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Letting Go
Expanding the Transpersonal Dimension in Hospice Care and Education

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Abstract
As the hospice movement continues to grow, caregivers are increasingly required to interact with dying patients for longer periods and in more intimate and more meaningful ways. Practical models of competent and compassionate communication and understanding need to be developed to accommodate the changing environment of the patient and caregiver and their relationship. We therefore: (1) examine current death education trends in hospice care and education; and (2) describe the need for a more expansive and transpersonal view, and ways of fulfilling that need. The aware patient and the aware caregiver can learn much during the dying trajectory. We hope that someday the potential for expansiveness during the dying trajectory will be more commonly recognized and accommodated as a doorway to the transpersonal.

Western medicine classifies death under the rubric of disease, defining it as a biological process — a function of the body. The Hippocratic Oath, taken by all physicians in the United States, emphasizes the need to maintain life above all else. Thirty-five years ago, if a person stopped breathing for more than a few minutes, oxygen deprivation would cause the heart to fail and the brain to stop functioning, leading to death. Since then, however, the use of external cardiac shock, cardiopulmonary and mouth-to-mouth resuscitation, and mechanical ventilators has changed the course of the "normal" dying process forever.

Medical treatment and hospital care, "cloaked in clinical and social mystique" (Meyer, 1991, p. 1), exhibit a palpable preference for the curable, restorable patient, thus leaving many of those who are extremely old or incurably ill to suffer alone (Thompson, 1994). Those who are frail, elderly, or dying are moved to institutional settings such as skilled nursing and intermediate care facilities, where their dwindling lives can be artificially sustained by tube feedings. For some terminally ill patients

The twenty-first century is a fast-moving, impatient world. Technological advances have yielded unprecedented opportunities for both extending a healthy life and prolonging an unhealthy one. Longer life-spans, lingering deaths, and ever-improving life-support systems contribute to a recent estimate that one in eight Americans is over the age of 65, and that by 2020 it will be one in five (Levy, 1994). Unfortunately, the Western preoccupation with speed, youth, beauty, and strength does little to foster tolerance for old age, sickness, and death. And, although the persistent advance of old age and sickness can sometimes be forestalled, modern technology cannot put an end to death.

In heaven, Lord Indra heard empty stone vault doors closing one after another in echoes. Sight was closing, hearing closing, mind turning away. Spirit was rising and leaving empty rooms. The ether space within the heart was empty, fires and lamps turned off, locks and threads snapped and untied, and all released.

—The Ramayana
(quoted in Levine, 1989, p. 247)
the process of dying can cause cerebral death, but even then they are often kept vegetatively alive and monitored by mechanical feeding and breathing systems.

Institutions can provide physical care, but because of time restrictions and a general lack of willingness or knowledge, most staff members do not want to face existential questions about the meaning of life and the inevitability of death. Consequently, emotional, mental, and spiritual issues are usually not addressed (Moller, 1993). Many health care professionals today perpetuate the prevailing view that aggressive treatment and the cure of disease, even for those near death, is the only proper and ethical course of action (Kelner, Bourgeault, & Wahl, 1994; Webb, 1997). As a result, the inability to restore a person to health becomes a source of frustration and events seem dangerously out of control when efforts to save a person are unsuccessful.

Presumably, the incurable and the very old are closer to death than other people, and often the tendency is to avoid them rather than be reminded of technology’s shortcomings, of medicine’s failures, and of a general lack of expertise in understanding death (Fulton & Bendiksen, 1994). The Western medical focus on the cure and prolongation of life, regardless of the circumstances, has cultivated an attitude of denying death. One observer states: “Death represents a loss to those who, through modern technology, have been increasingly used to winning” (Bouwsma, 1996, p. 189).

Regarding treatment and cure as the main issues in medical care leaves the psychological aspects of dying for the patient and caregivers to cope with — alone. Death denial results in poor education and lack of preparation in understanding either the needs of the dying or our own mortality (Kastenbaum, 1992). Fear and anxiety often prevail when facing someone who is dying (White & Fletcher, 1995). Having never learned to address the fear of death, many people experience discomfort and do not know what to say in the presence of someone who is actually dying (Williamson & Shneidman, 1995). Even today, though discussions about death appear to be more frequent than they were twenty years ago, much of the content is confined to legal issues such as living wills and informed consent rather than a direct psychological confrontation with the meaning of death to an individual (Byock, 1997).

Dying is sometimes accompanied by phenomena that Western paradigms cannot easily explain. A lack of understanding about these events can further decrease and dilute interaction, and lead to a sense of isolation for both the patient and the caregiver; and it can prevent or diminish transpersonal experiences of the dying. Practical models of competent and compassionate communication, therefore, need to be further developed and expanded to include events that lie beyond ordinary concepts of states of consciousness. Transpersonal concepts are now sometimes recognizable in hospice care and education, but the need continues for a still broader and more widespread transpersonal vision in death education and care of the dying.

### Humanistic Influences: Emerging Hospice Ideals

The subject of death and the plight of the dying were almost completely ignored prior to the research of Elisabeth Kübler-Ross in the 1950s. Focusing on the whole patient rather than just the disease, she introduced a humanistic approach to her practice of medicine. Kübler-Ross (1969) recognized that dying involves not only the deterioration of the body but also the dying of the individual. As she listened to her dying patients, she became concerned about the many experiences of isolation and fear reported to her. Kübler-Ross (1969, 1970) developed a theory which proposed that most people go through five distinct stages in the process of dying: (1) denial; (2) anger; (3) bargaining; (4) depression; and (5) acceptance. According to Kübler-Ross, some patients may experience all five of the stages while others might experience only one or two. Although her stage theory was later criticized (Buckman, 1992; Corr, 1993, 1995), it remains an enduring landmark in providing a practical model for understanding the unique and psychological needs of the dying.

Kübler-Ross’s compassionate research also addressed the needs of her dying patients for
communication and understanding during the emotionally difficult time of coming to terms with dying and the end of life. She found that in the hospital setting there was little patience or tolerance for the existential needs of the dying, even among her medical colleagues. She writes: “These patients represent a failure of the institution in its life-sustaining role and there is nothing in the system that provides for human nurturance to the soul when the body is beyond repair” (Kübler-Ross, 1975, p. 6).

Kübler-Ross' findings and their dissemination opened up the “taboo” (Feifel, 1963; Gorer, 1980) subject of death to large numbers of people. She found that, for patients and caregivers alike, it is often easier and less threatening to avoid any psychological interaction around the dying than it is to risk getting involved in a discussion about something as terrifying as death. Kübler-Ross focused public awareness on how the needs of the dying were not being met because of the unpopularity of death as a subject for dialogue or reflection. During the 1970s, public awareness about death and dying slowly began to grow, and now, in addition to humanistic influences pioneered by Kübler-Ross, transpersonal themes are also being investigated (Byock, 1997; Foos-Graber, 1984; Levine, 1987, 1997).

The humanistic view of personalizing death, with its focus on compassionate treatment of the dying person rather than aggressive treatment of an already fatal disease, was advocated in Britain by another physician, Cicely Saunders. Saunders turned her attention to the needs of the dying and envisioned the development of an environment in which each terminally ill patient could experience a unique and individual death (Boulay, 1984). In London, during the 1960s, Saunders pioneered the first modern hospice, St. Christopher’s, wherein she established the fundamental conceptual framework that still guides hospices in Europe and the United States today (MacCormack, 1994). Hospice care, sometimes called palliative care, is primarily concerned with compassionate, thoughtful and individualized care for the dying patient and his or her family. Shifting the focus from the disease to the patient as a person promoted a change in attitude about the needs of the dying, and the hospice concept was the result (Carson, 1989; Chirban, 1985). Currently, the ideal hospice environment is considered to be one in which a dying person has the opportunity to experience death in a uniquely individual way, without physical pain, and with a surrounding sense of emotional, intellectual, and also spiritual support (Callanan & Kelley, 1993; Lamers, 1995; Millison & Dudley, 1992).

The humanistic idea that each individual has a unique and not necessarily typical response to his or her experience is deeply incorporated into the hospice philosophy, which affirms that an individual's dying cannot be categorized into one predictable course. During the 1970s, in the United States, the hospice movement gathered exceptional momentum and over 1400 hospices were established. Today that figure has grown to over 2000 hospices (National Hospice Organization, 1994-1995). Many of the first hospice programs in the United States were located in hospitals, and today some hospitals incorporate a hospice unit in their census.

Hospice Ideals and Transpersonal Influences

HOspice care extends beyond just the physiological dimension. Pain, for example, is considered to be caused not only by diseased organs but also by social and spiritual stresses. The exploration and appraisal of psychosocial processes began early in the hospice movement. Later, inquiry and evaluation of spiritual events began to evolve. During the late 1970s, more groups emerged to meet the needs, including transpersonal needs, of both the dying and their families. For example, the Shanti Project and the Hanuman Foundation Dying Project both arose out of a concern for all the people involved in an individual’s dying trajectory. The Shanti Project, organized by Charles Garfield in 1974, provides peer counseling and volunteers for companionship to terminally ill patients and their families (Garfield, 1978). The Hanuman Foundation Dying Project, opened in the late 1970s by Stephen Levine and Ram Dass, assists...
people who want to utilize the dying process (their own or that of a significant other person) to help them gain insight through what is called a "spiritual awakening" (Levine, 1989).

In the preface to Stephen Levine's book Who Dies? (1982), Ram Dass writes that the purpose of the Hanuman Foundation Dying Project "is to create a context for the process of dying in which the work on oneself would be the central focus for all involved — be they healers, helpers, families or the individuals approaching death" (p. x). Levine worked with Kübler-Ross, Ram Dass, and others in counseling the dying and in leading and organizing workshops on the subject. He valued certain techniques from Asian psychologies such as meditation and visualization for their effectiveness in assisting dying patients and family members to relax and witness their experience from a more centered state of mind. Levine (1997) recently published another book which further illustrates his evolving understanding of death and dying. This volume describes the experiences and insights he gained, while healthy, from living for one full year as though it would be his last.

The transpersonal dimension includes experiences in which self-identity, as Walsh and Vaughan (1993) state, "extends beyond (trans) the individual or personal to encompass wider aspects of humankind, life, psyche, and cosmos" (p. 3). As awareness of the transpersonal dimension in hospice caregiving continues to grow, so too does the need for caregivers to learn how being open to their own feelings about death might enable them to become more understanding of the dying patient. The transpersonal dimension makes an important contribution to thanatology by providing caregivers and patients with more expansive ways of understanding the dying trajectory and death, and providing care for the dying.

Transpersonal experiences can be important elements in the interaction between patients and caregivers, and such experiences can best be expressed and reflected through open-minded communication and listening and the development of empathy and compassion. We are beginning to recognize that much of what the dying reportedly experience and communicate is beyond conventional knowledge and explanation, and some of it lies in the realm of the transpersonal (Lorimer, 1990; Osis & Haraldsson, 1986; Ring, 1988). During the dying trajectory, ordinary noises and distractions of the world may become stilled, and other, perhaps less self-limiting, voices can be heard. To the extent that a caregiver's understanding is limited by a lack of awareness of death or the transpersonal dimension, the ability to listen receptively and empathetically to transpersonal experiences is curtailed. As Vaughan (1993) writes, "the widespread denial of death in Western culture reflects an equally widespread denial of transpersonal realities" (p. 163).

Being with the terminally ill requires confidence and presence. During the dying trajectory, communication is often nonverbal and listening is accomplished by skillful eye contact and other subtle responses. Death and dying can evoke ambiguous and uneasy feelings which tend to elicit reactions rather than spontaneous responses. Caregivers who react automatically without listening receptively may impose personal beliefs onto the dying trajectory; such beliefs can inhibit empathetic interaction and rob patients of their individual expression and experience of the dying process.

Empathy and compassion are thus important elements contributing to a transpersonal vision of death and dying. Empathy is the ability to feel what another person is experiencing by being receptive and open-minded in the interaction. Empathy seems necessary if caregivers and patients are to understand one another "beyond pills and the scalpel" (Brody, 1994). Recognizing the common human destiny — that everyone will eventually die — tends to broaden one's worldview. Compassion, too, is necessary: it includes having empathy for another person's suffering, and a desire to help alleviate that suffering. For the caregiver, compassion must go beyond professional warmth to a genuine open-minded, and open-hearted relationship with a patient and his or her individual circumstances.

Empathy and compassion also arise with the recognition that we all experience the same transpersonal destiny, we breathe the same air, and share what the Dalai Lama (1984) calls
“universal responsibility” for the well-being of the entire planet. And empathy and compassion tend to generate a sense of forgiveness for the perceived flaws of oneself and of others. Caregivers can convey the freedom inherent in the profound act of forgiveness and thereby influence a dying person’s peace of mind by encouraging the resolution of personal and interpersonal conflicts. Resolving conflicts, in turn, lessens tension and may allow the patient to be more receptive to the transpersonal dimension in death and dying.

The skilled caregiver can also be the patient’s advocate and with proper education will know how best to intercede on behalf of the patient who asks. For example, some patients withdraw from worldly concerns to the extent that they may no longer want to socialize with certain people but, out of fear and concern for others, they say nothing. An informed caregiver can correct the situation, with gentleness and sensitivity, by informing others of the true wishes of the patient.

Death Awareness

The death of friends or loved ones usually forces an unwelcome confrontation with mortality and the shocking personal realization that death is inevitable. Despite the difficulty of accepting this reality without appropriate preparation, the promotion of death awareness continues to be largely neglected, even in directly related areas such as healthcare education. Students in medical school are still generally taught relatively little about death and dying, and many say they graduate feeling unprepared to deal effectively with dying patients (Dickinson & Tournier, 1994; Holleman, Holleman, & Gershenhorn, 1994).

The inescapable fact that death awaits each of us is a powerful reason to explore and develop alternative viewpoints about understanding death. Ways to cope with negative outcomes such as caregiver grief, fatigue, and burnout have been studied (Rando, 1988), but less is known about the positive, transpersonal, and transformative outcomes that are also possible during the dying trajectory. A lack of death awareness can also hinder more effective interactions with the dying and contribute to their psychological distress. The influence of the transpersonal dimension in death and dying therefore needs to be further explored, especially in terms of understanding and developing a model for reciprocal listening, communicating, and learning between dying patients and their caregivers. Patients and caregivers alike can be hindered by the anxiety that arises from a lack of death awareness and the confusion and fear that can arise when death is imminent (Borysenko, 1987; Lnetto & Templer, 1986). Armed with some knowledge about death and dying, individuals may have a less stressful, more positive physical, emotional, mental, and spiritual experience during the dying trajectory.

The need for a continuation of what some have labeled the revival of death awareness (Walter, 1994) is imperative in order to assist people in coping with the stressful situation surrounding death. Today, it is not only the prolific “raging silver wave” that is responsible for the increasing need for death awareness, but also epidemics like AIDS, aggressive acts such as the Oklahoma City bombing, and natural disasters such as widespread fires and flooding.

When my brother was about two weeks away from death, his body had withered to a skeleton and his skin hung loosely from his jaw. His eyes were sunken and dark, but they sparkled like reflectors. Most would probably know he was Wheeler, but he didn’t really look the same anymore. He would sit for hours gazing at some imaginary world of mystery that he talked about in broken whispers. His teeth were collecting stains, like a person who smokes too much, and his arms and legs had lost their vitality. He could barely stand anymore. He would reach out and pick at the air in front of him, talking to people and sometimes calling out, “Lift me up, please lift me up.”

One day Dad arrived. He walked into the room with a heavy presence. We were afraid of him. A direct beam of the setting sun shot through the window and reflected for one dazzling moment on the beveled edge of his glass as he raised his scotch-on-the-rocks to his lips. He was wearing a beautiful three-piece suit.
still smelling of cigar smoke from his afternoon meeting at the California Club. Dad was the personification of security and permanence to me. He looked at Wheeler on the bed, then glanced apprehensively at me. I could see how uncomfortable he was. To him death was a damnable and useless annoyance: it definitely lacked elegance, intrigue, or profit. Wheeler tried to lift his head up a little as he said, “I’m sorry Dad, I guess I am not doing very well.”

There was a silence, a disturbing uneasiness, and Dad said, “Oh don’t be ridiculous, you are going to be fine. Why don’t I get you a cocktail?”

I felt so sad for all of us in that moment of denial, yet because of my own fears and beliefs at the time, I was unable to intercede and help either Wheeler or Dad.

Contemporary Transpersonal Elements in Caring for the Dying

As mentioned earlier, rapid growth of technology has been a landmark of the twentieth century, and along with it new models of caring for the dying have emerged. Medical models based on elegant diagnostic techniques and sophisticated treatments solved many of the physical dilemmas of the dying patient, but did not address the human being as a whole. Psychosocial and spiritual needs of the dying, for example, went largely unrecognized until the hospice movement emerged, and, as Cicely Saunders once said, put “a human face on hard medicine.”

Hospice methodologies offered physical, emotional and, in most cases, spiritual support for the terminally ill who wanted an alternative to the prevailing medical model of aggressive treatment. Heretofore, certain transpersonal and transformative experiences accompanying the dying trajectory seemed to lie beyond understanding, could not be explained by existing Western models, and were more easily ignored by professional caregivers. With the growth of the hospice movement and the emergence of transpersonal studies, however, some of the transformative and transpersonal events such as deathbed visions, near-death experiences, and other transcendent states reported by dying people have begun to be studied and better understood in a more open environment.

Abraham Maslow was one of the first psychologists to explore and promote transpersonal psychology as a discrete branch of psychology. He believed that there were states of awareness in which a human being could transcend the ordinary limits of individual identity and experience. Maslow suggested that this dimension is reached by “getting out of your usual locality...away from time and space concerns” (quoted in Hoffman, 1996, p. 74). The dying trajectory seems to be one of the triggers which can induce transcendent states of consciousness and of time and space.

As death approaches, concepts of ordinary time and space seem to become less and less interesting to the dying. As a hospice nurse, many times I have observed dying patients drifting into a state of consciousness that seems somehow otherworldly — certainly their focus seems somewhere beyond the conventional time and space in which I function professionally. It is not uncommon to see a dying person suddenly rise up out of complete stillness, and with seeming surprise, reach upward with extended arms calling out and conversing with someone I don’t see. Though these visions are a common phenomenon, they remain an enigma to most observers, and are rarely discussed with the patients. Most caregivers accept these events as unknowable and beyond the limits of human understanding. Some of these events are felt by the heart, rather than seen by the eye (Schneider & Bernard, 1996). This is an area for inquiry wherein the transpersonal viewpoint can serve as a bridge between patients and caregivers by offering a broader understanding of human experience.

Exploring the transpersonal dimension of death and dying also encourages introspection as a complement to existing paradigms that rely solely on the manipulation and control of external factors, such as pain and certain psychosocial issues. The transpersonal dimension promotes an open-minded approach to evaluating the unusual events that can occur during the dying trajectory.
Rather than being limited to preexisting models and metaphors that might be incomplete or even outmoded, the transpersonal perspective acknowledges that some human experiences, whatever their ultimate explanation, may represent phenomena beyond existing conceptions of conventional science and medicine.

Patient and Caregiver Stress

The role of stress in caregiving is an important element in understanding the transpersonal dimension of hospice care and education. Caregivers and patients are often involved in an intimate and deeply meaningful journey as they experience the dying trajectory. It is ethically imperative that the caregiver have empathy, compassion, and understanding for any experience the patient might have. Beyond these considerations, lie broader issues of understanding. Experiencing the dying trajectory tends to open the mind to an expanded, more transpersonal view of reality, and one which can provide different, potentially more satisfactory explanations for loss and death. As well, the transpersonal view offers patients and caregivers alike the hopeful alternative that death may be a transition rather than ultimate destruction. This alternative view may help to reduce the stress experienced around death and dying.

The limits of conventional thinking can confine a person's ability to cope with the stress that is produced by the tenuous and uncertain circumstances of a dying trajectory. Studies show that those who have a more narrowly constructed view of reality (i.e., greater need for predictability, certainty, and control) are less able to cope with stress than those who have a broader view (Lehman, Ellard, & Wortman, 1986).

The correlation between different types of psychosocial stress and a person's physiological stability is also an area of psychoneuroimmunology that is now contributing to the contemporary arena of transpersonal elements in caring for the dying. This is because an individual may be better prepared to be receptive and open-minded about the transpersonal by being aware of the extraordinary capacity he or she has to influence internal balance and homeostasis through the mind-body connection. Psychological stress — highly correlated with reduced immune system function (can contribute to a person's susceptibility to disease as well as diminish the ability to function optimally (Booth & Ashbridge, 1993; Kemeny, 1994). Knowledge of the connections suggested by psychoneuroimmunology has led to an understanding of the important role coping strategies play in the physical well-being of both patients and caregivers as they sustain life in the face of death (Katz & Sidell, 1994; Kemeny, 1994).

Caregivers, too, are exposed to a number of stresses. One of the most common is a pervasive and intense fatigue that results from the work itself — a profound physical and emotional exhaustion that inexorably ensues for many who care for the dying. Another source of caregiver stress is maintaining the vigilance required to adequately meet the demands and needs of a constantly changing and uncertain situation. Studies show that the dying trajectory can be accompanied by a sense of isolation, sorrow, and depression for those involved (Alexander & Ritchie, 1990; Marquis, 1993), and this also augments the level of stress that accompanies death. The caregiver in a hospice setting faces the decline and ultimate death of every patient who is admitted. Many times the caregiver develops strong and important ties with certain patients and consequently experiences intense pain when such patients die. Caregivers often express many of the same feelings of denial, anger, and depression as the dying person. A family member in the caregiver role may have the additional burden of having to struggle with situations involving other family members.

As with dying patients, caregivers are also subject to the psychological distress caused by the deeply felt existential questions that death and dying can provoke. To better care for and understand a dying person, the caregiver must also evaluate his or her own attitudes, beliefs, and feelings about death (Rando, 1984, 1988). The professional hospice caregiver must adapt
to the reality of losing every patient to death; coping well with stress and remaining healthy are job requirements for professional hospice caregivers. Transpersonal practices and insights that enhance the cultivation of self-awareness can help the caregiver to develop the uniquely fulfilling ability to interact effectively with the dying and not to become physically exhausted or psychologically depressed.

Meditation and Visualization

*Meditation interrupts* the usual flow of tense, sometimes fearful thoughts that seem to habitually preoccupy the mind. Concentrating the mind by means of a meditation technique seems to diminish the number of random thoughts, as well as the attachment to those thoughts. Through a process of calming and focusing, meditation draws the mind away from the time and space concerns of daily life and related stresses into a more relaxed state. As the meditative mind rests free of its habitual thinking patterns, the whole body becomes more relaxed. In this state, the mind tends to be less susceptible to compulsive reactions and more receptive to insightful perceptions, and one is less governed by individual, self-protective colorations. The meditative state of mind thus seems to be especially conducive to apprehending the transpersonal dimension. The value of meditation for both patients and caregivers also lies in its capacity to produce serenity and peace of mind so that one can listen and hear better. Strength and confidence can be built from the inner clarity that arises during meditation. It is also apparent that when the mind is centered in meditation, the quiescence and receptivity engendered can evoke significant psychological and spiritual insights.

Another technique in caregiving with transpersonal implications is visualization, which usually involves the creation of a mental picture that is positive and self-affirming. Studies show that there are physiological and psychological changes that can accompany visualization (Dossey, 1995; Gringberg-Zylberbaum, & Ramos, 1988; Lehrer & Woolfolk, 1993; Zachariae, Kristensen, Hokland, Ellegaard, Metze, & Hokland, 1990). Sometimes participants in a dying trajectory may visualize the situation on their own within a framework that is characterized by anxiety or helplessness. But it is possible to replace self-defeating visualizations and their habitual patterns of behavior with positive self-affirming visualizations that cultivate a deeper and more meaningful appreciation of life and enable patients and caregivers to interact more effectively.

The technique of visualization emerged in Western medicine with a study of patients who had experienced spontaneous remission of their disease; all of them revealed that they firmly held a positive self-vision of wellness (DeSpelder & Strickland, 1996). Epstein (1989) has studied the healing effects of visualization on many conditions, including physical ones. He asserts that the fundamental value of visualization is its call to going “beyond the given, to the newness that we all are capable of, and to our capacity to renew and re-create” (quoted in Dienstfrey, 1991, p. 128).

Meditation and visualization are thus approaches to healing that may ease the dying trajectory for patients and caregivers. They are based on the assumption that the re-creation of one’s self and one’s world begins in the mind. As the Buddha taught, “We are what we think. All that we are arises with our thoughts. With our thoughts we make the world” (in Byrom, 1976, p. 3). Although not in themselves a cure for disease, thoughts can be effective in assisting the healing process of an individual. Healing, in this case, is “the title we give to the phenomenon of the mind and heart coming back into balance...The deepest healing seems to take us beyond identification with that which causes and experiences sickness” (Levine, 1982, p. 199).

New Models of Interacting with the Dying: The Life-Review, Prayer, and Comeditation

*Dying is* typically felt to be an ending. Someone will die, there will be loss, and something important will be gone. To this perceived finality of death, the transpersonal perspective, which offers a wider range of possible explanations about death and dying,
has begun to inspire some new models of interaction for patients and caregivers. New methods aim to cultivate an ongoing, mutual exchange that is both open-minded and nonjudgmental, and allow for a process of caring that enriches and deepens the meaning of life (Mayerhoff, 1990). The synergistic healing effect that can be produced by the positive and effective interaction of patient and caregiver is the focus of three of the newer methodologies, the life-review, prayer, and comeditation.

The life-review is a process wherein individuals recall and recast the events of their lives within the context of their current understanding (Waters, 1990). It has been suggested that the process of reviewing one's life is not only a naturally occurring activity but that, especially in later life, it is an essential psychosocial development (Rubenstein, 1995). By participating in a life-review an individual may make significant gains in the sense of life satisfaction and psychological wellbeing (Haight, 1992) including transpersonal insight. Levine (1997) calls the life-review a “feast for the heart” (p. 85).

The process of evaluation that occurs may also enable the dying to settle unresolved problems, especially in their relationships and misunderstandings with friends and loved ones, and to put some of these problems into perspective. For caregivers who sometimes need to find an appropriate way to relate to certain patients, the life-review can be a useful tool to use in opening a meaningful conversation that will be of benefit to both. By simply commenting on an object related to the patient, such as a picture or keepsake, a caregiver can initiate a conversation that may transport patients out of their anxiety and discomfort into another time and place in their lives.

The structured life-review can be initiated within a planned and sequential format, such as Erikson's theory of the stages of life from birth to old age (Olson, 1997; Waters, 1990) or Maslow's theory of self-actualization (Giltinan, 1990), or by asking a question such as: “If you had your life to live over again what would you do differently?” (DeGenova, 1992). The outcome of a sequentially planned life-review has been compared to the spontaneous life-review reported by near-death experiencers in that both types of life-review can be transformational, that is, they appear to increase insight and produce positive changes in the subject's sense of purpose in life (Holden & Guest, 1990). The caregiver can choose to assist the patient by introducing the life-review in either a structured or unstructured format. When appropriate, the family, too, can be of help, such as by providing photo albums or other mementos that can catalyze memories for the patient.

Throughout history, people have relied on prayer as a way to cope with trying circumstances. During the dying trajectory, prayer can provide comfort and consolation in the midst of the often disturbing changes that inevitably occur. Prayer can also provide a means of interaction that caregivers and patients can both participate in together. Scientific studies about prayer and its role in medicine and healthcare are increasing. Dossey (1993), in his book Healing Words: The Power of Prayer and the Practice of Medicine, reports on over a hundred scientifically performed studies providing evidence that prayer produces a significant effect. Prayer was investigated scientifically as early as the nineteenth century. The researcher who brought the concept of individual differences to bear on psychology, Francis Galton, explored the question of whether or not prayer affected the course of illness. Though his data contained little evidence to support the influence of prayer on disease, he advocated prayer as a means to make patients feel better (Forrest, 1974). Other researchers have studied the effects of prayer on the sick (Collipp, 1969; Joyce & Welldon, 1965), and though the studies, in general, have been considered to be flawed (Benor, 1990), the data seem to suggest that prayer has the potential to affect patients and caregivers positively (LeShan, 1974, 1989; McCullough, 1995; Schneider & Kastenbaum, 1993).

Whether scientifically validated or not, prayer is not only petition and repetition, but can evoke a transpersonal quality of consciousness and a tendency towards compassion, caring, empathy, and love. Prayer reaches out with a sacred attitude towards that

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which is beyond the confines of time and space. The relationship between prayer, well-being, and health continues to be a subject of empirical study (see McCullough, 1995) and some day research may yield more definitive understanding and applications.

Comeditation is an ancient Tibetan Buddhist form of meditation that focuses on the breath and involves the participation of two people (Boerstler & Kornfeld, 1996); it can be especially useful in caring for the dying. In comeditation, one person is the recipient and the other is the guide. To begin comeditation, the recipient lies as flat and straight as possible, while the guide prompts a progressive muscle relaxation procedure. Deep, slow breathing is maintained. When completely relaxed, the recipient and the guide together accompany each exhalation of the recipient with a soft word or sound such as one or “ah” that the recipient has previously chosen. Deeper into the exercise, only the guide makes the sound, while the recipient is silent and listens. Both the recipient and the guide reportedly experience feeling calmed and comforted by the meditation process.

Comeditation is shared breathing, or cross-breathing, and can be used by any two people. As the participants relax into the meditative state by breathing slowly and deeply, the relaxation response can produce such effects as reduced heart rate, respiration, temperature, blood pressure, anxiety, and stress (see Murphy & Donovan, 1988). Comeditation is a practical and effective method for interacting simply and compassionately with the dying, and can provide for the participants “an opportunity to bridge the aches and pains of physical infirmity to the awareness of peace” (Boerstler & Kornfeld, 1996, p. 43).

The need for more education and understanding about interacting with the dying is imperative. Methodologies that include the transpersonal dimension need to be further developed in order to allow patients and caregivers to participate in a reciprocal journey of exploration that may enable them to find suitable meaning and purpose in their lives. The transpersonal dimension is an important element of interacting with the dying because, as Liester (1996) states, “While our rational minds view life in ‘either-or’ terms, transpersonal experiences are of the ‘both-and’ genre. They view parts as components of a larger whole” (p. 9). By fostering greater unity between the caregiver and the patient, death can potentially become an extraordinary event not only for the dying person, but for caregivers as well.

Whether or not the transpersonal perspective is appropriate for all those on a dying trajectory, it can provide some tools and a framework for at least some patients and caregivers to face the existential fears and questions that so frequently arise during the dying trajectory.

Transpersonal Hospice Care and Education: Preparing for the Future

Traditional Western medicine, being disease-centered rather than patient-centered, tends to overlook death and the needs of the dying, and the hospitalized, terminally ill patient is often ignored or neglected by family members and caregivers who feel incompetent and afraid when faced with the dying and death.

The needs of the dying seem a dim consideration when busily active in the world. But when a friend or loved one becomes terminally ill, the dying trajectory is brought vividly to life. When this happens, knowledge about death and dying is needed, knowledge most have not acquired. I experienced this in the early 1970s in New York City, when a friend, whom I will call Branny, became terminally ill. As children, Branny and I had lived down the block from each other on Murfield Road in Los Angeles. Later, as debutantes, we had danced and partied together in elegant white dresses, but it wasn’t until she got very sick that I really got to know her.

She had been given a prognosis of “three months to live” by her oncologist at the Sloan-Kettering Cancer Institute in New York City. How or where she was supposed to do the dying was not discussed, but, for her, dying in the hospital was not a consideration. Deciding to
take the responsibility for setting up an at-home dying situation for Branny, a team formed. Three nurses, two doctors, and about 15 other friends worked out the details of arranging for her care and wellbeing. We experienced first-hand the difference between learning about death and dying from books and the actual experience of a dying trajectory. We had to devise many of the solutions to the dilemmas we encountered in Branny’s care as the situation unfolded.

It was the early 1970s, and Branny’s oncologist told us that he had never had a patient choose to die at home, and he was unable to direct us to any other dying-at-home resources. We had to solve the problems on our own, as they arose. A tranquil and peaceful environment was created in Branny’s apartment where she could visit with her children and friends and continue with her meditation practice. Weekly meetings kept the team coordinated and running smoothly. The biggest problem became Branny’s increasing level of pain, and the oncologist’s decreasing willingness to prescribe an adequate amount of pain medication. We had heard about Brompton’s solution, a mixture providing excellent pain relief for cancer patients in England. However, Brompton’s contained some ingredients, such as diamorphine (heroin) and cocaine, that were illegal for use in the United States. This was my first experience with the lack of death education in the medical field. Physicians treated the pain associated with terminal cancer in the same way that they treated any kind of pain — on a prescribed schedule and from an addiction prohibitive point of view. Knowledge about palliative care was a rarity.

There were no established hospices in New York then, and a general lack of understanding about the needs of the dying prevailed. Branny’s team had to find alternative methods outside her primary physician’s plan-of-care to meet her needs and control her excruciating pain. One of the physicians on the team calculated a very effective mixture of different drugs that when given together seemed to increase the pain control: an injection of Morphine, a rectal suppository of Compazine, one-half teaspoon of cocaine dissolved in a tablespoon of cognac sweetened with honey. Later, when the oncologist learned that it was costing upwards of $300 a week for the team to buy illegal “street” cocaine to use as a potentiator for Branny’s morphine injections, he finally prescribed pharmaceutical cocaine. This breakthrough event occurred on the day she died.

After Branny died, we all felt that our efforts to achieve a positive environment for Branny — one that met both her psychosocial and spiritual needs — had been successful. The great difficulty we experienced twenty years ago in obtaining sufficient pain control for her continues to be a problem for some patients and their physicians even today, except within healthcare environments that focus on patient-centered care, such as hospice. Fortunately, today the ideal hospice environment is considered to be one in which a dying person has the opportunity to experience death in a uniquely individual way, without physical pain, and with a surrounding sense of emotional, intellectual, and spiritual support.

The hospice movement arose to better address the needs of the dying and to focus on patient-centered rather than disease-centered care. Hospice instituted the multidisciplinary team approach, and an important hallmark of this patient-centered care is the development of an individualized care plan for every patient. Nurses, social workers, physicians, and other caregivers are among the team members; each contributes to the ongoing care of every patient. Much patient-centered hospice care is delivered directly in a patient’s home. From time to time, hospice caregivers visit to give guidance, direction, and assistance to the family and caregivers. Often the primary caregiver and others in the family have little or no experience in relating to, or caring for a dying person. Consequently, the hospice team is relied upon as the main source of information and support.

In the United States today, both the changing economic structure of healthcare and the increasing population of the elderly are causing an increase in the demand for patient-centered
hospice care. Hospice units are appearing more frequently in hospitals, and independent hospice homes have begun to emerge in communities. Staffed by professional caregivers, hospice units provide the hospice alternative to patients who do not have a caregiver. Some hospice units are specific clinical areas of the hospital that have been converted to a more comfortable and less institutional environment. Many of the hospice homes are converted single-family residences situated in community neighborhoods.

The demand for hospice homes and the professional caregivers needed to staff them is growing. The professional caregivers in these homes are with patients for eight to twelve hours a day and confront death as a full-time job. Have they been prepared to face death with an open mind and compassionate heart while accomplishing the other clinical requirements of their work? The patient-centered hospice care and education methodologies practiced in these homes will require innovation and flexibility to meet the evolving needs of both the patients and their professional caregivers effectively.

Caregiver Needs: Broadening the Circle of Concern

The aging population and the experiences of loss and death that accompany aging are on the rise. Consequently, more caregivers are being called upon to spend time with the terminally ill and relate to them. In order to adequately meet the psychosocial and spiritual needs of the dying, caregivers increasingly are being required to interact with a degree of skill and understanding that many have not learned in their training. A caregiver can be better prepared to interact effectively within a dying trajectory if he or she has: (a) an awareness of various personal death beliefs; and (b) knowledge about the transpersonal dimension of death and dying. Caregivers often have not received death education that encourages the development of either (Attig, 1992; Wass & Neimeyer, 1995).

During the 1980s and 1990s the hospice philosophy popularized by Kübler-Ross, Saunders, and others gained widespread public attention to death and dying and helped to promote some degree of death education in many schools throughout the United States. Today, counting all levels of general and specialty education, there are many schools that include at least some minor form of death education in the curriculum; however, most of the topics focus on the legal and economic issues involved in death. Courses that focus on concepts about the meaning of death, attitudes about death, or ways of coping with death are more scarce (Bennett, 1994).

Hospice typically provides broader death education to caregivers by offering volunteer training programs that include topics and exercises that usually address personal beliefs about death and dying. In such training, self-awareness about personal death beliefs can be encouraged in different ways. Participants begin to explore their own death anxiety so that they will be better able to interact with their hospice patients. Even in hospice training, however, relatively little is taught about the transpersonal dimension of death and dying although many of the experiences reported by the terminally ill are transpersonal in that they reach beyond individual identity to more transcendent states of consciousness.

In the hospital setting, many patients, families, and other caregivers view the registered nurse as their main source of information, support, empathy, and guidance, but professional duties often disallow the use of time to focus on psychosocial interactions with patients. Death and dying or terminal nursing care is rarely addressed; most hospitals make little mention of evaluating a nurse’s skill in enhancing end-of-life care either for patients or their families (Boyle, Tracey, & Benton, 1995; Zinner, 1992).

Some hospital nurses, such as those who work in intensive care, cardiac care, emergency, and oncology units, routinely encounter death. Yet even in these specialty units, the machinery of technology (e.g., intravenous lines, cardiac monitors, oxygen cannulas, suction machines, and drainage pumps) interposes a physical barrier between caregiver and patient. Here, no matter how guarded the patient’s condition is, the focus tends to remain on treatment and...
cure. The psychosocial and transpersonal elements of the dying trajectory are not likely to be addressed.

In the West, death education sometimes emerges as a direct response to the existence of new or changing cultural phenomena. For example, in the United States a rise in teenage suicide prompted the growth of suicide prevention courses in high schools (DeSpelder & Strickland, 1996). Television coverage of national tragedies such as the Oklahoma City bombing and the explosion of Trans World Airlines Flight 800 has brought death and dying into living rooms across the nation and can be instrumental in stimulating talk about mortality. Nevertheless, although proactive death education, prior to a loss, seems to be of vital importance in learning to adequately cope with death and dying, it is still the least developed form of death education (Aiken, 1991; Morgan, 1990).

For a variety of reasons, death education enhances a caregiver’s ability to interact with the dying. It provides an opportunity to develop understanding about the social structure of dying and the variations of beliefs within and among cultures. It also encourages open-mindedness by teaching ways in which a culture’s traditions create and reinforce personal attitudes and behaviors regarding death and bereavement; and death education can dispel death-talk taboos and reduce avoidance behaviors that cause uncomfortable and insensitive interactions with the dying.

Much of the quality of life of a terminally ill patient depends on the information base and psychosocial skills of the caregivers (Corless, Germino, & Pitman, 1995). Patients, family members and other caregivers rely upon the expertise of physicians and registered nurses for strategies in coping with death and dying; yet in these professions, just as in the general public, death education is often lacking or superficial. Death education in nursing and medical schools will provide physicians and nurses with more information about death and dying to enable them to be more knowledgeable, supportive, and understanding during a dying trajectory. Death education can also help to generate tolerance and cultivate empathy, which can strengthen the health care profession by fostering openness and effective communication between the two disciplines. Lack of communication impacts negatively upon patient-centered care (Duffy & Jackson, 1996).

As the aging population continues to grow, avoiding the dying will be less possible. Learning to communicate responsibly and effectively with a dying person, therefore, is becoming an educational imperative for more people, especially professional caregivers. The conspiracy of silence that surrounds the denial of death must give way to knowledge and acceptance if the needs of the dying and their caregivers are to be met adequately (Hall, 1993; Hawkins, 1990; Herzlich & Pierret, 1987; Webb, 1997). Caregivers today are especially being challenged to acknowledge two important elements in their communication with the dying. One is that their interactions with patients have consequences; the other is that their own understanding and self-awareness about personal death beliefs and fears determine the quality of their interactions with patients (Heaven & Maguire, 1996; Hoover, 1994; Hunt, 1992).

The subject of death can be incorporated into both general and professional education simply by identifying and exploring the death beliefs and values that students bring to school with them. Encouraging students to discuss their own fears and dilemmas may provoke their interest in more critical thinking and reveal to them how personal biases and assumptions can limit the ability to interact with people who are dying. Encouraging a biopsychosocial perspective (rather than adhering strictly to the biomedical framework) can provide a broader context within which to understand and cope with the difficult and painful issues that often accompany death and dying. Providing knowledge of the transpersonal dimension can assist patients and caregivers to interact more
effectively in situations that extend beyond the limits of individual identity and conventional thinking to encompass a broader range of consciousness and experience. In the appendix, we present an example of a transpersonally oriented death education course for professional caregivers.

The transpersonal dimension in hospice care and education may assist participants to view the dying trajectory within a framework of peace, acceptance, and mutual exploration, rather than one of confusion, denial, and closed-mindedness. The art of interacting with the dying, which often calls on caregivers and terminally ill patients to interact in extraordinary ways, requires an open mind that is at ease and unafraid of death. Designing hospice care and education that will assist caregivers and patients to communicate with an open mind at every level of interaction requires that the transpersonal dimension be included because it offers an expanded view of life and death as well as addressing experiences that sometimes are a part of the dying trajectory.

Including a transpersonal dimension in hospice care and education also offers an orientation that can also help integrate and develop different approaches in caring for the dying, as well as bringing to caregivers and patients alike a greater sensitivity and receptivity to the entire range of potential human experience. Currently there are several hospices that incorporate transpersonal approaches in their care and training programs. For example, the Zen Hospice Project in San Francisco has developed a program to teach its caregivers the fundamentals of hospice work within the broader context of meditative awareness. Here caregivers learn not only the practical skills needed to care for the terminally ill, but also a meditation technique intended to develop a “listening mind” — a quality which is of great benefit to the many patients who need to be heard. As well as institutions, there are outstanding teachers such as Stephen Levine (1987, 1989, 1997), Elisabeth Kübler-Ross (1969, 1975), Ram Dass (1991), and Sogyal Rinpoche (1992) who have richly contributed to the transpersonal understanding of death and dying in the West.

If the ideal environment for a hospice home is one that remains flexible and adaptable to change, then the caregivers who work there must also learn how to be flexible and adaptable to change. Though many professional caregivers are willing to be flexible, most do not know how. Just as in developing physical flexibility, emotional, mental, and spiritual adaptability require learning and practice over time. The more effort and care that is put into nurturing the professional caregivers, teaching them, by example, that a centered presence and open-minded listening are fundamental to the art of being a good caregiver, the more deeply they can learn to listen and hear what the patient has to teach them about dying. The caregiver who has the courage and compassion to actually stop for a moment, take a deep breath, and be with the dying person — sit down and actually listen to the dying person — is interacting effectively and meaningfully. Too often, the external world preoccupies the caregiver, the family, and the loved ones. As Morrie Schwartz (1996) wrote during his terminal illness:

There is a kind of secrecy about illness, and it hurts us all. It causes a person who is sick to feel isolated and miserable. But it also makes the person's family and friends feel disconnected from their loved ones. By trying to avoid talking about what is so important to them, each person feels not only fearful and guarded but alone. (p. 78)

A caregiver with presence and open-mindedness can be a source of great comfort to a dying person and the family. In my experience, most patients do not want to discuss worldly issues regarding life and death, rather they want a caregiver to sit quietly with them and wait and listen. Sometimes, within the opening that silence can bring, patients begin to discuss fears about death, and some may even tell stories related to an inner world — a world that is often filled with light and extraordinary experiences. For example, one of my most vivid recollections is an extraordinary event that occurred in Brentwood, California, while my brother lay dying in his home off Sunset Boulevard. It was unquestionably an urban area, though many eucalyptus trees grew along
the street below and provided a barrier to the sound of cars swishing by every few seconds. It was difficult for me to understand how my brother knew that owls would be his escorts — his companions — at the end of his long, terminal illness. But he kept saying that there were owls outside the window. And then, suddenly, the rest of us there started to hear the owls. They hooted every night outside the bedroom window. I heard them hooting when he died, and I heard them hooting as his body was being carried off into the night by the morticians. We continued to hear them throughout the remainder of that mournful, eerie night, and then soon after they were gone. The owls disappeared just as mysteriously as they had appeared. If my brother had not told me about the owls, I would have missed the reconnection altogether. And it was with the greatest wonder and appreciation that his grieving daughters heard me tell the story of the owls. It elicited a powerful sense of reconnection with their dead father, and they felt uplifted in recalling their hearing the owls themselves. Though an event such as this can be explained in different ways, its greatest importance lies in the fact that it brought joy and comfort to the bereaved. As Sharp (1996) says:

The mirror awaits us. She awaits our hand extended not in judgment of how she should die or what she should feel. She asks only for our opening hand and heart. We need do nothing, say nothing. We need only sit bedside and be naked with her. (p. 64)

It is part of the caregiver’s responsibility to be aware of the intrinsic value of what the patient is saying or experiencing. There is freedom in awareness; not only does it generate an openminded attitude in the caregiver, but it also opens the possibility that the caregiver might learn something from the patient. Many patients have transpersonal treasures of understanding buried deep within their own minds (Coberly & Shapiro, 1998). It is knowledge about the inner world that evolves during a dying trajectory. A dying person has the potential to bestow this gift on the receptive caregiver, thereby enhancing the caregiver’s understanding about death and the ability to interact with other dying people. Once caregivers become aware that the source of all their experience lies within their own minds, they may begin to recognize that they and their patients are already intimately interacting with each other in the transpersonal dimension.

### Confronting Mortality: A Doorway to the Transpersonal

Facing a dying patient brings a caregiver into a direct confrontation with his or her own fear of death. Being near death can catalyze the shattering realization that everything is impermanent. Recognizing that everyone will eventually die can cause a sense of deep uneasiness and fear. It is an apprehension that often disables effective interaction. As a nurse, I have sometimes found that in the presence of a dying person the trivialities of life lose importance and small talk becomes meaningless. “What am I supposed to say?” I ask myself, “Why do I feel so incompetent about communicating with this person?” Suddenly faced with fewer barriers to genuine interaction, rote habitual responses are no longer appropriate. The dying person seems somehow more “real” than I do, more “there.”

Many people say that they have never been so alive as at the time they are dying. Perhaps this is because at last the investigation of what is real has given their life meaning...The preoccupations of a lifetime no longer obstruct, filter, and dull the mystery. (Levine, 1982, p. 59)

If the dying person only evokes the caregiver’s own fear of death, meaningful interaction will be difficult. The patient needs to sense love, acceptance, and openness in the caregiver. To embody these attributes, it is important for caregivers to confront their own mortality by reflecting on death prior to facing a dying person.

Reflecting on death is a powerful experience. It tends to break the habitual thought pattern that life is permanent and change avoidable. Facing death strikes a fatal blow to the myth of certainty. It brings immediacy to the present moment and forces caregivers as well as
patients to look within and face and resolve deep existential issues. Michel de Montaigne (1958) remarked: "...in this last scene between ourselves and death, there is no more pretense" (p. 35). The dying are often ready to drop the masks they wore in "real" life and are open to new experiences. The aware patient and the aware caregiver can learn much during the dying trajectory. The process of self-evaluation and reflection precipitated by death awareness can give rise to a calm presence in the face of death: to being at peace with oneself and the environment at large (Hennezel, 1997). We look forward to the day when the dying trajectory can more commonly become a doorway to the transpersonal.

Let the mind be enlarged, according to its capacity, to the grandeur of the mysteries, and not the mysteries contracted to the narrowness of the mind.
—Francis Bacon

References

it were your last. New York: Bell Tower.
Appendix

A Model Death Education Course for Professional Caregivers

To begin depriving death of its greatest advantage over us...let us deprive death of its strangeness, let us frequent it, let us get used to it; let us have nothing more often in mind than death...We do not know where death awaits us: so let us wait for it everywhere. To practice death is to practice freedom.

—Michel de Montaigne
(Quoted in Sharp, 1996, p. 128)

The International Work Group on Death, Dying and Bereavement states:

Death, dying and bereavement are fundamental and pervasive aspects of the human experience. Individuals and societies can only achieve fullness of living by understanding and appreciating these realities. The absence of such understanding and appreciation may result in unnecessary suffering, loss of dignity, alienation, and diminished quality of living. Therefore, education about death, dying, and bereavement is an essential component of the educational process at all levels, both formal and informal. (Quoted in DeSpelder, Strickland, & Baughier, 1996, p. 1)*

Purpose:

To promote and encourage death awareness, including the transpersonal dimension, in professional caregivers who increasingly are required to interact in more meaningful ways with terminally ill patients. The shield of technology can no longer hide the burgeoning need for professional caregivers who, through learning to evaluate their own fears and beliefs about death, can learn to cultivate open-mindedness and compassion when interacting with the dying.

Objectives:

• To highlight the importance of death education as a preparation for living
• To explore old perspectives about death
• To discover new perspectives about death
• To reflect on death as a complex topic, encompassing many perspectives
• To increase the awareness of personal death beliefs
• To recognize how habitual assumptions about death and dying may hinder open-minded interaction
• To expand the connection between death and life
• To provide professional caregivers with specific applications that may be useful in their practice

Topics:

1. Death denial in a technological society


Discussion question: Life and loss: Why do we want to deny them?

2. The needs of the dying


Discussion question: If death is intrinsic to human experience, why do the needs of the dying often go unmet?

* A useful, broader statement of assumptions and principles concerning education about death, dying, and bereavement can be found in DeSpelder, Strickland, and Baughier (1996, pp. 1-6; reprinted from Death Studies, 16, 59-65).
3. Impermanence: The inevitability of change and death


Discussion question: If impermanence is the source of the sense of loss, what is the nature of renewal?

4. Transpersonal psychology and healthcare


Discussion question: In what ways have you personally experienced the transpersonal dimension in healthcare?

5. Transpersonal psychology: Caregiver applications


Discussion question: How would you apply the transpersonal dimension in caregiving?

6. The near-death experience


Discussion question: In what ways are healing, transformation, personal growth, and spiritual opening represented by the near-death experience?

7. The mind-body connection


Class project: Life/Death masks

8. Curing versus healing


Discussion question: How do you interpret Morrie’s advice, “Talk openly about your illness with those who’ll listen. It will help them cope with their own vulnerabilities as well as your own.”

9. Mind, meditation, and visualization


Discussion question: How can empathy and compassion be incorporated into the professional caregiver’s interactions with a patient?

10. Presentation of class projects


The class project will be a report about: (a) a transpersonal caregiver-patient situation in which you participated; or (b) a report that begins with this sentence: “Today is the last day of my life as a professional caregiver and I would like to be remembered for the way I interacted with my dying patients because I was able to...” The report will be handed in after it is presented orally to the class. You may use prose, poetry, or dialogue for your presentation.
Notes

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1. Observations presented in the first person derive from the first author's professional experience in caregiving.

There is no cure for birth and death save to enjoy the interval.
—George Santayana