CHAPTER 38

Facing fear through primary care of the soul

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Healing is about relationships. The healing process is one of establishing, tending, and deepening relationships, and may be experienced as a sense of connectedness and meaning. Fear of change, which is, in essence, the existential fear of the unknown and of death as the ultimate unknown, can impede or even prevent this process. While there is something in us that is inherently afraid of death, there is also something in us that is not afraid of death. As clinicians we continuously make choices about to how to prioritize our therapeutic interventions. In this context, we might ask ourselves: do we begin by trying to contain and lessen our patients' fear or by attending to that in our patients that is unafraid? This matters, hugely, because as psychologist William James reminds us, 'What we attend to becomes our reality, and what we don't attend to fades out of reality.'[1]

In this chapter we explore the relationship between fear of death and suffering. We consider how, if unrecognized, this same fear in clinicians may be counterproductive, sabotaging our best intentions to alleviate the suffering of our patients; possibly even compounding the situation. While continuing our clinical efforts to lessen suffering by containing fear, we suggest that it may be helpful for us to move beyond models of care that focus exclusively on problem-solving and damage limitation to ones where, from the outset, care of the soul is prioritized. We propose that the most effective way for us as clinicians to do this is to cultivate and practice a 'therapeutic use of self' by attending to our own inner depths, and to that in us that is not afraid of death.

Map of the human psyche

What is it in us that is afraid of death? What is it in us that is not afraid of death? Why and how does this matter? We can approach a possible answer to the first two of these questions by considering a psychospiritual map of the psyche. This map is based on concepts from the work of depth psychologist Carl Gustav Jung and from Buddhist Philosophy. With this as a backdrop, we will consider the third question by examining some of the intra-psychic dynamics of fear.

A useful metaphor for the individual human psyche is that of a wave on the ocean (Figure 38.1). The tip of the wave is the conscious part of the psyche in which the ego, the executive aspect or 'control room' of the psyche, is most at home (Figure 38.2). Other than its very tip, the rest of the wave represents the unconscious aspects of the psyche. Of note, the wave does not end at its base. Rather, the base of any individual wave flows into the ocean currents and is in continuity with the other waves on the ocean's surface.

Within this model the unconscious has three dimensions—the personal unconscious, the collective unconscious, and what we refer to as 'the deeper stream' (Figure 38.3). The *personal unconscious,* also known as the subjective unconscious, contains, for example, memories, repressed instincts and emotions, and is specific to that particular wave. The *collective unconscious*, also known as the objective or universal unconscious, is comprised of content that is shared 'collectively' among all human beings. Depth psychologist Carl Gustav Jung calls this the 'two million wise person within.'[2] He hypothesizes that the collective unconscious contains 'archetypes', latent patterns of distilled human wisdom that are activated in specific life circumstances, for example, at times of crisis or major transition. Below these layers of the unconscious is the *deeper stream*; an energetic flux that connects the individual wave to other waves and to the ocean's infinite depths.

The three dimensions of the unconscious are taken here to comprise 'soul'—the *depths of psyche*. This connection between soul and depth was highlighted by Heraclitus of Ephesus, the pre-Socratic Greek philosopher who wrote, 'You could not discover the limits of soul even if you travelled every road to do so; such is the *depth* of its meaning.'[3] Archetypal psychologist James Hillman amplifies this as a defining aspect of soul when he says, 'The dimension of soul is depth (not breath or height) and the dimension of soul travel is downward.'[4] Throughout the rest of this chapter we use the terms 'soul' and 'depth' interchangeably.

Seeing the unconscious figuratively as multilayered or multidimensional gives us a metaphor that allows us to appreciate that there are qualitatively different energies within the unconscious. It is important to emphasize that depicting the unconscious in this way is not intended to imply a hierarchy of value or importance, nor that these are static, reified entities. Rather, it seems more likely that these energies are part of a dynamic weave that is constantly moving between the unconscious and the conscious, between being and matter and that these energies are not confined to an individual 'wave' (i.e. psyche).

The ego, therefore, is that in us that is afraid of death. For the ego, security and control are synonymous. The *raison d'être* of ego is *maintaining the status quo*. For the ego, death represents a loss of self and of control and is the ultimate dread.

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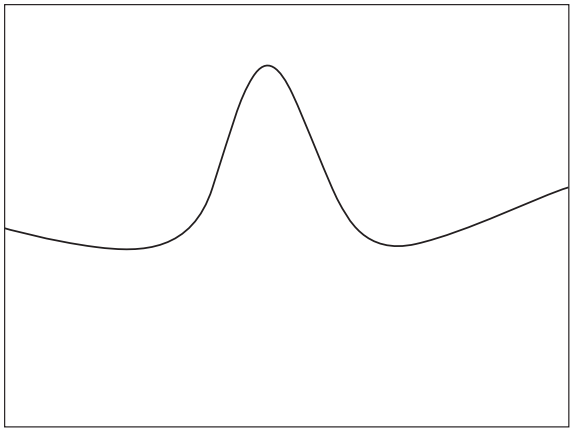

Figure 38.1 Metaphor for the individual human psyche.

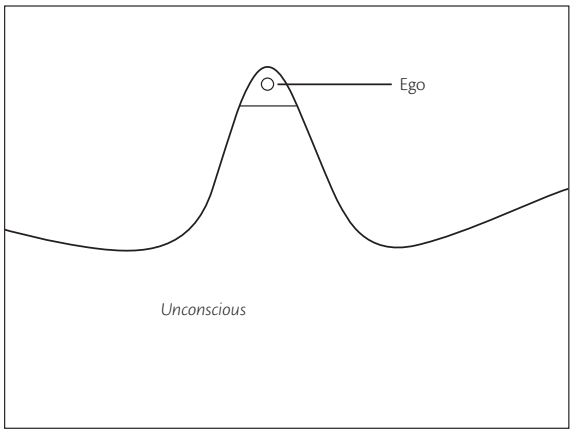

Figure 38.2 'Control room' of the psyche.

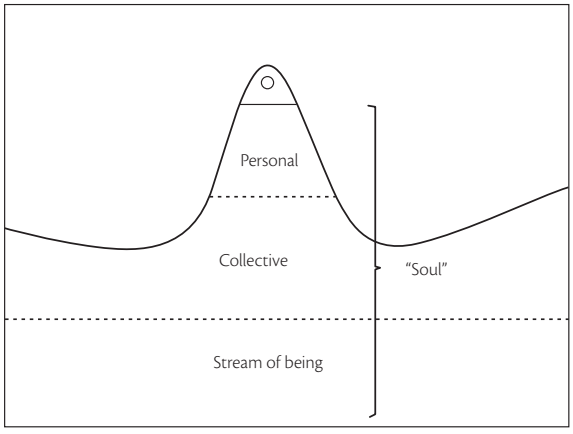

Figure 38.3 'The deeper stream.'

Understanding the dynamics of the frightened ego

In terms of the map of the psyche consider how might it be for the ego, perched on top of the wave, looking downwards (Figure 38.2):

> From the tip of the wave ego looks down into the ocean's depths and sees only darkness; a great unknown. Ego recoils to the tip of the tip of the wave. Ego feels safer there, closer to the light and in the driving seat. While this may bring some relief, this is, at best, temporary. What is more, there may be unforeseen and disturbing consequences ...

Understanding the dynamics of the frightened ego is clinically relevant. It enables us to more compassionately and effectively contain our patients' fear and facilitate the healing process. The dynamics are eloquently described by Ernst Becker in his book, 'The Denial of Death',[6] which inspired an approach called Terror Management Theory.[5] For over thirty years Solomon *et al.* have tested and validated the these ideas. Their research is well summarized in the book, 'In the Wake of 911: The Psychology of Terror,'[7] and the award winning documentary film, 'Flight from Death'.[8] In essence, their findings confirm what we know from experience: that fear of death causes us to pull back from what is different or unfamiliar; to cling to what is familiar, and to distance, denigrate, and destroy what is perceived as a threat to the familiar.

In terms of the map of psyche we have outlined, 'the familiar' is the tip of the wave, with ego firmly in control. Threats to ego-control, such as reminders of mortality, terrify the ego, which retreats to the safety of the tip of the tip of the wave. The intra-psychic implications of Terror Management Theory are that we then act to support and maintain ego-control by over-valuing rational, materialistic, and literal forms of thinking, and distancing ourselves from perceived threats to ego control and reminders to our mortality; including the dark, alien, and unknown of the unconscious. While such strategies may have short-term benefits for the ego, as they reinforce its sense of control, they are, at best, short-lived. Furthermore, such distancing and disconnection from depth results in an anxious and rigid ego that is cut off from whatever healing potential there is in soul. This may manifest as intractable physical symptoms, to what hospice pioneer Cicely Saunders calls 'Total Pain,'[9] and/or to an experience of disassociation, alienation, isolation, and meaninglessness; 'soul pain.'[10]

The dynamics of the frightened ego are relevant throughout the illness trajectory. For example, with a new diagnosis the ego is given what is tantamount to a death sentence: 'Life as you knew it is over. Finished. However life will be from now on, it will never again be how it was'.

What is it in us that is not afraid of death?

Soul, as the unfathomable depths of psyche, includes that in us that is not afraid of death. Two authors, one writing from his lived experience of illness, the other the perspective of years of meditation and spiritual practice, raise an intriguing possibility: could it be that that is us that is not afraid of death is that in us that does not die?

In his book, 'Body and Soul: The Other Side of Illness,'[11] Jungian analyst Albert Kreinheder chronicles his experience of

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living and dying with chronic illness. In the final pages of his book he writes:

> The more we are with soul, the less identified we are with the ego. We know our center to be a larger stream of life transcending ego and going on beyond our death. The soul is somehow in union with this larger being. And as I align myself more with soul and less with ego, the soul's story becomes my story. Then I cannot grieve unduly for the ego. It is like a candle that has had its hour and now must flicker and go out.[12]

Hindu scholar and teacher Sri Madhava Ashish, quoting from the *Kathopanishad* writes, 'Some wise man, seeking what does not die, with in-turned gaze beheld the Self'.[13] Commenting on this he says, 'That was neither mythology nor religious doctrine. It was a real man seeking a real answer to the emptiness of existential meaninglessness, seeking and finding at the very root of his being ... [It describes] the innate human capacity to experience the immaterial roots of self-awareness—call it the level of Self, soul, or what you will—and so receive the reassuring touch of what does not die, and with it the sense of a meaningful existence'.[14] He suggests that this process of self-discovery should not 'wait for the last days of terminal illness, when pain is the spur to try anything that promises relief, instead [it should be] seen as part of a life-long preparation for entry into a meaningful existence.'[15]

While Kreinheder writes from a Jungian and Sri Madhava Ashish from a Hindu perspective, there is a deep congruence in what they say. Common to both is a description of a transformational experiential encounter in realms beyond the ego. Both speak of a search, of a finding (or being found by), and of a letting go to and an aligning with 'soul' or 'Self'; portrayed here as a non-reified dynamic process. Then, 'the soul's story becomes my story.'[16] Then, I may find my 'self-identification with what does not die.'[17] Sri Madhava Ashish makes it clear that this inner quest is at least a lifetime's work. While it is evident that Kreinheder's final words are the fruit of years of analysis and introspection, there is also a sense that the illness experience has accelerated this process for him. The theme of illness as potentially catalytic to the spiritual journey is further explored by other authors: see 'Grace in Dying,'[18] 'The Alchemy of illness;'[19] 'Ego and Archetype;'[20] 'Learning to Fall.'[21]

How to care for the frightened ego?

We have considered what it is in us that is afraid of death: ego. We have considered what it is in us that is not afraid of death: soul. We have considered how the dynamics of the frightened ego can lead to a disconnection from soul and existential distress. How then might we go about caring for a fearful ego that can wreak such havoc?

The therapeutic approach we choose either increases or lessens the fear of the ego. A therapeutic approach that *only* attends to the biological aspects of disease can all too easily become an escalating spiral of fear. When the frightened ego of the patient meets the frightened ego of the clinician the dynamics of fight and flight are activated. While this may lead to a successful outcome, such as a cure or a helpful referral on to another clinician, if unsuccessful, which it is likely to be when the patient is experiencing existential suffering, it may instead compound the suffering as the patient experiences the excesses of over-treatment and/or abandonment.[22]

A more integrated therapeutic approach recognizes the importance of depth work and the need to attend to both body and soul.[23] Here, because we are aware and sensitive to the fundamental need to care for soul and appreciate the possible contribution that our colleagues from other disciplines can make in this, we include them in the care plan from the outset, in tandem with other clinical interventions. The plan of care then resembles a combination of disease and symptom modifying-treatments and approaches that also bring attention to soul, for example, by incorporating one or more of the approaches listed in Box 38.1.

However, here too there may be a problem. The prevailing norm in Western healthcare is, *first*—treat the disease and contain the suffering; then, if and when satisfactory results have been achieved and the necessary resources are available to do so, *then*—take care of the soul. In practice, within this linear schema, we rarely if ever get to care of the soul because the needs of the frightened ego are urgent and endless, and resources are limited. By comparison, care of the soul may seem an unnecessary luxury, of secondary importance; 'someone else's responsibility'.

There is a third possibility. To understand this, begin by calling to mind someone who you would consider to have 'died well'; someone, who, even if in some pain, was awake, alive, 'themselves'; someone in whose presence you too felt awake, alive, 'yourself'. What happened here? One possibility is that this individual encountered that in her/himself that is already well; that in her/himself that is not afraid of death. As we have already noted, this is not so much a reified thing or place as a process, a quality of awareness that arises from immersion in depth; from, in the deepest sense, 'going with the flow'.

How might we enable our patients to experience this way of seeing and of being? We suggest that the components of this response are similar to the prevailing approach outlined above, but with a different emphasis. Here, *we attend to and care for soul from the outset*, while simultaneously considering how best to treat the

Box 38.1 Plan of care: a combination of disease and symptom modifying-treatments and approaches that also bring attention to soul, for example, by incorporating one or more of the approaches listed.

- Art therapy
- Bodywork, e.g. massage, yoga, Qi Gong, Watsu
- Creative and artistic expression
- Dream work
- Gratitude journaling
- Humour, laughter, levity
- Meditation practice
- Music therapy
- Quality time with significant others
- Reflective writing
- Reminiscence therapy
- Spiritual and religious practice
- Time in nature

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disease and contain the suffering. In other words, the therapeutic approach here, which we might call 'primary care of the soul', is one that positively biases towards depth; one that deliberately prioritizes care of soul. One reason why this is necessary is because Western healthcare is strongly, if unconsciously, 'psyche-phobic'. It is embedded in and wedded to a wider culture of materialism and empiricism that by default devalues, distances itself from, and denigrates soul.

So, what might primary care of the soul look like at the bedside? What this does *not* mean is offering a patient in pain 'meditation before medication'. That would be impractical, and cruel. First things first: pain needs to be taken care of before someone has the psychic space and energy to turn her/his attention inwards. What it means and what matters is that depth infuses our attitude and our work from the outset. And this is only possible if we ourselves are self-aware and grounded in depth. What matters is that we as persons, who happen to be clinicians, have embarked on our own, 'experiment in depth'.[24] For, as we do this we become familiar with those spaces and places and energies within that are not afraid of death; we are touched by the mysteries, and our quality of presence is transformed by immersion in the luminous dark. Then, even our simplest acts of care become depth work and care of the soul.

So, there is *a practice before the practice*; doing what we need to do as clinicians to become familiar enough with depth that it informs our quality of presence as we move towards another in crisis. If this has not happened, if we are not already familiar with depth through introspection, then approaches such as such as those outlined in Box 38.1 may be little more than a sham; ego-reinforcement techniques masquerading as complementary or integrative therapies. It's not about techniques or sophisticated skill-sets. It's about commitment to our own inner-journey. It's about immersion in depth. It's about allowing ourselves to be initiated into another way of seeing, another way of being, another way of behaving. It's not about what we do. It's about becoming the healers we already are.

'We are the medicine': An educational programme in the therapeutic use of self

Even if these ideas encourage us to set out on an inner journey, or to renew our commitment to the journey we are already on, we should not underestimate the challenges involved. We are embarking on what will most likely be a life-long process. We are choosing a path that is strongly countercultural and for which we may not get much if any support. We should be aware that we are in a culture that idealizes a version of the hero as one who conquers by over-powering others. What we are imagining here is another kind of heroism. Irish poet and philosopher John Moriarty describes this other kind of hero as, 'One who lays down her/his sword and lets nature happen to her/him.'[25] This kind of hero is one who can be passive as well as active; one who has the courage to make hard choices, but who is rarely, if ever, in control; one who heeds Jung's words, 'Don't drown—dive!'[26]

It may be helpful to consider what else we might expect as we begin this process. For example, in the early stages of introspection, while some will be lucky enough to sink into calm and quiet right away, this is not usually how it is. Much more commonly there will be a sense of agitation as we notice how many worries, plans, memories, day-dreams, fantasies, and feelings float to the surface, like a lake whose depths have been disturbed and whose surface is covered in debris. We may feel discouraged and troubled, and find ourselves agreeing with author Anne Lamott's comment: 'My mind is a neighborhood I try not to go into alone!'[27] At this point, we may be tempted to leave the 'neighborhood' and go outside and find whatever distractions will numb the pain. Either that or fall asleep. Agitation or somnolence.

These are some of the reasons why we should not attempt this journey alone. Having a guide is valuable—someone who knows the terrain from walking it; someone who is not overwhelmed by the process or the problems. We need encouragement. Someone alongside who says, 'Yeah! That's normal. You're not crazy or inept. Just human!' Having a teacher helps—someone to teach us how to avoid falling into distraction or drowsiness; how to be simultaneously relaxed and highly present. Being highly present in a relaxed way is something that most of us need to learn. It is possible to cultivate this as a way of attending to whatever arises and it helps to have good instruction in this rather than being left to our own devices.

There are four overlapping and complementary practices that can be helpful in developing a therapeutic use of self. These are self-knowledge, self-empathy, mindful-awareness, and contemplative awareness. We now briefly consider each of these:

- *Self-knowledge* prepares the ground for the therapeutic use of self. This means becoming familiar with our family history, our cultural, racial and religious history, as well as our individual strengths and limitations. Having insight into our background allows us to work through emotional challenges so that these will not get repressed or projected onto others. This allows us to recognize *transference* (the unconscious redirection of feelings from one person to another, for example, from patient to clinician) and *counter-transference* (the clinician's unconscious projection onto the patient and/or his or her reaction to the patient),[28] enabling the clinician to engage in the therapeutic encounter with more awareness and less reactivity. Some possible ways for the clinician to increase self-knowledge include counseling or psychotherapy, peer-group or individual clinical supervision, and reflective writing.
- *Self-empathy* is the essential complement to self-knowledge. As we become more familiar with ourselves through the practice of self-knowledge, we may not like what we see and become self-critical, judgmental, overwhelmed and/or discouraged. Self-empathy includes noticing how hard it is for us to accept our imperfections and mistakes with an attitude of warmth and self-acceptance, while simultaneously being committed to finding a way to become more forgiving and compassionate towards ourselves. Certain practices from the Buddhist tradition are especially helpful in developing self-empathy. Metta or Loving-Kindness Meditation is an explicit practice of opening the heart with empathy and compassion towards ourselves and others.[29]
- *Mindful-awareness* refers to the cultivation of three particular awareness skills: focusing, noticing, and expanding. The development of mindful-awareness is helpful for introspection and in enabling us to relate to our patients in a sensitive and sustainable way.[30] Mindfulness meditation, another meditative practice from the Buddhist tradition that is now extensively used within

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healthcare,[31] can be used to cultivate these three cognitive skills. Meditation teacher and author Jon Kabat-Zinn, describes Mindfulness meditation as a process of developing careful attention to minute shifts in body, mind, emotions, and environment, while holding a kind, non-judgmental attitude towards self and others.[32]

- *Focusing* is the foundational skill in mindful-awareness and refers to the steadying and direction of attention and, therefore, the mind. Tibetan Buddhist teacher and author Alan Wallace emphasizes the importance of deep relaxation, stabilization of the mind, and an attitude of vividness in his method of teaching mindfulness of breathing to focus the mind.[33]
- *Noticing* arises naturally from focused awareness. It means witnessing the stream of thoughts, physical sensations and feelings that arise from moment to moment, with gentleness and respect and without commentary, reaction, or comparison. A further aspect of noticing is becoming aware of the subtle stream of awareness itself, which runs concurrently yet on a finer frequency than other phenomena. *Expanding* is a cognitive stance that permits the clinician to enlarge her/his awareness so that it is possible to simultaneously monitor his or her own subjective experience and the needs of the patient and/or the work environment.

These three aspects of mindful-awareness work synergistically together. Expanding builds on the skills of focusing and noticing. Through focusing and noticing we stabilize our attention and witness our experience in a non-judgmental way. As we do so, we may be aware of moments of meta-awareness, when we are aware of the quality with which we attend to the object of our attention, or, possibly, that we have just been distracted by a thought. With practice we can deliberately chose this cognitive stance, use it to monitor the quality of our attention in meditation practice and introspection, and, with time, to self-monitor our interactions with our patients. This can help to prevent us from getting trapped in reactivity or self-preoccupation, allow us to respond to the patient with more flexibility and greater sensitivity, and to experience a form of empathic engagement called 'Exquisite Empathy', which may be mutually beneficial to patient and clinician.[34]

- *Contemplative Awareness* is awareness that we as individuals are situated in a larger field of relationships. Psychologically this includes the recognition of the inter-subjective field in the therapeutic encounter, and of an archetypal or universally shared dimension to our experience. Spiritually, it can be understood as the experience of our relationship to 'the numinous' or the sacred. It includes becoming aware of how we find meaning through our values, our cosmology and our philosophy of life. Mount, Boston and Cohen describe this as a process of establishing 'healing connections', and observe how these healing connections can engender a sense of meaning.[35] Practices to develop contemplative awareness are unique to each individual. They may include some of the approaches outlined in Box 38.1.

The 'mystical' could be understood as the direct experience of contemplative awareness. A mystical process that may arise from practicing the three components of mindful-awareness, discussed above, is what is called 'awareness of awareness'. Here, we come to glimpse the stream of awareness itself, which is always present as a backdrop to emerging phenomena with qualities of stillness, luminosity, and knowing. Alan Wallace describes this aspect of perception as follows:

> Discerning this fraction of a second as pure-perception, before concepts, classifications, and emotional responses overlay ... This brief instant is important because it is an opportunity for gaining a clearer perception of the nature of phenomena, including a subtle continuum of mental consciousness out of which all forms of sensory perception and conceptualization emerge.[36]

A metaphor for awareness of awareness is a grandmother standing quietly behind a playing grandchild. The child represents the breath or other focus of attention, and the grandmother the ever-present flow of awareness in the background. Sri Madhava Ashish reminds us of the radical potency of self-awareness for both the individual and others when he writes:

> The root of the mystery of being lies at the root of the awareness that perceives the universe. Every human being is human by virtue of that awareness. Every human being is or can be aware that he is aware. When that self-awareness is traced to its inner source, then only can the identity of the individual with the universal be found, then only can the mystery of being be solved. And only when there are enough such individuals can sanity return through them to our troubled world.[37]

The process begins with naked attention to bodily sensations. Next, as we attend to the breath and experience greater and greater stillness, we may become aware of awareness itself. Finally, even for moments, we may come to rest in that awareness. To rest in awareness, an awareness that is contiguous with the awareness that fills the universe, is deeply peaceful. We are now participating in the sacred interconnectedness of all things.

Conclusions

As we return to the bedside, to the ones who suffer, we now do so with a new mode of perception, one that affects how we see and what we see; one that affects the treatment choices we make; one that affects how we do what we do.

'Prayer is not something we say or do. Prayer is state of being. And once we are in that state of being, everything we do is prayer' (W. Wapepah, personal communication). So, too, soul-work is not something we say or do. Soul-work is a state of being. Once we are in that state of being, everything we do is soul-work. Then, each of our simple acts of attention and kindness become care of the soul. Offering a drink, bathing, giving medications, and suturing a wound, care of the soul.

While we may automatically assume that approaches such as those in Box 38.1 are soul-work, this may or may not be the case. They are soul-work when they are offered by a clinician who embodies soul, where they work synergistically with the quality of the clinician's presence to bring attention to depth; to what is not afraid of death; to what does not die; to what is already deeply well. As clinicians who offer these approaches we are not doing something to or even for our patients so much as joining with them in compassionate celebration of what is.

Facing fear through primary care of the soul is, ultimately, about who we are; our quality of presence. And the journey inwards, *our* journey inwards, is where we start. This is the journey to the heart. For a moment, imagine yourself rooted, like some great tree, in Grand Prismatic Spring in Yellowstone National Park.[38]

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Here your roots descent into the depths of the universe, which flows through you like some great, breathing ocean. Here, through the rust-red chords of relationship, you are connected to your brothers and sisters; to all your relations. The poet TS Elliott describes how it begins: 'Quick now, here, now, always—, a condition of complete simplicity, (Costing not less than everything)'.[39] Novelist Henry Miller offers these words on how it ends: 'At Epidaurus, in the stillness, in the great peace that came over me, I heard the heart of the world beat. I know what the cure is: it is to give up, to relinquish, to surrender, so that our little hearts may beat in unison with the great heart of the world'.[40]

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