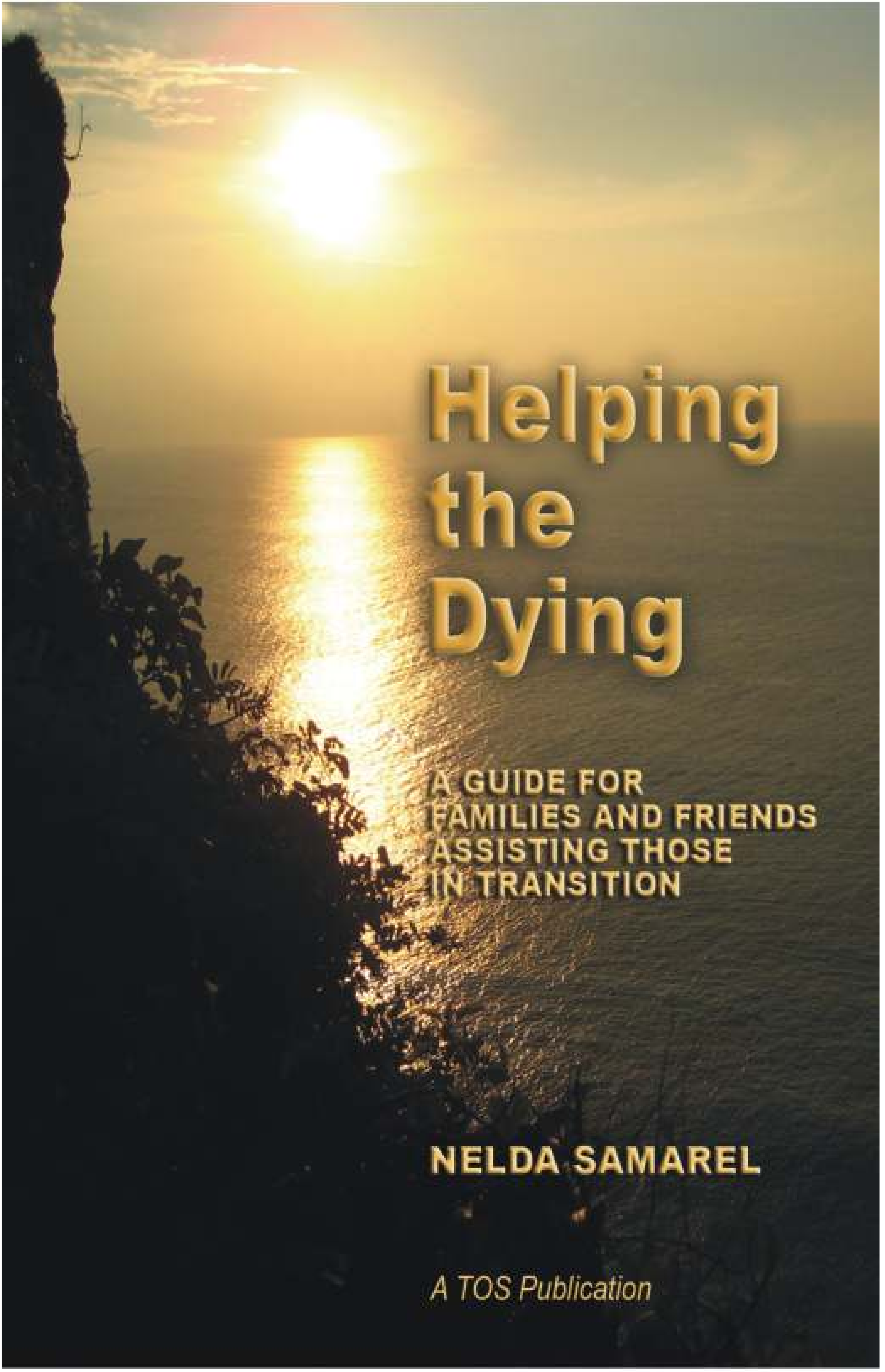

Helping the Dying

A GUIDE FOR FAMILIES AND FRIENDS ASSISTING THOSE IN TRANSITION

NELDA SAMAREL

A TOS Publication

Helping the Dying:
A Guide for Families and Friends Assisting Those in Transition

Nelda Samarel

A Theosophical Order of Service Publication

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“A union of those who love in the service of all that suffers”

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A Story

Once upon a time in ancient Bagdad, there lived a rich merchant. One day he sent his servant to the market for some oranges. While in the market, the servant looked up and, across the market place, he saw the image of Death staring at him. Terribly frightened, the servant immediately ran back to the merchant's home and asked for help in escaping the image of Death.

Being a very kind man, the merchant gave the servant a camel and some money so that he may leave Bagdad and ride to Samara in order to escape from Death. The merchant then went to the market to buy the oranges that he desired. When in the market he saw the image of Death. Walking directly to Death, he scolded him, asking, "Why did you frighten my servant this morning?"

Death replied, "I am so sorry, sir. I did not mean to frighten him; I merely was surprised to see him here in Bagdad as I have an appointment with him tonight in Samara."

Introduction

All who are born must face death at some time; none may escape. Many traditions have theories and beliefs about the after-death states that may assist in one's acceptance of death. The *process* of dying, however, although not often discussed, is known because it is witnessed and described by those who actually have been involved in the process. As a process, dying takes place over time and most often requires assistance for the dying and for those who are helping, for the family, for the loved ones. Becoming familiar with the dying process enables us, empowers us, to be of assistance.

This booklet is organized into three sections. Section 1 deals with the helpers' own personal beliefs about death, insight into which is important before meeting the needs of dying. It also discusses how to meet the dying person's physical, emotional, mental, and spiritual needs. Without some understanding of the actual experience of the dying process, providing assistance is difficult, if not impossible. The discussion on meeting emotional, mental, and spiritual needs includes, therefore, essential background information and various theories about the process.

Section 2 deals with the dying person's changing needs at the end of the dying process; it includes brief descriptions of those needs and methods of meeting them. Although the suggestions are particularly helpful at the end of the process, most also may be used throughout the entire experience.

Section 3 is about how to live with dying. This *Guide* is intended to offer practical help for those who seek to assist their dying loved ones.

It is best to first read Section 1 in order to meet the primary physical needs, followed by the emotional/mental/spiritual needs. Sections 2 and 3 should be read *prior* to the end of the dying trajectory in order to be better prepared to utilize the practices suggested.

A list of Useful Resources is provided for more in-depth information on many of the concepts introduced in the *Guide*.

1

Understanding Essential Needs

1. PREREQUISITE TO ASSISTING THE DYING: UNDERSTANDING PERSONAL BELIEFS ABOUT DEATH

Family members so often strive unsuccessfully to assist their dying loved ones in their final passage. These efforts may be unsuccessful for two reasons. First, the efforts may be uninformed. Helping during the final stages of dying requires knowledge of the physical, emotional, mental, and spiritual needs inherent in the process. It is only through knowledge of these unmet needs that they can be met.

Second, because we are unaware of these needs, in attempting to help our dying loved ones, we often unintentionally seek to alleviate ou*r own* pain instead. However, even after we are educated as to these needs, there is still another obstacle to overcome: our own attitudes and beliefs about death.

Thus, in order to better relate to the dying, we first must examine our own attitude toward dying in general and toward our own death in particular. Do we fear death? Or do we view death as a part of life?

It is necessary to give thought to the issues of life and death in our own life before it is possible to provide care for others who are dying. Each must give thought to and reflect upon the personal meaning that death holds: ambivalence; thoughts of a "life beyond," God, and heaven, for example; and the presence or absence of emotions connected with our own death, including fear, anger, sadness, and resentment.

Two recurring themes expressed by many with regard to their own death are: loneliness, or dying alone and leaving loved ones behind; and the personal fear of dying and death. Unless we recognize any personal fear associated with death, it is not possible to assist another through the process.

Regardless of how we feel about our own death or about the death of loved ones, it is essential that these feelings be acknowledged and identified *as our own personal feelings.* They then can be placed aside, differentiated from the dying loved one's feelings and resultant needs. Only after our personal thoughts and feelings about death are acknowledged and dealt with, is it possible to be of optimal assistance to another in their passage.

A "Good Death"

Each person usually holds their own idea of what constitutes a "good death." A good death may be: being comfortable and in no pain; not being alert, or dying in one's sleep; being alert and dying consciously; feeling peaceful; having family present; having all affairs in order; and so on. One person summarized:

> "A good death is whatever the particular person wants and needs. For instance, if a person has to resolve certain issues with a family member and does so, that is a good death for that person. Or if they want to be asleep and are [asleep], that is a good death. But to be asleep is not for everyone. . . . A good death is, in essence, defined by each person."[1]

Once it is recognized that each dying person must define what constitutes a good death and how the dying process should proceed, we may provide assistance in facilitating that process. It is important to keep in mind that we must be alert for cues or signals of what a loved one sees as a "good death" because some individuals may not clearly communicate their needs.

2. MEETING PHYSICAL NEEDS

Physical comfort is a primary concern for the dying and, therefore, for their families. It is difficult to have any quality of life while experiencing severe physical distress and, certainly, it is most

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[1] Samarel, Nelda. *Caring for Life and Death, Washington,* D.C.: Taylor & Francis, 1991, p. 71.

upsetting for those attending the dying to witness their loved ones in physical distress. Each illness has specific symptoms with which it is associated, symptoms that may be unique to that illness. For example, the person dying from brain cancer will experience different illness-related symptoms than the person dying from heart disease. It is beyond the scope of this guide to deal with the vast variety of possible illness-related symptoms.

In addition to those physical symptoms specifically related to the individual's illness, however, are additional physical symptoms indicative of impending death, regardless of the type of illness. It is important to note that all these symptoms may not, and most probably will not, be present in any one person. Measures to assist this person are palliative, or designed to provide comfort rather than to reverse the symptom or improve the person's condition. Most often, physical needs are met by health care professionals. However, this is not always possible. Moreover, being able to personally assist in making our loved one more comfortable not only will reduce our own sense of helplessness in this situation, but also is appreciated by the dying. Who would not appreciate having a daughter or a son assisting them with their own hands? Therefore, although health care professionals usually are present to meet physical needs, it is helpful to briefly summarize some of these needs and also make some suggestions for ways to help.

It is difficult to predict exactly when someone will die, but there are various signs that may be present days or weeks before the moment of passage. These include: restlessness and agitation, withdrawal, drowsiness, loss of appetite, pauses in breathing, and swelling. Some common physical symptoms associated with the dying process, along with suggestions for comfort measures to relieve the symptoms, are included in Table 1. This is not meant to be an all-inclusive list, nor to replace the professional care required. It is meant, rather, to provide a summary of the most common physical challenges of dying individuals in order for us to understand the care given by health care professionals and also to assist the dying as necessary and appropriate.

Table 1.

PHYSICAL SYMPTOMS OFTEN PRECEDING DEATH AND APPROPRIATE COMFORT MEASURES

Physical Symptoms	Comfort Measures
Loss of muscle tone, as observed by decreased body movement; relaxation of facial muscles (i.e., sagging jaw)	Position comfortably with pillows and towels. Change positions whenever necessary, every 1 to 2 hours (not if asleep).
Agitation or confusion	Check to see if pain or discomfort are causing the agitation. Be calm and reassuring, creating a quiet and peaceful atmosphere. Limit the number of visitors.
Difficulty speaking	Do not ask frequent, unnecessary questions that require complex answers. If able to write, provide pen and paper. Be patient, allowing time for self-expression. Do not leave alone with no means to summon assistance. (Provide bell or other means to summon assistance when necessary to leave room temporarily.)
Difficulty swallowing, causing pooled secretions and drooling Loss of gag reflex, causing choking	Position sitting or side-lying to facilitate drainage of saliva. When providing fluids, use a straw (cutting straw in half often makes it easier to use). When no longer able to sip through a straw, provide fluids using a syringe *without the needle*, being sure to aim the syringe into cheek, not into the center of mouth. Provide frequent mouth care using soft moist gauze to moisten lips and wipe inside of mouth. Apply lip balm to lips.

Continued on next page

Table 1. Continued

Physical Symptoms	**Comfort Measures**
Decreased intestinal activity causing nausea, gas, and constipation	Position comfortably, side-lying if possible. Using a clockwise motion, gently massage lower abdomen.
Decreased control of bladder and bowel	Use incontinence pads. Check frequently for incontinence and maintain skin clean and dry.
Difficulty breathing	Elevate head on pillows. Ask about medications to ease breathing.
Sensory impairment, including blurred vision, impaired taste and smell (hyper or hyposensitive)	Use soft lights. Identify yourself when approaching. When handing any item to person, place item directly in their hands, being sure they are gripping item. Keep unpleasant odors to a minimum.
Poor circulation causing diminished sensation, blueness of extremities, cold skin	Use extreme care when touching and moving. Maintain sufficient warmth. Massage gently, using slow strokes. Assist with use of visualization of increased circulation and warming of extremities.

3. MEETING EMOTIONAL/MENTAL/SPIRITUAL NEEDS

As with physical needs, it is essential that we understand the emotional, mental, and spiritual needs of the dying individual in order to be of assistance. To understand these needs, it is helpful to consider what is known of the actual experiences of the dying. Awareness and recognition of these experiences will assist us to feel more comfortable in their presence and also to be able to communicate more helpfully.

To this end, it is useful to consider a few ideas about the experiences of dying persons. Certainly, it is not necessary to study all of these. However, some understanding of them will be invaluable in identifying the experiences being observed, resulting in greater awareness of needs, expressed or unexpressed, and make the entire experience less intimidating.

Contexts of Awareness

Four basic types, or levels, of awareness are shared by the dying and their loved ones: closed, suspected, mutual pretense, and open.[2]

In *closed awareness,* the person does not recognize that they are dying, although everyone else does. All join in a conspiracy to help keep the secret well-guarded by preventing communication of information that may lead to a realization that death is a prospect. If the person begins to ask questions about their condition, family may improvise explanations to distract from or explain away new symptoms or developments in the progression of the illness. As the person becomes increasingly ill, the explanations become unconvincing and the relationships become strained as family and friends become “on guard" in an effort to protect their secret. Closed awareness causes great tension and is deceitful; everyone is engaged in the conspiracy of silence so that the dying person has no one with whom to speak.

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[2] Glaser, Barney G., and Strauss, Anselm L. *Awareness of Dying*. New Brunswick, NJ: Aldine Transaction, 2005.

In *suspected awareness,* the person suspects what others know and attempts to verify the suspicion of dying by luring or tricking family or friends to divulge that information. The person's suspicion often is aroused by others' changes in attitudes and behaviors, changes in medical treatment, and noticeable deterioration of condition. In this situation, caregivers usually prefer to allow the dying person to realize the knowledge of their impending death independently rather communicating it directly. This often results in avoidance of answering direct questions related to the condition. Suspicion usually leads to either mutual pretense or open awareness.

Mutual pretense involves the best known and, yet, most subtle of the awareness contexts. Although everyone involved in the situation is aware that the person is dying, all continue to act as if this were not so. The pretense is continued, often with great effort, through a mutual conspiracy of silence fostering an avoidance of death talk. Occasionally, the dying person may offer cues signifying an understanding of the knowledge that they are dying. Loved ones are unwilling, however, to speak the truth. This results in a "let's pretend" situation in which all are aware of the others' knowledge, but will not openly admit it and thus keep up the pretense that recovery is possible. Mutual pretense may be useful in giving some dying persons more privacy, dignity, and control. It may, however, result in alienation.

Open awareness exists when the dying person and loved ones know that death is near and acknowledge the fact in their interactions. It affords the opportunity to complete the necessary tasks associated with dying, such as bringing relationships to closure, reflecting on one's life, and coping with psychological problems such as fears and regrets. Although the open awareness context is preferable to the other three, it may be the most difficult due to the many questions and problems faced by loved ones. For example, a decision needs to be reached as to whether the dying should be made aware of all facets of the situation, including the details of the prognosis. Would such knowledge cause depression or, possibly, suicide?

It is helpful to understand the awareness context in which an interaction takes place because all talk and action are guided by what one knows. Although a shift toward open contexts of awareness usually is encouraged, it must be noted that it is not always possible or desirable to maintain an entirely open awareness. Some dying persons or their loved ones may not be prepared to function in an open awareness context due to high anxiety, limited communication ability, or a tendency toward the use of denial. Denial, in fact, may be healthy and necessary for many individuals. What is most important is not to impose a particular context of awareness on another, remembering that *every individual has developed different coping skills and views death differently*.

The Dying Trajectory

Dying may be considered a process and occurring over time. As such, dying may take a variety of forms, or trajectories[3,4]. All trajectories take time and have a certain shape through time. For example, the shape of the trajectory may plunge straight downward; move slowly and steadily downward; vacillate slowly, moving slightly up and down before plunging downward; or move downward, reach a plateau and hold, then plunge rapidly downward toward death.

The duration of the dying trajectory may be either lingering, expected quick, or unexpected quick. Certainty and time yield four types of dying trajectories: 1) certain death at a known time (e.g., late diagnosed metastatic cancers); 2) certain death at an unknown time (e.g., chronic fatal illness, such as chronic kidney failure); 3) uncertain death at a known time when certainty will be established (e.g., radical surgery for cancer, where a successful outcome may be known, but the threat of recurrence may be continually present); and 4) uncertain death at an unknown time when the question will be resolved (e.g., multiple sclerosis or other chronic disease of uncertain outcome).

It is important to recognize that dying trajectories are subjective rather than actual courses of dying and may, in fact, be inaccurate.

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3 Glaser, Barney G. and Strauss, Anselm L. *Time for Dying*. New Brunswick, NJ: Aldine Transaction, 2007.

4 Benoliel, Jeanne Quint. “Health Care Providers and Dying Patients: Critical Issues in Terminal Care,” in *Omega,* 18, 1987-88.

Uniqueness of the Personal Experience

There is the notion of an *appropriate death* as a style of dying that is adaptive to each specific person. A respect for each individual's personality and values define what may be "appropriate" for that person. Each must live their own life and death in a manner consonant with their own pattern of living and dying, their own definition of life and death, and within their own context. Thus, an appropriate death is different for each individual.

It is imperative to understand the ways in which dying individuals have lived through and experienced previous stressful life events in order to understand how they respond to the challenges inherent in the dying process. How individuals behaved during earlier life crises will give significant clues to how they will behave during dying. In other words, people die in the same way that they live. The situation (dying) may be extraordinary, but the psychosocial variables such as personality traits and coping history remain long-established and will result in similar styles of dealing with challenges of dying. (See Section 1, "A 'Good Death.'")

Stages of Dying

Five stages that refer to the person's successive mental and emotional responses to dying have been identified: denial, anger, bargaining, depression, and acceptance.[5]

Denial ("No, not me."), the first response to learning that one is dying, is an attempt to negate or escape from the idea of one's own death. Most individuals experience partial and temporary denial. Denial is a form of natural protection and allows us to manage fear. To provide support for persons who are in denial, it is helpful to invite them to talk about their fears without, however, attempting to force them out of denial.

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[5] Kübler-Ross, Elisabeth. *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families.* NY: Simon & Schuster, 2009.

The second stage, *anger* (“Why me?”), often characterized by envy, rage, and resentment, is often difficult for family members who may be the target of the anger. This stage is stimulated by fear and frustration. Understanding that anger is a normal response to a terminal illness can help to keep outbursts in perspective and to accept this behavior as temporary and normal.

In *bargaining* (“Yes, me, but ...”), the third stage, the dying person attempts to forestall the inevitable by making a deal with the doctor, family, God, or fate if permitted to live somewhat longer. At this point in the dying process, the person recognizes the prognosis but is still attempting to modify the outcome. Sincere listening and realistic support can be offered.

Depression (“Yes, me” grieving.) is associated with the ultimate future loss of life and may be characterized by fatigue, loss of function, feelings of guilt, and fear of dying. The dying person realizes that bargaining is of no use and becomes sorrowful and withdrawn. Simply being present and accepting when a person is depressed is more helpful than attempting to talk them out of their depression or to distract them.

The final stage, *acceptance* (“Yes, me.”), signifies the end of the struggle. Rather than being accompanied by a happy or serene feeling, acceptance is often associated with an absence of all feeling.

These stages are not rigid, nor are they mutually exclusive. Moreover, hope is associated with all stages, even with depression and with acceptance. Indeed, it is asserted that, without hope, death follows shortly. (See Section 2: “Maintaining Hope.”)

Although many dying individuals do experience these stages in clearly observable ways, it is essential to remember that if the stages do in fact exist, there is no evidence that they actually move through the five stages in a linear fashion, or that they experience all stages.

Factors Influencing the Dying Process

There are several factors that influence the experience of dying, specifically, age, gender, the nature of the disease and environment, and religion and culture.

Chronological age affects the way in which dying and death are comprehended since the intellectual grasp of death is related to the individual's developmental level and to the extent of life experiences. Accordingly, a particular experience for a mature adult with diverse life experiences will vary considerably from that of a young child who may not comprehend the nature of death. An example clearly illustrates the influence of age on the experience of dying. A young child with a diagnosis of terminal cancer and a life expectancy of less than six months began to question her future when the pain from her bone cancer interfered with her ability to walk. She struggled to understand the concept of death but could not easily move beyond the fear of being alone, that is, without her parents. Her major concern was who would take care of her.

Age further influences the dying process with respect to the opportunity for control over the situation, with children and adults having different opportunities to exercise control. The same young child mentioned above understandably had little opportunity to participate in the decision-making process regarding her treatment and attempted to exercise control over the situation in other ways. For example, she would refuse to respond to adult conversation at times, indicating that *she* would be the one to decide when and if conversation would be initiated, emphatically declaring in response to a statement or question, "Not now! We'll talk after the cuckoo (clock) strikes!" Age also influences the perception of others and the ways in which one is treated. Although this child clearly was in the terminal phase of cancer, the treatment team found it difficult, if not impossible, to make the final decision to terminate treatment, as is often the case when treating young children. In cultures where youth is greatly valued, it often is difficult to reconcile the "untimely" death of a child. Conversely, advancing age may result, not always appropriately, in a less aggressive treatment protocol.

Gender affects the dying experience because of the difference in life roles for men and women and, therefore, the difference in values. For example, a man who is facing a life-threatening illness may be more concerned with financial provisions for his family, while a woman may be more concerned with family integrity and caregiving activities ("Who will cook for my husband?").

Disease, *treatment*, *and environment* critically influence the experience of dying. Individuals die of a particular cause in a particular place. For example, a lung condition associated with breathing difficulty and being treated in a hospital is likely to cause more alarming symptoms than is a home death due to chronic kidney failure, where one may become increasingly lethargic as death approaches.

Religion and culture deserve some attention here since one's attitudes and beliefs about life, living, and death, as shaped by religion and culture, influence the dying process. For example, a person who believes that death signifies the end of all life as they know it may have a fear of the dying process and of death. Conversely, a person who believes in an afterlife or in reincarnation may fear the anticipated separation from loved ones, but not the dying process or death. The profoundly different nature of these two individuals' fears will influence the ways in which they respond to the dying process and the ways in which loved ones can assist them through the process. One way in which conversation about the dying person's beliefs about an afterlife may be initiated is simply to ask, "What do you believe happens afterwards?"

Having a faith, too, influences the experience of dying. One hospice nurse indicated that,

> "At the end, those with a faith — it really doesn't matter in what, but a faith in something — find it easier. Not always, but as a rule. I've seen people with faith panic and I've seen those without faith accept it [death]. But, as a rule, it's much easier [for those] with faith."[6]

The "Suggested Resources" at the end of this *Guide* list several books that may be helpful within various philosophical contexts.

Words from Those Nearing Death

Persons nearing death quite often will speak, within their own frames of reference, of preparation for travel. For example, the businessman may fret about needing to find his passport, while the

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[6] Samarel, Nelda. *Caring for Life and Death.* Washington, D.C.: Taylor & Francis, 1991, p 64 – 65.

sailboat buff may ask about the tides. The recurrence of this theme is consistent with the concept of death as a passage or journey. A prevalent theme is that of the dying person being accompanied by another who already has died. Most often, the dying recognize a relative or close friend who previously has died; occasionally they speak of angels or religious figures.

In one beautiful situation, an elderly dying woman was seen by her adult granddaughter to be conversing with her long-dead husband. Following this "conversation," she announced with great serenity to her granddaughter that Grandpa had stopped by to tell Grandma not to be afraid and that she would be joining him soon. He also said that he would be guiding her on her journey among beautiful gardens. She shortly drifted off to sleep, her face tranquil and calm; she died a short while later.

One imminently terminal man, asleep in his hospital room, awoke with a start, became quite alert and called the nurse to his bedside. He said that, while asleep, he had "seen" two angels who would be with him when he was ready "to go." Several days later he serenely pointed to a corner of the ceiling and announced in a matter-of-fact manner, "There they are, the angels. They've come for me." He then took one final breath and closed his eyes. The messages here are that dying persons are not alone and may, in fact, be blessed with help in a form unique to them.

2

Changing Needs at the End of the Dying Trajectory

1. DISENGAGEMENT

In addition to those experiences previously discussed (denial, fear, depression, etc.), one of the most remarkable signs of impending death is an increasing *disengagement* from the world of the living. Persons who are aware of their terminal illness and have accepted their impending death gradually disengage, or separate, from the world of the living. In the last few days or, in some cases, weeks, dying persons, in an attempt to pull away from loved ones, often seem to withdraw into themselves for increasingly long periods of time. Indications of disengagement may include less verbalization, rejection of others, and increasing sleep. Often, they appear to be totally distracted by inner thoughts or work.

Dying individuals who are in the process of disengaging prefer not to be disturbed, but would rather have the opportunity to continue their separation. Occasionally, they will clearly communicate this, as in the case of one 63-year-old woman.

"Selma" was lying motionless in bed, very pale and still, with eyes open, sad, and pensive. Her husband of 40 years entered the room, kissed her forehead, sat in the chair next to Selma's bed, and attempted to take her hand in his. Selma looked startled for a moment, apparently not hearing him enter her room. She withdrew her hand from his and said gently, almost pleadingly, "Not now." She then closed her eyes, as if to temporarily shut out the world, and continued with her private thoughts. Selma clearly was in the process of disengaging and needed time alone to continue the process.

Often, the disengaging person is not as gentle as was Selma in communicating her needs to be alone with her inner thoughts. Seven-year-old "Amy" knew she was dying. She had spoken about leaving her family and going to be with her "grandpa" and her dog, both of whom had predeceased her. During the last six days of her life, Amy spent more and more time lying quietly in her living room; her eyes remained closed while her family went on with life all around her. During those quiet times, Amy's mother or father occasionally knelt beside her bed and attempted to take her small hand in their own or touch her forehead. Amy very clearly communicated that she did not want to be disturbed at those times. She would whine loudly and withdraw her hand, or turn her head away shouting, "Leave me alone!"

Disengagement appears to be a private experience that dying persons refrain from sharing. From the comments that they have shared, however, it seems that the process may involve one or two separate tasks, either singly or in combination. The first is introspection and reflection, the "life review." One person shared, "I'm getting my mental and emotional house in order." The second task is related to preparation for travel or being accompanied.

It has become apparent that preparation for dying is not done without effort — physical, mental/emotional, and spiritual. It is important not to interrupt the progression of this effort. That is, when caring for the dying, family members *must be aware of their loved one's needs for solitude* and must respect those needs. This must be carefully explained to family members who may feel rejected when they do not understand the disengagement process as being normal.

2. FEAR OF ABANDONMENT

Equally as important as recognizing and respecting the dying person's need for disengagement is the recognition of their need not to be abandoned. Fear of abandonment is easily understood when we realize that dying, of necessity, is something that is done alone. The dying are alone in their experience; loved ones are left behind. It is necessary, therefore, to reach a balance whereby the dying have their needs for disengagement and their needs not to be abandoned met concurrently. Ways to accomplish this balance are discussed throughout the remainder of this Section.

3. PAIN MANAGEMENT

Maintenance of physical comfort has been briefly discussed earlier. Pain management, however, is so important that it needs to stand on its own. For persons dying of cancer, pain may be a reality or it may be a fear for the future. Unfortunately, cancer and pain are still closely related in the minds of many. It is beyond the scope of this work to discuss the pharmacologic methods of pain relief. Suffice it to say that, with the variety of analgesics and medication delivery systems currently available, it is unnecessary and unjust for anyone to suffer needlessly. It is important for the dying person, loved ones, and health care provider to partner so that effective pharmacologic pain relief is provided. Non-pharmacologic methods of pain management will be addressed below in the discussion of complementary practices.

There are emotional and spiritual components, as well as physical ones, to the experience of pain. It has been said that pain is soul destroying and no person should have to endure intense pain unnecessarily. Pain has its roots in the Greek word “poine,” meaning punishment. This is not surprising when considering that persons who are experiencing prolonged and severe pain often perceive their experience as a punishment. This is especially true with children, as evidenced by one child’s comment regarding her severe cancer pain:

> “I must be a bad girl. I don’t know what I did that was wrong, but I’m really bad. Otherwise I wouldn’t have cancer and it wouldn’t hurt so much.”

This child had carried that thought with her for an unknown period of time. Had it not been for a casual comment made to her mother, this child’s interpretation of pain as punishment might have accompanied her to her death. Thankfully, her mother was given the opportunity to reinforce to her daughter that she was not a bad girl; that she was, in fact, a very good girl; and that cancer is an illness that many good children get. The attitude change in that child was remarkable. It was as if she had a burden lifted, highlighting an extremely important aspect of caring for dying persons, with or without pain: effective communication.

4. FACILITATING EFFECTIVE COMMUNICATION

Open communication between the dying and their loved ones is essential for the well-being of all concerned. Too often, however, open and honest communication is something that is taken for granted, yet not thought about or achieved. Consider the following example of a conversation between a hospice nurse and her dying patient, 62-year-old “Mr. Lane.”[7] They were speaking about Mr. Lane’s wife:

Mr. Lane: “We’re (my wife and I) pretty much alone. We really don’t have anyone but each other.”

Nurse: “That must be really difficult for you. You love each other very much.”

Mr. Lane: Tears welling up in his eyes, looking down.

Nurse: “Have you told her?”

Mr. Lane: “Told her what?”

Nurse: “That you love her.”

Mr. Lane: “Those things are really hard to say. And, anyway, she knows how I feel about her. She knows how much I love her.”

Nurse: Gently, “Yes, I’m sure she does. But I believe you both will feel a lot better if you talk about those things. It’s really important, you know. I understand that it’s really hard to say some things, especially when you are not accustomed to. But I think you will both feel a whole lot better if you talk to each other about what is going on and about how you are feeling.”

Mr. Lane: “I’ll give it some thought. Maybe you can help me. It’s really so hard.”

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[7] Ibid., p 33-35.

Quite obviously, this man hadn’t thought to communicate his feelings of love to his wife. Such words are difficult and, often, painful to verbalize because they bring people face-to-face with the reality of the present situation. Later that same day, when Mrs. Lane was visiting, he used the call bell to summon the nurse. Upon entering the room, she saw Mr. and Mrs. Lane seated silently next to each other at the window:

Mr. Lane: To nurse, “Oh, I hope I wasn’t disturbing you. But I wanted to thank you for talking with me this morning.” Turning to his wife, “Katie (the nurse) and I had quite a conversation this morning, didn’t we?” turning back to the nurse and looking searchingly at her.

Nurse: “Yes, we did.” Then, turning to his wife, “Your husband was talking about how difficult this whole thing is for both of you. And about how much he cares for you.” To the patient, “Isn’t that so?”

Mr. Lane: Looking down, with tears rolling down his cheek, “Sometimes it’s so hard to talk about the things that matter most.”

Mrs. Lane: Takes a tissue from her purse and clutches it in her lap.

Mr. Lane: “Talking with Katie today made me realize how much I really love you. I think that’s probably the hardest part of this whole thing.”

Mrs. Lane: Gets up from her chair, kneels in front of her husband, taking both his hands in hers, and looks up at him silently.

Mr. Lane: “Oh, God.” He begins weeping.

Mrs. Lane: Rests her head in his lap and places her arms around his hips, weeping.

Mr. Lane: Placing his hands gently on wife’s hair, “I *do* love you, you know.”

We can help our dying loved ones to share their final wishes, to share their feelings, and to say “good-bye.” Although difficult and, at times, painful, an open expression of feelings may serve to bring family members closer and also prevent the regrets often experienced later on.

At times, the dying process takes longer than anticipated and many wonder if it’s all right to tell their dying loved one that they may “let go.” How much control each of us has on our own or another’s dying is not known, but perhaps the dying person has more control over this than suspected. If it appears that our loved one is having difficulty letting go for our sake, it is appropriate to tell them that they may let go. We simply may say, “It’s all right to let go.” We also may add that we love them and always will love them, but that it is time for them to go on. This may be quite difficult to do as it may be mistakenly interpreted by loved ones of the dying as telling the latter that they are not loved. Giving permission, however, or releasing the dying, is one of the most loving, generous, selfless, and freeing things that may be communicated.

Counseling and Therapy

Emotional support in the form of empathetic understanding, clear and honest communication, and acknowledgment of feelings may be provided by loved ones and/or health care providers. In addition, counseling by mental health nurses and social workers, psychologists, and psychiatrists may be more focused, intensive, and structured. Types of psychosocial services range from informal peer support groups to formal structured psychotherapy.

Support groups designed to help people adapt to terminal illness are based on the premise that dying people benefit from contact with other such people through mutual social support. Many groups offer much more than peer support; they are facilitated by professionals who are prepared to provide expert information and guidance. Examples of such groups offering both support and education for individuals and families facing death include programs supported by the Cancer Society in many countries, including the United States, and The Ruby Care Foundation in Europe and New Zealand.

Individual and family psychotherapy is a more intensive intervention than support groups and may be needed to help meet the challenges of terminal illness. This may be suitable for many who are dying, but is particularly recommended for the more vulnerable with difficulties in coping. These include: those who live alone or have few friends; children, young adults, or those over age 75; the financially stressed; parents of dependent children; people who have suffered multiple life stresses; members of families characterized by high levels of conflict; or people with other personal or family illness.

5. MAINTAINING HOPE

Hope is an essential aspect underlying the entire dying process and all dying persons express some type of hope until the end of their lives. In fact, Kübler-Ross[8] found that, when hopelessness was expressed, death followed within 24 hours. Fanslow-Brunjes[9] maintains,

> "All of us can live with the knowledge that we have an incurable disease, but none of us can live with the thought that we are hopeless."

Some often believe that, in order to assist their dying loved one to maintain hope, it is necessary to lie about the prognosis of the disease, thereby betraying a trusting relationship. It is possible to allow a dying person to maintain hope without lying about the seriousness of the illness. When asked by a person who is dying, for example, whether we think a remission is possible, an honest yet hopeful response may be, "Remission is a possibility." This reply enables the patient to maintain hope for a remission, unrealistic though it may be, without stating that a remission is probable.

According to the "Hope System" for dying persons,[10] as individuals come closer to death, hope is maintained differently and progresses through four phases as the dying person's nature of hope changes: hope for cure ("I hope that whatever I have is curable"); hope

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[8] Kübler-Ross, Elisabeth. *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families*. NY: Simon & Schuster, 2009.

[9] Fanslow-Brunjes, Cathleen. *Using the Power of Hope to Cope with Dying: The Four Stages of Hope*. Sanger, CA: Quill Driver, 2008, p 31.

[10] Ibid.

for successful treatment ("I hope that my tumor can be completely removed by surgery"); hope for prolongation of life ("I hope to live longer so that, perhaps, a cure may be found"); and, finally, hope for a peaceful death.

The focus of the hope changes from hope for extended life to hope for other things. For example, one may hope to remain free of pain. Or one may hope that there be no burdens such as unaffordable funeral expenses left with family. To assist the dying person to maintain hope, we must know what it is that is being hoped for. This sounds elementary and unnecessary to discuss, but how often have we thought to ask, "Tell me what it is you are hoping for?" The response to this question may be surprising. Often, the dying person has not yet thought about what it is that is hoped for and will welcome an opportunity for reflection. Such an interaction empowers them and provides the opportunity to bring to consciousness a positive hope that yet may be achieved; it empowers us who may be given the opportunity to help our loved one achieve the expressed hope.

For example, one dying 43-year-old mother of three teenagers, when asked, "What is it that you are hoping for," replied:

> "What I was really hoping for was that I could live long enough to see the three of them (her children) spend some time together as friends. You know, without fighting. But I guess that can't happen at their ages. And I know I won't be around too much longer."[11]

Often, family members desperately want to be of assistance, but feel helpless and inadequate. When this mother's children learned of their mother's hope, they were amazed at how simple it was to fulfill. And how empowering it was for them to be able to provide tangible assistance for their dying mother.

Although difficult, family members and health care providers need to accept it when a dying person stops expressing hope.

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[11] Samarel, Nelda, "The Dying Process," in Dying: Facing the Facts, 3rd Ed. Hannelore Wass & Robert A. Neimeyer, eds. Washington, D.C.: Taylor & Francis, 1995, p 108.

6. BEING PRESENT

Being truly present enhances the value of interactions with the dying or, for that matter, with anyone. Being truly present means being with the person physically, emotionally, mentally, and spiritually; focusing one's full attention on the present time, in the present place, with the present person. To be truly present is to be in the here and now. This means to listen with our ears, eyes, mind, and heart. It means not entertaining any extraneous thoughts while with someone; not thinking that it may be too warm in the room; not thinking that we are exhausted from a particularly stressful day; not thinking that we have not yet had our lunch. In other words, to be truly and sincerely present, we need to temporarily suspend thought, to stop the inner dialogue of the chattering mind and give full attention to the present situation.

An effective way to learn to be fully present is through meditation, or centering. (Also see page 32.) Meditation is a means of focusing and concentrating our attention and requires physical and mental stillness for 10 to 20 minutes, during which time we sit or lie in a comfortable position with eyes closed. There are many forms of meditation, but the ones most commonly used are focusing on the breath, or repeating a word or phrase.

The following breathing exercise may be helpful in stilling our mind in order to help us be more fully present:

1) Assume a relaxed posture with an erect spine and eyes closed or half closed.
2) Observe your breath at the area from just inside the nostrils to and including the area above the upper lip; do not change the breath; simply observe it.
3) Observe that sometimes the breath is deep; sometimes the breath is shallow; simply observe.
4) Sometimes the breath flows through the right nostril; sometimes through the left; simply observe.
5) If mind wanders, gently bring it back to the breath.

It is helpful to practice this once or twice daily. Once we have practiced and are familiar with that sense of stillness of mind, it may be effectively used to help us to be present with our dying loved one. When we are centered, in that place of stillness and peace, simply by being present with our loved one, we may bring them into resonance with that place within ourselves. This is a great gift to give to the dying.

Whether being present is done through speaking, listening, touching, sharing, or silence, it always involves sincerity and requires practice. This does not mean that we need to be super human. What it does mean is that, as a family member or anyone else who wishes to communicate on a deeper and more caring level, we simply need to be fully attentive to the moment. A full attention, or a true presence, is felt on many levels. Sensitive individuals, and especially children and those who are dying, can sense and relate to a true and complete presence by relaxing physically, emotionally, and mentally and feeling the freedom to express themselves. This presence, too, will ease any sense of abandonment that the dying may be experiencing.

7. ASSISTING THE PASSAGE

When death appears to be imminent, it often is appropriate to assist the dying in their final passage. This notion seems foreign to most people. After all, how can the living assist a person to die, to go where the living may not? It is true that we cannot accompany the dying on their entire journey, but we can offer our presence and support throughout most of the process.

When a dying person is responsive, their need for assistance may be apparent through facial expression, gesture, or verbalization. The unresponsive, too, may need assistance, although unable to express it.

The most important way in which we may assist another in the transition from life to death is to assure them that they are not abandoned, as previously discussed, and to provide them with a sense of peace. Peace means to be free from all pain — physical, emotional, mental, and spiritual; it is a profound sense that all is well with the world. Peace is the most valuable gift that may be given to the dying.

A sense of peace may be conveyed despite some physical discomfort (not severe distress) and despite any unfinished business. As death becomes imminent, it seems as if the need for peace supersedes all other needs. In order to convey this peacefulness to another, however, we must be peaceful within ourselves. To find that peaceful place within ourselves, we must be still, be present in the moment, and accept the moment. (See previous section, paragraphs about meditation.) To accept the moment means to accept death without fear. If we are fearful, that fear will be communicated to the dying person. Therefore, to be helpful to the dying in this manner, it is necessary to reconcile death in ourselves. Only when this is achieved, or at least recognized, is it possible to assist the dying, whether they are responsive or unresponsive, to find peace.

The following, adapted from a combination of methods developed by Dora Kunz and Cathleen Fanslow-Brunjes[12], is quite effective in conveying a sense of peace to a dying person:

1) Sit with the person, holding one of their hands firmly in both of your own, thereby providing the physical feeling of security;
2) Gently affirm your presence and the fact that the person is not alone;
3) Mentally project your own sense of peace, visualizing (see page 32) that peacefulness flowing from your heart, through your arms and hands, to your loved one’s hand and arm, to and permeating their heart; and
4) When appropriate, slowly and gently release their hand.

This may be taught to loved ones who often hover helplessly near, wishing they could be of use but not knowing what to do.

Continued pain or discomfort, as well as long-term weakness, can be disorienting. When it appears that death is imminent, it is beneficial to remind our loved one of their highest spiritual aspiration, if known.

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[12] Ibid.

This is best achieved through symbols rather than through words. For example, sing or play a recording of a special song they found uplifting or inspiring, or chant a mantra to which they particularly related.

8. CHOOSING WHERE TO DIE

End-of-life care may be provided in an in-patient facility like a hospital, hospice, or nursing home, or may be provided at home. At times, there is a choice among these, at times, not, such as when a person already is hospitalized for a serious illness and the dying trajectory is rapid. This decision is best reached with discussion and consideration of the wishes of the dying person and the ability of the family members. Each situation is unique and there is no one decision that is appropriate for all persons or all situations.

9. COMPLEMENTARY HEALTH CARE PRACTICES

A complementary health care practice is defined as a nontraditional, holistic intervention that is offered in addition to (not instead of) traditional health care. Complementary health care practices have been increasing in popularity and have been found to be useful in the care of the dying, possibly because of the holistic focus, the focus on body, emotions, mind, and spirit, that is so essential during the dying process. The following three complementary health care practices are by no means an all-inclusive list; they are examples of specific practices found quite useful with dying persons.

Meditation

As described above in the section on “Being Present” (page 29), meditation may be taught to the dying person and is effective in helping them to relax, decrease feelings of discomfort, and increase the duration and effectiveness of pain medication. Meditation also is helpful in enabling dying persons to become more aware of the emotional and spiritual aspects of their beings, thus facilitating a sense of peace. It can be used very effectively in combination with imagery or visualization.

Imagery or Visualization

Imagery or visualization, the creation of positive mental images, is usually preceded by progressive muscle relaxation. People find visualization easy to learn and satisfying to use.

One 52-year-old man with lung cancer, distraught about leaving his 10-year-old son without a father, was taught to visualize his son as surrounded by a white light that symbolized all the good in the universe. He was instructed to practice this visualization for two minutes each day for a week. One week later he shared that it was remarkable how his anxiety about his son seemed to ease. He said that he "knew" that his little boy would do fine "afterward." Moreover, this man said that he was now able to spend time with his son whereas, before he used the visualization, he could not be with the boy because he was afraid of becoming too emotional and scaring the boy.

To facilitate a sense of peace for the dying person, we may use visualization to bathe our loved one in a white or blue light to decrease anxiety and assist with the transition.

Therapeutic Touch

Therapeutic Touch[13] has been identified as one of the most effective practices for the dying person. It is derived from the ancient practice of the laying-on of hands but is not done within a religious context nor does it require a professed faith or belief by either the practitioner or the recipient. It consists of several steps taken by the practitioner: assuming a meditative state of awareness and mentally making the intention to help the recipient; using the hands to assess the recipient's energy flow and needs; and using the hands to repattern their energy field. Because Therapeutic Touch is based on the assessment and modulation of a person's energy field, no direct physical contact is necessary in this practice. The beneficial effects of Therapeutic Touch on recipients' experiences of serious illness include increased relaxation, reduced pain and anxiety, and increased

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[13] Samarel, Nelda. "Therapeutic Touch: Healing Based on Theosophy and Science," in *Quest,* July-August 2006.

positive mood. It is recommended that Therapeutic Touch be learned through special training. However, books describing its practice are included in the section on “Useful Resources.”

10. CARING: THE ESSENTIAL COMPONENT

Regardless of which interventions are used when assisting dying persons, the essential component required to make any of them effective is caring. In true caring, devotion must be present. This devotion is manifested by our total presence of attention and by acceptance of obligations. Ingredients of caring include knowledge, patience, honesty, trust, humility, hope, courage, commitment, and selflessness. It is expressed nonverbally more so than verbally and includes those activities which provide assistance to another individual based on an interest in or concern for that human being, or to meet an expressed or unexpressed need.

One of the most basic and honest ways in which caring may be communicated to the dying is through the use of touch as a conscious and deliberate act. As a fundamental means of communication, caring through touch becomes particularly important for those dying who may be experiencing sensory impairment such as visual or hearing deficits. A caring touch conveys presence, understanding, and compassion. In a truly caring interaction we and our dying loved one come together through the dynamics of an honest and open human relationship, regardless of the brevity or length of that relationship. The interaction affects both and both gain something of value as a result of the relationship.

The deep caring required in care for the dying must embrace the spiritual dimension. If we are to truly care for our dying loved one, we must accept the reality of our own death, thus facilitating establishment of a bond with our dying loved one.

The effectiveness of sitting silently with the dying person and simply holding their hand can not be over-estimated.

3

Living with Dying

From the moment of birth we all are engaged in the dying process. However, most of us do not consider ourselves to be dying, nor do we often, if ever, think about personal dying. Once an individual comes face to face with a serious illness whose outcome often is associated with death, life changes; the eventuality of death becomes more personal.

Following acceptance of the diagnosis, dealing with the reality of the illness, and coming to terms with the reality of eventual death (if not from a specific illness, then from old age!), many indicated that they made conscious decisions about how they would live with a terminal illness and about whether the illness would have a positive or negative influence on their lives.

How can a potentially life-threatening illness have a positive aspect? The Chinese character for crisis is a combination of two words: danger and opportunity. With the new diagnosis of a life-threatening illness, the dangers are obvious and the idea that anything beneficial ever could result from such an event seems ludicrous. The true challenge of such a situation is to use the experience in a positive way, extracting from it what we have learned and applying those lessons to every area of our life. There are benefits inherent in coming to terms with mortality. When we learn to understand our own deepest feelings, we may become a more complete and compassionate human being, helping to change our perspective on all life. Changes are noticed in an improved ability to communicate, enhanced relationships, and feelings of empowerment. Resolution of previous issues, such as low self-esteem, may occur and enrich the rest of our life. Moving past the danger of life-threatening illness permits us to take full advantage of opportunities provided by the crisis experience.

Despite the fact that dying means separation and the resultant grief, there are also high points, or peak experiences, in caring for the dying. The following description of one family member's experience with her mother at the moment of death poignantly reflects much more than an acceptance of death. It reflects an appreciation of life on the physical plane, of which death is a part. According to this woman:

"It became very still. Not quiet, but still. But it was as if a lot was happening. There was almost a presence felt in the room. And it wasn't bad [that my mom was dying]. It felt calm, peaceful, and okay. No, it was more than okay. It was right and it was beautiful. And, all of a sudden, I felt the same kind of joyful tears that I felt when my first baby was born. Then I realized that, at that very moment, she had died. Death seemed to be the same miracle as birth was."[14]

Being present at the moment of her mother's passage was, for this daughter, a personal, profound, blissful, transcendent, illuminating, and mystical event, resulting in feeling differently about the world. And so it seems that dying can be a transformation, not only for the person who is dying, but also for those accompanying them during the dying process.

Understanding the process of dying presents a formidable challenge to every one of us, for we all are engaged in this process, living with dying. The fact that we are all a part of this process every day of our lives necessarily implores us to be a part of this process for all our loved ones, thus ensuring the presence and caring that so enrich the human interaction.

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[14] Samarel, Nelda. *Caring for Life and Death*. Washington, D.C.: Taylor & Francis, 1991, p 72.

Useful Resources

The following resources, listed by topic, may be especially helpful in assisting the dying. This is by no means an all-inclusive list, but it does contain resources selected for their specific potential to be of assistance to readers of this *Guide*.

Care of the Dying

Books

Babcock, Elise. *When Life Becomes Precious: A Guide for Loved Ones and Friends of Cancer Patients*. NY: Bantam, 1997.

> Teaches how to provide support and love through communication.

Callanan, Maggie and Kelley, Patricia. *Final Gifts: Understanding the Special Awareness, Needs, and Communications of the Dying.* NY: Bantam, 1997.

> Information about the process of dying and dealing with people who are dying.

Coberly, Margaret. *Sacred Passage: How to Provide Fearless, Compassionate Care for the Dying.* Boston: Shambhala, 2002.

> Draws from Tibetan Buddhism to demonstrate how people who are dying may experience emotional and spiritual healing.

Davis, Maggie Steincrohn. *Caring in Remembered Ways: The Fruit of Seeing Deeply.* Blue Hill, ME: Heartsong, 1999.

> A series of essays about taking care of (caring for) our fellow human beings.

Fanslow-Brunjes, Cathleen. *Using the Power of Hope to Cope with Dying: The Four Stages of Hope*. Sanger, CA: Quill Driver, 2008.

> Addresses all levels of the dying experience: physical, emotional, psychological, and spiritual.

Kübler-Ross, Elisabeth. *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families.* NY: Simon & Schuster, 2003.

> Groundbreaking work describing the way in which some people cope with death, including the five stages of death and dying.

Kübler-Ross, Elisabeth and Myss, C. *On Life after Death.,* Berkeley, CA: Celestial Arts, 2008.

> Four essays by Kübler-Ross discussing dying as a transition to a different form of life.

Lattanzi-Licht, Marcia, Miller, Galen W. and Mahoney, John J. *The Hospice Choice: In Pursuit of a Peaceful Death*. NY: Fireside, 1998.

> Describes hospice and palliative care to better prepare patients and families for hospice care.

Longaker, Christine. *Facing Death and Finding Hope: A Guide for the Emotional and Spiritual Care of the Dying.* NY: Doubleday, 1998.

> Using the Tibetan Buddhist perspective, clearly and compassionately identifies the typical fears and struggles experienced by the dying and provides a new framework of meaning.

Malkin, Gary R. and Stillwater, Michael (eds.). *Graceful Passages: A Companion for Living and Dying* (Book and 2-CD set). Greenbrae, CA: Wisdom of the World, 2006.

> Guides in the communication about life, death, forgiveness, and acceptance with chapter contributors including Ram Dass, Ven. Thich Nhat Hanh, Dr. Elisabeth Kübler-Ross, Rabbi Salman Schachter-Shalomi, & Fr. Maximilliam Mizzi.

McNees, Pat (ed.). *Dying: A Book of Comfort.* NY: Warner, 1996.

> An anthology exploring a range of experiences: living when you know you are dying; caring for and about someone who is dying; saying goodbye; and dealing with how it feels to be left behind.

Websites

Cancer Care: www.cancercare.org

> Provides counseling and support groups, education, financial assistance and practical help.

Help the Hospices: http://www.helpthehospices.org.uk/hospiceinformation/

Access to information about UK hospice care and how to find a hospice along with information about international palliative care and overseas services.

Hospice Foundation of America: www.hospicefoundation.org

Provides guidance regarding care at the end of life.

Macmillan Cancer Support: http://www.macmillan.org.uk/Home.aspx

Provides practical, medical and financial support.

National Hospice and Palliative Care Organization: www.nhpco.org

Provides resources on a variety of end-of-life issues.

NHS:
http://www.nhs.uk/LiveWell/Endoflifecare/Pages/Endoflifecarehome.aspx

A comprehensive information service intended to help with health choices.

Ruby Care Foundation: http://www.rubycare.org/

Provides care, counseling, and support.

Spiritual Care Program: www.spcare.org

Buddhist insights to improve end-of-life care.

Meditation

Books

Bodian, Stephan. *Meditation for Dummies* (book and CD). Hoboken, NJ: Wiley, 2006.

Thorough non-denominational exploration of meditation, including instructions for practice.

Ellwood, Robert S. *Finding the Quiet Mind*. Wheaton, IL: Quest, 1997.

Simply and clearly presents a wide variety of ideas, methods, and suggestions to make meditation accessible.

Kornfeld, Jack. *Meditation for Beginners.* Boulder, CO: Sounds True, 2008.

Step-by-step guide for beginners through insight, or Vipassana, meditation.

Paramananda. *Change Your Mind: A Practical Guide to Buddhist Meditation.* Birmingham, U.K., 2005.

A guide to the practices of the mindfulness of breathing and loving-kindness.

Websites

How to Meditate: http://www.how-to-meditate.org/

Provides beginning instruction in a variety of types of Buddhist meditations.

Meditation: http://www.mayoclinic.com/health/meditation/HQ01070

Provides beginning instruction in basic meditation.

Meditation Society of America: http://www.meditationsociety.com/index.html

Valuable information on meditation techniques and concepts from all traditions; for beginners and experts.

Therapeutic Touch

Books

Kunz, Dora and Krieger, Dolores. *The Spiritual Dimension of Therapeutic Touch.* Rochester, VT: Bear & Co., 2004.

Examines the dynamic interrelationship between healer and patient, and the role of expanded levels of consciousness.

Macrae, Janet. *Therapeutic Touch: A practical guide.* NY: Alfred A. Knopf, 2005.

A comprehensive instruction guide to the gentle, powerful, non-invasive healing technique being used increasingly both inside and outside the medical profession. Available to anyone searching to help others.

Sayre-Adams, Jean and Wright, Stephen. *Therapeutic Touch.* London: Harcourt, 2001.

Provides background, framework, and description of therapeutic touch, also describing its practice.

Websites

"Therapeutic Touch: Healing Based on Theosophy and Science:"
http://www.theosophical.org/publications/questmagazine/julaug06/samarel/index.php

> Article providing overview of therapeutic touch, including scientific and theosophical basis for the practice.

Therapeutic Touch:
http://www.umm.edu/altmed/articles/therapeutic-touch-000362.htm

> Overview of therapeutic touch.

Other Complementary Practices

Websites

Complementary and Alternative Therapies (American Cancer Society):
http://www.cancer.org/docroot/ETO/ETO_5.asp

> Thorough overview of a wide variety of complementary and alternative therapies.

Complementary and Alternative Medicine (National Cancer Institute):
http://www.cancer.gov/cancertopics/treatment/cam

> Thorough overview of a wide variety of complementary and alternative therapies.

Spiritual/Philosophical Resources

Theosophy – The Nature of Human Life

Besant, Annie. *The Seven Principles of Man.* Adyar, India: Theosophical Publishing House, 2005.

> Describes in simple language the theosophical concept of humans as divine beings clothed in different garments, or sheaths (physical, emotional, mental, etc.).

Ellwood, Robert S. *The Pilgrim Self: Traveling the Path from Life to Life.* Wheaton, IL: Quest, 1996.

> Describes the individual self as a Pilgrim journeying from life to life, learning, growing, and evolving toward that state of infinite purity from which we come and which is our true home.

Nicholson, Shirley. *The Seven Human Powers: Luminous Shadows of the Self.* Wheaton, IL: Quest, 2003.

> Draws on ancient spiritual traditions and modern depth psychology to help access innate powers involving body, emotions, mind, and spiritual consciousness.

Taimni, I.K. *Self-Culture.* Wheaton, IL: Quest, 1976.

> A description of the septenary constitution of the human being, along with suggestions for the development of each of the seven “bodies” (physical, emotional, mental, etc).

Theosophical Perspectives on Death and After

Besant, Annie. *Death and After.* Adyar, India: Theosophical Publishing House, 1977.

> Describes the process we call death, by which the immortal Self of man withdraws from physical experience towards higher realms, the fate of the different components of the passing personality, and how the Self returns to Earth for a new incarnation.

Farthing, Geoffrey. *After Death Consciousness and Processes.* San Diego: Point Loma, 1996.

> A compilation of extracts from the writings of H.P. Blavatsky and her Initiate Teachers about the universal cycle of birth, death, and rebirth, as well as the processes undergone between two incarnations.

Farthing, Geoffrey. *Exploring the Great Beyond.* Wheaton, IL: Quest, 1978.

> A commentary on H.P. Blavatsky’s writings on the after-death states; also a good introduction to theosophical principles.

Hodson, Geoffrey. *Through the Gateway of Death: A Message to the Bereaved.* Adyar, India: Theosophical Publishing House, 2001.

> Describes theosophical teachings regarding death and provides information about after death.

Leadbeater, Charles W. *The Astral Plane.* Adyar, India: Theosophical Publishing House, 2008.

> A clairvoyant describes the world in which we will find ourselves after death, proposing that we are separated from that world because of our lack of awareness and that we can be conscious of it during sleep.

Leadbeater, Charles W. *The Devachanic Plane.* Adyar, India: Theosophical Publishing House, 2008.

> Describes the characteristics of the "heaven world," Devachan, to which the soul withdraws after death.

Leadbeater, Charles W. *The Life after Death and How Theosophy Unveils It.* London: Theosophical Publishing House, 2009.

> Depicts the processes the soul undergoes after death — called Purgatory and Heaven in Christianity—as well as the different entities (human and angelic) that help the departed one in transition.

Leadbeater, Charles W. *The Other Side of Death.* Adyar, India: Theosophical Publishing House, 2002.

> Based on clairvoyant research, a thorough description of after-death life, clarifying religious misconceptions.

Perkins, James S. *Through Death to Rebirth.* Wheaton, IL: Quest, 2007.

> Introduction to cycles of death and rebirth as a definite and purposeful process, addresses continuity of consciousness and after-death states.

Theosophy - Websites

The Theosophical Society, Adyar, Chennai, India: http://www.ts-adyar.org/

> The Theosophical Society is a worldwide organization whose primary object is Universal Brotherhood based on the realization that life, and all its diverse forms, human and non-human, is indivisibly One. The Society imposes no belief on its members, who are united by a common search for Truth and desire to learn the meaning and purpose of existence by engaging themselves in study, reflection, purity of life and loving service.

The Theosophical Society in Australia:
http://www.austheos.org.au/clibrary/bindex-online-libraries.html

> Links to theosophical texts online.

The Canadian Theosophical Association Theosophical Library:
http://hpb.narod.ru/lib.htm

> Links to theosophical texts online.

Quest Books:
http://www.questbooks.net/category.cfm?catname=theosophy

> Quest is the imprint of the Theosophical Publishing House, the publishing arm of The Theosophical Society in America.

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Dying often requires assistance, not only for those in transition, but also for their families and loved ones. This Guide is intended for those who are helping. It discusses how to meet the dying person's physical, emotional, mental, and spiritual needs through all phases of the dying process, offering not only an understanding of the experiences of the dying, but also practical suggestions to assist them through their final transition.

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