

On spiritual pain in the dying

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ABSTRACT *Spiritual pain is enmeshed in human history. In the dying, it is part of their total pain: physical, mental, social and spiritual. Spirit is beyond definition, but is a phenomenon that can be studied like any other. Spirit refers to inspiration, soul to depth, though both terms are often used synonymously. Spiritual characteristics include: life force; the essence of a person (an unchanging centre, meaning, depth, the numinous, relationship and intimacy); immortality (memories, spiritual experiences and near-death experiences); and levels of consciousness. Spirituality is common to all people of any or no belief. Religious distress is about problems relating to a pre-existing set of beliefs. Spiritual pain is recognized in physical and psychological symptoms, disorders of relationships, and specifically spiritual symptoms (meaninglessness, anguish, duality and darkness). Intuition and 'bifocal vision' (seeing symptoms both literally and symbolically) are needed in discerning spiritual distress. Effective help involves being present (attending, relating). Facilitating this process includes listening, reminiscence, imagery, finding meaning, letting go, touch, symbolism, rituals, prayer and contemplation.*

My only food is sighs, and my groans pour out like water.
Whatever I fear comes true, whatever I dread befalls me.
For me there is no calm, no peace; my torments banish rest
(NJB, Job 3:24–26).

Introduction

Suffering, death and the human spirit are intertwined themes enmeshed in the very fabric of our existence here on earth. Think back to the times when cave people hauntingly recorded the deaths of hunted animals on the rocky walls of their dwellings and trephined holes in the skulls of the sick of their communities; move forward to the present when, scarcely 50 years after the Holocaust, one tribe in Rwanda massacred nigh on a million of its neighbours in the space of weeks, and where Western society sees death as the great enemy to be destroyed. Throughout history humanity has wrestled, like Jacob and the Angel, with these enigmas, inspiring extraordinary works of art and literature and extraordinary lives of quiet heroism and courage, often in seemingly ordinary people confronting the dark valleys of human mortality.

This struggle is particularly stark in the dying. Their carers will, therefore,

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in witnessing their anguish, be moved to ask themselves how they can help. Physical pain demands skilful action and an extensive body of knowledge has built up in recent years—it is deeply satisfying to relieve successfully what had been an intractable and feared burden. If, however, the dying person starts to talk of feeling that life is pointless or to ask: ‘Why me?’ then answers are not so easy—spiritual pain has made itself known and will not be satisfied with a pill.

Spiritual distress, along with physical, mental and social pain, has been recognized for many years as a component of total pain (Saunders, 1993, pp. 6–13) in the dying. Trying to define physical pain is hard enough; how much more so, then, spiritual pain. Indeed attempts to do so are like trying to catch hold of the wind. And yet, it is so important an element of suffering in the dying that it must not be ignored. Perhaps the reason for the difficulty is that it is *beyond* definition, that is, it operates at a level where logic is insufficient. This may seem strange to Western ears where logical thought is often considered the ultimate mental activity. It is, however, very familiar in Eastern spiritual traditions. Hinduism, for example, recognizes several levels of consciousness, of which the thinking mind is by no means the highest and is in fact considered quite limited compared with the higher states (Griffiths, 1992, p. 176; Wilber, 1993). Buddhists meditate on koans, paradoxical statements such as: ‘What is the sound of one hand clapping?’ (Johnston, 1983, p. 98) in order to attain enlightenment. The West, too, has similar traditions—many famous Christian mystics, such as St Teresa of Avila (1957), describe remarkable transcendental experiences.

Spiritual distress is a phenomenon that can be studied just like any other process. A purely quantitative approach would, however, not be enough. It would be like trying to measure sadness by the volume of tears produced. To engage with soul pain, we must enter the world of the qualitative and of the subjective, of stories, particularly of people’s personal life-experiences, of intuition and of feeling.

‘Spirit’ and ‘soul’ are used by different authors to mean different things—sometimes they are distinguished one from another, sometimes they are considered identical (Hanks, 1986; Moore, 1994). They refer to our deepest Self, the essence of who we are. For the sake of simplicity, distinctions between the two terms will not be addressed in detail in this article. However, as a broad generalization, spirit may be thought of as to do with inspiration, values and light, whereas soul suggests depth, feeling and richness. They may, nevertheless, be considered as different aspects of the same thing, like the North and South magnetic poles of our planet. The psyche, being the domain of thoughts, feelings, sensations, memory and behaviour, is often considered as separate from spirit or soul, these terms, then, being reserved for the incorporeal essence that survives death. It may be truer to say, however, that spirit or soul enfolds the psyche in the same way that the sea encompasses the rain that falls on it.

In addressing the issues pertaining to spiritual pain, three major questions come to the fore: what is it, how is it recognized and how can we help? In the discussion that follows, unless otherwise indicated, all cases quoted are based on

the author's own clinical experience working as a doctor caring for the dying in a hospice setting.

What is spiritual pain?

Although it may not be possible completely to define spiritual distress, it is, nevertheless, possible to look at its qualities. To do this, we must first ask what 'spiritual' is and then look at how this relates to suffering.

Spirit as life force

The survival instinct, that is the assertion of the life force in a person, is remarkably powerful, even in the face of impending death. Some, told that their cancer is incurable, will go to inordinate lengths desperately searching for a cure and prepared to try even experimental and highly toxic chemotherapy in the faint hope of remission. Rationality plays little part here; for example, one woman in her thirties, with widespread pelvic cancer, and having been told there was no further treatment, commented: 'I'm going to fight this to the end'. Denial and fear were part of her instinctive attempts to escape death, which were joined by the so-called fighting spirit as she began to face her condition. This is expressed very forcefully in Dylan Thomas's (1960, p. 629) famous lines:

Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.

The survival instinct may be vicarious, as in the case of a woman whose husband was dying of a brain tumour. She was frantic for him to live and would pour feeds down his throat though his swallowing reflex was compromised and he was often only semi-conscious. This was despite the doctor's warnings of the dangers this posed. At a deep atavistic level, food symbolized life for her, and this overrode her rationality. Parents of dying children may feel this anguish especially, as John Betjeman (1980, pp. 224–225) so poignantly expressed it:

O, little body, do not die.
You hold the soul that talks to me
Altho' our conversation be
As wordless as the windy sky.

And yet, there are situations where we can transcend this compelling instinct and let go of physical life when the right time comes. In the following quotation, a daughter is talking to her mother:

'I've been thinking about what Dad said to me last night', Kathleen said. 'When he was saying, "Now I can lie down," he wasn't talking about taking a rest, he was talking about letting go. He wanted me here

in the house so you wouldn't be alone when he died. And he died the way he lived: he was quiet and peaceful and he protected us both in his dying as he did in his living. It was the last thing he could do to take care of us' (Callanan *et al.*, 1992, p. 192).

Yet more remarkable is the person who gives up his life for another. An example is the story of the passengers on a plane that in January 1981 crashed into the icy Potomac river in the USA. The survivors who could stay afloat were rescued by helicopters, their crew throwing down life-rings to haul them up. One man kept passing the rings to others in the water 'as though it were the most natural thing in the world—and with the life rings he passed over life itself'. When his turn came, he had disappeared under the waters and drowned (Ferrucci, 1990, p. 308).

Spirit as essence

We are faced with mystery if we ask what the essence of a person is. A simple experiment may, however, help as a beginning:

The reader is invited to close his or her eyes and think back to his or her earliest memories. Next, move on a few years and bring to mind significant recollections of that time. Repeat this process several times until the present time is reached. Now, try and get a sense of who it is that remains unchanged over all these years even though physical being and external circumstances have completely changed.

Many people trying this exercise will readily become aware of that within them which is always the same and uniquely them, an *unchanging centre*.

Exploring this further, it becomes apparent that essence is concerned with *meaning*—we all need to have some sense of what our lives are for, what makes us get up in the morning. This has been elaborated by Victor Frankl (1985), who was a concentration camp inmate during the Second World War and, being a psychotherapist, set himself the survival strategy of observing the behaviour of the camp guards and prisoners. He found that those prisoners who had a sense of purpose in their lives were more likely to stay alive than those who did not—for himself, as an example, it was the thought of seeing his wife again after the war that kept him going. Meaning, then, is not just a nice idea; it keeps us alive physically, psychologically and spiritually. Thus a hospice patient with a brain tumour (which did not impair his thinking), spent sometimes several hours a day talking to different members of staff, trying to make sense of his illness, of his dying, of what happens after death and of his beliefs, before he died soon afterwards.

For many people, living in a competitive action-centred Western society, meaning is tied up with what they can do, their work, their physical strength, their skills and so on. Hence, it is a catastrophe if their abilities become impaired. Suddenly they are left facing a blank, an unknown void, and they do

not know how to approach this crisis. It is not that there is no meaning even in a terminal illness, it is more that it takes time to find it, and it can be a very painful process. One man with a paraplegia wanted to buy a new car, despite being told that there was no prospect of his recovering the use of his legs. His family was understandably distressed at the thought that he would be out of pocket to the tune of several thousand pounds.

A sign of the discovery of meaning is in the ill person's *depth* of relationship and communication. As C.S. Lewis (1966, p. 13) put it, remembering his dying wife:

It is incredible how much happiness, even how much gaiety, we sometimes had together after all hope of recovery was gone. How long, how tranquilly, how nourishingly, we talked together that last night.

Here is a place of truth and profundity, whether in action or simply in being. This contrasts painfully with those who are still struggling to come to terms with their illness and who focus instead on a particular symptom of more manageable proportions than facing death—'If I could just get rid of this pain (or stand on my feet, or get stronger), I'd be all right'.

As a person approaches the depths of himself or herself, and as we, the carers, share in this, a sense of the *numinous* begins to emerge: we are, as it were, standing on sacred ground. Words, which are after all only a vehicle, become inadequate to convey what the dying person is going through; indeed it may not be at all obvious to the casual observer. It is an experience and like all experiences impossible to describe directly, but only inadequately by analogy:

For what is it to die but to stand naked in the wind and to melt in the sun? And what is it to cease breathing, but to free the breath from its restless tides, that it may rise and expand and seek God unencumbered? (Gibran, 1926, p. 94).

A few, however, have led such violent or chaotic lives, that the embers of this destructive past still smoulder in their final illness and they seem light years away from the numinous. For example, an elderly man who had systematically abused his daughter physically and sexually over many years when she was younger, was admitted to a hospice, dying of cancer and now physically and mentally frail. Angry profanities, sexual and otherwise, poured from him when he was approached and he resisted attempts to talk with him on any level. Only occasionally would he evince brief glimpses of remorse or sadness to the nursing staff as they attended to his needs.

The last aspect to consider is that of *relationship* and hence of *intimacy*. This has already been touched on implicitly and is surely the crux of all meaning in our lives: 'No man is an *Island*, entire of it self', as John Donne (ODQ, 1953) put it; and if he tries to be, he loses touch with life and becomes dried up and dead within. Jesus' appeal to 'love one another just as I have loved you' (NJB, John 13:34), is, then, more than poetic words but actually life-enhancing and

crosses all religious boundaries. The following true story from the slums of Calcutta may serve to illustrate this:

A blind man ... was squatting ... in front of a small boy struck down with polio ... After a few minutes, he stood up and took the boy delicately by the shoulders to get him on his feet ... The blind man spoke and the lad put one foot in front of him ... Again (he) pushed him gently forward and the child moved his other leg. After a few minutes they both were making their way down the middle of the alley, the little boy acting as a guide for his brother in darkness and the latter propelling the young polio victim forward. So remarkable was the sight ... that even the children playing marbles on the kerbstones stood up to watch as they passed (Lapierre, 1992, pp. 372–373).

In caring for the dying, we may be faced with the end stages of prolonged and bitter family disputes which are thrown into sharp relief because one of the combatants is about to die—suddenly there is no more time and those involved have to ask themselves whether they really want such conflicts to continue even as far as the grave. Reminders of our mortality act as extraordinarily powerful catalysts in healing relationships. Often, remarkable reconciliations take place, although not always: one woman, a recluse dying of breast cancer, adamantly refused any visits or contact from her family; they would come to the ward in the hope that she would change her mind, but each time she rejected their overtures and it was only on the day before her death that she allowed them briefly to look round her bed curtains while she lay dying.

The tragedy of such conflicts is poignantly expressed in the *Baghavat Gita*, one of the Hindu sacred scriptures: the great warrior, Arjuna, contemplates with horror the impending dynastic battle in which he will fight: family against family, cousin against cousin, teacher against pupil:

O day of darkness! What evil spirit moved our minds when for the sake of an earthly kingdom we came to this field of battle ready to kill our own people? ... Thus spoke Arjuna ... he sank down in his chariot, his soul overcome by despair and grief (Mascaro, 1962, p. 47).

Spirit and immortality

With such widely differing views on whether there is life after death, is it possible to find any common ground that would apply to all who are dying? To do so, we must look at people's actual life experiences rather than any dogmas.

One important element is that a person lives on in the memories of his or her family and friends, who can recall the wisdom that he or she transmitted to them and good times that they shared. Memorabilia such as carefully preserved photographs, letters and heirlooms are a significant part of this—they are like archives of the unique culture of an individual family. In some cases, that person becomes a keystone, remembered by the whole world as having embodied

something of universal and lasting value—Jesus, whose death and resurrection are of such central significance in Christianity, and the Buddha are obvious examples. Some leave a tangible legacy—Mozart's great Requiem was inspired by his fateful preoccupation with his impending death.

Others, unhappily, leave a bitter heritage of hate. One of the saddest sights in palliative care is the person dying alone, unforgiving and unforgiven in some family dispute from the distant past. Here, then, is a key aspect of hospice care—to value and care for such people, despite their unlovableness, when no-one else will.

Another shared theme is of spiritual experiences, which are no respecters of religious, racial or cultural boundaries. It might be thought that these are the rarefied preserve of mystics but experience tells a different story. William James (1977) has documented their variety and shown them to be a common phenomenon occurring in all walks of life. This is reflected in the stories the dying have to tell. One woman, for example, described waking in the middle of the night in a darkened palliative care ward where two other patients were close to death. She suddenly experienced lights very brightly, far above her; she looked around but there seemed to be no-one there and everything was silent; this she found extremely beautiful and peaceful and she thought she was dying and in heaven. This experience was for her profoundly moving and reassuring and she recounted it the next day with complete lucidity. Many mortally ill people will describe analogous, if less dramatic, events (Callanan *et al.*, 1992) which they have found helped them to come to terms with their impending death.

Near-death experiences (NDEs) too are a recurring theme and the subject of an increasing body of literature (Callanan *et al.*, 1992; Kellehear, 1996; Moody, 1976). Here is part of one person's experience:

I floated right straight on through the screen, just as though it weren't there, and up into this pure crystal clear light, an illuminating white light. It was beautiful and so bright, so radiant, but it didn't hurt my eyes. It's not any kind of light you can describe on earth. I didn't actually see a person in this light, and yet it has a special identity, it definitely does. It is a light of perfect understanding and perfect love (Moody, 1976, pp. 62–63).

There is no doubt that these are common occurrences. While there are differing views as to their reality (Kellehear, 1996, pp. 1–21), the important point is that those who undergo NDEs find them inspiring and helpful in facing their actual death with equanimity and even a pleasurable anticipation. One elderly lady, dying of cancer in a hospice, spoke of a NDE she had as a young woman and commented that this had wholly changed her view of death such that she ceased to be afraid and she asked the ward staff to reassure her anxious daughters who could not understand how their mother could be so calm.

The obverse, or shadow, side of these experiences is not often reported in NDEs. However, the dark delusions of psychoses are not uncommon in palliative care and, while they usually have an obvious physical cause such as a

brain tumour, it is still worth paying attention to the content of the confusional state rather than just dismissing it as a meaningless delirium. Thus, a Polish patient, who had survived the horrors of a German labour camp during the Second World War, became confused while on a hospice ward. He thought he was in the labour camp again and that the staff were the guards. The other patients he saw as fellow prisoners and if one died this did not surprise him as it tallied with his past experience. It may be that he had dealt previously with his traumatic memories by suppressing, rather than working through, them and it was only when he became confused that the buried past, clamouring for healing, could bypass his rational defences and resurface.

Spirit and consciousness

In the discussion so far, no sharp distinction has been drawn between psyche and spirit. In this context, Wilber (1993) uses the analogy of the electromagnetic spectrum to develop a tiered concept of consciousness. He describes four main levels forming a spectrum of consciousness in which one blends seamlessly into the other as do the colours of the rainbow. The primary or deepest level he calls Mind, meaning the spiritual realm, and this merges imperceptibly with the next plane. So it is with the boundary between the worlds of the spirit and the psyche. This ambiguity is reflected in the Greek roots of 'psyche' meaning both mind and soul. It is not surprising, therefore, that there is an overlap such that some psychological and spiritual themes are expressed in similar language. Furthermore, there has been a tendency in Western medicine to place anything to do with the inner state of a person, for want of anything better, in a psychological pigeon-hole. This ignores the subtlety and complexity of the relationships between body, mind and spirit. Thus, depression may be psychological in origin, such as from a bereavement, but cause spiritual distress. Conversely, spiritual distress, such as from an existential crisis of meaning, may itself cause depression. It is crucial to recognize this, since, in addition to antidepressants as an effective pharmacological remedy, it is important to address and work through the existential crisis itself. It may be better, therefore, to think of body, feelings, mind and spirit not so much as levels, but rather that the spiritual sphere contains within it the elements of body, feelings and mind in the same way that white light contains, is made of, and yet is more than, the primary colours, red, blue and yellow.

Spirituality and religion

These two terms are not synonymous (Kearney, 1990; Stoter, 1995, pp. 2–7). Spirit, as previously described, is the vital principle that unifies and transcends all other aspects of a person: body, mind, culture, race, and so on. Spirituality, then, is about meaning, depth and values and, being universal, is a term that can be used by theists, agnostics and atheists alike. Religion, however, is the expression of spirituality in particular ways and according to particular pre-

existing sets of beliefs, such as in Islam or Buddhism—it is not universal. Religious distress is, therefore, an aspect of spiritual distress. It occurs when a person begins to question, and so come into conflict with, his or her previously faithfully held religious beliefs; it may be seen, for example, in the evangelical Christian who believes that if he or she has sufficient faith then a cure is certain, yet who cannot come to terms with God delaying to answer his or her prayers.

How may spiritual pain be recognized?

A Zulu saying states that: ‘A person is a person because of people’. In other words it is our relationships that make us who we are, whether they be to God, to others, or to ourselves. Hence spiritual pain will manifest itself in disorders of these affinities.

Signs, symptoms and symbols

Body, mind, feelings and spirit are intimately associated. Hence spiritual distress may be revealed through any of these aspects of a person. However, those experiencing spiritual distress as a physical symptom may not recognize it as such, the root cause being buried in their unconscious. To discern this, it is necessary to look at symptoms with *bifocal vision*: firstly the literal level as presented by the ill person, and secondly the metaphorical or symbolic plane where the symptom has a deeper meaning. This was an approach very familiar in earlier times where the state of the entrails of sacrificial animals augured well or ill for, say, a forthcoming battle. Curiously, this ancient belief is still reflected like a lingering ghost in our present-day language—we talk of angry people venting their spleen, or of a depressed person being melancholic (literally ‘black bile’).

Some of these symbolic associations are, however, by no means outmoded and still hold an archetypal power—we need only consider how we talk of someone dying of a broken heart. As the American psychotherapist, Thomas Moore (1994, p. 155), says:

The human body is an immense source of imagination, a field on which imagination plays wantonly. The body is the soul presented in its richest and most expressive form. In the body, we see the soul articulated in gesture, dress, movement, shape, physiognomy, temperature, skin eruptions, tics, diseases—in countless expressive forms.

The problem of breathlessness, a much feared symptom in the dying, is a pertinent example. The physiology of respiration is, of course, very familiar. Less obviously, the etymological roots of words used to describe breathing reveal another dimension (Heyse-Moore, 1993, p. 19). The words used for breath in Latin (*spiritus*), Greek (*pnoia*) and Hebrew (*ruach*) are also used to mean ‘spirit’. In other words, breathing was linked in these cultures with the very essence of a person’s life. This doubling up is evident in English: ‘inspiration’ means to

breathe in and to be inspired. 'Expiring' means to breathe out and also to die. So breathlessness will imply to someone dying of lung cancer not only restriction of mobility but also a threat to life itself. Thus, a woman with breast cancer and lung metastases said of her breathlessness: 'I actually feel that I am not going to come through it ... I thought I was going to die before anyone got there ... You've got to fight for that last gasp of breath ... It's very, very frightening when you're on your own'.

Reflection on our cultural inheritance and the origins of words used to describe life-threatening illnesses and their attendant symptoms will readily yield similar findings. For example, the word 'cancer' itself, from the Latin for 'crab', evokes deep fears in many people with its nightmare connotations of being inexorably trapped in the pincer-like, unstoppable and smothering growth of a tumour (Heyse-Moore, 1993, p. 19).

Psychological symptoms

Here again, bifocal vision permits entry to unsuspected vistas. Fear, anger and depression represent our instinctive reactions to threat at a bodily level and are therefore common emotions in the dying.

Even though some patients may know rationally that death is imminent, they may be overcome by fear and insist on going home, as to them this represents safety and an escape from the dangers of cancer. The fact is that the tumour travels with them like a loathed shadow and they cannot escape it. Switching the focus, however, reveals the unconscious pun on the word home, which symbolically may represent death and entering the afterlife. The soul, unafraid, calls out for this while the ego flees in terror to its earth-bound precarious haven. Similarly, anger may be seen not just as an emotion but also as part of the mythic struggle of the hero-figure against a deadly monster. Different cultures abound with such stories—Theseus and the Minotaur, or Beowulf and Grendel (Raffel, 1963), are examples. The tragedy is that the battle is of the ill person with him- or herself since cancer is an uncontrolled growth of that person's own cells. Depression at this archetypal level has elements of the sacrificial (literally, 'making holy') victim in its make-up. There is also its shadow aspect of guilt and blame, which has, since early biblical times, been portrayed as the scapegoat that was driven out into the desert, symbolically carrying away the sins of the community (Perera, 1986).

I, Thou and It

Martin Buber (1958) has distinguished two kinds of relating, namely I-Thou and I-It. The first is about true relationship, person to person, which has meaning and depth and is, one might say, soulful. The second occurs when one person treats another as an 'it', as one might an inanimate object. There are many reasons for this. Often it is a device used by a person, hurt in previous relationships, to protect him- or herself from further pain; the story already

quoted of the dying woman who refused to see her relatives is an example. Or it may be a way of exerting power, even at the expense of another person, as typified by dictators such as Hitler. The irony here is that as soon as this happens and the soul goes out of a relationship, there is a loss which negates the hoped-for gain; we exist to relate to each other and if we do not our spirit dries up within us like a desert.

This situation does not only apply to human relationships but also to all of creation. St Francis of Assisi expressed this beautifully in his famous *Canticle of the Sun* when he called the sun, the wind and fire his brothers, and the moon, water, the earth and even death his sisters (Goudge, 1961, p. 267). This mystical affinity with the natural world is felt to some degree by all people, including the dying, and its healing power is made use of in the importance attached to the environment in hospices—light, gardens, indoor plants, and so on.

Spiritual symptoms

It is hypothesized here that, in addition to the symptoms already considered, there are some that are specifically spiritual in nature.

Firstly, *meaninglessness*: as Victor Frankl (1985, p. 121) says:

Man's search for meaning is the primary motivation in his life, and not a 'secondary rationalisation' of instinctual drives. This meaning is unique and specific in that it must and can be fulfilled by him alone ...

With the dying, however, they are losing their roles (such as parent or breadwinner), their health and even life itself, the very source of all meaning. With these losses, they may enter a grey world, so to speak, of 'existential frustration' (Frankl, 1985, p. 123) where nothing seems to have any point any more; they feel lost and helpless. Questions such as: 'Why me?' or 'Why should I go on?' may come to the fore. Physically, they may take to their bed, lying curled up and avoiding conversation.

Anguish is another such symptom, typified by the Gethsemane experience of Jesus:

And he began to feel terror and anguish. And he said to them, 'My soul is sorrowful to the point of death. Wait here and stay awake' (NJB. Mark 14:34).

St Luke talks of Jesus' sweat falling to the ground like great drops of blood (NJB, Luke 22:44). Such anguish may sometimes be seen in patients near to death with unresolved issues in their lives, whose coping mechanisms weaken along with their deteriorating physical state.

These two conditions are related to a third, *duality*, in which the dying person feels cut off from everyone and everything. There is, therefore, a deep loneliness and a sense of isolation, one of the stages of adaptation to dying described by Elisabeth Kübler-Ross (1970). This may be accentuated by loss of

hearing, eyesight, speech or mental acuity, making even the simplest communications painfully difficult and subject to misinterpretation and ridicule.

There is also the condition of *inner darkness*, described by St John of the Cross as the dark night of the soul. Those experiencing this are, as it were, stumbling blindfold through the last days of their lives, metaphorically unable to see and not knowing which way to go, although paradoxically this darkness may hold the key to the way through to inner vision:

Upon that lucky night
In secrecy, inscrutable to sight,
I went without discerning
And with no other light
Except for that in which my heart was burning
(Campbell, 1979, p. 11).

Intuition

Intuition means literally ‘inner knowing’. It is posited here that this, along with bifocal vision, is an important part of assessing whether a dying person is suffering from spiritual distress. It does not mean understanding in the sense of thought concepts but rather knowing in the sense of ‘being one with’ so that an inner certainty rises from deep within oneself that recognizes the depths of the Other and so his or her suffering—inscape speaking to inscape, to use a word coined by Gerard Manley Hopkins (Gardner, 1953). But, how are we to tell if such an intuitive perception is correct? There are a number of indicators: a sense of rightness about the perception; it fits with other elements of the dying person’s story; the insight may be very unexpected, but immediately recognized as apt (the so-called ah-ha! experience); past encounters in similar situations back up the intuition; and most important of all, it fits for the patient. This implies that those working with the dying need to be committed to their own inner growth to facilitate this process.

How can we help?

Spiritual pain secondary to suffering from an illness amenable to surgery or drugs can be helped by these therapies. However, spiritual distress itself may be the root cause of symptoms which mimic physical or psychological illnesses, and the above-named procedures may be tried inappropriately but found ineffectual or even harmful. So, what *is* effective? It will be apparent by now that it is in relationship that ways forward appear.

Presence

How often have any of us experienced another person being fully present to us? Perhaps not very often. But when it does happen, it may be very memorable.

Consider the following extract from *Siddhartha* by Herman Hesse (1991, pp. 83–84):

Later, when the sun was beginning to set, they sat on a tree trunk by the river and Siddhartha told him about his origin and his life and how he had seen him today after that hour of despair. The story lasted late into the night.

Vasudeva listened with great attention; he heard all about his origin and childhood, about his studies, his seekings, his pleasures and needs. It was one of the ferryman's greatest virtues that, like few people, he knew how to listen. Without his saying a word, the speaker felt that Vasudeva took in every word, quietly, expectantly, that he missed nothing. He did not await anything with impatience and gave neither praise nor blame—he only listened. Siddhartha felt how wonderful it was to have such a listener who could be absorbed in his own life, his own strivings, his own sorrows.

Why is such attention so healing? Firstly, there is safety, the creation of a secure inner space, like a force-field encompassing the two people involved; the ill person can feel that here is someone who will accept whatever he or she says without judgement and without being put off. A bridge has been made and this gives the patient the courage to begin to face the pain that has until then been denied through fear, by the provision of at least a modicum of objectivity.

Secondly, these encounters are person to person. In order for the professional carer to see the person behind the illness, the ill person must see the person behind the caring role; in other words, I meeting Thou again. The chemistry of such a meeting catalyses the changes the ill person needs to prepare for dying. It is, however, essential for palliative care workers to beware of over-identification with the sufferings of the dying, and hence burn-out. A balance must be achieved between concern and objectivity.

The names by which this quality of I-Thou relationship goes are many—compassion, concern, care, friendliness, love, respect and others. In the end, it is not so much to be conceptualized as experienced, whether in our own personal relationships or in remembering dying people we have looked after who, inverting the usual roles, have taught us, the carers, something about what it means to be alive. This process is the foundation of all therapeutic work of any kind, whether medical, nursing, psychotherapeutic or pastoral. Without it, ill people are reduced to automata treated mechanically like cars to be fixed or discarded.

Process

If presence is about being, process is about doing. Effective action in spiritual pain is, however, very different from, say, pharmacological therapy. In the first

place, it must respect the dynamics of soul. As Thomas Moore (1994, p. 122) puts it:

The intellect works with reasons ... But the soul practices a different kind of ... logic. It presents images that are not immediately intelligible to the reasoning mind. It insinuates, offers fleeting impressions, persuades more with desire than reasonableness. In order to tap the soul's power, one has to be conversant with its style and watchful.

We are dealing, then, in a currency of personal experience, imagery (which may include all the senses), stories, dreams, memories, transpersonal experience, desire and emotions. Therapeutic activity here is not so much about achieving goals, it is more like taking part in a play or performing a piece of music. There may be a beginning and an end, but the unfolding between is just as important and may invite deep reflection over a long period in order that it may yield all its fruits. Soulfulness will not be hurried, though when the time is ripe, patients may undergo major inner transformations very rapidly.

What tools do we have at our disposal then? In the first place, there are the ways that we as carers present ourselves to the dying person. How we look, dress, move, talk, and touch are all continually sending out signals. The ways people perceive us, whether accurate or not, flow from this.

Language is very important here—'Elle est en quelque sorte le souffle mis en musique' [It is in a way the breath set to music] (Odiar, 1995). Speech is a symbolic medium through which the dying can explore the existential crisis with which they are struggling and discover meaning. This is an opportunity, then, verbally to sculpt the myth, as sacred story, of their lives. Talking, in the presence of an attentive *listener*, becomes a passport to their feelings, memories and life experiences and so the rediscovery of their aliveness, even in the presence of death.

Although some people want to talk at length, at times there is only a brief throwaway line. One woman, going into a hospice for the last time, said to her niece, as she made her farewells to her beloved flat and looked out at her garden: 'Don't forget to feed the blackbirds'. Her niece, as she talked after her loss to a bereavement volunteer, said she knew her aunt was telling her indirectly that she would never come back and was handing over the reins. By switching the focus of understanding from the literal to the metaphorical, this becomes clearer. If we consider how the Holy Spirit is usually pictured as a dove, how angels are almost universally portrayed as winged and how flight is a well-known metaphor for transcendental experiences, then the birds of this story may be interpreted as representing spirit or soul, and the colour black, then, its transition through death.

So it is the discovery of the *significance* of one's life that is a major task in the dying process, and as this happens, so the dying can *let go* of their ties with the world:

'He and Mom had a long talk about funeral plans; Mom had him call the priest. Father Wheeler came over and they put together a cer-

emony, and Dad's been crying all evening. Now Mom's working on a list of what she wants the grandchildren to have ... She collects music boxes and she's tagging her favorites (sic) so we know who gets which one' (Callanan *et al.*, 1992, p. 58).

We see here, too, the importance of the family and their impending loss, and, further, the way the dying person hands on enduring tangible memories. Other ways might include letters to be opened after the patient has died, tapes, or diaries.

The ways carers *touch* ill people carry multiple messages. Rough handling implies a lack of consideration and hence a devaluing of that person. Gentleness of touch has a healing and calming quality about it—hence the popularity of massage and other complementary therapies involving physical contact. Physical examination by a doctor, or the nurse changing a dressing, are both opportunities to convey respect and reduce anxiety. Indeed, listening to the body with a stethoscope is akin to listening to the patient's words aurally. Sometimes, touch has a hieratic quality, as in the Christian ritual of anointing the sick, where the priest anoints the ill person with holy oils on the forehead.

Symbolism plays a vital role here, as has already been implied. This may be visual: a picture of Christ or Krishna or the Buddha by the patient's bed, or family photographs are examples. It may be tactile, such as the prayer beads used in Christianity, Buddhism and Islam. Sound may be involved, as with favourite music or tapes with spoken messages sent by families living abroad. The scent of flowers may evoke pleasurable memories and traditional meals prepared by the family are a reminder of past good times spent together, nourishing not just the body, but the inner being as well.

One woman with advanced breast cancer and grossly swollen arms was depressed at her condition, especially as she was too unwell to walk. The hospice nurses, taking advantage of a spell of good weather, wheeled her in her bed outside into the sun, with a parasol to protect her. For two weeks she would spend hours outside each day by a pond, watching the clouds sailing across the blue sky and the trees waving in the wind. Gradually her mood was transformed and her depression left her. We may discern here the symbolisms of divine light, the aliveness of nature, air representing the spirit, and calm water representing healing of emotional turmoil.

Guided imagery as a psychotherapeutic method in transpersonal psychologies such as psychosynthesis (Ferrucci, 1982, pp. 21–22) relies on the power of symbols for its effect. For example, Kearney (1992) describes the case of a distressed dying patient who was adamant he would get better and whose physical pain was inconsistently controlled despite high doses of strong analgesics. During several sessions involving relaxation and guided imagery, boats and sea journeys were recurring themes; his physical pain improved dramatically and needed only low doses of opioids for effective control. An excerpt gives a flavour of the sessions:

When asked what he felt as he began this journey Sean replied, 'I feel

some fear as I don't know where this boat is going and when I look back at the harbour wall and see those I love standing there, I feel sad. But I also feel excitement ... light, sun, life. I sense I will see beautiful things along the way, like dolphins in turquoise water. I love travelling' (Kearney, 1992).

Such an approach does not imply an escape from a reality too hard to bear, but actually a healing of that reality. Indeed, sometimes, dark images surface; paradoxically, these may hold a key to the process of making whole again and are, therefore, not necessarily to be rejected. Kearney (1996) makes use of the Greek myth of Chiron the centaur as a way of understanding this. Chiron, a renowned healer, was incurably wounded by a poisoned arrow and was only healed when he agreed to give up his immortality and descend into the darkness of Hades on behalf of Prometheus, who was being punished for stealing fire from the gods. After nine days and nights, Zeus took pity on Chiron, restored his immortality and raised him to the skies as a constellation of stars. Kearney elaborates the change from 'the heroic stance' paradigm exemplified by the hubristic attempts of Western medicine to destroy death, to 'the way of descent' which may become a path through suffering and a doorway to inner healing. He distinguishes five stages in this process of coming to terms with dying: the wounding, the struggle, the choice, the descent and the return.

Rituals can also be helpful. They may take a traditional form, such as the Roman Catholic Mass or Buddhist meditation or lighting the Jewish seven-branched candlestick. Redolent as these often are of childhood memories, they may be deeply comforting to the mortally ill. One dying man, for example, was troubled by guilt and frightened by diabolic hallucinations. He was visited by the chaplain, who assured him that he was forgiven and that God would always protect him and take care of him. Visibly relieved, he sank back into his pillows. His physical condition had until then not changed greatly, but after talking to the minister, he rapidly became weaker as though he was now able to let go of life and he died peacefully a few hours later.

Sometimes such rituals take a surprising and unusual form. One man wanted to go home from a hospice, but there were difficulties as to how he would be cared for. When asked why he wanted to return home, he replied that he had a red cut-glass goblet and he wanted to have one last dinner with wine drunk from the goblet. He agreed this could take place in the hospice and the goblet was duly fetched. He enjoyed his banquet and the next day, at peace, he died (Daniels, 1995).

Prayer, meditation and contemplation

These deceptively simple words contain a vast wealth. Does this richness, however, have a universal relevance to all dying people of whatever conviction? Are they not the preserve of card-carrying believers? I do not think so. Rather, they are as natural to us as breathing and as necessary as the food we eat. As always, it is in each person's experience of life that common ground is most

easily found: walking in the country, sitting by a fire in the evening, listening to the sound of a waterfall, watching the wind blow in waves across a field of sunlit wheat; each of these, and many, many others, may induce in us a state of contemplation that is independent of conceptualizations of belief and may happen to us every day. It is when this state of being is ignored, suppressed or denied that spiritual pain manifests itself and it is when a reconnection is made with the deep Self that healing of the spirit can take place. The stories already discussed bear vivid testimony to this reality.

Of course, ways of prayer and techniques of meditation abound in all religious traditions (De Mello, 1978; Kamalashila, 1992; Wilber, 1993). However, it is necessary to find what suits each individual, rather than their desperately relying on dusty childhood memories of snatches of prayers learnt by rote. Those words or images or silences that resonate deeply within a person (Latin, *per sonare*: to sound through) are the ones that heal. Consider, for example, how Simone Weil, the Jewish philosopher and mystic, approached the familiar Lord's Prayer in an unfamiliar way. She would recite it every morning and if her attention wavered for a moment, she would repeatedly start again:

On occasions the very first words tear my mind from the body and transport it outside space, where there is no perspective, no point of reference. Space opens up. The infinity in the ordinary space of perception is replaced by an infinity at the second or even third power ... this infinity ... fills itself everywhere with silence (Ferrucci, 1990, pp. 256–257).

Conclusion

In summary, then, the nature of spiritual pain as occurring when a person becomes estranged from the essence of who he or she is, has been considered. Spiritual distress has been demonstrated as manifesting through physical, psychological or spiritual symptoms, these last being meaninglessness, anguish, duality and darkness. Intuition and bifocal vision are necessary elements in assessing whether spiritual distress is present.

Effective help implies that the carer is fully present in relationship to the sufferer, person to person, deep calling to deep. The process of helping is based on the ill person finding meaning, through this dialogue, in his or her life experiences. Words, touch, symbolic imagery and rituals may all be vehicles for this unfolding story, which is, in essence, a contemplative process. It may truly be said that a person is healed by this in becoming whole while at the same time dying, so that death itself is not seen as a disaster but part of life.

The following final extract about Harriet, a Tibetan Buddhist of European origin dying of cancer at the age of 44 in a Catholic hospice in Southern Ireland, paints a very different picture, a very different way ignored by our death-denying culture. Her room had been decorated with Buddhist pictures and hangings, and her husband and friends stayed with her.

We had made a tape of Harriet's favourite Ngöndro chants ... This

played softly over and over. A great peace had settled on the room. Even the smoke from the incense, as it curled through the roses, seemed to say that it was all right. Friends came in without speaking, sat in silence, and left. Sometimes the nurses would come to stand by the bed and whisper a prayer.

Then someone came to get me from the telephone, saying that Harriet's breathing had changed. I knelt by the bed and placed my mala (rosary) blessed by the Dalai Lama in her hand. The whole room felt so sacred that my feeble attempt at 'practice' or 'prayer' seemed irrelevant, almost irreverent. I united my breathing with hers. In a timeless space beyond sorrow or pain, thoughts rose and subsided without meaning. Small events splashed like raindrops on a distant window-pane. The Dalai Lama (on tape) started to chant the 'mandala offering'. This seemed so perfectly appropriate at that moment. Harriet's whole life was an offering for the preservation of the old wisdom, and now, so too, was her death.

Then the sun came out to shine through the crystal that stirred in a light breeze, to spread dancing shapes of rainbow light around Harriet's head on the pillow. It took care of itself, in the silence of indescribable peace. She gave three long gentle outbreaths. Her last outbreath coincided exactly with the last long deep syllable, and the chanting ceased (Cornish, 1994).

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Biographical note

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