thp: "Be aware of the feel of the air against your skin."
26. Thp: "People do not always feel relaxed immediately, and they do not always feel that they have done very well."
APPENDIX XII

Discarded Factors After Independent Rating of Second set of Cards

These incidents were discarded because no majority agreement could be reached among the independent raters (any identifying information has been edited).

1. I see what I do as a kind of parenting.
2. I tell clients I am experienced in this form of (cathartic) therapy.
3. I have clients sign a contract that they cannot hurt me, themselves or break up the office. They sign a waver.
4. It is very important that there is appropriate equipment so the client knows that they can safely discharge. You need mattresses, things that they can pound the shit out of. I orient my clients to this in the first few sessions. I say I have this mattress for this purpose. I have this punching bag for this purpose. I provide an environment where it is okay to let it rip in here.
5. When clients reveal this vulnerable and revealing material; you have to receive it well and encourage.
6. I do not do short-term therapy only long-term therapy.
7. In terms of expression it is wide open including negativity towards me.
8. I provide a slowing down—I take the adult restraints away. I want the office to have a sense of timelessness. Clts can do whatever they want; to actually become like children.
9. I get them to write about their childhood; their autobiography.
APPENDIX XIII

Common Factors/Behaviours/Conditions
(thp = therapist-subject)

A. Staging
1) Soundproof Reliving Room
2) Rm has Mats/Recliner/Pillows

B. Client/Therapist-Subject Relationship--Time Element
3) Therapist-Subject Seeing Client 2 months & up
4) Therapist-Subject Seeing Client 1/2 times weekly

C. Therapist-Subject Directs and Monitors the Client’s Body/Position/Movement/Reactions
5) Body Position "B": Clt is Lying Down/Reclines and Therapist-Subject Sits Beside or Behind
   -client is lying down/reclining on his back with thp beside or behind
6) Therapist-Subject Monitors Client’s Body--Position/Movements/Reactions
   -thp monitors the clt’s posture, body position & movements
   -thp monitors the clt’s bodily reactions
7) Therapist-Subject Directs Client’s Body--Position/Movements
   -thp directs the clt to change body position
   -thp directs the clt to move his body in a certain way, e.g. kick

D. Relaxation
8) Therapist-Subject has Client wear Loose/Comfortable Clothes
9) Therapist-Subject Monitors & Directs Client’s Breathing
   -thp monitors client’s breathing
   -thp describes client’s breathing
   -thp directs client to breathe or breathe in a certain way
   -thp is focussed on client’s breathing

E. Emotional Safety
10) Therapist-Subject Will Extend Session Time
11) Client May Call Therapist-Subject After Session

F. General Therapeutic Techniques
12) Therapist-Subject Tone of Voice is Calm/Gentle/Relaxed
13) Therapist-Subject & Client Talk for 10-30 minutes
14) Therapist-Subject Monitors Client Talking About Symptom/Issue/Past scene in Past Tense
   -client talks to therapist about a problem--past or
present in past tense
-client recalls/talks to thp about a past event--not in the present tense

15) Therapist Directs Client Speak/Behave in Present Tense
-thp directs client to speak to a person as if he is there
-thp asks questions about an event as if the client is really there
-thp directs client to behave as if past event is really occurring

16) Therapist Monitors Client Speaking/Behaving in Present Tense
-client speaks in present tense about past event
-client behaves as if a past event is really occurring

17) Therapist Monitors Client’s Emotions
-thp describes client’s emotional state
-thp is aware and monitors client’s emotional state

Uncommon Factors/Behaviours/Conditions

18) Subdued Lighting in the Reliving Room
19) Body Position "A": Therapist-Subject & Client Sitting Opposite or Beside Each Other
20) Session is Extended to 1 1/4 to 1 1/2 hours
21) Scheduling After Session
-thp does or does not give directions to client

22) Therapist-Subject Touches Client
-thp touches the client’s body

23) Therapist-Subject Directs Client to Relax
-thp directs client to relax
-thp directs client to relax his muscles
-thp directs client to be calm, peaceful, restful, less tense

24) Therapist-Subject Directs Client do Guided Imagery/Autosuggestion/Desensitization

25) Therapist-Subject Directs Client to Focus on Feeling
-thp directs client focus on a feeling
-thp directs client to "stay" with the feeling
-thp directs client to express the feeling

26) Therapist-Subject Comforts and Reassures Client
-thp offers protection/support
-thp is respectful of boundaries

27) Therapist-Subject does Nothing During Relive Process
-thp just sits back; watching & listening

Other Factors/Behaviours/Conditions

28) Therapist-Subject Uses Music
-thp puts music on or off
-thp has music playing in his session
-thp is about what to do after the session

29) Therapist-Subject Directs Clt to Recall Past Scene
-therapist directs client to remember a past scene
-therapist directs client to recall a past scene
30) Therapist-Subject Directs Clt to Focus on Body Feeling
   - thp directs client to focus on a feeling in his body.
31) Time factor
   -thp states that a particular event took
     a certain amount of time
32) Miscellaneous
   - any incident that does not fit into any category

Factors considered most critical by the 15 therapist-subjects
in the facilitation of the reliving process.

A. Qualifications of Therapist

-therapist must be well trained and must have gone through
cathartic therapy as a client as part of his training; in
order to understand and not to panic or block the process

B. Qualities of the Therapist

-therapist is empathetic, supportive, accepting, caring and has
unconditional positive regard for client & faith in the clt
-therapist is honest, warm and shares his feelings (self-
disclosure) with the client
-the therapist must have his own life; take care of himself and
be in tuned with himself and his feelings

C. Trust/Rapport within Therapist and Client Relationship

-rapport must exist between therapist and client which often
takes time
-client must trust the therapist which also takes time

D. Therapist Provides Emotional Safety

-therapist respects client’s boundaries and does not push him
to go further emotionally than the client wants to go nor does
he touch him without permission
-therapist informs client about his methods and about the
process of therapy
-provides a debriefing, re-integration and proper closure
at the end of the session
APPENDIX XIV

Table 33

Table 40 represents all the factors/behaviours/conditions considered crucial by the 15 therapist-subjects in the facilitation of the reliving process. The frequency of specific factors was not accounted for in Table 33. For example, if a particular therapist identified a specific factor more than once, albeit within a different context, his/her 2 responses were categorized under the same heading and counted as one.

Table 33

Factors/Behaviours/Conditions Considered Crucial by Therapist-Subjects in the Facilitation of the Reliving Process

<table>
<thead>
<tr>
<th>Factors</th>
<th>Primal</th>
<th>Hypno</th>
<th>Bio</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Qualifications of Thp</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>15</td>
<td>100%</td>
</tr>
<tr>
<td>B. Qualities of the Thp</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>C. Thp &amp; Clt Relationship</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>12</td>
<td>80%</td>
</tr>
<tr>
<td>D. Thp Provides Emotional Safety</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>73%</td>
</tr>
<tr>
<td>E. Client Motivation</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>F. Thp Focuses on Body/Breathing</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>33%</td>
</tr>
<tr>
<td>G. General Therapeutic Techniques</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>47%</td>
</tr>
<tr>
<td>H. Other</td>
<td>1</td>
<td>--</td>
<td>4</td>
<td>5</td>
<td>33%</td>
</tr>
</tbody>
</table>

Note: Bio = Bioenergetic therapist-subject. Hypno = Cathartic Hypnotherapist-ect; Thp = therapist-client; Clt = client.