

CATHARSIS AND SELF-REGULATION REVISITED: SCIENTIFIC AND CLINICAL CONSIDERATIONS¹

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At this point in time, it is obvious that Bioenergetic Analysis can neither remain solely within the limitations of its original energy concepts, nor can it afford to lose its roots and become lost in the recent relational and process oriented approaches. In part, its viability will require that it expands its conceptual framework and cast a curious eye on the research from contemporary neuroscience. A continual reevaluation of old and integration of new concepts is necessary for surviving and thriving. This is also true in similar ways for the broader arena of body psychotherapy and much of my article will apply to other schools of body psychotherapy.

This article reevaluates and attempts to modernize an old concept, once crucial and revered, but now considered mainly inappropriate for clinical use. It explores whether the classical concept of catharsis, once a hallmark, still has a place in contemporary Bioenergetic Analysis; and if so, how it needs to be modified and elaborated. A reevaluation of the catharsis concept will also need to include a renewed understanding of self-regulation, the process catharsis does (or does it?) set in motion. For a while now, I have been interested in what roles high and low energetic charge, and the duality and balance between them, play as agents of change in the therapeutic process. The concept of catharsis is definitely a focal point in the debate about the significance and usefulness of therapeutic work with high vs. low charge.

My main thesis is that catharsis-promoting interventions and cathartic experiences can have an essential and well defined role in body psychotherapy, if and when a patient's high intensity cathartic experiences become integrated within the patient's self and are transitioned and extended into her everyday life - with its lower levels of intensity.²

¹ This article is the translated and revised version of an earlier article published in German, in: Geissler, P. (Hg.) (2004): Was ist Selbstregulation? Giessen. (Psychosozial Verlag), S.95-119

² For stylistic brevity, I will employ the pronoun "her" throughout this paper.

In order to explore this thesis, I will begin by reviewing the role that catharsis has played in the evolution of psychotherapy as we know it today. Recent approaches from the neurosciences and theories of emotion, their research findings and their theories, shed new and helpful light on the concept of catharsis, and I will review and apply this material that is particularly relevant for an in-depth understanding of cathartic processes. I will then move on to define, describe and differentiate the various therapeutic processes involved in catharsis, and argue that an expanded concept of catharsis hinges on an expanded concept of self-regulation and the integration of cathartic experiences into the person and into her ongoing life. Finally, there will be some case-vignette notes to illustrate how the expanded concepts operate in actual clinical practice.

History and Current State of Affairs

From their founding years, through the humanistic psychology movement and then into the 1980s, a considerable number of body psychotherapies considered cathartic experiences an essential goal of therapy, leading to the widespread and sometimes exclusive use of catharsis-promoting interventions. They relied on cathartic experiences for a variety of reasons: it was dramatic, it was different, it seemed to show fast results, and at the end of the session the patients felt good (and the therapists powerful). Then came a major paradigm shift, a rollback, relegating cathartic work to the slightly “dirty” corner, with non-cathartic, i.e. softer interventions becoming the hallmark of the “good” therapist”. And we are still living out this shift. This dramatic change is partially due to an attempted rapprochement to more mainstream therapy schools, particularly the relational theories and trauma related approaches, and partially - not to be underestimated - with political correctness and the “feminization” of the therapy professions.³ And at the same time, the self indulgent “love affair” that some body psychotherapists had with their interventions and the often insufficient attention to the patient’s words and the lack of relationship that used to go hand in hand with cathartic interventions, also played a significant role in this Hegelian counterreaction.

Historically, the use of cathartic methods, like hypnosis, and the therapeutic relevance of cathartic experiences dates back to Freud, Breuer and the beginnings of psychoanalysis. In their studies of hysteria, they emphasized the importance of affect and its discharge, arguing that remembering without affect is ineffective (Freud and Breuer 1970). But soon Freud cast cathartic methods aside in favor of

³ It is probably more than accidental that the intense energy models were developed by men, at a time when male therapists dominated the therapy profession by sheer numbers. With the “feminization” of the profession, relationship oriented models took center stage. Looked at with a Hegelian eye, the next movement should be towards a synthesis since both passion and relationship are central to human life.

other methods that he developed for bringing repressed and unconscious material to consciousness, i.e. the techniques of free association and the interpretation of dreams.

Reich considered the abandonment of catharsis a major error, picked up on Freud's original work on catharsis and made it a central aspect in his classic work on character analysis (Reich 1983). He expanded Freudian drive theory by introducing the concept of bodily defense mechanisms, the energetic counterpart to psychic defenses, thus developing an understanding of, and model for, the interaction of mind and body. Subsequently, he went on to develop not only new methods for treatment but a holistic model of human behavior, based on an intuitively appealing but scientifically questionable energy concept. This is not the place for a comprehensive assessment and critique of Reich's theories and ideas, and I will rather refer exclusively to the concepts that are relevant for our purposes.⁴ Reich differentiated between the neurotic and the genital (healthy) character, and his therapeutic treatment consisted of confronting and breaking through the character armor and dissolving the characterological and energetic resistances in order to reestablish the free flow of energy, unblock emotional impulses, and finally increase and deepen sexual experience.

Both, Reich's concept of the character armor that needs to be breached as well as his approach to treatment seem representative of his deep belief in the efficacy of cathartic methods. Once the armor was dissolved, he relied on the self regulating capacities of the human system (Reich 1983, p.185):

“As far as our clinical practice is concerned, there can no longer be any doubt that every successful analytical treatment, i.e. one which succeeds in transforming the neurotic character structure into a genital character structure, demolishes the moralistic arbiters and replaces them with the self-regulation of action based on a sound libido economy“.

Cornell, in discussing Reich's ideas, points out how much self regulation is seen by Reich as a direct consequence of catharsis, and is viewed as an automatic process that requires no further therapeutic effort and thus no therapeutic relationship for integration.

“It seems that for Reich if the armor could be dissolved in session, the patient/organism becomes more self-regulating within his own somatic and energetic processes. The body comes more alive through the deepening of somatic and orgastic capacities. The relational “work,” relational change, comes through the genital embrace. The relational “work,” as such, occurs outside of the session” (Cornell 1997, p. 55).

⁴ Without doubt, Wilhelm Reich is one of the most influential but also one of the most controversial founding fathers of body psychotherapy. His ideas and treatment methods are at the root of a number of contemporary body-oriented therapy schools (prominent among them my own approximate professional home, Bioenergetic Analysis). Many of Reich's original ideas and their understanding and interpretation inspired an ongoing, often controversial discussion in our discipline. An extensive, detailed and differentiated overview is found in Cornell (1997) and Downing (1996).

Lowen based his formulations and development of the basic concepts of Bioenergetic Analysis clearly on a number of Reich's early ideas, particularly on his understanding of character and character analysis (Lowen 1958). His own understanding and use of catharsis though changed over time. Bioenergetic Analysis aims not just for feeling but for depth of feeling and has developed interventions to reach that goal, so cathartic work in the tradition of Reich was frequently employed in early Bioenergetic Analysis. Over time though, and at least in his later writings, Lowen changed his position and is surprisingly relational and process oriented, creating room for the role of the therapist and the necessity of integrative work.

“However, the breakdown of ego defenses is not a legitimate goal of therapy. Such defenses are to be respected unless one can help the patient develop a more effective way of dealing with life stresses. The breakdown is only valid if it leads to a breakthrough. This involves the development of insight and integration of the new feeling into the personality.” (Lowen 1980 p.157).

While cathartic work played an important role for many body psychotherapies in the expansive and taboo-breaking sixties and seventies of the last century, it subsequently became the target of severe criticism. The use of cathartic experiences as agents of therapeutic change, growth and healing has steadily declined, as relational theories, trauma therapies and spiritual approaches have taken center stage. The bulk of the criticism points particularly to three potential problems: the possibility of retraumatization through the high charge and intensity involved in this work (Ogden & Minton 2000), the assumed short lived nature of insights originating from or conceived during cathartic experiences, and the danger of getting stuck in an ‘addiction’ where patients keep seeking out cathartic experiences for their feel-good potential. These criticisms and concerns are part of the more general debate about the role of and balance between energy and relationship, security and intensity, low vs. high energetic and emotional charge as therapeutic agents. The most comprehensive critique - albeit within the frame of a critical appreciation of the ideas of Reich and Lowen - comes from Downing (Downing 1996, p.74):

“In my mind the concept of catharsis suffers from the fact, (...) that many patients with early disturbances (whom we call borderline patients today) did not benefit from this treatment. The feelings that were set free were simply too overwhelming. (...) Some of the more stable patients that felt quite comfortable with strong emotions seemed to “get stuck” in their cathartic outbreaks. As a result their affective explorations became stereotypical and slightly artificial.”⁵

More generally, Downing thinks cathartic techniques are too provocative and aim too rapidly at a mobilization of intense feelings. I will respond to this criticism at a later point in this paper.

Very recently, the strong pendulum swing has been called into question, judging from some articles, conference contributions, and oral communication among colleagues. Cornell makes a case for “the reconsideration of the place of passion (...) within contemporary psychodynamic and body-centered

⁵All translations from German into English are made by the author.

psychotherapies” (Cornell 2003, p.2). Pope considers both catharsis and containment to be relevant aspects of a healing process and argues (Pope 2000):

“Abuses of the catharsis phase have created an understandable avoidance of ungrounded and overwhelming use of emotional expression. Over-reliance on containment can also cause a stuck or incomplete process. Shifting a focus to appropriate expression and action can help people tend to unmet needs and complete unfinished processes, establish self-regulation, and healthy contact” (Pope 2000).

Klopstech, with her definition of “energetic insight” creates a connection between deep emotional insights that accompany energetically and emotionally intense experiences with their cognitive-verbal representation of these experiences:

“By ‘energetic insight’ I mean the cognitive insight that goes together with the actual physical and emotional experience of a shift inside the patient.” and “The crucial component here is the almost-simultaneity of thought/feeling/body sensation. The simultaneous emergence and togetherness makes for the depth of experience and the experience of a shift inside” (Klopstech 2000, p.60; 2002, p.67).

An energetic insight often tends to include, with a little time lag, the more verbally symbolic brain, indicated by a verbal expression, a word or a sentence, but the resulting expression can also be physical, a deep sigh, a spontaneous gesture, or a smile.

What these recent contributions have in common is that they consider high intensity and deep feelings to have an important therapeutic impact, but they do not assume emotional health as an automatic and immediate consequence of the experience.

The Decade of the Brain and the Renaissance of Emotion Theories

Essential contemporary contributions to the body psychotherapy topic of arousal/intensity/energetic charge as well as to the notion of self-regulation come from unexpected sources outside of body psychotherapy: neuroscience and emotion theories. Through modern imaging techniques, the neurosciences experienced a growth spurt during the nineties, the “decade of the brain” as Damasio (1994), one of its early and prominent proponents, named it. At around the same time, theories of emotion experienced a renaissance, characterized by a variety of overlapping and competing models as well as by research data.

The neuroscience of regulation processes

In a relatively new interdisciplinary endeavor “the best of modern science [converges] with the healing art of psychotherapy” (Siegel in Schore, 2003a, Preamble), and the results from neurobiology and neuropsychology are applied to understand and describe the origin and development of the self. What emerges from this meeting and overlapping of the various fields of neuroscience, infant research and psychotherapy theories is a complex, dynamic and holistic (brain-mind-emotion-body) view of the human being. The new discipline of interpersonal or affective neuroscience focuses on the basic role that brain bodily phenomena play in the process of change. This new knowledge and scientifically based understanding is of particular importance for us as body psychotherapists because it relates to the interplay of body, mind, emotion and interpersonal relations, which is at the heart of our therapeutic enterprise. Very recently, bioenergetic therapists have started to consider the implications of neuroscience for their field (e.g. Koemeda 2004, Koemeda & Steinmann 2003, Lewis 2004, Resneck-Sannes 2003a,2003b). And, for the first time from outside of body psychotherapy, the body is treated as an active and necessary protagonist for understanding development and process in psychotherapy, rather than being considered helpful at best and not essential at worst.

“The brain is but one component of the complex system that is our body. We take in information and interact with the world through our bodies, and our bodies change with – and in some cases change - the cognitive and emotional processing” (Kutas & Federmeier 1998, p.135).

This is certainly a statement in keeping with the bioenergetic tradition!

What could the actual application and integration of neurobiological and neuropsychological findings into the therapeutic domain look like? One possible organizing frame is provided by the concept of self regulation and the critical relationship between affect regulation and the organization of the self. By far the most comprehensive work, an overview and evaluation of research data as well as a regulation theory and its application to psychotherapy and psychiatry, is provided by Schore in numerous articles and three remarkable books (1994, 2003a, 2003b). I will first present his view of the therapeutic relationship, then, more pointedly addressing our topic. I will focus on his regulation theory and his definition of self-regulation, both of which I view as neurobiological underpinnings for different aspects of cathartic processes.

At the heart of Schore’s understanding of the therapy process is his claim that

“...the therapeutic relationship can alter the patient’s internal structural brain systems that nonconsciously and consciously process and regulate external and internal information, and thereby not only reduce the patient’s negative symptoms but expand his or her adaptive capacities” (Schore 2003, p xvii).

He combines developmental research data of mother-infant interaction, neuroscience data and various psychoanalytic theories to describe the “psychobiological mechanisms by which the attachment relationship facilitates the development of the major self-regulatory structures in the infant’s brain” (Schore 2003a, p.xiii). He then applies the developmental concept to models of the

psychotherapeutic process: “If development fundamentally represents the process of change, then psychotherapy is, in essence, applied developmental psychology” (Schore 2003a, p.xvii). To make the shift from the maturing brain of infants to adult brains he uses neurobiological findings of continual right brain growth spurts throughout the lifespan “...the adult brain retains elasticity, and this elasticity, especially of the right brain that is dominant for self-regulation, allows for the emotional learning that accompanies a successful psychotherapeutic experience” (Schore 2003a, p.xviii).

For our agenda of revivifying the role of catharsis in Bioenergetic Analysis and body psychotherapy, Schore’s regulatory theory and his definition of self-regulation are of particular interest. He distinguishes between two different forms of regulatory strategies, the conscious, voluntary and verbal control of emotional states lateralized to the left hemisphere and a nonverbal right-lateralized regulating function. Both sides of the brain share in the task of self-regulation, but they have different functions and different patterns of cortical-subcortical connections. The conscious left-lateralized regulation of emotion is a “top-down” process (LeDoux 1996, p.172) with the upper and frontal parts of the cortex dominating subcortical activities. This is a more familiar regulation strategy, known as the concept ‘that we change the way we feel by changing the way we think’ and it is at the core of cognitive psychology and cognitive psychotherapy. Of more recent vintage, and relevant for the nonverbal, body-to-body communication between therapist and patient, is the research of the regulatory function of the right brain hemisphere. In general, the right hemisphere is dominant for the reception and expression of positive and negative emotions and for the coping with stress and uncertainty. More specifically this hemisphere is dominant for the implicit cognitive processing of facial, prosodic and bodily information that is embedded in emotional conversation. This applies to appraising interpersonal and social context, and it refers to such crucial nonverbal (and of course also verbal) therapeutic agents as attention and empathy. Thus, it encompasses information specific to the process of body psychotherapy, e.g. facial expression, quality of eye contact, voice, spontaneous gestures, touch and body contact. Contrary to the left hemisphere, information processing here is seen as a “bottom-up” process: More specifically, Schore considers the right brain to be the biological substrate of the unconscious. He describes a hierarchical model of the self with cortical and subcortical structures of the right brain representing the unconscious and deep unconscious, and the orbitofrontal regions the preconscious.⁶ In this view, as we shall see later

⁶ Schore gives a detailed description of his understanding of the right brain as the biological substrate of the unconscious. For that matter, he reconceptualizes both Freud’s structural model of the id, ego and super-ego, as well as the topographical model of unconscious, preconscious and conscious (Schore 2003a, p.250-277). I am using his topographical model here, where he refers to a “three-tiered vertically organized hierarchical limbic system, with the right orbital prefrontal cortex acting in an executive function for the right cortical hemisphere and its subcortical connections, that is for the entire right brain (Schore 2003, p. 272).

Not relevant for this article, but of particular clinical interest are his ideas about the origin of narcissistic disturbances (Schore 2003a, p.151-186) and his psychoneurological model of projective identification (Schore 2003a, p.58-107).

on, cathartic processes, and the energetic insights they generate, can be understood as brain bodily “bottom-up” processes, originating in the unconscious subcortical or cortical regions of the right brain, then emerging in the preconscious higher regions of the right cortex, and (most often) completing with a conscious and verbalized insight of the upper and frontal left cortex.

In addition, Schore provides a definition of self-regulation that includes Reich’s understanding and is also more encompassing in that it makes room, even emphasizes the role of the interplay between therapist and patient. He distinguishes between an interactive and an autonomous, non-interactive mode and he postulates the flexible use of both modes as the hallmark of successful self-organization: “... self-regulation [is] the ability to flexibly regulate emotional states through interaction with other humans - interactive regulation in interconnected contexts via a two-person psychology - and without other humans - autoregulation in autonomous contexts via a one-person psychology -” (Schore 2003, p.259).⁷ The source from which such flexibility evolves is a secure early relationship: “The adaptive capacity to shift between those dual regulatory modes, depending on social context, emerges out of a history of secure attachment interactions of a maturing biological organism and an early attuned social environment” (Schore 2003, p.259). The importance and essence of any dyadic self-regulation, e.g. in the therapeutic dyad, is the expanded affect-regulatory capacity of the individual through the joint resources of the dyad, which serves as a “growth facilitating environment”, as Schore calls it.

Let us now look at Reich’s understanding of self-regulation in the context of Schore’s. It is Reich’s prerogative to be the first theoretician and clinician to have formulated a holistic concept for the inherent human striving for self healing and self-regulation, and thus for the striving for full aliveness and vitality. At the same time, his concept was too constrained by his understanding of the therapy process and in all likelihood also because of the kind of person that he was. In the context of therapy, it was limited exclusively to autonomous self regulation and it viewed relational change purely as a result of this self-regulation, not as an integrated part of the broader therapy process. Within parent-child interaction though, Reich considered the capacity for ‘orgonotic contact’ by the parents to be an absolute necessity for the vitality and self-regulation of the child, but to my knowledge he did not draw any conclusions from this for adult self-regulating behavior.

In summary, taking together Schore’s model of the therapeutic relationship, his dual hemisphere regulation theory and his understanding of self-regulation, and theoretically applying it to a moment-to-moment body psychotherapy process, his view of an optimal therapy process might look something like

⁷ One-person psychologies focus rather on the inner dynamic and the autonomy of the patient, while one- and one-half- and two-person-psychologies focus more on the relationship dynamic between patient and therapist. Compare Stark (1999) for a psychoanalytic and Klopstech (2000) for a bioenergetically oriented description of these concepts.

this: The empathic therapist is attuned and pays attention to the patient with her body and “left ear”. This involves both cortical and subcortical processing in the therapist’s right brain: while the right amygdala acts as a sensor of unconscious affective communication, the right orbitofrontal cortex comes into play with the preconscious processes. It is here that amplification of affect takes place, within the intersubjective field, through the resonance of the therapist with his/her patient. This interactive regulation enables the patient to begin to verbally label the affective experience, first with an inner word that needs to be “heard” by the therapist, then with a spoken word. It is here that the left hemisphere comes into play.

“The patient’s affectively charged but now-regulated right brain experience can then be communicated to the left brain for further processing. This effect which must follow a right-brain-left-brain temporal sequence, allows for the development of linguistic symbols to represent the meaning of an experience, while one is feeling and perceiving the emotion generated by the experience” (Schoore 2003a, p.268).

Theories of emotion

Another source of important contributions is from recent theories and new research on emotion.⁸ I will present three different yet overlapping theories and therapy approaches that are both representative of their field and relevant for our understanding of catharsis, cathartic processes and self-regulation. Greenberg, a researcher/therapist, is well known for representing the humanistic-experiential direction within emotion theory. His ‘Emotion-Focused Therapy’ considers intensity, expression and reflection to be major agents of change (Greenberg 2002). These three elements are, as we shall later see, the same agents that make cathartic experiences happen and cause their integration to be possible. Greenberg defines emotions in terms of cognitive, affective, motivational-behavioral schemes that produce a bodily felt referent. He describes the adaptive and meaning producing quality of emotions (Greenberg 2002 p. 2): “... emotions are a fundamentally adaptive resource”, and he stresses the communicative and interactive function of emotions “[they are] also a primary signaling system that communicates intentions and regulates interaction”. He then concludes “Emotion thus regulates self and other and gives life much of its meaning”. With regard to therapeutic interventions Greenberg reviews research that provides mounting evidence for the close connection between emotional arousal, depth of experience and emotional focus on one hand, and therapy outcome on the other. He argues “that high

⁸ For the various definitions of emotion, its differentiation from affect and reviews about its role in psychotherapy, compare Greenberg (2002), Greenberg & Safran (1989), Roth (2001). As body psychotherapists, and particularly as bioenergetic therapists, our understanding of emotions tends to be based on energetic phenomena and I think it is important, if not necessary, for us to be well informed about how traditional psychology defines and understands emotions.

emotional arousal plus high reflection on emotional experience distinguish good and poor outcome cases, [at the same time pointing out that] (...) the expression and arousal of emotion can contribute to change (...) [but] the actual relationships among emotion, cognition, and somatic processes still remain unclear. Arousal and expression of emotion alone may be inadequate in promoting change” (Greenberg 2002, p.13). On the basis of these findings he concludes that emotional arousal has to be combined with meaning construction and reflection, i.e. with a process of metabolizing and integrating high intensity experiences. Greenberg’s work is particularly useful to body-centered psychotherapists since it is supported by research data and thus makes the therapeutic value of arousal (or in the language of bioenergetic analysis: energetic charge) academically respectable.

Another contribution relevant for our purposes comes from Traue (1998). At the core of his theory is the influence of emotional inhibition and repression on health and disease: “Emotion and health are two aspects of a psychobiological regulation where emotional inhibition plays a key role” (Traue 1998, p. 14). Similar to Greenberg’s approach he considers emotion to have a complex intrapersonal as well as interpersonal and communicative function. Taking this complexity into consideration he develops a multidimensional path model which describes the interconnection between inhibition and health. According to this model experience and expression of emotions have a crucial regulating function both for health and for social communication. Traue is within the academic tradition and has not developed his own therapy approach, but he provides a comprehensive overview of various therapy schools that promote expressivity, including a variety of body psychotherapies. In several instances he refers to the therapeutic efficacy of catharsis, stating:

“The scarcity of studies regarding the efficacy of cathartic elements in psychotherapy is surprising, because every psychotherapy promotes the patient’s emotional opening in expression and language. One could get the impression, that we are dealing here with an enduring aftermath of the psychoanalytical prejudgement of emotions, going hand in hand with the primacy of a culturally higher importance of cognition as opposed to the lowlife of the emotional ... Only an “emotional change” in psychotherapy itself could rehabilitate catharsis as an essential therapeutic agent” (Traue1998, p.376).

Yet another contribution, this time from the therapeutic domain, is provided by Fosha. With her ‘Accelerated Experiential-Dynamic Psychotherapy’ she develops a therapy model where “deep authentic affective experience and its regulation through coordinated emotional interchanges between patient and therapist are viewed as key transformational agents” (Fosha 2002, p.159). Experiencing, expressing and communicating deep affective states, Fosha calls them “core states”, as fully and viscerally as possible, is essential for achieving and maintaining emotional health.

“Core affect comes to the fore when defenses are not in the picture (...). The visceral experiencing of core affect releases adaptive action tendencies associated with each emotion (...). Examples of the adaptive capacities that come to the fore when core affect is fully and viscerally experienced are: the strength and

assertiveness facilitated by the full experience of anger, the clarity about one's basic needs and the resolve to address them often brought about by authentic self experience; or the capacity to trust, crucial to deepening intimacy, that comes with close and open relational experiences (...) [and going even further], the core state refers to an altered state of openness and contact, where the individual is deeply in touch with essential aspects of his own experience. In this altered state, the therapy goes faster, deeper, better: the patient has a subjective sense of "truth" and a heightened sense of authenticity and vitality; very often, so does the therapist" (Fosha 2002, p.160, 161).

It is the mutual regulation in the therapeutic dyad that fosters the full processing of core states. Like Schore, Fosha asserts that both individuals within a dyad have greatly expanded affect regulatory capacities resulting from the combined resources of the dyad. For the patient this means, that in expressing herself and receiving specifically tailored and attuned responses from the other, i.e. the therapist, the processing of core affect becomes complete.

Before taking a closer look at the different processes involved in catharsis, I will briefly review where these various research findings and therapy approaches converge, and how they relate to my considerations on catharsis. Greenberg, Traue and Fosha emphasize the importance of intensity and expression as therapeutic agents, with Greenberg focusing also on the after-the-fact reflection process. Intensity or high energetic charge and expression are hallmarks of cathartic processes, while reflection creates the path for their integration. Schore provides a model of a right-brain-left-brain process that can be understood as a neurobiological underpinning for the emergence of cathartic experiences and energetic insights. Schore and Fosha point to the enhanced self-regulating qualities for the patient through dyadic interaction, with Schore providing a neurobiological understanding for it. An expanded notion of self-regulation, including interaction between therapist and patient, is needed to make a plausible argument for a successful integration process after catharsis.

Catharsis

Catharsis: A definition

There is an absence of clarity and considerable confusion in the psychological and psychotherapeutic literature when it comes to understanding, applying and criticizing the concept of catharsis. As my next step I will attempt a working definition from which to make some clinically relevant distinctions between related, somewhat intertwined, but nevertheless different processes within the catharsis rubric.

'Catharsis' stems from the Greek word for cleansing, or purging, 'kathairein'. Merriam Webster's Collegiate Dictionary defines catharsis as

“ a) a purification or purgation of the emotions (as pity and fear) primarily through art; b) a purification that brings about spiritual revival and release from tension; c) an elimination of a complex by bringing it to consciousness and affording it expression” (Merriam Webster’s Collegiate Dictionary 1993, p. 181).

Given that Freud developed his ideas about catharsis inside the German language and that German is my mother tongue, I also will take into consideration a German language definition of catharsis. According to the Große Brockhaus, the quintessential German dictionary, catharsis is “the purification through emotional upset, according to Aristotle the impact of the [classical] tragedy, in psychoanalysis the abreaction of affect” (Der Brockhaus in einem Band 2003, p.466).⁹

The English language domain emphasizes more the impact and effect of the purification, while the German language domain emphasizes the cause and the development of purification. Together, these definitions account for the dramatic emergence into consciousness (insight): the process that brings something from the origin/ from the inside (emotional upset) to the outside/to the surface (expression). They also account for the quantitative and qualitative change (release of tension and spiritual revival). Catharsis is thus a concept which involves several distinct and different processes.

Cathartic experiences, the cathartic model, and processes by which catharsis is achieved

Cathartic experiences in body oriented psychotherapy are characterized by a discharge of tension; a spontaneous release of chronically tense holding patterns; a release that goes together with an undoing - dissolving, melting, breaking down - of characterological and energetic defenses; and by an emergence and breakthrough of feelings that aim for expression. This expression can take on very different forms: it can be a bodily expression like a gesture, or a vocal expression like crying or laughing, and/or it can be a verbal expression of a word, a phrase or a sentence. The result is a letting-go, a relief, a relaxation and a restoration; a release in the sense of a dissolving and in the sense of finding a solution; a freeing of impulses and words only dimly in the awareness and constrained and trapped in the preconscious, i.e.

⁹ Outside of the medical context of purification, the notion of catharsis was first used by Aristotle in his writings about the form and purpose of tragedy in his ‘The Poetics’. Catharsis in dramatic art has always remained an ambiguous notion. It never became clear – and has been interpreted differently throughout the centuries – if Aristotle meant for catharsis to be applied solely to the drama itself or if he described its intended impact on the audience. Catharsis is the moment of insight and simultaneously the moment of dramatic and characterological reversal. In this moment the audience, and then that was the entire community, becomes an involved witness. That is the high point of drama, the catharsis.

Catharsis as a community defining and community specific phenomenon seems to have an archetypal quality. All cultures, religions and societies tend to have some form of ritual catharsis, e.g. confession in the catholic church, the Yom Kippur day in the Jewish faith and community, grieving rituals of the Mediterranean people, puberty initiation rites of some indigenous tribes, even the forced self criticism of the Mao-Tse-Tung Regime falls into this category; or presidential elections in the US may also belong here.

I am indebted to my friend Kathleen Dimmick, a dramaturg and theater director, for spending her time with me in repeated discussions on the topic.

a “reorganization of impulses, action tendencies and inhibitions” (Geissler 1996, p.222); an opening to the outer world of things and people, and an opening to the inner world of sensations, feelings, images and memories. Cathartic experiences can either catapult us or, more gently, give us a glimpse into a world that is new or anew, different from just before, from yesterday, from ‘as usual’. This world may be clearer or more colorful or more serene, and in the subjective experience it is always somehow “better”. When the strong waves of emotions subside to a flow that is smooth and tender, cathartic experiences are frequently followed by a small or big wonderment, by a peacefulness and peace of mind, and by a much slower thought process:

“...the world looks clear and bright, the mind is awake yet slow, the feeling is sweet and the body at ease. For a while, feeling and thinking, inner and outer world are not in conflict with one another but in harmony; they follow the same rhythm and just are“ (Klopstech 1991, p.16).

With their “changed balance of impulse and resistance” (Geissler 1996, p.222) and their “turn around of sense and meaning” (Traue 1998, p.322) cathartic experiences become the ideal base for a new beginning.

And yet, there is reason for caution here: cathartic experiences and cathartic insights can, but do not necessarily have to lead to a long term purification, restoration or change. They are the basis for a new beginning, even an ideal basis, but in themselves they do not yet constitute or guarantee an enduring change. They carry an immense potential for healing, but they are not the healing itself. They are meaningful, at times earth shattering experiences, but they are experiences in the here and now that need completion and integration. Without an appropriate integration into the self and everyday life of our patients, cathartic experiences frequently are the missed chances in therapy. This notion is congruent with Greenberg’s research findings quoted earlier that arousal and expression of emotion have to be combined with meaning construction and reflection. ¹⁰

A cathartic model, i.e. a catharsis-oriented therapy model would see cathartic experiences as the primary goal of therapy and seek them out deliberately. Implicit is the assumption, that cathartic experiences have such a dramatic, even magical effect that they automatically either instantly create a personality change or automatically set in motion a self regulatory process that carries the seed for enduring personality change. The new feelings, thoughts, body sensations and insights are seen as taking hold in the self without further outside help, and they get magically and automatically integrated into life outside of the therapy session, i.e. they result in more or less encompassing behavior changes in everyday life. Once catharsis is achieved, phoenix rises from the ashes. Therapists who essentially work

¹⁰ Obviously, cathartic experiences and energetic insights overlap, but they do not quite describe the same thing. They both describe the same qualitative phenomenon, but they differ quantitatively: it would not be inaccurate to define energetic insights as “mini-cathartic experiences”.

in this therapy model may even get partial reinforcement for their approach, since the assumption of automatic self-regulation might at times apply for well functioning neurotic patients. We know how effective and resistant to extinction partial reinforcement is, and so, the cathartic model gets applied to all patients without diagnostic differentiation.

Another crucial differentiation pertains to the process of **arriving at cathartic experiences**. To this day, it is often erroneously believed that cathartic experiences occur only when defenses are confronted and broken down. The specific interventions leading to this break down are either very active and fast-acting mobilization techniques or physical techniques relying on stress and pain as the major agent; in either case they involve an increase of intensity and energetic charge.

Mobilization techniques are, in fact, frequently a method of deliberately creating cathartic experiences. But they are only one method among many others, and are in no way a method appropriate for every patient. The diagnostic capacities of the therapist play an important role here. For well functioning neurotic patients who use a powerful muscular armor to avoid experiencing powerlessness, insecurity and abandonment, or who cannot let down and relax, this may be the method of choice. The emotional turmoil, and the release and relief that they may only experience through a strong energetic discharge, frequently opens the door to buried feelings of vulnerability and tenderness. The path is freed for a new beginning, a restructuring where assumed-and-defended-against deficits can become potencies, where 'weakness' can become vulnerability, insecurity can become self-reflection and a sense of abandonment can be turned outward to motivate a reaching out to others. What takes place here is a shift in consciousness, the dramatic change of sense and meaning that is described by Traue.

For a fragile self though, that struggles to keep a secure footing and it's way in the world, the same intervention could be too overwhelming; the intervention may not lead to catharsis but to chaos, and rather than creating an opening, it can foster withdrawal and retreat from the world, or even dissociation.

In contrast to, but also in some sense complementary to mobilizing methods, are processes in therapy where the relationship between therapist and patient, or rather a momentary, particularized constellation of this relationship, can become the catharsis inducing factor. High energetic charge and emotional intensity plays an equally important role here, with the crucial difference being that the charge and intensity are generated inter-personally and not intra-personally. Body psychotherapy, with its abundance of body-to-body interventions has an extraordinary repertoire of techniques that can become carriers and facilitators for relational explorations. This happens if and when they are embedded in a proper context of transference and countertransference, in a 'co-created' relationship. The therapist provides either a corrective experience in the context of a one-and-a-half-person psychology or engages in an authentic relationship in the context of a two-person psychology. The cathartic experience comes

about through the felt intensity of relating and the accompanying or resulting emotions and body sensations. This kind of cathartic process, if in the context of a secure and safe relationship, can be particularly helpful for the treatment of fragile patients, because the experience is taking place under a high arousal level and yet is not retraumatizing. For trauma patients and patients with early disturbances, such cathartic experiences can play a key role in rekindling the faith in a ‘good enough’ world. Greenberg’s research described earlier in this paper constitutes a scientific underpinning of these kinds of processes leading to catharsis.¹¹

At this point, I will reiterate that therapeutic work with catharsis has its roots in Freudian analysis. Contemporary psychoanalytic relational theories, though not using the word ‘catharsis’, seem to manifest an acute interest in an interactive concept of catharsis, of course within their own therapeutic frame that does not involve direct body-to-body communication. Stern, Tronick and the Boston ‘Process of Change Study Group’ describe “moments of meeting” between patient and therapist that create an “open space” where a “shift in the intersubjective environment creates a new equilibrium with an alteration or rearrangement of defensive processes” (Tronick et al.1998, p. 915), not only inside the therapeutic relationship but also outside. Perhaps this is a rediscovery of catharsis, though not from the drive side but from a relational perspective.

And finally, there are cathartic experiences which are not consciously planned or and prepared for, but are just stumbled into. They can be generated by a “spontaneous condensation of relationship” within the therapeutic dyad. They can equally be generated by a “spontaneous energetic reinforcement” in the patient’s body, e.g. evoked by a specific remark or gesture. Often, it is enough for the therapist to stay back and just let the cathartic process unfold, to be the witness of something precious and new unfolding; at other times it can be helpful or necessary for the therapist to accompany the process more actively by getting relationally involved or by deepening the energetic and emotional experience via technique.

Thus, there are actually a variety of processes by which catharsis can occur. They range from ‘deliberately inducing catharsis as a therapeutic tool’ at one extreme to ‘recognizing catharsis and letting

¹¹ By no means do I want to give the impression that cathartic processes are a particularly suited method for working with trauma patients in general. They are not. But they are a possible method within the context of a safe therapeutic relationship. And for some patients, they actually help them develop a more robust ego and more tolerance for the world’s turbulence. Trauma therapies that emphasize step by step procedures (e.g. Ogden & Minton 2000) or focus on guided imagination with continual stabilization (e.g. Reddemann 2001) or incorporate both features like EMDR (Shapiro 1995) have proven to be quite successful, both in research and in clinical practice. At the same time, I do want to make a case for ‘somatic and interpersonal intensity’ as an agent of change, when it occurs in a safe and supportive therapeutic dyad and diagnostically selectively used for some patients with early disturbances and PTSD.

it happen as it occurs' at the other; from confrontative interventions to corrective experience interventions; and they can occur in an autonomous context or in an interpersonal one.

Much of the bad press for catharsis in body psychotherapy stems from an oversight or oversimplification of its process character. There is often an insufficient or missing differentiation of the various components involved and/or a resulting confusion between therapy goals, therapeutic agents and treatment strategies. And, the variety of interventions and individually different treatment styles and approaches that body psychotherapists have creatively developed and appropriated over the last quarter of a century have not been viewed as integral instrumentarium for therapeutic work with cathartic processes; too often catharsis is only associated with an outdated and simplistic 'hit-kick-and-scream' approach.

After Catharsis: The Integration Process

Another major criticism concerns the therapeutic process that follows cathartic experiences. Too often, there is no follow up process or if there is one, it consists more or less of a repetition of similar experiences, again and again. In my view it is the success or failure of the process following the original experience that determines the value of cathartic work in psychotherapy: Cathartic phenomena can have an essential role in body psychotherapy if and when a patient's high intensity cathartic experiences are integrated into the patient's self and are transitioned and extended into everyday life with its lower levels of intensity.

What does the process of integration and transitioning look like and how can and should the therapist move along and interact with this process? I have described how cathartic experiences with their freeing of impulses and feelings, rearrangement of defenses and creation of new meaning can serve as a basis for new behaviors and ways of being. I have also argued that this does not happen automatically, that self-regulation and integration are processes that need attention and tending. I want to refer again to Schore's definition of self-regulation and his description of an optimal therapy process. He describes self-regulation as flexible regulation, that can happen autonomously, i.e. with the patient relying on inner resources without help from the therapist, and it can happen as an interactive regulation within the dyad of patient and therapist. Both, the patient and the therapist need the capacity to be flexible, allowing them to switch, from moment to moment, between both regulation strategies.

For us as therapists, it requires attention and mindfulness, presence and acumen to adapt and respond to our patients' shifts. We need to listen with both our 'right' and our 'left' ear and look intuitively as well as with our analytical body readings in order to decide when we are needed as witness of a process and

“only” provide attentive presence, space and time, or when we are called forth to become more active as regulators.

For the patient, mindfulness and attention to their bodily and emotional impulses, small or large, and their impulses for action play key roles both for autonomous and for interactive self-regulation.¹² In the autonomous mode, the patient is keenly, and often quietly, self aware of her inner processes. She swings with them and allows for them to build until things fall into place and a crystallization of the experience occurs, either as a sentence, most often an ‘enabling sentence’, or as a completion of an impulse for action. The impulse may take the form of a spontaneous reaching for the hand of the therapist-- now the patient is ready to reach out into the world of people. Or, rather than being a movement just of the hand or the arm, it may be a movement of the whole body into the room, an expansive bodily movement that entails greater ownership of space. Or the patient’s inner process brings forth a sentence that captures the cathartic experience simultaneously with a new meaning. These sentences tend to show the way to future actions. I call them ‘crystallization sentences’ or ‘enabling sentences’ or ‘power sentences’. Typical enabling sentences for the first process just described could be: “My God, somebody is there for me! I just need to dare reach out” or for the second example “I am here, I am really here and this is my place!”. Dyadic interaction can help with further integration, by the therapist listening with a “resource-oriented ear” (Reddemann 2001, p.18) and looking with resource-oriented eyes. The therapist might offer herself for physical interaction, or offer a (body) experiment or a verbal exchange for further exploration of possible actions.

If we perceive that autonomous self-regulation is weak, we may be able to ‘hear’ a sentence that is yet inchoate for the patient or we may have a hunch about a gesture that is not born yet, and we can formulate the sentence or help the birth of the gesture, thus indicating, not leading the new way. Dyadic interaction builds a bridge here: From an ‘open space’ into the new land of a completed gesture and action, or new meaning and behavior. This is interaction at a low arousal level, at low charge. As body psychotherapists we also have the added advantage of more active interventions. Particularly, we can offer our direct somatic presence in the form of body-to-body-interaction and thus to direct right-brain-to-right-brain-interaction. The bodily interaction may ‘only’ consist of positioning ourselves in relation to the patient, standing or sitting, closer or further away, more to the right or the left, available for eye contact and directly in the field of vision or more to the side. The physical interaction can also consist in adapting the rhythm of our breathing to the patient’s rhythm, creating an intimate physical connection without direct body contact. Or, in direct body contact, we can offer our helping hand, our supportive

¹² Mindfulness is an ancient Buddhist meditation and healing concept, that has found its way into the western therapeutic arena, accordingly modified e.g. as “Focusing” in Gendlin’s work (Gendlin 1978), or as “Tracking” in Levine’s work (Levine 1997) and Ogden & Minton (Ogden & Minton 2000).

arm or we can actually ‘back’ our patient. And we can help our patients to get on their feet, first literally then metaphorically.

At this point I will describe a specific intervention that can be used in a variety of contexts, taking on different meanings within each specific context, and that has proven particularly useful in integrating cathartic experiences (Klopstech 1991). It is a simple, almost meditative intervention, that provides a somatic experience of unfolding, continuation and process. I ask the patient ‘to walk slowly and mindfully’, and with each step, have her feet make conscious contact with the ground, rolling the sole from heel to toe with the knees unlocked to encourage letting down and experiencing the presence and support provided by the ground. The head can rest easy on top of the spine, the eyes can relax and, without effort, look at what’s to be seen in the outside world. After a while, forward motion, emotions and thoughts blend into a rhythm and enabling sentences emerge: “life goes on, step by step” or ”things will work out, one step at a time” or “this is my way” etc. The felt forward-movement gives an experience of being grounded and simultaneously being in motion. This provides a sense of harmony with oneself and, at the same time, a sense of present and future, of being in process, more a right brain phenomenon, while the metaphorical sentence reflects the experience consciously and verbally, a left brain activity. Anchoring an experience in the self and transitioning it into everyday life, one step at a time makes sense energetically and emotionally. There are many opportunities for dyadic regulation here: I may witness and accompany with my voice and with words, or I may actually physically accompany the person. I may move towards my patient and we meet. At times we walk together, being on the same path for a while, until walking alone comes more easily. We may walk hand in hand, or just next to each other, looking out at the small world of my office, perhaps exchanging what we each see.

This integration is of a short term nature. It follows pretty much right after catharsis has occurred, making use of the release of tension, the let down of defenses and the resulting clearing. The same intervention, though, can be used for long term integration and transition. The felt forward-movement is an intervention involving the whole body and self, replete with metaphors like ‘moving ahead’, ‘ongoing movement’, ‘life goes on’, ‘to meet halfway’, ‘talking the talk and walking the walk’, and can be viewed and used as a way of ‘checking in’ with the integration process. In general, the cognitive processing changes with time, different yet related aspects and enabling sentences emerge, manifesting increased self-regulation and and at the same time increasing further self-regulation. The physical process may change, too. Insecure, tentative steps may transition to more secure footing over time, small steps may become more daring and longer while giant steps prone to wobbling may shrink to a manageable size. How well the physical and the cognitive processes match, the degree of balance between the body and mind, is an indicator of the quality of the integration process.

The high intensity and drama of catharsis may overshadow the fact that everyday life takes place on a lower level of intensity and excitement and that high intensity experiences do not automatically and magically integrate. The ongoing integration process needs continued attention and “care”. The therapist has the task of holding the integration and transitioning processes in the dyadic consciousness, i.e. to keep it alive in the therapeutic process without becoming responsible for it or controlling it. For some patients integration is easier for several reasons. They have more access to their inner life, are more action oriented in general, or are surrounded by people that help and support their endeavor – interactive self-regulation outside of therapy. For others, it is harder because the memory of the cathartic experience and its feeling of well-being are ethereal, and the new behaviors keep slipping out of reach. In this case, interactive self-regulation in the growth facilitating environment of the therapeutic dyad becomes even more important.

Clinical Moments

The following are examples of cathartic processes drawn from therapy. Some differ with regard to the processes leading up to a cathartic experience, others with regard to the integration processes, and still others differ in both regards. These segments are not case studies or even vignettes since they are cursory and moment-focused. They rather have the character of snapshots, embedded in and enriched with some background information. I call them clinical moments.

Classical mobilization

This clinical moment takes place during the sixth session. The patient is a rather stiff, shy woman in her late thirties with held back aliveness which at times breaks through in an unexpected laughter. Her main presenting problem is her social awkwardness, particularly in stress situations, resulting inevitably in sudden nausea occasionally accompanied by vomiting. At this point in her therapy we are both aware of the importance of movement for her. She finds it much easier to talk with me while walking around my office, moving her arms as she talks. From the context of this and previous sessions, I propose an experiment: to lie down on the mattress and move her arms and legs strongly in a kicking motion while at the same time using the word ”I”. It is as if a dam breaks: her whole body becomes involved in a series of increasingly strong, loud and determined “I” statements leading up to a triumphant finale. After a long pregnant silence she opens her eyes and her first words are “I see colors. Everything here in the room is so much more colorful ... three dimensional ... clearer ...”. As she looks at me, she blushes and gives words to what I also experience in this moment: “You feel so much closer now”. I tell her that my experience matches hers and ask her if she likes the feeling of being closer. This brings her back to the discovery of her new self and she starts thinking about whom she would like to be closer to in her outside life and which “I” sentences she can find to express her wish to her beloved ones and other

people in her life. She experiences herself as more engaged than usual and the world as more exciting and less thwarting. During the following sessions she frequently stops herself, takes a good look at me and tunes inside, checking out if and when she wants more closeness with me. She coins the phrase “Now I want to check in with my ‘closeness-I’. In her life she starts feeling less awkward and instead more carefree and easygoing.

Somatic and interpersonal intensity

The following cathartic situation occurs after three months of therapy. The patient is a forty year old woman. At this point in therapy, we are both aware that a big part of her life consists of fighting, starting with her family of origin South America and continuing here in the US where she started out as an immigrant without a Greencard, rising to become a well regarded physician. Her fighting mentality is manifested in a hard muscled body with the strong jaw of a warrior. Her overdeveloped calves and thighs insure that nobody will push her over! She feels understood and accepted in the relationship with me, and so I can offer her an intervention, deliberately not telling her its purpose so as not to influence her reaction. I tell her that I want to carry her on my hands and explain the technique. Her immediate reaction is surprise, disbelief and the concern that she will be too heavy ... then an apprehensive nod of her head. I lie down on the floor, on my belly with my arms extended forward and my palms turned upward. She slowly starts to move onto my hands with the soles of her feet. I can feel in my hands how she is letting down more and more, giving me more of her weight, relying on me to support her. She tells me how relieving this feels to her. Then I hear a deep sigh and she breaks into a sobbing that shakes her whole body ... but she remains on my hands ... crying for a long time. What comes to her mind when the sobbing abates is something she has not realized before: how much she criticizes and bosses her husband around with sentences like ”Why didn’t you do ...”. She is horrified. I say to her “demands harden and wishes soften”. She is quiet ... I ask her to slowly leave my hands and to move back onto her feet. She experiences the ground as softer than before, with more give. I ask: ”The way you would like to be?” The next session she tells me that during the past week she made a point of asking her husband rather than demanding and that she felt less exhausted than usual. “Also” she says half embarrassed, half fascinated “sex was much better”.

Spontaneous condensation ... and somatic and relational intensity

The next cathartic situation happens after half a year of therapy, unplanned and initially not deliberately encouraged by me. The patient, a tall but inconspicuous woman in her mid-forties, is married to an unreliable and flaky husband; he wants more space in the relationship, she wants more closeness and reliability. She comes from a large family whose roots go back to the first American settlers and whose men played an important role in American politics in the last century. We spent the last sessions dealing with how unimportant she felt in her famous family but also how this guaranteed her a place, albeit a

marginal one, in the family. This is a difficult topic for her! She becomes energetically ‘smaller and smaller’ as she talk. She bites her lips, lets her head hang, breaks eye contact and falls silent. I offer her the opportunity to hit on a foam cube with the words: “I am here and this is my place.” This is obviously not a helpful intervention and the hitting stays mechanical. I change my position, placing myself next and close to her so that she can see me from the corner of her eye and say ” I would like to know what you want to say ... what you want to say.” Her head flings up and she cries out violently “I don’t know where to go”. I respond “to me, now, today, here, to me ... with your eyes to me”. While she keeps sobbing, we spend the remainder of the session turned towards each other, half sitting, half lying on the mattress; she opens her eyes and I am there with mine, she closes her eyes and I stay there with mine and I am there with my eyes when she opens hers again. Now her words start to flow, many memories come up and find their way into words and sentences, memories of her family and what she had wished for; how much she wanted to be picked up by her father, wanted to sit on her mothers lap, how much she wanted a “normal family life”. She starts blossoming as we talk, our eyes still locked. At our next meeting she brings in several pictures that she painted after the last session. They are all colored drawings showing herself and her immediate family members. She either wears a red or yellow dress, always being center stage, on her mom’s lap, her dad’s arm, hand in hand with her brother. While she keeps painting pictures for the next sessions, bringing them in, showing me her fantasized and painted ideal family life, and while I listen to her and look at her in our therapy sessions, her actual family life of today starts improving. The relationship with her husband undergoes a significant change; she pulls him more down to earth and more into responsibility for the ongoing business of their daily lives. At the same time she becomes more open to his wishes for more individuality and boundaries in the relationship. They learn, together and from each other, to wish, to demand, to give in, to negotiate.

Concluding Remarks

Reflection on the therapeutic effect of catharsis is more than 2000 years old. It started with Aristotle, who ascribed – in contrast to his teacher Plato - to passion and catharsis the effect of promoting insight, of increasing the power of reasoning rather than squelching it. And to this day, artists, philosophers, theologians and anthropologists have struggled with the concept, each from their own vantage point and with their own agenda. For me, psychotherapy, which is a relatively young discipline can only profit both as an applied science and as an art, by sitting at the table with these long established disciplines and by becoming involved in the ongoing debates about the ever changing nature and meaning of ancient but enduring ideas and concepts. Catharsis is one such concept.

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