

Stanislav Grof's Holotropic Therapy System

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Abstract

This article explores the *Holotropic Therapy System* of Stanislav Grof. Although Grof's psychotherapeutic system is not well known, it will show that it is an important system and, in fact, acts as a theoretical framework within which many better known and more traditional systems of psychotherapy can be located. Grof has always fully recognised the *psyche* (soul) in psychotherapy, where the trans-egoic experiences tapped during therapeutic sessions facilitate the movement to full psychological health and, from there, to the full utilisation of human potential. An overview will be given, covering origins, underlying theory, the practice and the relationship between Grof's system and more traditional therapies. This will cover the cartography developed by Grof to embrace the range of therapeutic experiences undergone by 4000 clients. These experiences were located by Grof into one of three categories: *psychodynamic*, *perinatal* and *transpersonal*. In each category there is a matrix of states where they may be positively or negatively charged. The psychodynamic matrices are primarily biographical, the perinatal matrices relate to the four major phases of clinical birth and the transpersonal matrices cover those experiences that transcend ordinary ego states. Grof argues that healing comes about in the reliving of these experiences where they are integrated into adult

Taking an essentially survey approach, using the members of a New Zealand-based holotropic training group, by means of a mail survey and in-depth face-to-face interviews, the author explores the key concepts underlying holotropic therapy (eg, that altered states of consciousness are entered and that in these certain key experiences are relived) and the claims made of it (eg, that integration of the therapeutic experiences into waking consciousness brings about healing). Findings are presented.

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PART I

INTRODUCTION

In a book that is widely regarded as a comprehensive handbook of the activities included under the heading of psychotherapy, Raymond Corsini's and Danny Wedding's *Current Psychotherapies* (Corsini & Wedding, 1995), you will not find any reference to any of the following: Stanislav Grof, Holotropic, COEX, Basic Perinatal Matrices, good and bad womb experiences, body armour (except, perhaps, indirectly in a section on Bioenergetics Analysis), or Transpersonal matrices. I find this rather strange because, as this paper will show, the name Grof, and the other terms relate to a therapy that not only deserves mention, but is worthy of a section to itself. I will not speculate on why the therapeutic system I shall describe does not get at least a mention. That issue, in itself, could be the basis of a doctoral thesis.

However, as I go on, I hope that two things will become apparent. Firstly, I hope to show that not only is the therapeutic system I shall discuss worthy of a full statement in any putative handbook on psychotherapy, it has an overarching nature such that it embraces many other more traditional therapies. Secondly, I hope to show that this therapeutic system deals with aspects of human nature that either are not dealt with in any other therapeutic system, or are dealt with inadequately.

But more than wanting to provide evidence of the strengths of Grof's claims, I want to show psychotherapists that in his system not only do they have a theory and set of techniques they can use with clients, they also have a tool for use in their own self-growth. It is my firm conviction that, for psychotherapists to work successfully with clients they have to have done work on themselves. It is not enough to have a grounding in the theories and to have been trained in the practices. One's own stuff has to be at least faced, then progressively dealt with, before one can really understand where the client is coming from. There are many ways to this selfknowledge. However, for psychotherapists, clinical psychologists and other mental health professionals, I know of

no more effective way than Grof's techniques for rapidly accessing deeply repressed material and for working toward wholeness. In addition to these benefits, the theoretical underpinnings of the system are in a conceptual language that is readily anable to the mental health professional.

In this paper, I shall firstly give an overview of Grof's system. I will then move on to a presentation of the findings of an empirical study I have conducted using members of a New Zealand based Holotropic Breathwork group as subjects.

STANISLAV GROF

Stanislav (Stan) Grof (Grof, 1970a; 1970b; 1970c; 1972; 1973; 1975; 1980; 1985 and 1988) started his career as a medical doctor working in a psychiatric clinical setting, in his homeland of Czechoslovakia. There, in 1956, he joined the Psychiatric Research Institute of Prague, researching into psychedelic (meaning psyche revealing) drug use, using normal volunteers as control groups and schizophrenic patients as experimental groups, and applying a standardised set of examinations and tests. This team looked for the differences in effect between psychoactive drugs such as Lysergic Acid (LSD), mescaline and psilocybin. Grof did not share the growing view at that time that LSD-induced states were simply an unspecific brain reaction to a noxious substance (Grof, 1970c). In particular, to support his stand, there was the enormous range of responses he had observed. The classical description of an LSD session just did not fit everyone, and he began to see a psychodynamic association.

He sought to relate the phenomenology of the LSD experience to the personality of the subject, allowing for biographical data and the current life situation. In this work he did in Prague, he generated a large data base. Analysis of these data, arising from his work with his patients, indicated the highly specific relationship between LSD and subjects. What w needed was a formal understanding of the specific effects and symbolic language involved (Grof, 1972).

For most of Grof's patients one LSD session gave temporary relief of symptoms but, in the main, there was little permanent change. Over several sessions, however, with the same patient, there appeared a continuity which represented a successive unfolding of deeper and deeper levels of the unconscious. In particular, memories seemed to be relived (Grof, 1972). Grof adopted the term psycholytic therapy, a term which was coined by Sandison (Sandison et al, 1954), where lytic suggests dissolving or releasing tensions and conflicts. The LSD dose was optimised over several sessions (usually 200 micrograms, but sometimes as much as 500). Only low doses were needed for hysterics, but high doses were needed for obsessivecompulsives (Grof, 1972). The techniques in his therapeutic sessions were developed over a period of time, where these involved the support, supervision, safety measures, use of music and staff training. Important was not only what happened during sessions, but the dynamics of the postsession changes.

In 1967, Grof left Czechoslovakia to work in the United States of America, continuing his work at Spring Grove, in Baltimore, Maryland, at the Maryland Psychiatric Research Centre, where controlled LSD studies were being conducted. There the approach was

different, where the goal was the facilitation of deep religiomystical experiences (sometimes at the expense of the underlying psychodynamic issues: Pahnke & Richards, 1969; Grof, 1972). The doses were very high (500) and only three sessions were involved. This approach was called psychedelic therapy, where psychedelic means manifesting or revealing the psyche.

At the time Grof joined the Baltimore team, more than twenty five years had elapsed since the discovery of lysergic acid diethylamide (known also as dlysergic acid or LSD-25) by the Swiss chemist Hofmann in 1943. At the time of that 50s, the International Association for Psychodelytic Therapy was formed, and in 1959 an international conference on the uses of LSD in psychotherapy was held in New York City.

The safety issue was addressed in 1960, when Cohen demonstrated that the risks were minimal (Cohen, 1960). Cohen's finding has more recently been supported (Strassman, 1984). Dramatic treatment effects were claimed, but many studies were methodologically flawed, and later research showed that these induced states differed markedly from real psychosis in many respects (Pahnke & Richards, 1969).

Two other areas of LSD use at that time was in producing aesthetic experiences, and in inducing religiousmystical experiences (Panhke & Richards, 1969). Both aroused fierce controversy, especially that of the possibility of chemical or instant mysticism. There were those who stood against such claims, because of the implications for the array of longterm practices used by mystics and meditators to achieve mystical states. But there were also those for whom such claims supported their aim to remove all such mystical experiences from the sacred to the profane (Clark, 1969).

A further dimension was added when young people started using LSD in an uncontrolled way in the mid 1960s, which took the debate from purely scientific circles into the social and political arenas (Lee & Schlain, 1986). Two widely divergent groups emerged: those who saw LSD as humankind's saviour and those who saw it threatening the societal infrastructure (supported by sensationhungry press reports). The Hippie movement added yet anothe dimension. Finally, there was the fear that LSD caused chromosomal damage and cancer (Cohen 1960). But, for Grof, lying at the root of all these issues was the fact that LSD acted as an amplifier of mental processes that brought to the surface deep levels of the unconscious (Grof; 1972, 1973, 1975).

LSD is the most powerful psychoactive drug known, producing effects with as little as 10 micrograms (Di Leo, 197576; Stafford, 1983). After application, there is a latency period (10 minutes to 3 hours), unless administered directly into the cerebrospinal fluid where the effect is immediate. The session or trip can last between 4 to 12 hours. The experience is mediated by dose level. Activity during the session is also a mediating factor. If the subject is moving about with eyes open the effect is reduced. If lying supine with eyes closed, the effect is heightened. Listening to music during the session also has a heightening effect. There are both sympathetic (eg, accelerated pulse rate) and parasympathetic (eg, lowered blood pressure) symptoms. There are also general symptoms (eg, flu like) and motoric phenomena (eg, jerking limbs). There are perceptual changes, most often visual, but also with hypersensitivity to sound. There are also olfactorygustatory changes. In addition, there are spatiotemporal diortions, including

regression to earlier parts of the participant's individual history. Emotional changes appear very early, with euphoria being common, but ranging across all possible emotions. Cognitive processes are also altered (eg, speeded up), and there may be insights or problem resolutions. In general, however, there is an overall impairment of mental efficiency.

Usually, there is a very clear memory of the session because there is usually none of the confusion/disorientation seen with the use of other drugs. Libido may be completely suppressed or greatly amplified (usually with a perverse strain sadomasochistic). Aesthetic experiences are common, especially of music, and these can persist long after the session. The same is true of religious/mystical experiences (Pahnke & Richards, 1969; Grof; 1972, 1973 & 1975; Richards et al, 1972).

Grof's earlier clinical experience in Prague with LSD entailed some 2500 LSD sessions. He also had access to records of over 1300 sessions run by others in the Baltimore team. The clinical subjects had a wide variety of disorders. As in Grof's Czechoslovakian researches, there were also a wide range of normals (nurses, doctors, students, artists and so on). These large amounts of data completely refuted the earlier notion that there was some typical mandatory pharmacological effect (Grof, 1972; 1973; 1975). The Baltimore team found that there was no single symptom that was truly invariant across the 3800 LSD sessions. Even optical changes (the most likely candidate for the noxious effect theory Cohen, 1960) did not fit. This included pupillary dilation, where sometimes even constriction was noted. This is not to say that LSD has no physiological effects (the very high doses used in animal research show this; Pahnke & Richards, 1960). Dose sensitivity depended on complex psychological factors rather than biological variables (Grof, 1972; 1973). But within the dose levels used for humans, the physical manifestations are not the direct result of pharmacological stimulation of the central nervous system. The records of these psycholytic sessions became the basis of Grof's assumptions and theorising. Grof came to see LSD acting as a catalyst, activating unconscious material (Grof; 1972, 1973 & 1975).

Grof found that the degree of sensitivity to dose depended on complicated psychological factors, rather than on biological variables. Those diagnosed as overcontrolled in everyday life exhibited high resistance to LSD and showed few symptoms. So too with those who had set out to resist the effects of LSD as a challenge. Obsessive-compulsives, too, were found to have high resistance. In terms of dose level, effect saturation seemed to occur at around 500 micrograms (Grof, 1972; 1973; 1975).

Grof found that the real effect of LSD was that of a powerful unspecific amplifier/catalyst, creating undifferentiated activation facilitating the emergence of unconscious material from different levels of the personality. The maps or cartographies that Grof has identified (Grof, 1975, 1985, 1988) seem to be fully compatible/parallel with other therapeutic systems. Grof has developed four levels or types of LSD experience to explore the topic, but insists that such delineations are artificial (Grof, 1975). The levels he evolved and still uses are; abstract/aesthetic; psychodynamic; perinatal and transpersonal.

Grof now calls his technique holotropic (moving towards wholeness) therapy (or holonomic integration), and no longer relies on psychoactive drugs to induce the deep experiential states his therapy requires (Grof, 1985; 1988).

This shift in method of inducing an appropriate therapeutic state was necessitated by the fact that, from the early 1970s, he was experiencing difficulties practicing with LSD under the everincreasing rigidity of the American Food and Drug Administration. Also, because of this, he attracted only minority interest in his work and findings (Clark, 1975). He now uses a mixture of controlled breathing, music, focussed body work, and mandala drawing. It was never LSD itself that drew Grof. He viewed LSD as a catalyst. It was what it catalysed that was of far greater interest and importance (Grof, 1985). Thus, as long as he could find a technique acceptable to society in general, the therapeutic value and importance of his system remained undiminished. Also, LSD had simply provided an efficient route to uncovering the cartography of psychic states and structures that form the theoretical bis of Grof's system (Grof, 1985; 1988).

Grof asserts (Grof, 1975; 1985; 1988) that all other therapies prior to his do not deal with actual physiological responses. Most deal with biographical material (eg, the psychodynamic therapeutic models and their derivatives). Some deal with the affects, but most operate at the cognitiveverbal level. Only his therapy uses the body's own activities as a part of the therapy. This assertion, though generally true, is not absolutely true, because it ignores the therapeutic system devised by Alexander Lowen called Bioenergetics (Corsinni & Wedding, 1989).

THE THEORY

Mentioned earlier were the four experiential characteristics that Grof identified as: abstractaesthetic; psychodynamic; perinatal and transpersonal. Although these experiences were facilitated initially using LSD, Grof found, with the exception of the first category (the intense perceptual alterations and distortions that occur in the LSD trip), these to arise using his holotropic techniques (to be described in a later section). The exposition given here of the theory underlying holotropic therapy is taken from Grof's three key books (Grof, 1975; 1985; 1988). Because the aestheticabstract category does not form a part of the cartography of experiences accessed during Holotropic Breathwork, I will not mentaion them further. The interested reader will find several authors who cover these experiences listed in the Reference and Bibliographic sections of this papers; eg, Grof (1980), Pahnke & Richards (1969) and Lukoff & Zanger (1990).

Psychodynamic

This deals with the traditional psychodynamic processes and structures, where the experiences seem to originate in the individual unconscious, particularly those relating to unresolved conflicts and repressed material.

Experiences range from reliving memories (perhaps unpleasant) from the past to unconscious material appearing in a highly symbolic form. The intensity depends on the

state of the person. Clinical patients have far more repressed material, hence reliving at the psychodynamic level figures strongly, whereas emotionally stable people produce little at this level. The phenomenology of the psychodynamic experiences in these sessions largely agrees with classical psychoanalysis. Psychosexual dynamics manifest with unusual clarity. However, not all that happens at this level falls within the psychodynamic framework.

For this psychodynamic or biographic category of experience, Grof uses the acronym COEX, which stands for condensed experience, where these are specific memory constellations. The memories belonging to a given COEX system have a similar basic theme, or contain similar elements, and are associated with a strong emotional charge. The deepest layers come from very early childhood. The more superficial layers are from later in life and current situations. Each COEX system has some very specific theme, such as all those experiences in the life of an individual that relate to being humiliated, where self-esteem is damaged. Other themes may be anxiety, claustrophobia or frightening events. Common, is the theme that presents sex as dangerous or disgusting, along with aggression and violence. Also of importance are those dealing with extreme danger and lifethreats.

COEX systems have fixed relations to certain defence mechanisms and clinical symptoms. They organise components into distinct functional units. COEX systems are either negative (unpleasant) or positive (pleasant). Although there is some overlapping, each COEX functions fairly autonomously. They selectively influence a person's self and world view. The outer most layers, representing most recent experiences, are linked back in a regression that ultimately lead to perinatal experiences, the core of the COEX system. With clinical patients, Grof found that a typical holotropic session starts with the reliving of memories related to the presenting symptoms (eg, extreme obsessive-compulsion). As the session continues, the memories come from further and further back in the life, until early childhood is reached. Although, at this point, there may be a deepening of insight as to the causes of the presenting problem, there may be no relief of symptoms at this point. However, the deepest layer is ultimately reached, a this always involves the birth experience. It is the reliving of this that discharges the negative energies and heals.

The reliving is vivid and hard to distinguish from the reality (eg, the body image corresponds with the age to which those memories belong). Some achieve deep age regression in the first session (characteristic of hysterics). More typically, several sessions are required. Relived at the earlier stages of infancy are a range of mainly unpleasant memories (eg, coldness, hardness, bombardment by noise, weaning and so on). Later infancy/early childhood contain COEX systems relating to urination/defecation and sexual feelings.

In later childhood are COEXs containing shocking/frightening events, cruel treatment, sibling rivalry, harsh criticism and so on. Prepuberty events rarely appear as COEX cores unless associated with a shocking event (eg, sexual molestation). Pleasant COEX are much simpler than unpleasant.

Authenticating relived experiences is difficult in most cases, but Grof was able to do so in certain cases (Grof; 1972, 1973, 1975) where striking accuracy was noted (eg, near-photographic accuracy description of a room occupied in infancy, but never again seen as child or adult). Each relived episode seems to contribute a certain missing link in the psychodynamic understanding of the patient's psychopathological symptoms. The totality of the emerged unconscious material then forms a rather complete gestalt, a mosaic with a logical structure. But, even where the relived experience has no basis in reality, it has psychic reality for the patient. The reliving of traumatic experiences is usually accompanied by powerful emotional abreaction. The intensity can seem out of proportion to the relived events, until it is realised that this event summarises similar events throughout the life. Also, there follow far-reaching changes in the clinical symptoms, behaviours, values and attitudes.

Grof uncovered the fact that more recent experiences must be lived through first, in order to get back to earlier ones, because the later ones are the outer components of the COEX cluster, and cover the deeper ones. Most important in the COEX systems is their core experience, because this laid the foundations for the rest. It is not clear why certain events from infancy/childhood should have so profound and long-lasting an influence. Grof speculates that determinants may go beyond the individual into ancestral, racial or even phylogenetic memories, including past-life memories (Grof, 1975). Important is the emotional atmosphere of a family and its interpersonal relationships. A single traumatic event is amplified in significance when set against a discordant familial background. Patients themselves recognise the generalising nature of a single important relived event.

The historical development of a COEX is important. In very early childhood, the child is a passive victim of the family environment and has no active role in the core experience. In later childhood, the child is more instrumental. Once laid, the foundations of the COEX influence perception of the environment, world experiencing, attitudes and so on. The core influences expectations towards certain others (eg, that people in general cannot be trusted, or that emotional attachment is threatening). Such a priori attitudes and expectations result in specific maladjusted behaviours toward all new persons entering one's life. A person whose new human encounters are contaminated by the influence of strong negative COEX systems enters new relationships heavily biased. The gradual successive growth of COEX systems by positive feedback could account for the latency (incubation) period between the original trauma and future neurotic/psychotic episodes.

Such symptoms appear at times when the COEX system reaches a certain critical extension, and traumatic repetitions contaminate important areas of the patient's life, interfering with satisfaction and basic needs. There is a strong parallel between the contents of the core experience of their COEX systems and patterns of their personal interactions at the time of the onset of clinical symptoms. Multiple repetitions of themes from one or more COEX precede immediately the first manifestation of disorder.

When a strong negative COEX emerges in a session, the normal flow of images and sensations are disrupted, and the subject feels as if in a whirlpool consisting of fragments from the past. Later, when the core experience is relived, the fragments make

sense. There is also a disassociation between object and affect (eg, a water jug eliciting strong sexual feelings). The seeming absurdity is removed on reliving the core experience. The arising in a session of intense anxiety, panic and so on also signals the onset of a COEX, as too with dramatic motoric activities (eg, nausea, vomiting or intense pain). There is a repetitious quality in movements and speech which seem to precede the emergence. The emerging COEX assumes a governing function and determines the nature/content of the session. For example, the therapist can take on the form of someone hated or that of a tormentor. There is also the reliving of the roles of victim and aggressor.

There is a tendency to act out the reliving of the COEX and shape the circumstances of the session to the COEX theme. This is because it is painful to experience a mismatch between certain intense feelings and outer events. Thus, the emergence of deep feelings of guilt may cause the patient to act the role of therapist, or provoke hostility in the therapist. It is absolutely essential that therapists avoid being manipulated into replicating the roles the patient is demanding of them. Similar dynamics can be exhibited in the case of positive COEX systems.

Serial psychodynamic sessions can be viewed as a process of gradual unfolding, abreaction and integration of various levels of negative COEX systems, opening pathways for the influence of positive ones. Elements of a particular COEX constellation keep appearing in the sessions until the oldest memory (core) is relived and integrated. Sessions cause profound change in the dynamics and mutual interrelations of COEX systems and initiate dramatic shifts in their selective influence on the subject's ego.

Where unconscious material is not worked through, a patient can remain under the influence of a COEX long after the session. Or, the resolution may be incomplete and result in a precarious emotional imbalance. There may also be belated flashbacks outside of the therapeutic session. Conversely, resolution during a session produces a highly positive, tensionfree experience. If this occurs earlier in the session, a positive COEX emerges. There is usually a striking clinical improvement. There may also occur a COEX transmodulation, wherein the hegemony of one negative COEX is replaced by that of another.

This will be paralleled by a dramatic change in clinical manifestations, to such an extent that clinical rediagnosis is needed. The duration of sessions in which a given negative COEX dominates varies enormously from one to 15-20.

Perinatal

The characteristic of the perinatal experience is existential, relating to pain and the frailty of the human condition (Bache, 1981). There is the life in death, and death in life paradox. People who experience these deeply also come to see the utmost relevance of things religious/spiritual. For one reliving the birth experience the physical manifestations can seem like those of dying. Grof says that a causal link between the actual birth and the unconscious matrices for these experiences is yet to be established (Grof, 1975). These levels are reached only after a great number of more typically psychodynamic sessions (at least with psychiatric patients). With normals, the perinatal level can be

reached in far fewer sessions. According to Grof, alcoholics and drug addicts have the quickest access. Grof points out that there are other routes to this level, than that of holotropic therapy (eg, gestalt, encounter, bioenergetics and rebirthing: Orr & Ray, 1977). Grof sees these perinatal experiences as representing an important intersection between individual psychology and transpersonal psychology (Grof, 1975).

Grof noted a transition between the purely Freudian level and Rankian level (Otto Rank Rank, 1945) where the experiences are physical rather than psychological (eg, reliving threats to bodily survival). These elements appear in four typical clusters, matrices or experiential patterns. There is a deep parallel between these patterns and the clinical stages of delivery. For this reason, Grof calls these clusters Basic Perinatal Matrices (BPM), of which there are four. This is a useful model, and does not imply a causal nexus. The BPMs are hypothetical dynamics governing systems that have a function on the Rankian level of the unconscious, similar to that of the COEX systems on the Freudian level. They have a specific content of their own perinatal phenomena and have two components, biological and spiritual. The biological consist of concreterealistic experiences related to delivery stages. Also, each physical stage has a spiritual counterpart. The BPMs function as organising principles for the material from other levels of the unconscious, namely the COEX systems, as well as some transpersonal material.

Basic Perinatal Matrix I: BPM I experiences rarely emerge in the first few sessions. This level relates to the original intra uterine condition of symbiotic unity. Usually, this is near-paradisiacal, but can be disturbed either temporarily or permanently (eg, mother's temporary illness or drugaddiction). This enables us to differentiate between a good and bad womb in much the way Sullivan talked of good/bad nipples (Sullivan, 1953).

When a good womb is involved, the common relived feeling is of oceanic bliss, timelessness, and ineffability. Some may feel themselves to be tiny, and have a head much larger than their body. There are often religiomystical connotations. The world seems a friendly place, permitting a childlike, passivedependent attitude of trust. There may be experiences of a sequence of visions allowing for interpretation in historical time. For example, embryonic sensations, ancestral memories, elements from the collective unconscious and even phylogenetic flashbacks. The COEX associated with good womb experiences include carefree childhood games, satisfying love relationships, natural beauty and human works of great art. In the case of bad womb experiences, the COEX are the reverse, including childhood dysfunctions, familial difficulties, dirty industrialised cities and polluted countryside. At the Freudian COEX level, there are no tensions in the erotogenic zones, where all partial drives are satisfied.

Where a bad womb is involved, the intra uterine condition was far from perfect, and the holotropic experiences reveal this, as in feelings of discomfort, oceanic visions suddenly blurred by an ugly film. There may be feelings of weakness, influenzalike attacks and small muscle tremors. There may also be unpleasant tastessmells. Visions of wrathful deities can also be present. Even schizoidlike states can arise. These contrast sharply with the sense of spiritual enlightenment accompanying the undisturbed womb states. Grof points out the closeness of the two contrasting situations and the ease with which some schizophrenic patients oscillate between them (Grof, 1975). At the Freudian

COEX level, erotogenic zonal tension is experienced. Satisfaction of these needs can result in a superficial partial approximation to the tension-free state of the good womb.

Basic Perinatal Matrix II: BPM II is related to the first clinical stage of delivery, where the idyllic intra uterine existence comes to an end. There is both chemical and mechanical interference, and there arises a situation of extreme emergency. Uterine contractions occur, yet the cervix is closed and there's no way out. Mother and foetus are a source of pain to one another. There is, of course, a tremendous variation in this phase, ranging from a short labour and easy birth, to pathological delivery (eg, Caesarean) and complications.

The therapeutic experiences may be purely biological in form but, more characteristically, there is the feeling of no exit or hell. There are often visions of the metaphysical/religious hells, and of the most negative aspects of this world (eg, world wars). There is also an empathy with all who are downtrodden, or who have to die in pain and alone. Coupled is the feeling of a robotic cardboard world which is ultimately meaningless. It is here that the link is made between birth and death, where the existential crisis is at the root.

Feelings of separation, alienation, metaphysical loneliness, helplessness, inferiority and guilt are standard components. These may be symbolised as in the case of Greek figures such as Sisyphus, Ixion, Tantalus and Prometheus, or expulsions from paradise, Gethsemanes and Dark Nights. There is often a feeling of intense but vague anxiety, even of paranoia and the danger of cosmic engulfment.

Typical physical symptoms include extreme pressure on the head/body, ringing in the ears and difficulty with breathing. BPM II is the matrix of all that is unpleasant in the extrauterine life (eg, disease, operations and injury). There are associated feelings of abandonment and rejection. At the Freudian COEX level, all of the erotogenic zones are experiencing extreme tension such as thirst, retention of feces/urine, sexual frustration and labour pains. Sophisticated clients can readily relate BPM II experiences to such as bondage to the Wheel of Becoming, and realise that the more one struggles to be free the more one is impaled in the senseless reality.

Basic Perinatal Matrix III: BPM III relates to the second stage of delivery where the uterine contractions continue but the cervix is now wide open. There is an ensuing struggle for survival with crushing pressure and suffocation. But, at least, there is release. There grows a synergy between mother and child to end this painful experience. There may also be the contact with the mother's faeces and urine. This is a complex matrix, involving a variety of phenomena at different levels. There are four distinct experiential aspects: titanic struggle, sadomasochistic, sexual and scatological, with the underlying theme being encounter with death. There are, too, associated physical symptoms such as crushing pressures, cardiac distress and breathing difficulties.

The key is the titanic struggle component, which, in holotropic therapy, can seem to be more than a human can bear. It is symbolised by vast natural disasters (eg, Krakatoa), or atomic explosions. Some witness scenes from the destruction of Pompeii, where fire

is often the destroying element. The suffering reaches beyond what is bearable and transforms into rapture/ecstasy, but of the volcanic type, rather than the oceanic type of BPM I.

Sadomasochism is a prominent feature where energy discharges are both outwardly destructive and self-destructive. Visions of cruelty and bestial orgies arise, including self-mutilation and such figures as Salome, or others, who have employed sadistic torture.

The third component is that of sexual arousal, which seems to have a physiological basis (males hanging on gallows frequently exhibit erections and even ejaculation: Grof, 1975). Some subjects spend hours in an all pervasive sexual ecstasy, with accompanying orgiastic images.

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There may be visions of redlight districts, or identification with famous figures such as Casanova. There is a generalised releasing of repressed sexual energy and aggressive impulses.

The scatological element involves contact with all that is repulsive (eg, emerging in excreta or products of putrefaction). However, the initial disgust can change to passive acceptance or even pleasure. There may be scatological visions (eg, heaps of rotting matter or corpses).

The consuming fire feature of BPM III is what seems to purify the subject after having seen all that is worse in self and others. The fire destroys all that is rottencorrupt, and prepares for the renewing/rejuvenating experience of rebirth. The Phoenix is a common symbol here. There are also religious symbols, as in the punishing gods (eg, Yahweh in relation to Sodom and Gomorrah). BPM III experiences have helped subjects understand such as Black Masses or Satanic Rites where sex, aggression and sadomasochism are all involved. There are often visions of great painters' works, entailing scenes of destruction, orgy, death and fire. The Gothic era is especially relevant, as is purgatory, Faustus and Parsifal. All this causes patients to reevaluate their lives and values. Contrasts such as complex versus simple living, professional ambition versus family life, and real love versus lustful promiscuity. At the Freudian COEX level there is the sudden release of tension (eg, swallowing, defecation, urination and orgasm).

Basic Perinatal Matrix IV: BPM IV is related to the third and final stage of delivery where the neonate emerges down the birth canal. The first breath is taken and the cord is cut, and anatomically independent life begins. Although this stage is infinitely better than the preceding two, it is worse than the first of symbiotic union. There may be a concrete reliving of the birth experience, or it may remain purely symbolic/psychological, which relates to the death/rebirth experience. Suffering/agony culminate in total annihilation on physical, emotional, intellectual, ethical and transcendental levels. The world seems to collapse and all referents are lost. There is egodeath. The cosmic bottom is hit, then follows feelings of liberation. So, there is some overlap between BPM I and BPM IV.

In BPM IV, positive selfvalues can be discovered (eg, love and a sense of beauty), and these are not amenable to psychoanalytic analysis. However, the positive side can be interrupted by unpleasant experiences, such as pains in the umbilical region or genitals. There is a rich symbolism in BPM IV, and usually centres on sacrifice, death then resurrection. There can also be images of heroic deeds, as in the Greek myths. The liberating aspect is often experienced as radiant, blinding or supernal light, or perceiving God as pure energy.

The more secular symbolism involves overthrowing of dictators, the ending of a long war or termination of great danger. In terms of nature symbolism, typically, in BPM II, there are barren wintry landscapes, in BPM III fiery volcanic eruptions and hurricanes, whereas in BPM IV there are scenes of spring, melting snows and green meadows and calms after a storm. In physical terms, there is withholding of breath, muscular tension then sudden relaxation and wellbeing. Memories in B IV relate to endings of wars, surviving danger, and a problem resolved by one's own skilleffort. In Freudian terms, there is the satisfaction that comes from discharging or reducing tension (eg, quenching thirst, or the feelings after orgasm).

It needs to be stressed that the chronological sequence presented above is rarely maintained in actual therapeutic sessions. There are great individual differences. In highly disturbed clients, after the psychodynamic material has been worked through, the noexit experience of BPM II is met, then the birthdeath struggle of BPM III, some of BPM IV rebirth experience and cosmic unity of BPM I. Beyond this are the more transpersonal experiences. In less disturbed people, the sequence is often positive BPM IV I, then some BPM II and III, then the fuller versions of BPMS IV and BPM I.

Important is the BPM governing the terminating phase of the sessions. For example, if BPM I is governing then, long after the session, there can be a depression (with many of its clinical symptoms) that persists for days. Conversely, if BPM III was dominant, the feelings are of anxiety, apprehension and irritability. The governing by BPM IV is best of all, where all presenting symptoms disappear and life seems good and simple. Similarly for BPM I.

Transpersonal

Transpersonal experiences occur rarely in the early sessions. They are more common once the psychodynamic and perinatal material has been worked through. The common denominator in these experiences is the feeling of expansions beyond the usual ego boundaries and spatiotemporal boundaries. Gone is the strong body image and sensory dominion. Grof has developed the following classificatory scheme:

Extension within objective reality:

1. Temporal:

embryonal; ancestral; collectiveracial; phylogenetic; pastlives; extrasensory.

2. Spatial:

ego transcendence; identification with others; group consciousness; animal and plant identification; oneness with life; consciousness of inorganic matter; planetary and extraplanetary consciousness; outofbody experience, travelling clairvoyance, telepathy.

3. Spatial constriction of consciousness to organs, tissues or cells.

Extension beyond the objective framework: This involves; spiritistic/mediumistic experiences; encounters with superhumans; experience of other universes; archetypal experiences; mythological sequences; encounters with deities; intuitive grasp of universal symbols; chakra activation; arousal of kundalini; consciousness of universal mind; experience of the VOID.

The embryonal/foetal experiences are not to be confused with those of the BPMs. These transpersonal experiences are specific memories of intra uterine life, and include that of sharing the mother's affective states and a telepathic rapport. It is hard to know whether these are truly relived memories or simply experiences. But Grof (1975) has had many corroborations of these particular experiences, including the fact that often experiencers are displaying a knowledge of intra uterine conditions well beyond their prior knowledge.

In ancestral experiences there is a regression in time to before conception. Usually these are many generations in the past rather than recent past. They may be specific, as in tuning in to one individual, or they may be more generalised. Often, information unknown to the subject in ordinary awareness is contacted.

The collective/racial experiences relate to the Collective Unconscious posited by Jung (1970). They can relate to any country, period and culture, although often the culture is ancient and having a highly developed religiophilosophical culture (eg, ancient Egypt, India or China). This is quite independent of the subject's background. The information contacted is usually very accurate, even when occurring in unsophisticated subjects having no prior knowledge of such cultures. Some subjects (without prior knowledge) exhibit mudras or obscure yogic postures.

Phylogenetic or evolutionary experiences involve realistic identification with animals. They often seem to transcend human limits of fantasy/imagination.

Past incarnation experiences consist of fragment scenes, or entire sequences of events. The subjects maintain ego identity, and even though experiencing themselves as some one else, feel themselves to be basically the same individual. There is a strong déjà vu feeling.

Belief in reincarnation is not a prerequisite. Relived Karmic links can be positive, as in good relations with past others, or negative as in the reliving past pain, suffering and hatred. The mere reliving is not enough. The events must be transcended emotionally, ethically and spiritually to be classed as truly transpersonal. Sometimes, the laws governing reincarnation are transmitted by nonverbal or intuitive means to subjects as they relive them.

In experiencing extra sensory perception (ESP) phenomena there is the transcendence of spacetime limitations. Objective verification is usually difficult and, after the session, the subject does not display any increase in ESP ability. Egotranscendence is characterised by going beyond the usual spatial limits of consciousness. There is a loosening of the ego boundaries, while retaining an awareness of identity. Related is the feeling of identification with another person, where the sense of selfidentity is lost. Often this identification is with some famous personage, where the Christ and Buddha figure prominently. There is also group consciousness or identification (eg, with the persecuted Christian of Roman times). The animal identifications must be distinguished from the more superficial autosymbolic animal transformations which are psychodynamic in origin, and carry some cryptic message for the experiencer. Genuine animal identification cannot be derived from other unconscious material. Plant identifications are more rare, and usually occur in advanced stages of the treatment. They can be accompanied by philosophical or spiritual insights (eg, into the purity and selflessness of the plant kingdom). In rare cases, subjects experience an expansion to encompass all life on earth, human or otherwise.

The consciousness of inorganic matter is fairly common, such as in feeling oneself to be the ocean, or of the forces unleashed during a natural catastrophe. Subjects conclude that consciousness is a basic cosmic phenomenon, and related to the organisation of energy. Also, there is a new understanding of animism and pantheism. Planetary consciousness is rare, and occurs only in advanced sessions. In these experiences the earth seems a living entity with which the subject identifies. Extraterrestrial consciousness is just as rare. Outofbody and related experiences are more common. There may or may not be a feeling of being able to control the experience. ESP is common too and, although difficult, Grof has occasionally been able to verify these experiences (Grof, 1975; 1985; 1988).

In the spatial constriction mode, consciousness is confined to areas smaller than the body, such as to organs or cells. Again, there are accompanying insights and evidence of knowledge that lies outside the subject's prior knowledge.

Spiritualistic experiences are rare, wherein the subject enters a quasi trance state, including voice and facial changes. Similarly with spirit guides or teachers, perceived by the subject as superhuman.

Mostly, the contact is nonverbal and the beings are of light or energy rather than of human form. They may give advice or information about the session and its value to the subject, or they may take the subject on a guided tour. There are, too, experiences of alien worlds and other universes having strange physical laws and totally different life-forms.

A more important class of experiences are those that involve complex archetypal and mythological sequences. Grof is using the term archetype here for all static patterns or dynamic events within the psyche that are transindividual and universal in quality. Some such are the martyr, fugitive, outcast, ruler and wise old man. More universal still are Great Mother or Cosmic Man. There are also, commonly, experiences of the animus, anima and shadow. There may also be myths such as of Tantalus and other heroic or

tragic figures. Related are encounters with deities. These latter fall into two categories: those associated with the forces of light and good such as Isis and Apollo; and those of darkness and evil such as Kali and Satan. These experiences usually first appear in the perinatal phase, where the dark deities accompany BPM 2 and 3, and the bright deities BPM 1 and 4. There can also be an experiencing and understanding of universal symbols, such as geometrical or mandalic. The most frequent symbols include the cross, sixpointed star, swastika, crux ansata and circle. Subjects with no prior knowledge of occult systems have had profound insights into such as cabbalistic symbols (Grof, 1975).

Many experiences bear striking resemblance to the phenomena described in Kundalini Yoga, such as the activation of the chakras or the rousing of kundalini, where kundalini is a psychospiritual evolutionary force. Neither prior experiential nor intellectual knowledge of kundalini is a prerequisite for having these experiences. However, the actual arousal and upward movement of kundalini is extremely rare in a therapeutic session. The most profound experience in this category is the consciousness of universal mind, in which ultimate understanding is felt to be reached. Similarly, consciousness of the Buddhist condition of the Void.

The influence of transpersonal experiences last well beyond the session in which they occurred. Much depends on the nature of the experience and the level at which it occurred. Especially influential are experiences that remain unresolved in the session. Where there is resolution, actual changes can come about in the person's life circumstances as though some past karmic blockage has been removed. This can be startling in the case of relived past incarnations, where changes occurred in relation to people who are part of the experience. There is in this strong support for Jung's notion of synchronicity (Jung, 1970). The intense level of identification with another experienced during a holotropic session can, in real life, spill over into a new understanding of and love for that other. Similarly with more collective identifications.

Grof believes that many helping professionals either ignore the evidence offered by transpersonal experiences, or regard them as too bizarre and are ready to label them as psychotic (Grof, 1975). This view is more recently supported by the researches of David Lukoff (Lukoff, 1988). Some professionals accept the validity of the experiences, but produce their own bizarre theoretical framework rather than utilise that of the perennial philosophy. Often, their theories are highly reductionist (eg, treating mystical experiences as primary infantile narcissism eg, Deikman, 1963, 1969,). It is a rare few of eminent psychological theorists that have shown a genuine interest in transpersonal phenomena. In particular, Grof mentions James (De Arney & Skousgaard, 1986), Jung (1970), Assagioli (1965) and Maslow (1968; 1976; 1993). Grof is convinced that transpersonal phenomena are not reducible to psychodynamic concepts. Grof's own background as a psychoanalyst and physician had set him against the acceptance of transrsonal experiences, and also against the notion of memories from before birth (he regarded the foetal brain as being too immature). However, his own LSD trips and the witnessing of thousands of other such trips convinced him otherwise (Grof, 1985; 1988).

THE PRACTICE

The holotropic therapist is a facilitator who facilitates and assists in the healing process, and must support the experiential unfolding even when this is not understood. While LSD (and other psychoactives) is the most powerful route to deep material, as explained earlier, Grof was obliged to develop a nonpharmacological technique, which is characteristic of ancient procedures such as those in shamanic practices. One especially powerful technique is that of intense breathing or hyperventilation (a form of yogic pranayama). Grof (Grof, 1988) confirmed the findings of Reich that psychological resistance and defences use breath restriction. Conversely, selfinitiated deep breathing removes autonomic control and resistances. This releases many conscious experiences (eg, being flooded with light and love).

Grof (1988) argues that the physical symptoms of hyperventilation are usually seen in pathological terms (eg, carpopedal spasms tetanic handfeet contractions). Grof has found that only a few clients exhibit such symptoms, even when the sessions go on for long periods. Rather, there is a progressive relaxation, intense sexual feelings and mystical experiences. There is also a progressive decrease in muscular tensions and difficult emotions. This occurs through intense abreaction, which can entail tremors, twitches, dramatic body movements, coughing, vomiting, screaming and increased autonomic activity. In addition to abreactive processes, there is the prolonged contraction and spasms of muscle groups, which use up a great deal of pentup energy. The typical outcome of a good holotropic session is profound emotional release and physical relaxation. Grof calls this, pneumocatharsis.

The emotional qualities expressed in a session cover a wide range, including anger, aggression, anxiety, depression, guilt and disgust. Some clients show little motor activity, while others are very active. Pains occur in certain parts of the body at times, and these are psychosomatic in origin, as intensified forms of pains the subject is familiar with. Grof has, over many sessions with many clients, been able to catalogue the relationship between the locations of the pains and the underlying psychological causes. For example, painstensions in hands and arms reflect deep conflicts between strong impulses and their opposing tendencies. The typical release finds outlet in creative activities, such as painting. Tensions in legs and feet have similar structures, but these are less complex, because these limbs have a simpler role. The other common locations all seem to relate to the locations of the chakras. Release in these centres liberates that energy that is traditionally related to that centre (eg, love ancompassion in the heart centre).

Music is also combined with the hyperventilation, where skillful use of musical selections facilitates the emergence of specific contents such as aggression, emotional and physical pain. The music is usually played very loud and over high quality equipment. It is important to surrender to the flow of the music, letting it resonate in one's entire body and respond in a spontaneous, elemental fashion. Intellection should be suspended. The music is chosen by the facilitatortherapist to suit the phase the subject is going through (eg, sexual experience is facilitated by such as the Venusberg music from Wagner's Tannheuser, and aggression by Holst's Mars) and is always of high artistic quality. The major objection to the use of music is that it has a strong structuring influence on the experience. But, because the music is usually chosen so as not to be well known, learned responses are prevented. Also, songs are rarely used because the

lyrics produce a cognitive focus. Sometimes, even white noise is used, to aid the structuring effect, and the recipient transforms this into their own internal music.

Focused body work is a supplement to the general therapeutic regime, and is not always used, because many sessions run smoothly without need for intervention. It is used where distress occurs. The principle is to use it in the terminating period of a session. Localised pains are exaggerated either by the subject or by the sitter and possible helpers. Physical supportive contact is also used, such as touching and holding hands. This contravenes the taboos in many other therapies, especially the talkonly variety. However, these meet the anaclitic needs of the client (anacletic comes from the Greek anaklinein = to lean onto) which relate to basic mothering. The choice and timing of such interventions involves the intuition, but a general rule is that it is used when the subject is deeply regressed, helpless and vulnerable. Most of Grof's work is done in group settings, so the risks of impropriety are much reduced. The members are always divided up into an experiencer and sitter, who are allowed to choose each other. Some sorting out goes on over the first few sessions, until people tend to stay in a certain dyadic relation through the remaining sessions.

Grof uses a basic preparation procedure with each group of clients before actual therapy begins. This makes the clients aware of the sorts of things that may happen and the procedures used to ensure personal safety, and about the setting and appropriate clothing and so forth. The room needs to be big enough, the floor padded, located where loud noises (eg, screams) will not cause problems, and where music can be played loudly. The lighting is reduced, and tissues, buckets etc... are provided. Pre-session screening is used to eliminate those clients with severe disturbances (they would go to individual sessions), and those with certain medical conditions (eg, heart problems or pregnancy). Also, clients should be off all medication and not be currently using drugs.

Usually a session starts with relaxation exercises and guided imagery. The focus should be the here and now. Expectations should also be absent (in client and sitter), because the work is open-ended. The sitter/therapist is far from the active agent, because the therapeutic outcome of most sessions is indirectly proportional to the amount of external intervention. Grof also uses mandala drawing in his sessions, in combination with the other procedures.

In part, Grof bases his understanding of the dramatic healings he has witnessed on some mechanism akin to that working in shamanic healing (Grof, 1988). Associated is the pseudoreligious conversionlike process that sometimes occurs in those who have come very close to death. Holotropic therapy seems to use similar mechanisms, but without the biological danger/crisis.

One explanation offered by Grof lies in that holotropic therapy intensifies the conventional therapeutic mechanism of abreaction. Grof (1988) points out that Freud knew this, but played its value down and focused instead on transference as being the important process.

Abreaction applies to strictly biographical material, whereas the more generalised release of emotional/physical tension is called catharsis. The value of these two has

been known at least since the ancient Greeks. A reason given by Grof as to why Freud and others have played down abreaction is that few psychiatrists have the training or inclination to take a patient through a fullblown abreaction as Grof describes it (Grof, 1988).

However, abreactioncatharsis is not the only factor. The experiencing of traumatic events from infancychildhood while being able to evaluate them as an adult permits their integration. The adult can face such traumas that the child could not face, in addition to which the therapeutic setting offers support that the childhood one probably did not. Also, it is likely that the original event was not fully experienced, due to its interfering with consciousness (eg, fainting).

In holotropic therapy, the potential for transference is greatly enhanced, but is seen as a hindrance rather than a curative factor. In fact, Grof (1988) argues that it should be seen as a resistance to or defensive ploy to the process a way of opting out.

The general strategy in Grof sessions is to reduce negative charges by: abreactive discharge; conscious integration of painful material; facilitating experiential access to the positive dynamic constellations of COEX, BPM and transpersonal matrices; and terminating each session by successful integration of that day's psychological gestalt. Those tuned into some negative matrix view themselves pessimistically and experience varying degrees of emotional and psychosomatic distress. The reverse is true for those under the influence of positive aspects. In general, the nature of the influence relates to the nature of the COEX or BPM. The exact effect of the transpersonal matrices are more difficult to describe synoptically, because there is such richness and variety.

Many cases of dramatic improvement can be explained in terms of a shift from a negative system to a positive one. This is not to say that all of the negative material has been worked through. This is what Grof calls transmodulation, and can occur within COEX or within BPMs. There can also be transpersonal transmodulations. A typical positive shift initially involves the intensification of the negative system, followed suddenly by a dynamic shift to a positive one. This does not necessarily lead to a clinical improvement. If the shift is from a positive to negative or from one negative system to another negative system, there can be a change of symptoms which, if severe, can need rediagnosing (eg, from depression to hysterical paralysis). The latter Grof calls substitutive transmodulation.

The therapeutic potential of the deathrebirth process is very powerful, because negative BPMs are an important repository of emotions and physical sensations of great intensity. Symptoms such as anxiety, depression, guilt and sadomasochistic tendencies have their roots in the BPMs. In particular, in successful sessions, suicidal tendencies will go or are greatly reduced, as does a reliance on alcohol or drugs. Similarly with sadomasochism, aggression, impulsive behaviour and selfmutilation. Likewise a variety of phobias and sexual disorders. Many of the states that traditional psychiatry brands as psychotic result from activation of the perinatal matrices.

There are also therapeutic mechanisms on the transpersonal level, where many of the presenting problems of a complexsubtle nature have their origin (eg, embryonal

traumas). The resolution of, or insight into, pastlife conflicts and traumas can eliminate certain problems. Likewise, certain negative archetypes bring an evil influence into a person's life, akin to spiritpossession. The experiencing of Universal Mind and identification with the Metacosmic Void have extraordinary therapeutic potential, bringing spiritual and philosophic understanding of such a high level that everything in the person's life is redefined.

Healing can be regarded as a movement toward wholeness, which implies a common dominator. Such a universal mechanism implies that consciousness is allpervading, and primarily an attribute of existence rather than an epiphenomenon of matter. Human nature is paradoxical in that everyday consciousness seems to conform to the Newtonian worldview yet can, at times, function in an infinite field and transcend space-time. The first type of consciousness Grof calls hylotropic and the second holotropic (Grof, 1988). In the former, we experience only the here and now of consensus reality, whereas the holotropic mode has unlimited access to other times and other spaces. Also, it can experience the superphysical realms, such as astral and beyond. A psychogenic symptom represents a hybrid between the hylotropic experiencing of the world and the breaking through of a holotropic theme. Grof (1988) argues that neither hylotropic nor holotropic in their pure forms present problems, only their admixture. Viewing psychopathology as the negative mixing of hylo and holotropic modes throws a new light on therapy. This new view entails the use of methods of inducing nonordinary states of consciousness.

Emotional and psychosomatic healing occurs in experiential forms of therapy, because these loosen defence mechanisms and dissolve psychological resistances in a much more efficient way than the purely verbal therapies, where these can takes months or even years (Grof, 1988). Grof argues against performing holotropic therapy on oneself while alone, because even the most balanced person is liable to experience traumatic and seeming lifethreatening modes of being. Also, the nourishing human contact with the sitter is a key part of the method. In holotropic therapy, there is a clear causal link between the procedure and results, whereas in the traditional verbal approach the sessions extend over such a long period that such a causal connection is hard to establish and too many other variables contend as causes (Grof, 1988).

The pursuit of a more rewarding life strategy is facilitated by holotropic psychotherapy, which goes far beyond the mere relief of psychopathological symptoms. Victor Frankl (Frankl, 1963) talked of noogenic depression a condition experienced by those who were far from being either psychotic or neurotic who, in fact, due to their seeming balance and worldly successes, were the envy of friends and others. At root this condition manifests as an intense awareness of life's seeming meaningless coupled with an inability to enjoy success. The uncovering of perinatal, biographic and transpersonal factors by reliving them can remove this noogenic condition. There is the discovery that the entire life to that point is inauthentic and misdirected. This is usually due to the influence of some one or several negative matrices. For example, BPM 2 produces resignation, submissiveness and passivity toward life, whereas BPM 3 gives an unrelenting obsessive drive toward future goals such that the present moment is never perceived as satisfactory. At the planetary level we are seeing the negative results of this obsessive drive taken beyond sanity.

A shift to the positive aspects of the BPMs brings an ability to enjoy the moment, and the emergence of an ecological consciousness in which one participates in life rather than viewing it as a challenge or threat. When the selfexploration reaches the transpersonal levels, the philosophical and spiritual quest comes to dominate. People who live only in the hylotropic mode, even when healthy by clinical standards, are cutoff from their real source and need healing.

TRADITIONAL HOLOTROPIC RELATIONSHIPS

Grof (Grof; 1985, 1988) argues that LSD research and other experiential selfexploration methods throw light on the labyrinthine nature of the traditional systems of therapies, and the conflicting views surrounding them. In Grof's original system of psycholytic therapy (using LSD) and his more recent holotropic therapy, initially the patient's reliving of biographical material fits the basic Freudian schema (includes Adlerian and Sullivan's views).

The patient moves beyond this into a stage which can be conceptualised by Reichian therapy. There follows a stage best framed by the views of Otto Rank (Rank, 1945), then onto one which fits the Jungian view (Jung, 1970). Once the sessions move on into the transpersonal realms, only Jung and, to some extent Assagioli's psychosynthesis (Assagioli, 1965), can address the processes involved, because the experiences take on a philosophicalspiritualmysticalmythological emphasis (Grof; 1985, 1988). The therapy at this point equates with the spiritual quest. Taking each of the key theorists in turn, Grof argues as follows.

Freud

Grof (1985) argues that, above all, Freud sought to make of psychology a science in the same sense that physics is a science. Especially, he was influenced by classical mechanics and conservation of energy. In Freud's topographical descriptions, dynamic processes are intimately interwoven as specific individual structures of the psyche (Freud, 1985). There is also a classical causal determinism in Freud's scheme. Also, there is (as in the NewtonianCartesian world view) the objective, independent observer.

Freud's contributions are three thematic categories: a theory of instincts; a model of psychic apparatus; and a psychoanalytic therapy. Important to his theory are the pleasure and reality principles (Freud, 1985). However, Freud found that aggression does not always serve selfpreservation, thus seeming to undermine the theory's Darwinian basis. Thus, Freud had to develop the notion of an instinct toward destruction (or Death).

The Id represents a primordial reservoir of instinctual energy, governed by thprimary process. The ego retains its close connection with consciousness and external reality, yet performs unconscious functions. The superego only comes in fully with the resolution of the Oedipus complex, and one of its aspects is the recovery of the narcissistic perfection of early childhood. Another aspect reflects the introjected prohibitions of parents backed by the castration complex. Superego operations are largely unconscious, and carry some Idlike aspects (eg, its cruel streak) (Grof, 1985).

Freud (1985) distinguished between real anxiety (due to concrete danger) and neurotic anxiety (due to some unknown cause). Not only is there a strong mind/body split, but problems are isolated from their interpersonal, social and cosmic contexts. Where only biographical levels of the unconscious are involved, psychodynamics fits the data from Grof's LSD research (eg, observed regressions to childhood are very common). However, Grof feels that psychodynamics has no right to generalise the way it does from such material, to other areas of the COEX systems (Grof, 1985). The shift of emphasis from biographically determined sexual dynamics to the dynamics of the basic perinatal matrices is possible because of the deep experiential similarity between the pattern of biological birth, sexual orgasm and the physiological activities in the individual erogenous zones.

Grof (1985) further argues that psychodynamics has failed to explain many aspects of psychopathology that his LSD research throws light on (eg, the puzzle of the savage part of the superego, or failure to embrace anthropological findings as in shamanism). Importantly, Freud (1985) tended to classify anything relating to prenatal conditions as fantasy, in contrast to postnatal experiences. Grof feels that Freud failed to see that birth/sex/death form an inextricable triad, intimately related to ego death. For example, the link between castration fear with dentate vagina is readily understood in terms of the potential danger of the contracting vagina during the birth process (includes the cutting of the cord). Even the more recent Egopsychology (As developed by Federn in 1952, a close associate of Freud, and as modified by J. Watkins: Watkins, 1978) fails in the same respects, because bound to a narrow biographical orientation.

Adler, Reich, Rank and Jung

Adler remained linked to the biographical level, but had a different focus, being teleological/finalistic (Adler, 1959). The guiding principle was to be complete, with a built in inferiority complex (includes insecurity/anxiety). Adler argued that consciousness and unconsciousness are not in conflict, they are two aspects of the same system serving the same purpose. Social usefulness is important. Neurotics and psychotics have a private logic, protective in nature.

Therapists take an active role, interpreting society to the patient. Grof (1985) argues that his LSD research shows that Freud and Adler, due to the inadequacy of their approaches, focused on two categories of psychological forces that, at a deeper level, are two facets of the same process. Both were deeply concerned about death (Freud feared it, and Adler narrowly escaped it at age five Grof, 1985).

For Reich, it was the suppression of sexual feelings that caused neurosis which, in turn, were the result of a repressive society. He developed a system which released energy using hyperventilation and bodily manipulations, leading to the ability to experience full orgasm. Later, he became involved in the Orgone affair, which led to his imprisonment and death (Grof, 1985). LSD work confirms Reich's views about the psychoenergetic and muscular aspects of neurosis. However, rather than being due to pent up libido, in Grof's view the energy represents powerful forces from the perinatal level of the unconscious. The mistake made by Reich and his followers was due to BPM III having a substantial sexual component. Grof believes that Reich teetered on the edge of a

transpersonal understanding, but he never reached a true understanding of the great spiritual philosophies, and confused true mysticism with mainstream dogmas.

Otto Rank (Rank, 1945) departed considerably from mainstream Freud, where his system was humanisticvoluntaristic (opposed to Freud's reductionist, mechanistic, deterministic scheme). He also emphasised the birth trauma, and insisted that a patient has to relive it in therapy, because post partum separation is the most painfulfrightening experience. This led to primal anxiety and primal repression. He saw sleep as reliving the intra uterine life, and the Oedipal process in relation to desire to return to the womb. Rank argued that women can relive their immortality by their procreative ability, whereas for men sex is mortality and only in nonsexual creative acts can they find their strength. Rank saw the ultimate goal of religious activity as an attempt to return to the womb. Grof's LSD therapy strongly supports Rank's thesis about the birth trauma. However, for Rank, the trauma lay in separation and the unpleasantness of extrauterine life. In LSD work, these facts are true, but also the passage down the bth canal is extremely traumatic. Additionally, Grof argues (Grof, 1985) that most psychopathological conditions are rooted in BPM I and BPM II (prior to postnatal experience).

Grof regards Jung (1970) as the most famous renegade of the original Freudian camp. His analytical psychology is far more than modified Freud. Jung accepted the new relativistic physics and saw the CartesianNewtonian paradigm as deficient. He also respected the mystical traditions of both east and west. Jung's ideas are closer to Grof's than any other western psychological tradition, because Grof regards Jung as the first transpersonal psychologist (Grof, 1985).

ExistentialHumanistic Psychotherapies

These arose as a reaction to the mechanistic and reductionist nature of behaviourism and psychodynamics, and began with the work of Rollo May (May, 1967), but had roots in the work of Kirkegaard and Husserl. Individuals are unique, inexplicable in scientific terms, and have freedom of choice, where death is inescapable. This comes out strongly in the experiences of the BPM II condition (eg, feelings of meaninglessness, ratrace, treadmill). Frankl's Logotherapy also relates to these experiences (Frankl, 1963). Maslow was the great champion against reductionism in psychology, and introduced for psychological study topics such as love, a sense of beauty, justice and optimism (Maslow; 1968, 1976, 1993). He also saw value in combining observation with introspectionism. From this arose true humanistic psychology. There also arose a neo-Reichian school (eg, Lowen, Rolf, Feldenkrais, Kelly and Trager: Grof, 1985), which attempted to liberate lockedin human potentials, with the emphasis on the bioenergetic systems (eg, the Rolfing massage system Rolf, 1977).

There also arose the Gestalt therapy of Fritz Perls (Perls et al, 1951), with its focus on reexperiencing conflicttraumas, and the hereandnow. Perls' therapy involves working as an individual in a group, using breathing, attention to posture and so on. Related is primal therapy (Janov, 1970), wherein pent up energy is released in a scream. Janov's therapy dispels the unreal system that drives one to neuroticdefensive behaviour. Grof argues, however, that the results lag far behind Janov's original claims (Grof, 1985).

LSD research strongly supports the humanistic theses and the human potentials movement in general. Perls' system is probably the closest to what Grof is describing here.

Transpersonal therapies

The humanistic goal of selfactualisation was seen as too narrow, and the recognition of spiritual dimensions came to the fore (Sutich, 1968). The important representatives of this Fourth Force in psychology were Jung, Assagioli and Maslow, where Jung stressed the importance of the unconscious, mystical, creative and religious. Jung developed the notions of complexes (constellations of psychic elements) and their primordial base archetypes, where these create a disposition and synchronistically influence the very fabric of the phenomenal world. Dreams were seen as individual myths, and myths as collective dreams. Libido was not seen as a purely biologicalsexual force aiming at mechanical discharge, but as a creative force in nature. Unlike Freud, who saw a historicaldeterministic cause in his patient's problems, Jung saw a relativistic, acausal world.

Grof argues that his LSD research has repeatedly confirmed Jung's insights (Grof, 1985). The system of complexes is very similar to that of COEX systems, at the biographical level. Also supported is the collective unconscious, and archetypal dynamics.

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However, Jungian analysis doesn't deal effectively with the psychosomatic dimensions of the birthdeath process, nor with the actual biographical aspects of perinatal phenomena. Jung explored some transpersonal aspects in great depth (eg, collective unconscious, mythopoeic properties of the psyche, certain psychic phenomena and synchronistic links between psychological and phenomenal reality: Jung, 1970). But there was no exploration of transpersonal experiences that mediate connection with various aspects of the material world.

There is some similarity between Assagioli's and Jung's cartography of the human personality, since it includes the spiritual realms and collective elements of the psyche. Assagioli (1965) posited seven levels, where the lowest relate to primordial instincts and emotional dynamics, the middle to Freud's preconscious, and the highest to superconscious which is the seat of the intuitionsaspirations. His system is called psychosynthesis, where the therapeutic goal is selfrealisation and the integration of the subselves around a unifying psychological centre. However, as broad as this scheme is, there is, again, a lack of recognition of the biological components.

Maslow (1976) studied peak (mystical) experiences, and defined the stages leading to selfactualisation in his concept of a hierarchy of needs. In this he analysed human needs and revised the theory of instincts, where higher needs are not reducible to base instincts. Grof (1985) has found that Maslow's ideas receive powerful support from LSD work, as for example in peak experiences and Maslow's structure of the personality, with its lowest Freudian end and its highest transpersonal end. Grof concedes (Grof, 1985)

that the Dianetics of L. Ron Hubbard (more recently called Scientology) has far reaching parallels with his own work and findings, as pointed out earlier by Gormonsen & Lumbye (1979).

HOLOTROPIC THERAPY AND THE FUTURE

Grof (1988) argues that holotropic therapy has implications far beyond mere therapy, because its results point to a new understanding of human nature and human society. In particular, it gives insight into the underlying causes of malignant aggression in all its manifestations, because war in many aspects is relived in BPMs II and III. The difference between these two is that in BPM II the experiencer is a passive victim, whereas in BPM III he/she can also be the aggressor. The warlike situations relived range across time and cultures, and even seem to include futuristic battles between star ships. There are also scenes of violence, aggression and torture from settings other than battles (eg, ritualistic human sacrifice, inquisitions and torture). Scenes involving protagonists locked in combat are common (eg, tyrant and revolutionary). The sexual element of war and aggression is also relived. So too is the scatological aspect evident in mounds of debris and rotting corpses.

All this seems to sum up to the fact that the human psyche has energies that will often manifest in violence and especially warfare. Clients have the insight that a tyrant or dictator has the mental set of one struggling to get free of the birth canal (a mix of impulsive aggression, selfdoubt, megalomania, childlike anxiety and insatiable ambition). The dictator mind set ends as the client moves into BPM IV.

The energies of BPM III are fine for a revolutionary overturning of the old order, but fail when trying to implement what is to replace it. BPM III energies are good at destroying and liberating, but cannot reproduce the paradisiacal state of BPM I. Thus, new repressions soon emerge from the ruins of the unfulfilled utopia (the newborn's struggle is to a freedom entailing coldness, wetness and discomfort). Grof cites Nazi concentrations camps as examples of most of the negative aspects of BPMs II and III. Many political and military leaders, rather than being strong oedipal figures are garbage collectors of all that is negative and destructive in the human psyche and provide socially sanctioned channels for the acting out of these forces. Often the verbal images used by such leaders in political and war crises have a perinatal symbolism (eg, the second atomic bomb dropping on Japan, where the airplane was named after the pilot's mother, the bomb called Little Boy, and the completed mission signalled as the baby is born). Under certain conditions, the psychological defences that prevent negative perinatal energies from surfacing in the individual, can breakdown for large groups of people (eg, in riots), and such people are then easily led by a leader who can evoke powerful images that trigger these energies (eg, Hitler).

Modern science and technology has provided the wherewithal to send people to the moon and do many other truly amazing things, and yet has done nothing for humankind's primitive instincts. According to Grof (1988), what we seem to have done is exteriorised our BPM III nature, as would be expected from the view of an evolving humanity. This can be seen in many aspects of modern life, from sexual promiscuity, through interest in the demonic and cults expecting salvation. The scatological element

is there, too, with global pollution. All this seems as inevitable in the human race as it is in the individual undergoing holotropic therapy. It is the only way to reach what Grof calls higher sanity that based on holotropic consciousness.

PART II: AN EMPIRICAL STUDY

INTRODUCTION

For a system as allembicing as Grof's, one would expect that not only would it be more widely known but would also have been empirically researched. As I have already pointed out in the first part of this article, the system is not widely known.

But, worse still, very little empirical research has been conducted to verify or refute Grof's claims for his system. In a recent literature search I could come up with only two pieces of empirical research relating to Grof's system: Pressman (1992) and Spivak (1992). Pressman's article deals with the therapeutic potential of entering nonordinary states of consciousness, and uses clinical case studies to support Grof's claim that it is in the integration of the accessed material with ordinary subjective awareness that healing occurs. Unfortunately, the Spivak article is in Russian. But it appears that Spivak studied the effectiveness of a holotropic breathing technique when used in conjunction with music, using clinical patients with a variety of neurotic states. His paucity of research led me to consider conducting an empirical exploratory study of my own, using a New Zealand sample.

In addition to studying Grof's system since the mid 1980s, in the early 1990s I attended a number of Holotropic Breathwork Workshops run by Greg LaHood, a psychotherapist based in Auckland. LaHood trained under Stan Grof and is licenced to practice the Holotropic Breathwork technique here in New Zealand. From this basis of my theoretical (headwork) understanding and my direct experiential (body and heart) knowledge, I have come to highly value Grof's technique as a therapy and as a process of self-discovery. While I personally have no doubt as to Grof's claims, as a scientist, it seemed important to make a start in establishing an empirical basis in the public domain for these claims. In this way, others of a more traditional point of view might come to see the value of Grof's technique and the robustness of the cartography he has created.

Sophisticated statistical analyses are not applicable to this study. Nor does the design permit the examination of causal or correlational interactions. It is not an experimental procedure having a comparison control group in which confounding variables are controlled for. This study cannot provide support for Grof's claims or for any hypotheses I might have. This will be the work of future research. Thus, there can only be a simple quantitative and qualitative presentation of the data. However, valuable information has been established about the type of person who attends the Breathwork workshops. The data also provide information about the types of experiences that occur in workshop sessions, their frequency and the relationships between them. Finally, the data provide a rich source of hypotheses for any future controlled design.

METHODOLOGY

Subjects

The subjects in this study were all members of the only Holotropic Breathwork group operating in New Zealand. The original contact was made with Greg LaHood, a psychotherapist who, having trained under Stan Grof and licenced to practice by Grof, runs the New Zealand workshops.

The research proposal was put to LaHood and received his enthusiastic support. He subsequently contacted his group and sought their permission for the study to take place, which they gave. The list of members and their contact details was compiled by Christine Jackson, a member of the group and one of LaHood's assistants. The entire group consists of some 50 or more people. Some have been involved in the workshops since they were first offered. Of this original core group most have continued with the workshops. Others have have come and gone, and come back again. Still others are very recent to the group. It cannot be claimed that the research sample is representative of the New Zealand adult population, most likely quite the reverse. But the final responding sample is large enough to be representative of the entire group. As the findings will show, the sample (N = 38) covers a wide age range (19 to 52 years) and has a wide socioeconomiceducational status. The exact gender split of 50% males and 50% females was a natural outcome and was not determined by the author.

All subjects freely volunteered to participate on an unpaid basis, the motivation being purely the belief that the study was a valuable one.

Procedure

A fairly straightforward research design was used in this study, consisting of a mailed out survey instrument followed by indepth facetoface interview. A simple quantitative analysis of the data was conducted looking only at percentages of the sample for any given elicited response. The interviews were tape recorded and the transcription was carried out by the author. A composite of these individual transcriptions is included within the Findings. The research was conducted between the months of November 1995 through to January 1996.

The survey instrument categories and questions were generated from the author's theoretical experiential knowledge of Grof's system. It was also guided by the author's interest in the manner in which Grof's system fits within the wider context, especially in terms of the perceived paradigm shift occuring in science in general and in psychology in particular. The original draft instrument was critically reviewed by Christine Jackson (mentioned above) who gave invaluable feedback as to content and structure.

Using the finalised list, the subjects were each sent an information sheet, a survey form, an interview consent form and a replypaid envelope.

Materials

The survey instrument (questionnaire) consisted of a tenpage document in four sections. Section one gathered information which yielded a profile of the research sample, asking questions about aspects such as, gender, age, educational status, religious persuasion and so on. Section two gathered information relating to specific Holotropic Breathwork experiences, such as number of workshops attended, COEX and BPM experiences. Section three gave the respondent an opportunity to freely comment on Grof' system in general, and the New Zealand workshops in particular. Section four gathered information about other forms of psychotherapy and clinical diagnosis.

The interview was relatively unstructured, but guided by openended questions which led the interviewee through a logical sequence from a summary of their selfexploration activities to date, through what they felt had been the healing benefits of their Breath Workshops to how they saw the future of Grof's system in New Zealand. The interviewees were provided with a written list of the questions to be asked prior to the interview.

FINDINGS

Survey

The following data were obtained by an analysis of the responses to the survey instrument and are presented in the same order followed by the questions in the instrument. In this section most data are given as a percentage of the total responding sample, where N = 38.

BIOGRAPHICAL VARIABLES

gender male 50%

female 50%

daily activity caregiver 18.4%

voluntary work 10.5%

paid employment 65.8%

student 5.3%

education no qualifications 0%

secondary 21%

tertiary 79%

These data are fairly self-explanatory. Paid employment may be part-time or full-time. Secondary qualifications range from School Certificate to Bursary level. Tertiary ranged from trade certificates to masters degrees.

AGE DISTRIBUTION

The frequency distribution of age shows three distinct modes centred on: the early twenties, the late thirties and the late forties. The age range was from 19 to 52 years.

SUBSTANCE USE

FREQUENCY (percentages)

SUBSTANCE occasionally often very often

Alcohol

past 50 23.72 6.3

current 89.5 10.5 0

Drugs

past 60.5 18.5 21

current 78.9 21.1 0

In terms of substance use or abuse, an interesting pattern emerges between past and current use. For example, in the case of alcohol, in the past, prior to the Breathwork workshops, 26.3% of the sample used alcohol to the point of abuse, and several of the subjects are recovering alcoholics. But now, none of the sample abuse alcohol, and only a small percentage (10.5%) use it often. A similar pattern emerges in the case of drug use, where drugs in this case are mainly of the mind/mood altering variety.

RELIGIOUS PERSUASION

Agnostic: 5%

Buddhist: 21%

Christian: 21%

Hindu: 5%

Other: 48%

Other includes: mystical traditions, shamanism, esoteric paths, spiritual goddess, and Baha'i

VALUES HELD

rating

value high moderate low

enlightenment *

goodness *

happiness *

holiness *

mental efficiency *

selfunderstanding *

serenity *

spiritual growth *

service to others *

worldly success *

The data obtained from the survey were rather complex in that each item could be ranked between 1 and 10, and where every single subject might give a unique ranking. However, an analysis showed a definite pattern, where this is shown in a simplified form in the above table. There was a variation across items in any given category. For example, the cluster mental efficiency, selfunderstanding, serenity and spiritual growth attracted a somewhat higher overall ranking than did enlightenment or goodness, even though all six items attracted a high ranking.

BREATHWORK WORKSHOP VIEWS AND EXPERIENCES

PRIOR KNOWLEDGE: None: 50%

OF GROF'S SYSTEM Some: 45%

Extensive: 5%

WORKSHOPS ATTENDED: total across the group = 374 average = 10.4

WORKSHOP VALUE

VALUE FIRST SESSION CURRENT SESSION

no value 0% 0%

useful 44.7% 23.7%

great value 55.3% 76.3%

These data show that the perceived value of the workshops increased with time on average.

RELIVED EXPERIENCES

FREQUENCY VALUE

never 15.8% no benefit 0%

occasionally 50% limited 13.2%

frequently 34.2% great value 86.8%

These data refer to relived experiences in general and show their frequency and perceived value. Most of the sample had had such experiences (over a third frequently) and a large percentage viewed them as of great value.

KNOWLEDGE RECOVERY OF UNREMEMBERED PAST EVENTS

RECOVERED = 76.3% of the sample VERIFICATION AS TRUE = 15.8%

These data refer to the recovery of knowledge of which the subject had no conscious memory. For example, a previously unknown event in early childhood might be relived. The verification of such event was carried out by the respondent by checking the actuality of the relived event with family/relatives. The data show that a large percentage of the sample recovered such knowledge, and nearly 16% were able to verify these as true.

SPECIFIC WORKSHOP EXPERIENCES

PERINATAL EXPERIENCES

RATE PERCENTAGE

never 26.3%

occasionally 52.6%

frequently 21.1%

These data refer to experiences which the subject identified as coming from one of the BPMs, and show the overall rate of these experiences.

TYPE OF PERINATAL EXPERIENCE

blissful exciting frightening insightful neutral

55.3% 31.6% 55.3% 50% 5.3%

These data refer to specific types of perinatal experience, where the key ones experienced by this sample is shown here.

COEX EXPERIENCES

FREQUENCY LOCUS

never 26.3% childhood 36.8%

occasionally 52.6% adolescence 63.2%

frequently 21.1%

These data refer to experience from the COEX matrices, where frequency and the locus (age stage) are shown. Over half the sample occasionally had these experiences, and nearly a third were from adolescence.

100% of the sample gained freedom from the conditioning of a given COEX once relived. For example, a given powerful negative COEX may have conditioned the subject into viewing intimate relationships as aversive. The reliving and subsequent integration of this COEX enables the subject to break free from this conditioning and come to see intimacy as nonaversive.

TYPE OF COEX EXPERIENCE

TYPE

anger 73.7%

despair 50%

fear 55.3%

frustration 65.8%

loss 55.3%

guilt 31.6%

joy 39.5%

sexual 44.7%

shame 31.6%

other 5.3%

These data refer to the specific types of COEX experience, and show that anger, frustration, a sense of loss, and despair figure very strongly.

The list of types of experience covers most of the those had by the subjects, where the other category attracted only a 5.3% response.

TRANSPERSONAL EXPERIENCES

FREQUENCY OF EXPERIENCE

RATE PERCENTAGE

never 5.3%

occasionally 60.5%

frequently 34.2%

These data refer to the overall frequency of the experience of the transpersonal matrix. Over a third of the sample had transpersonal experiences frequently.

TYPE OF TRANSPERSONAL EXPERIENCE

EXPERIENCE PERCENTAGE

none 5.3%

ancestors 15.8%

animal life 39.5%

archetypal 60.5%

ESP 15.8%

other worlds 23.7%

outofbody 50%

past life 39.5%

planetary 15.8%

superhumans 15.8%

There was a wide range of transpersonal experiences, with archetypal and outofbody being quite common, and ESP, planetary, contact with superhumans and with ancestors being infrequent.

BENEFITS OF TRANSPERSONAL EXPERIENCES

Almost 80% of the sample experienced a significant and lasting increase in the following:

a sense of unity with all life

an ability to heal themselves

compassion for others

inner strength

insight into the events of their lives

wisdom

IN RELATION TO BODYWORK

94.7% of the sample needed bodywork at some time during a breathe.

FREQUENCY

RATE PERCENTAGE

rarely 63.2%

frequently 36.8%

every time 0%

These data show the overall frequency of required body work during a breathe, and shows that over a third of the sample required this frequently. However, overall, bodywork is a relatively rare occurrence for this sample. The effects of receiving bodywork were various, but in particular were feelings of:

anger (71%); feeling stuck (55.3%); fear (39.5%); and pain (39.5%)

LASTING BENEFITS OF BODYWORK

BENEFIT PERCENTAGE

rebirth 28.9%

sensitivity 65.8%

breakthrough 81.6%

peace 50%

bliss 31.6%

to new level 31.6%

These data show the frequency of the lasting effects of bodywork, where a breakthrough from stuck states is experienced by over 80% of the sample. Also fairly commonly experienced are an increase in sensitivity and a sense of peace. Of interest is that less than a third of the sample benefitted from the experience of rebirth during the session.

VALUE OF THE WORKSHOPS

OVERALL VALUE

little value 5.3%

medium value 15.8%

great value 78.9%

These data relate to the perceived overall value of the workshops, where a very small percentage found them of little value, and nearly 80% found them of great value.

INSIGHTS GAINED

never 0%

occasionally 26.3%

often 73.7%

Of the insights gained during breathing sessions nearly 74% experienced these often. No one in the sample had never experienced an insight.

HEALING OBTAINED

insignificant 0%

satisfactory 21.1%

powerful 78.9%

These data show that nearly 80% of the sample claimed that powerful healing had occurred as a direct result of their workshops experiences, and the remainder had experienced a satisfactory level of healing. 94.7% of the sample claimed to have integrated their relived matrices into their daily lives.

CONTINUING WITH THE WORKSHOPS

yes 63.2%

no 10.5%

unsure 26.3%

Interviews

The following is a composite of the individual interview transcriptions, and follows the order of questions as asked in the interviews. This composite was produced by extracting the key features of each transcription.

Selfexploration: There have been as many modes of selfexploration as there were subjects. But, in all cases, there is a picture of someone who has learned a great deal from their struggles in life. Most of these subjects have experienced failed romantic partnerships or a breakdown in family relationships. There has also been a great deal of pain in childhood with many reasons for anger at parents. A number of subjects, as adults, reached a point where they sought a traditional therapy but found it wanting.

One subject, a registered psychologist in private practice in Wellington, described a pattern starting with abandonment as an infant, not having contact with his mother for the first four years of his life, and the way he has struggled with the outcomes of this in his life. A key realisation for him was the use of his intuition in his private practice. For him, of the key psychological theorists, Jung made the most sense, and he undertook Jungian therapy followed by Jungian training. A number of subjects have formally studied psychology. This was seen as aiding self development, but one saw this study as too formal/academic, not addressing real issues, and not his language at all. Several of the male subjects have attended men's workshop in an attempt to reclaim their masculinity and to get in touch with the feminine side of their nature. Most of the women are oriented toward a feminist world view, and several have been sexually abused as children (one even raped as a young woman) and have been working to come to terms with this. A

number of the subjects have experimented with LSD and other mind altering drugs. Some have studied the world's religions along with esoteric literature, and still others, anthropology (eg, rites of passage and shamanism). These studies helped to make sense of the conceptual system proposed by Grof, and provided a framework within which to understand the transpersonal experiences of the breathwork. A number of subjects have studied meditation and one had spent 13 years as a Buddhist Monk, only recently disrobing. Also, some subjects had already experienced rebirthing prior to the Grof workshops, with one subject being a trained and registered rebirther in private practice. Several have taken part in psychodrama and two saw it as complementing their selfdevelopment and the subsequent holotropic breathwork. Psychodrama, like the breathwork, does not require one to be in a specific ego state and provides considerable freedom.

What led to the breathwork: In several cases, the subject was introduced to the Holotropic Workshops by a friend, and in one subject's case, by her mother. In the case of a psychological counsellor, he was introduced by his supervisor. In most other cases, the subjects came to the workshops from having seen an advertisement in a newspaper. Very few subjects had read anything of Grof's work, and several said that they were glad not to have done this, feeling that it might have inhibited them, or created expectations. However, several said that after some workshops, they felt the need for some cognitive framework. But one subject had read one of Grof's early books when he was 22 years old, at a time before Grof had developed his holotropic techniques. One subject attended a public introductory talk given by the facilitator. Some felt drawn to a workshop despite having qualms about what might happen there. Two intense mystical experiences led one subject to wonder about spacetime realities. Later, this same subject read one of Grof's books and his experiences then made sense. When he saw an advertisement for a holotropic workshop he had no doubts that this was for him.

The appeal of Grof's system: A wide variety of features were reported. A common point was the supportive, nonjudgemental nature of the group, the absence of moralising, the high level of acceptance, which facilitated one being one's self without fear of rejection. There is a freedom to try things out (eg, expressing one's anger fully, or shouting and yelling). Many were convinced that this mode of working could not work outside of a group setting. Some got as much out of sitting as breathing, being there for the breather. Also, there is no obligation to say anything during group interactions. There's no compulsion or pressure from the group. Several said that it is good to see others being so supportive of each other. One subject said that he is apt to cling on to spacetime reality and not trust himself to go into an altered state. The nature of the group made it possible for him to do this. The registered psychologist said that the group setting forced people to the edges of their boundaries. This created a tension in which growth could occur the greater the tension the greater the potential for growth. The group is needed to set up and maintain this tension. There is a group energy that one can call on. One subject said that it is not all serious work one can have a lot of fun, and there is growth and empowerment in this. Many found the group to be nurturing. On the theoretical level, one subject finds the system to be big enough to hold a vast range of experiential activities without cutting them down to size. This same subject said that Grof seems to have his feet on the ground and points us back to human nature without creating dogmas or encouraging a groupies effect. There are no frills. Several subjects loved the

powerful music, finding it massaged their emotional bodies and readily facilitating entry to an altered state.

Negative features of Grof's system: The facilitator's role is vital in keeping the workshops safe and effective. Several subjects disliked being rushed to finish their breathes, and having to come out of the breathe with the process still powerfully going on. The facilitator has to allow enough time for everyone in the group to get to a safe place inside before going home. This does not always happen. Related to this is the fact that the facilitator is there for the others only during the workshops. There is no opportunity to make followup contact between workshops as, for example, in rebirthing work. The registered psychologist of the group felt strongly that this work is only for the strong, where people with fragile egos would be better off using a gentler system such as rebirthing. He also felt that, because intimacysexual boundaries were often challenged or crossed, these workshops were probably better suited to people who were not in a committed romantic relationship. These very same issues affect the facilitator who must be very careful to be there entirely for the group, being able to set personal agendas and needs aside during the workshops. This is particularly true when sexuality is a theme of a given workshop. The facilitator wields more power in this type of work than in many others, where transference and countertransference can be very powerful. It seems vital that the facilitator have regular access to a supervisor. Also, the issue of transference should be brought out into the open by the facilitator right at the beginning of each workshop.

One subject interestingly referred to her having so taken on board Grof's theoretical framework that she went around seeing everything in terms of Grof's matrices, and trying to sell these concepts to others. She found this dangerous, and limiting for her growth. For a while she felt like a religious convert who goes around trying to save others. Another subject reported the dangers of becoming addicted to the breathes in the same way she had, for a while, become addicted to blissedout statesin meditation. One subject echoed Wilber's criticism (see the discussion section later) that there is no room in Grof's cartography for a developmental axis. We have a wonderful series of maps of consciousness, but no developmental aspect. This same subject, a psychotherapist, felt that Grof's technique is intrapersonal rather than interpersonal and in this sense is incomplete.

Healing benefits: Being able to get into altered states has been healing for one woman. One subject relived the birth of her stillborn child and came to a deep and healing understanding of this traumatic experience. There is a cathartic effect in discharging the negative energies of the matrices. Being able to act out anger and violence was very healing for one female subject. One subject reported carrying a huge load of hurt from previous experiences. He had invested a lot of power in his mother giving her enormous authority over him, and this transferred to the women in his adult life, creating relationship problems. The lack of boundaries in the workshops enabled him to deal fully with these issues there is no set limit on the amount of tears or joy that can be expressed. The freedom that comes in the workshops transfers to life outside.

Many of the healing experiences were of a jumplike nature (sudden) rather than gradual. A very young subject finds she has made tremendous strides in herself, moving toward

some one he wants to be, getting more comfortable with herself, more accepting of herself, breaking free from past conditioning (and a rape experience) and the expectations of others. Being with a group of likeminded people was very healing for a man who has bordered on being paranoid toward others. This same subject found mandala drawing very healing. Digging up deep dark stuff has great healing potential. Getting in touch with the body and releasing its pent up forces is healing. The registered psychologist has given himself up to a higher being (the god within) which, for him, is the greatest healing movement. Simply knowing about altered states and that these are natural was healing for one woman, bringing her a real experience of her soul. She now feels less fearful about things, and has a much reduced fear of death. She has got intouch with her inner healer, gone into all the dark places inside, finding the killer within and overcoming fear of that outside of herself. Seeing just how perfect everything reallywas, even when feeling very sad, was healing. This same subject has come to trust others more. There is the entry into a space where everything is all right as it is. One male subject has come into touch with his sexuality in a liberating way, enabling him to enter the world of men, freeing him from the clutches of the women in his life and ending his obsessive involvement with his mother.

A male subject who had been Buddhist monk for thirteen years found he'd become a cold observer of life rather than a vital participant. The breathwork brought him down into his body. He'd never danced and found it liberating. Also, being celibate had been a very convenient way of avoiding his sexuality. He is fascinated by the synchronistic relationship between what is going on in the inner life and the way this seems to engineer events in his life. One woman took three days to be born, and discovered during a breathe just how unwanted she was by her mother (her mother wanted a boy). A specific workshop experience healed hr, enabling her to stop trying to please her mother. This dramatically improved her relationship with her mother.

Relived experiences: One subject had memory blocks around the age of ten. He'd blotted out visual memories of the house he'd lived in. During a breathe he relived the emotions he'd had while living in that house (never did recover the visual images) and found this healing, no longer having to live with the feeling of something lurking in the past. This type of work in the workshops have turned several key areas in terms of self-understanding and personal power. He'd been unable to see that things could be different, and is certain that traditional forms of counselling (he is a psychotherapist) would never have helped him resolve this. Such therapy produces adjustments to situations rather than bringing about fundamental changes allowing a richer life. In the reliving of experiences during breathes, several subjects said that the courage-confidence gained then transfers to life outside the workshops. In particular has been the loss of a fear of death. For one subject, her mandalas are important in recapturing what happened in herreathes, enabling the integration process. She has found that, over a large number of breathes her mandalas have shifted from being very concrete to more and more abstract (less about objects and events in the world). The registered psychologist felt that there can be addiction to the breathes. The prepost breathwork is also very important, where the breathes are the valleys or hills that provide the intensity. It is the integration of relived material that has been the most healing for one woman, but integration has not been easy to achieve. She's had to do some radical things to bring this about. It has been hard work and not as simple as having some amazing breathe

experience and suddenly being healed. What you do with this outside the workshops is very important. One man said that in reliving experiences, it is as though the body unpacks itself into full reality. However, this reality is not readily amenable to verbalisation, so when out of that state, later on, it is difficult to put it all together and integrate it. Reliving is not the whole thing. Much depends on the individual's Karma. Pain keeps our centres closed. The breathwork sweeps through all the centres (chakras) and releases energy, but has to become intersubjective and not remain simply intrasubjective. A woman who is a rebirther in private practice said that trauma can be experienced very suddenly in a breathe. She sees all of us as traumatised by some original experience and this is trapped in us. It gets stuck in the body and we close down in that area, but remain affected by this in the way we live. Reliving this releases the trauma, and when this happens she expects things to be different.

Beyond this lies integrating this relived experience into one's life. Important are support systems outside the workshops. The releasing of one cluster of experiences can trigger off other negative clusters, and these come up outside the workshop.

Patterns of unfolding: There are two aspects to this. Firstly is the issue of patterns in terms of Grof's matrices. Secondly, is the patterns of unfolding and growth undergone by the subject.

On the first issue, there seems no pattern to the way in which experiences come up in any given breathe or workshop. For most subjects the experiences flip from one matrix to another, within workshops and even across workshops. However, there is a vague pattern in that, on average, COEXs seemed to be tapped before significant tapping of the perinatal matrices. A more definite pattern seems to be that a fair amount of COEX and perinatal experience needs to be worked through before one gets into the truly transpersonal material.

On the second issue, the experience of patterns varies from subject to subject. Some examples follow: One subject had initially to address fundamental unexpressed emotion and pain. There seemed a lot of catching up to do. Then ego issues emerged. He has never had to repeat things once integrated. Another subject has consistently moved to becoming more open and confident. For her, issues that had been unconscious have become conscious. There has also been a relationship between her bodywork in terms of typefrequency and her outer life unfolding. Once a channel is opened the bodywork needed to do that is no longer needed by her. A male subject has experienced a pattern in relation to his sexuality, the mystical mother (Kali) and women in general. The breathe experiences have brought tensions between feelings of abandonment and forms of mystical erotic sexual expansion. Once integrated, his new state tended to threaten his monogamous family structure. Until recently, this all died down, until his partner (fema) attended a workshop and had sex with someone there. At one level he could celebrate her growing sexual freedom, but at another the old abandonment stuff came up again. He knows that she'll pass through this. But it has altered the relationship and he seems faced with many choices now.

Therapy or discovery: Most subjects regarded it as both, depending on the need and stage of the individual. One woman reported having used the workshops in a therapeutic

way initially, but now feels she's ready to move onto something else. Now, the earlier phase of needing the workshops every six to eight weeks has passed, and two or three times a year would be enough. Another woman came to the Grof workshops to deal with her eating disorder, but other stuff came up, and it became a process of selfdiscovery and growth. Yet another subject felt that to come to the session knowing exactly what one wanted was egohead centred stuff. If you tried this with the workshops you'd soon discover what you really needed. It is about letting go of what you think it is all about and facing what is really there for you.

It is very hard not to get real with this work. The male subject whose partner is now actively exploring her sexuality with other men used to control his sexual urges through a rulebound process, but now there is no control, just a staying in his heart and staying with what is happening. He feels that in this there has been a movement from seeing the Grof workshops as therapeutic to being a process of self discoverygrowth. One subject felt that it was not a therapy for everyone. Some people are so badly traumatised that the retraumatizing during a breathe could be harmful.

Future of Grof's system: One subject, a psychotherapist, feels that acceptance of a system such as Grof's in New Zealand will be slow. We are not very open to new approaches. It is unlikely to be publicly funded and will move forward on the backs of a dedicated few, with a fair degree of burnout likely. A woman felt that though the system has enormous potential, much depends on the facilitator currently running it here. Another would like to see the concepts taken on board by other therapies. The registered psychologist has used his workshop experiences in his own private practice. He believes strongly that the extent to which therapists can be with their clients is dependent on the amount of work they've done on themselves. This is a huge area of concern for him he knows of no other registered psychologist in the Wellington region, who is working with clients, who's done anything looking like work on themselves (not even at the basic psychodynamic level). One subject felt that there are only a small number of people willing to do this level of work on themselves, willing to look at all sorts of stuff and take some risks. A male subject who works as a psychotherapist in a hospital setting would like to interate Grof's techniques into his work with his clients. He would like to see places like mental health units in hospitals change such that there could be rooms in which one could do breathwork. He'd like to see therapeutic communities to which people could come and move through deep processes like those accessed in the Breathwork. We simply don't have such places. Also, there are too many health professionals who will not move out of their comfort zones. This same subject said that, in terms of the present workshops' future, to spread more widely, they need someone with good organising skills who can hold a structure together more than at present. The rebirther made the interesting point that systems like Grof's, that worked best in a group setting, were more costeffective than oneonone techniques: they were cheaper for the client and consumed far less therapeutic resources.

DISCUSSION

These data raise a number of issues and, perhaps, generate more questions than answers at present. However, while not providing support for Grof's claims, they do paint a detailed picture of the subjects and their relationship with Grof's practices. I believe we

now have a clearer picture about the type of person who undertakes this type of therapy or mode of selfdiscovery.

At least in Australasia, this was not so before this study. This is an important set of data because if it is likely that there is a strong relationship between the profile of a person and Grof's system, then such a personspecific relationship would place limitations on the breadth of applicability of the system. We also have a much clearer picture about the types of experiences that might be had during a Holotropic Breathwork session, their perceived benefits and some of the negative features of this mode of practice, at least for this sample.

These data help clarify issues of both a theoretical and practical nature. For example, the data suggest that there is little relationship between the expectations a person takes into a breathe and what actually comes up. Related to this is the concept of the inner healer which many of the subjects used to explain to themselves what was going on during their breathwork. The pattern claimed by Grof in regard to the order in which the various matrices are experienced seems to have been followed by this group. That is, for this group, there was no particular order in a given breathe, but across many breathes the emerging pattern was COEX, followed by some perinatal and only then by significant transpersonal experiences.

In terms of conducting the practice, some interesting information and views have come to light. For example, it is now much clearer to me just how important are the skills, knowledge and general approach of the facilitator. While certain skills and knowledge are needed in all forms of psychotherapy, the sheer breadth of activities and types of experience associated with holotropic breathwork sessions makes very big demands on the facilitator. This person has to be there solely for the group to a degree that will not be equalled in many other situations. Whatever the personal needs and agendas the facilitator might have must be totally set aside during the sessions. By the very nature of the practice, the breathers are in a very vulnerable state during the breathes, and probably for some long time after a particularly intense session. A wide degree of knowledge both of the theory and types of experiences to be had is also vital. Only in this way can the facilitator know what to do under a given set of circumstances. Without this knowledgeability psychic damage could occur. Also, the facilitator must be unusually sensitive to and in rapport with each breather. Only in this way is there certainty as to where breathers are at and where their experiences are coming from and leading to. Without this degree of sensitivity, even with wide knowledgeskill, a crucial phase might be missed, or an inappropriate response might be made. At the very least, this will mean a lost opportunity for healing, and at the worse some psychic damage. What all this means is, aside from an adequate level of facilitator training (and of this, there is no doubt in the case of this group), supervision is vital. Without this the facilitator (and, by consequence, the group) is left in a vulnerable position. This is especially true in regard to certain boundary issues, sexual ones especially. The issue of transference and countertransference will be very prominent in this type of system, and will need to be dealt with in a totally up front mane with the group, and between the facilitator and a supervisor.

Unlike virtually every other mode of psychotherapy practiced in New Zealand, Holotropic Breathwork has no local association or accrediting body, nor a publicly available code of ethics and system of supervision. These lacks would have to be addressed if this system is to gain acceptance and become more widespread in its practice.

At a more theoretical level, the tension between Grof's and Wilber's views, alluded to in the first part of this paper, are of great interest and importance for this system. I feel that the data presented here throw some light on this issue. Grof's theoretical system is a cartography of states of consciousness ranging from repressed bodily states, through biographical states to transpersonal ones. That is, we have a twodimensional map having X and Y coordinates. Wilber's system (Wilber, 1995) is a developmental one which models the structures and functions involved in the process of spiritual growth, hence of the evolution of consciousness, which amounts to a vertical or Z axis dimension. To date, I am not aware of any attempt to produce a model embracing all three axes.

While Wilber does not deny the possibility of healing occurring as the result of accessing a given matrix, he argues that this in itself does not constitute nor lead to spiritual growth. The thrust of his argument seems to be that such growthdevelopment occurs only when the intersubjective element is present, pointing out that only intrasubjective aspects are entailed in a breathe experience. What Wilber seems to be saying is that simply having a heightened intrasubjective experience as a result of accessing repressed materials is no guarantee that this constitutes nor will lead to evolution in consciousness. He argues that such experiences are transient and not necessarily founded on a longerterm stable pattern. Spiritual growth, by definition, implies a consistent upward movement through identifiable stages, wherein new ground is progressively broken, new plateaux reached, then movement on again. This, in turn (according to Wilber), means intersubjective interactions must take place, because spirit can ufoldevolve only through its mechanism, the persona. This demands that personas interact with each other and not operate in a state of splendid isolation. A related issue for Wilber is the distinction he makes between what he calls pretranspersonal and transpersonal experiences. In the former, he argues that we have an experience in which repressed materials are accessed (eg, a birth is symbolically relived) or a lesser psychic state is experienced (eg, a diffuse pleasant feeling). He argues that there is a great temptation for some people to classify all of these states as of a higher transpersonal nature whereas, in fact, many of the experiences (Wilber implies most of them) will be pretranspersonal and amount to egoic regression. However, there are instances of truly transpersonal states (eg, those reported by those of the mystical traditions) where ego boundaries are transcended, and higher states of consciousness are accessed. Wilber argues that the failure to distinguish between these two quite diffent levels of experience or consciousness has led to claims about the progress made by followers of certain new age groups.

At times, Wilber seems to be so scathing and derogatory of such groups (Wilber, 1995) that he loses objectivity and one is forced to wonder about Wilber's own unconscious material.

However, Wilber's distinction is a crucial one, and must not be lost sight of. The big question for Grof's system in this respect is whether any of the experiences to be had by accessing the matrices are truly transpersonal, or whether all are simply inflated pre-transpersonal states. Clearly, some of the states reported by my subjects are pre-transpersonal. But I would argue that just as many were transpersonal, especially where they were perceived to come from that matrix. I suggest that these data reflect the fact that both pretranspersonal and transpersonal experiences do occur. But, more than this, the data presented here suggest that in a total workshop experience (breathes plus other activities) intrasubjective and intersubjective interactions occur, and that both are vital to the healing that occurs, and the longer term progress that is made outside of the workshops. Wilber's contention with Grof's model ignores the fact that for full healing to occur, work has to be done outside the workshops, as reported by so many of my subjects. By its very nature, this postworkshop activity is going to have both intra and intersubjective elements. I also feel that Wilber is overlooking a fundamental issue: that of the distinction between the evolution of the incarnating entity (soul or psyche) and the development and maturation of the persona (mask) it chose to express itself through in this incarnation. His oversight is evident in the consistent way he dismisses what he brands oneoff psychic experiences, as if these occurred in isolation to everything else, and could happen without the soul's knowledge and ratification. But these are the experiences of a given persona, the soul of which has been following an evolutionary path perhaps for aeons. So are there in truth such isolated oneoff experiences? Are they not all part of the evolution of that given soul? Is not every experience of significance (even where not too obviously connected with spiritual growth) commissioned by the incarnating soul for its own growth? What is the real meaning of Jung's concept of synchronicity unless it relates to the interconnectedness between inner unfolding and outer events, wherein the former tend to engineer the latter as so many of my subjects report? It is not that Wilber does not give these notions credence. He does. He may not choose to use the term soul, coming from a Buddhist background, but he fully accepts the concepts of Atman, Karma and Reincarnation. It is beyond this short study to pursue these issues further, but they are important ones, deserving of further thought and research.

In the absence of a control group or other rigorous means of making empirical comparisons, I am not permitted to claim that the healing that takes place in this mode of therapy is due essentially to what happens in the workshops. However, these data strongly suggest this, especially in the case of subjects who've engaged in the workshops since the early 1990s. An analysis (not possible with the present data) of the relationship between specific workshop experiences and perceived/witnessed healing across time would highlight any existing pattern.

As pointed out in the introduction, this study is exploratory in nature. It does not use an experimental or correlational design, and thus cannot establish causal or correlative interactions between variables. However, the data do provide a rich picture of the type of person who undertakes this mode of therapy or selfdiscovery, the types of experiences they undergo and of the perceived benefits they gain. In this sense, my aims in carrying out this study have been amply met. There now exists a carefully collected body of data (quantitative and qualitative) relating to a New Zealand experience of Grof's system of Holotropic Breathwork. These data provide a rich source of hypotheses for testing under

an appropriate research design, where the focus might be specific (eg, the possible causal relationship between a given category of relived experience and the claimed/perceived benefits) or broad (eg, the relationship between the typical profile of the type of person who is drawn to this mode of working, their exctations of it and the value they place on it).

My understanding of Grof's theoretical concepts, my own breathwork experiences, and now these empirical data, all convince me of the value of Grof's system. But this is just a beginning. It merely points the way forward to further empirical research. It is up to further research to convince others of this by use of a scientifically acceptable methodology. However, there are considerable difficulties facing the researcher who would like to take a more "scientific" approach, using a correlational or an experimental design. What type of design would one use for an experimental design of sufficient rigour to suit the scientific fraternity? What type of control group would be needed and what types of placebo activities would the control group engage in? How would one control for such a huge range of confounding variables? What types of change would one be looking for between the control and experimental groups? One could focus on a narrow aspect. For example, how real are the relived experiences? One might attempt to objectively validate an experienter's claims. But this would deal only with experiences of observable, recorded events (eg, reliving one's birth). One cannot objectively validate a claim of relived repressed material by definition repressed materials are highly subjective phenomena. If one takes a much broader focus, what would that be? The broadest focus would be concerned with erall therapeutic outcomes. After all, just as in any other system of psychotherapy, the outcomes are distal by nature. We are looking for longterm and permanent beneficial changes of state in the client. How does one measure these? What criteria does one apply. But all these questions and more must be answered if a traditional scientific approach is to be taken.

Having considered the enormity of such an undertaking, I am inclined to the view that perhaps this is not a domain for classical logicalpositivistic science. Perhaps domains such as psychotherapeutic processes and systems of selfgrowth are not amenable to the piecemeal, reductionist approach of the classical science that psychology loves to ape. That approach seems to demand that the investigated domain fit neatly into the Procrustean Bed without noticing that the head and legs have been chopped off!

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