COMA

The Dreambody Near Death

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To
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7. Altered States & Coma

One of the basic ideas of this book is that there are powerful, dramatic, and meaningful events trying to unfold themselves in comatose states. One reason for the dramatic power of comatose events is certainly the innate drive for self-knowledge possessed by people like Peter and John. It seems to me that all of us share this drive.

The style of the individual therapist, however, may also promote or inhibit the unfolding of such trance processes. Above all, beliefs, past experience, and training contribute to determining how deeply and thoroughly we can help people near death to dive down and return with new life.

Thus the second part of this book is devoted to learning how to work with people in altered states and comas and how to understand the unusual experiences they encounter.

Background Paradigms

The governing idea behind my work is a mixture of scientific realism, phenomenological respect for individual experiences, and the suspicion that everything that happens contains the seeds of our totality.[1] This latter belief makes me a modem alchemist. Whereas the early alchemists worked on transforming matter into gold, the matter with which I work is the client's perception. I tend focus less on the content of what a person says,

and more on the emotional and intellectual spirit or energy of the person.

Like all alchemists, I am a believer in nature and a spiritual person. The hundreds of people I have encountered in extreme states have shown me that hidden in the most impossible or absurd conditions is something wondrous. I see human nature as a deity, for in the most confusing chaos one finds the seeds of creation.

My theory is that the interventions required for a given person in a given situation can always be found in the processes occurring. Amplifying the total process and working with perceptions bring people the feelings, insights, and relief they seek. But in order to find these interventions, we must be able to differentiate what we perceive.

Process Structure & Altered States

Process theory attempts to deal with events in neutral terms, without dividing them into matter and psyche, mind and body, conscious and unconscious. Thus the same theory and associated tools are used in a variety of psychogenically oriented states, regardless of their connection to metabolic or structural brain pathologies. Learning process work in normal situations is helpful for work with the dying, and conversely, work with the dying is excellent background for understanding normal states of consciousness. The states that dying people go through are similar to the states found in ordinary process work. Only the intensity and wonder are greater. It seems to me that nothing happens in a coma that is not trying to happen to people all the time.

Comatose states, however, do differ in specific ways from other states. Coma is the deepest form of unconsciousness. If consciousness stands at one end of the awareness spectrum, then coma stands at the other end, with the many forms of

altered states in between. Coma is an extreme form of life in which the individual can almost never be aroused to respond to noxious influences. We have seen, though, that special forms of communication can enlighten this dark hole of life.

Comatose states differ from psychogenic disturbances such as catatonia in that the former are almost always connected with organic lesions or metabolic changes in the brain.[2] Process work with comas first involves relieving any possible causes creating the coma, such as glucose and oxygen deficiencies (especially with diabetics and in neardeath situations). Only after the individual has been treated for organic lesions is it possible to focus on behavioral signals.[3]

Coma & Trances

All states of consciousnèss that are different than the ordinary ones with which we identify ourselves I will call *altered states.*[4] In normal states people are capable of giving verbal or nonverbal feedback to questions and can talk about the same everyday realities that interest others. In altered states, such as those we encounter in dying processes, feedback to questions about everyday realities is diminished or absent. People cannot enter and leave these states easily. They seem absent, their memory may be disturbed, and they usually have poor space and time orientation. The duration of such states depends to a great extent upon our ability to communicate with the person.

Let us say that *normal reality* is the world agreed upon by consensus opinion. This is the world to which our normal identities are connected, our everyday life. In this world we are able to give more or less immediate verbal or nonverbal feedback if we choose. In this state we express some degree of interest in the rest of the world. Thus we can say that when Peter said to me the last day of his life that I could go back home and that I

should care for his wife, he was in a normal state of consciousness.

Quarter trances describe those states in which feedback to communication is slightly delayed or unrelated. Hence, we are in a quarter trance when we are sleepy or occupied with something internally. Most of us are in quarter trances when we relate to others without wanting to.

Half trances are states in which feedback to communication is strongly delayed or very unrelated to the stimulus. We still have the feeling of connecting to the other person while we are in half trances. When writing or doing something strongly internal, we are usually in a half trance relative to the outer world. Half trances can usually be given up if need be. Half trances often occur when we listen without wanting to and our eyes become glazed and unfocused.

Three-quarter trances, also known as *semicornas*, may be related to organic problems. In this state people cannot seem to control their swings between half and full trances. This state is common for people coming out of comas or passing between waking and sleeping. The difference between the lesser trances and the three-quarter trance is that in the latter we have immense difficulty speaking about anything, especially about this world. We can be reached only with difficulty by others.

Trances, or *full comas*, are profound states of apparent unconsciousness where one cannot respond to any verbal or nonverbal approaches. Total comas may be induced by slight or seriously traumatic organic disturbances. If you scream at or pinch a person in a coma, you will not get a normal response.

First Exercise

To understand trances experientially, I would like to invite you to try the following exercise. This exercise can be done alone or with another person.

If you work alone, do this exercise as an internal series of pictures. Imagine yourself lying down and pretend that you are in a deep trance or coma from which you cannot be easily awakened. Getting into a deep trance state is easy, and it is equally easy to come out of it if you tell yourself that you must come out of it in three minutes. Trances are always just below our threshold of consciousness, waiting for us. We can feel them many times during the day.

If you work with a partner, let your partner sit next to you and simply hold your hand. Both of you simply note the kinds of experiences you are having. It is important for the sitter to say when the three minutes are up. If you are working alone on yourself, this is the end of the exercise. If you are working with someone else, then switch roles, without talking. Do the same with your partner for another three minutes, and then share the experiences that you had.

Many people who have done this exercise were surprised to note what a pleasure it was to be in a deep trance with someone else there. Others noted how lonely it was to enter into a deep state and to have another person nearby who seemed to have no connection to the state.

Some of those sitting by noticed that they felt distant from the person in the trance. Others experienced frustration at not being able to care for the person. The one in the trance also felt frustrated to discover how insufficient simple caring was. Such experiences are the goals of this exercise.

Most caring professionals have a hard time entering the world of the patient. Just being nice is sometimes not enough. Once we learn how to work with people in comas, our increased sensitivity will show us how insensitive simple nursing and caring can sometimes be! The ordinary helper deals with the comatose patient as an ill person who cannot care for himself or herself, not as a physical and spiritual being in the midst of working on the inner self to whatever extent is possible.

Since we are insensitive to our daily altered states, we ignore them in others. Neglecting our deepest innermost experiences makes us lonely. Such insensitivity may even drive us into early death or coma in order to experience our totality in peace without the disturbances of our "normal" insensitivity.

Thus coma is a trance from which the person cannot be easily aroused. In a coma, breathing is disturbed. Breathing is generally noisy, because the soft palate in the mouth is paralyzed and the tongue gets caught in the mouth. The heartbeat is frequently strong and often variable, and the unconscious state is usually associated with apoplexy, stroke, or some other disturbance to the brain such as hemorrhage, blood clot, or (especially in children) high fever. Comas may also be connected to diabetes mellitus, Bright's disease, alcoholism, cerebral tumors, meningitis, insulin overdoses, or opium or carbon monoxide poisoning.

Brain & Mind

There is no simple connection between organic brain disturbances and coma, since not everyone with an organic brain disturbance has the same degree of trance. Psychological factors determine how our processes organize themselves around organic problems. The brain and the mind are not exactly the same. A useful analogy that fits many people with brain injuries is that the brain functions like a television set and the mind like the television station. A disturbance to the set means that we cannot get sound or pictures even though the sender (mind) is working.

The case of Dan is a good example of this analogy. After a severe stroke, he was totally paralyzed; nothing moved except his tense, shaking left arm. When we amplified the movement of this arm (such movement work will be explained in greater detail), his coma lifted as he responded with eye movements

and facial expressions in conjunction with our interventions. He let us know that there was a lot happening within him even though he could not express himself adequately.

Coma Vigil

In a "coma vigil" one or both eyes remain open with minimal or no detectable evidence of responsiveness to outer stimuli. This happens with acute organic brain syndromes and is often related to cerebral accident or infection.

Ron, for example, lay totally paralyzed in bed after a brain operation for cranial bleeding resulting from a fall during a bout of heavy drinking. To the medical observer untrained in process work, he appeared to give no noticeable response to anything in the outer world. One of his eyes remained open in a comatose vigil, but even this eye did not at first respond to what was in front of it. As we began to amplify and follow his breathing and chest sounds, his eye began to follow events around him, and his breathing pattern changed, particularly in response to our recommendation to shut both his eyes and sleep if he needed to.

Those who remain in persistent vegetative conditions are understood to be brain damaged or "brain dead." Such patients are the object of an intense controversy today. Should they be kept alive? This debate will be discussed in greater detail in Chapter 12. For now, I must answer this question with a simple "yes." I will show that people who are still breathing should be allowed to live. We need to learn how to communicate with them and give them the chance to make their own decisions about life and death.