
STANISLAV GROF'S SYSTEM OF HOLOTROPIC THERAPY: A THEORETICAL PRESENTATION

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Abstract

This paper explores the *Holotropic Therapy System* of Stanislav Grof. Although Grof's psychotherapeutic system is not well known, 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*. Grof argues that healing comes about in the reliving of these experiences where they are integrated into adult waking consciousness.

Introduction

In a book that is widely regarded as a comprehensive handbook of the activities included under the heading of psychotherapy, Corsini and Wedding's *Current Psychotherapies* (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*. 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 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. I also 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. 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 amenable to the mental health professional.

Stanislav Grof

Stanislav (Stan) Grof 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. 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. 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.

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 was also a wide range of normals (nurses, doctors, students, artists and so on). 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 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 experience. 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). He now uses a mixture of controlled breathing, music, focused 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

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

The Theory

Of the four experiential characteristics: *abstract-aesthetic*; *psychodynamic*; *perinatal* and *transpersonal*, Grof found, with the exception of the first category (the intense perceptual alterations and distortions that occur with LSD), that the next three arose using his holotropic techniques. The exposition given here of the theory underlying holotropic therapy is taken from Grof's three key books (Grof, 1975; 1985; 1988).

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 life-threats.

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 outermost layers, representing most recent experiences, are linked back in a regression that ultimately leads 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. 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, and 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 (for example, 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 (e.g., 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 (e.g., 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, such as, 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 (for example, 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 is 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 (for example, 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 (for example, 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, of course, absolutely essential that therapists avoid being unconsciously 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, tension-free 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 twenty.

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 (such as, 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

(Rank, 1945) where the experiences are physical rather than psychological (for example, 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 concrete-realistic 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 1

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 (for example, mother's temporary illness or drug-addiction). 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 religio-mystical connotations. The world seems a friendly place, permitting a childlike, passive-dependent 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, influenza-like attacks and small muscle tremors. There may also be unpleasant tastes-smells. Visions of wrathful deities can also be present. Even schizoid-like 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. BPM 1 experiences rarely emerge in the first few sessions.

Basic Perinatal Matrix 2

BPM 2 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 (for example, 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 (e.g., 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 2 is the matrix of all that is unpleasant in the extra-uterine life (for example, 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 faeces-urine, sexual frustration and labour pains. Sophisticated clients can readily relate BPM 2 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 3

BPM 3 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, and 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 (for example, 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 1.

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. There may be visions of red-light 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 (for example, immersing in excreta or products of putrefaction). However, the initial disgust can change to passive acceptance or even pleasure. There may be scatological visions (e.g., heaps of rotting matter or corpses).

The *consuming fire* feature of BPM 3 is what seems to purify the subject after having seen all that is worse in self and others. The fire destroys all that is rotten-corrupt, 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 (for example, Yahweh in relation to Sodom and Gomorrah). BPM 3 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 re-evaluate 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 (for example, swallowing, defecation, urination and orgasm).

Basic Perinatal Matrix 4

BPM 4 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 ego-death. The cosmic bottom is hit, then follows feelings of liberation. So, there is some overlap between BPM 1 and BPM 4.

In BPM 4, positive self-values can be discovered, such as 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 4, 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 2, there are barren wintry landscapes, in BPM 3 fiery volcanic eruptions and hurricanes, whereas in BPM 4 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 BPM 4 relate to endings of wars, surviving danger, and a problem resolved by one's own skill-effort. In Freudian terms, there is the satisfaction that comes from discharging or reducing tension, such as 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 no-exit experience of BPM 2 is met, then the birth-death struggle of BPM 3, some of BPM 4 rebirth experience and cosmic unity of BPM 1. Beyond this are the more transpersonal experiences. In less disturbed people, the sequence is often positive BPM 4 – 1, then some BPM 2 and 3, then the fuller versions of BPMS 4 and BPM 1.

Important is the BPM governing the terminating phase of the sessions. For example, if BPM 1 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 3 was dominant, the feelings are of anxiety, apprehension and irritability. The governing by BPM 4 is best of all, where all presenting symptoms disappear and life seems good and simple. Similarly for BPM 1.

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 spatio-temporal boundaries. Gone is the strong body image and sensory dominion. Grof has developed the following classificatory scheme:—

Extension within objective reality:

Temporal: embryonal; ancestral; collective-racial; phylogenetic; past-lives; extrasensory.

Spatial: ego transcendence; identification with others; group consciousness; animal and plant identification; oneness with life; consciousness of inorganic matter; planetary and extraplanetary consciousness; out-of-body experience, travelling clairvoyance, telepathy. Spatial constriction of consciousness to organs, tissues or cells.

Extension beyond the objective framework:

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 religio—philosophical culture, such as 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 fragments–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 *deja 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 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 non-verbal or intuitive means to subjects as they relive them.

In experiencing extra sensory perception (ESP) phenomena there is the transcendence of space-time limitations. Objective verification is usually difficult and, after the session, the subject does not display any increase in ESP ability. Ego-transcendence 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 self-identity is lost. Often this identification is with some famous personage, where the Christ and Buddha figure prominently. There is also group consciousness or identification, as with the persecuted Christians 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, as 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. Out-of-body 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.

Grof's System of Holotropic Therapy

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 non-verbal 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, six-pointed 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 psych-spiritual 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 lasts 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. 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 (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 (for example, treating mystical experiences as primary infantile narcissism: Deikman, 1963, 1969). It is a rare few eminent psychological theorists who have shown a genuine interest in transpersonal phenomena. In particular, Grof mentions Jung, Assagioli and Maslow. 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 transpersonal experiences, and also against the notion of memories from before birth (he regarded the foetal brain as being too immature). However, his work has 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 psychoactives are the most powerful route to deep material, Grof was obliged to develop a non-pharmacological 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 (1988) confirmed the findings of Reich that psychological resistance and defences use breath restriction. Conversely, self-initiated deep breathing removes autonomic control and resistances. This releases many conscious experiences, as being flooded with light and love.

Grof (1988) argues that the physical symptoms of hyperventilation are usually seen in pathological terms (for example, carpopedal spasms – tetanic hand-foot contractions). He 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 pent-up energy. The typical outcome of a good holotropic session is profound emotional release and physical relaxation. Grof calls this *pneumocatharsis*.

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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, pains-tensions 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 the energy that is traditionally related to that centre.

Music is also combined with hyperventilation, where skilful 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 facilitator-therapist to suit the phase the subject is going through. Sexual experience is, for example, facilitated by such as the Venusberg music from Wagner's Tannheuser, aggression by Holst's Mars. It 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 avoid 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. 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 talk-only variety. However, these meet the anaclitic needs of the client 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 will not cause problems, and where music can be played loudly. The lighting is reduced, and such things as tissues, buckets 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, such as 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, 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 pseudo-religious conversion-like 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 full-blown abreaction as Grof describes it (Grof, 1988).

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

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The general strategy in holotropic therapy 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 positive to negative or from one negative system to another negative system, there can be a change of symptoms which, if severe, can need re-diagnosing, such as, from depression to hysterical paralysis. The latter Grof calls *substitutive transmodulation*.

The therapeutic potential of the death – rebirth 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 be greatly reduced, as is a reliance on alcohol or drugs. Similarly, sadomasochism, aggression, impulsive behaviour, self-mutilation and a variety of phobias and sexual disorders may go or be greatly reduced. 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 complex-subtle nature have their origin (for example, embryonal traumas). The resolution of, or insight into, past-life conflicts and traumas can eliminate certain problems. Likewise, certain negative archetypes bring an *evil* influence into a person's life, akin to spirit-possession. 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. It can also initiate its own crisis.

Healing can be regarded as a movement toward wholeness, which implies a common dominator. Such a universal mechanism implies that consciousness is

all-pervading, 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 world-view 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, we 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 hylotropic and holotropic modes throws a new light on therapy. This new view entails the use of methods of inducing non-ordinary 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 take 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 life-threatening 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, but 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

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challenge or threat. When the self-exploration 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 cut off from their real source and need healing.

Traditional – Holotropic Relationships

Grof (1985, 1988) argues that LSD research and other experiential self-exploration 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 (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 philosophical- spiritual - mystical - mythological 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 Newtonian– Cartesian 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 self-preservation, 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 the primary process. The ego retains its close connection with consciousness and external reality, yet performs unconscious functions. The super-ego 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 Id- like aspects (for example, 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 (for example, 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 (such as, 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 *Ego-psychology* (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

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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 3 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 (1945) departed considerably from the Freudian mainstream. His system was humanistic–voluntaristic as 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 painful-frightening 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 non-sexual 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 birth canal is extremely traumatic. Additionally, Grof argues (1985) that most psychopathological conditions are rooted in BPM 1 and BPM 2 (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 Cartesian–Newtonian 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).

Existential – Humanistic 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 2 condition (eg, feelings of meaninglessness, rat-race, 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), which attempted to liberate locked-in human potentials, with the emphasis on the bioenergetic systems, for example, the Rolfing massage system (Rolf, 1977).

There also arose the Gestalt therapy of Perls (1951), with its focus on re-experiencing conflicts-traumas, and the here-and-now. 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 is said to dispel the unreal system that drives one to neurotic-defensive 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 self-actualisation 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. Jung stressed the importance of the unconscious, mystical, creative and religious, and 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 biological-sexual force aiming at mechanical discharge, but as a creative force in nature. Unlike Freud, who saw a historical-deterministic 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. However, Jungian analysis doesn't deal effectively with the psychosomatic dimensions of the birth-death process, nor with the actual biographical aspects of perinatal phenomena. Jung explored some transpersonal aspects in great depth – 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 intuitions-aspirations. His system is called psychosynthesis, where the therapeutic goal is self-

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realisation and the integration of the sub-selves around a unifying psychological centre. However, as broad as this scheme is, there is, again, a lack of recognition of the biological components that certain psychosynthesis practitioners are integrating.

Maslow (1976) studied peak (mystical) experiences, and defined the stages leading to self-actualisation 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 (1985) that Dianetics (more recently called Scientology) has far reaching parallels with his own work and findings, as pointed out earlier by Gormonsen & Lumbye (1979).

Conclusion

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 2 and 3. The difference between these two is that in BPM 2 experiencers are passive victims, whereas in BPM 3 they can also be the aggressor.

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 3 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.

REFERENCES

- Adler, A.** (1959) *Understanding human nature* Premier Books, NY.
- Assagioli, R.** (1965) *Psychosynthesis, a Manual of Principles and Techniques* Hobbs, Dorman, NY.
- Bache, C M.** (1981) On the emergence of perinatal symptoms in Buddhist meditation. *Journal for the Scientific Study of Religion* v 20 no 4, p 339 – 350.
- Corsini, R J and D Wedding.** (1995) *Current Psychotherapies*. 5th edition. F E Peacock Publishers Inc, Itasca, IL.
- Deikman, A J.** (1963) Experimental meditation. *Journal of Nervous and Mental Disease* v 136, p 329 – 373.
- Deikman, A J.** (1969) Deautomatisation and the mystic experience. *Psychiatry* v 29, p 324 – 338.
- Frankl, V E.** (1963) *Man's Search for Meaning*. Washington Square Press, NY.
- Freud, S.** (1985) *Early Psychoanalytic Writings*. Collier, NY.
- Gormonsen, K and J Lumbye.** (1979) A comparative study of Stanilav Grof's and L Ron Hubbard's models of consciousness: Presented at the *Fifth International Transpersonal Conference*, Boston MASS, November 1979.
- Grof, S.** (1970a) Psychotherapy and human culture: Part I. *Journal of the Study of Consciousness* v 3, p 100.
- Grof, S.** (1970b) Psychotherapy and human culture: Part II. *Journal of the Study of Consciousness* v 4, p 167.
- Grof, S.** (1970c) The use of LSD in psychotherapy. *Journal of Psychedelic Drugs* v 3, p 52 – 74.
- Grof, S.** (1972) Varieties of transpersonal experience: observations from LSD psychotherapy. *The Journal of Transpersonal Psychology* v 4 no 1, p 45 – 80.
- Grof, S.** (1973) Theoretical and empirical basis of transpersonal psychology and psychotherapy: observations from LSD research. *The Journal of Transpersonal Psychology* v 5 no 1, p 15 – 53.
- Grof, S.** (1975) *Realms of Human Unconscious: Observations from LSD Research*. Viking Press, NY.
- Grof, S.** (1980) *LSD Psychotherapy*. Hunter House, Pomona, CA.
- Grof, S.** (1985) *Beyond the Brain: Birth, Death, and Transcendence in Psychotherapy*. State University of New York, NY.
- Grof, S.** (1988) *The Adventure of Self-Discovery: Dimensions of Consciousness and New Perspectives in Psychotherapy*: State University of New York, NY.
- Janov, A.** (1970) *The Primal Scream: Primal Therapy – The Cure for Neurosis*. GP Putnam's Sons, NY.
- Jung, C G.** (1970) *Analytical Psychology: Its Theory and Practice*. Random Press, NY.
- Maslow, A H.** (1968) *Toward a Psychology of Being*. 2nd edition. Van Nostrand Reinhold, NY
- Maslow, A H.** (1976) *Religious Values and Peak Experiences*. Viking Penguin, Harmondsworth,
- Maslow, A H.** (1993) *The Farther Reaches of Human Nature*. Viking Penguin, Harmondsworth.
- May, R.** (1967) *Existential Psychology*. Random House, NY.

- Orr, L and S Ray.** (1977) *Rebirthing in the New Age*. Celestial Arts, Millbrae, CA.
- Perls, F, R Hefferline and P Goodman.** (1951) *Gestalt Therapy*. Julian Press, NY.
- Rank, O.** (1945) *Will Therapy, Truth and Reality*. Knopf, NY.
- Richards, W A, S Grof, L Goodman and A Kurland.** (1972) LSD – Assisted psychotherapy and the encounter with death. *The Journal of Transpersonal Psychology* v 4 no 2, p 121 – 150.
- Rolf, I.** (1977) *Rolfing: The Integration of Human Structures*. Harper & Row, NY.
- Sullivan, H S.** (1953) *The Interpersonal Theory of Psychiatry*. W W Norton, NY.
- Sutich, A J.** (1968) Transpersonal psychology: an emerging force. *Journal of Humanistic Psychology* v 1, p 77 – 78.
- Watkins, J.** (ed.) (1978) *The Therapeutic Self*. Human Sciences Press, NY.

BIBLIOGRAPHY

- Bateson, G.** (1972) *Steps to an Ecology of Mind*. Chandler Publishing Co, San Francisco.
- Gelso, C J and R E Fassinger.** (1990) Counselling psychology: theory and research on interventions. *Annual Review of Psychology* v 41, p 355 – 386.
- Goldfried, M R, L S Greenberg and C Marmar.** (1990) Individual psychotherapy: process and outcome. *Annual Review of Psychology* v 41, p 659 – 688.
- Goodman, F D.** (1986) Body posture and the religious altered state of consciousness: an experimental investigation. *Journal of Humanistic Psychology* v 26 no 3, p 81 – 118.
- Grof, S and C Grof.** (1980) *Beyond Death: The Gates of Consciousness*. Thames & Hudson, London.
- Laing, R D.** (1972) *Politics of Experience*. Ballantine Books, NY.
- Lukoff, D.** (1988) Transpersonal perspectives on manic psychosis: creative, visionary and mystical states. *The Journal of Transpersonal Psychology* v 20 no 2, p 111 – 139.
- Lukoff, D, R Zanger and F G Lu.** (1990) Transpersonal psychology research review: psychoactive substances and transpersonal states. *The Journal of Transpersonal Psychology* v 22 no 2, p 107 – 148.
- Lukoff, D, R Turner and F Lu.** (1992) Transpersonal psychology research review: psychoreligious dimensions of healing. *The Journal of Transpersonal Psychology* v 24 no 2, p 41 – 60.
- Pressman, T E.** (1992) The therapeutic potential of nonordinary states of consciousness, as explored in the work of Stanislav Grof. *Journal of Humanistic Psychology* v 32 no 3, p 8 – 27.
- Tart, C T.** (1991) Influences of previous psychedelic drug experiences on students of Tibetan Buddhism. *The Journal of Transpersonal Psychology* v 23 no 2, p 139 – 173.
- Wilber, K.** (1995) *Sex, Ecology, Spirituality: The Spirit of Evolution*. Shambhala, London.
- Zaehner, R C.** (1972) *Zen, Drugs and Mysticism*. Vintage Books, NY.