The Journal of Process Oriented Psychology

Bodydreaming: Illness, Coma and Death Processes
At the Edge of Process Work

An historical perspective of symptom work
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Bodydreaming: Illness, Coma and Death Processes At the Edge of Process Work

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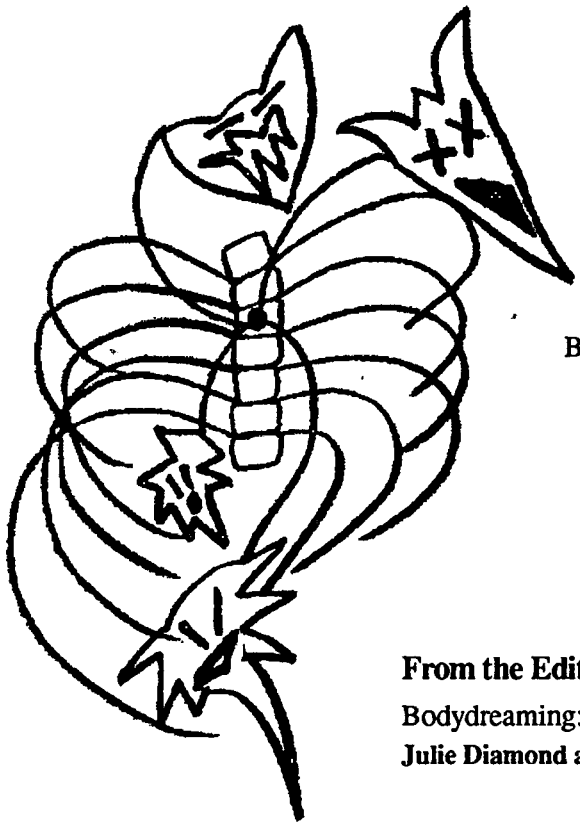

The Journal of Process Oriented Psychology Contents

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About the Cover Art

One day I was visited by a crow in the wilderness of Eastern Oregon. Crow's feathers glistened against the blue sky. Crow said, "You must never forget that you can dream and change shape. At death we all change shape."

I like the freedom of art to express everything, no matter how crazy or forbidden. Like music and dance, or nature itself, art celebrates the eternal spirit that is always free. My work has been strongly influenced by indigenous art from around the world, and by the struggle for human dignity. Gemma Summers

The Artist

Gemma Summers is originally from Sydney, Australia. She now lives in Portland, Oregon, where she works with individuals and groups. She is interested in the integration of politics, psychology, and spirituality, and is currently writing her dissertation on process-oriented conflict resolution. Art is an important aspect of her self-expression.

Submitting articles and art work

The journal welcomes articles on theory, research, and related areas of Process Work. We welcome articles on a variety of topics but preference will be given to those addressing the focus of the issue. Selection of articles is based on originality, significance of findings, contributions to theory, and clarity of presentation. Articles should be no longer than 10 pages. Format should be according to the Modern Language Association (MLA) stylesheet. Stylesheets may be requested from the Journal. Send articles to: **The Journal of Process Oriented Psychology**, Lao Tse Press, P.O. Box 40206, Portland, OR 97240-0206, U.S.A. All articles should be submitted in triplicate, double spaced and clearly printed. After the article is accepted we will request a computer file. No handwritten manuscripts will be accepted.All materials submitted for publication become the property of **The Journal of Process Oriented Psychology** and cannot be returned to the author. All ownership rights revert to the author after publication.

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From The Editors

Bodydreaming[1]: revolution in health care

by Julie Diamond and Kate Jobe

Billions of dollars worldwide are being spent on health care and healing. From these monies, at least in the United States and Europe, a larger and larger portion is being spent on alternative health care and healing. Although many conclusions can be drawn from this, no one can argue that consumer needs are shifting. But, in what way are they shifting? Is it toward a new model of wellness and health? Is it toward a more integrated system of personal, psychological and physical care? Is it the traditional doctor-patient relationship which is being called into question? These and other shifting tendencies are surely factors in explaining the rising interest in alternative health care.

This issue of *The Journal of Process Oriented Psychology* presents a new approach to health, healing, illness, coma and death. Depending on the reader's orientation towards health and healing, these ideas may be familiar or they may be hard to swallow. We invite you to have a look at the offerings in this issue, and see for yourself what appeals to you. Health, healing, symptoms, illness and death are some of, if not the, deepest parts of personal development and living. For most of us, our approach to illness and healing is a very personal and, in some ways, spiritual matter. We deeply respect these individual approaches and honor the choices people make, whether we choose to go to the neighborhood allopathic specialist or to the healers of Brazil. All of these choices may be process-oriented, depending on the attitude taken towards the illness and the person suffering, for attitudes rather than specific techniques or theories make a medical approach process-oriented.

A process-oriented attitude towards health and healing is essentially one where the concepts of good and bad health melt into the flow of human experience. Symptoms are seen as essential aspects of one's personality which are trying to express themselves using the only means available.

[1] The term "Bodydreaming" came from Arnold Mindell in a conversation on symptoms and concepts of health. Many of his ideas are reflected in this editorial.

In this model, "healthy" does not necessarily mean symptom free. Symptoms are a part of living that help inform us about ourselves. Have you ever noticed how strange the world gets when you have symptoms? Arnold Mindell noticed this tendency and started treating symptoms like "body dreams." He noticed that there are patterns in symptoms that directly reflect our lives, dreams, and relationships.

The goal of Process Work is not to eliminate symptoms. However, when the patterns and energy wrapped up in the symptom have had a chance to be expressed and lived, the patient often experiences some relief from the symptom, and symptoms have been known to disappear.

For some of us there are good things about thinking of ourselves or another person as sick. It gives us a way to categorize our experience of feeling rotten and relieves us of the chaos of not knowing what is going on. But there is a large problem with it, too: a power differential almost always occurs between the one who is "well" and the one who is "sick." There are many implied paternalistic, judgemental attitudes towards sickness, reflected in all aspects of our culture, from Judeo-Christian religion to New Age spirituality. These attitudes see the patient as having caused or deserved his or her malady. Additionally, sick people are often infantilized and robbed of their individual rights, as anyone who has spent time in a hospital can attest. Frequently they are merely pitied by the healthy. One of the strongest teachings of the Lava Rock Clinics, a series of bi-annual seminars initiated by Max Schuepbach and Arnold Mindell for people with chronic and terminal illness, is that when symptoms are approached as opportunities for growth instead of as instances of pathology, the person feels met and understood, and tends to blossom.

In this issue you will find a sampling of process-oriented research on symptoms. It is by no means a complete representation of all the excellent and pioneering work that has been done, but it is a cross section. There are articles on historical perspectives of process-oriented symptom work, death and dying, coma work, childhood dreams and chronic symptoms and the Lava Rock Clinics. In addition to research articles on symptoms, you will find at the end of the Journal a new section called *Expanding Horizons*. The Process Work community is a growing international group, and *The Journal of Process Oriented Psychology* has a vastly diverse readership. For this reason, we are including a new section that is not strictly research in Process Work, but a resource for our readers, offering new and/or cross-cultural perspectives. This section includes: an interview about living and dying with cancer; an article about psychotherapy in Slovakia which offers a perspective on practicing psychotherapy in a formerly Communist country, and an article which provides a history and overview of African thought. We hope that this section will continue as a means of broadening our world views.

You may notice that our name has changed. We are now called Lao Tse Press in honor of the sage upon whose wisdom Process Work builds.

Julie Diamond and Kate Jobe

November 1, 1993

The Role of Dreambody Concepts and Practice in the Development of Process Work: a personal memoir

by Joe Goodbread

Process Work emerged in Arnold Mindell's psychotherapeutic practice from a background of Jungian analysis sometime around 1973. Although much has been written about this emergence and what motivated it, I wish, from the perspective of some twenty years of Process Work, to look back on the initial structure of this emergence and how I believe it patterned the developments which have taken place in the following twenty years. I feel that this is a useful exercise because this evolution is still proceeding, and the pattern of its present development is very similar to the model established by Mindell at the very beginning.

The dreaming body

There are two events which Mindell cites as paradigmatic for his development of the dreambody concept. The first concerns a client of his who had just had surgery to remove a malignant tumor from his stomach. Although the tumor had been removed, he still insisted, in the altered state of consciousness immediately following his surgery, that he felt the tumor in his body. He began to strain and push from his abdomen. Mindell, committed to Jung's principle of expanding upon and amplifying his clients' perceptions, but fearing that his client would injure himself, invited him to follow his perception, first to continue to strain and push, but then to make an image of what was pressing in his belly. His client fantasized creating internal pressure until his belly exploded...and then recalled that he had dreamt of an exploding skyrocket. In the dream, he had known that if he could become a skyrocket himself, his cancer would be healed.

This takes place against a background of Mindell's attempt to work on an illness of his own using the tools of Jungian analysis. In particular, he had noticed the dreamlike quality of illness but had felt powerless to deal with it using the usual tools of dreamwork available to him.

One of these tools is the Jungian concept of amplification, in which personal associations and collective mythology are used to add flesh to the bones of particular dream images. Another is active imagination in which the dreamer attempts to continue the dreaming process by actively interacting with the elements of her dream. Both of these techniques were originally developed as a way of interacting with dream images. These images are typically personified as dream figures, behaving, as they do, much in the way of flesh-and-blood animate beings. Having a life of their own, they could walk and talk and serve as partners in conversational interaction.

Talking to body parts

Seeing these similarities between dreams and physical symptoms, Mindell attempted to work with symptoms as though they were dream processes.

His first attempt to interact with his symptoms on an experiential level was based on his knowledge

of active imagination. He tried visualizing the part of his body in which he experienced the symptom and then talked to that part. But an ailing body part, when addressed verbally, frequently responded in a voice which was already familiar. There seemed to be little that was new or unknown about these voices. They did not seem to fulfill Jung's notion that messages from the unconscious brought new, often startling information to light. Although it was clear that physical symptoms carried information from the unconscious, talking to the affected part was evidently not the best way of getting to it.

Lessons from a child

An important key to accessing the messages of the unconscious through the body came from Mindell's work with a six year old child who had been brought to him by the boy's parents. He had injured himself in a schoolyard fall. His scraped arm was healing, but he could not refrain from picking at the scab. Instead of scolding him and telling him not to pick, Mindell had the idea that the act of picking at the scab could itself be meaningful, and therefore encouraged the boy to do it even more vigorously. As the child picked, Mindell observed and noticed that his hand was formed into a kind of claw as it scratched and picked at the scab. He asked the boy to emphasize the claw-like nature of his hand even further, at which point he hunched his shoulders, wrinkled up his face and said, "I'm a witch!" Mindell thereupon began to interact with the child-as-witch, and found out that he had dreamt about a nasty witch that went around scratching little boys. From this emerged a story about how the boy had gotten in a fight with another child in the schoolyard, but a teacher had interrupted it, telling him that fighting was forbidden. The boy's obstreperous nature, repressed by a teacherly *Verbot*, had re-emerged in the form of the witch's hand scratching his injured arm, and in the dream.

The key to accessing the symptom's information was in observing the child's total interaction with his symptom, rather than in prescribing a particular method for working with it. Mindell's young client was amplifying the symptom on his own, through movement, by scratching open the old injury. It is unlikely that simply talking to the injured arm would have led to the clawed hand, the further scratching movement and the story of the witch.

This is something many of us do. When something hurts, we are seldom content to let it be, but probe and test the injured part to "see if it still hurts." One would think that if something hurt, we would do everything in our power to make sure it stopped hurting and would be grateful for any lapse in the pain. There is, paradoxically, often an urge to keep re-accessing the pain. Mindell saw in this phenomenon something quite similar to a dream: the body itself was dreaming in its own way, through movement and feeling instead of merely through images and sound. His notion of the dreambody emphasizes both the tendency of somatic experience to be mirrored in nighttime dreams and the dreamlike quality of somatic experience itself.

The channel idea

Symptoms seem to yield the most interesting and surprising information when amplified in the way they are perceived. It is this discovery that led to Mindell's notion of channels of process awareness. The meaning inherent in the disturbance is most easily accessed through the modality in which it is perceived. If I experience my symptom visually, as when I see the redness of a bloodshot eye, then it may be most productive to use visual accessing techniques and active imagination to interact with it. If I feel the symptom, like the itching of a skin rash, then amplifying it proprioceptively may yield the most rapid results.[1] If I perceive it as causing or influencing movement, as when an arthritic condition limits the motion of my shoulder, then movement may yield the most interesting information about that symptom.

These channels of perception are not freely interchangeable. Like different languages, each has its own structure and its own way of representing content. And while languages can often be translated one into another without losing the essential charac-

[1] Except of course, if it is *too* painful, in which case I may first need to work visually with it in order to be able to stand it at all.

ter of their messages, the information carried in various channels of perception cannot be freely translated without some loss of meaning. It is usually difficult, if not impossible, to verbally describe a pain, or a feeling of ecstasy in sufficient detail to be sure that someone else really feels it in the way that we do.

Perhaps more importantly, the very act of trying to describe a body feeling verbally takes us away from that feeling and back into the realm of language. Asking someone to describe a body feeling or talk to a body part may serve as a paradoxical intervention which immediately diverts them from the feeling and into hearing. Instead of amplifying the experience, it may have quite the opposite effect of driving it underground and rendering it even less accessible to our awareness.

Mindell's lesson from his young client showed one way out of the dilemma: to try to follow as closely as possible what the client himself is doing and to see this as an attempt to unfold his experience in the channel in which it is occurring. But this is a difficult task. Mainstream culture in North America and Northern Europe is not finely attuned to either feeling or movement; it is, rather, a verbal and vi sual culture. Given the choice of focusing on either the verbal/visual or the somatic part of an interaction, we will almost always choose the verbal. It will be automatically chosen; we will, in most cases, spontaneously repress the feeling and movement aspects of the experience in favor of speech and image. Furthermore, this tendency is typically true of both client and therapist, so that the therapist will tend to be inattentive to precisely those somatic signals which, for the client, may be the key to following the way of the unconscious.

Do we have to invent a whole new way of focusing our attention on the somatic part of experience and communications, or has this work perhaps been done for us, in some already existing system of concepts and perception?

The role of bodywork methods

There are whole systems of bodywork which focus on particular aspects of somatic experience. Hatha Yoga, in a sense one of the oldest of body "therapies," amplifies proprioception through the assumption of particular body postures, the asanas. There are asanas which are specific to various internal organs and which emphasize proprioception in many areas of the body. One of the more interesting features of yoga with respect to Process Work is the observation that people spontaneously recreate the asanas in their attempt to better feel their bodies. If the process worker can recognize an aspect of a particular asana in the client's posture, sometimes recommending that the client try a more complete version of that asana will lead to a dramatic amplification of the particular somatic experience that initiated the posture.

This is important for two reasons. In the first place, it suggests that many bodywork methods may have evolved through observation of the body's own attempts to amplify and complete experience on a somatic, rather than a cognitive level. In the second, it suggests that developed systems of body therapy may provide us with a rich vocabulary of patterns of somatic experience which we can then use as "templates" to enable us to differentiate a wide variety of otherwise similar-seeming experiential patterns.

Both of these aspects of Mindell's experience with bodywork were to form basic elements of his further development of Process Work in the areas of interpersonal relationships, coma work, extreme states of consciousness, group process and conflict resolution. They therefore merit a closer look, as they hold the key to maintaining the openness to new data which has been a mainstay of the process approach.

Why study bodywork?

Studying existing systems of bodywork has three benefits for the process worker:

1) It directly increases the process worker's somatic awareness by focusing awareness specifically on somatic channels.

2) It provides access to a vast body of technique through a huge number of ready-made patterns of somatic experience to serve as templates for amplifying somatic experience.

3) It keeps the process worker's viewpoint open by providing not one but a multitude of possible patterns for a given emergent experience. Some systems, by contrast, offer only a limited number of patterns as descriptions of clients' experience; this, in turn, limits the number of different sorts of phe-

nomena which the therapist perceives and tends to force the client's experience into a one-dimensional mold.

Three principles

Mindell abstracted three basic principles from Jungian psychology to deal with the dreamlike quality of somatic experience. These, in turn, form the groundwork for unfolding the dreamlike quality of any form of experience.

They are:

1) Spontaneous amplification points the way toward the unfolding of experience. "Following the process" means noticing the ways in which experience and behavior spontaneously unfold and helping them to unfold further in those directions.

2) Existing methods of bodywork and somatic mythology form a store of patterns useful in helping somatic experience to unfold more fully. The more details of a person's somatic experience we can gather, and the broader our knowledge of somatic experiential patterns, the more specific we can be in recommending a trial pattern as a momentary path for amplification of the somatic experience.

3) A knowledge of the field of bodywork and somatic mythology broadens the range of phenomena which it is possible for the process worker to perceive at all. Without a knowledge of the vast range of possible body experience, it is unlikely that the process worker will be able to differentiate more than a handful of distinct body experiences, and will therefore be less useful to the client in unfolding the breadth and depth of her somatic experience.

A conceptual leap

Since the days of the dreambody, the scope of Process Work has expanded to include a broad range of human experience. Process Work is now applied to people in extreme and altered states of consciousness, including near-death and comatose states and to collectivities of all sizes, from couples to large groups, organizations and even political systems, in addition to its role as a broad-spectrum form of psychotherapy. In all of these activities, the stamp of the original dreambody concept is clearly visible. In one sense, the theoretical framework suggested by Mindell's original explorations of the body still forms the conceptual core of the entirety of Process Work. And this has been done without a significant proliferation of core concepts! It seems that whatever principles Mindell established in his research of disturbing somatic experience are applicable to human experience in general, and that the "rule" for performing this generalization can also be abstracted from his original dreambody work.

The process paradigm

Although much has been written about the so-called "process paradigm," I would like to give you a version which captures, for me, its conceptual core. Although it would be inane to speak of "unexperienced experience," certain aspects of our experience are closer to our awareness than others. For example, we may be deeply engaged in conversation with someone but be unaware that we are tapping our fingers on our knee. Even if our conversational partner calls our attention to that fact, we are likely to note it and then slip back into conversation, while continuing to drum with our fingers. The experience of conversation is the one that we embrace. The experience of drumming with our fingers is, by comparison, largely disavowed. We experience it, but do not attend to it. We identify more with conversing than with drumming. The difference in the way we relate to these experiences is great enough to warrant making two categories of them:

1) Primary experience is that which we embrace, to which we attend and with which we identify.

2) Secondary experience is that from which our attention is easily diverted, with which we are reluctant to identify and which is generally disavowed as being foreign to some essential quality of our self-image or self-experience. When we are encouraged to attend to secondary aspects of our experience, we are generally reluctant to do so. If we are pushed further, all manner of behavioral incongruities arise, and we exhibit edge behavior. The word "edge" refers to the boundary of our self-experience, the world of experience which we embrace and preferentially attend to. Beyond the edge is the world of experience which we attend to only with difficulty, with which we are reluctant to identify and which we generally disavow as being foreign or threatening to us. Yet it is just this disavowed experience which, when embraced, we feel to be the

agent of personal growth. Seen from this angle, disturbance originates in experience which is disavowed but nevertheless present on the fringes of our awareness.

The lessons of dreambody work go even further. They tell us that experience is not only a state or an object but also a process. Disavowal of aspects of our experience tends to render that experience state-like, since it is then pruned of any spontaneous extensions which tend to develop. Process Work can be seen as a way of facilitating the spontaneous extension of experience by encouraging the unfolding of its disavowed aspects. Viewed in that light, experience may be seen as a dynamic whole which, through selective attention and disavowal of some of its aspects, is maintained as a relatively coherent, but limited and static whole.

Toward a science of experience

Dreambody work not only suggests this theoretical framework, it provides us with methods for performing the unfolding of disavowed experience which forms the core of Process Work. These methods are far more than a body of mere technique; they are nothing less than the seeds of a new science of experience.

Patterns of experience

There is no such thing as chaotic, or unstructured, experience. Experience is structured by specific patterns; experience in new or unfamiliar domains tends to be structured by related experience in familiar areas.

Before we are taught to recognize the constellations of stars which belong to our own cultural heritage, we may either perceive the heavens as a uniform cloud of randomly placed stars, or we may order them into patterns of our own invention which have no relationship to the "official" constellations which are a part of our cultural heritage. At a certain point, we are taught that a particular group of stars is called "Orion" and that they form the picture of a mythical hunter. Our perception of these stars then becomes structured by this knowledge, and we come to perceive them as an orderly whole, as a pattern which literally did not exist for us before we were taught to see it.

Our perception of the constellations is patterned by a cultural template. If we grow up in another culture which sees other constellations, then we will apply a different perceptual template to the same set of stars. Which constellations "really" exist? We cannot say; the existence of the constellations is a function of the cultural heritage of the observer.

The experiential realm of "constellations" has yet more to tell us about the nature of experience. It is possible, for instance, to have a particular realm of experience structured by more than one experiential template. If, in addition to recognizing the constellation of Orion, we are taught the names and appearances of its component stars, we now have two ways of experiencing the same bit of reality. At certain times, we may see the whole pattern and think, "That's Orion," or we may think, "Ah, that star there is named Betelgeuse, and that one, the bright one in his leg, is called Rigel." Finally, we may study the "archaeology of constellations" and find that certain cultures of antiquity assigned some of the stars of our Orion to one constellation, and others to yet another. We could study these "ancient" constellations and have still a third way of perceiving structure in the same group of stars. We would have three different experiential templates with which to structure the same bit of the universe.

As abstract as this may seem in the realm of constellations, a completely analogous phenomenon tends to structure our experience of human collectivities. We may perceive a certain group of people as "the family who lives down the street," and see them only as a unit. But should we happen to take an interest in them and learn their names, they become, in addition, a group of individuals. Meeting one of them on the street, I may either think of her as Jenny, a 12 year old schoolgirl, or as "one of that family." Same person, different experiences. In learning more about the family, I might learn that their father has been in prison, or that all the children are virtuoso musicians or that they are all refugees from the political regime on Haiti. These experiential templates will form a multiplicity of ways in which I perceive the reality of that family's existence. The more ways I have of viewing them, the more details of their everyday lives and history I have, the richer and more complex will become my perception of them, and the greater will be my

difficulty in stereotyping them to fit the needs of my own projections.

It seems that perception of an experience is conditioned by the totality of frameworks in which that experience is embedded. Frameworks for somatic experience in Western mainstream culture are rather limited. Proprioceptive experience is usually pretty well covered by patterns from categories like sexuality, eating, elimination and physical symptoms. And since many people view such experiences as taboo, or as pathological, perceptual templates have been mainly provided by the pornographers and the medical profession. This is one reason why people will often giggle and make jokes when the word "body" is mentioned; body experiences are largely disavowed in our culture and this leads to a paucity of templates for the structuring of somatic experience.

What is chaos?

If, as I have asserted, "truly chaotic," unstructured experience doesn't exist, then what is chaos? Chaos is a particular way of experiencing certain aspects of reality for which we have an unclear or limited pattern. Chaos is a description which people use when contemplating an emerging facet of their experience for which they do not have a clear conceptual structure, or for which their conceptual structure leads to something inordinately unpleasant or even disastrous. For this reason, for instance, many people are unwilling to contemplate their own deaths. Their experiential structure for death is essentially a disastrous world of half-imagined torture and suffering, or perhaps a simple cessation of being, which is itself a barely imaginable situation.

Truly unstructured experience is generally not perceived at all! There is a story, which I believe is told by Marshall McLuhan, but whose origins I have lost, in which a group of well-meaning film makers went to an economically disadvantaged country to develop materials for teaching hygiene to the people. They made a film showing proper handling of food, waste disposal procedures and the like, and showed their production to a group of the people for whom it was intended. They then asked the people what they had seen in the film. Several reported having seen a chicken. The film makers were dismayed, first because the viewers had evidently missed the message of the film, and secondly, because they had no memory of having filmed a chicken! Since the viewers insisted that they had seen a chicken, the film makers reviewed the film, seeing nothing, and then examined it frame-by-frame. Sure enough, they found a segment in which a rather blurred chicken ran through a corner of the frame. Why had the viewers seen the chicken, which had been invisible to the film makers, but missed the whole message of the film?

Film turns out to be highly structured by perceptual templates. We must learn the conventions of film in order to understand it at all. The termination of a scene, in which a person suddenly disappears from the screen, is without its match in everyday visual experience. People disappear into the distance, they go through doorways or around corners, but they do not simply vanish. The chicken, on the other hand, was without salience for the film makers, who were focused only on their educational goal. It therefore went unperceived.

When an experience lacks coherence or salience within a particular perceptual framework, it simply goes unnoticed. Another example comes from the realm of medicine. A radiologist, showing you a chest X-ray, will point out features and anomalies of the lungs in what looks to you like a completely unstructured grey blob. Or where a city-dweller sees the woods as "a lot of trees," a walk with a seasoned naturalist will open a wonderland of hundreds of diverse plants and animals living in a microcosm of interdependent unity.

This sort of experience is not disturbing; it is merely absent. The woods are not threatening if our experience of them is limited to "a bunch of trees." But what of the terrifying screech which resounds through the woods at dusk? What of the dark shadows that flutter about in a clearing, dimly seen in the last light of day? These things, in the absence of a conceptual framework for owls and bats as harmless (for humans, at least) denizens of the night, excite our fantasy and invite us to supply our own versions of horrid and frightening beings to complete these bits of new and relatively unstructured experience.

Experience as conceptual structure

Somatic experience is disturbing to the degree to which it is unstructured in our perception. We tend to impose a structure on disturbing experience

which is based on what we already know about similar experiences. The hard lump we find under our skin must be, in our thinking, cancer. We know all about cancer, the chances of it being cured, and where it will lead us if the cure fails. The "cancer experience" comes pre-structured with fears, hopes and expectations. It is already a "closed" experience in the sense that as soon as we discover it, it is devoid of mystery.

There are moments when this tendency to structure our experience breaks down. These occur in what we call altered states of consciousness. The story which I told earlier, of Mindell's patient who had just had surgery to remove a tumor from his stomach, experienced the continuing presence of the tumor in the strongly altered state of consciousness following his general anesthesia. He was relieved of his "normal" or consensus state of consciousness which would have supplied a linear, medical model for events surrounding his tumor and his operation.

There is quite a contrast between this experience and the "standard" experience of cancer. The stan dard experience is structured by appeal to common knowledge, as well as to one's inward experience (feeling the lump, the sensations associated with medical procedures, any pain or pressure associated with the tumor). In general, we are encouraged to pattern our experience according to the common fund of knowledge, be it common sense, medical science or the authority of cultural convention. Our inner, personal experience is considered peripheral to the cancer process, so that it is no longer even considered part of the medical diagnosis. This is true to the point that many cancer patients have no immediate experience of their disease apart from their fear of its progression and whatever medical interventions are performed on them.

The experience of Mindell's patient is structured, but in quite a different way. It is an "unfolding" experience. Each aspect of the experience evolves out of that which immediately precedes it. It is only marginally influenced by "common knowledge." The unfolding of this process is, however, not totally spontaneous. It is structured by the interaction between Mindell and the patient.

If the patient had been left on his own, it is likely that the experience would have remained on the level of his being tormented by the feeling in his belly. If he had interacted more strongly with that feeling, he might have wound up ripping out his stitches, with very little consciousness of why he had done so. Certain features of Mindell's attitude toward the patient's experience were instrumental in helping the patient unfold his experience into increased awareness and to render it coherent with the mainstream of his pre-cancer life story.

Dreambody work as the master pattern

Our desire to explore experience is founded upon a seeming impossibility, a contradiction. We wish to follow a person's experience into uncharted waters, into the unknown. But we have seen that where there are no charts, there is no experience. We simply do not perceive things for which we have no pre-existing conceptual model. Similarly, what we experience in a given situation can be drastically altered by what we expect to experience. To help others follow the trail of their own unfolding experience into unknown territory is to risk, on the one hand, imposing an arbitrary structure upon it, and on the other, being unable to perceive any structure to it at all, seeing it as purely chaotic. But to see someone else's experience as chaotic is to risk exposing them to the condemnation of mental illness and to throw them to the dogs of arbitrary psychiatric power. To profess to follow someone's experience is therefore a serious and delicate business which calls for a profound understanding of both the philosophical and practical problems on the part of the process worker.

It is here that a generalization of dreambody work shows us a way out of the dilemma. We cannot unfold truly unstructured experience, but we can use the principles of dreambody work to help disavowed experience to unfold in its own direction.

We apply the first principle, that experience tends to amplify itself, to avoid imposing, at the beginning, any outside structure on a person's evolving experience. We observe instead of prescribing.

We apply the second principle, that existing bodies of method and myth pertaining to specific modes of human experience have evolved out of just such detailed observations of experiential patterns, to provide us with a series of hypotheses for amplifying the unfolding experiential process. By having access to a vast variety of such patterns, we reduce

the risk of imposing a single pattern and forcing the experiential process into a one-dimensional mold.

We apply the third principle, that a knowledge of a large range of experiential patterns is necessary to keep the therapist's perception open, to open ourselves to the greatest possible variety of human experience and behavior in order that we may remain empathetic and curious about the world unfolding before us. Otherwise, we run the risk of setting experiential and behavioral norms, along with the judgements of pathology which always form the shadow side of normative psychology.

With these three principles alone, I believe it is possible to extend Process Work as a general science of human experience. Much of the research that remains to be done in Process Work is research on patterns of experience. Almost any sphere of human endeavor would benefit from such research.

Human experience and the future of Process Work

Many questions remain unanswered. We know, for instance, that particular experiential patterns seem to be purely individual, yet there also seem to be recurring patterns which repeat in many places, throughout history. Were it not for these typical patterns, we would have nothing with which to amplify individual experience. As important as the elucidation of the relationship between individual and shared experience is for psychotherapy and work with physical symptoms, it assumes staggering importance in the area of conflict resolution and relationship between individuals and groups with widely differing world views.

Other questions arise in the field of psychiatry. Much psychiatric diagnosis is based on the evaluation of an individual's experience by reference to consensus experience and behavior. A broadening of our view of the experiential basis of behavior may be essential if we are to avoid using psychiatry as a way of artificially imposing mainstream values on humanity as a whole.

The world's biological community is presently engaged in the Human Genome Project, which has as its goal to completely map the human genetic code. It is tempting to dream about a similar project whose goal would be to amass an encyclopedia of human experiential patterns from historical, cultural and individual perspectives. Perhaps then we would begin to understand what an awesome project it is to be truly human.

Joe Goodbread, Ph.D., practices and teaches Process Work in Portland, Oregon and throughout the world. He is the author of *The Dreambody Toolkit* and numerous articles and manuscripts on various aspects of Process Work.

At the Heart of the Lava Rock Clinic: conversations with Max Schüpbach and Arny Mindell

by Salome Schwarz

On the Oregon coast where the mist curls around the cliffs and the waves play with the shore relentlessly, Max Schüpbach, Arny Mindell and a team of process workers facilitate the Lava Rock Clinic, where people can discover the mysterious meaning and creative process behind illness. Since 1990, a group of about a hundred people has come together twice a year. In this community atmosphere, which supports even the wildest, weirdest and most beautiful aspects of their natures, people explore how body symptoms invite them to live their wholeness, go beyond pain, transform themselves and inspire change in the environment.

The Lava Rock clinic is open to everyone. Many people with illnesses, medical practitioners, therapists and students of life attend. While the program is constantly changing to accommodate diverse needs, a typical day at the clinic might proceed as follows. In the morning, either Max or Arny[1] works with someone on a body symptom. They interview the person and help unfold the experience of the symptom. In the afternoon, people meet in small groups with trainers and assistants for personal work and exercises. In the early evening, Max and Arny offer supervision where therapists, clients and small groups get help with their processes and everyone can learn together. Participants also have individual therapy sessions, and a medical doctor and sometimes a Chinese medical practitioner are present throughout the clinic. Visiting practitioners give presentations in the evening, and a trained staff is available for help 24 hours a day.

The clinic has generated an interdisciplinary and international network of people interested in researching process-oriented approaches to illness. Individual cases are discussed via an electronic mail conference. There is also a participant newsletter which offers opportunities for people to share their personal experiences.

What has touched me most at these clinics is how the static mechanistic idea of the body melts under the minute attention given to a person and her physical experiences. Meeting with the impossible and facing untenable body processes can be excruciating, especially for our normal identities, but it can facilitate an expanded sense of who we are.

The following are interviews with Max Schüpbach and Arny Mindell, the founders and facilitators of the clinic. The interview with Max focuses on current issues at the clinic, while the interview with Arny focuses on the process of working with body problems and illness. Gemma Summers accompanied me in the interview with Arny, and I appreciate

[1] I will call them Max and Arny in the informal spirit of the interview.

her presence and ideas. I'm grateful to both Arny and Max for sharing their thoughts and inspirations and for undertaking the unique project of the Lava Rock Clinic.

A conversation with Max Schüpbach

Salome: Why did you start the clinic? Was there a dream?

Max: We wanted to start a clinic for a long time. I got impatient with the fact that there was no building. I thought, "How can we have the clinic before we have the building?" But we did!

Salome: What do you mean by "clinic?"

Max: I always wanted and hoped for a community setting to do ongoing work with people's body symptoms.

Salome: I remember you once said that the clinic is a democratic clinic which is based on people's needs and not on outer structures.

Max: The idea of a democratic clinic is important. My experiences working in different places around the world were also important. I saw people having great experiences working on their symptoms in seminars, but when I came back, people said that it was very hard to keep the experience alive without ongoing support. Many people return to the clinic, so it is a community event where people get ongoing support.

In the past, we thought that personal processes were the main issue behind disease. Now, in connection with Worldwork, we're seeing that social issues have a bigger influence on health than we were aware of. You can't really sustain the healing of an individual without addressing the community level. You can make changes but many symptoms are so connected to collective consciousness that you can't work on them by yourself. Of course you can, but in a way you shouldn't be able to.

Salome: So it's not only important for people to have a supportive community, but also for a community to deal with the processes of people who are sick?

Max: Right. It isn't always the case that being part of a community is better for people who are sick, but it can be necessary because the issues they are dealing with are community issues. They have to be worked on in a community. To work with an individual as "sick" is as antiquated as the idea that if somebody has a liver symptom, you deal only with the liver.

Another point is that hospitals and clinics themselves are relatively new. Hospitals and clinics were cultivated in China in the beginning of Buddhist practice. I was attracted by the Buddhist idea that if you meet somebody who is in need, this person becomes your responsibility and is part of your Tao. If you meet somebody with a symptom then you are, in a larger sense, responsible for it. My friend Kanitta, a psychotherapist in Thailand, ran into an abandoned child one morning on her way to the hospital where she works, so she adopted it. That makes my heart sing.

Salome: What have you learned personally by taking responsibility for running the clinic?

Max: The clinic has been a major learning in terms of my personal growth. Working together with a team and also being in a position of responsibility and eldership has been a huge challenge for me. I go back and forth between being an elder, a teenager and a baby. I try to support all of us who work at the clinic as a team and I try to make the benefit of the clinic my first priority. I've been swept around by the complexities of such an enormous project and have cursed it at times, but I'm very grateful for my learning. It has been a wonderful and powerful process. And working with Arny is the icing on the cake!

Salome: It's beautiful to see you think so much about the whole. From my experience with the low-income clinic in Portland, I know something about the struggle of growing into eldership.

Max: I get screwed up a lot too, but it's getting better. I have a leadership position in the clinic and yet I work within a team of peers. This is something I have not had much experience with and I haven't seen many models for this.

Salome: What about the connection between symptoms and Worldwork? What are the advantages and disadvantages of doing group process?[2]

Max: We've been experimenting with this idea for a while — that we need to bring in group process at the clinic. We have already done this in a way, but it needs further research. We're getting feedback

from participants who say that they want more group process, and then we get feedback from other participants who say that they don't want group process. In general, you can say that the more physically well you are, the more interested you are in group process. The more physically weak you are and the more serious your disease gets, the harder it is on the body to stay in conflicting atmospheres for extended periods of time.

My hope and vision is that more political action will come out of the clinic. I see us creating social activism groups for the issues that come up, so those who are interested can go ahead and address these issues in the world.

Salome: Have you thought about someone dying at the clinic?

Max: Sure. There are several issues here. First, what can we do in terms of medical support? From my own medical background, I feel that the biggest ally in regard to the safety of a person is humility, being aware of your limitations. Up to this point at least, we know that it is not possible, in terms of finances and staff, to have a medical safety net. We do have doctors, and together with the patients we try to figure out how severe each person's state is. We know that people could go into crisis or need an intensive care unit. It's possible to get somebody to a Portland hospital in less than an hour using a helicopter. In an ambulance it's less than an hour to a Newport or Florence hospital.

Other than that, we hope that the clinic will be a place where you can die. One idea is to connect the clinic with a hospice. There seems to be a need for that. You hear some participants say, "I nearly died, but I wanted to make it to the next Lava Rock clinic." Tom Hammond, who died a week or two after a clinic, said this. From what participants say about the contact that happens between them, this makes sense.

If someone died at the clinic that would be a good place to die. One thing that impressed me was when a client with an aneurysm, his therapist and Arny openly discussed their feelings about this. The therapist wanted a helicopter, the patient wanted the freedom to go for a walk on the beach and die there, the medical doctor gave various medical options, and Arny facilitated the whole process. People should be able to make their own decisions about how to deal with a particular situation.

Salome: It also seems important that the dying process is part of community life.

Max: There are some good books on the tribal life of Aborigines in Australia and of !Kung Bush People in Africa. Many of these people live in a way which reminds me of an ongoing symptoms clinic or Worldwork seminar. The way our communities are organized isn't tribal but some aspects resemble tribal life. In most tribes, birth and death have a naturally established place and people attend to them as they happen. For example, a group of the !Kung were running out of water. At one point, a few of the older people couldn't take it anymore and the tribe knew that as the group moved on, the older ones would stay back and die. Everybody knew that it was normal to die, so the group said good-bye and left the older people behind. For one reason or another, it rained that night and the next day the older people caught up again. Everybody was happy about that and they went on together.

The idea that death and dying are repressed in white Western society is well known. Focusing on the process of death has re-emerged through the work of Kubler-Ross and others who have increased general awareness of the dying process. The more this awareness happens in the clinic, the better.

Salome: What is your relationship to death?

Max: If it will come, it will come, but it ain't over until it's over. That's my viewpoint this morning. I thought I was dying a couple of years ago when I was in a car accident. I was amazed at the lack of drama in me when I thought I was dying while my car turned over! From working with dying people, I know that death is a powerful transformation pro cess filled with awe.

[2] Seminars generally include a time when the group focuses on itself as a whole; this attention to the group atmosphere is what is meant by "group process."

Salome: At the clinic, people find themselves having experiences as learners, patients, teachers and healers. Why do you focus on training in a clinic on illness?

Max: These are incredible questions because many of them are posed in the feedback we get from participants. I think that for many people it's just fun to learn. Aside from that, it's a reflection of the holistic idea that you cannot be sick without being a healer. The moment you become a patient you also become a healer. It isn't possible to be only a patient or a healer. Many people who are famous for studying particular diseases get the diseases themselves and die from them. Other people get a disease and then become healers. So if you want to work with disease, you have to train the healer in the patient.

Also, in death and dying many people become identified with being students or teachers. The teacher often comes forward strongly. We see again and again when we work with people on serious illnesses that the illnesses carry important messages. It's the fate of the carrier of these messages to bring them to us. So it's important to have training as a part of the clinic. However, we realize that training isn't a priority for everybody, and we try to create diverse opportunities for people to find what they need.

Salome: Do you have interests in terms of research?

Max: I would like to learn more about the connections between abuse, disease and social change. I'm also interested in the connections between allopathic medicine and other medical systems. It's a big research project to combine these different systems so they can work together, for the benefit of each other, in ways that allow us to follow people's needs. We're just in the beginning of understanding this interface.

We are also studying how particular diagnoses are connected to childhood dreams and contents of dreams. We hope to learn what kinds of symptoms are connected with particular processes, and how they connect to cultural and political life. At this point, we're just about sure that such a connection exists for breast cancer. In our opinion, many processes around breast cancer connect with the issue of being able to live a part of yourself that is tougher, knottier and less soft. If this is true, we can theorize about how individual processes and illnesses are connected to the zeitgeist. We don't know enough about this kind of epidemiological background of diseases.

Salome: If Process Work comes up with correlations between illness and certain processes, is there a danger that this will affect one's ability to follow an individual's process?

Max: I'm optimistic about this. There is the master of the tonal and the master of the nagual.[3] No matter what you study, there are people who are at home with the nagual and who want to follow the unknown, and people who by temperament and nature are more interested in following the tonal and in creating systems around it. We find these tendencies everywhere, even in process workers. Both inclinations are useful and should be supported.

Salome: Have there been any surprises while developing the clinic?

Max: The biggest surprise is to see the ecstasy, humor and detachment that is present when you go deeply into the processes of people who are dying. It is a privilege to go deeply into the experiences of disease. This is a politically incorrect thing to say because it is a privilege to have a healthy body, but, in terms of personal development, a disease can be an incredible opportunity. One of the reasons people are afraid of death and illness is because they are not aware of the incredible process in the background.

Salome: One final question: do you have a wish for the Lava Rock clinic?

[3] The terms "nagual" and "tonal" are used by the Yaqui Indian Don Juan as described in Carlos Castaneda's many books, especially in *Tales of Power* (New York: Simon and Schuster, 1974). Applied to Process Work, Mindell defines "tonal" as the doings of everyday life, the primary process. The "nagual" is the not-doings within the tonal, the secondary process (Mindell and Mindell, Don Juan seminar, 1992).

Max: Material ones! I'd like it if we could be financially sound. In the United States, at this point, being sick means being poor for many people. Half of our participants in the upcoming clinic will attend on scholarships. We would like to give them even more help, especially with travel, housing and ongoing therapy after the clinic. The staff works for minimal salaries. I hope to change this eventually. I also wish for our own seminar room, and it would be great to have a house which we could use as a hospice.

A conversation with Arny Mindell

Salome: Is there anything you'd like to say first?

Arny: The basic question of the clinic is,"What is life about?" Everyone involved in the clinic has to face the question of why we are here. I pose the question without answering it because people have their own answers. And people must answer this question, because whether they answer it consciously or unconsciously, it determines how they work with others.

Salome: How do you answer it?

Arny: In the context of the clinic, life is about discovering what nature is asking of people through their physical experiences. I'm concerned with helping people make sense of their experiences and to use them. My primary goal is not to heal people. While I am interested in healing, my primary goal is to make life so worthwhile that healing becomes irrelevant. I want to make life so wonderful, crazy and magnificent that the pain becomes irrelevant, and even if you still have pain, it becomes something amazing. We succeed every now and then in making this happen. That's why we see so many extreme experiences in the clinic.

Salome: What do you mean by extreme experiences?

Arny: Extreme experiences are experiences which are beyond a person's greatest dreams. They are beyond what people ever thought they could be. Getting in touch with such peak experiences is why I love being at the clinic.

Salome: What interests you right now in terms of body symptoms?

Arny: I'm interested in how your body doesn't belong to you and how many of your experiences are dreamt up.[4] They belong to the culture or are dreamt up by some other force. The happiest person is a woman or a man who knows that body experiences are only partially his or hers. They are yours to facilitate, and in this sense are like a group process where you facilitate what's trying to happen in the field. But you can't do much about your deepest body experiences. You can only adjust to them as the Tao. That's what fascinates me. It's a central issue for me.

Gemma: Do you mean that your body belongs to the larger field?

Arny: The body belongs to nature and is part of the evolution of the species. For better or worse, my job is to adjust to it.

Salome: This implies a connection between symptoms and Worldwork.

Arny: It's all the same thing, whether you're working with symptoms or Worldwork. The focus is to find the Tao and bring it down to earth. It's making the background field, energy, symbols and physical experiences realizable for people.

That's why it's possible for me to write so many books.[5] I'm not doing anything, in a certain sense. I'm doing the same thing all the time. I'm learning how to open up my own mind so that my virtual reality is other people's worlds. Then I can help them unfold their worlds. But I can't do that if my mind is closed. So a big part of my work is inner work, opening myself up to what's happening so that I can work with it.

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[4] See Arnold Mindell, *River's Way* (London: Routledge and Kegan Paul, 1985): 48-50 and Goodbread, "Dreaming Up Reality" Unpublished, 1989.

[5] Two of Mindell's books are especially relevant to working with body symptoms, comatose states and dying: *Working with the Dreaming Body* (New York: Viking-Penguin-Arkana, 1986) and *Coma: Door to Awakening* (London: Boston, MA: Shambhala, 1989).

Salome: How do you do that?

Arny: I notice when I don't understand something and when I feel uncomfortable. Then, I work on myself. I ask myself, "Why is it that I'm uncomfortable with this person? Where do I have to grow with this client? Where am I blocking out their reality?" I study myself first and then I study the client. For me, growing means opening up to the empirical world around us.

Salome: To open up continuously reminds me of shamanism.

Arny: Shamans open up to the spirit world. They're not necessarily opening up to ordinary reality. They may go into altered states to see what's behind that reality, but for me reality itself is a manifestation of the divine. Similarly, the Australian Aborigines see the real world as God and as the proof that God exists.

Salome: When you work with body symptoms, is it really spiritual work?

Arny: Working with people is a deep meditation for me, in which something in me dies and something else opens up to what's happening. I'm carried in the process by being open and empty at times. That's why I love working with people.

Gemma: When you talk about being open to everyday reality, it sounds like a form of diversity work. You are open to diversity in the everyday world, as opposed to being open to diversity in a "oneness" kind of way.

Arny: That's right. The focus is on experiences which are different than me and on allowing differences to happen.

Salome: What are your thoughts about working with people in the clinic who are close to dying?

Arny: I think about the clinic as a place for living your life and living your dying. It's possible that someone might choose to die there, but it's unusual for people to die while we are working with them because people who come to the clinic are usually interested in living their experiences. The only time someone died in my presence is when we worked on the issue of death and the person wanted to die. They were ready to die, so I supported them. People have died in my arms, but no one has ever just died.

I think about death, but it's not a big issue for me whether someone dies or not. At the clinic I'm more concerned with the people who are learning Process Work. Sometimes they aren't aware of subtle things, for example, that older people have brittle bones. Before you do anything energetic you need to ask people about their hearts and backs and other things, and find out if they are strong enough. People sometimes don't ask enough questions in regard to illnesses, although the clinic is there to train them in that.

Salome: Would you like to do more with training?

Arny: Yes. One aspect of training is really about inner work. In dealing with near death situations people have to clear up their resistances to death. People freak out when someone is about to die. Many of us resist the process of death. If that resistance were removed, people would be more detached and happy about death. They could notice it was time to die. It is easier for a person to die if the therapist supports this process and thinks that dying can be a good experience. In terms of relationship, it is always a sad experience when someone leaves the house, so to speak, but the more developed the therapist, the easier the client feels about death. On the other hand, the more the client accepts her process, the more the therapist can. We try to train people in this area, but we can't make them feel at ease with it. Accepting death requires inner work.

My hope for the clinic is that our work goes beyond the present paradigm of healing. "Do you feel better?" is an important question, but I want to go beyond feeling better. I want to help people enjoy themselves. Are you enjoying your life? Is your life weird and exciting, awesome and strange? Are you thrilled when you wake up in the morning with your symptoms? I want people to be totally alive in life and death. That's what I'm interested in and what I hope for both the Lava Rock and Extreme States clinics.[6] Both of these clinics should provide

[6] The Extreme States Clinic was developed by Arnold Mindell, Ph.D., George Mecouch, D.O., and Joseph Goodbread,

an opportunity to go beyond the traditional paradigm of psychology which distinguishes experiences as normal or abnormal, as healthy or pathological. Of course pathology is the great shadow smoking its fumes in the background, looking in on us and asking us if we can actually heal anybody. This question is also good because it makes us try hard.

Salome: How do people go beyond the healing paradigm?

Arny: It happens when we work with people and also, when the whole community gets inspired. The clinic has a social responsibility in this way. However, the clinic is only a few years old and hasn't been able to pick up much social responsibility yet. But its social responsibility is to make information about working with body symptoms available to the outside world. It should be on Cable New Network (CNN). Imagine if everybody in the United States watched CNN and said, "Wow. You mean the pain in my chest is this incredible power trying to come through me? My prostate cancer is really the sensuality I never had? Oh, I must turn the TV off right now and work on myself." That's the direction I want to take and see the project go in. We'll connect to the media when the time is right.

Gemma: I saw a report on the news that African Americans have twice as much heart disease as white Americans and that the treatment they get from doctors isn't as good. It made me really mad. Racism wasn't mentioned once in the whole report. Nothing was stated about the obvious.

Arny: This requires social action and refers to the fact that global problems influence body problems. Thus, to really do something about body problems and illnesses, society needs to change. That would be preventative medicine. So one aspect of the clinic is getting information out to the public, and another one is facilitating public change so that the stresses and strains on people are relieved. Mainstream conventionality, rigidity and lack of diversity screws us all up. Everything that's diverse in us, everything that's unusual, creative, fascinating and wonderful is at stake. We repress most of these experiences because of Christianity, Judaism, and other religions and belief systems.

Another interesting quest for me is to wake people up to the experiences of wellness and illness as they happen in a given moment. You can feel yourself getting ill when you can't accept what's happening to you and you start to repress it. I want to focus more on inner work which makes people aware of this. For example, I notice that in this moment I'm getting sick because of how I behave toward myself and the environment. Now the environment is making me ill, and what can I do to change it? The body is an antenna for yourself and the environment.

Salome: Your focus on minute sensations is touching and inspiring. Is there anything else you would like to say?

Arny: An alternative clinic for working with body symptoms and extreme states is actually a very unusual establishment! But it's not a clinic in the usual sense. The word "clinic" is an adaption to where people think they are at. It would be better to call it womb or birth. The clinic is a huge being giving birth to all these little dreambodies.

Arny Mindell, Ph.D., analyst and founder of Process Work, is author of 12 books. He is a former training analyst at the Jung Institute in Zürich and has been a resident scholar at Esalen Institute. He conducts seminars throughout the world and teaches at the Process Work Center of Portland and the Research Society for Process Oriented Psychology in Zürich. He works with large group conflicts, diversity and social change, and is co-leader of the Lava Rock and Extreme States clinics.

Max Schüpbach, Ph.D., is a co-founder of the Process Work Centers of Zürich, Switzerland, and Portland, OR. He works half the year in his private practice in Portland and travels worldwide teaching Process Work. He is the originator of the Lava Rock Clinic which he leads with Arny Mindell. The Lava Rock Clinic combines Process Work with

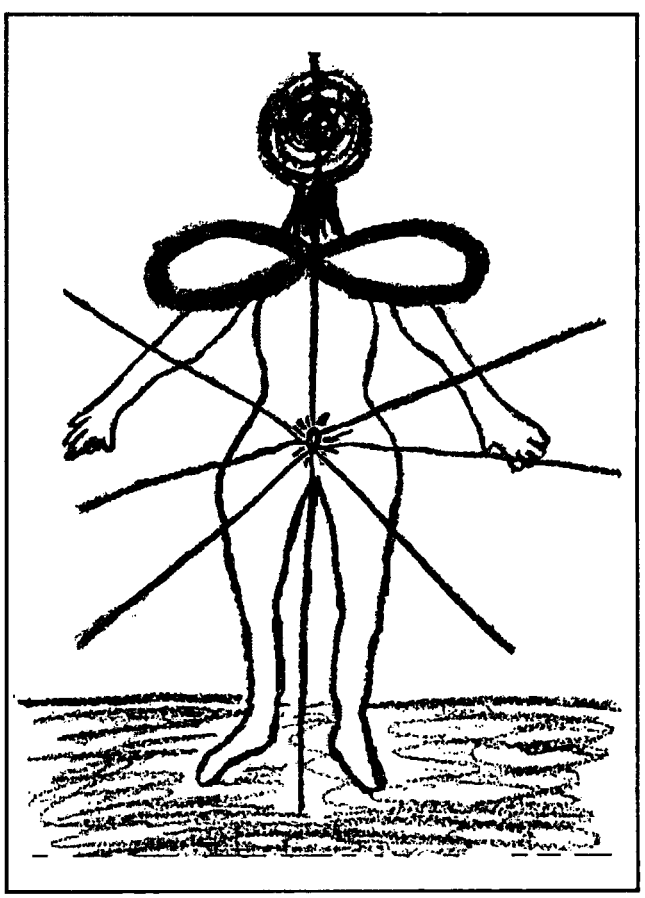
Ph.D. The clinic works with people in extreme states of consciousness, explores the meaning of these states, and trains people to work with extreme and altered states of consciousness.

psychosomatic medicine, allopathic and naturopathic medicine and community building.

Salome Schwarz, Ph.D. candidate, and Certified Process Worker, is a therapist, program developer and co-founder of Portland Health Services, a therapy clinic for people with low incomes. She co-facilitates workshops in various places in the world. She is currently writing a dissertation on living with irrational impulses, non-ordinary experiences and hidden forces in the atmosphere and their significance for therapeutic work and community development.

Symptom Art

The pictures which appear on various pages in this issue of the Journal were done by individuals working on their physical symptoms. The original art is in crayon on newsprint. The art has been published anonymously to protect the individuals' privacy. Thanks to everyone who took the risk to let us include their pictures here.



After Cervical Surgery

This picture was drawn at the Lava Rock Clinic. The woman who drew it had recently had cervical surgery. She says, "I feel a deep connection to the last four generations of women in my family and to their unresolved issues. There is a similarity in feeling between my invisible wound and the issues that my foremothers don't talk about. They are all so easy to deny.

This experience reminded me how fine the line is between being sick and being healthy. I am learning to integrate death more into my everyday life and relationships. I find that I have to stand up for what I really want, feel and know, as though I am going to die at any moment."

A Comparison of the Medical/Nursing and Process Work Approaches to Coma: a journey through the minefield of unconsciousness

by Kay Ross

In this article I compare the medical/nursing and Process Work approaches of working with those in comas. My background, first as a nurse in intensive care, and more recently as a Process Work student, has enabled me to develop my thoughts and ideas. Arnold Mindell's interventions and research have challenged my long-standing beliefs about how to support those who are unconscious. As a nurse, I was taught that the best thing to do for someone in a coma was to wake them up. The whole medical treatment and management program was geared towards waking people up, and this was my goal as an intensive care nurse. Looking back, I realize that I missed many signals and clues as to what was really going on with those I was caring for. Some of them just wanted to be left alone in their own private worlds, while others wanted to be allowed to die. I hope that the following ideas will challenge some of you as I myself have been challenged!

Background

I trained as a nurse twenty years ago and have worked in adult and pediatric intensive care units in Australia for ten years, caring for many people who were unconscious or in comas. The Process Work definition of a coma is "... profound states of apparent unconsciousness where one cannot respond to any verbal or non-verbal approaches."[1] The medical definition is "... a state of depressed cerebral function." [2] The emphasis in medicine has been on keeping those in a coma alive and arousing them. There has not been any acknowledgment that some people might want to be in a coma for reasons known only to them. Despite consistent negative feedback, such as people going deeper into their comas whenever they were approached or when medical personnel would try to arouse them, in a medical setting we would try everything possible to "get them to wake up." It wasn't only the medical profession that encouraged this; the first question relatives would ask when visiting was, "are they awake yet?" The media also sensationalizes those who come out of comas with headlines such as "...wakes up after four months in a coma." No wonder there is such an emphasis on "waking up." Mindell points out that people sometimes need the inner time in the coma to work on themselves. [3] He says that those in a coma are "... wakeful human beings going through one or more meaningful steps in

[1] Arnold Mindell, *Coma: Key to Awakening* (Boston: Shambhala 1989).

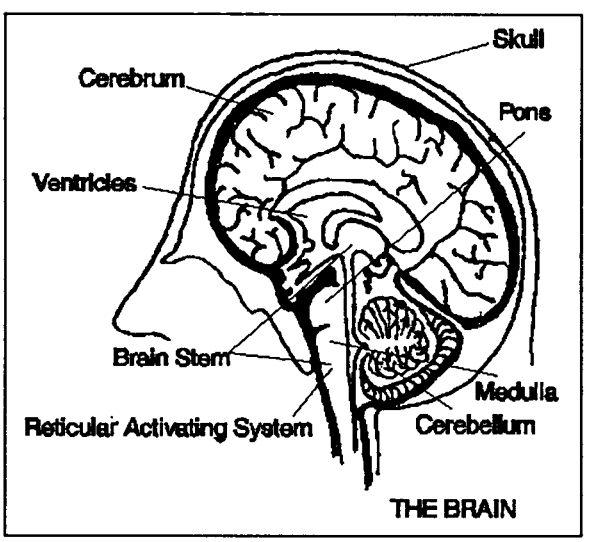
[2] C.J. Binninger, P.F. Healy, N.L. Polts, and D.E. Wilson, *American Review for NCLEX* (Pennsylvania: Springhouse, 1992) 445.

[3] Mindell, *Coma.*

their process of individuation." [4] He goes on to say that "Most dying people need assistance to experience fully the powerful events trying to happen." [5]

A brief medical overview of coma

The skull is a bony, rigid structure containing solids (brain and spinal cord) and fluid (cerebrospinal fluid [C.S.F.] and blood). If there is any swelling or increase in the contents, i.e., C.S.F. (hydrocephalus), blood (hemorrhage) or brain tissue (tumors, abscess) there is nowhere for the swelling to go. The swelling therefore impinges on the brain itself and causes brain damage due to edema and lack of blood and oxygen supply. Medical care is aimed at preventing and reducing brain swelling (cerebral edema) and any increase in the skull's contents (raised intracranial pressure).



The cause of unconsciousness is when this swelling presses on the reticular activating system (R.A.S.), which is a network of neurons and tracts that extends from the lower brain stem into the pons, midbrain, thalamus and cerebral cortex. Any disruption to the R.A.S. will reduce the level of consciousness and lead to coma. The cerebral cortex controls the content of consciousness while the R.A.S. is the on/off switch. [6] The R.A.S. receives information from all the sensory functions of the body. The messages are sorted and then sent to the cortex to be acted upon to maintain a normal state of functioning and activity.

Measures to prevent cerebral edema and increased intracranial pressure include: body cooling and sedation to decrease the brain's need for oxygen; ventilatory support to assure an adequate supply of oxygen and to decrease the levels of carbon dioxide; sitting upright in bed at 30 degrees to ensure venous drainage and steroids to decrease inflammation and swelling. Patients' fluids are severely restricted to limit the amount of circulating fluid and thus decrease the amount of body fluid and cerebral edema. Nutritional requirements are met with either intravenous replacement or intragastric feedings. All of these measures are also geared towards the patient waking up from whatever is causing the coma. Additional specific treatment includes draining the blood if there is a brain hemorrhage, antibiotics if there is an infection, removal of a tumor if one exists, and shunting of C.S.F. if there is hydrocephalus (accumulation of C.S.F. in the ventricles of the brain). General nursing care of the unconscious patient includes keeping the stomach empty via a nasogastric tube (vomiting and aspiration increase intracranial pressure), bladder catheterization, oral and eye hygiene (to stop the formation of corneal ulcers) and side-to-side turning to prevent the formation of decubitus ulcers (pressure area sores).

One of the most common causes of unconsciousness in acute care settings is cerebral edema and increased intracranial pressure, where the brain swells because of trauma (just as your arm would swell if it were badly bruised). Often these people are young and have been involved in automobile, motorcycle or sports accidents. Other causes of cerebral edema include hypoxia (lack of oxygen to the brain), metabolic disturbances (i.e., high or low blood sugar levels in diabetes mellitus), poisonings, electrolyte imbalance, etc. Aggressive treatment is aimed at preventing further swelling and decreasing

[4] Mindell, *Coma* 5.

[5] Mindell, *Coma* 10.

[6] A. Stolarik, "What the comatose patient can tell you," *Registered Nurse* April 1985: 28.

the swelling that already exists. It is not possible to drain this fluid because it is contained within the brain cells themselves.

Neurological observations

One of the major ways to assess the patient's condition is to assess her/his response to verbal and painful stimuli, the pupils' reactions to light and the spontaneous movements. The patient is "graded" according to a scale (response to verbal/painful stimuli, pupil response to light, limb movement, etc.). The higher the score, the better the chance of recovery. Thus, a patient's prognosis is based on the score. This scale is referred to as the "Glascow Coma Scale." Patients score points for their highest level of functioning in 3 different categories (see Appendix 1). The highest possible score is 15, and a score of 5 or less is seen as indicating a bad prognosis. In one study, 85.2% of those with a score of 3-5 died or were in a persistent coma two weeks after the onset of the coma.[7] The outcome for those in a coma is mainly dependent on the initial coma grade. The duration of coma and advanced age are also viewed as negative factors influencing the outcome.[8]

Brain damage is a broad term which describes the loss of function due to an assault on the brain. Signs of brain damage can include moans and groans, sucking on fingers, inability to respond to simple commands, abnormal posturing and uncoordinated or involuntary movements. These signs are seen as "evidence" of brain damage, "proving" that the person has suffered trauma to the brain. Often there is no attempt to follow the signals and to unfold the patient's inner process.

Process Work postulates that whatever is happening to a person is a meaningful expression of the dreaming process. The process worker encourages people to experience whatever is happening for them, to unfold it and to believe in its potential meaningfulness. Thus, if a person appeared to not be responding as they had previously, the process worker would understand their lack of response at that time as meaningful and necessary for them. The medical profession, however, tends to see that something is wrong if there is a deterioration in the patient's condition and would try to correct it by increasing medications or looking at other ways to rectify the problem.

We do need Western medicine, especially for acute emergencies, fractured bones and bacterial infections, etc. However, not everybody who is in a coma wants to wake up. I will discuss some of the people I have cared for to demonstrate this point. I do want to assert that without the medical profession, we would not have the opportunity to work with those who are unconscious; they would not have survived the initial onslaught of the coma without intense medical intervention.

Brain death, or "what is dead?"

The question, "What is dead?" has inspired a long and continuing debate.[9] Thirty years ago, this question simply did not arise: when a person's heart ceased functioning there was no means to resuscitate them, and they just died. Today the available medical technology enables us to save many who, in the past, would not have made it. Mechanical ventilators will pump oxygen into the lungs and thus provide a continued oxygen supply to vital organs such as the brain, heart, liver and kidneys. Medications will keep the heart pumping and the kidneys functioning. But the question arises; if the person has no brain function, are they still alive? The medical and scientific community has answered the question with; if there is no evidence of brain function above the brain stem, then the person is declared dead, and ventilatory support may be terminated. Lack of brain stem function is determined by the following criteria:[10]

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[7] R.L.Sacco, R. VanGool, J.P. Mohr and W.A. Hauser, "Nontraumatic Coma. Glascow coma scores and coma etiology as predictors of 2-week outcome," *Archives of Neurology* Vol. 47 (11), Nov. 1990: 1182.

[8] R. Kalff, W. Kocks, J. Pospiech and W. Grote, "Clinical outcome after head injury in children," *Child's nervous system* June 1989: 156-59.

[9] C.M. Fisher, "Brain Death—A Review of the Concept," *Journal of Neuroscience Nursing* 5, Oct. 23 1991: 330-33.

[10] J. Lynch, *Brain Injury: Tapping the Potential Within* (Melbourne: Hill of Content Publishing, 1992): 457.

1. absence of spontaneous movement
2. absence of any response to painful stimuli
3. absence of spontaneous breathing
4. pupils fixed and dilated
5. absence of caloric reflex
6. absence of gag response
7. absence of brain activity as evidenced on ultrasound or scanning.

This all seems straightforward except for the fact that there are many examples of people who have been pronounced "brain dead" or profoundly brain damaged, have had their life support discontinued, and have continued to live, despite medical pronouncements that this is impossible. Karen Quinlan is a much publicized example of this.[11] After a prolonged court battle, her parents won the right to have the ventilator turned off. It was assumed that she would die without ventilatory support. According to the medical profession, Karen should have died when her life support was terminated. She defied the doctors by spontaneously breathing on her own.

There are now many studies which question the concept of "brain death." Turog and Fackler [12] extrapolate that brain death may be accompanied by retention of central nervous system activity in the form of spinal reflexes and evidence of environmental responsiveness. Studies such as these raise the question, "should we terminate life support when "brain death" is diagnosed?" The many stories of people "waking up" as well as the research raise the possibility that these people may not be dead. This is an area where Process Work could be utilized. If we were able to work with "brain dead" people, I imagine that we would be forced to rethink our concepts of life and death. Ethics aside, [13] deep democracy demands that we support people in whatever state that they are in.[14] This includes those who are clinging to life by the means of life support.

I nursed a young boy who had been dragged out of a swimming pool after being immersed for over 20 minutes. "Timmy," 18 months old, was rushed to the local hospital where he was resuscitated, placed on a life support system, and transferred to the Children's Hospital. He scored 3 on the Glascow Coma Scale (the lowest score possible), and had no response to any stimuli. Two days later his parents were told that there was no hope of recovery, that his brain showed no activity and that his life support systems would be terminated. When his ventilator was turned off, Timmy started to breathe on his own. He remained unconscious for another two weeks, and then started to respond to his environment. After intense rehabilitation, Timmy learned to walk and talk. Two years later he was placed in a normal kindergarten. He shows some signs of clumsiness, and he has slightly slurred speech. Mentally he appears to be at the expected level of development for a child his age. This is despite the fact that he was pronounced "brain dead." The medical profession looks on cases such as Timmy's as "mistakes," assuming that somebody missed something. Another point of view is noting the fact that he met all of the criteria for brain death and survived despite this.

Living wills

Living wills are relatively new. A living will is a mechanism by which patients can communicate their desires for medical treatment at the end of life.[15] Most states have adopted legislation that allows patients to designate, by advance directives, the type of health care they would like to receive if they should become incompetent while suffering from a terminal illness.[16] Some health profession-

[11] See P.W. Armstrong and B.D. Colen, "From Quinlan to Jobes: the Courts and the PVS Patient," *Hastings Center Report* (18)1, Feb.-Mar. 1988: 37.

[12] R.D. Turog and J.C. Fackler. "Rethinking Brain Death," *Critical Care Medicine* 12, Dec. 20 1992: 1707-709.

[13] F. Miedema, "Withdrawing treatment from the hopelessly ill. Part I: The ethical case," *Dimensions of Critical Care Nursing* (1993): 40-45.

[14] Arnold Mindell, *The Leader as Martial Artist* (San Francisco: HarperCollins, 1992): 5.

[15] H.J. Silverman, J.K. Vinicky and M.R. Gasner, "Advance Directives: Implications for Critical Care," *Critical Care Medicine* 7, Jul. 20 1992: 29.

[16] J. Sugarman, M. Weinberger and G. Samasa,"Factors Associated with Veteran's Decisions about Living Wills,"

als push people to sign a living will which directs the type of care they will receive if they are critically ill or suffering from a debilitating, chronic medical condition.[17] Ely et al[18] surveyed a large number of physicians regarding their decision making process about feeding tube placement in an 89-year-old man who could not swallow or communicate after a stroke. Here it was assumed that because the man had lost his verbal skills and did not nod yes or no, he was unable to make a decision about his own life. The study showed that had he made a living will prior to suffering the stroke, the doctors would have followed his wishes.

This brings up a major problem with living wills. What if someone changes his/her mind? It is all very well to talk about what someone's wishes are prior to an incident, but this does not take into account changing circumstances. Mindell [19] points out the importance of establishing contact with those in a coma and asking what their wishes are in that moment. I believe that this is the only ethical way to establish whether the patient wants to live or die. Living wills take away the person's right to change his/her mind.

People's experiences of unconsciousness

There are many stories of people's experiences of waking up after being in a coma. Some talk of "near death" experiences, while others relate stories of imprisonment and deep sensory experiences.[20] Most reported near-death experiences include profound feelings of peace, joy and cosmic unity. However, even these experiences can be interpreted as unpleasant or frightening.[21] Near death experiences are associated with surviving a critical illness, and they have been reported by children as well as adults.[22] These studies prove that unconsciousness is a process that people experience differently. Care of those in a coma should include relating to them, responding to their signals and encouraging them to believe in the meaningfulness of what is happening. Gone are the days when those in comas were relegated to the back wards and left to vegetate. These people are undergoing profound experiences unique to them. As supporters of this process we need to accompany them on their journeys without any judgment or criticism.

I looked after a young girl who was 10 years old. "Mandy" was hit by a car on the way to school and received massive head injuries. She was rushed to the nearest hospital where she was resuscitated and placed on a life support system. She was then transferred to the Children's Hospital where a CAT scan (computerized axial tomography, a 3 dimensional X-ray) showed that she had a cerebral hemorrhage. She had surgery to drain the blood from her brain, and was returned to Intensive Care in critical condition. Mandy was diagnosed as "brain damaged" fourteen days later after not responding to treatment. For two weeks Mandy was totally dependent on the ventilator to keep her alive, and her parents kept a bedside vigil, waiting for her to wake up. It was finally decided to terminate all treatment and it was explained to her parents that there was no hope of recovery, that Mandy would not wake up and that she would be a vegetable for the rest of her life.

During this time I had a gut feeling about Mandy. I noticed that Mandy would open her eyes and appear to look straight ahead. She also moved her mouth in a sucking motion and whenever I carried out oral hygiene, she would suck on the swab stick.

Archives of Internal Medicine 2(6), Feb. 15 1992: 325.

[17] J. Hare and C. Nelson,"Will Outpatients Complete Living Wills?," *Journal of Geriatric Internal Medicine* 1, Jan.-Feb. 1991: 43.

[18] J.W. Ely, P.G. Peters, S. Zweig, N. Elder and F.D. Schneider, "The Physician's Decision to Use Tube Feeding," *Journal of the American Geriatrics Society* 4(5), May 1992: 471-75.

[19] Mindell, *Coma* 100-101.

[20] P. Tosch, "Patients' Recollections of their Post-traumatic Coma," *Journal of Neuroscience Nursing* 20(4), Aug. 1988: 224-26.

[21] B. Greyson and N.E. Bush, "Distressing Near-death Experiences," *Psychiatry* 55(1), Feb. 1992: 96.

[22] M. Morse, P. Castillo, D. Venecia, J. Milstein and D.C. Tyler, "Childhood Near-death Experiences," *American Journal of Diseases of Children* 140(7), Nov. 1986: 1111.

These signs were seen by the medical profession as evidence of severe brain damage. Looking back, I now know that these were signals of what Mandy was experiencing. Unfolding these signals might have led to a greater understanding of her process and what she was going through at the time. I was surprised that she was still alive despite the extent of her injuries. I talked to her constantly, telling her what day it was, where she was, and what had happened, as well as news about her family and friends. I also encouraged her parents to talk to her; because I believe we can always assume that hearing may be present.

The morning that the decision was made to stop all treatment and to terminate life support, I was caring for Mandy. Turning away from her bed to get something from her bedside locker, I heard a noise. A voice said, "I'm hungry." I turned around to find that Mandy had pulled out her endotracheal tube and was chewing on it like it was a banana (the endotracheal tube is an airway tube which is connected to the ventilator). She was fully conscious! Mandy made a full recovery despite her injuries and the predictions of the medical staff. Afterwards I asked what she remembered about being sick. She said "...it was like a dream where I was very tired and I needed to have rest." She added that she "...got angry about people poking her and telling her to wake up; she was too tired!" She also remembered some of the things that people had said to her, including the fact that her dog had had puppies while she was unconscious. The fact that she did not "respond" did not mean that she was not aware of what was going on around her. It meant, in this case, that she chose not to respond.

In medical terms, Mandy had an "unexplained full recovery from devastating head injuries." In process terms, the coma was meaningful to her; she needed time to rest while she experienced her own process. Attempts to wake her up did not work because, as Mandy said, she "... needed to sleep." Prior to the accident, Mandy's parents described her as a very active child who was always doing something. She worked hard at school, attended ballet classes, played basketball and was a member of the girl scouts. After her recovery, Mandy appeared to slow down and take things easy. Her parents and doctors thought that this was because of her physical injuries, but I wonder whether her "rest" also influenced this.

I also nursed another young girl who was unconscious after contracting meningitis (a bacterial infection of the covering of the brain). "Sue" was eight years old and had been in the hospital for 6 weeks. During this time she remained unconscious, with very little response to treatment. The doctors finally told her parents she would probably remain like this for the rest of her life. Sue's moans and groans were seen as "evidence" that she was brain damaged. In those days I didn't know anything about Process Work, so I did not explore these sounds and movements. When it was decided that Sue was not going to recover, she was sent to a medical ward where she received nursing care but no attempts were made to "wake her up." Ten days later Sue sat up in bed and announced that she wanted to go home. She said that she'd been to a "nice holiday place," where she could do what she wanted. She hadn't had to worry about doing what she was told because "...they finally left me alone." I wondered if she was talking about the previous ten days, when she was left alone because the medical profession had decided that there wasn't much point in continuing to try to wake her up.

Of course, not everyone who is in a coma will wake up; some will remain unconscious, and others will die. Again and again I have seen people in prolonged comas because their loved ones are unable to let go, or because they have unfinished business.

"Steven," 21 years old, was involved in a motorcycle accident. He received massive head, chest and abdominal injuries, as well as fractured limbs. Two months later he was still unconscious, with no response to verbal or painful stimuli. He was being fed by an intragastric tube, was breathing on his own, and did not appear to be aware of his surroundings. His relatives had been told that he had no hope of recovery; brain scans showed irreparable brain damage. Steven's wife, Nancy, would come in every day and tell him how much she needed him, that she couldn't live without him and to hurry up and get well. After each visit, Steven would become very agitated; he would scream loudly and would thrash about in bed. Finally, a nurse had a long talk with Nancy. She explained that it might be time to start letting go of Steven and to look at ways she might be able to say good-

bye to the man she had married. A few days later, Nancy told Steven that she still loved him, but if he needed to go, then she wouldn't stop him. She said her good-byes and sat with Steven. At first there was no response, then Steven opened his eyes, looked straight into Nancy's eyes, smiled, and slipped into unconsciousness. Two hours later he died peacefully, with Nancy at his side. It seemed that Steven just needed to know that Nancy would be all right before he could leave.

Stories such as these raise the question for the medical profession, "should we assume that everyone in a coma wants to wake up?" My answer is "no, some people want to be left alone; they need to be unconscious." A process worker would follow a comatose person's process, unfolding the signals and believing that everything that happens is potentially meaningful. From this perspective, a coma is something that needs to happen. By believing in the process we are able to let go of expectations of waking, being cured, etc. Medical professionals are trained to heal, and if someone is in a coma, then their response is to wake that person up by any means possible. My vision is that the medical system will work with process workers; together we can develop new approaches to supporting those who are unconscious.

Coma arousal therapy

A controversial approach to working with those who are unconscious is Coma Arousal Therapy (C.A.T.). Hunter[23] states that "It cannot be proven that there is no potential for recovery following brain injury, even in the most severe cases... because there is no diagnosis that can scientifically demonstrate that recovery of function will not occur... (therefore)... every attempt should be made to tap this...." C.A.T. is a "... planned series of activities aimed at arousing a person from a coma." [24] It consists of stimulating all the senses of the comatose patient,[25] and aims to activate the reticular activating system. It is a time consuming, labor intensive program where teams of people take turns systematically stimulating the person in a coma.

Methods include: shining a light in the person's eyes (visual); placing strong tasting substances on the tongue (taste); holding aromatic substances in front of the nose (olfactory); stroking/touching the skin with objects such as feathers (touch) and making loud noises (hearing). The person's movements are also stimulated by moving the limbs in a passive range of motion exercises, placing the person on a tilt table and lying the person supine or prone over a large ball and rolling them around the floor.

In process terms, most channels are being accessed by the team of care givers. My concern, however, is that it is done without any acknowledgment from the person who is unconscious. They are stimulated whether they want to be or not. Another difference is that a process worker attempts to follow the patient's signals which are happening and not impose stimulus on the person from the outside. Wilkinson[26] talks about her own son who underwent C.A.T. after nearly drowning. She describes his response as "...he could push things away from you if he didn't like the stimuli you were giving him." C.A.T. depends on this stimulus, and so Wilkinson's son continued to be stimulated despite his protests. He died a week after she made that statement.

Baker[27] states that "...Facial grimacing is an indicator that the taste sense is working." She does not acknowledge that the grimace might be an attempt to communicate that the person does not want those tastes placed on the tongue! She goes on to say "...smell... stimulus has been achieved if the patient grimaces or attempts to withdraw." Again, there is no attempt to follow the person's feedback.

Some points to remember

If you are working with or visiting someone who is unconscious, it is easy to forget that this person is a

[23] I. Hunter, *Brain Injury: Tapping the Potential Within* (Melbourne: Hill of Content Publishing Company, 1986): 46.
[24] J. Baker, "Explaining Coma Arousal Therapy," *Australian Nurses Journal* 17(11), June 1988: 8.
[25] J. Wilkinson, "Coma Arousal Therapy: Is There a Need?," *Australian Nurses Journal* 5, Nov. 16 1986: 45.
[26] Wilkinson, *Coma Arousal* 45.
[27] Baker, *Explaining Coma Arousal* 8.

living human being. All too often care givers and visitors treat the person as if he or she is not there and talk about them in their presence. Here are some tips I have drawn up after caring for those in comas, as well as talking to people who have regained consciousness:

1. Always knock and ask permission before entering the room. Introduce yourself. Explain why you are there and what you are going to do. Remember that for someone who is confined to bed, the bed and the room become extensions of the self. Do not abuse them by entering without announcing yourself, sitting on the bed, moving objects around in the room, opening/closing windows, etc. Always be aware of feedback and proceed slowly.

2. Talk to the nursing/medical staff before starting. Find out the best times for visiting. You may have to negotiate. Do not assume that you will be the only one who wants to see the person. Remember meal times and doctor's rounds, as well as any visits to X-ray, physical therapy, etc.

3. Tell the nursing/medical staff what you are doing. Invite questions and comments. Expect a hostile reception if you don't inform them of your visits. Any negative feedback is often because they are uninformed and are concerned for their patient's well being. Imagine what it would be like if someone came into your workplace and appeared to take over a vital task! Offer them reading materials and (if you feel confident enough) a teaching session. Expect them to come in and see what you are doing. Remember, they have the ultimate responsibility for the welfare of their patient.

4. Talk *to* the person you are working with. Always assume that they can hear you. Do not shout; speak clearly in a normal tone, close to their ear. Tell them everything, especially if you are going to touch them.

5. Expect to feel foolish when you are talking to the patient. We are conditioned to communicate on a verbal level, and when we do not receive verbal feedback, we feel one-sided and at a loss. This is an ideal opportunity to fine-tune our ability to notice minute signals.

6. Do not give the patient anything to eat or drink without checking with the nursing staff. The patient may be on fluid restriction or a special diet.

7. It will be easier to work with someone who is close to death if you have faced your own mortality and beliefs about death. Ask yourself if you believe in reincarnation, life after death, heaven/hell? What is the purpose of life? What are we doing here? These questions and more will be raised as you work with this special population.

8. If you have any queries about nursing/medical treatment, please ask. Do not go ahead with something if you are uncertain. Some medical equipment is vital to sustaining the patient's life. Don't touch anything without checking first what it is and what it does. Read up about your client's condition. Understand any medical terminology—some people use complicated terms to describe simple procedures.

9. Always keep relatives informed of what you are doing. Do not raise their hopes inadvertently. Select your words carefully; remember that they will cling to any hope that you give them. Do not use words like "...cure, wake up, get better, heal." Explain what you are doing and why you are doing it. Talk about what you expeet, i.e., "I am following what Joey is doing. See how he is moving his hand? Well I am touching his hand so that he knows that I am here. I don't know what it means but I believe that it is important somehow for Joey. Let's see what else is happening."

Keeping these points in mind will make it easier for you to work with those who are unconscious. Remember, always respect them and their process.

Conclusion

In this article I have attempted to outline the differences in the medical and Process Work approaches to working with someone who is unconscious. I have briefly outlined the medical paradigm and suggested additional ways that we might support those in comas. I hope that this has allowed you to appreciate their world and to acknowledge that "while there is life, there is hope."

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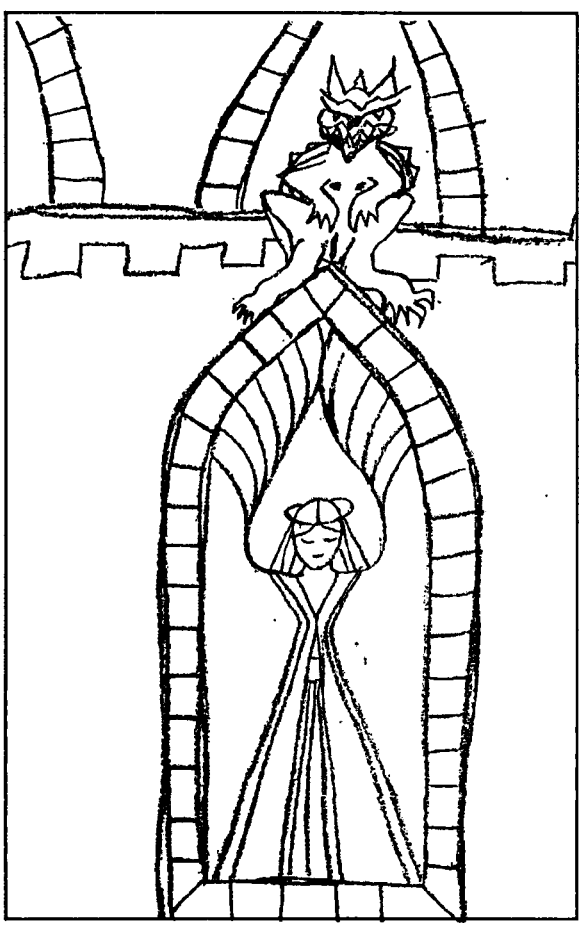
Appendix 1 | Glascow Coma Scale

Response	Score
Eye Opening	
spontaneous	4
to verbal command	3
to pain	2
none	1
Motor Response	
obeys	6
localizes to pain	5
flexion - withdraw	4
flexion - abnormal decorticate rigidity	3
extension - decerebrate - one	1
Verbal Response	
oriented and converses	
disoriented and converses	4
inappropriate words	3
incomprehensible sounds	2
none	1

Symptom Art

Cramping

A person working on a chronic cramping sensation around her eye and along her spine drew these pictures. Taking what most fascinated her from the first picture, she drew the gargoyle. She then danced this figure with glee.



...the monster that perches on top of the Gothic arch.

Training Issues in Coma Work: edges and personal freedom

by Amy Mindell

Ever since I joined my husband, Amy, in his work with people in comatose conditions, I have been confronted with many of my own feelings and growing edges about life, death and my ability to communicate with people in deeply altered states of consciousness. I have been teaching coma training classes in Portland as well as workshops with Amy in different places around the world for a number of years. In these classes and seminars I have found that other people also discover central growing edges which arise as they train in this work. By edges, I mean those exciting moments when we come to the boundary of our known identities and are challenged to consider new thoughts and behaviors. Coma training, therefore, is intimately connected to the personal development of the caregiver. It has been important to expand my view of training to include focus on the personal work of the coma worker. In this article I address some of the main edges or problems that repeatedly arise in the course of training and suggest exercises for working on these developing aspects of ourselves as coma workers.

In Amy's pioneering work on coma he says that "as long as the body lives, consciousness is possible."[1] This central belief in coma work, where we facilitate the person's inner process, calls for a new palette of skills for working with such states. In his book *Coma: Key to Awakening* he provides tools to join someone in an altered state of consciousness, help connect that person to her or his inner process and help this process to unfold. These skills make it possible for doctors, nurses, caregivers, hospice workers, friends and family to communicate with someone even if she or he is not talking, or is in a deep trance and not communicating in the "normal" ways we are accustomed to.

There are many skills which are helpful in working with people in comas. I will not expound on these skills or theory here.[2] Let me simply mention that anyone interested in working with people in comatose states needs some awareness training to follow and assist those in deeply internal and withdrawn states. Training in working with non-verbal signals, sounds, movements, visualization, body feelings,

[1] See Arnold Mindell, *Coma: Key To Awakening* (Boston: Shambhala, 1989) 97.

[2] The reader can find practical tools, theoretical background and case stories of coma work in *Coma: Key to Awakening*. Kay Ross' article in this journal is also a useful introduction to the medical view of comas and a comparison with the process-oriented approach. See also Stan Tomandl's manual, "Coma Work and Palliative Care: An Introductory Communication Skills Manual for Supporting People Living Near Death," for practical exercises in coma work. For an introduction to hospice work, see McLeroy et. al, "You Are Not Alone: A Handbook for Hospice Caregiving."

touch and work with the breath are important. In addition, some knowledge of dreamwork and imagery, childhood dreams, normal psychotherapy, family and relationship work are helpful. There are also particular methods and theoretical considerations which concern differences between metabolic and structural comas. Metaskills such as an openness to mysterious events, belief in what is happening, patience and compassion are central to coma work.[3]

Training and personal edges

Arny and I have discovered that learning to work with people in comatose states often brings up personal growing edges in students and caregivers. Training in this area causes many of us to consider our own altered and introverted states. We are confronted with our feelings about life, humanity, and death. Excitement and fear appear in almost everyone approaching the topics of personal expression and freedom in working with people in comas. The sense of intimacy and contact brings up many personal issues for trainees. It has become apparent that coma training is inseparable from a deeper exploration into the caretaker's personal work.

Given this context, training becomes a fascinating journey into the psychology of the "coma worker." In the following pages, I address some of the most prevalent personal edges which emerge in coma training. These include: 1) Edges to altered and internal states. 2) Edges about death. 3) Edges about making sounds and using movement and touch with people.

I want to stress, however, that certain people are exceptionally gifted in coma work. They have an ease with and an uncanny knowledge of altered states. These people often feel more at home with people in comas than they do with people in "normal" states of consciousness. You notice these individuals by their ability to get close to the comatose person, by their fluidity in non-verbal communication, and by their special compassion towards others.[4]

Our altered states

A central ethical consideration of coma work is that if we are not able to relate to someone in an altered state of consciousness,[5] then we as coma workers must change, not the person in the coma. We need to develop and learn communication tools that help us join the comatose person in her or his altered state and particular communication system. Research has shown that people in comatose states are working on themselves and need time to process internal experiences without the distractions of normal life.[6]

I remember, for example, walking by the bed of a young man in a hospital. He had suffered from brain damage and at this point his eyes were open and he was sitting up in bed. He was singing and humming to himself. The nurses came in and asked him if he knew which day it was and where he was. The man did not seem to notice their questions but continued to sing and laugh. He was obviously in an altered state from the states we are accustomed to. His feedback system was altered in that he did not reply directly to their questions and he was operating in a very different time and space from the nurses' everyday reality.

Yet the fact that someone is not communicating in customary ways brings many of us unexpectedly to an edge. Some of us feel fearful, uncomfortable, or awkward. I think that this lack of comfort derives

[3] There is much research to be done in coma work. I encourage anyone who is working in this area or has the chance to work with someone in a coma to keep detailed notes so that statistics can be compiled.

[4] In Japan many students were very skillful in this work. They seemed at ease, in our training seminars, with the comatose person, were very intimate and followed each signal with utmost care. Perhaps it is the emphasis on inner life and meditation which made these Japanese people so sensitively attuned to this type of work.

[5] An altered state of consciousness is a state of consciousness which is different from the one we normally identify with. Arny says that "In altered states, such as those we encounter in dying processes, feedback to questions about everyday realities is diminished or absent. People cannot enter and leave these states easily. They seem absent, their memory may be disturbed, and they usually have poor space and time orientation." (Mindell, *Coma* 55).

[6] Mindell, *Coma* 102.

from a lack of familiarity with our own altered states. We are accustomed to living in ordinary reality and often disavow the spontaneous altered states that come up throughout the day. Therefore, we are shocked, surprised and uneasy when sitting with those who are living and expressing themselves in an "altered" manner compared to consensus reality.

In order to understand what a comatose state might be like or mean for a given individual, and to access personal altered states, it may be useful to try this exercise:

> Lie down and imagine that you are in a deep trance state or coma. After a few minutes ask yourself: "What purpose might this state have for me? What might this state bring me? What meaning might it have for me to be in such a deep and internal state?" A second stage to this exercise, for training purposes, is to ask, "If someone were to assist me with my inner work from the outside, what could they do that would be helpful? What would be less helpful?" For example, how would you like this person to approach you? What kind of touch or verbal communication would be most helpful to you? What would be most disturbing?

Increased awareness and comfort with our own altered states is not only healthy but will also make it easier to be with people in comas, giving us a deeper understanding of what the comatose person may be experiencing. To further develop ease with altered states of consciousness, try to catch the flickering of altered states as they arise throughout the day. Notice when your attention drifts and something new is trying to arise. Notice the tendency to withdraw when you are with people and try to appreciate and follow these signals. Experiment with an openness to these altered states and try to help them unfold with inner work tools.

For example, if you are talking to someone and you notice that you are looking down and fading out of the conversation, follow this tendency to go inside. Find out what channel your process is flowing in at the moment. Are you seeing, feeling or hearing something or is movement happening spontaneously? Focus on the channel that your experiences are flowing in, amplify this, and add other channels to help fill out and unfold your experience. Perhaps you will discover that you need time to be quiet or want to change the subject. If possible, bring this information back into your relationship with the other person, thereby enriching your interaction.

This kind of fluidity with inner work tools is, in general, excellent training for working with anyone in a deeply inner state such as coma, catatonia, withdrawal or depression.

Fear of death

The fear of and confrontation with death has been a most apparent and important aspect of my own work with comatose people and in coma training. Coma workers are sometimes faced with their own mortality and that of others, with memories of or grief over past loved ones who have died,[7] and with fears of death and the dying process. The panic and fear some of us associate with death cause us to freeze in the presence of someone who may be dying and to project our own feelings about death onto this person.

In a new forward to *Coma: Key to Awakening*, Arny and I address this issue and possible avenues which may be helpful in working on our own issues around death and dying:

> The entire work with people in altered states of consciousness is complex and difficult, not because it is difficult to work with people in these states, but because many of us are not at peace with our own death. On the one hand, learning about death and dying is a matter of practice, and on the other it is a matter of personal development or inner work. Fantasies about dying for those of us in the midst of life often mean learning to let go of aspects of ourselves which are tired and worn out. Our inability to let go and let things happen, inhibits life by resisting death. There is a time for this fight of course, but if we continue to hang on and form sentimental ties to aspects of life which need dropping, we also hang on to the dying person and make life and death unnecessarily difficult for her or him.

[7] See Nisha Zenoff's manuscript "From One Mother to Another: Journey Through Grief" and article "Grieving: A process-oriented perspective" for further discussion of grieving and methods of working with grief.

The less centered we are ourselves in the processes of life and death, the more we inhibit the client's awareness and communication on these topics. Ill people are often uncomfortable speaking with others who seem against disease, death or permanent injury. The more open and detached we are about such states, the better it is for everyone. But the only way to get there, is to work on ourselves. The method of "practicing your death," facing the various feelings and unfinished business around your own demise still seems the easiest way to begin in this area.[8]

Therefore, the fear of death may not be due only to the fact that we will actually die, but also to the drive for certain aspects of our identities to drop away so that new aspects of ourselves can be born.[9] In some of our training seminars, Arny and I have given an exercise on "practicing your death." This means imagining that you die and letting go of parts of yourself that you no longer need; then, following your fantasies of what wants to live on, imagining what new parts want to be born and identified with.

For example, I remember a woman who experienced herself as depressed and plagued by internal criticism. She had constant fantasies that she would die. When she lay down and pretended that she did die, she imagined that she floated up in the air and looked down upon the earth. She suddenly broke out into uproarious laughter. She felt detached and could see that her ordinary troubles were not really very important. She imagined flying in the air feeling as free and playful as a bird in the sky. This woman's death fantasies were an attempt to drop her identification with her depression and identify with the childlike, free, and detached part of herself.

Arny has also said that much of our fear of death is connected with the fear of being trapped in vegetative states which cannot be used.[10] Many of us fear that if we were to fall into a comatose state, we would be trapped, lonely and unable to make use of the state. This may be due to a lack of working on our altered states before we enter the dying process and to not asking others to relate to us when we are in altered states. No wonder we feel lonely, afraid and unable to maneuver in deeply altered experiences.[11] Inner work practice helps reduce the amount of time spent in these states where we are unable to make use of our experiences. This fear may be alleviated in part by practicing inner work skills which help us navigate through deep inner experiences. It may also be helpful to ask others to be with us in these states.

Working with non-verbal processes and personal freedom

The goal of this work is to join the comatose person where he or she is and assist with the unfolding of his or her experiences. The coma worker notices tiny responses and signals and communicates in a similar manner to the comatose person. The kinds of interactions which are most helpful should match the types of signals and reactions that occur.[12] The best interventions are those that are happening already.[13]

Many people, due to a lack of familiarity with altered states, resort to their normal ways of communicating when confronted with someone in a comatose or withdrawn state. Many of us are shy around people who are not talking. Some feel awkward relating to another person who is lying down, who may be silent or making unusual sounds, does not look them in the eyes, makes tiny movements of the eyebrows, pushes with the heel of the foot, or purses the lips.

Arny once said to me that the client has all the options, and the therapist seems to have none! The client appears to have more fluidity with altered states

[8] A new edition of *Coma* will be published by Penguin-Arkana in the Spring of 1994.

[9] For further discussion of this point, see Arnold Mindell, *The Shaman's Body* (San Francisco: HarperCollins, 1993) Chapter 11.

[10] Mindell and Mindell, Seattle coma seminar, 1991.

[11] Mindell, *Coma* 47-48.

[12] Mindell, Personal communication.

[13] Mindell, *Coma* 54.

and we as helpers are often stuck in the ordinary realm of communication without the flexibility to follow what is happening. We end up, for example, talking to the person as if she or he were in an ordinary state of consciousness and expecting answers in like manner.

Learning to work with comatose patients challenges us to communicate in the most elementary ways. This includes using sound, movement, bodywork, touch and imagery. Comas due to brain injury particularly require the development of this skill. How, for example, will you communicate with the movements of the mouth, the eyelids, or the breath? How will you react to quick sounds, coughs, jerks of the hand, or a push of the heel of the foot? How do you work with signals which you do not initially understand? One student recommended that we remember what it is like to communicate with a baby in order to access this type of communication style.[14] Can you remember what it is like to communicate with someone without access to ordinary words?

Let's look at some of the edges which arise in response to this type of communication.

Working without content

Working nonverbally demands that we follow the person's internal experience of her or himself without necessarily knowing the exact content of the experience. We must try to follow and unfold information in a contentless way using blank accesses in sound, movement and touch.[15] Many people are shy to follow and interact with these seemingly contentless processes and tend to interpret information instead of allowing it to unfold in its unique way.

The kinds of signals we see in comatose states manifest from internal processes and do not match our usual associations to these signals.[16] For example, a frown may not be a sign of unhappiness, but could be an attempt to focus on an image. We are challenged to put our ordinary assumptions aside and develop a beginner's mind which notices and supports the various signals and processes as they emerge. We are reminded of a central aspect of Process Work which is related to the Buddhist concept of "right understanding." Right understanding means that we cannot understand the flow of the river by standing on the outside and deciding what it means. Instead, we must get into the stream of experience and through this, true understanding will follow. This requires an open mind and heart which supports and follows the mysterious unfolding of nature.[17] Perhaps we are challenged most strongly to follow this type of understanding when working with people in comatose conditions.

Try, for example, following your own process throughout the day with an open mind. Do not interpret what is happening but support and allow it to unfold and express its own wisdom. Interact with the part of yourself that wants to interpret as opposed to letting nature explain itself to you.

Edges to making sounds

A most useful intervention in coma work is making a sound of affirmation in response to signals that you notice from the comatose person. A simple vocal response to tiny signals gives the comatose person the feeling that you are present with her or him, in her or his process.

In many of the dyad exercises in my classes I ask that one person act like the "coma worker" and the other person lie down and pretend that she or he is in a "comatose state." In order to experiment with sounds, one exercise involves the person in the "comatose state" making slight sounds and the helper experimenting with vocal responses.

No one in my classes was aware ahead of time how shy he or she would feel when trying this exercise. For many, it was the most difficult and scary

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[14] Thanks to Debbie Hart for suggesting this.

[15] See Mindell, *Coma* 60-68 for a more detailed discussion on using blank accesses, not interpreting and training exercises for working with movement, auditory, visual and proprioceptive experiences.

[16] Personal communication with Amy.

[17] In their review of *Coma* in *Common Boundary*, July/August 1990: 44, Stephen and Ondrea Levine describe this kind of communication as letting "life in, to listen with a clear mind and open heart."

exercise of all. People felt embarrassed or ashamed and many had strong edges which prohibited them from making any sounds. When I suggested that someone sing a comforting lullaby to the person she was working with, the helper squirmed and blushed and found herself at a very central edge in her life to making noise or to expressing herself at all. Difficulties in making sounds brought up all sorts of blocks around speaking out, tightness in the throat, memories of having been silenced as a child and fear of being vocally expressive. Learning to communicate through sound with a comatose person requires a certain amount of inner freedom. It is a break with our culture, an alteration from many people's upbringing.

One way to work on your own edges in making sounds is to pretend that you are a child and make all sorts of goofy sounds. Imagine that you did not know words yet but could only express yourself through tones. If you are unable to do this or feel uncomfortable, find out who or what is against you doing this. What holds you back? Continue by working on the process between the one who makes sounds and this inhibiting figure.

Edges around touch and movement

Intimacy and touch

One of the biggest edges in coma work is the ability to be close and intimate with the comatose person. For example, when I have suggested that the "helpers" in my class go very close to their partner who is playing the "comatose" person and whisper into that person's ear, some helpers stayed quite far away. Many kept a distance because of shyness, a lack of comfort with such closeness, intimacy issues, or out of fear of being intrusive.

What about intrusiveness or intimacy? Arny has said that your intent is more important than anything. If your heart is in the right place and you really want to be helpful, then the comatose person will feel that. He has also said that he never met anyone in a comatose state who did not like intimate contact when it was done with extreme sensitivity to feedback. They felt just the opposite. People love compassionate focus! People may experience you as invasive if they are in the mood for normal communication, but this is not the case with someone in a comatose state. They appreciate the kind of intimate and helpful communication that you can bring.[18] Hospice workers whom I have met have said that people in comas need lots of body contact and tactile stimulation, especially if the person has been in the hospital for a long period of time. They said that people who are in comas for a long time so appreciate the intimacy, touch and contact we can give them.

The ability to use touch in a compassionate way makes it possible to assist the comatose person in his or her expression and the unfolding of his or her process. I remember a woman, for example, whose head was turned slightly to the side. When her head, cheek and neck were stroked lightly in the direction her head was facing, she turned her head further to the side and tears began to flow out of her eyes. The turning of her head to the side was a signal which, when followed with touch, allowed her to connect with her need for love and caring.

What is the goal of touch and bodywork? Arny has said that, for those individuals who are in comas as a result of structural injury, touch and movement are important because the comatose person may not have the motor apparatus to respond and execute outwardly what they would like to do. With help, they can begin to make these movements. For those in metabolic comas, the motor apparatus is present, and touch allows them to unfold the experiences they are having. In all cases Arny has said that the goal of touch and bodywork is knowing that the body is dreaming, then helping the person become conscious of her dreaming process and helping the person connect to an inner awareness.[19] He expresses the importance of this kind of touch as follows:

> ...we must not forget that many people going through these altered states need our help to realize their total selves. Indeed, they want intimate communication. Many prefer it to ordinary

[18] Mindell, Control Case seminar, Fall 1992.
[19] Mindell, *Coma* 97.

loving compassion. For without it, a special moment can be missed as the mind spins wildly in a turbulent river flowing to the sea.[20]

People who do this naturally seem to relate to the comatose person as if he or she were a close friend. They have a special love and appreciation for the individual and their unique process and a kind of open touch that allows the process to unfold.

One way of working on intimacy is to practice with another person. Approach the person and notice the kinds of feelings you have as you get closer. Take time to process these experiences. Also, experiment with the sense of touch with someone else. Go slowly and ask yourself what it is like to touch someone else, what feelings come up inside of you, what are your edges and how do you feel about contact and people?

Movement

Many of the signals of comatose people are movement signals such as slight motions of the mouth, the arms, the legs, heels, and eyebrows. It is sometimes helpful to use movement to test the limbs, for example, by slowly lifting the arm from the bony part of the wrist, to notice what kind of movement responses you receive and to help the inner dreaming process to unfold.

We worked once with a man who had been in an accident and suffered from massive brain damage. He had been laying passively in a coma for many months. When we first saw him, his hands were tightly clenched in a corticoid posture because of the brain injury. Assuming a beginner's mind, and believing that the hand signals might not only be due to his physical condition, we slightly pulled on his fingers to see how he would react. In response, he clenched his fists more tightly. As we continued, he began to bend his elbows and pull his arms in, as we pulled away from him. We were suddenly involved in a pulling match! Finally he started to make growling noises and even began to lift himself out of bed! It turned out that he had previously been a weight lifter and had not used his muscles or strength for many months! At this point, a relative in the room made the comment "Oh, there he goes again, bragging about his strength!"

Movement is one of the most forbidden channels for many people. Those of us who have learned to sit quietly, to inhibit our movements and movement expression are confronted with new edges. Experiment with your own freedom in movement. Simply begin to move and notice the kinds of inhibitions which arise. Which movements are forbidden? Is movement forbidden all together? What stops you and how will you process this further?

Experiment with moving someone else. How do you feel as you do this? How much ease or comfort do you have? Don't forget to use movement with clients in ordinary states of consciousness, as many of us revert solely to verbal communication here as well. It is not only fun to work with movement but it will also provide more ease in movement work with people in comatose states.

Conclusion

Research has shown that people in comatose states appreciate the intimacy and assistance a helper can provide to access and unfold their inner experiences. Working with people in comatose states requires that we as helpers and caregivers confront some of our personal edges connected with such issues as intimacy, fear of death, altered states and personal expression, particularly in the expression of sound, movement, and touch. By focusing on these edges in our own lives and in coma training, we may become more free to communicate with people in comatose states, and we will learn more about our own inner lives, our feelings about life and death, and our relationships to others.

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The Nobody Who Could Become Anybody: a tribute to Tom Hammond

by Dawn Menken

In September of 1992, Tom Hammond came to the Oregon coast to attend the Lava Rock Clinic. He arrived a few days late; it had been a long journey for him travelling from Seattle. Though he was suffering from various symptoms related to his AIDS, he was also radiant, displaying a natural ease in just being himself. He said that he had made the journey to the clinic to say good-bye. About 100 people were present when Tom said good-bye. We were sad but glowed in the warmth of his love as he wrapped his spirit around us. We sat huddled together, awestruck students hanging on his every word while he drew us into the other world where eternal love connects us all. About a week later, Tom died.

I first met Tom in the winter of 1989 when he attended an intensive Process Work course in Zürich, Switzerland. I was so deeply moved and inspired by his work with Arny Mindell on some of his physical symptoms that I wrote a chapter about his work for my dissertation. Unfortunately, during the editing process, that chapter didn't fit well with the whole of the work and was cut.

After arriving home from the Lava Rock Clinic, I thought about Tom and remembered this chapter. I found it filed away and sent him a copy. I don't know if he ever received it.

I feel blessed to have known Tom and to have seen him work publicly on his AIDS many times. His experiences have always been meaningful for the group. I personally have experienced him as a teacher; a brazen warrior leading the way down the path of discovery and transformation. I have rewritten this chapter about Tom, wanting to keep his spirit alive and to share some of his experiences that have enriched many of us. The following is a shortened version of the videotape transcript from the Zürich intensive course and a summary with comments. The transcript of the videotape remains in the present tense, to preserve the feeling of the work and to provide the reader with a sense of immediacy. Comments directly about the transcript are also in the present tense. This was one of the earlier pieces of public work that Tom did in the Process Work community.

Zürich, 1989

It is a wintery Friday afternoon in 1989 at the Hotel Zürichberg, a simple hotel in Zürich where numerous intensive courses have taken place. Arny taught each Friday and his courses were open to both intensive course participants and the general public. A group of about 150 people has gathered this afternoon to attend one of his classes.

Before Arny begins to work individually with Tom, they sit with two other men in the middle of the circle. One man has leukemia and the other, like Tom, is diagnosed HIV positive. The three men are deciding who will work first with Arny. Through the decision making process they form a kind of brotherhood. They speak about being in the same boat; all of them are in life and death situations. Continuing with the image of a boat, they talk about drifting downstream to where the stream meets the ocean. They speak about being at different places in the stream; Tom says that he is at the

end of the stream where it empties out into the ocean. This information will be useful later in the work. Arny begins focusing on Tom.

Arny: Do you have symptoms that are troubling you?

Tom: The most dramatic symptom I had was in April of '87 when I had a case of shingles. It went from here to around there [he uses his hands to trace the path from the middle of his chest to his back]. Other than that my only symptoms have been skin rashes, redness in my face and fatigue.

Arny: If you could feel free to get whatever you needed, or at least felt free to ask for it... I don't know if we could do it, but what would it be?

Tom: I want to live a longer life and still hold on to this feeling of being able to die at any moment. There is something about not knowing when I am going to die, and the possibility of it being sooner than later, that fills me with a certain amount of awareness of being alive and deciding what I want to do with my day and whom I want to be with. This is directing and focusing for me, and I like that. But I don't want to die. I want to live a long and happy life. So I want to have my cake and eat it too.

Arny: When you say you want to live a long and happy life, do you have the sense that you are not going to have the opportunity?

Tom: It's a possibility. I don't know how much control I have over it. I think I have some and there is some I don't have.

Tom says that he was diagnosed with the HIV virus in 1985. Arny and Tom discuss medical statistics about AIDS.

Tom: I don't want to measure it by statistics, to take an outside reality and apply it to what is happening inside of me and say what it is going to do; that it is going to lead me and say okay and surrender to that outside vision which so many people do, and me too, sometimes [he puts his hand on his chest and moves it outward].

Process structure

At this moment Tom's primary process seems to be his desire to learn more about himself and his symptoms. He would also like to live a long and happy life. He says that he doesn't have much control, meaning the one who controls is less known, or secondary, to him. This goes along with his description of the medical world, an entity which is outside of him with the potential to lead and direct him. The controlling and leading is something that will probably come up in this work.

I remember being drawn in as a group member when Tom spoke about the feeling of being able to die at any moment and the special kind of awareness that it brings to his life. This is also something that happens to him; a new kind of focus or direction wants to emerge. Based on Tom's signals, we could guess that this new focus will happen in both proprioceptive and movement channels. He describes his focus as a feeling. His description of his shingles, rashes and fatigue are things he feels and he uses hand motions to describe them as well.

The channels that his momentary perception is occupying seem to be visual, because he looks upward when he speaks about himself, and auditory, because he is very related to the verbal conversation.[1] Arny picks up on the last movements that Tom was making.

Arny: When you talk about it you put your hand here [Arny touches Tom's chest] and talk about what it is doing to you. Do you experience AIDS, or death or your symptom creator as being in your chest somehow?

Tom: I don't have a direct experience of this bugger virus in me except in what it does on the surface of my skin. I am making a causal connection that is also externally biased.

[1] Arnold Mindell in *River's Way: The Process Science of the Dreambody* (London: Routledge and Kegan Paul, 1985) 16-17, mentions how eye cues are helpful in determining occupied and unoccupied channels. Also see Joseph Goodbread, *The Dreambody Toolkit* (London: Routledge and Kegan Paul, 1987) 185-186. Goodbread also refers to Bandler and Grinder, *The Structure of Magic* (Palo Alto: Science and Behavior Books, 1975) 25.

Arny: When you say that you don't have an experience of this bugger virus, I know that one of the most complex things about AIDS and some types of cancer is that there is very little experience involved. But, the concept of it being a bugger...

Tom: An ornery little critter... [here Tom sounds excited. He sticks his tongue out of his mouth slightly, flicking it like a snake].

Arny: You make a certain face when you say that.

Tom: An ornery little critter is not a mean and rotten son of a bitch. He is somewhere in between.

Arny: Yeah, well, this is your experience of AIDS. It is a very interesting thing, an ornery little critter who makes faces like that.

Tom: Yeah, and he is sitting in the bloodstream going like that [he twiddles his thumbs as if he is waiting and the tongue motions repeat themselves].

Arny: He sits in the bloodstream going like this [Arny mirrors Tom's movements] and what is he thinking? [they are both twiddling their thumbs, making faces and clicking their tongues, looking as if they have something up their sleeves].

Tom: Yeah, he is thinking uhhhhh...

Arny: Yeah, he is thinking yum yum...

Tom: [Laughs] Yeah [the tongue comes out of his mouth again and he pauses]. Yum yum was a little scary. A little more than ornery. I am blushing.

Arny is trying to access the symptom maker, to connect Tom with the dreaming process or spirit behind his symptoms. It appears surprisingly in his language as a "bugger;" the way it just slipped out reveals that they are in unknown territory and that the bugger is something they will want to investigate. Tom gives immediate positive feedback to Arny's repetition of the word bugger, associating to it further, and making the faces and tongue and thumb motions which belong to this ornery figure. Arny unravels the virus process on its own terms by following the modes of communication which it presents. Within a few minutes an ornery critter, the spirit behind the virus, is sitting there.

Arny: Are you noticing something?

Tom: Yeah, I am thinking about how ornery I am. I can be kind of ornery sometimes.

Arny: Sometimes, not as a general rule?

Tom: No, sometimes. I think I shouldn't be so ornery. I would lose friends if I was ornery so I keep it back here someplace [he points to his back left side].

Arny: [looking back there] How far back is it?

Tom: It is like on my shoulder, hanging on my shoulder a little bit.

Arny moves to the back of Tom's shoulder and plays this ornery critter. He uses a higher voice which sounds half menacing and half teasing.

Arny: Well, well, yeah, it is me back here, the ornery critter. It is me, yum. Your old friend who you keep putting back here because you think if you let me forwards in relationship then you are going to, hee hee hee... but I am still back here.

Tom: Yeah, I know, and I let you out sometimes.

Arny: Well, if you let me out once in a while I'll give you a little freedom too. I have given you a few years. You think you are giving me freedom and I feel like I have got the controls. Hee hee.

Tom: Well, I probably have a lot more control than you do [he turns around and faces Arny, who is playing the ornery critter]. You want to eat me up?

Until this point, the primary process has understood the virus as a bugger. However, this description comes from the perception of Tom's identity. It is not the perception of the bugger itself. The work will be geared to accessing the perception and awareness of this bugger, which would be the new awareness that Tom is seeking. Tom has done a tremendous thing in facing the ornery critter. He has begun to take over the controlling energy of that figure just by facing the bugger and frankly asking him if he wants to eat him up. This is a strong moment. Tom's state is different and more active now. It looks almost like the critter's state.

Tom initially described his shingles as "dramatic." This ornery critter is one of the great dramatic figures in Tom's repertoire.

Arny: Eat me up?

Tom: Yeah, I want to find some way of bringing you in.

Arny: [Still with the voice of the ornery critter] Yeah, you want to bring me in, haaaa yaaaa. Smart guy, yeah, you want to bring me in. That is just what I have been hoping for [they embrace]. Now I am wondering how you can bring me in and befriend me. I am already feeling a lot better about you, but I'd like you to be a little more like me.

Tom: Well, could you teach me?

Arny: You want me to be your teacher? Haaa, yaa yaaa ha [rubbing his hands together mischievously]. The teacher, yes. I could teach you.

Tom: Without losing any friends in the process.

Arny: Well, I am not interested in being the same kind of related that you are. I have other forms of relationship.

Tom: Like what?

Arny: Like, well, you know, other things. [Arny is purposefully keeping the form blank and waiting for Tom to fill in what these other forms might be. Arny is still playing the ornery critter, rubbing his hands and waiting]. Did you do something?

Tom: Did I do something?

Arny: Yeah, with your lips? [Tom licks his lips again]. Yes, that is one of the forms of relationship that interests me.

Tom: Yeah, yum, yum [Tom hangs his tongue out, moves it around and laughs].

The tongue signal has repeated since the beginning of the work, and the sender of this signal seems to be this ornery critter. While Tom wonders what the other kinds of relationship might be, Arny waits for the answer. Tom is not the one who will be able to give an answer, because it is not really Tom who is requesting a change. It is the ornery critter. We have to look for other signals and ways that the ornery critter will make his desires known to us. The tongue gives us the answer.

Arny: That is an interesting and wise looking tongue, and that tongue wants activity.

Tom: It is a yum yum tongue [Tom is looking around the room at the people].

Arny: Well, since this all has to do with relationships [they both look out to the people now], maybe you can be a little bit ornery. You seem like you are beginning to pick me up. How about making some ornery movements.

Tom: Can I practice on you?

Arny: Why not. Make some ornery movements to me or in relationship to me.

Tom's tongue is hanging out. Grinning, he approaches Arny and embraces him. They hold on to each other, moving slightly. Tom pats Arny's head and tries to look at his face.

Arny: I notice our tummies and pelvises are in contact.

Tom: Yeah.

Tom gets uncomfortable here and wants to look at Arny. Looking at people is his primary way of relating. Looking is not the way of the ornery critter. The unintended information is the body contact they have. Tom is now at an edge to go further with this. Arny tries to return to the difficult point.

Arny: I would like to go back to where we were before. [Arny brings him back to their embrace]. I want to go on with this part a little bit. [Tom is stiff]. Are you there?

Tom: Uh, no. I was there [laughter].

Arny: Where are you?

Tom: I don't know. Well, I feel our stomachs together.

Arny: What is happening right here? [Arny touches his chest and shoulder area].

Tom: As little as possible. [Everyone laughs, enjoying Tom's good humor. His tongue also pops out again].

Arny: Your honesty is heartwarming.

Tom: There is nothing happening.

Arny: What is the nothing that is happening?

Tom feels internally and says that he feels a little warmth. He makes pulsing motions with his hands coming outward from his chest. The experience in his chest is one of proprioception and movement; it is warm and it pulses. Tom has reached an edge in the body contact. Arny works gently at the edge, not pushing Tom. Dropping the body contact

between them, he follows the signals around the chest.

Arny: Let's pretend that there is warmth in there and that it could also come out in movement, not just a feeling, but a movement that could express itself. What would it be?

Tom looks around at the group and then walks out towards the people surrounding him.

Tom: I am directly looking at many people here, and [he moves arms outward from his chest] I am showing myself, opening up who I am.

Arny: Yes, it looks like it makes more relationship, not less.

This is a fascinating point; the identity and its way of perceiving the world is always limited. Because the identity is so afraid of what it does not know, it sometimes makes incorrect assumptions about secondary processes. Tom's primary process thought that he would have less relationship, but paradoxically he discovers the richness in the kind of relationship that his "ornery" secondary process is trying to bring him.

I think Tom was a great relationship teacher. I can see him in groups in the Process Work community bringing out unusual and less conventional modes of relationship. I also remember Tom as a gay activist, often standing alone as a gay man in large groups and teaching people about love between men.

As Tom continues to look at the people, Arny encourages him also to feel the feelings he has as he does this.

Arny: Let's say that feeling could be a stream and that you can describe your feelings in terms of the image of a stream. What kind of a stream would be coming out to these people?

Arny uses the image of a stream because Tom's usual way of perceiving is through visualization and he is having some trouble perceiving his feelings. Using an image to describe feelings will help him access this information. In the beginning, the three men were speaking about life as a stream. Arny is simply using the images which are already present.

Tom: It is like a multi-levelled stream that has a deep part that winds around and then there are shallower parts, little pools on the sides. The water continues down and [he is walking around describing the stream] sometimes it stays in a little pool and sits there for a while. Other times it goes off way deep. [He makes a large sweeping motion swinging his arms outward towards the group].

There is now a silence and he looks out towards the sea of about 150 people.

Tom: I just got this image of this being the ocean [he points to where people are sitting and beyond], and how sad and scary it might be to get to the end of the stream. Because when I said we were close it felt like I was right here [walks to the edge of where the ocean begins, where the people are sitting] at the end of this exciting stream and not knowing what the hell this ocean was. It is so big, like with waves and darker parts and lighter parts and depths and it has a fuzziness to it. It is not so sharp, so I don't know what I am getting myself into.

Arny: I don't know either, but maybe if we get into it, it will answer us. [Getting into the ocean is the next step, the next piece of information that needs unfolding].

Tom: I don't know how to get in. Maybe I can just walk into it.

Tom walks forward and Arny encourages him with a gentle tap on the back. Tom stands at the edge of the ocean and then walks in through the people. He is very agile, climbing over people and chairs in the crowded room, and then stopping and looking around. The atmosphere is quiet, full of respect and anticipation. Tom moves towards the back and takes a seat in the sea of people. He looks around. He looks very still and contemplative; the mood around him is different than before. After a while he gets up and speaks.

Tom: I got here and I wanted to sit down and become part of the ocean, just undifferentiated from the rest of the ocean. It happens a little, but I mostly feel like the stream.

Arny: It happens just a little because something else happens too.

Tom: Yeah, memories of the good ole stream, for example.

Arny: Which ones?

Tom: Which stream?

Arny: I don't know what I mean.

Tom: Huh?

Arny: What?

Tom is in the middle of a change of world view and at this point things become very confusing. While he is having new experiences which do not fit with his primary way of understanding the world, he is organizing the new information from the perspective of his governing philosophical beliefs. His primary belief is that when he goes into the ocean he will become an undifferentiated part of it. A piece of new information which does not fit into his belief system is holding him back from becoming totally identified with the ocean and losing his sense of self.[2] He has an edge to it, meaning that he stops at this point and cannot go any further with his perception. Arny tries to discover what stops him, and at this point Tom suddenly cannot follow the conversation anymore. This is what happens to all of us at perceptual edges; something new and mysterious comes up and we blank out or feel confused. Confusion means that the normal mode of organizing perception and understanding the world is not able to comprehend that which is outside its parameters.

Tom does something else typical of what we all do when confronted with something that does not fit our world view: he thinks that he has done something wrong and his perception is not accurate. He does not take the disturbance as new information, but complains because he is not able to accomplish the experience he had anticipated. Going into the ocean is a secondary process and a new experience for Tom. Since he takes his primary orientation with him, he is unable to value the new experiences which occur in that ocean because they do not fit into his awareness. The task now will be to connect Tom with the awareness process of being in the ocean. Discovering how he perceives in this ocean and who he is when he perceives this way will be the next step.

Tom: It is hard to become part of the ocean.

Arny: I understand. How do you know you are not part of the ocean?

Tom: I still feel separate. I still feel like everyone's eyes are on me and I can see my picture on the TV [the seminar is being video-taped], and I still have these internal sensations and feelings. I feel my face getting red.

Arny: Yes, you still have an awareness of yourself even though you are in the ocean. It sounds right. That is great.

Tom: I want to let go a little more, or maybe I don't. I don't know. I thought that when I became part of the ocean that I just let go of all that.

Arny: That is what you thought. But your awareness stays with you.

Tom: Yes.

Arny: Well, that sounds like what happens.

Tom: Yeah, that is what is happening.

Arny: So go ahead and follow that happening for another couple of minutes. Maybe you can give me a report of what's happening while it is happening.

Tom: [Tom is quiet for a while experiencing this new awareness of being in the ocean]. Well, at the moment, I don't feel like anybody special.

Arny: Yeah, me either. Isn't it great not to be anybody special?

Tom: Yeah [with laughter and amusement].

Arny: Let's pretend that you are nobody special in the moment. Like you are nobody special.

Tom: Nobody special. Humm. I am part of this whole ocean here, another drop in the sea.

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[2] Editor's Note: During his work at his last Lava Rock Clinic, Tom was asked what would happen to him when he died. He said that he would first come and visit people here in this world, then he would enter and become a part of everyone and everything, thereby becoming nothing.

Arny: Another drop in the sea. We're nobody special. I'm another drop over here. Hi drop.

Tom: Hi.

Arny: We are nobody special. There is a certain freedom in that. And not being anybody special we can be anybody, not special.

Tom: Yeah, that's true. There is a certain fluidity in that.

Arny: Yeah, we are just drops in the sea, now we can be fluid. Now, since we don't have to be anybody special, we can be anybody. [Tom licks his lips]. What do you want to be?

Tom's awareness in the ocean is to be nobody special and in that he can be anybody. I am reminded of how the Yaqui Indian shaman, Don Juan Matus, one day surprises his apprentice, Castaneda, by wearing an exquisite suit. Having lost all of his personal history, Don Juan was nobody special. [3] Being nobody special, without a set identity, he could be anybody and even look like a conservative gentleman.

Arny's interventions are geared towards keeping Tom in this new form of awareness and deepening it. Talking about the experience would be a step removed from actually experiencing it. Therefore, he jumps into the system with Tom. Together, as two drops, they can discover this new world. The two drops talk to one another and decide that since they are nobody, they really can be anybody. Tom says he wants to be an adventurer, like Lewis and Clark. He wants to have new adventures and go on quests. As Tom says this he again looks around at the people, and his tongue occasionally licks his lips. The looking is indicative of the adventurer who is already investigating, but Tom is not identified with it at this point.

Remember that Tom reached an edge in relationship with Arny earlier in the work? We are now returning to it. The strong repetitive tongue signals and frequent looks outward toward the people in the group indicate that the work will have to come back to the relationship channel.

Arny: Let's start looking right now for something.

Tom: This is hard for me.

Arny: You got your eyes on people?

Tom: Yeah, I do.

Arny: Well, let's check them out. Some of them look pretty juicy.

Tom: [Tom appears nervous and fidgety, but he smiles and looks around the room, licking his lips]. Yeah, there are some pretty juicy ones in here.

Arny: Which one looks juicy right now? [Tom shrieks with delight and laughter, as does everyone in the room]. Come on, you be Lewis and I'll be Clark. Come on Lewis, let's do our investigating. We are just anybody. We are nobody investigating anybody special. Nobody special is investigating the juicy things.

Tom is shy. He is at a big edge to reach out to people with his new adventurous personality. Arny is again joining the system, being an adventurer with him. This encourages Tom. For him, it is lonely to do something so new with everyone else on the outside watching. Arny is not only being the adventurer; he is also helping Tom keep his access to the new world view of being nobody. Tom needs to be nobody in order to be anybody. In order to go over this edge, he needs a new perception of the world.

Tom approaches a man, tells him he looks juicy and asks his name. They shake hands. Arny and Tom go through the room, approaching a few different men, greeting them and explaining that they are investigating unknown territory. Arny is right with Tom in this new adventure.

Arny: Hi. We want to be just anybody getting into an adventure.

Tom: Yeah, just anybody, not somebody.

Arny: Yeah, we are going to leave the old somebody behind. Let him die and let's live.

A man asks Tom what he finds so juicy or interesting about him. Tom talks about his face and hair, making slight movements with his arms and pelvis

[3] Carlos Castaneda, *Tales of Power* (New York: Simon and Schuster, 1974) 103.

as he speaks. Amplifying this movement brings out a strong thrust and a loud "Yahoo!" Both men thrust themselves forward and shriek ecstatically. This way of relating was trying to happen earlier, but could not emerge without a pattern, a new belief to pave the way.

Tom has now had a tremendous breakthrough, but integrating this into his everyday life will be a challenge and he wants help with this.

Tom: How can I stay with being nobody special? It is so easy to get back into thinking "this is who I am."

Arny helps Tom integrate the experience by trying to bring it into his normally occupied perceptual channel, which is vision. Arny suggests that Tom watch Arny interacting with another man.

Arny: As long as I am somebody I have to meet people like this. [He approaches someone and very politely says hello and shakes his hand.] Now, if I am really nobody special, with awareness, and I am not just everybody, then I can meet him like this. [Full of movement and excitement, Arny approaches the man, slaps him on the back and grabs him into an embrace.] I can just be there and experiment. It is an adventure.

Tom: Yeah, that helps. He is an adventure. Yes, I got it. Now I just want to look at the group as if I was nobody special. [He squats down and stares out into the group with the same contemplative and centered look he had had before in the ocean. He nods to himself]. This is great. I don't feel self conscious and that is so great. Thank you.

Tom embraces Arny and finds his seat in the larger group.

Erasing personal history[4]

Erasing personal history seems to be one of the essential human challenges. The last time I saw Tom at the Lava Rock Clinic, he had an awesome quality, like a mist around him. I couldn't tell you who he was anymore. He danced over edges with the grace of a deer. Nothing bothered him, and he seemed truly open to whatever fate was to bring him.

In the work in Zürich, Tom was beginning his work in this direction. He was clearly identified with having to be somebody, having an identity to which he was bound, and then being self conscious about it. In *Journey to Ixtlan*, Carlos Castaneda struggles with the same problem. Don Juan introduces a new view which totally baffles poor Carlos. Don Juan says that he himself has no personal history and urges Carlos to erase his. They argue philosophically, and Don Juan tries to explain to Carlos that having no personal history means being free, not being tied down by the thoughts of ourselves and others. Carlos argues back and insists that Don Juan knows who he is. Don Juan asserts that he does not know who he is. Staring out to the mountains, he says: "How can I know who I am, when I am all this?"[5] It seems that nature often brings us this experience, allowing us the relativity to lose our sense of being confined to a specific identity.

> You see, we only have two alternatives: we either take everything for sure and real, or we don't. If we follow the first, we end up bored to death with ourselves and with the world. If we follow the second and erase personal history, we create a fog around us, a very exciting and mysterious state in which nobody knows where the rabbit will pop out, not even ourselves.[6]

Both Tom and Don Juan stress the adventure of being nobody, the mystery and excitement of looking at the world as an adventure. In this world, as Don Juan says, nothing is sure or real. In other words, nothing is set or fixed or predictable. Being somebody furthers a view which confines us and creates boundaries of what we are and what we are not. The fog that Don Juan mentions is analogous to the fuzziness and lack of definition Tom experienced when he went into the ocean and discovered what

[4] See Carlos Castaneda, *Journey to Ixtlan* (New York: Simon and Schuster, 1972) Chapters 2 & 3, for a discussion on erasing personal history. Also see Arnold Mindell's *The Shaman's Body: A New Shamanism for Transforming Health, Relationships and Community* (San Francisco: HarperCollins, 1993) for further discussion on the topic.

[5] Carlos Castaneda, *Journey to Ixtlan* (New York: Simon and Schuster, 1972) 14.

[6] Castaneda, *Ixtlan* 17.

life was like without being somebody, or having personal history.

At the Lava Rock Clinic erasing personal history becomes a daily occurrence as individuals who are in pain, feel physically limited or are near death suddenly feel free. These are awesome moments and great teachings for those of us present. Last year around the time of Tom's work, I came across an article about Anne Frank in the Portland newspaper. I was deeply moved by how this 13 year old was able to erase her personal history. From the horror of Bergen Belsen she writes:[7]

> I have found that there is always some beauty left—in nature, sunshine, freedom, in yourself; these can all help you. Look at these things, then you find yourself again,...
>
> I want to go on living even after my death! And therefore I am grateful to God for giving me this gift, this possibility of developing myself and of writing, of expressing all that is in me....

Historical background of being nobody

In Western culture becoming somebody is a high goal. Much of our ambition is channeled into creating an identity in which we feel at home. In psychological circles there is often a goal of strengthening the ego. Self-help books have titles like "gaining self confidence," "how to be assertive," "empowerment for women," etc. All of these books feed our desire to build up those parts of our personalities which concern self-image and identification.

Judeo-Christian belief supports this strong sense of self and ego. In Genesis, "God said: Let (man) have dominion...over all the earth; And behold it was very good." [8] Man is created with power and a strong sense of self, able to control nature's unpredictable temperament. Additionally, God made a convenant with man, stating that nature is permanent and that God created a permanent world. Thus we are warned that if social and moral attitudes are not upheld, nature will be disturbed and God will break his convenant.[9] Therefore, humans have the personal responsibility to uphold the status quo and thus live in a permanent and static world. From this perspective being somebody is essential. Tom's new experience is the opposite of this world view, but finds an echo in the Eastern part of our planet.

In the Far East, especially in Buddhism, the highest goals are the extinguishing of self and the dying out of separate individuality.[10] The motivation behind these goals is the cessation of suffering. Suffering and anguish exist because of our attachment to self, meaning our attachment to sense experience, our attachment to the material world, and our desire for permanence.[11] By giving up sense perceptions and impressions and the cravings that are attached to them, one experiences the death of self and individuality. One gives up self by surrendering all that one thinks of as one's self. Then, paradoxically, self is found.[12]

In Buddhism the senses are not perceived by "I." They are not "mind" and they are not "self." In Siddha Yoga, sense experience is understood to be Shakti and the perceiver is Shiva.[13] There is no individual or personal perception or perceiver. Shiva perceives Shakti; what Muktananda called "the divine play of consciousness." The tendency to identify with our perception is a search for permanence, which the Buddhists say is impermanent. The impossible attachment to permanence creates suffering. We all have the experience of wanting to hold on to particular states forever and becoming depressed and disappointed when we cannot. The Buddhists say that realizing the non-permanence of self is the only thing that is permanent. Eternal freedom is the state where one no longer strives for permanence or suffers from the impermanence of

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[7] Anne Frank, *Diary of Anne Frank*, (New York: Doubleday, 1989) entry: Tuesday April 4, 1944.
[8] H. Smith, *The Religions of Man* (New York: Harper and Row, 1958) 232.
[9] R.C. Zaehner (Ed.) *The Concise Encyclopedia of Living Faiths* (Boston: Beacon Press, 1967) 30.
[10] Zaehner, *Living Faiths* 308.
[11] Zaehner, *Living Faiths* 287.
[12] Zahener, *Living Faiths* 281.
[13] Swami Muktananda, *The Play of Consciousness* (Camp Meeker, California: SYDA Foundation, 1974).

human life.[14] Smith expresses this well in his definition of nirvana.

> Nirvana is the highest destiny of the human spirit and its literal meaning is extinction. But we must be precise as to what is to be extinguished; it is the boundary of the finite self.[15]

What Tom extinguished was his finite idea about being somebody. This state of impermanence or nirvana is also characterized as emptiness, nothing or no self. We usually suffer from our inability to be fluid and our tendency to identify with one state, one somebody.

Beyond Buddhism?

> When we are selfless we are free but that is precisely the difficulty, to maintain that state. Tanha is the force that ruptures it, the will to private fulfillment, the ego oozing like a secret sore. It consists of all those inclinations which tend to continue or increase separateness, the separate existence of the subject of desire.[16]

These statements describe Tom's conflict. He went into the ocean and left his separate self behind. Tom, too, wanted to attain this selfless state. However, once in the ocean he began to perceive himself as a separate entity, a self, part of the stream. His desire to maintain a state of selflessness and merge with the ocean was changing. Since Process Work has no goals as to what state Tom should achieve, Arny was free to follow the unfolding of Tom's unique process and see that as valuable. Tom could then follow his individual awareness within the ocean. This awareness developed into perceiving himself as a drop, and then as nobody special. Could it be that Tom's experience adds something to the Buddhist belief? Nirvana too, seems to be a state which changes. Whereas Buddhist belief might detach from the everyday world, Tom's process brought him more strongly into it. Being nobody gave him the fluidity to be anybody; he was then free to relate as passionately, physically and unconventionally as he felt. Tom's work demonstrates a kind of fluid ego that is free to identify with whatever it perceives in the moment.

The spirit behind the symptom

Returning to Tom's AIDS, we could conclude that his body is using the virus to speed along this nobody process. The ornery character was the beginning of nobody. He had the controls and could do what he wanted. He was fluid. The ornery critter, or symptom maker, was trying to live this state of being nobody. People in altered states, dying states and other fatigued and flu-like states are often trying to contact this state of being nobody.[17] In this state, all of the energy from the primary identity is reduced and we are free to be anybody.

Mindell has found that people with life threatening illnesses have a powerful individuation process ahead. Something very strong wants to emerge and it will not wait for the individual to make organic changes. The primary process has to die; the individual is pressed to identify as another kind of person.[18]

Crossing cultural borders

Tom's work shakes him out of a common Western world view and drops him into the domains of another culture. It seems that part of our individual growth is often in the direction of learning about other cultural beliefs in a very personal and intimate way. This frequent occurrence indicates that our personal growth also furthers our collective growth.

Concluding thoughts

I know that for the many people who knew him, Tom's spirit is very much alive. In this work and other times throughout the years when he worked publicly on his AIDS, he was a role model inspiring us with his courage and his openness to change. At

[14] R.C. Zaehner, *Living Faiths* 287.

[15] H. Smith, *The Religions of Man* (New York: Harper and Row, 1958) 111.

[16] Smith, *Religions* 101.

[17] Mindell made this comment in a discussion concluding this work.

[18] Mindell has made this comment in numerous public courses from his work with symptoms and people who are dying. Also see Arnold Mindell, *Coma: Key to Awakening* (Boulder: Shambhala, 1989) Chapter 6.

the Lava Rock Clinic while he lay on the ground surrounded by a sea of people, we were all held together by the strength of his love and knew this was only the beginning.

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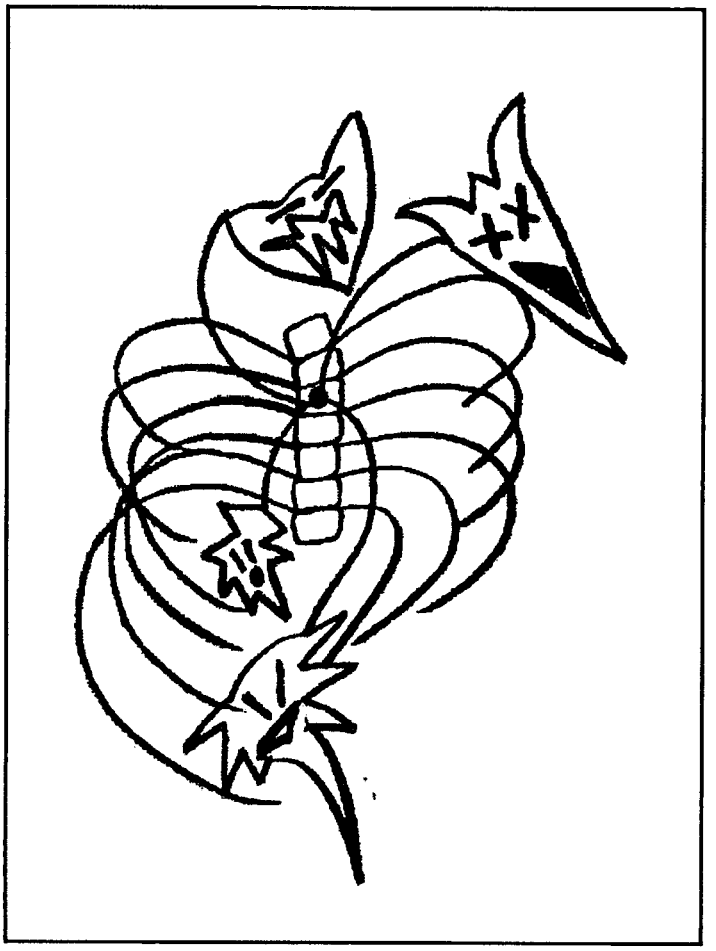
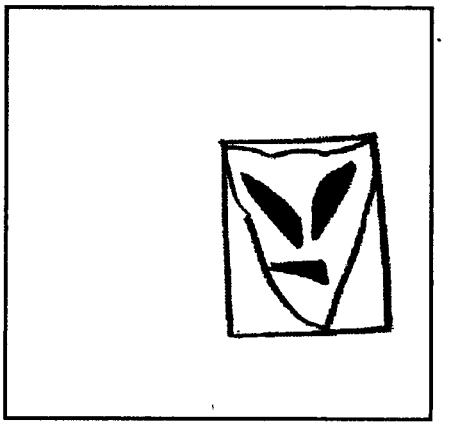
Symptom Art



Lung Constriction

These "masks" were drawn by someone working on a chronic lung constriction. The "mask" faces express the vital energy wanting to emerge from her chest.



The Wisdom of the Dreaming Body: a case study of a physical symptom

by Alan Strachan

In working with childhood dreams, I've discovered that they point to a life pattern of the dreambody behavior. Very often, chronic illnesses appear in the childhood dreams. These major dreams pattern our lives, our problems with the world, and our body problems.

— Arnold Mindell

Are the basic patterns of our lives evident in our childhood dreams? Can the content of childhood dreams be manifested in chronic physical symptoms during adulthood? Do physical symptoms contain messages which lead to personal growth and healing? These questions intrigued me as I began my doctoral research on the relationship between childhood dreams and chronic physical symptoms that occur in later life.

As I reviewed the literature on dreams and illness, I quickly discovered that this topic has fascinated observers for thousands of years. In ancient Greece, Hippocrates, Aristotle and Galen wrote that dreams were highly sensitive to the events of the body and instrumental in helping physicians diagnose illness. Freud's publication, *The Interpretation of Dreams*, ushered in the modern age of dream research. He was convinced that disorders of the internal organs often instigate dreams, and that dreams could be useful in diagnosing and forewarning of illness. Modern empirical studies demonstrate a connection between dreams and a wide range of illnesses, including heart attacks, cancer, migraines, tuberculosis, hypertension, ulcers, asthma, arthritis, diabetes and back pain. These studies show that dreams can play a role in diagnosing an illness, determining a prognosis and formulating a treatment plan, as well as contributing to the healing process.[1]

Psychotherapist Arnold Mindell has proposed an even deeper connection between dreams and illness. In contrast to most of the modern studies in which the dream and illness occur within a day of each other, Mindell observed that certain childhood dreams may manifest years later as chronic physical symptoms.

For the past 20 years, Mindell has been developing a psychotherapeutic modality which he calls Pro cess Oriented Psychology, or Process Work. In the course of his training, Mindell discovered some remarkable statements about children's dreams made by C.G. Jung. In a series of unpublished lectures de-

[1] See Caro Lippman, "Recurrent Dreams in Migraine: An Aid to Diagnosis," *Journal of Nervous and Mental Disease*, 120 (1954): 273-276. J.A. Hall, *Clinical Uses of Dreams: Jungian Interpretations and Enactments* (New York: Grune and Stratton, 1977). S. Hyman, "Death-in-Life—Life-in-Death: Spontaneous Process in a Cancer Patient," *Spring* (1977). M. Sabini and V.H. Maffly, "An Inner View of Illness: The Dreams of Two Cancer Patients," *Journal of Analytical Psychology* 26 (1981): 123-150.

livered in 1938-39, Jung described "far-seeing" dreams which reveal at an early age the basic qualities of a person's "life myth," i.e., the unique pattern or story that characterizes an individual's life and imbues it with a fundamental meaning and purpose. [2]

Jung believed that the form of the personality is established from birth, and that the far-seeing dreams are unconscious, symbolic representations of the wholeness of the personality. Far-seeing dreams are especially prevalent in childhood because the child's ego is less developed and thus less separated from the unconscious. Jung believed that a person cannot individuate, or become whole, without remembering and integrating these dreams.

Mindell agrees with Jung that childhood dreams reveal a fundamental life pattern or life myth. A major difference is that Process Oriented Psychology places far more emphasis upon, and works more directly with, physical symptoms. From the perspective of Process Work, dreaming and presenting physical symptoms are simply different ways of conveying the same information. Mindell has observed that processes underlying recent body symptoms always appear in a person's ongoing dreams, while long-term processes such as chronic physical symptoms are related to childhood dreams.

As I surveyed the literature on dreams and illness, I discovered four articles which described a meaningful connection between childhood dreams and a variety of illnesses—migraines, cancer, heart attack, hives and backache—that appeared in adulthood. [3] These studies were a beginning confirmation of Mindell's theory. A comparison of the articles showed that the childhood dreams had four characteristics in common: they tended to be recurrent, were frequently the earliest dream remembered, evoked strong feelings in the dreamer and portrayed a situation which remained unresolved when the dream ended.

For my doctoral project, I decided to examine Mindell's theory. I located a videotape of a psychotherapy session in which Mindell worked with a client on both a chronic physical symptom and a childhood dream. According to process theory, an analysis of the tape should show a structural correspondence between the dream and the body symptom in terms of the client's primary and secondary process, occupied and unoccupied channels, edges and dream figures. Here is what I found:

Mindell's client—I will call her "Marla"—is 26 years old and a graduate student of psychology. Marla and Mindell begin the session by sitting on the floor facing each other, surrounded by seminar participants [Figure 1]. Marla describes her presenting complaint:

Figure 1

> I have a chronic symptom in my chest and a constriction across my back. [Marla swings her arms front to back, parallel to the floor, like a breast stroke.] I'm always trying to get more room. And that's a chronic thing.

A basic tenet of Process Work is that every client's process has an underlying structure. Symptoms such as Marla's are viewed as meaningful, purposeful conditions. Often the reason our symptoms per-

[2] Carl Jung, "Psychological Interpretation of Children's Dreams," (Zürich lectures: unpublished 1938-39).

[3] See Lippman, *Recurrent Dreams* 273-276. Russell Lockhart, "Cancer in Myth and Dream: An Exploration into the Archetypal Relation Between Dreams and Disease," *Spring* (1977). Leon Saul and Clarence Bernstein, "The Emotional Settings of Some Attacks of Urticaria," *Psychosomatic Medicine* 3/4 (1941): 349-369. Daniel Schneider, "Conversion of Massive Anxiety into Heart Attack," *American Journal of Psychotherapy* 27 (1973): 360-378.

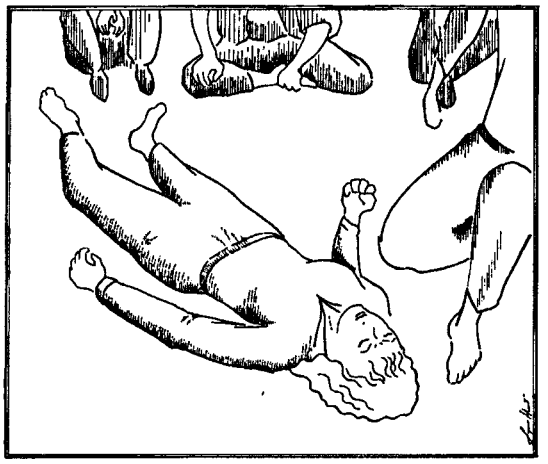


Figure 2

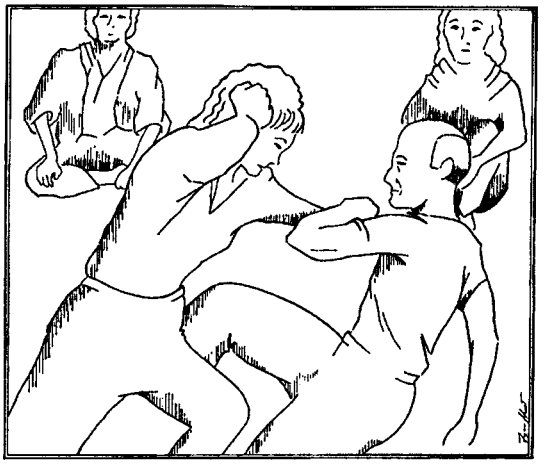


Figure 3

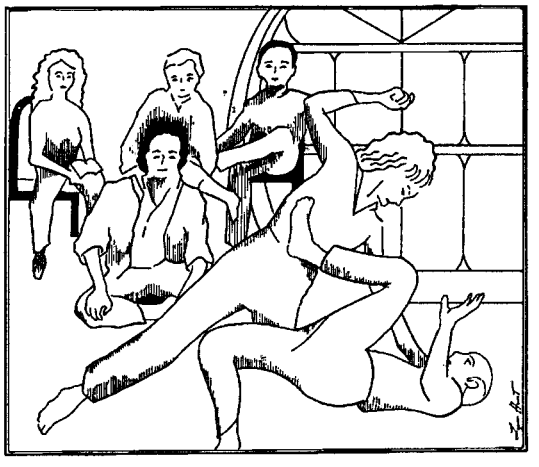


Figure 4

sist is that we cannot decipher their message and use the information they are conveying.

One of Mindell's tasks is to help Marla decipher her symptom. To do this, Mindell must first help Marla amplify her symptom, to make the signal it is sending more intense. He accomplishes this by paying close attention to the way in which Marla experiences her symptom, i.e., by noticing the channel in which it is occurring. The most basic channels are vision, hearing, feeling (or proprioception) and movement. Marla's symptom is occurring in her proprioceptive channel (her chest pain) and her movement channel (her sense of constriction). In a separate exchange, Mindell determines that Marla's main channel is vision, a fact which will be important when Marla is ready to integrate what she is about to learn.

Mindell recommends that they begin working on the chest pain, and Marla agrees. Marla lies down, and together they locate the painful point on her chest. With Marla's permission, Mindell begins to press on the point, to intensify what Marla is feeling, and she variously reports that it feels like a "bruise...a black and blue mark...sharp pain."

After a few minutes Marla says that the pain is "like a knife." As she speaks she also makes a fist and raises her arm [Figure 2]. This is significant, for it means that Marla has changed channels, i.e., that she is beginning to experience her symptom as movement rather than as a feeling. Mindell facilitates this process by providing resistance to her knifing motion.

Mindell then asks, "Who is this knifer?" and Marla replies, "A killer." Within the next minute, Marla raises her head, sits up and turns to face Mindell. The killer is no longer just in Marla's arm! Instead, Marla is embodying the killer.

Mindell then begins to play the role of the killer's victim. Marla makes a knifing motion [Figures 3 and 4], repeatedly stabbing the place on Mindell's sternum which corresponds to her own pain point. In Process Work terminology, the killer is the "dream figure" who is creating the pain in her chest.

Marla stands up, faces Mindell, and continues to threaten him with her "knife" hand as she makes full eye contact for the first time. Her facial expression, posture and gestures all indicate that she has

fully identified with the role of the killer. But in order to gain a complete grasp of her process, Marla needs to explore more completely the role of the killer's adversary, which is her usual or primary process identity. She needs to fully experience the pain.

Mindell initiates the role reversal by imitating the killer's posture and raising his arm to make a knife stroke. Marla makes several vigorous attempts to ward off the killer by swinging her arms with great force in front of her. As they interact, Mindell is closely monitoring his reactions to playing his role. He notices that Marla's actions have not been enough to make him stop his attack, and he remarks, "The pattern of a chronic symptom is being up against a force that you are stalemated with." Mindell remembers that proprioception was Marla's least occupied channel at the beginning of the session, and therefore the one in which she is most likely to learn what she needs to know. He therefore suggests that they return to Marla's original symptom—her chest pain—in the hope that they can find a way out of the stalemate, and Marla agrees. With Mindell's help, Marla amplifies her feelings until she is grimacing with pain and her body is contracted [Figure 5].

Mindell then initiates another role-playing sequence by resuming the role of the killer. He wants to see if Marla can use the depth of her feeling reaction in direct confrontation with the killer. He warns, "I'm going to kill you..." and "stabs" her in the chest. Marla responds to the knife stroke by becoming even more tense and contracted than before [Figure 6]. Mindell, severely affected by her reaction, tells her, "I can't strike you when you do that. It's an incredible protection. I can't play my role any more."

Marla's strong reaction made it impossible for Mindell to continue with his role. Marla used her entire body as well as her facial expression to fully express her pain. The killer had been challenging her to react strongly, and after her reaction, the nature of their relationship changes. In the moment, at least, there is no longer a need for a "killer."

The killer's challenge was an extraordinary one, for he called upon Marla to express a range and depth of feeling that was far beyond her usual experience. The killer had not been concerned with the relatively superficial motivation to seek pleasure and avoid pain. Instead, he conveyed to Marla the wider need of the psyche to know itself completely and thereby to move toward integration and wholeness. From this broader perspective, Marla's pain is not a burden but a profound teacher about her fundamental character and way of being in the world, helping her learn—for example—about her sensitivity, expressiveness, and impact on other people.

But another, crucial step for Marla is to integrate what she has learned. There are several phases to this process, but the most critical one occurs when Mindell suggests that she draw the killer. He makes this suggestion because Marla's most powerful experiences during the session have been proprioceptive, while her most familiar way of processing her experience is through her visual channel. In order

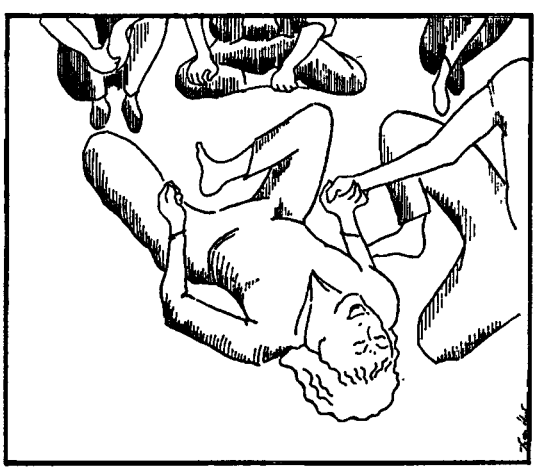


Figure 5

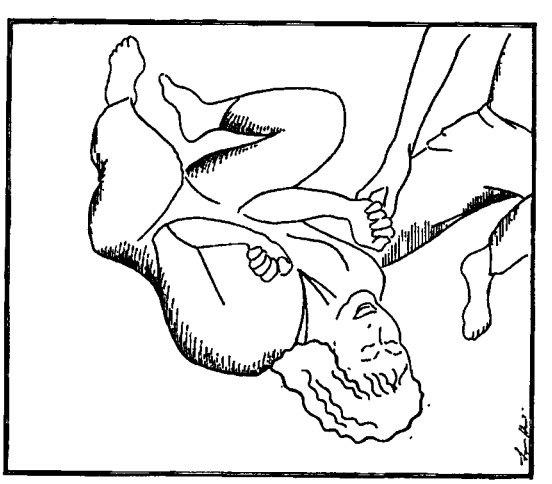


Figure 6

to begin to integrate her proprioceptive experiences, she must translate them into visual form. Mindell therefore suggests that she draw the killer. Marla complies and, when she completes her drawing [Figure 7], a remarkable thing happens. As she looks at the face and body of the killer, Marla remarks, "It's like a missing figure in my childhood dream."

> In one of my childhood dreams there is this kindergarten girl locked up in the bowels of the earth. And there are all these boulders. And I just recently found out who she was locked up by. I forgot that part of the dream when I was younger. She was always alone. And it was, like, this giant. And I could only hear him. [Hits her hands on the floor, making sounds like footsteps.] Boom, boom, boom. I was terrified of him.

When Marla associates the drawing of the killer with the dream, the session reaches a much deeper level. Early in the session we discovered that the painful place in Marla's chest was the killer's point of contact with her. Now, when Marla remembers her childhood dream, we realize that the killer is related to an even more ancient figure, i.e., the giant in her dream. By recounting the dream, Marla also helps us understand why she has the chronic sense of being confined: she is still "locked up in the bowels of the earth." Her childhood dream has been in the background, patterning her experiences and creating symptoms which hint at the deeper process. Marla's dream fits the basic pattern described in the literature: it was recurrent, evoked strong emotions and portrayed an unresolved situation.

Four years after the psychotherapy session, I interviewed Marla to explore how she had been affected by the Process Work. At that time, she said that working on her symptoms and her dream produced both physical and psychological changes. Recalling the session, she said, "I remember being really

Figure 7

struck by the pain I was in and showing that pain. I remember the emotional pain and the thing that stopped the giant was the intense agony." She further stated that she was becoming, "more and more fluid...in showing my hurt" in relationships, and that, on a physical level, her chest symptom was "not really up as a focal issue...I don't have a lot of pain with it."

Focusing strictly on Marla's physical symptom would be a mistake. The orientation of Process Work is to increase awareness of the processes underlying body symptoms and dreams. This awareness may result in changes in physical symptoms, but it is not a goal.

In Mindell's view, Marla's childhood dream and her chronic symptom are reflections of a more fundamental process—her life myth. Marla has learned about her life myth from a variety of experiences: her childhood dream, pain in her chest, the feeling of not having enough room, her relationships and observations of her family. At this deep level of personal reality, the line between dreams and chronic physical symptoms becomes blurred. It is the underlying process—the life myth—that defines and guides us.

In our interview, Marla reflected about her personal myth: "I think that figure [the giant] has always haunted me....If I think of that, I think of something very wild and earthy inside of me. And at the same time, there is the other part of it which is this little girl. She's very sensitive, shy, and quiet." Marla recognizes that part of her myth appears to involve bringing those two aspects of herself together.

Learning from chronic physical symptoms and childhood dreams and integrating that knowledge is a life-long challenge. Marla explained, "I find my childhood dream and chronic symptoms are fluid things. So whenever I work on them, I always understand something more. It's not like I have one particular breakthrough and then I've understood the dream. I feel there is always a lot more that I can learn from it. Once it will be important learning about the little girl part of the dream, other times about the giant, and other times about the relationships...."

Marla recognizes that her chest pain and her terrifying childhood dream are more than symptoms. She knows that they are priceless gifts, which, if treated with the respect and attention they deserve, will guide her throughout her life, teach her to recognize and live in accordance with her deepest truths, and help her unite body, mind and spirit as she fulfills her personal destiny.

As I reflected on the results of this study, I became convinced that the investigation of childhood dreams and chronic body problems could have a far-reaching impact on the practice of psychotherapy and health care. Although I restricted my research to childhood dreams, both Jung and Mindell claim that early memories play a similar role. Thus psychotherapists could utilize either early dreams or memories as symbolic statements from which they could form working hypotheses about the client's personality structure, basic attitudes and relationship patterns.

In addition, the process-oriented approach to chronic body symptoms has important implications for the field of health care. Typically, a patient feels victimized by physical problems, particularly chronic ones. It is not unusual for health-care practitioners to pathologize the patient and to view the symptom only as evidence of what has gone wrong and needs to be fixed.

The basis of the process-oriented approach is to regard all symptoms, including physical ones, as positive in the sense that they carry information which, if processed and integrated, furthers individuation. Recurrent problems occur for a reason, and that reason can lead us to an important understanding of ourselves. The more chronic the problem, the more it says about who we are. If we assume that the symptom is trying to tell us something, then we can become active, curious participants in a process of discovery rather than re-active, depressed victims of a process of pathology. This positive attitude allows us to access parts of ourselves that are essential for our development. A further practical implication, as indicated by Marla's remarks during the follow-up interview, is that discovering and acting on the meaning of the symptom may have a positive effect on the symptom itself.

A final implication concerns the spirit with which we face life. If our oldest and most persistent prob-

lems ultimately lead us to fundamental insights and growth, then we may be encouraged, as Marla was, to embrace the unfolding miracle of our lives.

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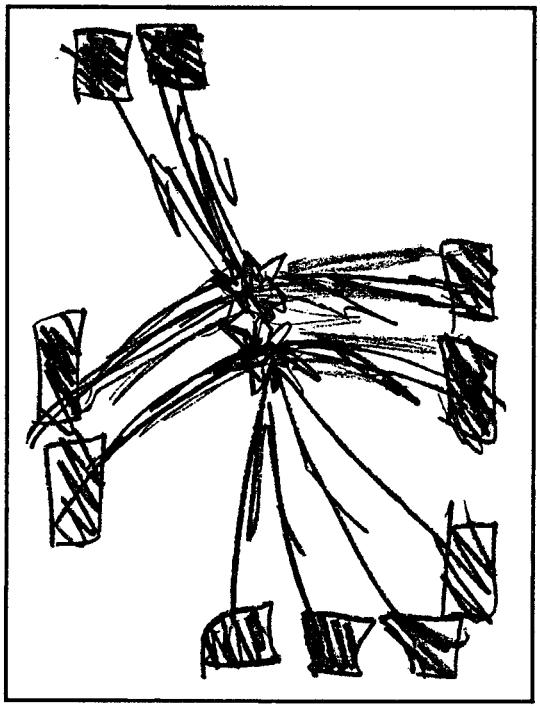
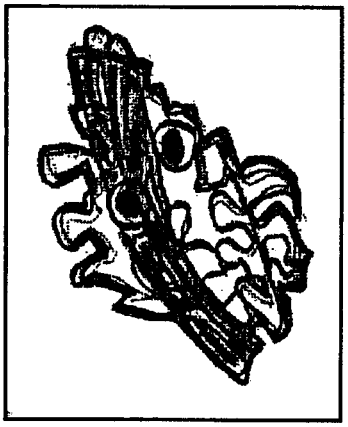
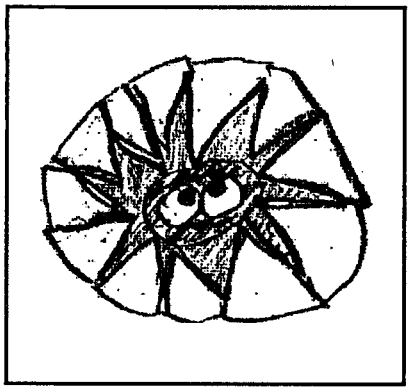
Symptom Art



Back Pain

These pictures were done by someone working on tension in her back. She started with the drawing on the right and then started moving in a way that was suggested by what she had drawn. She reached an impasse in the movement and went back to drawing; the little creatures at the bottom emerged.





Preparing for Death and Planning to Live: an interview with Marianne Pomeroy

by Sara Halprin

I first met Marianne Pomeroy in August, 1987, when I was a new student of Process Work. I was drawn to her good humor and warmth, and I remember she helped me work on a symptom I had at the time, a lump in my breast which turned out to be a fluid-filled cyst. Marianne had already had a mastectomy, and my mother had recently died of breast cancer. We had a lot of common ground. Later, in California, Marianne came with me to visit my first client, a young woman who was dying of a massive brain tumor. We made several trips together to visit my client in the hospital and then at the friends' home where she was staying. During this time, we became firm friends.

Although death has been in the background of our friendship from the beginning, I was still amazed to see Marianne, as a member of a support group for women with advanced breast cancer, on Bill Moyers' public television series about mind-body healing. That's how I found out that her cancer had returned. When Marianne came to the Lava Rock Clinic in Waldport last spring, I was so happy to see her again. The seriousness of her physical condition somehow seemed to fade beside the warmth of her laugh. We resumed our old friendship immediately.

After listening to some of the things Marianne had to say about her illness and her dying process, I asked if she would let me interview her for the Journal. She agreed, thinking as I did that the interview might be of interest to other women working with breast cancer, as well as to therapists and Process Work students.

My focus is on Marianne's experience of breast cancer and the ways she relates that experience to her thoughts about life and death. This has been a theme at the bi-annual Lava Rock Clinics on chronic illness, where a number of people with serious illness have begun by working on a symptom, and the work has moved into the realm of life/death issues. Looking back on my own symptom work, I realize that I hope, through living my symptoms and connecting them with my fears and fantasies of death, to live more fully. Another aspect of this theme are my relationships with dying friends. These relationships, I have discovered, do not end at death, but continue to be part of my life, as my friends' courage and intensity at the edge of life and death continue to inspire me.

Marianne, in the process of working on issues of identity and awareness in relation to her thoughts and feelings about living and dying,

has developed a teaching side which she was shy to bring out in the past. In addition to the Moyers' series, Marianne has appeared on other television shows, speaking about her cancer and its effect on her life. Cancer, Marianne told me, is "an epidemic." She said it kills one in nine women, in some areas one in eight women.[1]

When I sent her the transcript of our interview, she asked me to add the following:

"I feel extremely vulnerable having some of the deepest parts of myself out in public. I wish that people who read this please not criticize or analyze me or my process—but please hold me in unconditional love. If they can do that—then I am open to any questions or communications they may wish to pose.

I am opening myself in the spirit of service. I hope my life and work can be useful."

Following Marianne's wish, I have edited our conversation minimally in order to offer a record of her thoughts about life as she prepares for her death.

Lava Rock Clinic, Waldport, Oregon, April 7, 1993

Sara: Marianne, can you start with a history of your experience with breast cancer?

Marianne: Eleven years ago I discovered a lump in my breast. I got out of the bathtub and a light came and shone on my right breast. A voice came into my ear and said, "Check your breast." So I did, of course, and I found a tumor, a large lump about the size of a plum, firm but not hard. Within a week I had a mastectomy. They removed my right breast and took the lymph nodes out of my armpit. I had two positive nodes, which is not great. It's not a really bad thing in the medical world, but it was enough that they advised me to have a year of chemotherapy.

So I started on chemotherapy, moved to California, and completed my chemotherapy while I finished my master's degree in transpersonal psychology. A year after I finished the chemotherapy, I was again guided to check my incision site. I discovered a garbanzo bean size lump at the site. I went and had it removed and had six weeks of radiation therapy because that lump was also cancerous. Then I did pretty good.

About three and a half years ago, my regular bone scan showed a little shadow on my rib, and the doctor said it was nothing, or that it was an old fracture, or that it was radiation damage or something like that—it didn't look like cancer. But I felt it was something important. It looked to me like a star, and I felt that I needed to go inside and follow my own star. At that time I made a lot of changes in my life. I dropped out of the Process Work program and stopped working on my dissertation, and I rescheduled my therapy practice so I'd have more time off. I started to be a little more inward.

After about a year of knowing I had this star on my rib, I was still not feeling good about my private practice. I felt burned out and needed a lot of time away. I didn't want to go to work. One day I was sitting with a client, and a voice came into my ear and said, "You've got two drops left, what are you going to do with it?" I immediately started the pro
cess of closing my practice.

I finished my practice two years ago, in March, and I thought, "I'll change professions. I'll go back into nursing, I can do that part-time. It'll be easy compared to psychotherapy" (laughs). So I took a couple of refresher courses—I loved studying the body. That was really exciting. While I was doing that, I discovered from a scan that the spot on my ribs

[1] June Jordan recently pointed out, as other feminists have, that while roughly four times as many deaths have been caused in the last ten years by breast cancer as by AIDS, AIDS research has been targeted as a major concern by the U.S. government, but not breast cancer. "Of course," Jordan comments, "breast cancer kills women." See "Seeking an attitude," *Women's Review of Books* X(8), May 1993.

had grown. This seemed more serious, and the doctors were getting more interested. They debated for a couple of months about whether it was or wasn't cancer.

I didn't have any symptoms. My blood tests were all normal, and my surgeon even said, "I just don't believe this is cancer. It doesn't look like it." Two years ago in September I had a biopsy on my rib and the surgeon said the rib was complete mush; there was no structure left at all. I had a tumor in my chest wall, and that had gone in deeper, through the chest wall and into the pleura, the lining of the lung. But it wasn't in the lung. So last year I spent about seven months in chemotherapy and six weeks in radiation to try and stop the tumor growth. It hasn't stopped. It is continuing to grow. Now I'm only taking some tamoxifen to try to interfere with the growth of the tumor. I'm hoping the drug will help slow it down. I think it's interesting that this tumor is considered to be an indolent tumor (laughs).

I identify myself with being rather indolent, but I'm discovering I'm not as indolent as maybe I should be. The tumor is slow-growing, and it doesn't go distances. It stays in the same place and just goes deeper. So that's what I'm trying to do (laughs).

Sara: You're picking up on what your tumor is doing?

Marianne: Yes, you know, there's something about the qualities of my tumor that I really identify with. I think it's funny that I fought against indolence all my life. I thought I was lazy and had to push myself so hard. And now all of a sudden I'm given a symptom that says, "You'd better be more indolent!" I like that. I mean, I like having permission to stay still for a while, and go deeper.

Sara: What do you think it has taken for you to give yourself that permission?

Marianne: Oh, God! A lot of internal and external battles. I had to really work on myself, and on my critic that says I'm lazy, I'm not useful and I have no value as a human being unless I'm working. I didn't even get that until last year. For the first time in my life I had severe bronchitis and asthma for three months. I couldn't do anything but lie in bed and breathe. And I just pondered that question,"What good am I? What use am I? I can do nothing." I realized that it's enough just to lie here and breathe (tears in eyes). It's a profound teaching for me. And it took more than cancer for me to get that. The asthma taught me. It took something to
really put me in bed, make me still, make me quiet
er and make me go more deeply.

I think this is a common thing, at least with other women I've talked to who have breast cancer. It's like, "I'll just keep on with my life, I'll just keep giving, I'll keep doing, you just tell me what to do, I'll do it." We have a lot of identification with being valuable because we're helpers. I'm saying "we" now. I'm thinking especially of the women from my support group for metastatic breast cancer, and I think for all of us, saying that we are needy is almost impossible. I see these women struggle with this issue at every meeting. And I think I've come a long way in that struggle. I'm more willing now to just be. And I don't give much (laughs). I don't give as much, and it makes me feel really good. I feel almost like a bad little kid; I'm not going to give. I'm not going to give, I gave at the office and every place else in my life.

The history of that goes back to my relationship with my mother at birth and shortly after birth. She had a really hard time with me. I wasn't breathing, I was choking a lot, and she freaked out and treated me like a farm animal. I had trouble eating because she didn't have breast milk. I was also born low birth weight. And so when I would nurse she would only have blood. I would spit up blood and she, well the story is, she ran three miles with me to the doctor's, and he put me on formula and I would choke. So she would put her finger down my throat and put me under the cold water faucet to make me breathe. As a result of that, I very early split off from a place that says, "I need." Very early.

Sara: You have a lot of feelings when you tell this story.

Marianne: Yes. I split off from a place that says, "My experience is valid." I split off from any kind of assertion or aggression. Those are still really hard things I'm dealing with.

Sara: That's an incredible story you just told, it's so painful. What happens now when you feel some need to be assertive or aggressive?

Marianne: Right now I'm seeing it in relationships. It comes up in my relationship with my husband. I have to deal with my neediness. I've had to tell him I'm really needy and I'm scared, and I've had to teach him how to respond to me.

Sara: In the past, before you felt any pressure to deal with this, what would you have done?

Marianne: I just stayed busy. If my needs weren't met I got mad and felt abandoned. Then I'd go away to a workshop or something.

Sara: How does this issue come up for you now?

Marianne: Being aware of dependency and neediness? I've had various thoughts with it. The first stuff I worked on was the split-off aggressive part of myself. My first dream figure was a hairy monster who lived in the basement and ate rats. She was wonderful!

That was my first work with Arny [Mindell]. It was the first work I ever did around the cancer. The work gave me courage, since this was a dream figure that was extremely primitive—it had been kept in the dark all my life, all its life. Somehow that work cleared up any fear I had about what was inside of me. I knew that whatever I was scared of and wasn't able to bring into awareness would come from this hairy monster.

I had a dream when one of the women in my group died that her mother was arrested for homicide. And in a sense it wasn't a dream of my own mother, I mean I know it's true in my own personal work, but I have a sense that it may also be the collective work. In my group many of the women often talk about troubles with their mothers. I think it's mother work. Beyond that I think it's repression of the wild woman, repression of the feeling aspect in our culture and the denigration of that aspect.

Sara: It sounds as if the hairy monster has been a great ally for you.

Marianne: I think it's helped me stand up for myself as a feeling person. Learning to value myself has been one of most important aspects of this illness for me. I have learned from a community that showed me it's okay to value myself and that feelings are valuable and necessary. And I learned it in the process community, I learned it in Zürich. I remember exactly when it happened. Jean-Claude [Audergon] had a huge feeling and he completely supported himself in it. I'd never seen this before. The whole atmosphere in the group had come about because people weren't saying their feelings. I felt really ashamed at that moment. Ashamed, and also happy at the same time, to know that if I had brought my feeling into the group it would have made a difference.

Sara: Do you think there's been any value to the experience of having breast cancer?

Marianne: Yes. It's the other side of the indolence. It's a funny thing, I've never thought about this before, but if I'm really indolent in the right way then I'm more awake to something else that needs to happen.

Sara: What's the right way of being indolent? (Both laugh).

Marianne: Well the right way of being indolent is to really support oneself in indolence. I mean to get behind it and really allow it. For me it means having a room to myself here, pulling up chairs and resting when I'm tired, walking away when I need to and just being one hundred percent behind myself doing that. Because there's also a message to hurry up. Hurry up and be alive! (laughs). Be alive to everything that you have.

I think I've been on automatic for most of my life. I have lived in a sleepy way, but the wrong kind of sleep. That makes me think of fairy tales. I don't know which one...You would know a fairy tale, but it's something like, "I've been indolent but it's been the wrong kind of indolence. I've been lazy about,

no, I don't want to say lazy. Well, okay, I've been a little lazy."

Sara: Once upon a time there was a lazy...

Marianne: Once upon a time there was a very lazy woman and she just slept all the time. She didn't want to do any work. She originally just liked to smell the flowers and stuff like that, but life sort of came in the front door one day and said, "No no no no, you have to do this and that and the other thing!..."

So she said,"oh, okay, I'll do it." She didn't even ask herself. She just did it. That's the lazy part. She just did it. She didn't know how to fight it.

Sara: What did life look like?

Marianne: When it walked in the front door it looked like the world saying, "You! Get married and have kids and go to school and..."

Sara: That kind of life. Conventional life.

Marianne: Conventional life walked in. And she was probably an unconventional person. She could have been more of an unconventional person most of her life if she'd only been able to live more of the hairy monster. So then she lived this conventional life and did everything really well. She had five children in five years, went to school and got her master's degree, had a love affair and a twenty hour a week job all at the same time, lived on diet pills, it was wild. Then it all fell apart. The conventional life fell apart.

Sara: How?

Marianne: Well, she divorced her husband and she decided she didn't want any more conventional life. Somehow she knew that it was either get out or die.

Sara: How did she know that?

Marianne: She was up against the wall. She knew, it was either do it or die!

Sara: How did she know? Who said that?

Marianne: She had that feeling inside. Must have been a voice! I think it was a voice. It must have been this wonderful teacher inside that saved me, you know, in the nick of time. It's a male voice, it's very clear, and it doesn't come very often. I've never asked for it, it's just something inside of me that seems to be in my best interests. It's like an inner teacher. It's almost impersonal. It says things like, "check your breasts now." It's just like my own special guardian angel inside (laughs). It comes in at the nick of time and says,"Whoa!" You know, I have a rather impersonal feeling myself that says I will die from this thing.

Sara: From this breast cancer?

Marianne: Yes, it does say that. And I have lots of feelings about it! There's a whole part of me that doesn't want to have anything to do with it, you know, "Forget it, I want to live forever!" I know that part. It's this little kid in me that says, "I will live forever! And I'm not ever gonna die— don't talk to me about going out into space and going to the sun, forget that! I want to have fun! (laughs). I'll never go in a little box, you're not gonna put me in a box, I'm not ever going to die!" She's incredible. My life force comes from her. And that's a neat part of me.

Then there's this detached, light self that says, "You're in a group of people with the same disease you have, they're dying, nobody goes out of this life alive, you're going to die. It's logical to expect that you will die from this." Since I am there in this group and facing this process, it has meaning for me, that I need to face my death. I don't want to, you know.

There are different ways that I do it. If I do it impersonally it's fine. I'm willing to go and it's okay (laughs). We keep talking about this other part of ourselves. Right now my little girl is saying, "No way! You know, no way!" But I know, of course, that I will die and I don't know when. Nobody knows when. I think that's one of the mysteries of life. I'm willing to be with the mystery too.

Sara: It looks like there's also a more maternal part in you, who pats the little kid...

Marianne: Yes, that's the part that's escorting me through all this. She's the one who takes me in for the treatments and helps me through the medical stuff. She also helps me when I

need her, when I'm scared about relationship stuff and things like that. She'll give me hugs. So I feel that's a good mother. That's important, I'm glad you saw that.

Another part is a little different, and that's when I go into the actual feeling mode of dying. It doesn't happen very often. But when I do that it's really scary. I get very frightened, and I don't know exactly what I'm frightened of, but I'm very anxious and very afraid and that seems extremely important for me to experience. I notice it's not a simple thing to let go. When I think about that part and ponder its usefulness, I see all the times that I go through a dying process in my life. Which is more often than we think, more often than I think. When something has to die, or I have to let go of something.

I'm thinking of when I started to have pain in my body a few months ago. Here I was, a person who had cancer but didn't have any pain. So my identity was as a person who had cancer, and it was a serious thing and I needed to deal with it, tadadadada. Then, all of a sudden, I started to get this pain in my body. When I first experienced the pain, I felt the fear that I was telling you about, the fear about dying and the hanging on to what I was before. It's like in slow motion, actually, I can see it. It's that fear. "No I don't have pain, no, no!" Then moving into this place of, "I do have pain." This is a new thing. This is me with pain; this is a new identity. It took me several days to integrate that information into the new body. This is me, I'm having symptoms in my body and this is how I'm working with it. This is what's happening. Now I have a new identity. I'm seeing it in macro, in slow motion. I'm a lot in the middle of the process of moving from one identity to another.

I'm thinking of this in process terms; I'm spending a lot of time around the edges (laughs). And in that edge place I'm disintegrating. It's like a dying process at the edge. Then, in two or three days, I'm in a new form. Am I making sense?

Sara: It sounds as if you're letting go of your old identity and opening yourself up to a different sense of identity, to what is happening moment by moment?

Marianne: I think that's my dying work. That's what dying is. And I'm doing it without physically dying. I'm hoping, you know, my intelligence says, "maybe if I do it really well, do it enough and get enough awareness around it, my own death will be more familiar for me."

It's learning about,"how am I as an individual, how am I with transition?" This process, the transition between one form and another, has let me slow it down so that I can see it and feel it, more clearly.

Sara: Between having a body that doesn't hurt to having...

Marianne:...a body that does hurt. Or between having a body, and not having a body.

Sara: You can conceive of not having a body?

Marianne: Yes, I think so. I think I can do that. The part of me that wants to die is really... I can't find it right now. I don't think I have any part that wants to die. I think that I am taking care of my needs really well. And I'll still die.

Sara: But it doesn't look like this moment is the right moment.

Marianne: No, I'm very alive now. I tell people I'm preparing for my death and planning to live! (laughs).

In June, Marianne sent me an addition to her interview

"I do not know what caused my cancer or anyone else's for that matter. The important thing for me is to find some meaning in my illness, to somehow bring my entire life and self into some sense of cohesion.

My mother is not the cause of my illness. We had some difficulties and that helped form my personality. She also gave me lots of good nurturing and was brave enough to share my early history with me without excusing or hiding her participation. I respect her for that. I feel that the abusive mother is inside me and

also in the collective. My real personal mother is larger than my issues."

In June Marianne spent a month in Zagreb, Yugoslavia, with her Sufi group, working with peer support groups of Bosnian women who have been in rape camps. She says her ongoing work with the Bosnian women makes her "feel that just being who I am is useful. It's a way to serve people who are worse off than I am." She continues, "I've also had to face the shadow side of being useful—giving beyond my body's capacity. It's sort of a razor's edge."

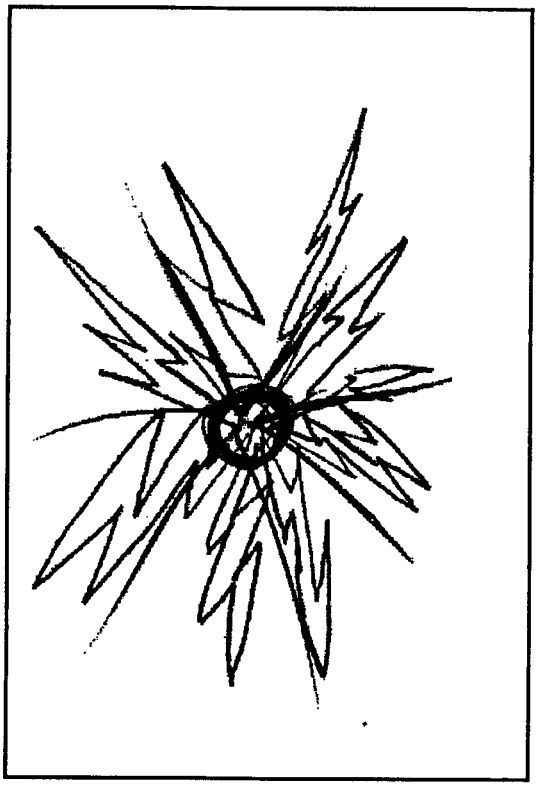
I realize that Marianne has taken her work on her early sense of abuse and dependency into the world channel. She is working compassionately with some very grave abuse issues for other women, and at the same time modeling a sustainable way of being a good mother, by paying attention to her own body and her own needs. She said, in a videotaped session of her support group which she sent me, that the work with Bosnian women has put her own struggle with breast cancer in a larger perspective. Marianne's issues are world issues. They are larger than her own personal history.

Marianne's image of the hairy monster who lives inside of her, her ally in standing up for her feelings, is very touching and revelatory for me. Dreaming into her image, I see a very unfeminine monster, but a very female creature who is hairy, feeling, lazy, persistent, ready to fight for women's survival everywhere, and in touch with pain and with love.

At the time of writing (September 25, 1993), Marianne reports that she's feeling well. Chinese herbs have helped with her pain and she's almost entirely off painkillers. Her Sufi group has just succeeded in bringing six women to California from Bosnia, and she feels a great sense of completion in having helped do that. As we spoke I felt completely at ease with her, in the presence of this woman who knows herself very well and is living life deeply in each moment.

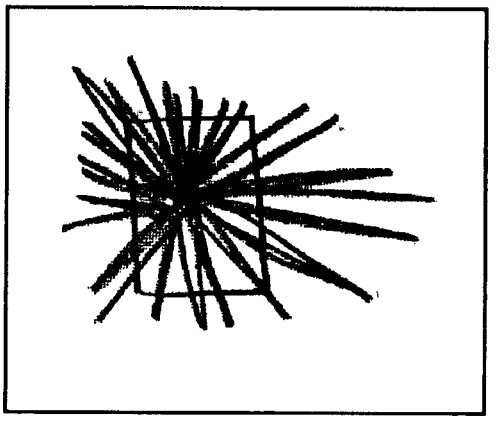
Sara Halprin, Ph.D., lives in Portland, Oregon, where she writes, practices and teaches Process Work and Tai Chi, and lives a complex and unpredictable life. She has a diploma in Process Work, a Ph.D. in literature, and background in university teaching, film making, and video production. Her book, "Look At My Ugly Face: Myths and Musings on Beauty and Other Perilous Aspects of Women's Appearance," will be published by Viking in 1994.

Symptom Art



Abdominal Pain

The drawings on this page were done by a person working on abdominal pain. Since these drawings, this individual has been experimenting with living more like the "lightning" which appears in the larger picture.



History and Contemporary Trends in Clinical Psychology in Slovakia

by Anton Heretik

As an introduction, let me begin with a few notes on the history of Czechoslovakia, which was founded in 1918 after the disintegration of the Austro-Hungarian monarchy. This so-called First Republic was, with the exception of the years during World War II, a democratic European state. Between 1948, when the Communists came to power, and the "Velvet Revolution" of 1989, the country was under Soviet dominion, which significantly shaped not only the socio-economic but also the spiritual atmosphere of society. The victory of democracy in Czechoslovakia has, paradoxically, led to a revival of nationalist tendencies. Beginning on January 1, 1993, Czechoslovakia divided itself into two independent states, the Czech Republic and Slovakia. Today, the two Republics have 15.5 million inhabitants, of which 9.8 million are ethnic Czechs, 4.8 million are Slovaks and the rest are comprised of the national minorities: .5 million Hungarians, Gypsies, Ukrainians and Germans.

At this point I would like to introduce a few process-oriented views on the separation of Czechoslovakia. The 1989 revolution was called "velvet." It had a totally peaceful character; millions of people in the squares called for love and forgiveness, and no one wanted to lynch either the Communists or the secret police. Underneath this apparently peaceful revolution simmered forty years of frustration, concealed nationalism, anti-Semitism, aggression, hatred and longing for revenge against the repressors. The intellectuals and artists leading the revolution did not perceive this underground sentiment and lost contact with the political reality of the country. Consequently, they were unpleasantly surprised by the results of the elections in 1992.[1]

History of psychology in Czechoslovakia

Until the middle of this century, psychology in Czechoslovakia was shaped solely at the universities. The most influential universities have been Charles University, founded in 1348 and located in Prague, in the Czech Republic, and Comenius University in Bratislava, the capital of Slovakia. The introduction of applied psychological disciplines, particularly

[1] Editors' note: In the 1992 elections, the previously liberal political climate, characterized by the presidency of Vaclav Havel, shifted strongly to the right.

clinical, educational, organizational and industrial psychology, was marked by the 1950s atmosphere of ideological dictatorship and dogmatism.

During the Communist era psychology was officially considered a "bourgeois pseudo-science." Psychology, along with cybernetics, genetics and psychotherapy (particularly Freudian psychoanalysis) was evaluated as purely speculative and, in the case of psychoanalysis, suitable only for hysterical middle-class women. The only accepted psychological theory during the Communist era was the Pavlovian conditioned reflex theory. This theory was used to explain all psychic phenomena, the psychology of learning, and the impact of psychological interventions such as hypnosis.

Since the 1960s, the spiritual atmosphere has become more liberal. Clinical and counseling psychologies in particular have been given a definite place in psychology, and psychological services have been broadly applied. Even though clinical and counseling psychologies became more widely known, the Communist government's neglect of psychology in general has been apparent in the low wages paid in state psychological institutions and in the poorly funded research grants in psychology.

At present in Slovakia, there are about 1200 active psychologists. Most of them work as clinical psychologists in health institutions (20%), as counseling psychologists in education and psychological centers (18%), in marital counseling centers (5%) and in state institutions for scientific research (15%). As a consequence of the political and economic developments of recent decades, practically all psychologists are state employees; they are rarely found in private practice or in private firms.

With the ratio of psychologists to inhabitants approximately 200 psychologists per million inhabitants, Slovakia has the highest percentage of psychologists among the post-Communist countries. The ratio of psychologists represents approximately one half of the ratio in well-developed European countries and about one third of the U.S. ratio (according to I.U.P. statistics). The ratio of women among the members of the Slovak psychological society continues to grow, with women representing more than 70 percent. General interest in psychology is enormous. For example, there are over 700 psychology applicants to Comenius university, from which, after two rounds of entrance examinations, only 50 can be admitted.

Contemporary trends in clinical psychology

Of all the practical applications of psychology, clinical psychodiagnostics has the longest history and the greatest social acceptance. Psychology has often been associated with testing, with counseling being seen as a secondary function. This is probably due to the normative, quantifying or "marking" methodology of psychodiagnostics. Practically all the important performance tests, including the Wechsler scale, personality inventories such as the MMPI, Cattel 16 PF, and Eysenck's inventories, were standardized for the Czech population during the 1970s and 1980s. The projective tests, i.e. the Rorschach and, in the last ten years, the Hand-Test (TAT), enjoy a special reputation in Czechoslovakia. Every clinical psychologist working at a psychiatric clinic must master the Rorschach method, since the majority of our psychiatrists believe that the most differentiated diagnosis can be achieved through this test. The greatest portion of clinical research concerns test methodology. My dissertation, for instance, dealt with the use of projective methods, rating scales and performance methods in differential diagnosis of depressive states.

In the realm of psychotherapy, the situation is still more complex, since various ideological influences have played a greater role. Behavioral psychotherapy has had the greatest level of acceptance. This is due to the fact that classical behaviorism has its theoretical roots in Pavlov's theory of conditioning. The explanative and interpretative schemes of behavioral psychotherapy are so lucid and clear that it has gained acceptance by materialist psychologists. However, in the last ten years, not just in Czechoslovakia, but in the world, the behavioral-cognitive orientation has gained preva-

lence, especially for treating depression. The work of Beck, Lewinsohn, Rehm and Lazarus has been applied in Czechoslovakia as well as in the rest of the world.

In spite of disfavor on the part of the official, biological orientation in psychiatry and Marxist psychology, group dynamic psychotherapy, inspired by the work of M. Jones, Yalom, Battegay and others, is highly popular in Czechoslovakia. Due to censorship, training in group psychotherapies has developed under illegal conditions. The training lasts roughly five years and includes 500 hours of personal experience in the techniques. In the last 25 years hundreds of psychologists and psychiatrists have gone through this training.

The literature on dynamic and humanistic psychotherapy, from Freud and Jung to contemporary authors, has been secretly translated and disseminated, as have the works of dissident authors. In the past, spreading dissident literature was extremely dangerous. A psychologist friend of mine was imprisoned for a year for translating George Orwell's *1984* and circulating it among his acquaintances. It is a paradox that in the country where Freud was born, it has been not just difficult but almost impossible to get training in psychoanalysis. In Czechoslovakia there are estimated to be only 10 to 20 psychoanalysts, all living in Prague, who are licensed to train others.

The revolution of 1989 resulted in a fundamental shift in psychology. Dozens of titles by previously banned authors have been published. Furthermore, psychotherapists of various theoretical orientations are organizing training in their methods. In Slovakia, for example, long-term training is now available in person-centered psychotherapy, Gestalt therapy and systemic psychotherapy. In Bohemia, a new center for transpersonal psychology is being established, and training in holotropic breathwork is being organized by Prague native Stanislov Grof. I am organizing training courses in Process Oriented Psychology. Process Oriented Psychology has become, as an optional seminar, a component of the pre-graduate study program in the Department of Psychology at Comenius University in Bratislava. Post-revolutionary changes are reflected in the structure and content of psychology curricula at the universities. Our graduate students now have a choice of optional seminars on individual psychotherapy including Rogerian, humanistic, process-oriented, etc.

One positive consequence of this liberalization is the increased availability of psychotherapy. This is apparent not only in state mental health institutions but also in private practice, even though the majority of private practices are still part-time. It is interesting to note the difficulty my colleagues and I have charging clients for private practice. In Western psychotherapy, the therapists's paid services are an inevitable part of the therapeutic relationship. During the era of Communism, in the framework of the so-called free state health service, it was forbidden to take money from the client, even for therrapy hours spent with him/her beyond "office hours." Even now, coming from this background, I feel uneasy and guilty when I tell a client the cost of a session.

Another side-effect of liberalization is the emergence of popular healers, spiritual therapies and charlatans who take advantage of the short-comings of the state health care system by advertising cures for all illnesses, from hypochondria to cancer. I myself have been working with a client whom a "healer" diagnosed with cancer and then attempted to cure. My client became depressed and attempted suicide. In order to protect clients, a team from the Slovak Psychotherapeutic Society is currently developing guidelines regulating the practice of psychotherapy. These guidelines will be based on contemporary European norms, especially Austrian Law.

Future trends and needs

In spite of the political changes connected with the division of Czechoslovakia, which I consider to be an historical error, there is no longer a threat that society will be closed to outside input. Clinical psychology will remain open to the influences of new trends and currents of thought from the West.

The economic problems of our state will probably curtail the growth of clinical psychology, so that the number of clinical psychologists will not be comparable to that of Western countries. However, some changes in the structure of the institutions in which psychologists work may be expected, as well as in the types of problems encountered. The number of psychologists in private practice and the number of specialized private clinics oriented to outpatient services are expected to grow. We may also see growth in institutions providing psychotherapeutic services to clients, which will also serve as centers for education and training in psychotherapy. As for social and health problems, we expect a sharp increase in drug problems and juvenile delinquency. These areas have previously played only a minor role in Slovakia, compared to alcohol addiction. More psychologists will probably be dealing with psychosomatic problems.

If the West is interested in helping Eastern European countries develop in the field of psychology, material is not nearly as helpful as current information. Eastern European psychologists, whether university psychologists or those in private practice, need to gain experience, both positive and negative, from countries which have 30 to 40 years head start in the practical application of clinical psychology. Donations of material and technical help are not necessarily the most effective steps that can be taken: if someone receives a fish, he will eat for a day, but if he learns how to fish, he will eat for a lifetime.

Anton Heretic, Ph.D., is a clinical and forensic psychologist. He is an Assistant Professor and currently heads the Department of Psychology at Comenius University in Bratislava. He is working with psychodiagnostics and psychotherapy at a psychiatric clinic and in private practice, and developing a training program for Process Work in Slovakia.

African Thought and Spirituality

by Moses N. Ikiugu

African thought and wisdom, like the wisdom in other powerless communities, is largely unknown. Indeed, when we talk about knowledge, we think of scientific and philosophical knowledge commonly associated with Western thinkers. Regarding Africa specifically, many thinkers in the past have seemed to believe that Africans are incapable of any serious thought, scientific invention or work of art. We see such attitudes in the writings of leading European thinkers like David Hume, who in 1735 said that:

> The Negro is naturally inferior to the whites. There scarcely ever was a civilized nation of that complexion, nor even any individual, eminent either in action or speculation. No ingenious manufacturers among them, no arts, no science.[1]

Such statements no doubt lacked objectivity and were downright racist. In process-oriented thinking, we know that they are outward manifestations of a system that is polarized and is striving towards self-balan cing.[2] The problem is that this polarization has not been amplified and the positions of the two poles are unknown to each other. Unless the polarities are able to state their positions and interact, the system cannot self-balance. The purpose of this article is to speak from one of these poles, the African position. I aim to clarify this polarity by presenting a case for this world view in an attempt to challenge some of the stereotypes about Africa.

I will demonstrate that African thought was and is deep, rich logical and full of wisdom. Although this wisdom is not written, we know that Africa, like all other parts of the world, has produced great thinkers. Within the area of African thought, which may be referred to as African philosophy, I will focus on two topics: some aspects of African thought and African religion.

Aspects of African thought

A friend of mind once made a comment that really got me thinking. He said, "Well, you know what happened in South Africa. The Boars came there and met Africans who were busy dancing on gold and diamonds. So they told them, 'well, stay aside for a while, we'll get the gold and diamonds and then you can continue dancing.'" This was a joke. However, if we look closely, we find it is true that Africans love to dance, to talk and to feast. They will seize every opportunity, whether it is a wedding, an initiation and, in some communities, even a funeral to celebrate and feast. I started asking myself, "Why is it that Africans love dancing, celebrating and feasting?" This question cannot be answered unless we understand one basic fact about the African mind. Of course, we must remember that so-called

[1] Ngugi Wa Thiong'o, *Writers in Politics* (Nairobi: Heinemann Educational Books Inc., 1981) 14.

[2] Arnold Mindell, *The Year I* (London: Viking-Penguin-Arkana, 1989); Arnold Mindell, *The Leader as Martial Artist* (San Francisco: Harper3333Collins, 1992).

"African culture" is a diversity of cultures, and there are different patterns of thought in various African communities. In all these communities however, there is a basic emphasis on relationship.

By relationship we mean the fine and tight connections that bind people to each other. As Senghor said, "... the African is tightly held in a tight network of vertical and horizontal communities, which bind and at the same time support him."[3] This strict binding is made possible by the high position given to relationships. Generally, Africans hold life sacred. Because of this attitude, all activities are aimed at preserving and propagating life. One activity that enables this preservation is the development of meaningful caring relationships. Due to the emphasis on relationships, all activities are meaningful only to the extent that they improve relationships. Thus, the way time is spent, the way work is done, all daily activities are influenced by the emphasis on relationships. That is why feasting and dancing are so important to Africans. Even when working, there has to be time for eating together, singing together and touching each other. These relationship connections are considered more important than any work.

Having seen how important relationships are to African communities, let us explore what constitutes these relationships. Relationships start with the family, the clan and then the whole ethnic community, or what colonists called "tribes." Individuals exist through and derive their identities from these three units. I will discuss each of these three elements separately.

The family

When we speak of a family, many people from the West may immediately imagine the typical nuclear family consisting of two adult parents, usually a female and a male, and a number of children. In Africa, however, the concept of the family is different. When we talk about a family, we are talking about parents and their children, the aunts, uncles, grandparents and other relatives. In cases of polygamy, we are also talking about many households in the same compound. Each household consists of the mother and her children, with the husband's hut at the center of the compound. We can begin to see that in African thought the family is a wide and complex unit. It also includes:

> ... The unborn members who are still in the loins of the living. They are the buds of hope and expectation, and each family makes sure that its own existence is not extinguished.[4]

In this context, the family is a complex unit of numerous interrelationships. These interrelationships provide basic support for the individual and ensure continuation of life. Of course, the disadvantage is that this arrangement tends to suppress individual development. In Africa, the individual is important only as a member of the family. When there is a clash between individual interests and family interests, the family interests prevail. This tends to create, especially nowadays, tension in individuals who feel they want to develop on their own.

The clan

The clan is an extension of the family. In some African communities, after the family there are bigger units known as "gates."[5] "Gates" consist of people who belong to or share the same ancestor, going back eight or nine generations. Clans are much larger than "gates." Like members of a "gate," members of the same clan share a lineage. In some cases, they can trace their origin to a common founder, but in other cases, they cannot. Unlike in "gates," where membership is only through blood, clan membership may be by marriage, or some other

[3] Leopold S. Senghor, *De La Negritude Psychologie du Negro-Africain* (Nairobi: Heinemann, 1962) 41.
[4] John S. Mbiti, *African Religions and Philosophy* (Nairobi: Heinemann Educational Books Ltd., 1992) 108.
[5] Mbiti, 1992.

form of kinship. In most cases, one is born into a clan and cannot change membership.

In many cases, members of the same clan may not inter-marry, although in certain types of clans (exogamous clans) they can. Clans may be patrilineal, with descent through the male lineage. Many African clans are of this nature. In some communities clan descent is matrilineal. Just as in families, membership in a clan includes those who are not yet born as well as those who have died. All are part of the same lineage and clan activities such as sacrifices and ceremonies must take account of the unborn, the living and the dead.

Clans have always been the base of support for individuals and families. Ceremonies such as weddings, circumcisions, the celebration of childbirth and funeral rites were performed with the help of the clan. Currently, in some communities, clans help arrange weddings and funerals and assist in calamities such as the loss of a home due to fire. In some cases, clans also raise money to help pay school fees for children from the poorest families. Even today, clans are very important in African communities.

The ethnic group

Members who share a common language and common culture form one ethnic community, which may have up to several million people. The colonists derogatorily called these ethnic communities "tribes." So-called "tribes" are large communities, divided into clans and, in some cases, subdivided even further into "gates." The major characteristic of every ethnic group is that its members share a common language, a common myth of origin, common customs and beliefs as well as a definite social and political structure.

Kinship

Kinship is a strong concept in African thought. Kinship is about relationship, be it by blood or by marriage. Simply stated, kinship is a vast network of relationships which binds all members of an ethnic community. It is both vertical and horizontal, involving those not born, and those who have left the world. This network of relations:

> ...controls social relationships between people in a given community: it governs marital customs and regulations, it determines the behavior of one individual towards another. Indeed, this sense of kinship binds together the entire life of the "tribe," and is even extended to cover animals, plants and non-living objects through the 'totemic' system.[6]

The kinship system demonstrates the African emphasis on relationship discussed above; kinship is the lifeline of the ethnic group. Under the kinship system, everybody is related. Thus, one has hundreds of fathers, mothers, aunts, uncles and so on. Every time two people meet the first function is always to establish how related they are. To understand the African mind, as far as relationships are concerned, it is essential that one understand the concept of kinship well.

Time

The concept of time is another important aspect of African thought. When foreigners come to Africa, often the first thing they complain about is the inability of the African to keep time and the tendency to "waste" time. In the Western mind, time is a commodity to be sold and used. It can be utilized well or mismanaged.

In contrast, to the African mind time does not exist on its own as a commodity. It exists only in the context of an event, which often will include a relationship component. The relationship aspect is so important that it supersedes any other use of time. For instance, if you meet a friend on your way to an appointment, you cannot say, "I am sorry, I am late for an appointment and cannot talk to you now." If you do that, your friend will be offended and will

[6] Mbiti, 104.

consider you rude. No matter how busy one is, one is required to have time to exchange at least a few words with other people.

As already mentioned, time is contextualized. It is related to events. Thus you will find seasons named according to certain activities such as the time for planting, circumcision season, wrestling season and so on. Another way of conceptualizing time is according to natural events such as a period of flood, drought or invasion by locusts. Thus, if you ask an old African man when he was born, he will not tell you he was born in 1940. Instead, he will tell you he was born during the big famine, or during the big war or during other such events.

Because time in the African mind is related to events, it is not abstract. Events have either occurred, are occurring or are yet to occur. If events have no probability of occurring then they do not exist. Conversely, there can either be "actual time" or "probable time." Time is two-dimensional, with a past, present and no future. The only future available is foreseeable future or what constitutes "potential time."[7] Mbiti actually points out that in most African languages, there is no future tense for time extending beyond a few days to two years.[8] This means that existence is made of the distant past, the past and the present. All life arises from the past and recedes into the past.

Work

Similar to the concept of time, work is not measurable in terms of time. It is very difficult for an African to see much sense in reporting to work at 8:00 a.m. and singing off at 5:00 p.m. Many organizations in Africa find themselves having to discipline workers who fail to keep time. Because of this, foreigners tend to think that Africans are lazy. This stereotype is not true. Work in Africa is glorified.[9] Laziness is an offense against other people and against the spirits. Dhinua Achebe brings this out clearly in his novel, *Things Fall Apart*, [10] when he narrates Unoka's encounter with Chika, Agbala's Priestess:

> "Every year," he said sadly, "before I put any crop in the earth I sacrifice a cock to Awi, the owner of all land. It is the law of our fathers. I also kill a cock at the shrine of Ifejioku, the god of yams. I clear the bush and set fire to it when it is dry. I sow the yams when the first rain has fallen, and stake them when the young tendrils appear. I weed..."
> "Hold your peace," screamed the priestess, her voice terrible as it echoed through the dark void. "You have offended neither the gods nor your fathers. And when a man is at peace with his gods and his ancestors, his harvest will be good or bad according to the strength of his arm. You, Unoka, are known in all the clan for the weakness of your machete and your hoe. When your neighbors go out with their axe to cut down virgin forests, you sow your yams on exhausted farms that take no labor to clear. They cross seven rivers to make their farms; you stay at home and offer sacrifices to the reluctant soil. Go home and work like a man."[11]

Africans do not allow any excuses for laziness, but the idea of being driven by time is alien to the African mind. An African is more used to being given a certain amount of work to do, such as a field to clear. He can begin to work early and work until late, or may begin work late and work until he is through with the task. The number of hours he works do not count. It is the amount of work accomplished that matters.

Work is not an end in itself. It is a means to a better life for the whole community and is also a way of enhancing relationships. So, very

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[7] Mbiti, 17.

[8] Mbiti, 7-18.

[9] Moses N. Ikiugu, "The Influence of Social, Cultural and Economic Changes on Mental Illness in Ruiri Sub-Location, Meru District, Kenya," diss., College of Health Professions, Nairobi, Kenya, 1985.

[10] Chinua Achebe, *Things Fall Apart* (Nairobi: Heinemann Kenya Ltd., 1991).

[11] Achebe, 12-13.

often, people will be found working together. The usual practice was, and in some places still is, to work on each other's fields, build each other's houses, and work collectively on all tasks of living. This was the origin of Kenya's "Harambee" clarion. "Harambee" literally means, "let's pull together." There was no individual work; like everything else, work was shared.

Work was never measured in terms of time. Therefore, when people met to work they would work until the work was finished or until they felt tired. Then they would sit down to drink and eat together. Eating and drinking together was an essential component of work, which included the emphasis on relationships. This is why, even today, many Africans will find it difficult to work in a place where they are supposed to sit alone quietly and work.

People will often visit each other in offices and other places of work and take time to chat. A Western minded person will think such people are wasting time. But actually, when relationship supersedes everything else, this is a natural behavior. Even work is a means of enhancing relationships.

African religion

An examination of the African way of thinking is never complete without considering the religious/spiritual aspect. This is because Africans are extremely spiritual people. Religion permeates the whole of their lives, from birth to death.[12] What this means is that, to the African, religion is not acquired. You are born into a spiritual world and spiritualism permeates your whole existence.

Religion is not practiced on certain days. It is a part of each person's life. The very act of birth is a religious experience, and the name one is given has a religious meaning. When a person wakes up, he or she wakes up into a religious world. Everything you do, eating, working, relating, has a religious quality. Christianity may not have truly taken root in Africa because it did not take into account this aspect of the African mind. The Christian dichotomy between spiritual and worldly things is alien to the African mind. To the African, there is no dichotomy between what is heavenly and earthly or what is physical and spiritual.

Everything is spiritual. It is not possible to understand African religious thought without understanding the African concept of God and the spirits. Many scholars have portrayed Africans as people who pray to animals and spirits.[13] Nothing could be further from the truth. Africans had the concept of one all powerful God; however, their spiritual world was ontologically constructed.[14] In this ontological structure, God was at the top followed by the spirits, man, animals and non-living objects, in that order.[15]

This ontology mirrors the African's strict hierarchical social structure based on seniority. Seniority is determined by age and social status. In this structure, the higher one is in the hierarchy, the more weight her word carries. At the bottom of the hierarchy are children. Children depend on adults for guidance and also for nurturing and protection. Next are mature adults. Next in line are old people. Adults look to elders for guidance and even for intervention in spiritual matters, such as when a sacrifice has to be made. Old people are considered very powerful, since they are about to enter the spiritual world.

After the old are the "living dead." The living dead are those who are dead but are still remembered by their family members. The living dead are believed to have some interest in what is happening to their families on earth.

[12] Mbiti, 1992.
[13] Mbiti.
[14] Mbiti.
[15] Mbiti, 16; Senghor.

Therefore, whenever there are difficulties, family members consult their living dead for guidance. They offer them sacrifices and share their meals with them through the pouring of libations. Some people believe that their dead relatives would occasionally appear to them or visit their families.

The living dead were consulted because they were seen as best placed to intervene with the spirits on behalf of their relatives on earth. This is because they were able to speak the language of the spirits while still understanding the language of the living. Once the dead had passed out of the memory of the living, they slid back into the past, into the world of the spirits. This happened when the last person who could remember the dead relative also died. Once one joined the community of the spirits, he or she became a spirit and no longer had ties with earthly relatives. After the spirits came God. Africans were seen to be praying to the spirits because they prayed to the spirits to intervene on their behalf to God. Even in ordinary life, in Africa, a subordinate never spoke directly to a superior. He spoke to his or her superior through an emissary. A son would send an elder to his father when he wanted to tell him something. One could not be expected to speak to God directly but would have to speak to him through a spirit. Naturally, one prayed to the living dead, who in turn conveyed the message to the spirits, who would then convey the message to God.

Conclusion

In this article, I have tried to briefly outline the key aspects of African thought and religion. Contrary to some previous Western impressions, African thought is rich, logical and full of wisdom. In African thought, the emphasis is on relationships and enhancement of community. Africans are fundamentally a religious people in the whole of their existence. Contrary to the common belief that Africans pray to animals and spirits, they have a clear concept of one powerful God. Spirits are simply intermediaries in people's communication with God. It is not possible to exhaustively examine African thought and religion in an article of this scope. Many details have been left out, and certain concepts have not been raised and explained. This article is an attempt to sensitize the reader to the nature of the African's mind and his or her religious system.

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