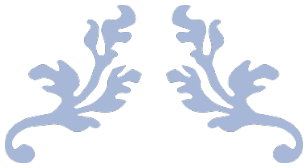

HEALING RELATIONSHIPS

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INTEGRAL YOGA THERAPY

Healing Relationships Study Guide

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Definitions of Healing

Healing: (n) the process of becoming sound or healthy again (Oxford Dictionary)

What is the concept of healing?

The operational definition that emerged from the concept analysis: Healing is a holistic, transformative process of repair and recovery in mind, body, and spirit resulting in positive change, finding meaning, and movement toward self-realization of wholeness, regardless of the presence or absence of disease.
(Firth K, Smith K, Sakallaris BR, Bellanti DM, Crawford C, Avant KC. Healing, a Concept Analysis. Glob Adv Health Med. 2015 Nov;4(6):44-50. doi: 10.7453/gahmj.2015.056. Epub 2015 Nov 1. PMID: 26665022; PMCID: PMC4653605.)

What is the biblical meaning of healing?

Healing occurs through the integrating forces that restore, transform, sustain and nurture the whole person (body, mind, spirit) at each phase and in every dimension of life, and within relationships of the person to the creation, to other people, and to God. Christian healing is a lifelong process which occurs by the sovereign grace of God, through faith in Jesus Christ and the empowerment of the Holy Spirit. Our transformative growth toward wholeness (shalom) is made complete when we die and are restored to God for eternity (van Loon, 2004).

(Baptist Care, SA)

What is the spiritual definition of healing?

Spiritual healing is **a systematic and purposeful intervention performed by one or more people to help another person, focused on improving their conditions** (6–9). There is evidence that the use of spiritual healing has been increasing rapidly over time, worldwide. (Explaining the Process of Spiritual healing of Critically-ill Patients: A Grounded Theory Study
Forough Rafii,[1] Mahmoud Eisavi,[2] and Mehdi Safarabadi[1)]

The Meaning of Healing: Transcending Suffering

Thomas R. Egnew, EdD, LICSW

Healing vs Curing

(Choices In Healing—Michael Lerner, MIT Press, 1994)

PART ONE

Paths of Hope and Ways of Healing

Chapter Two

Healing and Curing: The Starting Point for Informed Choice

Healing Goes Beyond Curing

There is a fundamental distinction between healing and curing that lies at the heart of all genuinely patient-centered approaches to cancer treatment and care. This is not some "flaky" New Age distinction, but one rooted in the greatest and oldest continuous traditions of medicine. It is a distinction yet to be fully recognized and honored in mainstream American medicine today. But while the distinction between curing and healing is widely recognized, the significance of these two complementary approaches to recovery from cancer is rarely explained to people with cancer.

As the term is generally used, a cure is a successful medical treatment. In other words, a cure is a treatment that removes all evidence of the disease and allows the person who previously had cancer to live as long as he would have lived without cancer. A cure is what the physician hopes to bring to the patient. Curing is what the doctors hope to do, the external medical process of effecting an outcome in which the disease disappears.1

Healing, in contrast, is an inner process through which a person becomes whole. Healing can take place at the physical level, as when a wound or broken bone heals. It can take place at an emotional level, as when we recover from terrible childhood traumas or from a death or a divorce. It can take place at a mental level, as when we learn to reframe or restructure destructive ideas about ourselves and the world that we carried in the past. And it can take place at what some would call a spiritual level, as when we move toward God, toward a deeper connection with nature, or toward inner peace and a sense of connectedness.

Although curing and healing are different, they are deeply entwined. For any cure to work, the physical healing power of the organism must be sufficient to enable recovery to take place. When a physician sets a bone or prescribes an antibiotic for an infection, he is doing his part for recovery by offering curative therapy. Yet when the inner healing power of the organism is insufficiently strong, the bone will not knit or the infection will not subside. Healing is thus a necessary part of curing–a fact with profound implications for medicine, since the authentically holistic physician is deeply aware of the essential role his patient's recuperative powers play and will do everything he can to encourage the patient to enhance those recuperative powers.

Healing, however, goes beyond curing and may take place when curing is not at issue or has proved impossible. Although the capacity to heal physically is necessary to any successful cure, healing can also take place on deeper levels whether or not physical recovery occurs. I have had many friends with cancer for whom curative treatment ultimately proved impossible. Yet, even as their disease progressed, the inner healing process–emotional, mental, and spiritual–was astonishingly powerful in their own lives and in those of their families and friends.

That you can participate in the fight for life with cancer–by working to enhance your own healing and recuperative resources–is a profoundly important discovery for many people. Cancer patients often experience themselves as losing all control of their lives. They become the passive objects of all kinds of decisions and treatments by their medical teams. They feel they must do what their physicians tell them. They may feel that they can do nothing to help themselves. Often, no one has offered them the opportunity to consider the distinction between healing and curing.

It is not yet known scientifically how much difference personal efforts at healing can mean in terms of life extension. However, it is clinically known by most psychotherapists who work with cancer that a patient engaged in personal healing work can make a transformative difference in his quality of life. An ever-increasing body of scientific evidence now suggests that a strong desire to live–a willingness to engage in the struggle for life–and a continuous movement toward a healthy relationship with life, do help some people in their fight for physical recovery. Conversely, long-term chronic depression, hopelessness, cynicism, and similar characteristics tend to diminish resilience and increase physical vulnerability.

Interestingly, the successful fight for life is not necessarily waged best by the person with an excessive attachment to the outcome. As we shall see, the shamans in traditional systems of medicine around the world found that if they sought first to safeguard the soul, rather than the body, the body tended to respond better. Similarly, a boxer who is angry at his opponent is usually less skillful and more likely to lose the fight. Surgeons do not operate on their wives or children because they know that their attachment to the outcome would lessen their skills. Soldiers in desperate battlefield situations know that to be trapped in fear of death may doom them: they need clear heads, courage, and hope, against all odds, to survive.

In Europe, mountain climbing stories have been meticulously collected from climbers who survived life-threatening falls, and these stories may illustrate the complexity of the healing response. As the fall begins, the climber does not scream as falling people do in the movies. Instead, time slows down enormously–as it does for many people just before a car accident. Everything seems to be taking place in slow motion. The survival benefit of this slowing down of time is that the falling climber has every opportunity to notice lifesaving possibilities–handholds or shrubs that might be grasped to break the fall. But if the opportunities for active self-preservation disappear, the faller then enters a state not of panic but of deep peace. He may experience the often-reported process of life recall, with his life flashing back before his eyes. He may hear celestial music. Hitting the ground is usually experienced without pain–he only hears the impact. Hearing is the last sense to disappear into unconsciousness.

By analogy, the healing response that takes place as we go into the “free fall” of a cancer diagnosis seeks every opportunity to maximize the possibilities for physical life recovery. Intelligence and intuition may be brought together in choices of treatment, hospital, doctor, and of complementary therapies or the paths of self-exploration, health promotion, and self-care. The very process that maximizes the opportunities to recover also prepares us to make the best of a long life with cancer, or the best use of whatever time we have available.

Thus the starting point for informed choice in both mainstream and complementary cancer therapies is the patient’s recognition that he can play a crucial role in the fight for his life. The recognition of the unique role that each of us can play in our own healing reaches beyond choices about therapy to choices about how we intend to live each day for the rest of our lives.

Universal, Common, and Unique Conditions of Healing

available to him during How do we set about healing ourselves? One of the best analogies Rachel Naomi Remen, M.D., uses is that of becoming a gardener of ourselves. We cannot grow ourselves in our garden by simple, direct volition. But we can create the conditions of growth, or the conditions of healing, by nourishing, nurturing, and tending within us that which we value and wish to help grow.

Obviously, there are many different kinds of conditions for healing: physical conditions such as diet, exercise, relaxation, clean air, good water, and time spent in nature; social conditions for healing, such as work that is meaningful, friends that you care about, and a loving family; and emotional, mental, and spiritual conditions.

It is useful to differentiate between universal, common, and unique conditions of healing. For example, inner peace is an almost universal condition of healing. A deep experience of love is also almost universally healing. (By contrast, anger or hate is a less common condition of healing; yet there are those cases of people who have recovered physically from the most life-threatening conditions out of an intense desire for revenge or sheer negative cussedness–the “too mean to die” phenomenon.)

There are many common conditions of healing. Many of us are healed by attention and care from our friends and family, by finding work that we deeply enjoy, by laughter, by music that moves us, by great art. But some of the most important conditions of healing are the unique conditions of healing. William Blake said that any man who would help another must do so in “minute particulars.” He was talking about helping another person by assisting him in the minute particulars–the unique way–that is most meaningful to him.

One of my favorite experiences of the discovery of a unique condition of healing was with a renowned elderly pediatrician–whom I will call William Sawyer–who attended the Commonweal Cancer Help Program with advanced prostate cancer after his wife had died a very difficult death with amyotrophic lateral sclerosis (sometimes called “Lou Gehrig’s disease<%4>”<%0>). He had nursed her throughout her illness, and had developed cancer while

she was ill. Rather than have the curative surgery that was his wife's final months, which would have required that he leave his wife alone, Bill chose palliative treatment so that he could be with her. After his wife died and his cancer spread, he flew across the country to attend our Cancer Help Program.

Bill made it very clear to us that he was not at all certain why he had come to Commonweal. Others, he said, wanted to live. He was not sure he did. Although he had never believed in life after death before, since his wife had died he had an increasing sense that he would join her when he died. And he looked forward to that prospect. It was not, he said, his cancer that distressed him. It was his depression over his wife's death.

I had no inclination to try to talk him out of his authentic experience of grief and his sober encounter with reality. So, I spent the week with him listening. Listening, by the way, is one of the greatest ways we can help others heal–one of the greatest ways to create conditions of healing. Most people back away from great pain that others are suffering, or rush in with suggestions for how to "fix it." At Commonweal, we do not back away and we do not try to fix it. We listen.

I acknowledged the truth of what Bill was telling me. But since he was alive for the time being, I wondered what gave him any kind of enjoyment. And Bill began to talk about the birds that he fed outside his home in rural Massachusetts. He loved birds deeply. He had also always loved cats–he had a special capacity to communicate with cats. I asked if he had a cat. No, he said, he did not have a cat because if he got a cat he would worry about what would happen to the cat if he went into the hospital or if he died.

So Bill and I spent the rest of the week working on whether or not he could have a cat. I said that I would help find people to take care of the cat if he went into the hospital. I said that I would be honored to take his cat if he died. Since my wife liked Siamese cats, I suggested that perhaps we should get him a Siamese that we might inherit one day. But Bill did not want a Siamese cat. He had taken care of poor, forgotten, and mistreated children all of his life. What he wanted was to go to the ASPCA and get a cat that had been abandoned–perhaps hurt–and nurse it back to health.

Bill left at the end of the week and went home. A few weeks later I got a call. Bill had found a mongrel kitten at the ASPCA that had been thrown from a moving car and had broken many bones. He was now nursing it back to health. At regular intervals until Bill's death we received cards and letters signed "William and the Cat."

I tell Bill's story because it is a perfect example of a person with cancer who needed to discover for himself a unique condition of healing. We could have talked to Bill forever about diet, exercise, imagery, and other common conditions of healing that have, in fact, been relevant for many other people on the Cancer Help Program. We could have urged him to fight for his physical recovery. If we had, we would have missed completely the opportunity to help him find his true condition for healing: giving himself permission to have a cat. But note that not just

any cat would do. He had to rescue a wounded and abandoned cat, as he had helped rescue wounded and abandoned children all of his life. It was a way that he could continue to express the love in his great heart, a way that he could continue to give.

One day years later Rachel Naomi Remen remarked to me that Bill's struggle over whether or not he could have a cat might have had a deeper significance. He might have been struggling, she suggested, with whether he was permitted to love again. Here was a man who had lost a wife whom he had deeply loved for many decades. He did not seek another wife, but he did seek another companion with whom he had deep communication.

Although his struggle with cancer continued, reinforced by many other ailments of old age, Bill lived on for many years. And through the struggle, the company of a cat that he rescued and nursed back to health remained a deep source of solace.

Biomedicine and Biopsychosocial Medicine

Cancer patients should be aware that a great debate is now taking place today as to what role, if any, modern medicine should play in helping patients with their healing processes.

On one side of this debate are proponents of biomedicine, who honestly and straightforwardly believe that the physician-scientist is a technician who should offer the patient his technical skills, and stay out of psychological and spiritual issues. This is a clean and reasonable position, not to be mocked.

On the other side of the debate are proponents of what George Engle has named "biopsychosocial" medicine. Biopsychosocial medicine recognizes that disease takes place in a psychological and social context, that these psychosocial contexts influence both the cause and the course of many diseases, and that the physician interested in the most effective curative processes must also be concerned with healing in the psychosocial context.2

Professional interest in biopsychosocial medicine has grown over the past few decades as popular and professional interest has increased in "mind-body" medicine and such emerging scientific disciplines as psychoneuroimmunology. Psychoneuroimmunology is an interdisciplinary field of study that proposes that the mind, the neurological system, and the immune system are a deeply interrelated single system. In psychoneuroimmunology and allied fields of behavioral medicine and health psychology, a growing body of research has indicated that it often matters to the physical course of disease what is happening in the emotional and mental processes of the patient. Hence George Engle, Norman Cousins, and numerous others have argued that the physician truly ought to concern himself with healing as well as curing.

Further thought about the distinction between biomedicine and biopsycho- social medicine has led to distinctions that can be genuinely useful for the cancer patient. Consider the following relationships:

Biomedicine (Science) Biopsychosocial Medicine (Human Experience)

Disease Illness

Pain Suffering

Curing Healing

Biomedicine is legitimately concerned with the physical processes of disease. Biopsychosocial medicine is concerned both with the physical process of disease and with the human experience of disease, which is illness.

Biomedicine is legitimately concerned with the relief of pain. Biopsychosocial medicine is concerned with the relief of pain but also with the human experience of pain, which is suffering.

Biomedicine is legitimately concerned with the physiological process of curing. Biopsychosocial medicine is concerned with physiological process of curing but also with the human experience of whatever is physically, mentally, emotionally, and spiritually possible in the face of illness, which is healing.

It is very important–and not adequately considered in the popular cancer literature–that medicine has a language that distinguishes biomedicine from biopsychosocial medicine, disease from illness, pain from suffering, and curing from healing. Within the vast biomedical-industrial complex that modern society has created, it is worth knowing that many great physicians have thought long and hard about these issues, and recognize that our modern sophistication with biomedical technology is matched on the negative side by an often shocking lack of sophistication or interest in helping patients become aware of and participate in their own healing process.

How to Begin Your Own Healing

How can you participate in your own healing process? Many great physicians and healers through the ages have given this question a great deal of thought, and have produced many answers–answers that usually take the form of questions. Here are a few:

If you could do (or be) absolutely anything in the world that you wanted during the rest of your life,<M> what would you truly want to do (or be)?<D>

This is the question that the pioneering psychotherapist Larry LeShan asks in Cancer as a Turning Point. “What is the unique purpose of your life, the unique song that you were put on earth to sing?,” LeShan often asks. Some people know the answer instantly. Others discover it after a time of living with the question. Still others have to work long and hard for the answer. It is a great question, and a great guide on the path to healing, for if you discover the answer,

LeShan's next question is: "Under the present circumstances, what would be the first steps you need to take to begin moving toward living this life?" Embarking on this path can bring great healing.

Another such question might be:

Since you have been diagnosed with cancer, what do you find has become important to you, and what that previously seemed important do you discover you are ready to let go?

A cancer diagnosis can thus lead to a profound transformation of values. Things that used to seem important often become less salient, while other values to which you may have given little thought take priority. This sorting process can go on throughout your life–What do I want to hold on to? What do I choose to let go of? and, more painfully, What that I care about am I able to hold onto? What that I care about do I need to let go of?

You might also ask yourself:

Within the circumstances of the cancer diagnosis, what would I optimally choose in every area of my current life? What kind of mainstream and complementary therapies should I undertake? What kind of relationships? What kind of work? What forms of relaxation or meditation? What forms of exercise or recreation? What kind of diet? What rhythms of daily life? What studies or activities? What kinds of support and response do I want from family and friends? What are some of the unique things–very personal to me–that would give me special delight and pleasure each day?

This is an exercise in making yourself aware of what feels authentic to you. It is surprising how many people with cancer have never given much thought to what they would actually like. Clinicians often report the impression that many cancer patients have been "givers" for much of their lives, subordinating awareness of their own needs to awareness of the needs of others. Learning to be aware of and to articulate what you would like can sometimes be a new and even frightening prospect. But discovering the little (and big) activities that give you special pleasure is both fulfilling and healing. One way of exploring this question is to divide your life into different areas of inquiry. What are the specific physical, emotional, mental, and spiritual conditions that could support healing for you?

Healing and Psychosynthesis

For cancer patients who want a more explicit map of the human psyche, one of the most interesting schools of transpersonal psychology is psychosynthesis. Founded by an Italian psychoanalyst, Roberto Assagioli, who had studied with both Jung and Freud and who was a close student of Eastern as well as Western spiritual traditions, psychosynthesis offers some helpful perspectives on the nature of healing.

Psychosynthesis recognizes with Freud that many people struggle with impulses coming up from their lower unconscious–impulses related to basic drives and appetites. But it also recognizes with Jung that some people also struggle with repressed impulses from their upper unconscious, or superconscious, and that one can be as neurotically miserable seeking to be less than one is in order to conform as one can be seeking to be more than one is in order to conform.

Psychosynthesis convincingly organizes much of our experience of the world into various personality substructures it calls "subpersonalities." Most people are able, if asked, to make a list of at least some of the subpersonalities that we unconsciously move in and out of all day. A typical list of subpersonality structures of a professional woman with cancer might include physician, mother, wife, daughter, friend, cancer patient, jogger, spiritual seeker, frustrated circus performer, etc.

The goals of psychosynthesis include becoming aware of the various subpersonalities, acknowledging that they are part of us, learning to identify and disidentify with them–how to step in and out of each subpersonality–and then gradually to synthesize and integrate them. The relevance of this to a cancer patient is that, if healing is a process of self-discovery, a process of becoming aware of and interested in our own process of self-actualization, then psychosynthesis provides one interesting map for coming to know ourselves.

Healing, Creativity, and Imagery

I have described healing as a process of becoming whole on many different levels through increasing awareness of the conditions of self-actualization and personal evolution.

Imagery, Rachel Naomi Remen says, is the language that the unconscious speaks in its efforts to communicate with us. Imagery is an extraordinarily powerful tool for communicating with the vast universe within ourselves that we are not aware of in ordinary states of consciousness. Imagery takes many forms: visual, tactile, olfactory, intuitive. We can see, feel, sense, touch, smell, or intuit a communication from within. We can discover imagery through meditation, prayer, hypnotherapy, guided imagery techniques, art, poetry, dreams, journal writing, music, or movement, to name only a few of the methods.

People with cancer often have very potent imagery close to the surface of consciousness. The enormous upheavals in their lives have brought this material into a range of ready access. Yet they may live for months or years without communicating with these extraordinarily powerful constellations of experience within themselves. Getting in touch with one's inner world through imagery can be an astoundingly powerful route to healing.

Creativity is closely related to imagery. W.H. Auden wrote some famous lines about cancer, in which a country physician ruminates about how curious cancer is:

Childless women get it
And men when they retire–
It's as though they needed some outlet
For that foiled creative fire.3

Many cancer patients resonate to these lines, and come to experience to what a degree they had shut down their own creativity and wholeness in the service of fitting into the lives they have constructed. All the questions about finding one's unique song in life, deciding how one wants to live now, and getting in touch with powerful inner constellations of energy by imagery are processes of reconnecting with that inner creativity, that "foiled creative fire."

We are not in the land of science here–we are in the inner imagic landscape. We should not assume that any of the things we have said in passing about some cancer patients–that they are often "giving" people, that they may have subordinated their own needs to the needs of others, that they may have lost some contact with their own creativity–are true for all or even most cancer patients. And I surely do not mean to suggest that these characteristics caused the cancer. I simply want to give the reader a few key ideas about what is involved in the journey of inner healing. (I will discuss the subject of imagery further in chapter 10.)

Healing and Spirituality

The healing process not only has a tendency to bring people closer to an appreciation of who they uniquely are and what their unique purpose is in this world. It also brings them closer to God, spirit, inner peace, connectedness, or whatever we choose to call that which is great and mysterious.

The longer I have considered this fact–the fundamental connection between healing and psychological development–the more I think it one of the most remarkable signatory details left to us by the architect of human consciousness, whoever that may be. Consider how truly elegant the design process is that created us so that in the face of the most difficult times of our lives, there is the possibility–not the certainty but the possibility–of access to states of awareness and experience that enable us to cope with these crises better than we otherwise could. And consider how remarkable it is that these states of awareness make many people say that they feel more alive and more whole with cancer than they ever felt before. Consider how curious it is that many people come to acknowledge, in the face of the pain, shock, and suffering of cancer, that there also can be gains of immense personal value.

A central tenet of all the great spiritual traditions is that pain and suffering, loss and sorrow, carry within them keys that unlock gates of spiritual experience that often had been closed before. How extraordinary that we should be designed in this way. What does it mean? What does it imply? (I will discuss spirit and healing further in chapter 9.)

Healing and Choice in Cancer

I place such emphasis on the significance of healing with cancer because I believe that awareness of the power and process of healing is the key to informed choice in all areas of cancer: choice in mainstream therapies, choice in complementary therapies, choice in life with cancer, choice in response to pain and suffering, and choice in living and dying.

There is no single right way to respond to any of the choices, large or small, that cancer brings. You will certainly experience pressures from physicians, family, and friends to choose one course over another. Physicians will offer you the best conventional medical wisdom about therapies. Family and friends may urge you to try alternative therapies, or conversely urge you not to try them. People may expect you to continue to live the way you did before, to continue to respond to them in the same ways. Or they may urge new ways of life on you.

At every turn there are bewildering arrays of choices, and often there is no adequate external guidance that you can count on. So when all the information is before you, consider turning inward to discover from as deep a source as possible what makes sense to you.

Information can help us develop maps of informed choice. But the healing process can be the inner compass by which we read these maps. Healing helps us discover "which way is up"–for us. Healing encourages us to move upward, toward higher and more integrated levels of awareness, toward courage, toward expansion–if not always toward extension–of life, and toward becoming more deeply the person we want to be.

Notes and References

1 Five-year cancer-free survival is often considered a "cure" with many cancers for statistical purposes, but this is a dubious use of the term. A truly "cured" cancer patient should live as long as he would have without cancer.

2 George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," Science 196:4286 (8 April 1977).

3 W.H. Auden, Collected Shorter Poems 1927-1957 (New York: Random House, 1966), 111.

What Yoga says: Divine Self,

What Yoga says: Disease, Dis-Ease, and Healing

YOGA SUTRAS of PATANJALI: Philosophy and Psychology of Yoga as Relates to Illness:
Presented by Nora Vimala Pozzi March 2016, Yogaville

Introduction to the Sutras

What? Sutras are the barest thread of meaning which a teacher might expand by adding his or her "own" experiences for the sake of his students. It is the absolute minimum to hold it together.

When? Controversial. Between 5000BC-300AD

Who was Patanjali? He is considered the "Father of Yoga." He did not write or created the sutras. He compiled and organized them in a scientific and methodical way. There are discrepancies on who he really was, from mystical interpretations, including doubts whether he really existed, to the certainty that he was a Grammatician who wrote a classical work, the Mahabhaya, for the cultivation of language; an ayurvedic doctor who wrote a treatise on the Science of Life and Health and a Yogi who wrote this book on the Sutra's.

The Book: Composed of 4 Portions:

1. **The Portion of Contemplation: Samadhi Pada:** This one was intended as an inspiration to beginner students in the spiritual path. It contains the theory of Yoga.
2. **The Portion of Practice: Sadhana Pada:** This is the practicum or application of the theory presented in the previous one. It presents the practical ways to attain the state of YOGA, its benefits, the obstacles on the path and how to overcome them. Only the first five (5) steps of the 8 Limbs of Yoga or "Ashtanga Yoga", are explored in depth, which includes the Ethical Codes of Behavior (Yamas and Niyamas), Asanas, Pranayama (Breath) and Pratyahara (sense withdrawal).
3. **The Portion of Accomplishments: Vibbuthi Pada:** This portion contains the three (3) last limbs of Yoga: Dharana (concentration), Dhyana (meditation), and Samadhi (self absorption).
4. **Portion of Absoluteness: Kaivalya Pada:** This section discusses Yoga from a more cosmic philosophical view point.

List of Relevant Sutras

Book 1: Samadhi Pada – Portion on Contemplation

S.1- Now the Exposition of Yoga is being made.

S.2- The restrain of the modifications of the mind-stuff is Yoga.

S.3- Then the Seer [Self] abides in His own nature.

S.4- At other times [the Self appears to] assume the forms of the mental modifications.

S.5- There are five kinds of mental modifications (vrittis) **which are either painful or painless**.

S.6- They are: Right Knowledge, Misconception, Verbal Delusion, Sleep and Memory.

S.7- The Sources of Right Knowledge are Direct Perception (experience)**; Inference and Scriptural Testimony** (any credible or authoritative source).

S.8- Misconception (wrong, false or erroneous knowledge) **occurs when knowledge of something is not based upon its true form.**

S.9- An image that arises on hearing mere words without any reality (as its basis) is Verbal Delusion (Imagination, Verbal Delusion arises when words do not correspond to reality)

S.10- The mental modification supported by cognition of nothingness is Sleep. (the wave-thought about nothingness)

S.11- When a mental modification of an object previously experienced and not forgotten comes back to consciousness, that is memory.

S.12- These mental modifications are Restrained (controlled; stilled) by Practice and Non-Attachment.

S.13- Of these two, Effort towards steadiness of the mind is Practice.

S.14- Practice becomes firmly grounded when well attended to for a Long Time, Without Interruption and in All Earnestness (faith, conviction, open heart).

S.15- T**he consciousness of self-mastery in one who is Free from Craving** (desires**) for objects seen or heard is Non Attachment.**

S.29- From this practice (the practice of Japa or repeating a mantra or sound vibration [OM]) **all the Obstacles disappear and simultaneously dawns Knowledge of the Inner Self** (gain mastery of).

S.30- Disease, Dullness (Mental Laziness; inertia; lack of interest; sluggishness), **Doubt** (Lingering Doubt), **Carelessness** (lack of attention), **Laziness** (idleness; sloth), **Sensuality** (sense gratification;

craving for sense pleasure), **False Perception** (delusion, wrong understanding), **Failure to reach firm ground** (lack of perseverance or not being able to hold on to what has been undertaken), **Slipping from ground gained** (inability to maintain the progress attained due to stagnation in practices; unsteadiness in concentration), **these Distractions of the Mind Stuff** (chitta) **are the Obstacles.**

(S.31- Accompaniments to the Mental Distractions include Distress (Grief; Sorrow), **Despair**, **Trembling of the Body**, **and Disturbed Breathing** (irregular breathing).

S.32- The practice of concentration on a single subject (or the use of one technique) **is the best way to prevent the obstacles and their accompaniments.**

S.33- By cultivating attitudes of FRIENDLINESS towards the HAPPY; COMPASSION towards the UNHAPPY; DELIGHT (Joy) **towards the VIRTUOUS; DISREGARD** (indifference) **towards the WICKED** (mean) **the mind-stuff retains its undisturbed calmness** (four (4) Locks and four (4) Keys)

S.34- Or that calm is retained by the controlled exhalation or retention of the Breath (pranayama)

S.35- Or the Concentration on subtle sense perception can cause steadiness of the mind. (Centering or the witness exercise).

S.39- Or by Meditating on anything one chooses that is elevating.

Book 2: Sadhana Pada: Portion on Practice

S.1- Accepting Pain as help for Purification (self-discipline), **Study of Spiritual Books** (Self study and study of books of credible source) **and Surrender to the Supreme Being** (Acceptance to what is; surrender to something bigger than us [God or Humanity] **constitutes Yoga in Practice.** [Kriya Yoga: Tapas; Svadyaya and Isvarapranidhana).

S.2- They help us Minimize Obstacles (Kleshas: causes of suffering; afflictions) **and attain Samadhi**. (remove the obstacles or minimize impediments to meditation)

S.3- Ignorance, Egoism, Attachment (to things we like or give us pleasure), **Hatred** (aversion to things we do not like or give us pain) and **Clinging to Bodily Life** (fear of death) **are the five (5) Obstacles.** (Kleshas or causes of suffering or afflictions).

S.5: Ignorance is regarding the Impermanent as Permanent; the Impure as Pure; the Painful as Pleasant and the Non-Self as the Self.

S.6- Egoism is the identification, as it were, of the power of the Seer [Purusha] (True-self; witness; consciousness) **with that of the instrument of seeing [Body-Mind]** (what we think we are).

S.7- Attachment is that which follows Identification with Pleasurable Experiences.

S.8- Aversion is Identification with Painful Experiences.

S.9- Clinging to Life (self preservation or attachment to life)**, flowing by its own potency [due to past experience], exists even in the wise.**

S.11- In the active state, they (afflictions, obstacles) **can be destroyed** (overcome) **by Meditation.**

S.16- Pain that has not yet come is Avoidable.

S. 17- The cause of that avoidable Pain is the Union of the Seer [witness, Purusha] and Seen.

S.26- Uninterrupted Discriminative Discernment is the method for its removal. (removal of Ignorance)

S.28- By the practice of the Eight Limbs of Yoga (spiritual disciplines), **the impurities** (afflictions or obstacles of the mind**) dwindle away and there dawns the Light of Wisdom leading to Discriminative Discernment**. (discerning the real from the unreal, the truth from the untruth).

S.29- The Eight Limbs of Yoga are: 1. Yama: Abstinence (Controls; Self-restraint); **2. Niyama: Observance** (precepts to follow); **3. Asana: Posture; 4. Pranayama: Breath Control** (control of prana); **5. Pratyahara; Sense Withdrawal** (control of the senses); **6. Dharana: Concentration; 7. Dhyana: Meditation; 8. Samadhi: Contemplation or Self Absorbtion.**

S.30- Yama consists of non-violence, truthfulness, non-stealing, continence, and non-greed. (basic rules of conduct that can be applied to oneself in relationship with others to experience peace). **1. Ahimsa: Non Harming** (Unconditional Love), **2. Satya: Non-Lying** (includes, not-denial, not excuses, not white lies), **3. Asteya: Non-Stealing** (not taking from others what is not ours), **4. Bramacharya, Moderation** (staying away from extremes), **5. Apariagraha: Non-Greed or Non-Hoarding.**

S.32-Niyama (Observances to follow in a personal level**) consists of Purity, Contentment, Accepting but not causing Pain, Study of Spiritual Books and Worship of God [Self-Surrender].** (They deal with the relationship to ourselves). **1. Sauca: Purity of heart and Mind** (internal and external

cleanliness); **2. Santosha: Contentment** (acceptance of who we are and what we have); **3. Tapas: Self-Discipline** (also Austerity of Speech: 3 conditions: Truthful, Pleasant and Beneficial. The practice of Silence and Compassionate or Mindful Listening; **Svadyaya: Study of Scriptural Testimony** (or any books or information of credible source); **Isvara Pranidhana: Surrender** (to a Higher Being).

S.33- When disturbed by Negative Thoughts, opposite [positive] ones should be thought of. This is Pratipaksha Bhavana.

S. 34: When negative thoughts or acts such as violence, etc. are caused to be done or even approved of, whether incited by greed, anger or infatuation, whether indulged in with mild, medium or extreme intensity, they are based on ignorance and bring certain pain. Reflecting thus is also Pratipaksha Bhavanam.

S. 46- Asana is a steady, comfortable posture.

S.49- That (firm posture] being acquired, the movements of inhalation and exhalation, should be controlled. This is Pranayama.

S. 53- And the mind becomes fit for Concentration.

S.54- When the senses withdraw themselves from the objects and imitate, as it were, the nature of the mind-stuff, this is Pratyahara. (Yoga Nidra, Brahmari Breath or humming bee breath technique)

Book Three: Vibhuti Pada – Portion on Accomplishments (Siddhis)

S1. Dharana is the binding of the Mind to one place, object or idea.

S2. Dhyana is the continuous flow of cognition toward that object.

S3. Samadhi is the same meditation when there is the shining of the object

Raja Yoga Overview (Jnani Chapman, 1990)

Integral Yoga: synthesis of various paths to suit individual temperaments

1. **Hatha Yoga:** postures and breathing, perfect physical form as vehicle for divine to flow through
2. **Jnana Yoga:** path of intellect, analysis, use mind to transcend mind, discriminate between transitory and unchanging.
3. **Bhakti Yoga:** path of the heart, expressing love, transforming emotion into devotion, using the arts to communicate with the divine.
4. **Japa Yoga:** singing and chanting—use of sound (mantra is a sound vibration) tuning in to the divine frequency.
5. **Karma Yoga:** path of selfless service, work as worship, do the best without attachment to results
6. **Raja Yoga:** the philosophy and psychology of Yoga, the kingly way, meditation practice.

Two Main Texts: **The Bhagavad Gita:** allegory, Krishna explains how we can use the different paths of Yoga to rise above our conditioned minds

The Yoga Sutras of Patanjali: 200 threads/statements compiled with various commentaries explaining Raja Yoga, the nature of the mind and how to transcend its limitations.

The Mind: has three parts: EGO, the identity, the "I", the individual
INTELLECT, the discriminating faculty
DESIRING PART, wants and attachments

Practice and Non-Attachment: two wings of a bird—both needed for the flight, needed to understand and to transcend the mind, to still it.

Practice is defined as "effort toward steadiness of mind" must have three components:

1. Long time (patience)
2. Without break (devotion, dedication)
3. Done in all earnestness (faith)

Non-Attachment: acceptance, non-resistance, non-judgement, attitude of gratitude. Non-attachment is an attitude, cultivate the inner witness who watches, no longer tossed by the winds of desire, free from craving, dis-identified, restless becomes restful.

Ashtanga: Eight Limbs of Yoga

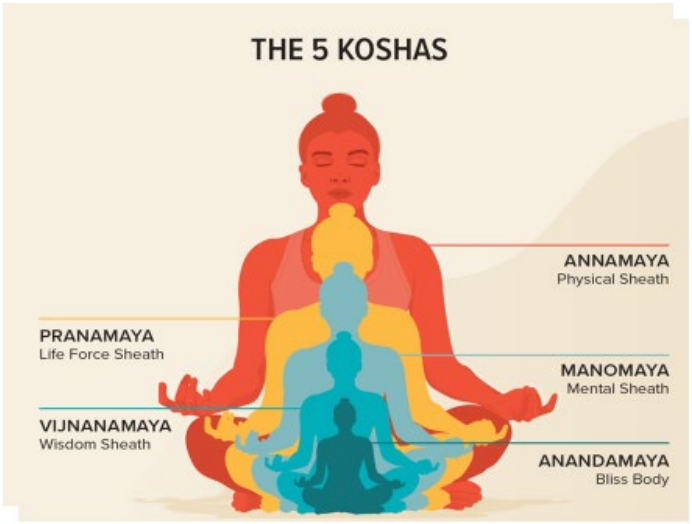
1. Yamas: Abstinences
   1: Non injury: refrain from harming oneself or others
   2: Truthfulness: refrain from being false

3: Non-stealing: refrain from stealing
4: Non-greed: refrain from greed
5: Moderation: refrain from over indulgence

2. Niyamas: Observances
    1. Purity: of thought, word and deed as well as of the physical form
    2. Contentment: acceptance, lifts the heart, brings joy
    3. Accepting pain as a purification without causing pain to oneself or others
    4. Study of texts that elevate the consciousness
    5. Surrender to a supreme being or higher power, however conceived
3. Hatha: physical postures designed to remove toxins and tension, to allow energy to flow freely so that our true nature of health can be maintained and restored
4. Pranayama: breath control; conscious, relaxed use of breath to direct thought and attention, allowing subtle support
5. Pratyahara: Sense withdrawal: the senses are the doors through which the consciousness goes out. It is the mind that experiences through the senses. Consciously withdrawing the mind from the objects of sense desire
6. Dharana: concentration: continual focus, bringing the mind back to one point. Experiment to find the right focus (the breath, a sound vibration like OM, an image of a great saint or of light or anything which elevates the consciousness) then stick with that practice.
7. Dhayana: meditation: the continuous flow of cognition, which can not be practiced but comes as a result of the practice of concentration (#6)
8. Samadhi: described as total absorption—is also a state that cannot be practiced but which comes as a result of meditation. As described it is a state wherein “the see-er, the seen, and the process of seeing become inseparable”, (or knower, known and knowledge.)

Koshas

Goal: remove obstacles and separation at each level that may be blocking the way to reaching the inner sheath (Source: Smitha Mallaiah, Sr. Mind Body Intervention Specialist, M.D. Anderson Cancer Center)



Chakras (Source: The Chakras in Grief and Trauma, Karla Helbert, p. 38

Table 0.1 The major *chakras* and their correspondences

Chakra	Symbol	Color	Sound	Element	Physical Body	Body Sense	Endocrine Gland
1st Base/Root *Muladhara*		Red	LAM Musical note C	Earth	Perineum	Smell	Testes/Ovaries
2nd Sacral *Svadisthana*		Orange	VAM Musical note D	Water	♀Sacrum/Cervix ♂ Sacrum/Top of pelvis	Taste	Adrenals
3rd Solar plexus *Manipura*		Yellow	RAM Musical note E	Fire	Just above navel	Sight	Pancreas
4th Heart *Anahata*		Green/Pink	YAM Musical note F	Air	Center of the chest on the sternum	Touch	Thymus
5th Throat *Vishuddha*		Turquoise	HAM Musical note G	Ether/ Space	Base of the throat	Hearing	Thyroid
6th Brow/Third eye *Ajna*		Deep blue	OM Musical note A	Spirit	Center of the brow	Extrasensory perception	Pituitary/Pineal
7th Crown *Sahasrara*		Violet/Gold white	OM Musical note B	Spirit	Top of the head	All senses known and unknown	Pineal and all of endocrine system

Personal Sadhana and Self Care

Starting Where You Are: Awareness

Awareness/Witness Practice

Being where we are in this moment is the only place we can be. Awareness is the foundation for conscious change and for making choices by giving one personal knowledge that empowers one through shifts and changes on all levels of being.

DEVELOPING THE WITNESS

Witness Practice is an awareness practice designed intentionally to bring attention to how the body is feeling. It enables us to attend to whatever is happening in that moment. This practice is an act of noticing without trying to change anything—it requires a willingness to simply observe one's self at the physical, emotional, mental, and energetic levels. Witness Practice is a physical and psychological check-in. It begins by noticing whatever is arising for the person here and now in this moment—not this day, not earlier or later, not in class last week or yesterday--right now. It begins at the physical level with a systematic, part-by-part exploration. It can begin at the feet, and move up the body to finish at the head or the hands; it can begin at the head, and slowly trace awareness downward. It can even begin at the inside and move out or can begin at the surface of the body and move inward to the center of the bones or organs. The Witness Practice enables a practitioner to notice sensations and feelings present in the physical body. These could be places of tension, discomfort or pain; places that feel uneven or asymmetrical; places that feel stagnant or hyperactive. While the practitioner might notice these present for them, the teacher/therapist will never cue these possibilities into the mind of the practitioner. Rather, the teacher/therapist's guidance remains neutral. Cultivate a gentle acceptance to what is, as it is for the practitioner. The Witness/Awareness practice is observation without judgement and it can be a deeply therapeutic experience for the practitioner when guided by a YCat teacher/therapist's use of language, pacing and presence. Guiding into the practice and out of the practice are important parts of the practice itself: how you introduce it and frame it and how you complete it and shift into the next practice. Please develop seamless transitions from stillness to movement, from internal focus to external focus in guiding the Witness/Awareness practice. Voice inflection and volume as well as the speed of the practice can be adjusted as you, the teacher/therapist, witness and observe the students during the practice. Like all practices, skill will develop with regularity and intention and this is for the practitioner as well as the teacher/therapist.

Move through each level in sequence giving enough time for the mind to direct itself to what is happening:

- On the physical level—notice feelings and sensations
- On the emotional level—become aware of feelings and emotions
- On the thinking level—notice thoughts, attitudes and ideas, looking at habituated recurrent themes
- On the energetic level—notice how one is feeling energetically. Suggest a scale all the way from tired or lethargic on one end to hyperactive or restless at the other end of the scale. Then add the suggestion that the person may be feeling somewhere in the middle of the scale… relaxed, tranquil, and calm.
-

Repetitive suggestions to acknowledge whatever is there, as it is are useful to encourage acceptance. Statements like, "Just let it be how it is; recognize it; acknowledge it. If any judgments arise, simply acknowledge them and continue directing the awareness."

From the energy level direct the awareness to the breath: Observe the breath as it is. Acknowledge it without trying to change it. Let it be exactly the way it is. Simply notice it—watch it—be aware of it. Are there places the breath seems to flow easily? Are there places the breath doesn't quite reach? As you feel comfortable watching the breath— on the way in or out or in between. Just notice how it is and let it be. As you feel ready please begin to count the natural breaths. How many seconds or parts of a second does it seem to take for the breath to come in? How many seconds or parts of a

second for the breath to go out? When you discern a regular pattern, remember it. We will use it later in learning basic Yoga breathing practices. Rest the awareness at the subtle level of deep harmony and connection to the whole.

Sample: Witness Practice Script

Jnani Chapman, RN

We will begin practice with a brief centering called the Witness Practice or the Awareness practice. Sitting as comfortably as possible in the chair, please have your feet hip distance apart and connected to the floor. Place a stool, pillow or folded blanket underneath the feet if they do not naturally touch the floor. Imagine that the feet are anchoring you to the earth, even as the spine elongates upward through the crown of the head. Draw the awareness along the spine, from the base of the spine up through the crown of the head. Let the eyes close if that is comfortable, or gently unfix the gaze downward toward the floor in front of you.

To begin this Awareness practice, please bring the attention to the crown of the head. Direct the awareness through the scalp muscles, through the face muscles, and through the whole head and neck, noticing any sensations and feelings that are present for you. Whatever you

notice, let it be exactly that way; and continue by drawing the awareness through the neck and the shoulders, through the arms, through the hands and all the way to the fingertips, simply observing whatever is present. It is as if you are taking an inventory as a completely disinterested party. Now, please bring the awareness to the whole trunk of the body. Notice the upper back, the ribs and the chest. You are simply saying, “Hello beloved body, how are you right now?” Let it be exactly as it is without trying to change anything. Bring the awareness to the middle of the back and to the lower back, to the abdomen, to the hips and the pelvis, to the buttocks, the thighs, the knees, the lower legs, and the feet. And when you feel that you have checked in physically with all the parts and places in the body…

Please bring the awareness to the emotional level, and notice if there are any feelings bubbling up for you just now that want to be acknowledged. And let them be there too. Simply witness them. And when you are ready…

Please bring the awareness to the thinking level, and become aware of each thought as it arises in consciousness. Whatever you notice, simply acknowledge. You may notice habituated patterns in thinking, or become aware of recurring themes of content in thought. Simply observe them.

And now, please bring the awareness to the energetic level. Become aware of any feelings of fatigue or tiredness that might be present at one end of the energy scale and at the other end of the energy scale, notice any feelings of restlessness or hyperactivity that might also be present. Or maybe, just now, you are primarily somewhere in the middle, feeling tranquil and calm. Simply acknowledge it, however it is and let it be exactly that way.

And now, please bring the awareness to your breathing. Observe your natural breath as it comes in and as it goes out. Let it be as it is, without trying to change anything. You are simply paying attention to your breath in its natural flow. See if you can notice how many seconds or parts of a second it takes or your natural breath to come in, and how many seconds or parts of a second it takes for your natural breath to go out. Notice if there are any stopping places in the breath, on its way in, on its way

out, or in between. When you have a sense of the natural rhythm and pace of your breathing, please remember it for later during your breathing practices.

Please bring your awareness to the physical body as it is positioned in space. Become aware of the parts of the body that are pressing against other body parts, or against the floor or the chair. Become aware of the presence of one another in this room—each one of us dedicated to healing in our own ways. And when you feel ready, please allow the eyes to open and bring your awareness back into the room. Begin to gently wiggle and stretch the body any which way, thanking it for this time of stillness and getting it ready for some gentle movements.

Therapeutic Relationships

Fundamental Qualities to be present to support healing between you and student
Kindness, patience, gentle touch (with permission), comfortable silence, ability to listen with complete attentiveness, being real, open, humor, eye contact, staying grounded (not fidgeting), confidentiality.

What other qualities would you add?

Components of Therapeutic Relationship:
A therapeutic relationship is defined as "an interactive relationship with a patient and family that is caring, clear, boundaried, positive and professional." (Pediatric Critical Care, Fourth Edition, 2011) From the psychotherapy perspective, pioneer Edward Bordin named three essential qualities of a therapeutic relationship as 1) an emotional bond of trust, caring and respect, 2) agreement on the goals of therapy and 3) collaboration on the "work" or tasks of the treatment. YCat Yoga explains the following two components:

1) Safety and Comfort: Physical (not pushing people to their physical edges), emotional and spiritual safety: "--not going to diss you no matter what. I am not going to put you outside of my heart no matter what you tell me-even a story of all the bad things you have done 20 years ago or all of the consequences that your actions have played in your life. And if there is a chance that what you are going to be hearing from someone; something that would cause you to separate and chase them out of your heart, then you aren't the right person to work with that person because you hold all the power in the relationship. Does this make sense? Accept how a person presents/don't disturb another person's faith (Swami Satchidananda)— validate whatever a person says." --- Jnani Chapman

Just being present is therapeutic: we want to rush in and give too much and don't need to. The gift of your presence is enough. The experience of someone with cancer, for example, is often either of two ways:

1: Isolated: friends are uncomfortable and stop coming around
2: Opposite: everyone is at them—you need to do this treatment, use this therapy, already overwhelmed and now have people giving you advice and inundating you with information.

Coming at someone is another invasion—person who is newly diagnosed— people show up with books and remedies and stories of them self or someone they knew and it is not necessarily what the person wants—awareness of boundaries

Sometimes, as the Yoga teacher/therapist, you will be the only place of safety to talk about what's up for them. Doesn't mean to move into fix it or help mode. Just being

there as a container is enough. Receive their story: I hear you. I am here for you. Presence is often so absent in our culture. Before you finish talking, someone is already trying to respond—not listen.
Sometimes you are going to receive a horror story: ex. A person says she is grateful for her diagnosis because for her it means she doesn't have to go to work anymore. Her work was such a toxic environment that she felt she needed to shower as soon as she got home to get out the toxicity off of her. Sometimes a cancer diagnosis might spark something wounded since childhood—some trauma that was never healed. If it is coming up, it is coming up for healing and by just receiving it from that person, you are helping to release it. The gift of your presence to another human being—it is also another place of boundary. If it causes you distress, you have to find a place to release it. The purpose of healing is not to dump on a person and then that person has to walk around with it. Keep working on ourselves to be that person to receive so we let it flow through us so it doesn't stick here.

2) Creating Trust: Two most healing statements : "I don't know" and "I'm sorry"

Trust: how does someone know you are listening? Eye contact, moving closer physically, stillness, repeating back, "what I heard you say" "Is that true?"

--asking what you need—goals
--what's happening for you today? How are you feeling?
--Foundation of holding space==I am the guide, you are the expert

In the Service of Life—Rachel Remen --Core of Therapeutic relationship –not at the doing level—at the being level--catch getting into fixit mode, back up and see how you can be of service
--back off idea that person needs anything—honor and respect what is.

How can we avoid separating and specimizing?

--no Sanskrit (only with explanation and with relevance) and not making a lot of corrections on physical level—use verbal cues first for entire class. --see person at essence and not at the world of appearances
--Standing in Yoga and staying within our scope of practice. We are not medical doctor's (unless you are!) but we can be part of the medical team by being brought in through the medical setting or privately.
--Often, yoga teacher present from diagnosis, through treatment, healing, and/or end of life and may tell us about themselves and

experiences and choices that they have not discussed with family of doctors.

Ex—CAM use, herbs, etc—will tell you and not physician. Encourage them to share with doctor or reliable person to work with who knows interactions.

--Goal: Assist student pursuit of personal intention. Relationship with student is about meeting their needs and not about teacher and their ego—can get cloudy for us. As teacher, continue to analyze motives. Mentoring with other professionals is one way to stay attentive to this.

--Teaching privately and working in group is different—working in facility rather than in someone's home is very different

--Way we get good at this work? Making mistakes—once its out there, its out there—what we do next will make the difference in continuing to build trust or lose student—ability to say "I could have said that another way" ex. Mother in law sitting shiva, brought pictures and many people had died

I am sorry, I don't know—engenders trust

Underneath trust is safety—above all things, do no harm

Therapeutic relationship has a beginning, middle and an end --asks you to be teacher (when trust is created, this is when work begins), while doing work, time to terminate relationship

--patient/client chooses to end –not taking personal—look at ourselves Know where your endpoints are: person can't pay, person moves, Don't create dependence—empower and create independence Know where boundaries are to maintain relationship—they are complete Clear boundaries—something you as teacher/therapist have to think about –if student can't come to class—I don't have the capacity to come to your house/or maybe you do—not our needs—role is to serve them (ex. Urban Zen patient in hospital)

Modeling self care:

When someone complains of something chronic, you see something funny, go get it checked

Person might be angry with us, fear shouldn't prevent us from saying it

Therapeutic use of self

--tragedy or experience in your family—only share if of use—discern --to support someone else not to vent or serve us—we aren't downloading to our students—when using yourself, has to be conscious—to serve or to emphasize something that could bring them toward healing—check boundaries

--make a point for student

--change identifiers in story

--language: listen to ourselves as we speak, what we are saying

Humor

--re: sharing your own cancer story—parameter is it being of service-—ok to share but it's how you share—share in a way that will create trust

--often because other issues besides cancer-being ourselves and sharing create trust

Introduction: from Jnani's lecture at LMU

From Swami Vivekananda:

"Not mind, nor intellect, not ego, nor feeling. Not sky, nor earth, nor metal am I. I am thee, I am thee, I am thee I am thee. Blessed spirit. I am thee. No birth no death no caste have I. Father mother have I none. I am thee. I am thee. I am thee. I am thee blessed spirit. I am thee. "

Thou art that. We are all that. That is all there is is that,-in reality. And a lot of the underpinning concepts and ideas that are the most useful and valuable to bring to people that are dealing with cancer, that are in the middle of cancer treatment, that are dealing with chronic illnesses or aging issues =in who they use to identify with and who they use to be, that they can't accept except in the world of appearances, and pretend there, this particular group of people, when you remind them of who they truly are at essence, there is a connection no matter what is going on in the roller coaster of good, bad, up down, high low in life, there is a place that can be an anchor at essence that can be there to get anyone through anything. Does that make sense? So that's where we are going to go. That's the most important thing. It's not what asana or pose that I can give. I'ts not at the level of mechanical, it's not at the level of physical. It's at the level beyond cellular, at the level of being. That when you meet somebody there--we say that we have the kosha's—the levels of being—the physical level, an emotional level, a thinking level, an energetic level and a subtle body and that all of those levels permeate. So any one door in is going to heal all of those other levels. And sometimes, getting to essence is the quickest way. And the easiest way.

In the Service of Life

In the Service of Life by Rachel Remen, MD

Serving is different from helping. Helping is based on inequality; it is not a relationship between equals. When you help, you use your own strength to help those of lesser strength. If I'm attentive to what's going on inside of me when I'm helping, I find that I'm always helping someone who's not as strong as I am, who is needier than I am. People feel this inequality. When we help we may inadvertently take away from people more than we could ever give them, we may diminish their self-esteem, their sense of worth, integrity and wholeness. When I help I am very aware of my own strength. But, we don't serve with our strength - we serve with ourselves. We draw from all of our experiences. Our limitations serve, our wounds serve, even our darkness can serve. The wholeness in us serves the wholeness in others and the wholeness in life. The wholeness in you is the same as the wholeness in me. Service is a relationship between equals.

Helping incurs debt. When you help someone, they own you one. But serving, like healing, is mutual. There is no debt. I am as served as the person I am serving. When I help, I have a feeling of satisfaction. When I serve I have a feeling of gratitude. These are very different things.

Serving is also different from fixing. When I fix a person, I perceive them as broken and their brokenness requires me to act. When I fix I do not see the wholeness in the other person or trust the integrity of the life in them. When I serve I see and trust that wholeess. It is what I am responding to and collaborating with.

This is distance between ourselves, and whatever or whomever we are fixing. Fixing is a form of judgment. All judgment creates distance. In fixing there is an inequality of expertise that can easily become a moral distance. Distance is a disconnection, an experience of difference. We can only serve that to which we are profoundly connected, that which we are willing to touch. This is Mother Teresa's basic message. We serve life not because it is broken but because it is holy.

If helping is an experience of strength, fixing is an experience of mastery and expertise. Service on the other hand is an experience of mystery, surrender and awe. A fixer has the illusion of being casual. A server knows that they are being used and has a willingness to be used in the service of something greater, something essentially unknown. Fixing and helping are very personal; they are very particular, concrete and specific. We fix and help many different things in our lifetimes, but when we serve we are

always serving the same thing. Everyone who has ever served through the history of time serves the same thing. We are servers of the wholeness and mystery of life.

The bottom line, of course, is that we can fix without serving. And we can help without serving. And we can serve without fixing or helping. I think I would go so far as to say that fixing and helping may often be the work of the ego, and service is the work of the soul. They may look similar if you're watching from the outside, but the inner experience is different. The outcome is often different too.

Service serves us are well as others; that which uses us, strengthens us. Over time, fixing and helping is draining, depleting. Over time we burn out. Service is renewing. When we serve, our work itself will sustain us.

Service rests on the basic premise that the nature of life is sacred. That life is a holy mystery, which has an unknown purpose. When we serve, we know that we belong to life and to that purpose. Fundamentally helping, fixing and service are ways of seeing life. When you help you see life as weak, when you fix you see life as broken. When you serve you see life as whole. From the perspective of service, we are all connected: all suffering is like my suffering and all joy is like my joy. The impulse to serve emerges naturally and inevitably from this way of seeing.

Lastly, fixing and helping are the basis of curing but not of healing. With 40 years of chronic illness I have been helped by many people and fixed by a great many others who did not recognize my wholeness. All that fixing and helping left me wounded in some important and fundamental ways.

Only service heals.

Imagery

Presentation for SYTAR 2019 CIC Cancer Session
June 13, 2019 Newport Beach CA
Sandra Susheela Gilbert, BA, C-IAYT, E-RYT500

Imagery is the conscious use of the mind and imagination and invokes all the senses: visual, tactile, olfactory, intuition, taste and senses of movement. Through this accessing of senses, physiologic change is affected. Imagery is pre-verbal and we use it everywhere but may not pay much attention that we are using it.
Marty Rossman says "Imagery is the interface between what we call body and what we call mind." In his book, "Guided Imagery for Self Healing," Marty explains that imagery works through the right hemisphere of the brain which thinks in "pictures, sounds, spatial relationships and feelings." He also states that the right hemisphere of the brain's ability to "grasp larger context of events, is one of the specialized functions that make it invaluable to us in healing." Essentially, he is talking about reframing habit patterns of the mind, which is what we practice in Yoga, by explaining that "a right brain perspective may allow you to put ideas together in new ways to produce new solutions to old problems."

I saw a recent FB post of a sign that said: "Worry is a misuse of imagination" And Marty Rossman says that worry is the most common form of imagery that effects are health. It initiates the stress response.

The history of imagery reaches across all cultures and religions—from shamans to the church to medicine and psychotherapy. A resurgence in the 20th century, imagery research in medicine has been active since the 1950's and can be considered one of the most researched aspects of Yoga. Imagery research outcomes include enhanced immune function, a decrease in anxiety, improved sleep and reduction of side effects from cancer treatment including pain. Carl and Stephanie Simonton and Jeanne Achterberg have done the most research with imagery and cancer using a scripted method that showed strong evidence of its effectiveness to boost immune function. It is here that much imagery was used in terms of fighting the cancer and creating armies to destroy the cancer cells or imagining a direct boost to cells and creating more WBC. Not everyone is comfortable with this type of imagery which is why it is so important to support our clients in using what is truly useful and personal to them. I am providing an interesting article by Marty Rossman in your handouts.

Non-scripted or receptive imagery is more the focus as Yoga Therapists and is supported by the work of Marty Rossman and Rachel Remen. In working with people with cancer, especially at diagnosis and the beginning of treatment, it is best to keep things simple and more toward supporting people in turning down the volume on the stress response. As practice continues and a person is more comfortable with imagery, deeper, healing imageries can be created. In my experience, this approach is very helpful for people who are dealing with the early distress often encountered at diagnosis and treatment.

Receptive, non-scripted imagery recognizes the unique meaning of an individual's images and symbols but also the unique meaning that cancer, illness, stress, emotions, pain and other symptoms may have for that individual based on who they are and their life experiences.

Meaning—images have importance-the meaning we attribute has an impact—may have to change the meaning for healing example: if the meaning attached to recurrence is "I am going to die" then changing the meaning would create different response toward healing. Joan Borysenko says, in her book "Minding the Body, Mending the Mind," that the body cannot tell the difference between events that are actual threats to survival and events that are present in thought alone." Through awareness, relaxation and imagery, there is the opportunity to explore meaning and shift and offers support for the journey toward healing. Another component with healing and imagery is creativity.

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Yoga Sutras (from Swami Satchidanda's interpretation) Yogas citta vrittis nirodha—the calming of the mind stuff is Yoga. From diagnosis of cancer, the mind begins to reel—it is the ultimate in terms of the stress response. The Yoga sutras give us the overall blueprint of how to control the mind—what are the obstacles, how we deal with them and what is the overall benefit. SS says: If you control the mind, you have control over everything. Then there is nothing in this world to bind you. He also says, that the mind must be quiet otherwise, it seems to distort the truth. That is why looking at what has meaning for someone is so important before you write a script or offer imagery—it is often a perception and not the truth but they believe it is the truth because of the meaning they have attached. For example: soldier research during WWII.

Two other examples of imagery in the sutras: Book 1: 8-9--discussing misconceptions, verbal delusions
and in discussing objects of focus in meditation: Book 1:39–imagining the picture of a spiritual teacher

The one tool of the Yoga sutras I use the most in working with students is Pratipaksha Bhavana: (II:33-34) "When disturbed by negative thoughts, opposite [positive] ones should be thought of. This is pratipaksha bhavana." This is a direct reference to images: you are thinking one way and are now going to consciously picture it being something else in order to change it.
(Side note: when using the Sanskrit, make sure to explain the meaning.) This is a beautiful way to move from the stress response into the relaxation response. PB can take time to cultivate so encouraging clients to be more aware of what is happening physically and with the breath and then taking some action to shift
Pratipaksha—opposite—take an opposite action from the one that is happening in that moment—when a person is in an emotional state, creating the opposite and suddenly thinking positively is very difficult—changing the physical is often more doable at the moment—i.e. changing the breath, getting off the couch and sitting in a chair by a window, walking around the room or the outside of the house—sometimes a simple task can help facilitate a change that can then create clearer thinking in that moment. It is not to dismiss the emotion or what is happening for you—it is a tool to create another perspective and the ability to discern and then make a clearer choice for you in the moment
Bhavana—cultivate

Being able to educate and offer patients these concepts can be empowering as they learn ways to self regulate the responses to the many thoughts, emotions and actions that are resulting from stress, or pain, anxiety or depression and other symptoms and side effects that occur. Again, keeping it simple and doable is very important. There is already so much to be overwhelmed with.

Guidelines for Practice in classes and with individuals

During diagnosis and treatment
—support people in finding their meaningful path and create imagery to support symptom management and empower to find out what has meaning in terms of the cancer or treatment and what has meaning in their life, in nature and objects they

may possess. And we can use all of it for imagery. Sometimes it may be reframing or shifting the meaning that is actually not the truth.
—in this way we are all supporting people in cleaning out the cobwebs of the mind and offer a clear path to experiencing essence—to experience a deeper healing.

— Imagery intake—(see below)
—We can use what the script for particular outcomes such as preparing for medical procedure or surgery but it is coming directly from the client rather than a concrete, specific imagery that I think will work for them
—Imagery intake can be used for use in group class as well. I am often surprised at how similar images are. This intake makes it easier in a group setting where we are being more generic in our approach because of the diversity.
Some examples: modified super hero pose or warrior 2: look out over your hands and fingers and imagine the possibilities or goals of your future, or look out into your possible future
Mountain pose: imagine the strength of a mountain, grounded through your feet and imagine that strength flowing into you from the bottoms of your feet through the entire body and into each and every cell.

—A good time for the use of guided imagery is at the end of Yoga Nidra or meditation when the mind is quiet and the imagery and creativity has the space to surface from the unconscious—research supports this

—If you are not comfortable with imagery yourself or feel you are not very creative, practice with your friends and with yourself before working with clients. Listen to your own intuition when sharing with a client. So many times, I have created an imagery spontaneously and the client comes out of it and asks how I knew to say something in particular and how much it meant to them. Trust yourself and at the same time be prepared.

—This is experiential and though we may create and offer guided imagery to our clients, where they go is where they go and not our control or our business. We are the guide that gives them the opportunity to move into a relaxed state and connect with their essence, their wholeness and allows the space for other images, emotions, beliefs, understanding, directions, meanings—to come to the surface of consciousness either for healing or to offer some insight toward healing.

Safety: Patients with psychosis and mental illness must be treated with expertise and professionals qualified to to work with them with imagery. I did encounter many

patients in my inpatient work who not only had cancer but severe mental health issues as well. Imagery was beyond my scope of practice with them as a Yoga therapist.
Dissociative disorders from severe trauma
Those with trauma can become more anxious and may not be able to close their eyes and may need more expert care

Not to be used in place of medical care

Tree Pose Imagery:

As you begin to bring the body into tree pose, imagine a tree of your choice—maybe one in your yard, your neighbor's yard, one seen on vacation or one you make up. Feel the feet root as you lengthen the spine as if it were the trunk of the tree. Reach the arms out to the side as you use your branches to balance and lengthen out through the crown of the head as if the top of your tree is reaching toward the sky. See yourself in the season of your choice and notice the color of your leaves. Keep the breath flowing, bringing vital life force and oxygen in. Notice if you begin to sway and feel the wind moving through your limbs and leaves and let it be. Mindfully begin to find the balance and come into the strong steadiness and stillness of this magnificent tree.

In closing, some thoughts from Bruce Roberts who is also featured in the book "Transformative Imagery." He says: "Guided imagery is a low-cost diagnostic and therapeutic tool that can help us to see what the MRI fails to reveal and heal what penicillin cannot touch."
He says: "Most of us live our lives by accident, following our subconscious negative thoughts, beliefs and images to dictate our reality. Whatever we believe or imagine to be true is true. If we cannot picture or image a better life for ourselves and on our planet, then we cannot possibly bring that into our reality."

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Images of Healing Intakes

PREPARING AN IMAGERY SCRIPT • Ask the client to tell you about some inanimate objects and things that have deep meaning for him/her (Not people). When a person begins to describe objects that carry meaning and personal value, ask him/her to say what particular qualities that object represents or reflects. Are there other qualities? Other objects? Give it the time. • Ask the client to look in his/her imagination at the natural world and to tell you what parts of nature speak deeply to him/her. "What aspects of nature are you strongly connected to... do you resonate with?" Give suggestions of possibilities from wide, sweeping, grand aspects of nature to small, subtle aspects. "Are there any vistas or places in life that sing or call to you or draw you in?" State possibilities like the clear blue sky, the stars at night, the ocean, a tree, the mountains, a leaf, the wind... • Are there any animals you are strongly identified with? (Query their qualities also.) Are there particular colors that feel healing to you... particular smells...particular sounds... particular textures... particular sensations... particular ideas? Once you have gathered this raw material use you imagination to develop it into an imagery session. * Do a centering practice together before beginning a meditation or a breathing practice. Then guide the client deep into a restorative, refreshing and relaxing, healing experience.

End of Life

PART SIX

Chapter Twenty-six

(Choices In Healing—Michael Lerner, MIT Press, 1994)

On Living and Dying

Even the wise fear death. Life clings to life.
– *Buddha*

I write this chapter on death and dying with the greatest respect for the reader facing the possibility either of his own death or of the death of someone he cares about. I have had too many friends die of cancer to speak to you in any other way.

For those who may have difficulty beginning to read this chapter, I want to say right at the start that I believe there are 12 critical things to know about death and dying:

1. There is skill, choice, knowledge, and control in death and dying just as much as there is in the fight for life with cancer.

2. Some people believe that death is the end; others that life after death is a certainty. My own belief, as Rachel Naomi Remen puts it, is that death is a mystery worth contemplating. Death for me is a mystery in the deep sense of the term: a real possibility exists that life in some form continues after death, and intriguing scientific literature supports the spiritual writings and the experience of many people who have had remarkable near-death experiences. Forceful arguments exist on the other side.

3. Whatever our beliefs about death, it is a fact that there is such a thing as dying well, and that we can consciously work toward dying well the way pregnant mothers work toward birthing well–and with the same uncertainty and absence of judgment about how we will actually fare in the event.

4. There is no single way of dying well, but an infinite variety of ways. A good death might be described mentally and emotionally as one in which–in the face of whatever biological experience we shall have–as much movement toward wisdom and healing as possible takes place for the one who is dying and for those who love him. A good death might be described physically as one in which pain and discomfort do not exceed what can be decently endured.

5. It is very useful to recognize the distinction between our fear of dying and our fear of death. This distinction then helps us focus first on specific fears we have about the dying process.

6. Most people are more afraid of being caught in interminable suffering during the dying process than they are of death itself. The reality, as we have seen in the chapter on pain, is that, in most cases, severe pain can be controlled and made tolerable.

7. Another fear people have is that they will remain alive when life no longer feels worth living, when they have become a burden to people they love, or when their dignity has been taken from them. This is a more complex set of concerns to respond to, but one important fact, emphasized by the great physician Eric Cassell, is that many people with cancer die within a relatively short time of having truly decided that they are ready to die.1

8. If death does not come to us at the point where we have truly decided that we no longer want to live, then we do have the option of taking our own life, if our religious beliefs allow it and if the suffering becomes intolerable. In the Netherlands, physician- assisted suicide for those facing a life no longer worth living is an acknowledged part of a public policy that requires the physician to follow a carefully prescribed protocol.2 In the United States, a great debate is currently taking place over whether physician- assisted suicide should be legal. Many American physicians do assist patients in dying if all that remains is a painful existence without dignity. Whether or not physicians are willing to assist us, many patients with life-threatening illnesses (AIDS patients have led the way in this) have simply learned what drug combinations are effective in suicide and have set those drugs aside for the day when life is no longer worth living.

9. It is critically important to make sure that you have the best possible medical and nursing care while dying. Those physicians who are wonderful when you are fighting for life may not be helpful when you are dying. The same is true of hospitals–a place that is superb for high-technology cancer therapies may not be the best place to die. One of the most difficult aspects of dying is the discomfort that may arise from many different sources. Helping a person relieve these symptoms and discomforts is a very high medical art that demands the interest, care, and attention of physicians, nurses, and caregivers. Finding the people in your community (they are often connected with a hospice) who are dedicated to this great human task can make a world of difference in the experience of dying. If you choose to die at home, the choice of home health care aides skilled in helping people die is at least as important as the physician and nurses you work with.

10. Some people are afraid that making practical estate arrangements or other arrangements for dying means that they have given up the fight for life. My general experience is that preparing for the possibility of death does not interfere with the fight for life at all–in fact it can enhance it, because you have taken away the worry of not having dealt with these very practical matters. Taking care of the things you want to take care of actually releases energy for the fight for life.

11. Part of preparing for death is giving some thought to helping loved ones with the grieving process. This can be tremendously important, because incomplete grieving often injures the rest of the life of a mate, a parent, or a child. In the process of a good death, a great deal of the

mutual grieving of patient and loved ones takes place while the patient is still alive and participating. If this process takes place as consciously and fully as possible, the death can sometimes become, strangely, a great healing for all involved. While there is still grieving to do–a great deal of grieving, perhaps–it starts from a solid base. There are some excellent books on grieving as well as good grieving support groups and therapists. I strongly recommend learning about these resources for survivors.

12. Our culture's attitude–in which death is a highly toxic subject and seen as a failure, either of the doctor or of the patient–is not only new historically but at odds with that of other cultures. In many cultures, dying is surrounded by rituals in which everyone participates. For many centuries in the West, this was also so. Death was often seen as the culmination of a life, and people gave great thought to how they might die well. It is possible in our culture to detoxify death by contemplating it, seeing what others have thought and said about it, and by giving ourselves time to be with it. In the face of sincere contemplation and prayer, the toxicity with which our culture has surrounded death often begins to dissolve.

All of this leads to exploration of what benefits we and those we love may receive from death and dying. We know all too well what the pain and losses will be. We know all too well that some people die with great difficulty and suffering, while others die peacefully. The question is whether or not we can find anything of value, in the midst of pain and loss, from death. The answer of some wise people over the centuries, and of many in our time, is that it is possible to find deeply meaningful and important experiences in the midst of facing death. In the rest of this chapter we explore some of these ideas in more detail.

The Literature on Death and Dying

One of the best ways to detoxify the subject of death and dying is to learn what wise people have had to say about their own experience with and meditations on death. In a sense, the classic and contemporary literature on death and dying provides a support group made up of some of the greatest saints, humorists, artists, cynics, and thinkers of all times. They speak across the ages to you–across time and space–with some very different ideas about how people have faced what William James called "the distinguished thing." I know they have helped me. Perhaps they may help you, too.

One of the best places to start an inquiry into death and dying is The Oxford Book of Death, a great collection of poems, other writings, and sayings about death. I have selected a number of quotations from The Oxford Book of Death to give you a sense of how reading what wise people through the ages have said about death can transform our own attitudes.

The editor of the collection, J.D. Enright, is a well-known poet and critic. "Reading for this anthology," he says, "I was moved to the thought that on no theme have writers shown themselves more lively." A survivor of one of the Nazi prison camps, quoted in the anthology, echoed this view with his observation, "when in death we are in the midst of life."3

“Death,” said Arnold Toynbee, “is the price paid by life for an enhancement of the complexity of a live organism’s structure.”4 There is a deep biological basis for this observation. As the Canadian naturalist David Suzuki explains, in primitive one-celled organisms, the original cell reproduced by dividing itself, so death was not inevitable. But complex organisms that could not simply divide developed sexual function as a means of reproduction. With the invention of reproduction, death appeared. Hence the very deep connections between birth, sexuality, and death.5 Montaigne put it simply: “Make room for others, as others have done for you.”6

Said Jung:

Life is an energy-process. Like every energy-process, it is in principle irreversible and is therefore directed toward a goal. That goal is a state of rest. In the long run everything that happens is, as it were, no more than the initial disturbance of a perpetual state of rest which forever attempts to re-establish itself. …. Thoughts of death pile up to an astonishing degree as the years increase. Willy-nilly, the aging person prepares himself for death. …. It is just as neurotic in old age not to focus upon the goal of death as it is in youth to repress fantasies which have to do with the future.7

Many writers agree that dying is more difficult than death itself:

PHAEDRUS: But is death as horrible a thing as it’s commonly asserted to be?

MARCUS: The road leading up to it is harder than death itself. If a man dismisses from his thoughts the horror and imagination of death, he will have rid himself of a great part of the evil. In brief, whatever the torment of sickness or death, it is rendered much more endurable if a person surrenders himself to the divine will. For awareness of death, when the soul is already separated from the body, is, I think, either non-existent or else an extremely low-grade awareness, because before Nature reaches this point it dulls and stuns all areas of sensation.8

Contemporary Views of Death

Some of the most interesting contemporary sociological views of death are collected in a book edited by Edwin S. Shneidman, Death: Current Perspectives. The first contribution is from Arnold Toynbee, who wrote a beautiful essay on death in which he emphasized that:

This two sidedness of death is a fundamental feature of death. …. There are always two parties to a death; the person who dies and the survivors who are bereaved. …. When, therefore, I ask myself whether I am reconciled to death, I have to distinguish, in each variant of the situation, between being reconciled to death on my own account and being reconciled to it on the account of the other party. …. My answer to Saint Paul’s question “O death, where is thy sting?” is Saint Paul’s own answer: “The sting of death is sin.” The sin that I mean is the sin of selfishly failing to wish to survive the death of someone with whose life my own life is bound up. This is selfish because the sting of death is less sharp for the person who dies than it is for the bereaved survivor.9

Ernest Becker won the Pulitzer Prize for The Denial of Death, which argued that our whole lives are organized around fear and denial of death. Heroism, Becker argued, is a "reflex of the terror of death":

We admire most the courage to face death. …. The hero has been the center of human honor and acclaim since probably the beginning of specifically human evolution. …. The hero was the man who could go into the spirit world, the land of the dead, and return alive. …. When philosophy took over from religion it also took over religion's central problem, and death became the real "muse of philosophy" from its beginnings in Greece right through Heidegger and modern existentialism.10

Summarizing the work and thought on death from religion, philosophy, and science, Becker distinguishes between the "healthy-minded" argument that fear of death is not natural to man, and derives from repressed or unfulfilled living, and the "morbidly minded" argument that the fear of death is natural, what William James called "the worm at the core" of man's pretension to happiness.

Jacques Choron goes so far as to say that it is questionable whether it will ever be possible to decide whether the fear of death is or is not the basic anxiety. In matters like this, then, the most that one can do is to take sides, give an opinion based on the authorities that seem to him most compelling, and to present some of the compelling arguments. I frankly side with the second school–in fact, this whole book is a network of arguments based on the universality of the fear of death, or "terror" as I prefer to call it, in order to convey how all consuming it is when we look it full in the face.11

Becker argues that the fear of death is biologically essential to the preservation of the species, and at the same time that continuous consciousness of this fear of death would be deeply counterproductive. He quotes the psychoanalyst Gregory Zilboorg: "If this fear were constantly conscious, we should be unable to function normally. It must be properly repressed to keep us living with any modicum of comfort."

And so, Becker says, "We can understand what seems like an impossible paradox: the ever-present fear of death in the normal biological functioning of our instinct for self-preservation, as well as our utter obliviousness to this fear in our conscious life."12

Another key point from this remarkable collection of contemporary views is Geoffrey Gorer's concept of the pornography of death. Gorer brilliantly argues that, while sex was pornographic to the Victorians, death has been the pornography of our time.13

Contemporary Psychospiritual Perspectives on Death and Dying

It is difficult in 1993 to realize what a transformation the last 30 years have brought in American attitudes toward death and dying. And indeed this transformation speaks volumes for the

broader transformation of American consciousness over this period of time. As Phillipe Aries wrote in his classic book, The Hour of Our Death:

Before 1959 when Herman Feifel wanted to interview the dying about themselves, no doubt for the first time, hospital authorities were indignant. They found the project “cruel, sadistic, traumatic.” In 1965 when Elisabeth Kübler-Ross was looking for dying persons to interview, the heads of the hospitals and clinics to whom she addressed herself protested, “Dying? But there are no dying here!” There could be no dying in a well-organized and respectable institution. They were mortally offended.14

Part of the best evidence for the transformation of the American mind through the 1960s, 1970s, and 1980s has been the opening of a substantial part of the population to an intense interest in learning from and caring for the dying. One of the foremost exponents of this work is Stephen Levine, author of a number of fine books on dying. Here is an excerpt from Healing into Life and Death:

Our intention is not to keep people alive or to help them die either. Our work seems to be an encouragement to focus on the moment. To heal in the present and allow the future to arise naturally out of that opening. …. We witnessed deep healings into the spirit of some who lived as well as miraculous healings in some who died …. clearly healing was not limited to the body. The question “Where might we find our healing?” expanded. It was [about] the healing of a lifetime. The healing we took birth for …. The deepest healing cannot be done solely in the separate. It needs to be for the whole, for the pain we all share. …. Seeing it is not simply my pain, but the pain, the circle of healing expands to allow the universe to enter.15

Levine expanded on this theme in an interview in Inquiring Mind:

IM: What do you mean by surrender?

SL: What we [Levine and his wife Ondrea] mean by surrender is softening and letting go of resistance, trusting the process. Many people misunderstand surrender as defeat. Surrender is actually the optimum strategy for living, including dying …. Surrender is really about letting go of the last moment and opening to the next. Of course everyone’s process isn’t the same. Some people work wonderfully with mindfulness mixed with loving kindness. Other people have so much regret about the way they’ve led their lives that we encourage them to work with forgiveness, forgiveness of themselves, forgiveness of those they reacted towards ….

We have seen people in severe physical discomfort who when they started to surrender their resistance–to enter into contact with sensation–experienced that multiple changing quality of the pain that they thought was so solid. Then they could begin to direct their analgesics into the areas where they were needed ….

IM: How much difference does it make for someone who is dying to have done a lot of spiritual practice?

SL: When a person has a sense of something greater than themselves, whatever it might be, it is very helpful when they are dying. Also, someone who has done spiritual practice probably has a little more concentration to bring to the meditations for pain, for heavy states, or for forgiveness …. People who have cultivated a willingness to go beyond safe territory–which means even beyond their practice–have an easier time with death.16

We can see in the work of the Levines the idea that the process of learning to live well is also the process of learning to die well and that cultivating a relationship with our innermost being serves us well at the time of death. Dennis Leahy, M.D. expands upon the idea of surrender as a way of healing into death: "[We have all] spent much of [our] lives in the conscious and unconscious cultivation of uniqueness. This process does not end as we begin to die. We see herein that in the process of letting go, our individualization may become more, rather than less complete. In this sense there is great hope."17

The Questions Raised By Near-Death Experiences and Reports of Communications with the Dead

Many people who come on the Cancer Help Program have had near-death experiences that have changed their lives–experiences in which they almost died, or did die medically, and were then revived. Others have had experiences in which people they loved who died returned, after death, with messages that were deeply reassuring.

One of the most moving of these experiences for me happened with Kim and Sarah, the couple whose fight for life I described in chapter 1. I visited Sarah in the hospital shortly before she died. At one point I said to her: "It is absolutely not all right with me that this is happening to you, Sarah. But if you do die, I'd like to ask you a favor. It would make my life a lot easier if I heard from some friends who died that they were OK on the other side. So if you go, please try to come back and let me know you're OK." She promised she would.

Many months later I was getting a massage during a break in the late afternoon on the first day of a Cancer Help Program. I remarked to Jnani Chapman, the Cancer Help Program masseuse who was working on me, that I did not understand what was happening but that God seemed to be very present–that my body seemed to be filled with a strong charge of deep joyful and peaceful energy. It was a very unusual experience for me–I am not given to frequent experiences like this. Later that night, I got a message that Kim had called. I thought it might be to tell me of Sarah's death. It occurred to me immediately that if Sarah had died, perhaps that was connected to the extraordinary feeling I had had of the presence of God. Perhaps that was Sarah trying to keep her promise to me. I called Kim, reached him, and during the conversation I told him of my experience. He said Sarah had not yet been in touch with him, but that he very much hoped she would.

The next morning I received a faxed letter from Kim as follows:

Dear Michael:

Sarah died at 2:15 P.M. on February 19. The night after her death I had the most extraordinary and vivid dream. I was in a hospital being restrained by three doctors. They were pleading with me not to go into Sarah's room. They said her body had decomposed and that if I saw her in that condition it would leave me with a very unpleasant final vision. I became angry and pushed them aside and told them I had to see her. I ran to her room and opened the door. Sarah was reclining unclothed on her side, in the way of the odalisque in the painting by Ingres. Her body was radiant, full and perfect. Her hair shined like golden threads and her lips and cheeks were pink and glowing. I stared at her in amazement. The doctors were wrong: she had become perfect. I went to her bedside and sat down. Her eyes were closed and her limbs hung limp. I embraced her and as I did her chest heaved, her eyes and mouth opened, her lungs filled with air and she came alive. My heart soared and my eyes filled with tears of joy. Sarah looked up at me and said "Kim, I am not alive." I paused and then asked her, "Is it good or bad where you are?" She looked at me and rolled her eyes in the way she would when I said something really dumb. She said, "Good and bad do not apply here." I said, "Well, is it OK? Are you OK?" Sarah's lips tightened and her eyes squinted as if to say, let me think about that one. Then slowly she nodded her head and said, "Yes, it's OK, but I need some time to get used to it." I held her shoulders and looked into her face and asked, "Sarah, when I die, will I be able to be with you?" She very simply said yes. Then her eyes closed and her body went limp again. I panicked and ran into the corridor and began a desperate search for the doctors. The halls were deserted. I decided to go back to Sarah's room, but could not find my way. I began opening the doors in the corridor, but all the rooms were empty. I then awoke sitting straight up in bed.

Waves of sorrow, sadness, incompleteness and emptiness flow over me on a regular basis. But when I think of this dream it gives me a deep sense of comfort.

I wanted to share it with you.

Peace and Love,

Kim

It could well be that Kim's dream was the vivid fulfillment of the wish of a grieving husband to know that his wife was well on the other side, particularly after I had suggested that perhaps my experience had been Sarah's attempt to keep her promise to communicate with me. But anyone with an open and inquiring mind who works for sustained periods of time around people facing death cannot help confronting the significance of near-death experiences, based on both reports from patients and on the clinical and empirical literature.

Joan Borysenko provides a beautiful personal experience in her book Guilt Is the Teacher, Love Is the Lesson:

Many years ago …. I sat with a young woman who was dying. Her name was Sally, and she had been living with a rapidly growing and rare rectal cancer for the year or so that we knew each other. We worked on meditation and imagery techniques that helped relieve treatment side

effects and brought Sally some peace. We talked of emotions, finishing old business, forgiveness, and grieving. We also talked of Sally's concept of death …. that consciousness died with the brain rather than surviving in any way beyond the body.

When the day of Sally's death came, I was visiting her in the hospital. I was scared because I'd never been with a dying person before and didn't have any notion what to expect. Her parents had gone off to have lunch when I came, so I had about 45 minutes to sit alone with Sally. To my great relief, she seemed comfortable as she drifted in and out of consciousness. We just sat together in the silence. Then after a while I screwed up my courage and asked "Where do you drift off to, Sally? Your face looks so peaceful." She opened her eyes and turned to look at me. Her eyes were full of love and wonder.

In a tiny, soft, and very amused voice, she said, "Well, you may have trouble believing this, but I've been floating around, touring the hospital. I've just been to the cafeteria, watching my parents eat lunch. Dad is having grilled cheese. Mom is eating tuna. They are so sad they can barely eat. I will have to tell them that my body may be dying but I'm certainly not. It's more like I'm being born–my consciousness is so free and peaceful." Sally faded out for a while and when she came back she told me: "It's so beautiful, Joan. I'm drifting up out of my body toward a kind of living light. It's very bright. So warm, so loving." She squeezed my hand a little, "Don't be afraid to die," she said looking at me with so much kindness. "Your soul doesn't die at all. You know? It just goes home. It just goes on from here" [emphasis added].18

I have wrestled for years with the question of whether I personally trust these beautiful accounts of the soul surviving death. For me the scientific literature on near-death experiences has deepened the question considerably, and tilted me toward a belief that there is a good chance that these accounts reflect a transcendental mystery.

The Scientific Literature on Near-Death Experiences

I find it intriguing that, at present, the scientific support for the survival-of-death hypothesis is much stronger than the scientific evidence supportive of any decisive "cure" for cancer among the unconventional cancer therapies. In other words, the evidence that we may survive death, while not conclusive, is certainly far better developed, and empirically more persuasive, than the evidence that any unconventional cancer therapy reliably leads most people to recover from cancer.

In addition, you cannot read the literature on near-death experiences and communications with the dead without slipping into realms of parapsychology that are difficult to evaluate and strain ordinary norms of credibility. That is, the science as reported is often reasonably good; but the implications of the scientific reports, if we credit them, lead toward a whole transpersonal reality that many of us (myself included) are not sure whether we can actually credit.

For many, the question of the survival of the personality after death is a key question. One perspective, often voiced by writers in the physical sciences, and one which echos many of the great spiritual traditions, is elaborated by Sir James Jeans in Physics and Philosophy:

When we view ourselves in space and time, our consciousnesses are obviously the separate individuals of a particle-picture, but when we pass beyond space and time, they may perhaps form ingredients of a single continuous stream of life. As with light and electricity, so may it be with life; the phenomena may be individuals carrying on separate existences in space and time, while in the deeper reality beyond space and time we may all be members of one body.19

Gertrude Schmeidler, an emeritus professor of psychology at the City University of New York, has contributed a sober evaluation of "Problems Raised by the Concept of the Survival of Personality After Death" to a multidisciplinary discussion of the subject.

Historians and anthropologists, she points out, tell us that the majority opinion of mankind has overwhelmingly held that the personality survives death, but an important minority has thought otherwise. Yet there is great diversity of view cross-culturally regarding what form this future existence takes. Still, Schmeidler finds "one common thread running through all the discrepant ideas of future existence: the idea that the surviving spirit is recognizable."20 Says Schmeidler:

The only self-consistent and complete set of answers, so far as I know, consists of attributing all that occurs to the will of God and then stating that the will of God is unknowable and out of reach of science. This means that from the scientific point of view, the commonly held belief that a recognizable personality survives death has no coherent theory to support it. But this does not necessarily mean that the belief is false.21

Schmeidler then turns to some of the types of data that address different specific questions regarding the personality surviving death:

One large set [of data] answers the question of whether the self can, without the intervention of its own body, interact directly with other bodies. This is a subject studied by parapsychologists, who often divide it into two subtopics: ESP [extrasensory perception], or information obtained without use of the senses, and PK, [psychokinesis], or physical changes produced without bodily intervention. There is by now clear evidence that such interaction can occur. I will cite a single example, chosen from many others that seem to me equally strong [emphasis added].22

The example Schmeidler cites is of a technique of studying psychokinesis using an instrument called a random number generator (RNG), which records events that physicists consider truly random:

In RNG research, a subject is asked to push a button on a machine so that the next recording will show a particular change (e.g., a faster rate of particle emission on some trials; a slower

rate on others.). This is an impossible task for our bodies. Our sense cannot tell us what the next random event will be and our effectors cannot change it. ….

Radin, May and Thomson …. summarized the data of all published RNG research with binary targets from the time this method was introduced …. to 1984. They found 75 reports, describing 332 experiments. When those experiments were evaluated as a whole, they showed success at rates astronomically higher than chance …. I suggest to you that this demonstrates that some nonbodily part of ourselves can interact with an object in the external world.

This in itself tells us nothing about survival, but it and other evidence for ESP and PK seem to legitimize the concept that our self (whatever it is) includes something that has properties which our body does not have. This in turn seems to legitimize queries about the possibility of nonphysical existence after the body's death, and thus the survival concept.23

Schmeidler then discusses the other lines of research that consider the survival hypothesis more directly "but do not give such clear-cut results."

Two of the methods study living persons. One is the near-death experience. …. Of those who revive after being considered clinically dead, perhaps half report having had vivid experiences while apparently dead. The experiences they report tend to have a good deal in common but are far from a complete overlap. Perhaps most impressive are the occasional cases where a person revived describes accurately events that occurred in a distant place during the time of apparent death.

The second method with living persons tests those who claim to have out-of-body experiences, that is, experiences of being at a location distant from one's body. Some have accurately described events at that distant place. ….

One method studies the dying. …. Fairly often a dying person claims that a dead relative has come to help with the transition to an afterlife. ….

Other methods study the dead. …. Apparitions sometimes give information that is later found to be correct …. At least one careful investigation has found that many messages gave correct and specific information known to no one who was present. And psychics and mediums, trying to obtain messages from a dead person, have often reported accurate information that was unknown to anyone present and (more rarely) that was known to no one alive until an attempt to check the message confirmed its correctness.

Each of these lines of evidence can be explained away by one or another counterhypothesis. The commonality among near-death experiences is explained as a combination of physiological change and wishful thinking. All the cases of accurate information are explained as extraordinary examples of effective ESP. …. The explanations are ad hoc and seem forced; they often postulate more effective ESP than has otherwise been found. They are more intellectually

satisfying than the survival interpretation, but whether they are more than the thesis of a spirit, separable from the body and surviving death, is still controversial.24

The beauty of this summary of the literature on near-death experiences and the survival of death is its neutrality. Schmeidler states the case exactly as I have come to see it: the solid ESP and PK literature clearly suggest that a part of us can function outside ourselves; this in turn is consistent with, but does not demonstrate, the legitimacy of the literature on out-of-body experiences; and both literatures then support, but do not demonstrate, the possibility that near-death experiences are more than simply physiological hallucinations; and this in turn suggests, but does not demonstrate, a rationale for accurate information coming from departed souls.

A number of separate investigators, as Schmeidler suggests, have found that between 35% and 48% of people who come close to death have near-death experiences suggestive of an afterlife. Poll data by George Gallup have also supported these figures.25

Karlis Osis and Erlendur Haraldsson did some of the pioneering scientific studies of near-death experiences of dying patients, reported in At the Hour of Death. They studied over 1,000 death or near-death experiences of patients in the United States and northern India in order to achieve a cross-cultural comparison of these experiences from two very different cultures.

They found, first, that the psychological experiences that patients had that were suggestive of postmortem existence were of shorter duration than hallucinations concerned with this life–just as ESP phenomena in general are of shorter duration than imagery related to this world. Second, they found these deathbed visions were mainly of dead and religious figures (by a 4:1 ratio), while only a minority of hallucinations in the general population concern dead and religious people.

This finding is loud and clear: When the dying see apparitions, they are nearly always experienced as messengers from a postmortem mode of existence. Of the human figures seen in visions of the dying, the vast majority were deceased close relatives. This is in agreement with our hypothesis that close relatives would be the natural guides in transitions to an afterlife. Hallucinations of mental patients and drug-induced visions seldom portray close relatives. The pilot survey revealed the most dramatic characteristic of deathbed apparitions: the ostensible intent to take the patient away to the other world. This was again found to be the dominantly stated purpose of the apparitions of the dying, as well as of come-back cases, in both American and Indian cultures….ê.

In the pilot survey, it was noted that patients responded to the otherworldly apparitions in a most surprising manner. They wanted to “go”–that is, to die. Some even bitterly reproached those who resuscitated them. Again, we encountered cases of such resentment in both countries. Nearly all the American patients, and two-thirds of the Indian patients, were ready to go after having seen otherworldly apparitions with a take-away purpose. Encounters with

ostensible messengers from the other world seemed to be so gratifying that the value of this life was easily outweighed [authors' emphasis].26

Patients who saw apparitions concerned with this world did not experience peace and serenity, while those who experienced "messenger" apparitions did. Patients who saw heaven or beautiful gardens reported strongly predominant feelings of peace, serenity, or religious feelings, while a small portion had negative experiences. Qualities of the scenes reported included brightness, intensity of colors, and great beauty. Some patients who saw no visions also became as serene and elated as those who saw messenger figures. And patients who were physiologically close to death had much more "complete" near-death experiences than those who experienced themselves as coming psychologically close to death.

We found that mood elevation near death resembles those ESP cases where a person will respond with emotions appropriate to a distant event, even though he is not consciously aware of what happened there….ê. There were some cases where patients ceased to feel pain. According to our afterlife hypothesis, the mind or soul may disengage itself from awareness of bodily pain and discomfort, as if gradually separating from its physical frame.27

The authors then review some of the alternative explanations of near-death imagery and experience. These include theories that the experiences are drug-induced; that they are related to brain disturbances caused by disease, injury, or uremic poisoning; that they are caused by lack of oxygen, or psychological factors associated with severe stress, or by cultural factors. In response, they argue that only a small minority of patients with these experiences had received hallucinogenic pain medications, and those that did had no greater frequency of afterlife visions than others. Brain disturbances in general either decreased or did not affect these experiences. Military research on oxygen deprivation, the authors state, does not support the anoxia hypothesis. And psychological factors, which can cause hallucinations, were not found to be related to phenomena associated with postmortem life.28

Cultural background, on the other hand, does influence near-death experiences. Indian patients, for example, saw a predominance of elderly male messenger figures while Americans predominantly saw younger female figures. But:

The phenomena within each culture often do not conform with religious afterlife beliefs. The patients see something new, unexpected, and contrary to their beliefs. Christian ideas of "judgement," "salvation," and "redemption" were not mirrored in the visions of our American patients. Furthermore, while we had many reports about visions of Heaven, visions of Hell and Devils were almost totally absent. …. We reached the impression that cultural conditioning by Christian and Hindu teaching is, in part, contradicted in the visionary experiences of the dying. It seems to us that besides symbolizations based on inculcated beliefs, terminal patients do "see" something that is unexpected, untaught, and a complete surprise to them.29

The core elements described above by Osis and Haraldsson give only a general sense of the near-death experience. Here is a composite near-death experience described by Kenneth Ring,

another influential researcher, from his popular Heading Toward Omega: In Search of the Meaning of the Near-Death Experience:

The experience begins with a feeling of easeful peace and a sense of well being, which soon culminates in a sense of overwhelming joy and happiness. This ecstatic tone, although fluctuating in intensity from case to case, tends to persist as a constant emotional ground as other features of the experience begin to unfold. At this point, the person is aware that he feels no pain nor does he have any other bodily sensations. Everything is quiet. These cues may suggest to him that he is either in the process of dying or has already "died."

He may then be aware of a transitory buzzing or windlike sound, but, in any event, he finds himself looking down on his physical body. At this time, he finds that he can see and hear perfectly; indeed his vision and hearing tend to be more acute than usual. He is aware of the actions and conversations taking place in the physical environment, in relation to which he finds himself in the role of a passive, detached spectator. All this seems very real–even quite natural–to him; it does not seem at all like a dream or a hallucination. His mental state is one of clarity and alertness.

At some point, he may find himself in a state of dual awareness. While he continues to be able to perceive the physical scene around him, he may also become aware of "another reality" and feel himself being drawn into it. He drifts or is ushered into a dark void or tunnel and feels as though he is floating through it. Although he may feel lonely for a time, the experience here is predominantly peaceful and serene. All is extremely quiet and the individual is only aware of his mind and the feeling of floating.

All at once he becomes sensitive to, but does not see, a presence. The presence, who may be heard to speak or who may instead "merely" induce thoughts into the individual's mind, stimulates him to review his life and asks him to decide whether he wants to live or die. This stock-taking may be facilitated by a rapid and vivid visual playback of episodes from the person's life. At this stage, he has no awareness of time or space, and the concepts themselves are meaningless. Neither is he any longer identified with his body. Only the mind is present and it is weighing–logically and rationally–the alternatives that confront him at this threshold separating life from death: to go further into this experience or to return to earthly life. Usually the individual decides to return on the basis not of his own preference, but on the perceived needs of his loved ones, whom his death would necessarily leave behind. Once this decision is made, the experience tends to be abruptly terminated.

Sometimes, however, the decisional crisis occurs later or is altogether absent, and the individual undergoes further experiences. He may, for example, continue to float through the dark void toward a magnetic and brilliant golden light from which emanates feelings of love, warmth and total acceptance. Or he may enter into a "world of light" and preternatural beauty, to be (temporarily) reunited with deceased loved ones before being told, in effect, that it is not yet his time and that he has to return to life.

In any event, whether the individual chooses or is commanded to return to his earthly body and worldly commitments, he does return. Typically, however, he has no recollection of how he has effected his "reentry."30

A crucial question is whether or not these near-death experiences are simply hallucinations of the dying brain. This suggested a fascinating line of research, part of which was initiated by the cardiologist Michael Sabom, who was initially a skeptic regarding near-death experiences, in his classic Recollections of Death. Sabom took special note of the fact that one aspect of the near-death experience is that it is simultaneously an out-of-body experience. Ring summarizes:

Sabom made a diligent search for detailed OBE (out-of-body experiences) accounts from NDErs [those who have had near-death experiences] on the grounds that such reports provide one of the few avenues through which to secure data about NDEs that can be independently corroborated. …. If a patient whose eyes, let's say, are taped shut, suffers cardiac arrest and has an OBE during which he later claims to have seen two physicians, one of them black, whom he has never met before, hurriedly enter the operating room to assist in the defibrillation procedure whose details he then describes in correct sequence, this is obviously an account that does not depend for its veracity on the patient's say-so. …. This is precisely what Sabom has done in a half dozen incidents where his respondents have given him highly specific and sequential accounts of their OBEs while near death. By interviewing members of the original medical team involved in these cases, talking to family members who had pertinent information, and checking the medical records directly, Sabom was able to produce impressive if not conclusive evidence of apparently accurate perceptions during OBEs. In short, according to Sabom, patients were describing events they could not have seen given the position of their body and could not have known given their physical condition.31

The work of Stanley Grof, a highly innovative psychiatrist who did careful research using LSD in psychotherapy with dying cancer patients, gives further interesting insight into the phenomenon of near-death experiences. In Grof's work, the patients he worked with, who were given LSD after very careful preparation and watched through the procedure, went through a set of phases that began with the very difficult experience of physical death and ended in an ecstatic experience of rebirth. When these patients had completed the death-rebirth experience, they were characteristically convinced that at the time of actual death their souls would survive, and they had no further fear of death.

The Great Art of Making the Dying Physically Comfortable

It is an expression of the malady of our time that while many people want to attend lectures on transcendent experiences in death and dying, far fewer people take the time to visit and sit with the dying, and fewer still are interested in the practical matters of making a dying person as comfortable physically as possible so that he and his family members have some chance to enjoy the last months, weeks, or days of life.

The reality is that practical knowledge is as important, and often more important, than an ungrounded spiritual impulse to assist the dying. As Sylvia Lack, M.D., told a training conference for physicians concerned with the care of the dying:

There is far too much talk in death and dying circles in this country about psychological and emotional problems, and far too little about making the patient comfortable. Any group concerned with service to the dying should be talking about smoothing sheets, rubbing bottoms, relieving constipation, and sitting up at night. Counselling a person who is lying in a wet bed is ineffective …. If people are cared for with common sense and basic professional skills, with detailed attention to self-evident problems and physical needs, the patients and the families themselves cope with many of their emotional crises. Without pain, well nursed, with bowels controlled, mouth clean, and a caring friend available, the psychological problems fall into manageable perspective.32

One of my favorite books on the practical aspects of dying is by Deborah Duda, A Guide to Dying at Home.33 In the chapter called "Getting on with It: Preparations and Homecoming," Duda covers what you need to die at home. Here she lists everything from the doctor, medicines, and bed to such essential details as hot-water bottles, a dishpan for bathing, and drinking straws that bend.

Duda covers in detail how to choose a physician who will honor your wishes, how to work effectively with a physician, pain control, and giving shots or injections.34

One of the best health professional guides I have seen in this area is The Physician's Handbook of Symptom Relief in Terminal Care,35 by Gary A. Johanson, M.D. of the Home Hospice of Sonoma County, California. The Physician's Handbook is a loose-leaf binder with color tab-coded sections that cover common problems the physician, patient, or family member may encounter. In offering this compendium, Johanson writes:

The degree of success achieved in skilled symptom control will greatly influence how effectively caregivers and families will be able to assist patients in realizing their emotional, spiritual and social comfort in the final days of their lives.

The greatest asset in terminal care is a listening/caring approach. The greatest skill is knowing when it is appropriate to apply which palliative measure.

No matter how much we deny it, the fact is that conventional treatment often becomes inappropriate, and therefore poor medicine in the terminal patient. We who care for these patients are not off the hook simply by plugging along on conventional treatment pathways when it is no longer appropriate. ….

There is always something that can be done for terminal patients. None of us can expect to know all the techniques that have been developed in the area of terminal care. For our

patients' benefit and our own education, we should not hesitate to consult a reference or a colleague for assistance.36

This handbook is not only useful for physicians but also for patients and family members who want to be knowledgeable about the options that physicians and nurses are (or should be) considering. Many physicians have relatively little interest in or knowledge of how to provide the best possible support for a dying person. It is a very high and, in fact, noble skill of the healer. Having this information represents another area in which the patient or family member is able to work more effectively in partnership with physicians and nurses.

While Johanson's Physician's Handbook does an excellent job of covering the more technical aspects of symptom relief in dying, Duda provides a practical introduction to making the senses comfortable and to providing enjoyable experiences wherever possible.

Her discussion covers touch (massage, hair care, hugging, holding, and cuddling), moving the person, smells, cleanliness, creating beautiful environments, hearing (sound, music, reading), and taste and diet. The issues of intravenous (IV) feeding and dehydration represent an example of a critical area in which knowledge and forethought can make a vital difference in the dying experience. Says Duda:

IVs are used to nourish people who can't eat or drink enough to stay alive. The decision whether or not to use IVs in terminal care raises again the question of the quality of life versus the quantity. Feeding the body cells by means of IVs often prolongs the life of the body. The cost is discomfort, less ability to move and the need to have a nurse. Dad said, "When I have all those tubes in I feel like a patient. When I don't, I feel like me."

The result of not taking enough fluids into the body is dehydration. The chemical imbalance created by a lack of fluids often causes a person to have a sense of well-being or euphoria [emphasis added]. It's a relatively comfortable death. The main discomfort, dryness of the mouth and thirst, is helped by sucking on ice chips and clean moist washcloths. It generally takes only a few days for a debilitated person to die from lack of fluids.37

Duda is supported by medical experts in this opinion on dehydration. Johanson suggests a policy for IV fluid therapy:

In the terminal patient, the benefits of dehydration can be many, including sedation, decreased vomiting, and decreased urine output and secretions. IV fluids should only be used if hydration seems like it will improve alertness, decrease nausea, prolong life in a positive way, or otherwise provide true comfort.

Conscious withholding of intravenous and other supportive measures is not a question of "non-treatment." Instead, it is a matter of what is appropriate treatment from a biologic, humane and spiritual point of view. Some patients suffer as much from inappropriate treatment as they do from the underlying illness itself.

In other words, IV infusion should be looked upon as primarily a supportive measure for use in acute or acute-superimposed-upon-chronic illnesses to assist a patient through a temporary period toward some recovery of health. To use such measures in the terminally ill, without such expectation of return to health, is generally inappropriate and therefore not good medicine. Such measures should ethically only be used if the treating physician is convinced they are clearly contributing to the comfort of the patient.38

Dying and Grieving

Dying and grieving are deeply interconnected, so it makes sense to treat them together. The dying person must engage in anticipatory grieving for the loss of himself. The family and friends who will be left behind have what is often as sharp–and sometimes even sharper–a grief to deal with. They, too, may do anticipatory grieving, and they will also grieve later.

Grieving is something that one can learn how to do. It is something that can cripple a life experience–or a dying experience–if it is drastically incomplete. Many cultures prescribe elaborate and effective systems of grieving. In the United States, we have lost most of these rituals–a very great loss, indeed. And so it has been the psychiatrists and other modern shamans who have taken on the job of helping us grieve our own deaths or the deaths of those we love.

One of the best known theories of the dying process has been presented by Elisabeth Kübler-Ross. In her famous book, On Death and Dying, she presents a theory of a series of stages in the human response to dying. The first stage of the dying process, according to Kübler-Ross, is denial and isolation:

Denial, at least partial denial, is used by almost all patients, not only during the first stages of illness or following confrontation, but also later on from time to time. …. These patients can consider the possibility of their own death for a while but then have to put this consideration away in order to pursue life. …. Denial functions as a buffer after unexpected shocking news, allows the patient to collect himself and, with time, mobilize other, less radical defenses.39

Actually, Kübler-Ross notes that the very first reaction may be a temporary state of shock, which is then followed by this initial response of denial.

The second stage for Kübler-Ross is anger.

The next logical question becomes: “Why me?”…. In contrast to the stage of denial, this stage of anger is very difficult to cope with from the point of view of family and staff. The reason for this is the fact that this anger is displaced in all directions and projected onto the environment at times almost at random.40

The third stage is bargaining:

The third stage, the stage of bargaining, is less well known but equally helpful to the patient, though only for brief periods of time. If we have been unable to face the sad facts in the first period and have been angry at people and God in the second phase, maybe we can succeed in entering into some sort of an agreement which may postpone the inevitable happening: “If God has decided to take us from this earth and he did not respond to my angry pleas, he may be more favorable if I ask nicely.”41

The fourth stage is depression:

When the terminally ill patient can no longer deny his illness, when he is forced to undergo more surgery or hospitalization, when he begins to have more symptoms or becomes weaker and thinner, he cannot smile it off any more. His numbness or stoicism, his anger and rage will soon be replaced with a sense of loss. This loss may have many facets: a woman with a breast cancer may react to the loss of her figure; a woman with a cancer of the uterus may feel she is no longer a woman. …. With the extensive treatment and hospitalization, financial burdens are added; little luxuries at first and necessities later may not be afforded any more. …. All these reasons for depression are well known to everyone who deals with patients. What we often tend to forget, however, is the preparatory grief that the terminally ill patient has to undergo in order to prepare himself for his final separation from this world. If I were to attempt to differentiate these two kinds of depressions, I would regard the first one as a reactive depression, the second one as a preparatory depression. The first one is different in nature and should be dealt with quite differently from the latter.42

In Kübler-Ross’s view, we can respond to the reactive depression with action–seeking to ameliorate the losses with word or deed. The preparatory depression, on the other hand, should not be met with any attempt to “fix it”:

The patient should not be encouraged to look at the sunny side of things, as this would mean he should not contemplate his impending death. It would be contraindicated to tell him not to be sad, since all of us are tremendously sad when we lose one beloved person. The patient is in the process of losing everything and everybody he loves. If he is allowed to express his sorrow he will find a final acceptance much easier, and he will be grateful to those who can sit with him during this state of depression without constantly telling him not to be sad.43

The fifth and final stage is acceptance:

If a patient has enough time (i.e., not a sudden, unexpected death) and has been given some help in working through the previously described stages, he will reach a stage during which he is neither depressed nor angry about his “fate.”…. Acceptance should not be mistaken for a happy stage. It is almost void of feelings. It is as if the pain had gone, the struggle is over, and there comes a time for “the final rest before the long journey” as one patient phrased it. …. While the dying patient has found some peace and acceptance, his circle of interest diminishes. He wishes to be left alone or at least not stirred up by news and problems of the outside world. Visitors are often not desired and if they come, the patient is no longer in a talkative mood. ….

He may hold our hand and ask us to sit in silence. Such moments of silence may be the most meaningful communications for people who are not uncomfortable in the presence of a dying person. We may together listen to the song of a bird from the outside. Our presence may just confirm that we are going to be around until the end. We may just let him know that it is all right to say nothing when the important things are taken care of and it is only a question of time until he can close his eyes forever.44

While these are the five stages of dying for Kübler-Ross, it is often forgotten that she also accords a special place to hope throughout the five-stage process.

We have discussed so far the different stages that people go through when they are faced with tragic news. …. These means will last for different periods of time and will replace each other or exist at times side by side. The one thing that usually persists through all these stages is hope. …. In listening to our terminally ill patients we were always impressed that even the most accepting, the most realistic patients left the possibility open for some cure, for the discovery of a new drug or the "last minute success in a research project."…. It is this glimpse of hope which maintains them through days, weeks or months of suffering.45

Other Views of the Process of Dying

Kübler-Ross's vision of the stages of dying has many virtues, but it has been strongly criticized by many thoughtful professionals. Edwin S. Shneidman is one:

In the current thanatological scene there are those who write about fewer than a half-dozen stages lived through in a specific order–not to mention the even more obfuscating writing of a life after death. My own experiences have led me to rather different conclusions. In working with dying persons I see a wide range of human emotions–few in some people, dozens in others–experienced in a variety of orderings, reorderings, and arrangements. The one psychological mechanism that seems ubiquitous is denial, which can appear or reappear at any time. Nor is there any natural law that an individual has to achieve closure before death sets its seal. In fact, most people die too soon or too late, with loose threads and fragments of agenda uncompleted.

My own notion is more general in scope; more specific in content. …. My general hypothesis is that a dying person's flow of behaviors will reflect or parallel that person's previous segments of behaviors, specifically those behaviors relating to threat, stress or failure. There are certain consistencies in human beings. Individuals die more-or-less characteristically as they have lived, relative to those aspects of personality which relate to their conceptualization of their dying. To oversimplify: The psychological course of the cancer mirrors certain deep troughs in the course of the life–oncology recapitulates ontogeny [Shneidman's emphasis].46

Another special observer of the dying process was Erich Lindemann, Professor of Psychiatry at Harvard, who studied loss and grieving for years before he developed cancer. Lindemann

described his own process of anticipatory grieving in the face of his impending death from cancer.

First, he wanted information from his physicians, and he wrestled with all the complex questions about what a physician should and should not tell a patient and how the news should be transmitted. Second, he struggled with what to do with the feelings that his impending death brought up for him. Third, he found that the agreement with family and friends on the ways in which he would be remembered was of critical importance to him:

It can only be represented by symbols, such as a book, or–there is a building named for me in Boston, the Lindemann Mental Health Center, which means an awful lot. So you have something which continues your identity's existence by a global attribute, a book or a building which then allows the survivors to remember those things which are pertinent to you, the particular person, just as at various stages of your anticipatory grieving you think about various aspects of that life which you are now reconstructing.

Now [this] …. was a revelation to me and led me to wonder, in looking at grief in patients, if they have similar tasks. They don't write books, but with members of their families, or the nurse, they have confidential exchanges about the sort of things they did with other people. They like to be visited by a lot of friends, so long as they don't feel too embarrassed about sharing their emotions, and would like to pick up items of their lives which they shared with the future survivors. And they will rub in these experiences with the family and friends, so they will be sure to remember when they are gone. So this constructing of a collective survival image of oneself which will still be there when one happens not to be there any more in the flesh is the core of grieving, which, if it is done well, is apt to be an admirable process–a fascinating process if one is lucky enough to witness it.

Then Lindemann comes to a beautiful and rarely described issue:

Every once in a while one hears about some person who is confronted with a severe illness and is not going to live, who is an inspiration to somebody else. And from our observations, it is these people who do such a good job of recalling their own lives and their own shared experiences, constructing an image which is a tenable image of a human being. ….

[Sometimes] there is not enough contact between the patient and his family. The family gets into a conflict over whether to stay or not, how much to share in the patient's illness; whether these sometimes trite things which the patient brings up are worth the time of the patient and everybody else. And for the family, a very important problem may come up …. namely, that one does one's grieving so well that one emancipates oneself from the person who is going to die and then has no relationship anymore. The [family] don't know whether to visit or whether to stay away; if they try to pull themselves out of the bondage they will feel they are disloyal. This problem of a relationship which may be severed too successfully becomes a difficult one for the anticipatory griever. Sometimes patients who have a terminal illness come to terms with this illness, are all settled; and then when people still come, they don't want to see them anymore.

One wonders what is the matter with them unless one is aware of the fact that a process has been going on, and one has to tap at what phase this process is now.47

Lindemann describes how important to him it was to go and visit places that had had great meaning to him:

I really became hypermanic, in the sense that I raced around and wanted to do all the things that would be wonderful to do once more. In other words, see that people who are confronting death are not in an environment which is restrictive of doing possibilities; that they are still as mobile as is compatible with their ailments, and still as rich in possible experiences for a little while. I guess it isn't silly to make up for the things you won't have any more of later, and token fulfillment along that line can make an enormous difference.48

Grieving for Survivors

"A person's death is not only an ending: it is also a beginning–for the survivors," writes Shneidman. Studies of widows who have recently lost a husband show a heightened likelihood of death from alcoholism, malnutrition, and other conditions. It seems "grief is itself a dire process, almost akin to a disease, and that there are subtle factors at work that can take a heavy toll unless they are treated and controlled."49

The death of someone we love can induce a response very similar to that found in those who have experienced a disaster such as an earthquake or explosion:

Martha Wolfenstein has described a "disaster syndrome": a combination of emotional dullness, unresponsiveness to outer stimulation and inhibition of activity. The individual who has just undergone disaster is apt to suffer from at least a transitory sense of worthlessness; his usual capacity for self love becomes impaired."50

Lily Pincus was a distinguished social worker who lived in England and wrote a book called Death and the Family: The Importance of Mourning.

All studies agree that shock is the first response to death. …. It may find expression in physical collapse …. , in violent outbursts …. , or in dazed withdrawal, denial, and inability to take in the reality of death.

Mourners often complain that they were not prepared for what it would be like: "Why did nobody warn me that I would feel so sick …. or tired …. or exhausted?"; "Nobody ever told me that grief felt so like fear"; "I wish I had known about the turmoil of emotions …."51

The acute shock, says Pincus, usually lasts only a few days, followed by a controlled phase during which the mourner is supported by relatives and friends.

The real pain and misery makes itself felt when this controlled phase, and the privileges that went with it, is over, and the task of testing reality, coming to terms with the new situation, and the painful withdrawal of libido from the lost person begin. It is then that the mourner feels lost and abandoned and attempts to develop defenses against the agonies of pain. Searching for the lost person, an almost automatic universal defense against accepting the reality of loss, may go on for a long time. ….

Most people are not aware of their need to search but express it in restless behavior tension, and loss of interest in all that does not concern the deceased. These symptoms lessen as bit by bit the reality of the loss can be accepted and the bereaved slowly, slowly rebuilds his inner world. ….

As the bereaved becomes more relaxed, and tension, frustration, and pain decrease, searching may lead to finding a sense of the lost person's presence…..

There are no timetables for what have been called the phases of mourning, nor are there distinct lines of demarcation for the various symptoms of grief which find expression during these phases. For the bereaved, the most alarming and bewildering aspects of grief are those in which he can no longer recognize himself, for example, the often irrational anger and hostility, which may be quite alien to the mourner's usual behavior and may make him feel that he is going insane. …. They express the ambivalence of the mourner toward all these people but most especially, and painfully, toward the lost person who is causing him so much distress by his abandonment.52

For the shock that may immediately follow death, warmth and rest and a nourishing protective environment can be a real help. For the controlled period that Pincus mentions above, the support of friends and relatives can make a great difference.

The great challenge takes place as we begin to face life without the person we loved, and here the truth seems to be "the fundamental importance of being able to mourn and to `complete the mourning process'." But, like the fight for life with cancer, there are no firm guidelines for how to complete the mourning process; each must be "allowed to mourn in his own way and his own time."53

The mourning process, like the process of physical healing, involves the healing of a wound, a new formation of healthy tissue. In mourning, however, the cause of the injury, the loss of an important person, must not be forgotten. Only when the lost person has been internalized and becomes part of the bereaved, a part which can be integrated with his own personality and enriches it, is the mourning process complete. With this enriched personality the adjustment to a new life has to be made.54

Conclusion

Of all the chapters in this book, this has been the most difficult to write. Writing this chapter immersed me in the awesome and varied literature on death, dying, and mourning. On the one hand I felt grateful for the experience because I learned in greater depth things that I can pass on to others in the Cancer Help Program and through this book.

But the simple fact is that as I write these words, death, in my eyes, has not lost its power. It may well be that the soul survives death. I was skeptical of this years ago, but now believe it to be as likely as not. It is certainly true that we can detoxify death–that we can remove the taboos of thinking and feeling about it, and that great comfort and understanding can come from this process.

But even if I knew for a fact that my soul and the souls of those I love will survive death, I am not sure the pain of death and loss would be gone. I remember the story of an enlightened Eastern teacher who lost his child to death. His students came to see him the next day and found him crying.

“Master,” one said, “you teach us that all life is an illusion. How is it that you are crying because of the death of your child?”

“It is true that life is an illusion,” the master responded. “But the death of a child is the greatest illusion of all.”

I go back to the words I started the chapter with, the words of the Buddha: “Even the wise fear death. Life clings to life.” We have read, and can read, of those who overcome this fear. But most of us fear death. There is no shame in this. Death remains a great mystery, the central problem with which religion and philosophy and science have wrestled with since the beginning of human history. Acknowledging this, we can, perhaps, come to face it with greater understanding, more preparation, and greater love.

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Ritual and Healing

Rituals For Cancer and Serious Illness

By Swami Vidyananda

Rituals speak the Universal language of symbols and imagery. They can bypass the resistance of the rational mind to uplift and heal. The Universal Consciousness (God) is beyond the mind & senses, so we use rituals to see God in a place and a form so we can open to that consciousness, and channel that power.

Rituals Can Be Used To:

- Focus the mind through beauty and the senses.
- Elevate the mind beyond the gross level to reduce suffering.
- Feed positive images into subconscious to mobilize healing energies.
- Calm the mind and reduce stress.
- Lead into healing meditations. Request healing and guidance.
- Comfort the suffering, request strength and understanding.
- Ask for peace and freedom while someone is dying.
- Comfort those who are bereft.

Basic Elements From All Traditions to create simple rituals:

- **Light** – candles, votive lamps, oil and ghee lamps. Camphor*.
- **Water** – for blessing purification and consecration.
- **Scents, fragrance*** - incense, essential oils, flower waters
- **Beauty** – flowers, sacred art and images, images of nature. Altars.
- **Food** - bless the mundane through intention—offer food to God.
- **Music** – chanting, sacred music, soothing and healing music.
- **Prayer and mantra**– speak to the higher power; sacred sounds.

Considerations For Rituals For People With Cancer:

- Be mindful of people's religious background. Incorporate what you both are comfortable with.
- * People undergoing chemotherapy may be highly sensitive to aromas—be cautious with incense etc.

- Some symbols may suggest funerals for some people and create anxiety (when they want to heal, not die).
- The needs of the sick person may be different than the needs of their family/caregivers. Prioritize the sick person.
- Do rituals for the highest good of all, with uplifting wishes at the end. Avoid specific rituals for selfish ends.

Development of Professional Relationship

Discussion Topics

Responsibilities and Teaching in a medical environment

HIPAA: Health insurance portability and accountability act

Legal and Ethical Issues

Professional referral and reporting requirement

Professional responsibilities

Continuing Education

Additional Resources for Healing Relationships
IYTH Module 2
Nov 30-Dec 17, 2022
Sandra Susheela Gilbert, BA, C-IAYT, E-RYT500

Choices in Healing Michael Lerner (available free: www.commonweal.com)

Kitchen Table Wisdom Rachel Naomi Remen, MD
My Grandfather's Blessings

The Healing Path of Yoga Nischala Joy Devi

The Chakras in Grief and Trauma Karla Helbert

Healing and the Mind Bill Moyers

Healing into Life and Death Stephen Levine
Who Dies?
And all other titles by Stephen and his wife Ondrea

Heal Thyself *Saki Santorelli*

Minding the Body, Mending the Mind *Joan Borysenko PhD*

Healers on Healing Various writings by Rachel Naomi Remen,MD, Norman Cousins, Ram Dass Joan Halifax, Martin Rossman, MD, O. Carl Simonton, MD and others

Graceful Passages Michael Stillwater and Gary Malkin
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Various articles by Jnani Chapman,RN Yoga Journal, LA Yoga Magazine
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