# The Healing Breath

*a Journal of Breathwork Practice, Psychology and Spirituality*

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# INNER QUALITIES OF A PROFESSIONAL BREATHWORKER

**by**

## Tilke Platteel-Deur

**This paper was given as a lecture at the International Breathwork Foundation's Global Inspiration Conference, France 1998.**

## Some history

After I finished High School, in 1956, I went to the 'Rotterdamse Dans Academie'. Modern Dance was what I loved most. I took exams in it and I taught it. All movements in this type of dance, which is Martha Graham style, are built on breathing. This technique uses the inhale to stretch the body and the exhale to contract the body and the movement evolves out of the exhale. This technique helped me enormously to get a deeper contact with my body, my feelings and with life itself.

In 1978 I had my first Rebirthing session.

It was a revelation. It felt like coming home in my body and in myself. I understood on a very deep level the contractions and the stretching that I had been doing for all those years at the dancing academy. I knew with a strong inner knowing how my body had been meant to move, and what it was capable of. I had a strong sensation of oneness, of being connected to something that I felt was the source of my being. I felt that I was love. I experienced my inner God. I was elated.

I didn't have the slightest idea what had happened to me, but I felt certain that something very important had occurred, something that was going to change my life. The thought that popped into my mind was: "This is going to be my second career, no matter what".

In those days we just knew that 'it' worked, but not exactly how it worked. So, when I myself started to give sessions – after some rather superficial training – I was everything, everything except a professional. I was simply acting on Leonard Orr's positive feedback and on his idea that having had about ten sessions was enough to start working. Today I know that it was not. I was a pioneer in those days, and God saved me hundreds of times from all kinds of disasters.

Having been a professional dancer however, I knew very well about the advantages of having a good technique. Since in those days there were no long term training programs, I started to travel around the world to try to get some technique and knowledge together. As Richard Bach says somewhere: "Teach what you need to learn." I worked, I learned, I got paid, and I slowly learned about what was to become my new work, work which would become a very fulfilling part of my life.

Today, after having trained several hundred therapists over the last 18 years, I most strongly recommend people not to start working the way I did, but to get a really good, thorough training.

## The beginning

When I met Hans Mensink, in 1979, we were – at least on the outside – total opposites. Nevertheless we decided to work together, after we found, during a short conversation, that we shared the same vision of creating a three-year training program.

There were two main reasons to do so.

1. Getting breathwork out of the corner of charlatanry.

   We were so enthusiastic about the deep effects of this simple technique that we wanted to help ourselves and others to learn to use it in a well-founded way, a way that would give credit to it.

2. Our own growth.

   All around us we saw trainers giving short workshops, lasting between two and five days. They would bring their participants up to a high level of energy and then they would leave, and were never able to see how, sometimes, people would fall into a pit, simply because the insights they had achieved were not integrated into their normal daily lives in any way.

We noticed a great danger in that, both for the participants in the trainings and for the trainers themselves. In order for trainers to grow and take on their own process, they need to give people the opportunity to get to know them really well and to give them honest feedback. That takes time!!!

So we started a program which grew organically over the next six years into the three-year training we wanted.

Today I can say; “Yes, I am a pro.” I don’t claim to have mastered absolutely all the qualities mentioned here. I am still working and learning. And that’s mainly because I do a lot of private work, for myself and with my clients

As a therapist, you have to get “It” into your flesh and blood. Because it’s work that you do with people of flesh and blood and it’s the kind of work that is done with blood, sweat and tears. So you need to study, to practice and to widen your knowledge. But most importantly, you need to do your own personal process of inner growth. Ultimately, you will be known by the content of your life and by ‘who you are’ more than by what you say or even do.

***Live, what you teach, it makes you reliable.***

## The Qualities of a Professional Breathworker

| | |
|---|---|
| **LOVE and LEARNING**<br><br>**through LOVE**<br><br>**and BEING MOVED** | **Trust** |
| | **Self discipline** |
| | **Authority** |
| | **Integrity** |
| | **Attention, Veneration** |
| | **Service** |
| | **Acceptance, Tolerance** |
| | **Purposefulness** |
| | **Humor** |

### Trust

Trust comes with learning and experience. Trust comes with the inner work you do and with learning craftsmanship. Both are equally important. So studying and learning, and trusting the inner power make the work easy, safe and pleasurable.

The *Course in Miracles*, Manual for Teachers states it very clearly:

> "Trust is the foundation on which the ability of God's teachers to fulfill their function rests. The teachers of God have trust in the world, because they have learned it is not governed by the laws the world made up. It is governed by a Power that is *in* them but not *of* them. It is this Power that keeps all things safe. It is through this Power that the teachers of God look upon a forgiven world." (p. 8)

Because we are human most of us have not reached that state of mind yet. Therefore we need practical skills.

There are a few skills I consider absolutely necessary.

1. A profound knowledge of breathwork, 'How to play the breath'.
I am still grateful to Leonard Orr for teaching me to play the breath like an instrument.

2. Besides that, you have to have techniques to work through "emotional stuff".
You need a frame of thought, an intellectual understanding of the work you are doing.
You need to understand how to work in the direction of stabilizing an adult personality. "An aware ego" as Hal Stone calls it. And you need to have a stable understanding of transference and counter-transference.

3. You need to really understand that this work is about integrating our judgements about ourselves and about life, and how integration works and can be brought about.

4. You need to be able to do Inner Child work.

- If you were to grade yourself on your intellectual understanding and on your technique, between 1 and 10, 10 being the most excellent, what would it be?
- Do you need to study and/or practice more?

## Discipline

Discipline means to become your own disciple. That means to stick to your purpose and to clear away the problems you may encounter. It is not a question whether it is because you are a little sluggish or because there is some 'outside' obstruction. Listen to your inner voice and listen to the good advice of people who have more experience. You won't lose face by asking for advice and listening to it.

- Do you have a certain routine to help you to stay grounded and centered?
- Are you open to feedback and do you ask for it?

## Authority

Being your own divine inner authority means to hold to your authenticity. Don't try to copy someone else. Be yourself. Find your personal style.

As I said before, you can't 'float' on your experience, you'll always have to develop, to study, and to take sessions. Grow inside and out. Your growth process always goes on. If you neglect this, your inner child will feel so insecure that your so-called authority will melt away. Maybe it is a pity, or may be it is fortunate that we have chosen

a profession that doesn't allow us to rest on our laurels. So take supervision. And practice, practice and practice even more.

Get to know yourself through and through, especially your vulnerability. As you'll often work with the vulnerable child of your clients, you had better be comfortable with your own!

And it's just as basic to get well acquainted with your anger and rage. When your anger is disowned, and not well known to you, you could be a threat to the inner child of others. Your anger, which is mostly a cover up of fear, would come out in a rather cold, polite and withdrawn way.

- Do you take sessions on a regular basis and/or supervision?
- Do you give to yourself what you're giving to your clients?

### Integrity honesty modesty

Learn to distinguish your own signals that warn you when you're going to make a mistake. If we are really honest, we all know when we're doing something that is unethical, dishonest, hurtful, etc. Sometimes we just don't want to hear this clear inner voice, but that's all together a different story.

Be honest to yourself and to others. Communicate if there's something that you feel incapable of. Modesty means knowing your own boundaries, your strengths *and* your weaknesses.

Don't make yourself bigger than you really are, and don't make yourself smaller.

Don't mess around with your clients sexually. You are mainly working with their inner child. Acting on their sensual, or sexual, feelings is like having sex with your three year old!!!!

- Are you honest about your "weaknesses"?
- Do you communicate when you feel that the work stagnates?
- Do you send someone on to somebody else if necessary?

### Attention veneration

Focus your attention on your client, in a loving, supportive and accepting way. You should come from a point where you know your client has got all the resources s/he needs to move further. You just need to be there to help him to remember. You don't need to "work hard." Lean backward and smile inside, in total appreciation for what you see hap-

pening in front of you. Whatever it is, it's always a miracle that we're able to create what we create. Whether it is positive or negative.

- Close your eyes and imagine giving yourself exactly the kind of attention you would give to your clients.
- Smile inside and breathe a little, appreciate yourself for being the creator of your life.

### To be of service

Willingness to be of service is essential to our professional attitude. It means, neither more nor less than to fulfill your function towards someone. It doesn't mean being servile or submissive. It is an attitude of being proud to be able to do the work you do, and doing it well.

- Are you willing to make exceptions and work for free just because someone is in need and you are willing to be of service?

### Acceptance

You need deep trust to be tolerant and accepting. Acceptance and trust are only possible if you're really working on your own inner process. If, inside of us, there still is a thick layer of non-evolved – which means not-worked-through – material, we will be judgmental about the same kind of stuff in others. Then we can't be in acceptance, so we can't work with that person.

So again it is essential to get to know the shadow sides of your personality. Life will present you with plenty of chances to do exactly that. Because every time you are irritated about someone or you find you are putting someone on a pedestal, you have a "disowned self" right in front of you. If you can start to see that as a gift and an opportunity to learn, rather than something unpleasant you are on your way to being a more complete human being.

Ask yourself honestly:

- Do I ask for supervision, or do I work on it in a session, each time I feel 'upset' by someone?
- Do I look at what it has to do with me and my beliefs when there is a problem in my life?

### Singleness of purpose

To know your purpose in life will help you tremendously to stay on your path. For me, doing my work is not my life's purpose, but it is the means for me to fulfill my life's purpose. It is the best way I know in the moment to express myself.

Life will always put you to the test in the form of placing obstacles on your path. Don't let yourself be distracted, but simply move forward. For that you need discipline, but you've got that already, right?

Do a little exercise:

- State as clearly and precisely as possible, your purpose for this lifetime.

This may take you some time to think about.

### Humor

Humor is a sure sign that you've stopped being identified with one part of your personality. As long as you are identified with something inside you, there is always an atmosphere of wanting to be right and of seriousness. The moment integration takes place and identification stops, there is room for humor and laughter.

When integration happens, tension is released. We stop feeling the desperate need to be right. It causes more possibility of choice. There is room for different opinions.

Humor, supported by a deep acceptance, allows us to look in appreciation at the creations of others and ourselves.

Ask yourself honestly:

- Can I really laugh about myself when I've made a mistake?
- Can I forgive myself and say "Sorry"?
- Am I amiable to someone who makes a mistake?

There is a nice theme to work on!

### Love, learning Through Love and Being Moved

The capability to be touched and moved by another person is a sure sign that your heart is open. It's OK to shed some tears, even when you are working, when you see how someone has a deep insight or revelation.

If there is no real sense of love for the person you are working with, you can't work.

In the Bible Jesus stated it quite clearly.

"There are these three, hope, trust and love.
But the most important of those is love."

Love is the most important, essential ingredient to succeed with our work. (This probably goes for all types of work) When we notice we are 'plugged in' about something or someone, our flow of love is distorted. Our connection with that person is disrupted. We can't see clearly anymore. The relation is not working, the therapy won't work either.

We need to be willing and prepared to learn through our feelings of uneasiness as well as by our deep longing for harmony and love. If we are willing to do just that, we will, in a very fundamental way, be able to contribute to the spreading of more consciousness and more love on this planet.

***The holiest spot on earth***
***is where an ancient hatred***
***has become a present love.***

## References


Stone, Hal and Sidra (1985), *Embracing Our Selves: Voice Dialogue Manual*, Marina del Rey, California: Devorss & Company, 1985.

*A Course In Miracles:* Foundation of Inner Peace,1985


## About the Author


Tilke Platteel-Deur has been practicing and teaching Breathwork and the dynamics of relationship, since 1979. After intensive training in the Psychology of Selves with Hal and Sidra Stone, she incorporated the Voice Dialogue technique, as they developed it, into her work. Together with Hans Mensink she has created the Institute for Integrative Breath Therapy, (Das Institit fur Ganzheitliche Integrative Atemtherapie). They offer a basic three year training and students have the option, after having worked at least a year as a practitioner, to take a fourth year to learn to become a trainer.

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# DIALOGUE ON HYPERVENTILATION

**BETWEEN**

# KYLEA TAYLOR AND JOY MANNÉ

## Introduction

Through 1997 Kylea Taylor and Joy Manné held an informal email discussion about hyperventilation (HV) in the context of the different kinds of Breathwork we each work with. Our discussion covered the definition of HV, and went on to cover HV in various contexts. We decided to put it together and to publish it in the form of a dialogue. It has been edited into the following sections: "Definitions," "Trusting the Breath," "Tetany," "Breathwork Goals" – in which we discuss nonordinary states or trances and shamanism, "Is there any danger in Breathwork?" "Breathwork and Healing," and "The Breathworker."

We hope you will enjoy what we have written and join in the debate.

**Kylea Taylor** teaches for the Grof Transpersonal Training and practices Holotropic breathwork (HB). She has written *The Breathwork Experience: Exploration and Healing in Nonordinary States of Consciousness* (Hanford Mead, Santa Cruz, CA) and *The Ethics of Caring: Honoring the Web of Life in Our Professional Healing Relationships*. She is the Editor of *The Inner Door* (the quarterly publication of the Association for Holotropic Breathwork International) and expresses her purpose as in this way, "I feel like my mission is to make sure there is a body of written work about HB and that we stay open to all kinds of input and other Breathwork systems. I am interested in fashioning a container which keeps to the integrity of the HB Principles." As an example, Kylea has told me, "I have taken two things that I have learned from Rebirthers – one into my practice of HB and one into my personal practice (20 connected breaths). The one I have incorporated into my practice is that I suggest after the group relaxation at the start of breathwork that people begin their rapid breathing by taking full deep inhalations and letting the air exhale fully of its own accord (so that a gentle exhalation is suggested, rather than the forceful exhalation that some might choose at first). But after the music goes on, I then trust the body to breathe in its own way as the spontaneous nonordinary state is introduced."

**Joy Manné** trained as a Rebirther and Spiritual Therapist with Tilke Platteel-Deur and Hans Mensink in the School of Integrative Breath Therapy in Holland. She has developed what she learned into a six-part structure for working with the breath which she calls Conscious Breathing Techniques, among which she includes Rebirthing. Joy has written about this and about Rebirthing and Breathwork in general in her book *Soul Therapy* and

in numerous articles.[1] Her mission is to get Breathwork better known and to contribute towards advancing its professional recognition. She has come out very strongly against the use of hyperventilation: "To ask a client to hyperventilate is incompetent practice in Rebirthing as it is in any breathwork.[2] Why? Because *hyperventilation rapes the unconscious.* The great and serious risk of hyperventilation is that it can bring up from the unconscious material that the client does not have the means to integrate. This is dangerous.[3] Fortunately many people have strong defence systems. Their unconscious defends itself against this abusive kind of attack and instead of letting potentially dangerous material through, it produces the pain of tetany.[4] Engaging in techniques which can be dangerous in the hope that one's defence system will hold out is "cowboyism" and has nothing to do with personal and spiritual development."[5]

**Joy** We are going to start with definitions. Perhaps it's good to start with defining what we each represent in this discussion. In a way I might be thought to represent Rebirthers, but I'm not a classical or traditional Rebirther. There are elements in Rebirthing philosophy which I find unrealistic and cannot support in any way. One of these is the commitment to physical immortality. I have adapted the Rebirthing I learned and combined it with my practice of Vipassana meditation. Through this process I discovered "Gentle Rebirthing" and then developed it further into a structured system of six stages of working with the breath which I call "Conscious Breathing Techniques." The purpose of the Breathwork I do is personal and spiritual development.

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[1] 'Rebirthing, an orphan or a member of the family of psychotherapies?' *International Journal of Prenatal and Perinatal Psychology and Medicine*, Vol.6 (1994), No. 4, 503-517.

1995 (i) 'Rebirthing and a method for working with the breath from the Pali Buddhist texts.' *Breathe International*, Issue No.60, 1995.

1995 (ii) 'Rebirthing, is it marvelous or terrible?' The Therapist: Journal of the European Therapy Studies Institute, Spring 1995.

1995(iii) 'The Language of Breath: The Use Of Conscious Breathing Techniques In Psychotherapy,' paper presented at the International Society for the advancement of Respiratory Psychophysiology (ISARP) conference, 1995, in Rapp, Hilde (ed.),*Experiences of Difference.* British Institute of Integrative Psychotherapy (BIIP): New Controversial Discussions Series. 1997, London: BIIP (21 Priory Terrace, GB-London NW6 4LG).

1997(i) 'Breath is a Language,' *Lectures and Transcripts,* Fourth Global Inspiration Conference of the International Breathwork Foundation, 'Breathwork and Psychotherapy,' Kirchberg/Pielach, Austria, June 6 - 13, 1997.

1997(ii) 'Breath Language. *Transpersonal Psychology Review: Journal of the British Psychological Society's Transpersonal Psychology Section*, Volume 1, No. 5, November, 1997, pp. 15-23.

1997(iii) 'Creating a contemporary Buddhist psychotherapy,' a review-article of David Brazier's *Zen Therapy* (London: Constable, 1995) and Mark Epstein's *Thoughts without a Thinker: Psychotherapy from the Buddhist Perspective* (New York : Basic Books, 1995), in *The Authority of Experience: readings in Buddhism and Psychology*, ed. John Pickering, Curzon Press, 1997.

1999 'Mindfulness Of Breathing And Contemporary Breathwork Techniques.' in Claxton, Guy et al (ed.) Papers presented at the conference 'Buddhism, Science and Psychotherapy,' Dartington Hall, November 1996.

[2] Manné, 1994.

[3] See also Timmons, 1994, p.284f.

[4] Manné, 1994; Manné 1997, Chapter 38.

[5] Manné, 1995(ii), p. 20.

In general, I'm not sure to what extent Rebirthers are homogenous – and that could be another topic for this journal to explore.

**Kylea** Holotropic Breathwork – HB – is a term trademarked by Stanislav and Christina Grof to describe a philosophy, technique, and container for doing deep, inner work. It is described in detail in their paper, "The Principles of Holotropic Breathwork".[6] The philosophy is one of "not-doing" rather than directing the process – more acting as a midwife, and only if necessary, than acting in the role of a therapist. The container is a group setting with two breathing sessions. Participants are paired so that one breathes and the other sits during one session and the roles are reversed for the other. There is a guided relaxation, evocative music, focused energy release work, artistic expression, and a sharing group for closure at the end of the workshop.[7]

HB people are in one way homogenous in that they have all trained with Stan personally. And yet they are different too, expressing their individual personal style in the work they do. They are supposed, however, to be using the same simple model he has set out which I've described above if they are using his trademarked name of Holotropic Breathwork; otherwise, they have been asked by Stan Grof not to use the name.

## I. Definitions

**Joy** I'd like to start by clarifying the category "Hyperventilation" (HV).When I read Fried[8] and also the recent discussions in ISARP (International Society for the Advancement of Respiratory Psychophysiology)[9] I get the impression that many people with a medical background believe that every medical complaint comes down to HV. HV has become an immense, limitless container into which everything goes, and the result is that it has lost any possibility of being sufficiently precise even to be a useful medical definition.

**Kylea** I think it would be a good idea to come to some agreement about this terminology as we breathwork facilitators enter into dialogue with the medical profession. As it is now, some of us say "Yes it is HV" and some say, "No, it is not."

**Joy** Fried does not discuss but only alludes to the possibility that psychological complaints underlie HV, and in such cases, he gives the impression that he considers only his kind of therapy as being of any use.[10] He seems not to be informed about the existing literature on breathwork in psychotherapy.[11]

I would say that the kind of breathwork we do cannot appropriately be described as HV.

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[6] Taylor, 1991. *The Holotropic Breathwork Workshop: A Manual for Trained Facilitators*. Hanford Mead Publishers. p. 79-82.
[7] Taylor, 1991. *The Holotropic Breathwork Workshop: A Manual for Trained Facilitators*. Hanford Mead Publishers. p. 79-82.
[8] *The Hyperventilation Syndrome*, Baltimore: Johns Hopkins, 1987.
[9] See *Breathing:* Newsletter of the International Society for the Advancement of Respiratory Psychophysiology (ISARP), Nos. 1, 2, 3.
[10] See Manné, 1997 (i).
[11] ibid.

**Kylea** I would rather say (and of course Stan Grof does too) that yes, Holotropic Breathwork's deeper and faster breathing is actually hyperventilation, but that hyperventilation is not pathological. It does not seem to cause physical problems, rather the effects described by medical reports are really psychogenic. By this I mean the hyperventilation seen in emergency rooms comes spontaneously because psychic material needs energy and permission to emerge. This is a totally different way of looking at it than to assume pathology. The problem has been that physicians are not trained in working with powerful emerging psychic material and they tend to see powerful imagery, sounds, and movements as pathological – something that needs to be shut down by breathing into a paper bag or taking tranquilizers.

**Joy** The first problem that we need to resolve concerns definitions and terminology. Once we have resolved it, we will be able more clearly to define the variety of breathing rhythms that we work with. I'd like to convince you, and – dare I hope – Stan too, and others who do our kind of breathwork to abandon the term HV to the doctors.

My first argument is that the term initially referred to a medical problem and should be limited to the description of that problem.

As I see it, we have two quite separate things. One is a medical problem, and the other is a breathing practice.

With regard to the *medical problem* which doctors call HV and which I will also call HV: One way it is defined is, "An increase in the periodicity of this [i.e. the normal] breathing cycle inconsistent with metabolic demand may result in an increase in the amount of $CO_2$ expelled from the lungs (hypocapnia), reducing the blood $CO_2$ content below that required for proper function (hypocarbia). This process is called hyperventilation and results in a momentary shift of the acid-bas equilibrium of blood toward alkalosis."[12] Another way HV is defined is by the HV-challenge. This "(has) the person breath deeply and rapidly (perhaps twenty to thirty breaths per minute [this is hyperpnea, overbreathing] for two to three minutes."[13]

With regard to the *breathing practice* which its first literature, *e.g.* Leonard Orr and Sondra Ray's *Rebirthing in the New Age*[14] describes as HV, I reject this definition as imprecise and misleading, and seek rather to be precise about the different breathing rhythms involved. It must be said that the second book about Rebirthing, Jim Leonard and Phil Laut's *Rebirthing: the Science of Enjoying All of Your Life*[15] rejects hyperventilation.[16]

With regard to "medical or pathological HV," my proposition is that the term "HV" is left to medical doctors to work on and refine as a diagnosis of a medical complaint, an ailment, a physiological problem with chemical – that is to say "mechanical" causes.[17] In this area alone there are enough problems and conflicts already among doctors with re-

[12] Fried, Robert (1993), (with Joseph Grimaldi), The Psychology and Physiology of Breathing: in Behavioural Medicine, Clinical Psychology, and Psychiatry. New York: Plenum Press. P. 302.
[13] Fried, 1993, p. 42. See Manné, 1997 (i) for a discussion of various HV definitions.
[14] Celestial Arts, Berkeley, California 1983
[15] Trinity Publications, Hollywood, California, 1983
[16] p. 51.
[17] See my paper 'Breath is a language' 1997(i).

gard to defining HV as a diagnosis as several recent issues of *Breathing*[18] show. What is more, this diagnosis is not free of scandal and some of the research that most support HV as a medical diagnosis has been shown to be fraudulent in a recent ITV programme which was followed by an unsuccessful libel suite.[19] A term which carries this sort of imprecision and this kind of a history is, in my view, best left alone.

My second argument is that *the medical diagnosis "HV"* is not an appropriate term for the breathwork we practice. If breathwork clients are doing rapid breathing, spontaneously or through an induction, this will only last a short time within the breathing session while HV is an ongoing medical problem. Patients do not "come out of it" after a limited period. They are stuck with it in their daily life, for whatever reason. What's more, when if clients are spontaneously breathing very rapidly – which does happen with distressful memories and which can, in my view, make the process go too fast – they can be mostly be guided to slow down their breathing. So they are not completely out of control of their breathing. Even in the sessions that bring up the most traumatic or the most agreeable breathing experiences – when clients are in a breathing trance (we'll have to discuss these too), or "being breathed," as we say – this comes to a natural, healthy, productive, creative resolution by the end of the session. There's nothing about it that can possibly be related to a medical illness or pathological problem!

So to sum up, my argument is that the term HV is not a very good medical diagnosis at the best of times, and that even if applied, it does not describe the kind of breathwork we do, as even when people may be said to hyperventilate during a breathwork session, that kind of breathing ends with the integration of the experience and does not persist beyond the session.

Now, do you distinguish between pathological and non-pathological HV?

**Kylea** I would rather bring out the whole truth and continue to use the term. To diagnose HV as pathology is not correct. Hyperventilation is a spontaneous mechanism of the body which itself represents a healing impulse. The problem is not the term, or the rapid breathing, but the lack of training in how to deal with the psychic material which emerges.

**Joy** I think I can accept the term "HV" if "pathological HV" and "non-pathological HV" are carefully distinguished.

With regard to the breathing practice: In the kind of breathwork I do, we have a breathing practice which uses different speeds and rhythms of breathing. These are used according to our ideas of what is the most useful and beneficial in particular circumstances, and what we regard as right practice. Chapter 8 in Leonard and Laut is very useful on this subject. It deals with subjects like the volume and speed of the inhale, the exhale, different kinds of circular breathing, nose or mouth, normal breathing and which part of the lungs are used.

I want to go on to propose some definitions for the kind of breathwork that we do, and some more precise descriptions of the breathing rhythms that we use than the medical

[18] *Breathing*: Newsletter of the International Society for the Advancement of Respiratory Psychophysiology (ISARP), most of the issues in 1997 and 1998.
[19] See *The New Scientist*, 27 September, 1997.

diagnosis HV can cover. However, as this section concerns definitions, I will start by defining the nature of the work that breathworkers do. I define it as *psychophysical Breathwork for personal and spiritual development.* Would you agree?

**Kylea** I think I would leave out the "psychophysical" just for simplicity's sake, but it is fairly accurate, yes.

**Joy** I will also define the sort of clients we are trained to work with: breathwork is carried out with clients who are for the most part healthy in body and mostly rather healthy in mind too. I would say that the people we work with have what Richard Mowbray would call "Sufficient Available Functioning Adult Autonomy"[20] and that breathwork, as part of Humanistic and Transpersonal Psychology, is not appropriate for people who do not have this. The use of Breathwork does not have to be limited in this way, I know. In Sweden Breathwork is used successfully and in a research context with people who would not fit this definition. But the training and the holding environment necessary for this kind of work are not generally available to breathworkers.

**Kylea** I agree. One needs a longer-term, residential setting for working with people who have more intense healing needs. Generally people need a good internal and external support system in place to do the work.

**Joy** Now back to the variety of breathing rhythms that we use in our work – and indeed, that spontaneously occur in our work. I think we can define and discriminate between the variety of breathing rhythms that occur and that we use intentionally rather well. As I said before, Leonard and Laut have some good diagnostic descriptions of different breathing patterns. The features they mention are the volume and speed of the inhale, the nature of the exhale, the various kinds of circular breathing: full and slow; fast and shallow; fast and full; nose or mouth, and the part of lungs breathing takes place in, as well as normal breathing.[21] I think we can add to that. You know my interest in breath as a language.[22] Here are some further suggestions: the faster rhythms can be defined as "panting" – which can be extremely gentle, as well as more vigorous, "rapid breathing," "rapid connected breathing," and "trance-inducing rapid breathing" ("pathological HV" clearly does not induce beneficial trances). Another term that I find useful is "augmented breathing" – making the breathing larger. In my work I use augmented diaphragmatic breathing (long deep breaths right into the belly), augmented intercostal breathing (breaths that open out the lower ribs and free the organs there), and augmented chest breathing (breath that opens up the heart area). Augmented breathing can have any rhythm from short and rapid to long and slow. Whole body breathing, in which one inhales from below one's feet and brings the breath right up through the body to over the head is another form of augmented breathing. I learned recently that this comes from the Taoist breathing tradition.[23] With such a rich vocabulary, the term HV seems dull and vague.

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[20] *The Case Against Psychotherapy Registration: A Conservation Issue for the Human Potential Movement*. London: Transmarginal Press, 1995, p. 183.
[21] Chapter 8, op.cit.
[22] Manné, op.cit. 1995(iii), 1997(i) & (ii).
[23] See *The Tao of Natural Breathing: for Health, Well-Being and Inner Growth* by Dennis Lewis, Mountain Wind Publishing, San Francisco, California, 1997, p. 101.

**Kylea** I have seen all these forms exhibited spontaneously by participants, but I don't think it is a good idea to coach people in some form of breath that someone external (*i.e.* not one's own inner healer) deems best in some way for that person. In other words, I completely trust the person's own inner wisdom or inner healer to determine the kind of breath necessary at any given point in the process when the person is in a nonordinary state of consciousness. The beauty of Holotropic Breathwork is that is accepts and allows all forms of spiritual and psychic experience to emerge spontaneously, as appropriate, including types of breathing practices known to various ancient religions.[24]

**Joy** I still absolutely exclude the use of "HV" in my practice and, not only that, I work to avoid that it happens – but I do include accelerated breathing of various kinds and rhythms. One way of accelerating the breathing is simply to ask clients to connect their breaths – to avoid the pause between in-breath and out-breath and between out-breath and in-breath. The breathing can be long and slow with no question of "HV" and the fact that it is connected facilitates the availability of unconscious material.

**Kylea** At the beginning of a session, we also suggest eliminating the pause between the breaths and deepening the breaths, but don't make additional suggestions.

## II Trusting the Breath

**Kylea** I have a question. I wonder that there is so much in your article, "Breath is a Language,"[25] which is about trusting the process, but that there is no underlying trust in the breath itself to teach and catalyse what is needed even if a sometimes forceful exhalation occurs spontaneously. You say some contradictory things concerning trusting the breath. Although you say there is a need to coach and slow down a breather's process, you also have quoted me saying that it would be counterproductive to program the content of a breathwork session and then agreeing by saying, "This is what gives breathwork its authenticity and profundity."

You also write about a client's experience, "She realized through this experience that she could not trust anything to happen on its own accord, not even respiration. Only what she controlled could occur." You are quoting Proskauer, 1968, p.258.

And again, you say, "There is no attempt to make the breath larger or smaller, faster or slower or to change or control it in any way. The body is trusted to regulate the breathing and guide the process." I realize that this is in only one stage of your system. In the early stages you do not trust the breath to direct, but maintain the need for a coach.

**Joy** I'll just come in for a moment to say that the Proskauer quote is taken out of context. The context was a report of the client's experience during a breathwork ses-

[24] Boroson, M. (Nov. 1998)."Radar to the Infinite: Holotropic Breathwork and the Integral Vision". *The Inner Door* Vol. 10, No. 4.. Santa Cruz, CA: Association for Holotropic Breathwork International. p. 5-7.
[25] 1997 (i).

sion, not a recommended attitude to the breath. The session illustrated how we can really trust the breath to teach us.[26]

**Kylea** What I am saying is that trust and control (as in coaching the breath) are opposite ways of doing breathwork. As I have said, the first thing that I suggest after the group relaxation at the start of breathwork when I am having the people begin their rapid breathing is that they take full deep inhalations and let the air exhale fully of its own accord (not the forceful exhalation that some might choose at first). But after the music goes on, I then trust the body to breathe in its own way as the spontaneous nonordinary state is introduced. This means that some of the people breathe in a way that you would call, I think, harmful hyperventilation. But I have not seen any overall detriment from letting people breathe in their own way and go through their own stages and self-learning with the breath as their inner wisdom directs.

**Joy** I think there are several topics here. One is "trusting the breath" and another is implied in your word "detriment." I think we will have to come to the controversial topic "Is Breathwork ever dangerous" as part of our discussion. Let's take "trusting the breath" first. As I understand it, it means letting the breath take us where it wants to go. I mean that both for the client having a breathwork session, and with regard to letting ourselves be led and instructed by our breathing rhythms in normal everyday life. You know I'm passionate about breath being a language. I am "trusting the breath" most absolutely, when I ask a client, "Put your attention on your breathing, let your body provide the rhythm, and tell me what happens." That is what I am asking the client to do – to trust the breathing rhythm that the body spontaneously produces at that moment and to go with it in awareness. Would you agree that this is an absolute base line for trusting the breath?

**Kylea** Yes, and I should say that sometimes people choose not to breathe at all, but have an experience nonetheless, and sometimes people have material so close to the surface that with only a few breaths (not 20-45 minutes of breathing as usual), they go into intense bodily and emotional expression.

**Joy** HB uses music, and when music is playing – any form of music from classical to drumming – the breath adapts itself to the music. It is led by the music and falls into the same rhythms and phrases of the music. That is one of the great joys of choosing the music that we listen to: it can lead our breath, and therefore our state of consciousness, into the direction we have chosen – probably unconsciously and instinctively. So my position is that the breath cannot be spontaneous, nor does the body breathe in its own way when there is music. The non-ordinary state is, in my view, also not spontaneous. It is induced by the music: drumming will induce a different non-ordinary state from soft lullabies.

Now, would you agree that every form of music leads the breath into particular rhythms relative to itself, and that therefore using music to introduce a breathwork session is not purely trusting the breath.

**Kylea** Since I have always worked with music, I again must disagree with you. When people are into their spontaneous process they may, (1) not even hear the music;

[26] See 'Breathing Therapy' by Magda Proskauer, pp. 253-259 in *Behavioural and Psychological Approaches to Breathing Disorders*, (ed) Beverly H. Timmons & Ronald Ley. New York, Plenum Press, 1994.

(2) breathe in an entirely different rhythm, using *kapalbhati* (the yogic fire breath), *bastrika* (the yogic bellows breath), or another rhythm and type in their own unique process at that time; (3) breathe to the music, or (4) stop breathing entirely for quite a while. They may be totally into the music and influenced by it (but of course projecting totally unique things into it – someone hears a train, somebody an African ritual, somebody else a Mid-Eastern one, someone else just uses it to become a panther loping through the woods.)

**Joy** I find this tremendously interesting. I could not have imagined that this would happen.

**Kylea** Some people have their material so close to the surface, they take only a few breaths and are off and running in the spontaneous nonordinary state. Again, terminology. I'm using spontaneous here to describe a process that is automatic, not controlled by the ordinary conscious mind. I know there is also a spontaneous process which can emerge anywhere – in bed, on an airplane, etc. The kind I mean here in breathwork workshops is the "spontaneous one" within a non-spontaneous setting in which a person chooses the time and place to enter, but does not choose the pattern of breath or any other of the material that emerges in the body, emotions, or mind.

Once the automatic process begins, the breath is also automatic (I'm not saying this happens every time or to everybody, but it has happened very much to me). Rapid and deeper breathing and music in HB is definitely "inducing" or at least part of granting permission for the nonordinary state. But the nonordinary state then takes over and does it. Nothing and no one else is required except as requested by the breather.

**Joy** You have now almost convinced me that the breath will take its own path independently of the music, only using the music insofar as it suits its purpose, *i.e.*, the music serves the breath. Here is one more challenge on this subject – you know that one of my goals in this journal is that a constructively critical attitude is taken towards Breathwork practices.

By chance just as we were completing this dialogue, I met a young man who had participated in a Holotropic workshop and who felt manipulated by the music used – especially the theme from the film, *The Titanic*. The music is melodramatic and he thought that anyone would be moved to tears by that music. He felt his tears had been manipulated from him, rather than flowing naturally through a more organic process.

**Kylea** Mostly when we choose music, we try to avoid well-known music or current movie themes for that reason. However, a facilitator could play *The Titanic* for many people, and they would not cry. They would have many varied experiences. I wonder if this man's process was (1) needing to cry, and (2) needing to become aware of a tendency to feel manipulated.

**Joy** This sounds very acute and perceptive and is an answer that convinces me.

Can we go on to the theme of the relationship between the breath and the unconscious. For me, trusting the breath to guide the process is the same as trusting the unconscious to do the same, to guide the process. Would you like to comment?

**Kylea** That seems right to me. I think that is what I have been saying.

I'd like to hear more on why you think there is need for a coach in the early stages and what groundwork you feel the client needs in order to trust the breath. I have not seen any detriment from letting people breathe in their own way and go through their own stages and self-learning with the breath as their inner wisdom directs.

**Joy** The coaching is part of the counter-transfer, and is is as if the client's unconscious cues the coaching that the therapist gives.

I'm becoming increasing aware through our dialogue that Breathworkers in the Rebirthing tradition are considerable more interventionist than those in the Holotropic tradition, and yet both claim to be trusting the breath. I've long been interested in transfer and counter-transfer happening through the breath in Breathwork. I'd like to say something about *leading the breath* and *trusting the breath* and how these can be the same. This comes down to trusting the unconscious – both the client's unconscious and one's own as Breathworker or breathing psychotherapist – listening to it and being guided by it. "Inducing" is a valid way of doing breathwork. With a skillful practitioner, it can be the same as letting the breath be "spontaneous" and "trusting the breath." What it feels like is as if the client's breath is asking for some recognition from the breathworker, and so one responds, giving some guidance as to rhythm and location in the body.

**Kylea** I can really understand what you are saying. This does happen. But I also think it is an invitation to self-deception. There are very subtle rationalizations that can occur when someone thinks their job is to be intuitive through their own inner healer. The subtle distinction I think we teach in holotropic breathwork training is for a facilitator to follow the overt requests of the breather. First, only intervening when there is danger or when specifically asked. Second, when working with the person doing focused energy release work, follwing the overt movements and muscle group tensings rather than intuitively thinking something needs to be done. If there is an intuitive idea, it is put in the form of a question or an option rather than just imposed upon the breather. Again, there is a delicate and subtle distinction at times, but there is no facilitator who is not vulnerable at some times to thinking he or she knows best and this kind of training helps to minimize the kind of intervention which is not simply of the midwifing kind—assisting what is already trying to happen.

**Joy** I really like best of all to leave the whole thing to the breath, to let the breath take the process to where it needs to go, but this does not work for every client. It works best for those who live closest to their unconscious, those who are the most mediumistic. Those who are more controlled, and for whom the unconscious is less accessible, do need guidance in the kind of breathing rhythms that help the ego to let go and facilitate the emergence of the unconscious as guide. I call this *leading the breath*. Observing carefully and understanding when the breath is asking to be led is, for me, part of trusting the process.

There are many ways of leading the breath. Music has that potential – although you convinced me above that this is not inevitable. In a breathwork session, the breathworker's breathing will often lead the breath, consciously or otherwise, unless the breathworker is very careful to follow the breath of the client. This is so interesting. Just as we harmonise our body movements with theirs when we are talking to a person, so we also spontaneously harmonise our breathing rhythms. This is the spontaneous occurrence

of the matching technique of Neuro-Linguistic Programming. We naturally match music with our breath, and just as naturally we match the breathing rhythm of our clients with our own breathing rhythm. This supports their process. We can also lead their breathing rhythms into following and matching ours by "breathing aloud," so to say.

**Kylea** I just want to say here that we in Holotropic Breathwork use the term *breathwork facilitator* or *practitioner* rather than *breathworker*, just because of how easy it is for us to slide into "leading" the breath. *Breathworker* sounds to me like someone else's job is to *work my breath*. We find that people learn how to find their own rhythm by breathing. When they have a problem with this, they come talk to us, and we might make some suggestions when they are in an ordinary state of consciousness so they can make a completely conscious choice about implementing those suggestions at the beginning of their next session.

**Joy** I trust the breath to tell me what interventions to make. I consider that I am trusting the breathing– consistently with my position that breath is a language – when it "tells" me that it is blocked. Then I respond by helping the breathing to become unblocked. One way I do this is by getting the client to become aware of when, where and why the breathing is blocking – to explore the blockage analytically; another way is by getting the client to breath through the blockage by means of some augmented breathing.

In any case, it is the unconscious that guides us to our choice of therapy or method and therapist – for better or for worse! Here I think what we go for and what we get is the fruit of our karma! We've talked about "trusting the breath." We often use phrases like "trust the process." I think "trusting the therapist" is another concept that is worth discussing. The mythology says we will only go as far as is safe with any therapist. And then we have the tradition of surrendering to the process. When one has a bad experience with a therapist, a good way to get something out of it is to be positive about what we have learned. Nevertheless, it is good to consider this point. I would not consider it a wise choice to do breathwork with a therapist who does not understand what you've written about in your books on ethics and on the guidance of nonordinary states![27] As you so wisely say, we have to be discerning about the therapist's goals.

## III Tetany

**Joy** How would you define tetany? What would you say makes tetany occur? Is it always "induced rapid breathing" or HV as the doctors understand it, chemically defined?

**Kylea** Stan Grof would probably say that this is thwarted impulse with psychogenic material surfacing about the thwarted impulse. One of the possibilities I have thought about is that when tetany occurs HB folks use focused energy release work to help release and express blocked material at the end of a session. In my own Rebirthing session with a breathwork facilitator trained by Leonard Orr (I know this person does not represent all Rebirthers) there seemed to be a prejudice against using any resistance or

[27] Op.cit.

release work on these tight body areas, and a preference for using only the breath and inner awareness to dissolve the tensions – more of a "meditation retreat" approach. I might deduce that Rebirthers want to control the breathing to prevent tetany and other body symptoms that might want to emerge otherwise, because they are not trained in releasing them externally and would need the breather to be skilled in doing this kind of inner breath release. I do not know if this is true. Perhaps you have a response to this.

**Joy** This sounds like a fair observation and a good analysis. I am not trained in how to release body symptoms externally, and nor do I think that many Rebirthers are. This sounds like an area where some common training for Rebirthers and Holotropic facilitators could be very fruitful.

I'd like you to explain what you mean by some of the terminology you use. What for example is "thwarted impulse"?

**Kylea** Tetany seems to occur when one gets in touch with wanting to do something, but being unable to. I have seen it occur during a breathwork session in the legs of a former pro-football player who could not play football anymore, or in the arms of someone who was re-experiencing a moment of reaching out for love that was not available. There is not always conscious awareness of the cognitive element of the unfinished business, but the connection is made often enough to substantiate this theory.

**Joy** What do you mean by "psychogenic material"?

**Kylea** Symptoms that arise as communication from the body-mind rather than from some organic malfunction.

**Joy** What kind of resistance or release work do you do?

**Kylea** The focused energy release work is another example of not-doing, rather than doing. The general philosophy is to help the participant amplify what is already happening with the idea that the symptom is arising as a healing impulse. This philosophy is similar to the healing philosophy of homeopathy where a similar remedy is applied to temporarily amplify the symptom.

**Joy** Could you give a case history so that I can be clear about the process you describe. If it is not too personal, can you say how the session with the rebirther might have developed if he had used resistance or release work?

**Kylea** First of all, that session did turn out well without emotional release work. I was able to do the inner work he was suggesting and experienced the release that way. It was excruciatingly painful, however. With the focused release work we use in Holotropic Breathwork, the practitioner would have asked if I wanted to work with the pain in my leg. I would have agreed. He would have asked where exactly I was feeling it. I would have showed him. He would place his hand, or knuckle there and ask me to breathe into it, then push against him. He would simple hold the resistance to the extent of the force I was using. The idea is that the person gets to experience both the feeling (usually of tension or pain) and the creation of the feeling by being the active one pushing. In some cases that allows the re-integration of the introjected perpetrator. In the experiencing of both, instead of projecting the perpetrator out and experiencing only the victim, there is healing. Again, I can't stress too strongly that this is not a "technique" but a philosophy of not-doing, making more of what is already there so a person can become conscious of

it. This is a very different thing than deciding someone *needs* something and doing something to them accordingly.

**Joy** I'm interested in this way of looking at tetany and will be trying it with clients in the future. I really feel I've learned something important from you here. But let me persist in my argument. You know I've said about "resistance" that it is all too often used pejoratively by therapists who do Ego Therapy, therapists who accuse their clients of "holding out" – *resisting* – when they do not conform to their own – i.e., to the therapist's idea – of how their development should go, when they do not see what the therapist wants them to see, or say what the therapist wants them to say, or feel what the therapist wants them to feel, or remember the unpleasant events that the therapist thinks they ought to remember. These therapists use the concept of "resistance" to blame clients for not seeing things their way.[28] So for me tetany is not "resistance" but the unconscious protecting the person from something s/he cannot integrate.

I came to the view that the beginnings of tetany indicated that there was other work that had to take place first. I call this other work "unloading the unconscious" This unloading frees the body from tension and avoids tetany. I use awareness work with the breath or analytical breathwork to accomplished this. It sounds like your release work accomplishes the same goal.

**Kylea** Maybe the difference is in when that intervention occurs. Many times the unguided, spontaneous breath will complete a process. In general, unless there is choking or a specific request by the breather, focused energy release work in holotropic breathwork comes at the end of the session, not at the beginning or in the middle.

**Joy** What I like to do is to prepare the client for more energetic – or shamanic – breathwork by doing "unloading" work to begin with. I think that here we are serving the same purpose even if we are not exactly using the same procedures.

I'd like to mention a case history here just to show that there are no rules! A young man of 30 came for sessions. He *loved* to breathe himself into tetany, and then would writhe and roll all over the floor of my workroom most dramatically, groaning with the pain. But when I suggested the kind of breathing that stops the tetany, such as slowing his breath, taking a longer inhale, letting the exhale out gently rather than pushing it out (which is characteristic of tetany) – he wouldn't hear of it. So I came to the view that he needed to wrestle with his demons and that this was his way. I think he did about five sessions like that, and then it was no longer necessary. Of course, now I would try your way of working with tetany with such a client.

The process is always mysterious, don't you think?

**Kylea** I wonder if people who have a more kinesthetic process might benefit more from a process involving bodywork and more from a meditation practice that involves movement like kundalini yoga, and those who have a more psychic process might benefit more from a process without need for bodywork and more silent sitting meditation style. Just questions. Fortunately, the inner healer guides one into the appropriate kind of work and expression.

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[28] See *Soul Therapy*, p. 133.

**Joy** Those are interesting ideas and worth exploring. Jim Morningstar has written about body types and Breathwork.[29] This is the subject for a whole new dialogue!

## IV Breathwork Goals

**Kylea** I have lots of thoughts about the idea of goals in this work. Does one want a sensation, or an experience – a form of spiritual materialism, comparable to the materialism of wanting a special new dress/shirt or a wonderful meal but on another plane – or is there something else? And who should judge which?

Some people of course are coming initially for that. We are all attracted and encouraged by some fantasy of "specialness", but that is only the teaser. The real stuff you get if you stick around is not "experience" but learning and healing and the main two things in my own life I would say I got from the automatic state were, (1) trust in the process (Trust the Process); and, (2) an experiential knowledge of what many have called by many names, but I will call The Living Evolutionary Force – a felt (sensorily and tangibly) force of power and impersonal love, Life that moves me and everything and is mysterious and beneficent.

**Joy** You've got an interesting point here. People do come for the dramatic experiences associated with breathwork: reliving one's birth trauma, breath release, and the rich variety of trances or altered states of consciousness or nonordinary states, as you call them, that breathwork induces. Perhaps historically attaining these experiences is connected with rapid upper chest breathing, which was the way I was taught to breathe in my first Rebirthing session in 1984. Now we know these altered states can be entered through many different breathing rhythms.

**Kylea** Or without any at all, or by many other means (fasting, pychedelics, etc.), but that, too is another article.

**Joy** I'd like us to say more about the variety of trances that the client can get into through Breathwork. I'm fascinated by this and hope to do research on it in the near future. You call these nonordinary states, which I think is a good description too. You've written an excellent and essential book on how to work with these.

**Kylea** Grof actually came up with the term, *nonordinary states*, because it seemed to describe states which are, in truth, more natural than the term, *altered states.*

**Joy** This brings me to the subject of shamanism. It is my favourite subject at this moment. I've just researched and written a paper "Was the Buddha a Shaman?"[30] The research for it was very exciting, and I believe I have shown that the Buddha followed an absolutely classical shaman's training. One of the methods the Buddha used was Breathwork. Breathwork is a fundamental part of Shamanic development. Breathwork is basic to chanting and to drumming. Breathwork can evoke Kundalini experiences. These are very exciting, and people may do breathwork with these as their goal.

[29] Morningstar, J. (1994), Breathing in Light and Love. Milwaukee, WI: Transformations Incorporated.
[30] This paper will be published in *Asian Religions and Psychotherapy* ed. Professor Ria Kloppenborg

**Kylea** I do believe that Breathwork is shamanic training, but there is always risk in applying that word because people start to call themselves *shamans*. There is a big difference between a shaman and someone doing shamanic exercises. There are many similarities between breathwork and shamanic work. One difference, at least with HB is that shamanic work usually has an intention and focused will in a given session that is more specific than the general purpose in Holotropic Breathwork of surrender taking the next step on one's path.

**Joy** Part of my own development in breathwork which happened completely spontaneously has been the development of certain capacities called "shamanic" and this has happened to my clients too.

**Kylea** We have seen this too. Also psychic abilities, kundalini phenomena, and probably best of all, an improved ordinary life and ability to live in relationship with oneself and others.

**Joy** Shamanic experiences are very powerful. The Kundalini literature shows that they can be completely overwhelming. It is very hard to become their master and to learn to live with them, even when they are prepared for.

**Kylea** Support is an important element in this work.

**Joy** With regard to what you've just said, that "probably best of all (Breathwork leads to) an improved ordinary life and ability to live in relationship with oneself and others," – perhaps we are making too little of this most important point because we are concentrating on problems and controversies!

## V Is there any danger in breathwork?

**Joy** I said we needed to come to this question. Here it is! Let's start by defining what we mean by danger and make a context. I say this because there is a certain mythology about breathwork being dangerous, and yet when research is done – as Gunnel Minett has shown[31] – there's no foundation for the accusations. I want to set a common sense context for any supposed danger. The first part is the question of the practitioner. In ALL therapies, there are incompetent practitioners. Psychiatrists and Freudian and other kinds of analysts are trained to deal with suicidal tendencies in their clients/patients, and their own feelings when they are unable to prevent the person actually committing suicide. I don't think we work with such severely troubled people.

**Kylea** Not if we assess correctly.

**Joy** The second part of this context is the question whether the kind of breathwork we do is ever dangerous.

I would say it is dangerous when a person leaves a session unable to drive their car or unable to conduct their life in a reasonably normal fashion. Then the destabilisation that enables therapy – i.e., healing – to happen has not been followed by the integration which *is* the healing.

[31] *Breath and Spirit*: *Rebirthing as a Healing Technique*, London: The Aquarian Press, 1994.

I have experienced some outcomes of breathwork, or read or heard about them, that have made me decidedly uncomfortable and which inspired me to my graduated system. Here is an example from Rebirthing: in my own training and in my own process, there was a time when I have to call what I was going through as "psychotic." My trainers were unable to get me out of this state. It did, however, wear off by the end of that part of the training. I've never understood what it was about or where it came from, and I don't feel I've drawn any benefit from it – except that it was part of what inspired me to my sixfold structure for breathwork. I would not have liked to have to deal with that nonordinary state alone and was very grateful for the containment.

**Kylea** We see this sometimes in the six-day or 13 day modules of the GTT residential training sessions. Even in a very grounded person, with a strong, protective ego, this kind of experience can occur. What seems to be the case, however, is that the psyche knows how much time it has. People who are signed up for two weeks at a time reach the nadir of such a process at 6-8 days and feel like they will never re-emerge. Over and over again, however, I have seen the psyche mobilize its resources and with the incredible support of the other trainees in community, and with encouragement to amplify the process (act even more "crazy" in the same ways within the session) the process amazingly completes itself. The group format provides safety, holding, and understanding and is crucial. It is so different from the private session with its "I am the expert, and you are the client who is in need of my help" model.

**Joy** I've written about another example in my book, where after a breathwork session, the client regressed to the age of four when he was locked up somewhere and had to escape. He walked around my workroom calling "Mama! Mama!" and for a while was quite autistic and did not remember who I was.[32] I was very unhappy with that outcome, although over the next weeks there was substantial healing of that wound. That experience, too, was formative in the development of my graduated way of working. I also began then to call what I did Gentle Rebirthing to really distinguish my style of working from the Rebirthing which I began to call "traditional Rebirthing' in the early books. I think I even invented that expression!

These examples come from the mid to late 80's. The practice of Rebirthing has changed considerably since then. Now I would say that Rebirthers fall into two categories: those who work gently, and those who still work in the old way. I remember that when I talked to my own teachers, Tilke Platteel-Deur and Hans Mensink, about how my work was developing, they said that they too had come to work in this more gentle way. So I think this was a natural development, as knowledge of working with the breath grew. One should remember that the first Rebirthing book was published only in 1976, which is not a very long time ago. There has been a lot of good development since then.

I've given you examples from Rebirthing where I thought the outcome was not really satisfactory. I have examples from HB too. A certain HB practitioner told me that after a workshop she gave, one woman participant was unable to drive herself home. I know you warn participants in HB workshops about this possibility in the *Informed Consent for Holotropic Breathwork™ Group* form. I think it is very honest and courageous of HB to give this warning.

[32] See *Soul Therapy*, p. 160.

I know that it is not only "non-pathological" HV – or as I'd prefer to call it "very rapid upper chest breathing" – that may destabilise people. Temperament has a lot to do with it. Someone with easy access to unconscious material will, I think, go too far when the methods are not gentle enough. Perhaps someone with too much control needs and searches for the stronger stimulus to be free. I think there is a lot to be thought about here for all of us who use new methods.

Now I have a different question. What is your position on breathing pauses, those long space when the client stops breathing? I know you've written an article about these.[33] I will admit that they can make me very nervous, and that after what I think is long enough – I was once told by a doctor that more than two minutes was dangerous – I end up reminding the client to breath. Now, when I do breathwork on my own, there are times when the pauses are very important to me, and I will let my own breathing stop until it starts again of its own accord. It seems to me this fear of other people's breathing pauses is part of my process that needs working through. We're going to come to the topic of the personal limits of the breathworker shortly. What is your view of these breathing pauses. Can they ever be dangerous? Can one always and under all circumstances trust the breath to begin again?

**Kylea** I have seen the breath stop for more than five minutes with no harm. I understand that the pearl divers of Japan, after hyperventilating for a while can hold their breath for eight minutes. In a workshop I did with a physician, one man was turning blue. The physician was not worried, so I stood back. The man began breathing again after about five minutes. In the sharing group he reported the kind of phenomena experienced in near-death experiences -- light, peace, learning something important. He was emphatic that he would not have wanted to be "brought back" prematurely.

**Joy** That is very beautiful and also convincing.

I've been absolute through our discussion about being careful and structured in our practice of breathwork, and this is something very important to me. However, whatever is interesting and meaningful in life does not have any absolutes and is never entirely safe – as sports, for example, show us, not to mention driving a car or crossing a road, or even daring to love completely! Life is never so simple as to be categorised in absolute terms. That is also what makes it wonderful and miraculous.

I'd like to go back to the relationship between breathwork and the development of shamanic capacities. This aspect of breathwork has a great relevance to the present discussion and now I'm going to say something rather opposite from what I said in the previous section. These days many people want to develop their shamanic capacities. What is not often taken into account, is that these are powerful capacities and are *earned*. They don't come served on a plate or out of a cash machine, and are certainly not the result of "spiritual materialism." Historically, apprentice shamans have failed and died in their attempt to become shamans. I am very keen on safety and predictability wherever possible, as my six-fold structure for breathwork practice shows. Perhaps I'm excessively cautious! We are obsessed by safety these days, and in part it is right, but whoever wants really to enter the shamanic and to develop it, has to learn to deal with the power of the uncon-

[33] "Yogic Sleep and Meditation States During Holotropic Breathwork," *The Inner Door*, No.7, 1991.

scious, and to become its master as well as its servant. The danger has to be confronted to be overcome!

**Kylea** Danger is a word that has elements of physical risk in it. I think usually in breathwork there is emotional risk, but not physical risk. There is emotional risk in reliving birth, but not physical risk in dying even if there was physical risk at the time of birth originally. Because one is already born, one has already lived through it! I do think all personal and spiritual growth entails risk of losing the known and facing the unknown. The whole idea of breathwork is to create a container so that there is permission and protection as well as companionship on the path.

## VI Breathwork and Healing

**Joy** In our correspondence you brought up the topic of the "relationships of the breath to various aspects of healing, healing history, and connections to the body." In part to counteract what seemed to me the excessive claims of the early Rebirthing books, I've been severe about claims to healing, going perhaps rather too far in the opposite direction. Perhaps also because too many new therapies make excessive claims for healing, and also, because I'm convinced that all good psychotherapy can lead to healing of physical problems as much as mental ones. I think of Bernie Siegel's work here.[34]

Please will you say more about the "relationships of the breath to various aspects of healing, healing history, and connections to the body." It would be useful if you could include some case histories.

**Kylea** There are some good articles about this in *The Inner Door*, our Association for Holotropic Breathwork Association newsletter [35]with specific healing stories about psoriasis, rheumatoid arthritis, and other ailments. I certainly agree with you that there is a mysterious connection between mind, body and spirit and that working in nonordinary states often produces healing on all levels. I also agree with you that one should not make claims for breathwork, because on cannot predict any person's process or benefits.

## VII The Breathworker

**Joy** You said something before about the personality of the client and the relationship to the process.

**Kylea** Again, I would call this role, breathwork facilitator or practitioner.

**Joy** It's been clear to me for a long time that I'm the limiting factor in the work anyone can do with me. My first experience with breathwork was with Vipassana

[34] *Love, Medicine and Miracles: Lessons Learned about Self-Healing From a Surgeon's Experience with Exceptional Patients.* New York: Harper & Row, 1986.

[35] A subscription to *The Inner Door* can be obtained by becoming a member of The Association for Holotropic Breathwork International. Send $45 or VISA/MC information to AHBI, PO Box 7169, Santa Cruz, CA 95061 USA for a year's subscription to this quarterly newsletter. Information www.breathwork.com.

meditation, which I learned in 1965. My temperament is meditative, so it is hardly surprising that what I consider of fundamental importance in breathwork is awareness and analysis. Incidentally it is surprising how much analysis there is in Buddhist Psychology, although it is a different kind of analysis from what a Freudian analyst would do. It is more a phenomenological analysis that has ever greater awareness of what is happening, mentally and physically, as its goal.

Then also, you said, "Some people have their material so close to the surface." I'm one of those people. I'm what's sometimes called mediumistic. For me the boundary between ego and unconscious is near and not difficult to cross. My work is to maintain the boundary, which is why I'm an expert on teaching grounding – I have to practice it all the time! I'm a person with easy access to my emotions, which goes with being mediumistic. So for me, any form of very "energised" work, can go too far too fast. Then my emotions are painfully strong and it takes me days to recover. If I can do quieter work, I can do just as much, and integrate as I go along. This suits me better. Obviously, my way of working is influenced by my personality. When I started working I wanted to be the "right" therapist for everybody! I was so idealistic. Now I realise that that is impossible.

**Kylea** I think it is important to say in this article just once, what is always the case: that breathwork is not for everyone. There are many techniques and many paths and people seem to be drawn in the right directions for them if they let themselves be.

**Joy** In my book I say that Tilke Platteel-Deur's way of breathing [Tilke with Hans Mensink taught me breathwork] is to take more breath. In the beginning this was threatening to me, as it made my process go too fast. Recently I've been working with Tilke again, and now I begin to manage to "take more breath" without being overwhelmed by unconscious contents: I can take more breath and absolutely enjoy it. However, Tilke made the wise observation, that some people can simply breathe through, but I need the analytical element: I need to understand. I think she has a valid point.

**Kylea** I think it is always wise to honor our defences and not try to storm the walls that have been put there for good reason. However, there are times when people have to get in touch with the part of them which storms walls as well as defends them. A session does not have to resolve a whole deep issue, but can take the next step in awareness with that issue.

**Joy** We work according to how we are and how we respond. It's frequently said that therapists – and shamans – are wounded healers who share what they believe has helped them to heal. The literature of every school of therapy supports this view.

## Conclusion

**Joy** Kylea, you know the credit for the idea for this article is yours. When you said, "We really need articles in our field of breathwork …, showing the roots and relationships of the breath to various aspects of healing, healing history, and connections to the body," I really became inspired. I then had to wait to have the time to put together what we had written to each other. It seems appropriate that I had the time while I was in India, the home of so much knowledge about breathwork, and it seems a lovely synchro-

nicity that I was there because my husband was lecturing at Pune University, a very famous centre for Sanskrit studies. The subject of his lectures was *karma*.

Your remark was also part of the inspiration that led me to create *The Healing Breath*. Besides that the books you have written, *The Breathwork Experience*, and *The Ethics of Caring* are excellent and essential reading for breathworkers. I've learned a lot from this dialogue with you, and I'd like to end it by acknowledging your important contribution to the development of breathwork.

**Kylea:** Thank you. I wish you lots of success with *The Healing Breath*.

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# INCENTIVE INSPIROMETER FEEDBACK FOR REDUCING THE REACTION TO ASTHMATIC PROVOKING TRIGGERS: A TRAINING PROTOCOL

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## Abstract

This paper describes a training protocol to reduce the onset and severity of asthmatic symptoms. Subjects with asthmatic symptoms were initially trained to master effortless diaphragmatic breathing with surface electrolyographic and incentive inspirometer feedback. Inhalation volume was the physiological parameter used to measure skill acquisition. The protocol consisted of a pre- desensitization phase (mastering effortless diaphragmatic breathing, relaxation, peripheral hand warming and generalizing effortless diaphragmatic breathing while performing daily tasks). The desensitization-training phase consisted of inhalation awareness and desensitization exercises to promote effortless breathing under most conditions (abdominal versus thoracic awareness, volume awareness, purposeful wheezing, imagery rehearsal of stressors, role rehearsal and actual exposure to allergens. The methodology and helpful hints are described for each practice. Most subjects mastered the skills, inhibited their automatic escalation of dysfunctional breathing, and demonstrated the ability to continue to breathe diaphragmatically under a variety of conditions. Although this protocol was used with patients with asthma, it could be adapted as a treatment approach to other disorders (e.g., hyperventilation syndrome, anxiety or panic).

Key words: Biofeedback, asthma, desensitization, incentive inspirometer, sEMG feedback.

## Introduction

In 1886 Mackenzie reported conditioning an asthmatic subject to a paper rose which suggested that asthmatic symptoms might be a learned response. Most likely, dysfunctional breathing is partially classically conditioned and part of the interaction of the biological / genetic precondition, psychological / social interactions, and physiological reactivity / response patterns that increase or decrease the probability of symptoms. A number of clinical reports have suggested that desensitization may reduce the onset of asthmatic episodes (Moore, l965; Yorkston et al., l974; Tibbetts & Peper, 1988).

Previously, Peper (1985, 1988) and Peper and Tibbetts (1992) reported that subjects with asthma reduced their symptoms when they learned to decrease their upper thoracic muscular efforts and simultaneously increased inhalation volume. These subjects often noticed that their inhalation volume decreased when they thought about or were exposed to environmental or emotional stimuli. This decrease in inhalation volume was also observed with non-asthmatic subjects when they imagined a stressful episode (Peper &

MacHose, 1990). This process was most easily observed when subjects learned to breathe large inhalation volumes at slow breathing rate (3-7 breaths per minute). When subjects learned effortless breathing they became aware of their own specific stressors and used them as cues to trigger slow diaphragmatic breathing (Peper & Gockley, 1990). In this way, subjects experienced a sense of control that decreased their helplessness when overwhelmed by their dysfunctional breathing. In a similarly manner, children can rapidly learn to ameliorate and improve their health by mastering effortless breathing (Culbert, Kajander, & Reaney, 1996; Kajander & Peper, 1998).

This paper describes a training protocol to reduce the onset and severity of asthmatic symptoms. It is based upon a physiological desensitization in which effortless diaphragmatic breathing is pared with exposure to stimuli that would evoke dysfunctional breathing such as breath holding or rapid shallow thoracic breathing. The approach utilized an incentive inspirometer to encourage increased inhalation volumes coupled with slow exhalation in a variety of conditions (Roland & Peper, 1987). The procedure focused upon reducing dysfunctional breathing that tended to consist of thoracic breathing, shallow breathing, gasping and breath holding during movement and stress. These breath patterns are often observed during asthmatic episodes and contribute to the development of hyperventilation syndrome, anxiety, panic, and even epilepsy (Lum, 1976; Fried, 1987).

## General training protocol

The protocol consisted of two phases (1) pre-training subjects to learn effortless diaphragmatic breathing and awareness of situations during which their breath patterns became more dysfunctional and (2) desensitization training to inhibit dysfunctional breath patterns with effortless diaphragmatic breathing by interrupting unconscious chained behaviors which may elicit asthmatic responses. The two phases of training included specific practices that were usually learned in groups. Even though there was a large group response to the practices, the subjects showed wide individual variations in their responses: some reacted strongly while others reacted minimally. For example, when subjects were instructed to focus on their abdomen, verbal instruction was sufficient for some, while others needed actual tactile stimulation to direct and hold their attention. Common to all the practices was the assumption that the therapist's breath patterns were contagious, hence, the therapists all could breathe diaphragmatically under many conditions and were adept at using the incentive inspirometer (Peper and Tibbitts, 1994).

### Subjects

Twenty volunteer subjects with asthma participated in a group research study. Mean age 33 (range 22 to 46). Mean length of asthma 11.9 years (range .2 to 32 years).

### Equipment

Inhalation volume was recorded with a Sherwood Medical Inc. incentive inspirometer (Voldyne).

## Phase 1: Pre-training

All subjects were pre-trained in slow diaphragmatic breathing with surface electromyography (sEMG) and incentive inspirometer feedback, relaxation, peripheral hand warming using guided imagery, and generalization practices (Peper, 1985, 1988, 1990; Peper, Smith, & Waddell, 1987; Peper, Waddell & Smith, 1987; Tibbetts & Peper, 1988). The pre-training mastery was necessary to facilitate recovery from the decreased inhalation volume that was usually induced by stressful events, thoughts, images, or activities (Peper & MacHose, 1990). Namely, after automatically responding to a stressor with decreased inhalation volume, the subject would rapidly return to the higher learned volume levels. The pre-training consisted of mastering effortless diaphragmatic breathing, relaxation and peripheral hand warming, and generalizing effortless diaphragmatic breathing.

### A. Mastering Effortless Diaphragmatic Breathing

The subjects with asthma received surface electromyographic (sEMG) feedback from their scalene/trapezius muscles to reduce upper thoracic muscle activity while simultaneously inhaling larger volumes through an incentive inspirometer to learn effortless diaphragmatic breathing. The group training program included information about respiratory physiology and factors than contributed to maintaining health. In a 15-month follow-up, Peper and Tibbetts (1992) reported that the subjects significantly reduced their scalene/trapezius sEMG activity while simultaneously increased inhalation volumes as compared to the beginning of the study as shown in Figure 1. They reduced their medication and increased their sense of control as shown in Figures 2 and reduced their emergency room visits and breathlessness episodes as shown in Figure 3.

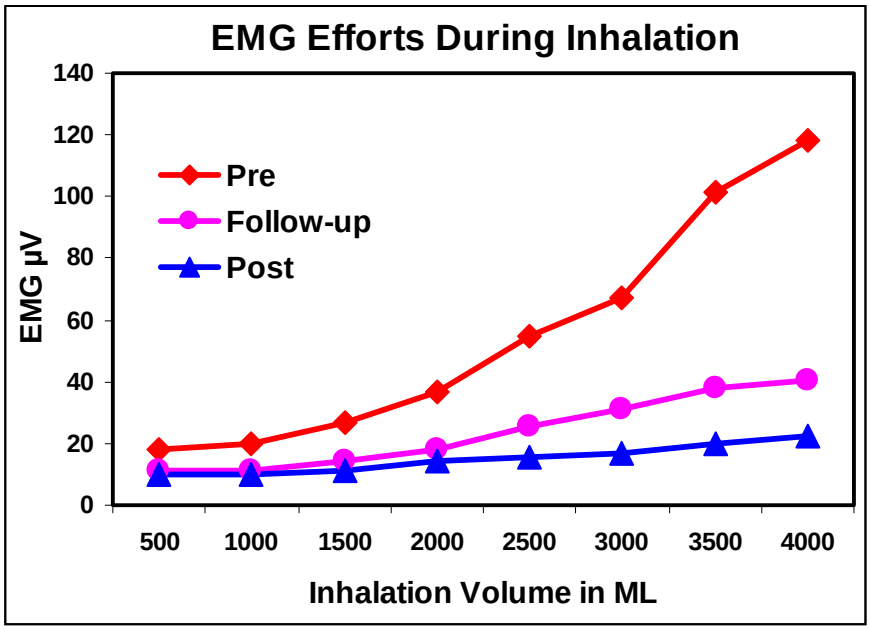


Figure 1. Group pre, post and 15 month follow-up measures of trapezius/scalene EMG effort of breathing. EMG activity represents the average of three sequential breathing trials at each volume (From Peper & Tibbetts, 1992)

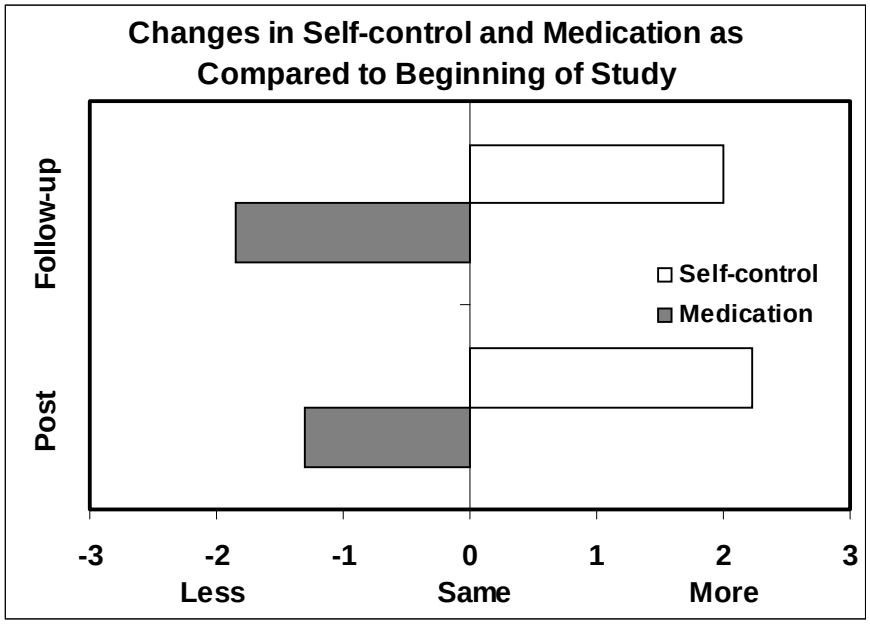


Figure 2. Changes in average emergency room visits per year and breathlessness episodes per day for the subjects who participated in the EMG and inspirometer feedback training program at the end of the training period (post) and after a 15 month follow-up (Adapted from Peper & Tibbetts, 1992).

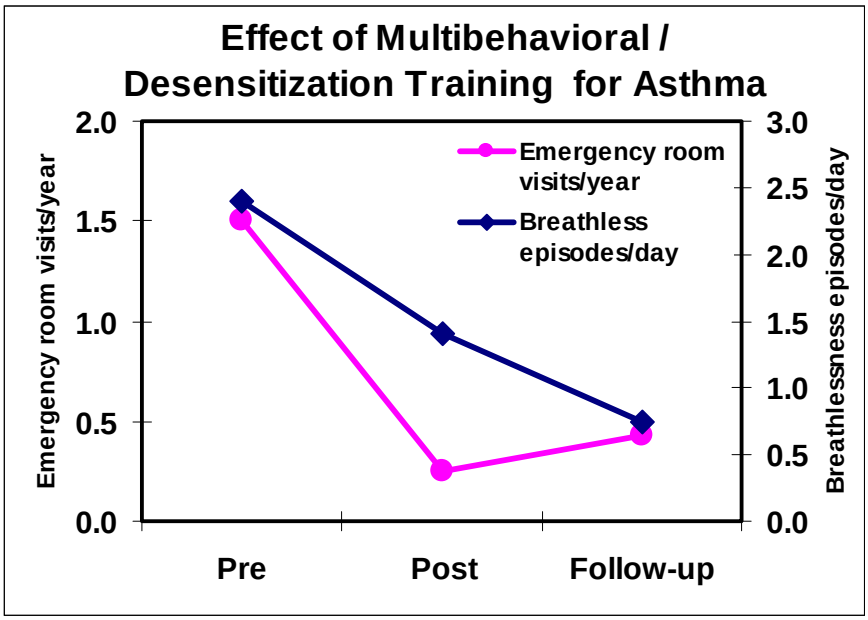


Figure 3. Changes in medication and subjective sense of control as compared to the beginning of the training program (Adapted from Peper & Tibbetts, 1992).

After subjects mastered slower breathing with increasing inhalation volume and less upper thoracic sEMG activity, they practiced lengthening their exhalation rate (lower flow rate for a longer time period). After they exhaled for a longer time period, they observed that their next inhalation volume usually increased when they allowed their abdomen to expand. This learning phase was enhanced with the use of numerous suggestions as previously described by Roland and Peper (1987).

## B. Relaxation and Peripheral Hand Warming

Relaxation and peripheral hand warming were taught with guided imagery and temperature biofeedback. Specifically, subjects first learned modified progressive relaxation which they practiced at home with a tape cassette. Then, subjects were taught to warm their hands using autogenic phrases, guided imagery and temperature biofeedback (Tibbetts, Charbonneau & Peper, 1987; Peper & Holt, 1993). The subjects generally practiced very slow diaphragmatic breathing (2-6 breaths/minute) while the exhaled air flowed through and down their limbs warming their hands and feet.

## C. Generalizing Effortless Breathing

The generalizing of effortless diaphragmatic breathing was encouraged by having subjects practice breathing while they performed various daily tasks (e.g., sitting, laying down, walking, talking and writing). More importantly they were taught to resume slow diaphragmatic breathing at the first signs of pulmonary discomfort to abort the onset of

dysfunctional breathing such as breath holding or shallow thoracic breathing (Peper, 1990; Tibbetts & Peper, l988).

## Phase 2: Awareness and desensitization training

The training focused upon awareness and desensitization to imagined and real stressors. It consisted of the following six practices: A. Abdominal versus thoracic awareness, B. Volume awareness, C. Purposeful wheezing, D. Imagery rehearsal, E. Role rehearsal, and F. Actual exposure to allergens. Although each practice was slightly different, they all used the following general procedure.

### General Procedure:

The general procedure was common to all the awareness and desensitization protocols. The aim was to inhibit decreasing inhalation volumes in response to imagined or actual asthma provoking stimuli. During the assessment and training, the subjects usually sat upright, eyes closed, with an incentive inspirometer placed at mouth level. Generally, the procedure consisted first of an effortless breathing pre-baseline, then an exposure to stressors, followed by a post-baseline of effortless breathing. The pre-baseline consisted of breathing a number of effortless diaphragmatic breaths without experiencing air hunger or discomfort. Sequential inhalation volumes were continuously recorded. This was followed by a specific exercise or desensitization strategy.

If inhalation volume decreased significantly or breathing difficulty occurred, subjects were instructed to immediately shift to the post-baseline effortless breathing condition. The post-baseline was similar to the pre-baseline. If the post-baseline was significantly lower (possible respiratory distress) then subjects were instructed to continue to breathe diaphragmatically until the post-baseline volume was similar to, or higher than, the pre-baseline volume. The subjects participated in the specific training exercises for varying lengths of time.

The training was done in groups of 6-8 subjects. Subjects worked with each other in that one subject would record volumetric data from their partner who underwent the desensitization practice. The subject who recorded the data simultaneously practiced breathing slowly and easily through their own incentive inspirometer. This in itself was a covert desensitization procedure that further encouraged the generalization of effortless breathing. After the actual practices were finished, the subjects continued breathing through their incentive inspirometer while writing what they experienced during the desensitization exercise. Finally, subjects practiced with an incentive inspirometer at home.

The specific order of the practices varied. The first two (abdominal versus thoracic awareness and volume awareness) can be taught in any sequence. However, before beginning the more stressful desensitization practices, subjects must have mastered effortless diaphragmatic breathing. The final four practices (imagery rehearsal, purposeful wheezing, role rehearsal, and exposure to allergens) should be taught in sequential order. The following section describes each practice, training observations and helpful hints.

## A. Abdominal versus thoracic awareness

The purpose of this practice was to reduce the subjective discomfort that some subjects noticed when they focussed their attention upon their upper chest. This shift in the focus of attention is often unconscious and may initiated be by the tightness and wheezing in their upper chest. The first step for this practice was to observe whether focusing attention on the upper chest or on the lower abdomen effected inhalation volume. The subjects closed their eyes and then attended and focuses their attention upon their lower abdomen, upper chest, lower abdomen, and then upper chest. Sequential inhalation volumes were recorded. At each focus of attention, they breathed 3-4 breaths.

### Results

Generally inhalation volume decreased when the subjects focused their attention on their upper chest and the volume increased when focusing on their abdomen, as shown in Figure 4.

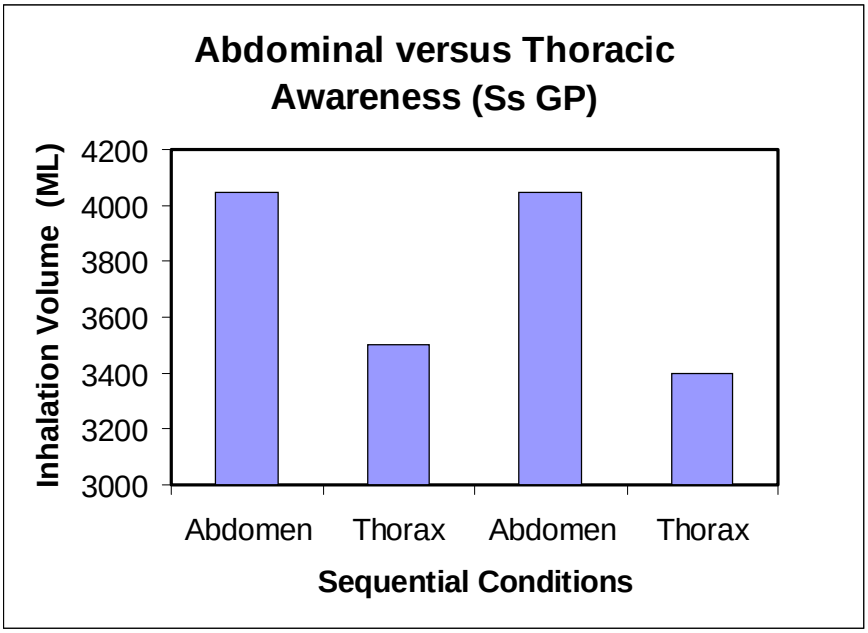


Figure 4. The effect of awareness of different body areas upon inhalation volume.

### Discussion

This procedure demonstrated to the subjects that a "positive" feedback mechanism could contribute to the onset of symptoms. Namely, attending to the asthmatic sensations in the upper chest could decrease inhalation volume and increase shallow thoracic breathing

thereby triggering wheezing and dyspnea. A similar mechanism may underlie hyperventilation, panic, and other types of chest pain.

During the training procedures, subjects were encouraged to initiate effortless diaphragmatic breathing whenever their attention shifted to their upper chest. In addition, subjects practiced sensing to their upper thoracic region while continuing effortless diaphragmatic breathing.

*Helpful hints:* To increase the subjects' responses to this exercise, direct the subjects' focus of attention to higher or lower body locations (e.g., notice the sensations in the head to amplify chest focus; feel the sensations in the legs and feet to amplify abdominal focus). For some the verbal instructions were insufficient and they needed to be physically touched at the body location to "capture" their attention. This was done by gently stroking upward on the inhalation and downward on the exhalation using the rhythm of their breath.

## B. Volume awareness

The purpose of this exercise was to develop awareness of inhalation volume since some subjects were unaware that their inhalation volume decreased when they thought about stressful events. To enhance the awareness of inhalation volume changes, subjects were trained to sense the sensations associated with the various inhalation volumes.

The procedure consisted of first recording a pre-baseline in which subjects were instructed, with their eyes closed, to inhale to sequential target volumes, such as 1700, 3000, 2200, 1000, 2500, and 1500 ml. Then they practiced breathing to these specific volume levels with their eyes open while attending to the internal sensations associated with that volume level. After practicing with their eyes open, they practiced with their eyes closed until they were able to attain that volume level. They were asked to practice the exercise at home. Success of internal awareness was assessed by measuring the percent error of target volume and calculated as follows: % error = (target volume - actual volume)/(target volume) x 100 (Peper & Crane-Gockley, 1990).

## Results

After practice, subjects were more successful at achieving the correct volume levels with their eyes closed. An individual skill acquisition curve for 9 sessions of inhalation volume training is shown in Figure 5.

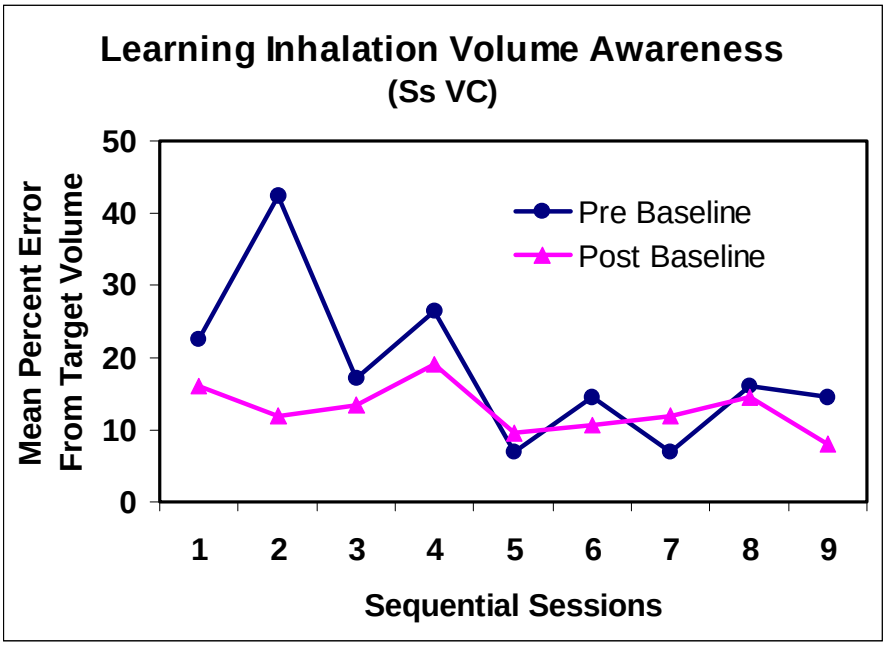


Figure 5. Skill acquisition curve as subject increased her sensitivity to inhalation volume.

## Discussion

Generally subjects were inconsistent in obtaining the correct volume levels during the pre-baseline. Once awareness of different volume levels was mastered, subjects were able to use this awareness on a daily basis to identify which stimuli was associated with a change in inhalation volume. In addition, they were able to use the enhanced awareness of decreased inhalation volume as a cue to shift to slow diaphragmatic breathing.

*Helpful hints:* The range of volumes used for this exercise needed to be within the obtainable inhalation volume range for each subject. The maximum practice volume cannot be above what the subject can achieve. This exercise should also be practiced at home, either alone or with a spouse, while keeping the eyes closed initially and then opening the eyes to check the volume.

## C. Imagery rehearsal

The purpose of this exercise was to observe how stressful images reduced inhalation volume and to desensitize subjects by paring effortless diaphragmatic breathing with stressful images. Previously, Peper and Machose (1990) showed that stressful imagery tended to decrease inhalation volume while positive imagery did not effect inhalation volume.

Subjects begin by breathing 6-8 slow breaths for the pre-baseline measurement. Then while continuing to inhale through the incentive inspirometer, they imaged a stressful scene for 4-6 breaths. When imaging it is important to encourage the subjects to be as re-

alistic as possible. Remind them to see or feel every detail of the image. The more involved the subjects were in the image, the more they responded with a reduction in inhalation volume. Subjects could image a known allergen and/or asthmatic stressor, a recent asthmatic attack or hospitalization, or a past or recent emotional conflict. After imaging, the subjects were instructed to let go of the image and return to slow diaphragmatic breathing for 6-8 breaths for the post baseline measurement. After collecting the data, the subjects wrote what they experienced and to what extent they thought their volume level changed while they were breathing through the incentive inspirometer. The subjective measure of changes in inhalation volume was then compared with the actual recorded data and discussed with the subject.

## Results

Most subjects' inhalation volume levels decreased when imaging a stressful event. During the training, subjects learned to maintain high inhalation volumes while imagining stressful events. A single subject's response to and ability to not respond to the imagined image after desensitization training is shown in Fig 6 and 7.

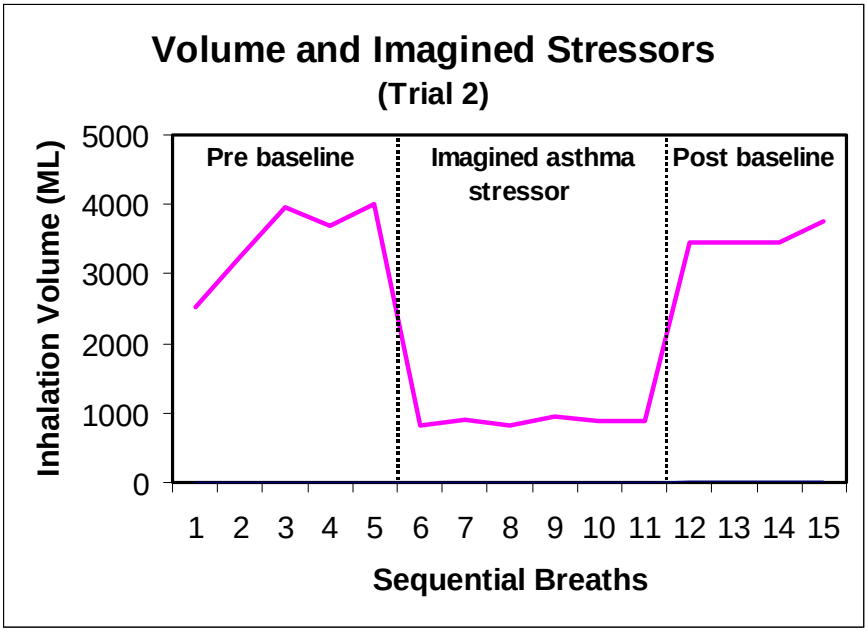


Figure 6. Inhalation volume response to imagined stressor.

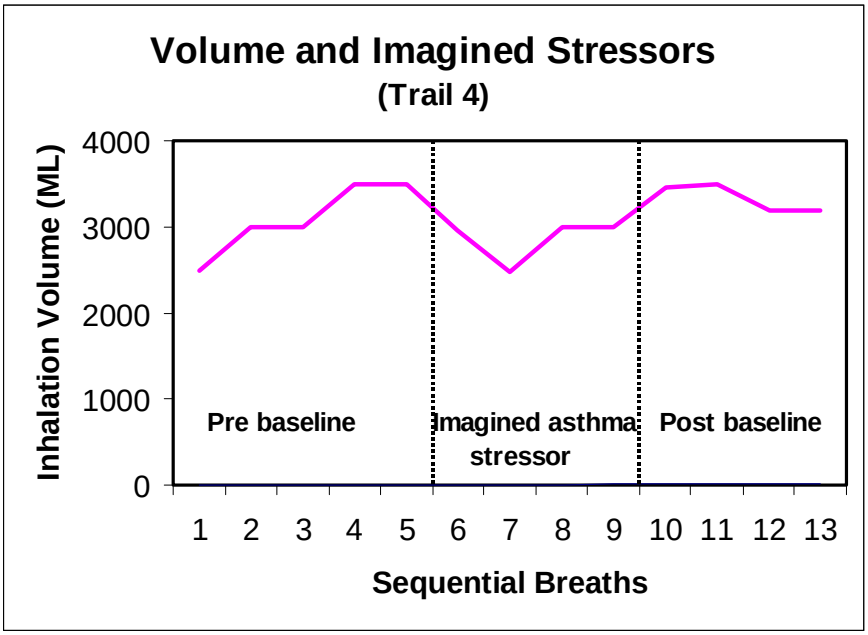


Figure 7. Inhalation volume response to imagined stressor after subject had practiced desensitization to the stressor.

## Discussion

While imaging, most subjects were able to learn to inhibit the decrease in inhalation volume by continuing to breathe diaphragmatically. In many cases, additional practice was needed so that they could inhibit this almost automatic reduction in inhalation volume to asthma inducing stimuli. The practice was a powerful learning tool for the subjects when they saw how imagined thoughts or emotions significantly reduced their inhalation volume. Nixon and Freeman (1988) have also reported similar observations with with coronary heart disease patients. They observed a significant decrease in end-tidal $CO_2$ when the patients thought about personal life stressors.

For some subjects the inhalation volume decreased radically and led to actual respiratory discomfort. Hence, the trainer needed to monitor the changes in volume levels. If there was a rapid and significant decrease in inhalation volume, the subject should stop imaging and practice effortless diaphragmatic breathing. In addition, some asthmatic subjects anticipated the exercise and unknowingly reduced their inhalation volume levels during the pre-baseline period. Hence, it is important to have previous baseline data on the subjects' inhalation volumes during effortless diaphragmatic breathing.

This exercise was also be used to teach new coping techniques such as, assertiveness skills, rewriting your past, and cognitive reframing (Peper & Holt, 1993). With practice, subjects could rehearse alternative coping strategies while breathing effortlessly. For example, one subject who had an attack every time while he rode his bike continued to breathe slowly and easily while imaging himself riding.

In a few cases, the training was not successful even though the subject could breathe slowly while apparently imagining a stressful scene. However, in these cases they were not involved in the imagery. Figure 8 illustrates such a subject who was highly allergic to cigarette smoke. In this case the subject reacted when the therapist simulated a smokers cough during imagery desensitization training which made the image "real" for the subject.

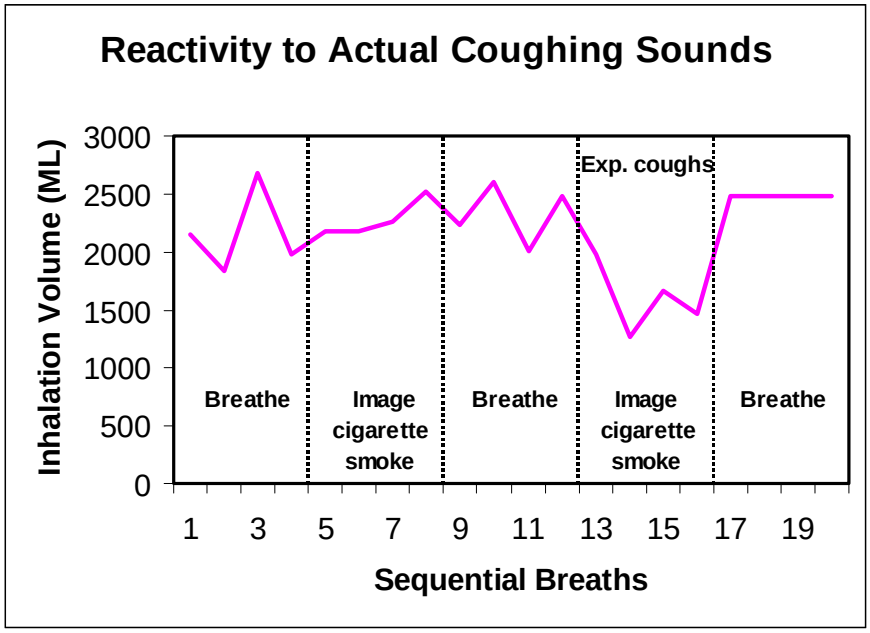


Figure 8. Example of incomplete desensitization. Subject appeared to not response to stressful image, however when more realistic cues were provided (coughing) she again reacted with a decrease in inhalation volume.

*Helpful hints:* Be sure the imagery is meaningful and relevant for the subjects otherwise their inhalation volume may not be effected. During the post-baseline condition check that the subjects let go of the image and practice effortless breathing. In some instances, the subjects became so involved (captured) with their imagery that they needed external guidance to redirect their attention. To avoid possible respiratory discomfort when subjects respond with large decreases in inhalation volume, practice this exercise for a shorter time period and/or develop imagery desensitization hierarchies.

### D. Purposeful wheezing

The purpose of this exercise was to reduce respiratory discomfort that often developed when subjects heard their own or other's wheezing sounds. The purposeful wheezing practice consisted of subjects breathing four to six effortless diaphragmatic breaths and then listening either to someone else wheezing or actually practice wheezing (simulating asthmatic breathing) for a few breaths. After wheezing or listening to the wheezing sounds, they practiced effortless breathing until the inhalation volume was similar or higher than during the pre-baseline. Before subjects begin practicing this exercise *IT WAS*

*ESSENTIAL THAT THEY HAVE MASTERED SLOW DIAPHRAGMATIC BREATHING*. The subjects must be able to breathe diaphragmatically to imagined wheezing sounds and to mild stressors, such as walking or writing. If subjects experienced slight asthmatic sensations such as, airway irritation, dyspnea or panic, discontinue the exercise and resume slow diaphragmatic breathing.

Begin by having subjects breathe 6-8 slow diaphragmatic breaths through the incentive inspirometer. Usually this will also increase respiratory sinus arrhythmia that promotes sympathetic/parasympathetic balance and reduce asthmatic symptoms (Lehrer, Carr, Smetankine, Vaschillo, Peper, Porges, Edelberg, Hamer, & Hochron, 1997). Then have the subjects either wheeze themselves or listen to another group member purposely wheeze for 5-15 seconds (two or three breaths). If subjects do not know how to wheeze, give them the following instructions:

> *"Take a short inspiration, then give a short cough, followed by a prolonged forcible expiration while pressing down on the chest. Attempt to close the glottis by tightening the throat and protruding the head prior to coughing while continuing the 'pressing' expirations" (Peter Mellet, 1978).*

After wheezing or listening to wheezing, have subjects return to the effortless breathing for 6-8 breaths.

## Results

Generally subjects' inhalation volume levels decreased while listening to or wheezing themselves. For many subjects the return to effortless breathing and increased inhalation volumes took a number of diaphragmatic breaths. Figure 9 shows a single subject before, during and after wheezing.

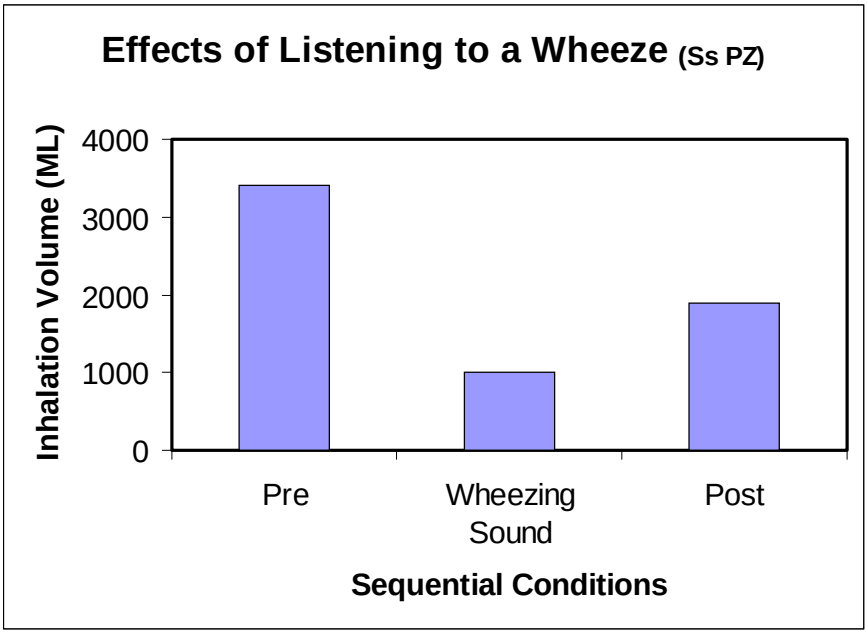


Figure 9. The effect of listening to wheezing sounds upon inhalation volume.

## Discussion

This exercise appeared most successful when taught as a group game. Most subjects did not want to practice this by themselves because it induced anxiety and fear that the asthma attack would escalate and really occur. For the group members who were listening to the wheezing sounds, their task was not to react to the sounds (e.g., no changes in inhalation volume). For many subjects the anticipation of this exercise often lowered their inhalation volumes before wheezing sounds were actually heard. While for others, the volume increased after the wheezing stopped (a sigh of relief). Hence, the exercise needs to be practiced until the subjects neither anticipated nor reacted to the wheezing sounds. This reactivity can also be practiced with electrodermal activity feedback (EDA). Often when the person anticipates or actually wheezes their electrodermal activity increases. When such an electrodermal response occurs, stop the exercise and have the person resume slow breathing. This approach is often very helpful with children.

The focus of this exercise was to desensitize the subjects to wheezing sounds and to enhance their feelings of self-control. This sense of mastery occurred in the process of shifting from purposeful wheezing back to slow diaphragmatic breathing without evoking breathing discomfort, which in the past could have led to an escalation of asthmatic symptoms. In addition, the sense of increasing panic was reduced when subjects practiced wheezing and then returned to slow diaphragmatic breathing.

Purposeful wheezing often irritated the airways and induced tightness in the chest and hyperreactive airways. Awareness of these sensations (feeling the chest) tended to reduce inhalation volume. By focussing upon their abdomen and legs (imagining exhaling through the legs and out the feet increased inhalation volume) subjects could reduce their breathing discomfort.

*Helpful Hints:* Be aware that this exercise may be threatening. We often encouraged subjects to practice purposeful wheezing in order to become aware of precursor symptoms such as tightness. These symptoms became the cues to initiate effortless diaphragmatic breathing.

It may be helpful to have the group leader/therapist demonstrate purposeful wheezing first and then ask for volunteers to allows those with more skill/confidence to show the other group members that they can control their own wheezing sounds. Since, purposeful wheezing irritated the airways, allow enough time (about 15-20 minutes) for the respiratory system to settle down. Be sure to set aside enough time for recovery with effortless breathing. Obviously, if subjects are in respiratory distress do not do this exercise. A similar strategy can be used with subjects who experience panic or hyperventilation. In this case the subjects practiced sequential exhalation of 70% of the previous inhaled air (Peper & Machose, 1993).

## E. Role rehearsal

The purpose of this exercise was to desensitize subjects to stressful events/allergens while maintaining large inhalation volumes. After subjects successfully imaged a previously identified stressful event, they were instructed to act out these stressors while continuing to breathe diaphragmatically, thereby generalizing the skill. Often subjects needed additional coaching and encouragement to transfer the newly learned skills into their daily lives.

Subjects began this exercise by first describing their previously identified triggers or situations which aggravated their asthmatic conditions to the group members. Then they assigned different group members to act out the specific roles such as, a family member involved in an emotional scene, a cat, or a painter in a paint shop. It is important that the subject, for whom the role-play is done, describes in detail what/how roles should be acted such as, where to stand, what to say and how to move.

After the initial baseline, have subjects continue to breathe through the incentive inspirometer while entering into the role-playing scene. For example, when members act out a scene in a spray paint shop, have one member physically move as if spraying paint while simulating the hissing noise of the spray gun. Repeating the above example with real props such as an actual air compressor can increase the reality. On the other hand, if talking is a necessary component of the exercise be sure the person allows the air to flow in diaphragmatically while talking and does not gasp for air. In addition, stop the scene occasionally and have the individual use the incentive inspirometer for inhalation volume measurements. After 4-5 minutes of role-play, return to the post baseline effortless breathing for 6-8 breaths. When subjects were able to simultaneously rehearse their role and continue effortless breathing, repeat the exercise without the incentive inspirometer.

## Discussion

For most subjects inhalation volumes decreased when they attempted to act out their stressful scenes. Often the subjects became so involved that without the immediate feedback of the incentive inspirometer they regressed to their habitual shallow rapid thoracic breath patterns. Many subjects reported feeling awkward when they first attempted to perform this exercise. However, they were encouraged to adapt a play like attitude and implement new coping skills.

*Helpful hints:* Often subjects needed to be exposed or taught alternative strategies because they continued to act in their previously unsuccessful strategies. New strategies can also be developed by having other group members demonstrate and role play various alternative options that they developed or used in similar situations. These new behaviors included communication and assertiveness skills. During the role rehearsal, involve as many of the participants as possible. Encourage all subjects to breathe diaphragmatically while speaking, moving, or acting in the role-play.

## F. Exposure to allergens

The purpose of this exercise was to have subjects breathe effortlessly while being exposed to actual allergens. The final step consisted of seeing and smelling the asthmatic allergens. This step was only taken if subjects were able to image and role rehearse without any breathing discomfort occurring.

Begin by having subjects bring in odors that had previously been identified as a trigger to increase asthmatic symptoms (Shim & Williams, l986). Then have subjects close their eyes and breathe 6-8 slow diaphragmatic breaths. Next, very slowly introduce a neutral odor while continuing to breathe through the incentive inspirometer. A neutral odor should have a distinct smell, like peppermint, to which subjects have no reactivity. Finally return to the post baseline breathing of 6-8 breaths. If no reactivity occurred then repeat the same procedure using one of the identified allergens or smells. When subjects work in pairs make sure only one of them is reactive to the odor. When subjects can continue effortless breathing while being exposed to the allergen, then repeat this procedure with the eyes open. For many subjects seeing the allergen increased their reactivity.

## Discussion

Initially subjects' inhalation volumes decreased in anticipation of the neutral and actual odors. After practice, many were able to continue slow diaphragmatic breathing while being exposed to the allergens. To avoid development of breathing difficulty, expose the subjects to the allergen for a very short period of time (initially a few seconds). Since some subjects have a delayed response to the allergen, allow enough time (about 10-20 minutes) to pass before repeating the desensitization. Interestingly, when subjects inhaled the allergen through their mouth they tended to react less than if they inhaled it through their nose. We wonder if this is odor conditioned pulmonary reactivity similar to that reported by Ader and Cohen (1975) who were successful at behaviorally conditioning imunosuppression in rats to taste and smell.

*Helpful hints:* Many subjects were very apprehensive about doing this exercise since they have never been exposed to odors without some symptoms occurring. It is helpful to ask for volunteers. Those who feel more in control can demonstrate to the group how this exercise can be accomplished. Only perform the in vivo exposure after subjects have shown no response to imagined or role played exercises.

## General conclusion

Many subjects learned to inhibit their normal asthmatic responses by breathing diaphragmatically when exposed to asthmatic provoking triggers although the desensitization to the stressors/allergens took a number of sessions. The acquired skill does not always generalize into the real world. At times when subjects were faced with the asthma provoking stimuli, they often reverted back to their shallow thoracic breathing. This implied that subjects need to over-learn their skills. Although not all subjects mastered this step, they nevertheless reported increased control over their asthmatic attacks.

Common to these exercises was the observation that "awareness" of habitual dysfunctional breathing patterns increased their feelings of anxiety or nervousness. Subjects suddenly realized how often they were breathing in a dysfunctional pattern and blamed themselves. It is important to reframe their self-blame by congratulating them on their newly discovered sensitivity and awareness. Remind them not to expect overnight success, since skills needed to be practiced for a long time before they are effective. Finally, they needed to learn new coping strategies such as, awareness of emotional responses, assertiveness and communication skills. By learning these skills many of the subjects experienced self-direction and self-initiative.

The desensitization exercises were designed to reduce the triggering and escalation of asthmatic symptoms. The subjects' response patterns varied dramatically. Some reacted with a 1000-2000 ml decrease in volume for 10 breaths or more, while others reacted with a 100-200 ml decrease for 1 or 2 breaths. Slow diaphragmatic breathing encouraged a reduction of sympathetic arousal and decreased allergic reactivity. By having subjects purposely wheeze, they used the onset of wheezing/tightness in the chest as a cue to trigger slow diaphragmatic breathing and thereby experience control. This allowed them to alleviate asthmatic symptoms. For example, a subject who always experienced breathing difficulty at his work in a paint factory, found that he could successfully inhibit wheezing with slow diaphragmatic breathing.

Using an incentive inspirometer as a feedback tool had the following advantages because it demonstrated that:

1. Pulmonary reactivity to imagined thoughts as a conditioned component and not just to an actual allergen.
2. Thoracic and shallow breathing (dysfunctional breathing) had lower inhalation volumes than effortless diaphragmatic breathing.
3. Self-control over breathing was possible even when asthma symptoms occurred and that often the symptoms could be reduced by continued effortless diaphragmatic breathing.

Overall, this protocol suggested that an integrated approach restored health although success depended upon transfer of learning effortless diaphragmatic breathing in many aspects of the person's life. The subjects practiced both in the group and also at home. The homework practice of inhibiting reactivity to asthmatic provoking stimuli was individually adapted. Subjects were encouraged to identify cues to begin slow diaphragmatic breathing. These cues ranged from dots on the telephone, seeing a cat on television, a pop up reminder on a computer screen, walking up an incline, to acknowledging an emotional feeling. The benefits of this program are best stated by one subject's report:

> *"I now catch myself sooner so I have a decrease in symptoms because they don't reach that point.", and "I have many times used the diaphragmatic breathing under stress situations when aware of wheezing coming on. Not only has it reduced my asthma but it has calmed my nerves, relaxed my mind and muscles so I don't overreact."*

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# TRANSFERENCE AND COUNTERTRANSFERENCE IN BREATHWORK

**BY**
**WILFRIED EHRMANN**

> *Transference is not only ascribing the characteristics of old objects to new ones, but also the attempt to re-erect and revive an infantile situation which is desired, either because it was so much enjoyed or so much missed, with any object which permits it. (Robert Waelder,* Die Grundlagen der Psychoanalyse*, Fischer 1973, p. 197, Translation by W.E.)*

Many therapeutic techniques, especially psychoanalysis, consider the concept of transference to be central. Sometimes therapy is organised in such a way as to create a transference relationship which can then be analysed, and eventually resolved. This long and difficult process has motivated other approaches, mainly those from the humanistic branch of psychology, to disempower the concept of transference. For example, Carl Rogers introduced the concept of congruence into the client-therapist relationship in order to eliminate or reduce projection and counterprojection between therapist and client. Nevertheless, it is obvious that phenomena of transference can never be excluded as soon as two people co-operate in a therapeutic relationship. It was Freud who noted: "*Transference comes up in all human relations ... spontaneously ... It was not created by psychoanalysis which only uncovers it to consciousness and uses it to direct psychic processes to the desired goal."* (*S. Freud, Über Psychoanalyse, G.W. Bd. 8, p. 55, Translation by W.E.)*

The analytical body therapist, George Downing, distinguishes three possible approaches to the handling of transference phenomena:

1. The therapist takes care of disturbances and brings up the transference only when it has become an source of difficulties that cannot be neglected.
2. The therapist checks from time to time whether there are issues of transference by occasionally asking questions about how the client feels in relationship to the therapy and to the person of the therapist.
3. The contents of the transference relationship gets explored systematically. The therapist follows the development of transference from the beginning of therapy in an active way, whether the process is going smoothly or not, and whether the therapeutic bond is strong or weak.

(cf. George Downing, *The Body and the Word. A Direction for Psychotherapy*. Ref. from the German edition: *Körper und Wort in der Psychotherapie. Leitlinien für die Praxis.* Kösel Verlag, München 1996, p. 261)

I want to complement this view which comes from psychoanalysis and strongly supports the third approach, with another view which looks at clients and their stage of development first before recommending a certain method.

In this view, we can find three types of clients:

1. Clients who are not able to build up a stable transference relationship.

   Among these are certain forms of psychotic or borderline clients in whom, due to strongly destabilising factors in their early mother-child relationship, major difficulties can arise with regard to constructing open, dynamic and alive relationships with other people as well as with therapists. It is therefore an important task in therapy to let this relationship grow step by step on a firm foundation of trust. It can be a good support to build up the relationship to the body in parallel. This can preferably be done by a gentle form of breath observation. A Breathwork session in the classical sense cannot be suggested at this level.

2. Clients who build up a strongly effective transference relationship unconsciously.

   Due to disturbances in the parent-child relationship, elements of this relationship that were missing or overemphasised will be projected upon the therapist. The client does not recognise these projections to be what they are, but takes them as reality and may react on an emotional level by resentment, aggression or admiration.

   The breathing process, attentively guided by the therapist, can bring up important elements in the relationship dynamics. For working them through and resolving them, breath therapy needs additional, more interactive approaches.

3. Clients who are able to build up a trusting relationship to the therapist and have enough awareness to perceive their projections in the main areas adequately.

   Here, transference either does not get in the way of the therapeutic process or can be worked through easily. Constantly searching for elements of the transference would impede self-exploration in these cases. Clients for breathwork usually succeed with the inner experience of the breathing process.

If these distinctions make sense then working with transference is not an unavoidable must in any therapy but an element which can be added in those cases where it is needed and left out in cases where it obstructs the process. If we use the principle of focussing in therapy, the principle of economy is applied; it concentrates on the essentials and leaves the non-essentials in the background. Body oriented therapies may claim that their work can go deeply and have profound results without working explicitly on transference in every case.

## Breathwork: In a realm free of relationship?

These preliminaries lead to the question of the position of transference in breathwork. A review of breathwork literature shows that breathwork rarely deals with the issue of transference. This may be because of the evident deficit in theory in breath therapy; it can also stem from the multidimensional aspects of relationship which are important in breathwork. This is what this article will look at in order to keep breathwork a clear and open process with the capacity to make access available to as many levels of consciousness as possible. Neglecting the contents of transference in the therapeutic interaction could

mean missing crucial points of repressed feelings which ought to be brought to light.

The primary focus of breathwork is less concerned with the client-therapist relationship but deals rather with the self-relationship of the client. The purpose of building and improving the inner organisation of the breath, i.e. the breath's own natural flow, is a deepening of feelings related to inner sensations and processes. The breathworker is mainly a provider of space for an inner experience which is directed by the breath. He encourages feeling deeper into the body and supports the autonomously induced process of inner opening.

Here, the therapeutic relationship is similar to the master-disciple relationship common in Eastern meditation practice. The teacher offers a technique and outlines the path to follow, along which the disciple proceeds in increasing self-competence until he eventually reaches mastery himself and does not need any further guidance.

In this system, the guide is always ahead of the follower, and every doubt about this categorical difference that comes up in the disciple is ruthlessly reflected back to him by drawing attention to the mind-controlled belief systems which create judgements instead of loving acceptance. In this way, self-responsibility for one's own feelings can be taught efficiently, but the opportunity to learn from relationship is extremely diminished and the undercurrent of transference and countertransference is overlooked. This can cause the idealisation of the master by neglecting one's own self-esteem, as well as an immediate rupture of the connection to the master by running away and continuing to live with the suppressed anger and hatred that stem from the unrecognised projections on to the master. This will happen when the personality is not developed to a level that is able to surrender unconditionally.

This disciple-master system includes therapeutic elements but is not dedicated to therapeutic work. Its direction is towards transcending the ego and paving the way for spiritual growth. It requires a highly elaborated sense of integrity and spiritual advancement in the master which is not merely obtained by training but also needs the context of meditation practice. Breathwork can be taught in this realm when this personal prerequisite is fulfilled in the person of the teacher. It has to admit its therapeutic limitations here, however, and can only serve people with a high motivation for a spiritual path.

If breathwork wants to serve as therapeutic tool, it has to take in account the various levels of a personal relationship between therapist and client, in order to identify the issues that can arise around transference and countertransference. These provide material that can be made use of in the process.

## The levels of the client-therapist-relationship

We can find three levels of relationship in the therapeutic situation in breathwork. At level 1, the therapist serves as the provider of a safe space of containment in which security and trust can grow in the client. He fulfils some basic needs of the client. At level 2, the therapist interacts in the process and tries to complement experiences of deprivation or frustration which can come up during the process. In this way he helps the client to find the resolution for these experiences and integrate them into a stronger self concept. At level 3, therapist and client join together in listening to a greater spirit supporting the

whole process. The therapist will provide insights and follow his/her intuition while withdrawing from the needs of his/her ego.

In terms of these three levels of relationship, we can find the following sources of transference:

### Level 1: Basic needs

This level mainly brings up projections from needs and motivations from early childhood which can be characterised by the following polarities:

- too much/too little caring
- too much/too little attention
- too much/too little presence
- insecurity vs. trust

The verbal and physical interactions during a breathwork session, whether they are communicated or not, can trigger intense feelings in the client which will be projected onto the therapist. So a client, reaching out with his hands, may expect the therapist to meet his hands to fulfil a need for contact. When there is a deep insecurity about contact and trust in the client, he may be as frustrated when his need is met as when it is not responded to. Another client may feel his need for touch and expect his therapist to react to this unspoken need. When the therapist intuitively understands what the client expects he may react to that and touch the client. This will bring up a feeling of gratitude in the client which he has to handle carefully as it can involve an exaggerated projection of a superhuman mother.

These are just two examples from the innumerable possibilities for interaction that present themselves on the level of basic needs during a breathwork session.

### Level 2: Interaction

At this level, the therapist's personality is the main object of projection. The issues that can become important on this level are:

- quality and adequacy of interventions: helpful vs. disturbing
- judgements (I should breath more, I am not good enough)
- control (I am under control, every breath is watched)
- power (I am under influence, the therapist disturbs me willingly, interferes insensitively ...)
- sexuality (I feel attracted to the therapist, I assume he feels attracted to me ...)

We sometimes come across clients who are reluctant to lie down on a mattress and close their eyes. This shows us that the client needs to make a major step in trusting and letting go of control just to enter the breathing process in a lying position. Even when a client lies down to breathe without comment, he can still get into contact with feelings of being controlled by the sitter, having to prove himself with a certain way of breathing, etc. These feelings usually fade when the emotional process increases and are soon for-

gotten. But valuable material for self exploration is lost when the therapist does not attend to it it by sensitively asking the client about these subtle forms once the breathing cycle is completed.

### Level 3: Spiritual opening

This level is mainly influenced by the state and experience of meditation: When we succeed in raising the healing process to the level of wholeness, we come to terms with the claim of oneness and build the bridge from therapy to meditation, from the healing of wounds to personal and transpersonal growth. Then the issues of transference and countertransference are overcome as mechanisms of projection and dissolve in the broader horizon. Breathwork often touches these realms, and at their border, specific transference issues can come up:

- the gratitude felt for what has been achieved and appreciation of the process can be attributed to the therapist's magical abilities
- the request for acceptance for everything that comes up from the client's level of experience can lead to non-reflecting and uncritical approval from both sides so as not to loose the achievements
- Attachment to the dissolution of boundaries and of separate roles and selves Confusing the levels of divine experience and ordinary life (cf. Kylea Taylor, The Ethics of Caring. Handford Mead Publishers, Santa Cruz, California 1995, pp. 149-151)

One of the challenges for the therapist in this realm is to look after the fragile borderline between overwhelming spiritual experiences and their egomaniac conceptualisation. Some clients make the spiritual gift received in a breathwork session an important issue in terms of their self-approval. The therapist has to point out the work which has to be done on the level of self-esteem while respecting the spiritual content of the experience.

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When we include the conscious and unconscious aspects of the client-therapist relationship, there are many of issues to consider which are specific to breathwork and related forms of therapy. These have to do with the setting, the forms of physical interaction, and the expanded states of consciousness which can be accessed in breathwork. We will start with an example which comes from a breathwork training group and illustrates the specific possibilities of transference in breathwork

### Example on the level of basic needs in a session

Tony explains to his sitter, Vera, before the session that he would like to share all his needs for being touched and physically supported. During the session he experiences feelings of longing for touch and body contact. With this need comes the desire to get these needs met without having to ask for it. Obviously a need from early childhood for skin contact arose, a need which is programmed genetically to be fulfilled immediately and unconditionally. Frustrating this need can cause despair.

Vera feels Tony's need for being held and touched when she accompanies his session. But she holds herself back consciously because Tony said before that he would share all his needs verbally.

In this way Tony succeeds in repeating his early childhood experience but cannot resolve it during the session as the projection onto his sitter of the denying mother figure is maintained during the session.

In the following sharing circle, Tony is still in his anger at his sitter. Although he declares that everything was clear after he shared with Vera after the session, everyone can feel that this is not the whole truth but only represents the mental level. When the trainer asks Tony to come from his angry part he bursts out resentfully: "I never get what I want by itself." And there is a lot of pain behind this resentful statement.

Now the transference is visible and spoken out aloud. The sitter is perceived as an insensitive and denying mother, and the resentment holds on to this image.

When the trainer asks Vera how she feels about Tony's reproaches, she says that she does not feel offended as she only followed his instructions. But from the way she shares the trainer guesses that she has some feelings of guilt. When he asks her if anything of Tony's blames touches her she recognises a pain which she connects to her mother who she describes as a very thin and dry person.

Now both sides of the dynamic are revealed. Tony is now able to integrate his anger, and Vera can release her feeling of guilt. This opens up the relationship between them.

### Working up transference verbally

This example shows, that transference has to be worked out verbally as it functions on a level of complexity that cannot be understood and resolved on a non-verbal level. Tony's ambivalence would have continued even if Vera had taken him into her arms later during the session or afterward it. The memory of the body retains the experience of lacking essential needs, and they cannot be made up for later on. The anger persists and turns into resentment. It is only when Tony understands on a cognitive level that he was unable to share his needs because these came from a situation of inner conflict with its roots in his childhood problem of coping with a denying atmosphere that he is able to integrate his experience into a wider context.

It became clear to Vera that she was trapped in a contradictory countertransference situation only when she could recognise that she had brought her own experiences of childhood denial into the session. This insight opened her to choices of behaviour which would eventually enlarge her abilities as a sitter in future. This way, she could let go of projection and see countertransference as countertransference.

Feelings do not know ambiguities and double messages; they are either there or not there.

This is why we cannot understand confusions stemming from double messages on the feeling level. Only by using language can we express these contradictions and hold on to them until we find an embracing context . We need language to understand that two sides of a coin can exist at the same time: attention and denial, closeness and distance.

### The working contract and its role for handling transference

Usually there is an equality between therapist and client at the beginning of a series of sessions when they share about the role contract. The therapist explains his role as a protective companion by describing what he would do to enhance and guide the process, and what he would not do in order not to inhibit the way of the breath. In this way the aspects for projections on father and mother are transparent and explicit from the beginning.

The therapist explains what can come up during the session and what kind of interventions he would apply in these cases; the client expresses what he feels appropriate for himself and where he would set his limits. He should also be able to share his needs during the session, verbally or nonverbally, as well as to reject certain forms of intervention. In this way, the therapist trusts the client to be able to keep a connection to his adult level of consciousness even in states of regression and experiencing of early childhood feelings. This connection can be a model for the inner co-operation between childlike neediness and vulnerability and mature adult behaviour which can eventually be transferred successfully into daily life.

It is the working contract that enforces self-responsibility in the client and a kind of treaty – a set of rules and roles – with the therapist. Transference is not totally excluded but is also not the main focus of therapy. As breathwork often leads to quick and sometimes surprising regression into early levels of experience, it is important to have a corrective in the form of formally agreed commitments in order not to evoke strong emotionally charged projections which could sometimes be difficult to handle in the situation in which they appear. This is a reason for downgrading the importance of analysing the elements of transference.

## Short term contracts

Often breathworkers offer a commitment of ten sessions to the client – a time limit which is considered to be the average time for opening to the breath and learning the method oneself. This time horizon can be beneficial for clients who easily find immediate and fulfilling results. For others, it can cause difficulties when their process has a different time structure.

There are clients who need a lot of time and more than ten sessions to find their own deeper and spontaneous breathing rhythm. When they come with expectations of a quick breakthrough and relief – which may be evoked by “marketing arguments” from the breathworker – but fail to achieve the desired results in the first sessions, they will either start to blame the therapist openly or unconsciously (by withdrawing co-operation, probably in the form of drifting away during the session) or take responsibility for this and deepen a distrust in themselves if the issue is not taken up and worked on. The therapist, too, can develop feelings of frustration, anger or self-criticism when the process is

stuck. Taking a conscious look at the dynamics of the relationship between therapist and client, from the beginning of the series of sessions can be on important support for breaking the barriers and open new pathways for the deepening of the process.

When starting a series of sessions with a new client, the therapist should carefully consider which approach to offer to the client. It can have a major influence on the process if it is described resolution-oriented or problem-oriented (cf. Wilfried Ehrmann, 'Is Breathwork problem- or solution-oriented?' in *The Healing Breath: a Journal of Breathwork Practice, Psychology and Spirituality*, ed. Joy Manné, www.i-breathe.com). The resolution-oriented approach would benefit from offering a certain time frame in which to attain the envisioned results as an orientation point in the future which could mobilise the resources of the unconscious. The problem-oriented approach would leave up to the process's own nature the time it would take. This decision should be left mainly to the client who will indicate what is appropriate for him by the way he describes why he came for breathwork. His reasons can either situated more in the area of problems he wants to resolve, or in results he wants to achieve. In terms of this position, the therapist can take up the client's ideas and offer his therapeutic perspective from this perspective.

## Countertransference on the level of the body

When the body is included in therapy (the body of the client as well as the body of the therapist), we access the dimension of "physical resonance" which creates a kind of averbal dialogue (cf. Peter Geissler, *Analytische Körperpsychotherapie: Gegenwärtiger Stand und klinische Praxis.* In: Psychotherapie Forum 3/1998 Springer Verlag Wien/New York 1998, p. 157f). During breathwork sessions, we can observe this dialogue on the level of conscious perception (the client hears the therapist's breathing), but there is also a dialogue going on on the subconscious level (the breath itself reacts to the way the therapist is breathing although the conscious focus is somewhere else, or although the breathing of the therapist is not audible).

The sitter observes her own way of breathing while the client is breathing. She can consciously follow the direction of her own breath and take responsibility for feelings and tendencies that arise in her. These phenomena of resonance can be used as indications of what is hidden in the client. In this way, the spontaneous breath reaction is utilised as an instrument of diagnosis through applying the framework of countertransference.

In some cases it can be possible to identify feelings of anger or sadness which are building up subconsciously in the client's process through the sitter's being attentive to the sensitive resonance of his/her breath. In this way, we can find the right form of care to help the client to feel and possibly to express these emotions. Slightly changing the breath by shifting from nose to mouth breathing or by accelerating or slowing down the breathing can help to access the emotion and make it available for deeper understanding. Touching the client's body in certain areas, or applying forms of massage can also achieve this result.

It is crucial for the therapist in these cases to learn to discriminate between his/her own impulses, which are derived from his/her own experiences and practice, and hidden impulses which are transferred by the client. If one combines one's own transference with

the countertransference, it may create confusion in the process, but at the same time it is a very valuable tool of therapeutic work. (cf. Peter Geissler, Analytische Körperpsychotherapie: Gegenwärtiger Stand und klinische Praxis. In: Psychotherapie Forum 3/1998 Springer Verlag Wien/New York 1998, S. 157f)

> A therapist who has not dealt sufficiently with personal subconscious thoughts and emotions may react involuntarily to the process he or she is guiding. The emotions expressed by the rebirthee may trigger similar memories in the therapist, which may start controlling his or her own breathing as a spontaneous reaction of the defence mechanism. Even if the rebirther can still guide the breathing correctly, it will inevitably influence the rebirthee. There is always a subconscious interaction between the two parties in a breathing session: the rebirthee is never allowed to release more than the rebirther personally feels safe. (Gunnel Minett, Breath and Spirit. Rebirthing as a Healing Technique. The Aquarian Press, London 1994, 117f)

* * *

What is the lesson that breathwork can learn from the schools which developed work with transference and countertransference? There is a vast amount of knowledge concerning this subject especially in psychoanalysis and related methods. When these methods are applied, they require a form of distance between therapist and client that is hardly compatible with the method and setting of breathwork. A lot of spontaneity and intuition is necessary when guiding a breathwork session, while analytical reflection can get in the way of the breath dialogue. Occupation with transference issues, therefore, will rarely get a prominent position in breathwork. But it enhances the qualities of a therapist if s/he is sensitive to the phenomena which can arise in the field of transference so that interesting perspectives on the dynamics of the relationship between client and therapist can open a pathway to alternatives in the therapeutic work.

## About the Author

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# VAPOUR

**BY**


## HILDE RAPP


*For Tessa and Aileen*

A single clear note
rises from each of our centres
each in its own place
of cultural formation
where the navel of the dream
connects each one of us
to the filiations
of our ancestral sufferings
and our ancestral transgressions.

What colour is the skin
of your heart
or yours
or mine?
I tell you
it is blood red
with passion

a passion that comes from the
suffering of our humanity
a passion
that comes from the rubedo
of our sanguine hopes
that despite everything
our hearts will go on
beating
to the beat
of a new time
which watches over us
which encases our separate
and several stories
each in their own way
in their own place
ready for the telling
in one and the same time

and in the telling
a single clear voice
will rise each from its own centre
from the root of our bodiliness
from the well spring
of our good will
it will rise
with the vapours of our liver
and with the black humours
of our sorely pressed humanness

it will rise
driven by the raging flame of our murderessness
and it will hover
above the waters of our gentleness
where the white milk and the red blood
will engender
a new discourse
people will  have ears
and they do hear
people will speak
and people will wail
and people will keen
with voices hovering
like the breath over the waters
as if for the first time
wetting the
bleached bones
of our ancestral souls
murdered and
resurrected
on the famished road
of our past and passing
violations
of one another's
bodies and
one another's souls
and one another's spirit

and yet still
the spirit will not die
even as the body lies mangled
and the soul cries out seared from evil
yet still
still clear voices will rise up
each from its own centre
in its own place
yet in the same time
moist from the vapour of living breath
and each will speak its part and
all the voices
will rise warmed by some new compassion
and they will find in one another
a new mirror
for their humanness
and they will tell their stories
in concert
accusing
and mourning
the bleached bones
of our ancestral souls
murdered on the famished road
where the white man's soul was murdered
so the white man could murder
the black man's soul
or the soul of the jew
the gypsy

or the soul of his son
his daughter
his woman
his mother
his father
in cold blood
with a barren heart
a wooden face
in stony silence

all this we will see
as black voices
woman's voices
children's voices
breathe their veiled mysteries
with vaporous breath
upon the white mirror
so that
through a misted glass darkly
will appear a palimpsest
of words
issuing again from living lips
open to an effaced discourse

let there be new hot red blood
coursing in the vein of speech
let it be mixed with white salt
crystallised out of the waters of our tears
let us wash those bones
let us
taste that bitterness
together
and let us
look
for the first
time
eye to eye
I to I

and let us look
for the first time
for beauty
and for likeness
and let something grow from the
wetted soil
on which we are standing together
to accuse and to mourn
the great tear in the earth
running like a curse between us
let us witness
the gulf
that generations of cruelty have riven
let us look into the chasm
and watch the swirling vapours
of what is past

and passing
and to come
and let us remember
that it is our past doings
and our past deeds that have made us
who we are
and that we do not know how to envision
the future

for looking ahead
has become that we no longer
look into one another's eyes
in the present
it has made us
not be present one with other
it has stopped us from witnessing
what was and what is
it has made flee from our centres
to a vanishing point
which sucks up our humanness
into the black hole
of not now
never now
always yesterday
always tomorrow
never you
never I
always an other
heartsnatcher
devourer of dreams
eraser
of
interstices
in which life
lives
between
the dry stones
like weeds
in God's untended garden

an other
who has had
our humanness bound on his back
and who has been sent out of time
into no time
a barren land
neither desert
nor wilderness
but scorched earth
disensoulded body and uninhabited mind
where nothing is
and nothing was
and where nothing will become

let us make our time pregnant
let us make our time
fruitful
let us
be present
in one time
each from our own centre
in our own place
and let our voices rise
like a cone of power
into the sky above us
and into the earth below us
let us make woman's garden
man's garden
daughter's garden
son's garden
grandmother's garden
and grandfather's garden
let us desist from ablating the parental images
let us not be the tyrannical children
who devour the earth
and who kill their ancestors
and throw their bones
on the famished road
without ceremony
and without burial

let us begin anew
in the round of the year
by telling our stories
let us speak our pain
let us sing
and let us dance
let joy into our hearts also
joy about new lives
joy about new loves
let us refrain from explaining away
let us stop persecuting life at the dark centre
with the torches of false enlightenment
in this new year
let us give voice to the enigma
that is you
and you
and
I.

*Hilde Rapp*
*London, 5 October 1993*

*This poem was the foundation stone on which the Transcultural Therapy/Counselling Forum was built as an alliance between four organisations, BIIP, RACE, NAFSIYAT, and Goldsmiths. The Forum now provides an integrated platform for debate about transcultural issues. It has hosted one major conference with over two hundred delegates from a wide diversity of backgrounds, (the published proceedings of which are available.*

# INTROSPECTIVE TOOLS

## THE ANGEL ORACLE

(Das Engel Orakel, © 1996 Sulamith Wülfing B.V., Amsterdam & Aquamarin Verlag, Grafing, Germany; ©1997 Bluestar Communications Corp., 44 Bear Glenn, Woodside, CA 94062, ISBN: 1-885394 – 20 – 9.)

Angels are in! It is official! *The Times Weekend* (Saturday November 28th, 1998) announced 'The welcome return of angels to earth.' For those of us who have used the Transformation Game with its pack of Angel cards for years (or – showing my age and forgetfulness – did we use the Angel cards before the game ever came out?), this was not really hot news. However, it is good to see that angels have made it to respectability.[36]

*The Times Weekend* article, which is by Ruth Gledhill, mentions "'Angel Ring', a collection of angel sites on the World Wide Web" and informs us that "books on angels (are) appearing regularly." Angel card packs, too, have been appearing regularly. One that I recently found is *The Angel Oracle* with its beautiful pictures and ideas created by Sulamith Wülfing.

The *Angel Oracle* consists of forty cards with pictures of angels on them. The pictures and colours on the cards are quite beautiful and the messages very inspiring. I'll start with these, and then come to the way the angels are depicted, as I have some problem with that.

Each card has a beautiful coloured picture on one side, and the same picture in black and white on the other side, with a key word on it followed by the author's expansion of the sense of that word which serves as a guide to meditation or creative thought. I find most of the expansions well thought out and truly inspiring. Here are some examples taken from the many that I like particularly (obviously any choice is bound to be subjective): the word *Karma* is expanded with the phrase, "One is punished by one's sins, not for them;" *Spirituality*: "On the spiritual life, all paths lead to the same place" (I suspect the translator put 'on' instead of 'in' here); *Fear*, "But the angel said to them, 'Do not be afraid;'" *Prosperity* "I cried because I didn't have shoes, until I met a man who didn't have feet." Some of the expansions are surprising and inspire me to deep thought and inner questioning: *Unity*, "Morals separate, only love unites." I'm still thinking about that one. There are a very few expansions that I find uninspiring (but as I said above, my response can only be subjective). Among those I don't respond to are: *Silence*: "A human being who does not own a single hour a day is not a human being;" *Life*; "Life vibrates. It does not move" (here again I wonder whether the translation does not do justice to the original German). I find a very few of the messages banal or trite, among these: *Love*: "Pure love is the willingness to give, without any thought of receiving in return," as I think *Love* is much more than that – or perhaps because this is a standard definition while so many of the other expansions are surprising. Another which I found dull is *Contact*: "There's nothing more natural than speaking with your Guardian Angel."

[36] Emma Heathcote, PO Box 7459, UK - Birmingham, B32 2TQ is collecting angel experiences and is keen to hear from people of "any – or no – faith."

With regard to the pictures, although they are all quite beautiful I was not able to perceive how every one of them corresponded to the word and expansion on the opposite side of the card. Many of them failed for me: *Inspiration* has a picture that I see as a rather scrawny and unhappy woman of forty with her eyes closed; *Spirituality* has an angel (taller and older woman) supporting a dreamy younger woman dressed in elaborate medieval clothes; *Relationship* too did not inspire profound introspection in me, but rather frustration and incomprehension. It is possible that much of the symbolism is drawn from medieval paintings and I do not understand it well enough and am therefore not inspired by it. In that case I believe that others too will lack this understanding. Enclosing some with the cards would be of use.

Some of the combinations of word and image inspired me to search deeply within myself. *Peace*, with its one girl-child dressed in blue raised up in the middle of six others, three on each side, dressed in yellow-gold and holding flames, takes me to a appreciation and stillness which is beyond words, and which I therefore cannot explain or account for here. *Death* and *Protection*, too, inspired me. Often I found the colours corresponded better to the word on the card than the images. *Inspiration* is in wonderful yellows and oranges; *Meditation* in blues, greens and gold; *Sacrifice* in orange-gold rising into blue, and *Meditation* in quite wonderful silvery-blue.

I also have a problem with the blandness of the faces. *Tao* has a wonderful picture of an angel with golden hair holding a butterfly over her heart, but the expression on the angel's face is bland. The same is sadly true for *Fear* with its lovely image of an angel in pink lighting up an indigo darkness, and *Revelation*, with its inspiring expansion, "There the angel of the Lord appeared to him in a flame of fire," and where the blandly pretty face of the angel seeming to play "peek-a-boo" behind her hand.

I said above that I had a problem with the way the angels are depicted. Almost all are depicted as female, with oval faces and blue or grey eyes. *The Times* article comments on the problem of whether angels ever had a sex (in the context of the British 1998 Christmas stamps with angel on them). They most often seeming pre-pubescent, occasionally appearing older, but always as "child-women." Only once is there an old face: the angel on *Search* is a crone. I find that although many of the faces have beauty and sweetness, many others are bland and expressionless and this is a drawback with regard to their capacity to inspire me.

It is obvious from the above that my preconception of angels is that their faces have magnificence and character and so I cannot respond all that well to most of the angels on these cards. Perhaps your images of angels are more like Sulamith Wülfing. In any case, the colours on the cards are so beautiful and most of the messages so deeply inspiring that it is worth a try!

Reviewed by Joy Manné.

# BOOK REVIEWS

## *Body Voices* by Carolyn Braddock

1997, Berkeley, CA: pagemill Press, ISBN: 1879290057. $!9.95. 275 pp
Reviewed by Kylea Taylor

For Breathwork practitioners who are not trained as therapists, *Body Voices* is a clear and useful primer for working with persons who have experienced sexual trauma. For Breathwork practitioners who are therapists, this book provides techniques that are consistent with holotropic theory and could be complementary therapeutically to breathwork sessions. The book is primarily concerned with women (although men are also mentioned briefly in text and illustrations), and it deals with the quite universal themes of women in therapy: finding one's voice, reclaiming one's body, and exercising one's choice.

Braddock discusses what she has categorized as three body types which form in reaction to sexual trauma--Rigid, Collapsed, and Inanimate. The map is definitely not the territory in *Body Voices*. Although some people may have a predominant orientation to one type or another, I have observed that the body types and psychological tendencies she describes are very often mixed together, or mixed in one person sequentially. Her three types are fairly simplistic. Trying to fit someone into one of three types might be more difficult than simply noticing where the process is going and acting accordingly. Nonetheless, the exercises involving breath, sound, and movement, if applied to *follow the process* rather than to name it or assume something about it, are good exercises. They are well-described, creative, and useful. I found myself writing various client file numbers next to examples in the book in order to refer back easily. I think these techniques will be useful in therapy outside of breathwork sessions for following and encouraging the client's breath, voice, and body movement in individual sessions and groups.

Braddock shows her deep knowledge of biographical experiences in nonordinary states of consciousness by her description and acceptance of some of the phenomena with which we are quite familiar in Holotropic Breathwork and other forms of breathwork: tetany, regression, release of urine. Since Braddock uses the breath intrinsically in her approach and recognizes that her clients are regressing and entering other states of consciousness in their therapeutic work, it is surprising that Stanislav Grof's books are omitted from the bibliography and his cartography is not mentioned in the theoretical part of the book. There is one briefest mention of anaesthesia in a birth process and no transpersonal experiences are discussed. As we know, many people healing from sexual abuse trauma have both perinatal and transpersonal components to their holotropic work. I also wished Braddock had referred to some of Christina Grof's excellent points in *The Thirst for Wholeness* when she was discussing both forgiveness of the perpetrator(s) and talking about addiction as a response to sexual abuse trauma.

I think The Braddock Body Process, which the author teaches in Colorado, is yet another way of working with the many clients who seek healing. I can see that certain clients,

who need a more interactive healing relationship, would benefit from working privately with a therapist using this method. I think Braddock's strength as an intuitive therapist using a synthesis of touch, breath, sound, movement, and traditional therapy has developed from a lifetime of study and her own personal journey of healing from sexual abuse and heavy alcohol use. From experience, she says she has found, as have most breathworkers, that, "This kind of work is not for every therapist; you must be willing to resolve your own issues, issues with your own traumas…before you can guide someone through this process."

*Body Voices* concludes with several chapters which might well be required reading for consciousness-raising about working with sexual trauma survivors. This sequence of chapters provides an excellent, concise overview of the particular issues of cultural context, sexuality, addiction, and spirituality which apply to clients who have been sexually traumatized. These final chapters are the most concise, thorough, and clear exposition of this material I have seen. As an anecdote about her consciousness-raising work, Braddock tells how at the end of the seventh week of her eight-week course on sexual trauma at an addiction center, the counselors were saying how surprising it was that they were seeing many "more" sexual abuse clients than at the beginning of the course. In this book, Braddock raises our awareness, so that we, too, will begin to see much more of what clients are already showing us, and we can act with greater sensitivity to the special needs of sexual trauma survivors regarding trust, safety, and empowerment.

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## Strawberries Beyond My Window by Waltraud Kirschke

1998, Moritz Egetmeyer, Oh Verlag, Postfach 1251 – 79196 Kirchzarten.
Reviewed by Joy Manné

This is a book about the range and development of the associative cards published by Moritz Egetmeyer, whose interest in these cards started with the OH cards which I reviewed in THB, Vol. 1 No. 1. I agree with their publisher when he calls these cards a masterpiece. (p. 7) I have used them for years, and it was interesting to learn their history, a tale of synchronicities, which is one way of explaining why associative cards work. For this rubric in *The Healing Breath* I've chosen the title Inspirational Tools, but it could just as easily have been 'Associative Cards.'

One way to view associative cards is as a relationship game. In his introduction, Egetmeyer says "When chance in play leads neither to gain nor loss … but rather to associations and ideas, a bit more trust emerges in our ability to deal with the unexpected – that is, in our capacity to integrate into our lives the elements introduced by chance. This … can result in our being able to face the future with more creativity than when we cling to the safe and familiar." (p. 10)

Kirschke starts her book with a chapter on 'The Birth of a Genre.' Here she points out that associative cards are different from cooperative games as in the latter the participants are competing against the game itself. OH cards are neither competitive like Bridge nor oracular like Tarot, but interactive. What is said about OH cards is true for all the cards mentioned in this book. They "act as a springboard into the imagination, and, like dreams, .. reflect the soul." (p.12) They bring about a feeling of interconnectivity, "the recognition that all we encounter … is a part of the greater whole to which we belong." They have no fixed rules.

She then has chapters presenting the OH, SAGA, HABITAT, PERSONA, MORENÁ cards, with recommendations for their usage and illustrative case histories.

OH cards consist of a set of word cards which "address mainly the intellect" and a set of smaller picture cards "which address the intuition and emotions,' and which fit on top of the words. Kirschke discusses how this combination works, "(speaking) both to the left and right hemispheres of the brain" and thus activating both intellectual and intuitive responses at the same time. (p. 33)

OH cards and the other associative cards produced by Egetmeyer may not have rules, but they have excellent guidelines which promote the autonomy of the person who has her turn and respect from the group. Their creator, Ely Ramon, is a gestalt analyst and the rules honour the essence of gestalt practice.

OH picture cards depict the Western world and its day to day life, and so tend to draw out the images and memories of everyday personal life. The SAGA cards are a set of pictures that "facilitate access to archetypal images:" fire, water, earth, air, king, queen, fool, warrior, witch, sage. (p. 46f) They invite us to discover our own fairy tales and myths. OH and SAGA picture cards were painted by Ely Raman.

Only abstract images are depicted on the ECCO cards which were painted by the artist John David Ellis "with no definite idea of what the impact of his images on the observer should be". (p. 51) Therefore, "like all abstract art ECCO lives through the imagination of its viewers." (p. 52) The combination of ECCO cards with the OH words functions this way: "the word steers the imagination in a direction and enables us to perceive the abstract image from a particular viewpoint." ECCO cards can also be fitted together like a jigsaw with limitless combinations. They can be means to the direct experiencing of feeling evoked by form and colour.' (p. 53)

HABITAT cards are painted by Christian Gronau. They "depict in impressive images the relationships of humans and nature. Kirschke reminds us that shamans have always associated themselves with nature. She proposes that the HABITAT cards can address us on three levels: (1) "the events depicted on the cards .. (present) us with an opportunity to recognize that we are endangering the very source of life when we destroy our environment." (2) They show us on the feeling level "that all forms of life are related," and (3) images of the external world can at the same time te seen as a prjection furface frorthe 'inner world'." (65)

PERSONA comprises two combinable decks of cards, one with portraits and one with relationship or interaction patterns schematically drawn. The portraits are painted by Ely Raman. They show people of different ages and diverse cultures. Some portraits are more abstracts, others are based on the works of old masters. Kirschke says, "PERSONA's challenge is to look through the eyes of another, to play a role not normally ours, to feel our way into a network of relationships not actually our own. …

Through such role-playing tolerance and acceptance of others can grow." (p. 70) I use these cards when I am teaching Voice Dialogue, a technique invented by Hal and Sidra Stone,* to introduce the experience of being composed of different "voices" or subpersonalities.

Kirschke explains, regarding the MORENÁ Cards, "MORENÁ is a name in the Xingu language for the place of human origin." These cards are painted by Walde Mar de Andrade e Silva. They capture the life of the Brazilian Xingu with images painted in the primitive style. " There are 88 picture cards and 22 cards which show tracks of humans and animals and are like the relationship cards in PERSONA. As in other mythologies, the memory of a dream age in which humans, animals and the entire creation were in unity lives in the stories that the Xingu tell." (p. 77) HABITAT depicts today's relationship with nature, MORENÁ depicts an ideal. Kirschke says, "MORENÁ presents an opportunity to seek through the activity of play our original condition." (p. 78)

In a chapter "An extraordinary attribute of the associative card genre and its significance fore the player," Kirschke says, "associative cards … drawn sight unseen can actually seem to reflect the life situation of the player who drew them, and this with an unexpected accuracy. … This observation, made repeatedly, has in some circles led to the associative cards being ascribed an almost magical force, as if the cards themselves have the ability attributed to oracles of being able to reveal the questioner's innermost self." (p. 85) In my experience this is absolutely true of the OH cards (the only ones I use regularly), to the extent that giving a demonstration is almost impossible. The cards show too intimately where I am in my life. When I show how to use them, during demonstrations and teaching, I do not turn the cards I have chosen up, but illustrate with 'safe' predetermined examples. Kirschke explains this feature of these cards in terms of Jung's theory of synchronicity or the Taoist idea of flow in life. She says, however, "a 'magical' understanding … distracts from the fact that it is always we ourselves who attribute meaning to the cards we have drawn, and that it is our own attitudes to life that we see reflected in our cards." She points out what is too little understood, that if we attribute oracular value to the cards, we hand over to them the responsibility for our own process … making the cards responsible for the message we receive when it is we who are telling ourselves something, with the catalysing help of the image and action cards." (p.91) This illustrates the difference between superstition and empowerment. The original intentions and guidelines for the use of these cards are empowering. Associative cards are cards for self-guidance. (p. 92)

In a long chapter, "Use of the associative cards as a playful tool in teaching and helping professions," there are examples where these cards have been used by kindergartens, schools and education; music education; psychoanalysis, therapy and counselling – on pp 117-120 there is an example of the cards used in the same way Bert Hellinger uses people to show a relationship constellation; team training for leadership; and working with the disabled.

An Epilogue draws attention to two new games, "neither of which is particularly concerned with introspection and self-experience but rather with association simply for fun and pleasure.' (p. 127) These are ORCA – with pictures of whale photographs taken by Alexandra Morton, and QUISINE – with pictures of foodstuffs. A pack of cards which one can paint on, called CLARO, is also available. A deck called TRAUMA is in prepa-

ration. In this contemporary world of floods of refugees, any method that goes towards healing trauma is definitely necessary.

*Stone, Hal and Sidra (1985), *Embracing Our Selves: Voice Dialogue Manual.* Devorss & Company: Marina del Rey, California: