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R E A C H

REDEMPTORIST ACADEMY OF COMMUNICATION & HOMILETICS
Tele : 578631

MT ST ALPHONSUS
RICHARDS TOWN, P.B.532
BANGALORE 560005

"COMMUNICATING WITH THE SICK" - III

An Intensive Pastoral Care Seminar

January 17th-26th,1979

LIST OF PARTICIPANTS

Srl No.	Name & Congr.	Address & Diocese	
1.	Sr.Pius,fcc	Marian Medical Centre Hospital,Arunapuram P.O.Palai,Kerala	PALAI
2.	Sr.M.Lumina S.M.M.I.	Our Lady's Convent,Arisipalayam Salem 9 Tamilnadu	SALEM
3.	Sr.Therese Pushpam I.C.M.	St.Josephs Hospital,Dindigul, Madurai Dt. Tamilnadu	Tiruchi
4.	Sr.Joan of Arc S.A.	St.Joseph Health Centre, Pulivendala P.O.Cuddapah	CUDDAPAH
5.	Rev.N.S.Mathew C.S.I.	Victoria Hospital,Dichpalli Nizamabad Dt. A.P.	MEDAK
6.	Mr.K.Christopher C.S.I.	Victoria Hospital,Dichpalli Nizamabad Dt. A.P.	MEDAK
7.	Sr.Alma Kizhakekara S.C.M.M.	Veroor P.O. Changanacherry, Kottayam Dt. Kerala	Changana Cherry
8.	Sr.M.Theodore F.M.M.	Mithra 802 RV Nagar,Anna Nagar Madras 600040	Madras Mylapore
9.	Sr.Teresa Jose F.C.C.	Fatima Mata MissionHospital, P.O.Kalpetta Kerala	CALICUT
IO.	Fr.Mariadas C.M.I.	" " "	"
II.	Fr.Jacob Nedumpillil	St.Josephs Hospital,Manantoddy, Wynad,Kerala	"
I2.	Sr.Chrysanthe,St Louis de Gonsagne	St.Louis Convent,via Thanderi, Gengapet,N.A. Dt. Tamilnadu	VELLORE
I3.	Sr.M. Stella F.S.S.J.	Arokia Illam,Vellore.N.A.Dt.	"
I4.	Sr.Myriam S.M.M.I.	Nirmala Giri,Kengiri,Mysore Road, Bangalore	BANGALORE
I5.	Sr.M.Chandra S.M.M.I.	St.Teresas Sanatorium,Rajaji Nagar,Ist Block,Bangalore	"
I6.	Sr.Rosily Antony S.M.M.I.	St.MarY's Convent, Chamarajapet,Bangalore I8	"
I7.	Sr.Rosette S.M.I.	88,Benson Cross Road, Bangalore	"
I8.	Sr.Tresa S.M.I.	" "	"
I9.	Fr.Harry Bijvoet M.H.M.	St.John's Medical College Bangalore	"
20.	Mr.John Pelly	" "	"
2I.	Sr.Asuncion F.I.	" "	"
22.	Sr.Gerosa M.S.J.	" "	"
23.	Sr.Cletta S.H.	" "	"
24.	Mrs Jacinta Nazareth	" "	"
25.	Miss Irene D'Souza	" "	"

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17.	Sr.Rosette S.M.I.	88,Benson Cross Road, Bangalore	"
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21.	Sr.Asuncion F.I.	" "	"
22.	Sr.Gerosa M.S.J.	" "	"
23.	Sr.Cletta S.H.	" "	"
24.	Mrs Jacinta Nazareth	" "	"
25.	Miss Irene D'Souza	" "	"

26.	Sr, M. Bertilla, Srs of Charity	Lourdes Hospital, Kelgheri Road, Dharwar	BELGAUM
27,	Sr. Claudia Noldin "	" "	"
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29.	Sr. Rita R.G.S.	" "	"
30.	Mrs Washington	" "	"
31.	Sr. Grace, Vincentian	Vincentgiri Hospital, Manantoddy, N. Wynad, Kerala	CALICUT
32.	Sr. Francis Thekkekara	St. Joseph's Hospital, Guntur A.P.	GUNTUR

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BANGALORE - 560 005

"COMMUNICATING WITH THE SICK"-III

An Intensive Pastoral Care Seminar

TOWARDS A TOTAL HEALING MINISTRY (Jan.17th - 26th 1979)

(Sponsored by the Catholic Hospital Association of India)

PROGRAMME — Coordinator : Fr.Frankie Menezes C.SsR.

17th January-Wednesday: ARRIVAL DAY

18.00 : Celebration of the Eucharist (for those who wish to join)
18.30 : Welcome to "REACH" & Useful information - Fr. F. Menezes C.Ss.R Director "Reach."

Getting to know one another

PRACTICALS-I: "Ice-breakers" - Sr. Germaine Hustedde PHJC
19.45 . Supper & Recreation

18th.Jan.-Thursday

07.45 : Breakfast
PRACT.II 08.45: Exercise to facilitate Group working -Sr.Germain P.H.J.C.
09.15 :Introduction to the Seminar: Need for a total Healing Ministry. - Fr.Frankie Menezes C.Ss.R.
LECTURE -I : Integra approach to Healing and Human Development - Sr.M.Breda R.G.S.

10.15 : Coffee break
10.35 : LECTURE -II : In Pursuit of Wholeness (2) - Sr.Germaine
11.35 : Break
11.45 : LECTURE -III: Surrendering to the NOW (3) - " "
12.45 : Lunch & Free
15.00 : PRACTICALS -III: Workshop on Lecture 2 & 3 " "
16.00 : Tea Break
16.20 : PRACTICALS -IV : "Report & Discussion (4) " "
17.45 : Free time
18.30 : LECTURE - IV : Clinical Pastoral Ministr need & approach Fr. Augustine Thareppel, M.S.F.S.
19.30 : Eucharistic Concelebration - Fr. F. Menezes
20.15 : Supper & Recreation

Friday,19th Jan.

07.00 : Eucharistic Concelebration - Fr.Harry Bijvoet M.H.M.
07.45 : Breakfast
08.45 : LECTURE - V. : Christian meaning of Helaing (1) - Fr. Gino Henriques C.Ss.R
09.45 : Coffee break
10.05 : LECTURE -VI : Scriptural basis of Christian Healing (2) Fr. Gino Henriques C.S.S.R.
11.05 : Break
11.15 : LECTURE -VII : Healing Ministry in the Church (3) Fr.Gino
12.30 : Lunch & free

12.45 : LECTURE-VIII : Patients' Attitude towards Helper (2) - Fr. Augustine

15.45 : Tea Break
16.05 : LECTURE - IX : Disease & the Reaction to disease (1) Surg. Commodore T.B.D'Netto
17.05 : Break
17.15 : LECTURE-X : " " " " " (2) "
18.15 : Free time
19.30 : Evening Prayer
20.00 : Supper
20.45 : PRACTICALS -V: Workshop: How to bring Christ to our suffering bretheren " "

Saturday, 20th Jan.

07.00 : Eucharistic Concelebration - Fr. Francis Pinto C.Ss.R.
07.45 : Breakfast
07.45 : LECTURE-XI : Healing Ministry in the Church-II- (4) Fr.G.Henriques
09.45 : Coffee Break
10.05 : LECTURE-XII : Different kinds of Healing-Physical and spiritual (5) " "
11.05 : Break
11,15 : LECTURE-XIII." Patients are People"-(1) Fr. Peter deSousa C.Ss.R.
12.30 : Lunch & free
14.45 : LECTURE-XIV: Psychosomatic & Psychospiritual Illness- (3) Dr. D'Netto
15.45 : Tea Break (& Discussion)
16.05 : LECTURE -XV/: Psychosomatic & Psychospiritual Illness -II (4) Dr.D'Netto
17.05 : Break
17.15 : LECTURE XVI: The Christian Counsellor & the Charism of Healing (5) Dr. D'Netto
18.15 : Free time
19.30 : Evening Prayer
20.00 : Supper & Recreation

Sunday 21st.Jan.

06.30 : Eucharistic Concelebration in Holy Ghost Parish Church
07.45 : Breakfast
08.15 : LECTURE -XVII:"Therapists are people too"-(2)- Fr.P.deSousa
09.45 : Coffee break
10.05 : LECTURE-XVIII; Helping the patient cope - (3) " "
11.05 : Break
11.15 : LECTURE -XIX: Emotional responses to Somatic Illness - Dr. Om Prakash (St.John's)
12.30 : Lunch & free

FREE AFTERNOON

Monday 22nd.Jan.

07.45 : Breakfast
08.45 : LECTURE -XX : Healing the whole person - Tational Emotive Therapy - I (4) Fr. P.deSousa
09.45 : Coffee break
10.05 : LECTURE & EXERCISE: " "-II (5) " "
11.05 : Break
11.15 : LECTURE -XXI : Body Language & Facial Expression (1) Fr. Claude D'Souza
12.30 : Lunch & free
14.45 : LECTURE-XXII: " " " " (2) " " "

15.45 : Tea break
16.05 : LECTURE -XXIII: Medico-Pastoral problems connected with birth (1) Fr.Felix Podimatam ofm.cap.
17.05 : Break
17.15 : LECTURE-XXIV & Discussion " " (2) " " " "
18.15 : Free time
19.30 : Eucharistic Concelebration Fr.Harry
20.15 : Supper
20.45 : LECTURE -XXV : How to discover the real disease (3) Fr.Claude D'Souza
21.45 : End of session.

Tues.23rd.Jan.

07.00 : Eucharistic Concelebration (Creation Liturgy) Fr.P.deSousa
07.45 : Breakfast
08.45 : LECTURE-XXVI: Leading the alchoholic towards wholeness (6) Fr.P.deSousa
09.45 : Coffee break
10.05 : LECTURE-XXVII: T.A. Skills in Guidance & Counselling the sick (1) Sr.M.Goretti r.g.s
11.05 : Break
11.15 : LECTURE -XXVIII: " " " " (2) " " "
12.30 : Lunch & Free
14.45 : LECTURE-XXIX : Working with the sick, terminally ill & the Bereaved (3) Fr. Augustine
15.45 : Tea break
16.05a: LECTURE -XXX : " " " (4) " "
17.05 : Break
17.15 : LECTURE -XXXI: Medico-Pastoral problems conected with death (3) Fr.Podimattam
18.15 : Free time
19.30 : Evening prayer
20.00 : Supper
20.30 : PRACTICAL DISCUSSION-VI: Medico-Pastoral problems (4) " "
21.30 : End of session

Wednesday 24th Jan.

07.00 : Eucharistic Concelebration (Theme,"Healing) Fr.P.deSousa
07.45 : Breakfast
08.45 : LECTURE -XXXII: Inner Healing -I (6) Fr. G. Henriques C.Ss.R
09.45 : Coffee break
10.05 : LECTURE XXXIV : Inner Healing -II (7) Fr. G. Henriques C.Ss.R.
11.05 : Break
11.15 : LECTURE XXXV : Therapeutic Skills in Hospital-(7) Fr.P.deSousa
12.30 : Lunch & Free
14.45 : PRACTICALS -VII: Role-Play & Evaluation on - Team: Fr.P.deSousa, (4 groups) "HOSPITAL VISITATION"-I. Srs. M.Goretti, Agnes, Rita
15.45: Tea break
16.05 : PRACTICALS-VIII : " " " I-II " " "
17.05 : Break
17.15 : LECTURE-XXXVI : Medical Team-Interrelations -Dr.C.N.Francis, Dean St.John's Med.College
18.15 : Free time
19.45 : Supper
20.30 : "PRACTICALS" IX : Healing Memories" - (8) Fr.G.Henriques & Fr.P.deSousa.

Thurs.25th Jan.

07.00 : Eucharistic Concelebration — Fr.Gino Henriques C.SS.R.
07.45 : Breakfast
08.45 : LECTURE -XXXVII : Deliverance -I (9) " " "
09.45 : Coffee break
10.05 : LECTURE -XXXVIII: " " -II (10) " " "
11.05 : Break
11.15 : LECTURE-XXXIX : Eucharist and Wholeness -Fr.Gerwin van Leeuwen ofm.
12.30 : Lunch & free
14.45: PRACTICALS -XI : Role-play & Evaluation on - (4 groups) "Hospital Visitation "III Supervised by Team
15.45 : Tea break
16.05 : PRACTICALS -XI : " " " IV " "
17.05 : " -XII: " " " V " " (or individual Evaluation of Seminar)
18.00 : Free time
19.30 : Supper
20.15 : ENTERTAINMENT
22.00 : End of programme

Friday 26th Jan.

07.00 : Morning Prayer
07.30 : Breakfast
08.30 : PRACTICALS-XII : Workshop-Group Evaluation of Seminar
09.30 : Coffee break
09.50 : REPORT OF WORKSHOP & Discussion — Fr.Frank Menezes C.Ss.R.
10.45 : Break
11.00 : Closing Eucharistic Concelebration " " "
12.00 : Dinner & Farewell

(b) Death is a real factor in the meaningfulness of life. In the face of death, says Viktor Frankl, as absolute finis to our future and boundary to our possibilities, we are under the imperative of utilizing our lifetimes to the utmost, not letting the singular opportunities - whose 'finite' sum constitutes the whole of life - pass by unused.

(c) Death, for the believer, is also a significant religious event : It is, as it were, the occasion on which we ratify the fundamental options we make in life. Those who, for example, believe in Jesus Christ, and in his passion, death and resurrection, as a salvific event, gain a new vision of death. Christ transforms death into the greatest manifestation of trust in the Father and love for all mankind. For the Christian, death opens on to life eternal. Every doctor should try to be cognizant of the hope and faith of his believing patients, the better to help them to face the prospect of death with equanimity.

3. The Moment of Death : In view of organ transplantation, this question has acquired special significance. After all, a person dying is still a person living, and he keeps his elimentary human rights up to the moment when life becomes extinct.

In short, the principle that brain death is synonymous with the death of the patient (or death of the person) has found universal agreement. A Harvard University team that studied this question in depth gave the following criteria: "It stated that in order for brain death to be designated the subject should be in deep and irreversible coma; manifest a total un-awareness to external painful stimuli; have no spontaneous muscular movements or responses to external stimuli; have no respirations when not in resuscitator; have no elicitable reflexes; have pupils fixed, dilated, and unresponsive to light; and have an isollectric EEG (flat EEG), with the foregoing characteristics having been maintained over a period of 24 hours." (Archives of Internal Medicine, 124 - August 1969 - p. 226-227)

4. THE PROBLEM OF THE PROLONGATION OF LIFE AND EUTHANASIA.

The right to live humanly implies the right to die humanly , i.e. with dignity and in freedom. Does this mean that the patient has the right to end his life or the doctor to assist him in doing so? In a recent document, the American Hospital Association approved a 12-point Declaration of Rights of Hospital Patients, which grants to the patient the right, among others, "to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of his action". This implies that an adult patient with no prognosis for recovery has a right to die without medical therapy. The point is: would this "right to die" justify the patient in asking the doctor to end his life, or justify the doctor in presuming this consent and acting in such a way as to cause death ?

THREE POSSIBILITIES : In the management of terminally ill patients, or patients whose brain has suffered massive destruction to the extent of being irremediably non-functioning, there are three major options :

(1) withdrawal of artificial and/or mechanical life-support systems (i.e. non-interference with death);

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(2) administration of pain-relieving drugs which will have the effect, among other effects, of accelerating the death process (i.e. hastening of death)

(3) administration of death-inducing or life-terminating agents (i.e. deliberate action calculated to cause death).

I think it is arguable, says L. Harmon Smith (ETHICS AND THE NEW MEDICINE, p. 167) that options 1 and 2 are now morally licit procedures in the management of terminal or brain-destroyed patients, but that option 3 is not needed if we properly understand and apply the dispensability (i.e. the non-manditorinees) of both extraordinary and ordinary means which are not remedies. The line between options 2 and 3 is a fine one, I know; but it is reinforced by the awareness that medical science and technology have developed many possibilities for which we have not yet developed the ethical wisdom and moral stamina necessary for exercising humanely responsible control.

SOME NORMS : In arriving at a morally discriminating decision, the following norms should be kept in mind.

(1) "A human person owes it to himself and to his community (to his family, to the society in which he lives) to keep his life intact and not to destroy the value that it represents. Human life lived in a personal way is the best that we can find in this world. Nothing else comes anywhere near it, in the hierarchy of values. It follows that both the individual and the community has a duty to do what can be reasonably done to preserve human life. This duty exists in the patient, in the doctor, in the lawyer, in the priest, in all who share a responsibility for life.

(2) Man has a right to his own dignity as a person even in approaching death. Therefore, once the reasonable means to keep him in life have been exhausted, he is not bound to destroy his dignity by expecting to be kept alive without being able to live, to think, and to feel as person. No one is bound to ask for medication that would prolong the agony of death. The same principle is valid for the community; its members are not bound to prolong the agony for a human being.

(3) There will always be complex situations and borderline cases where a clear moral judgment cannot be formed within the short time available. In this case we have to respect those who, animated by the first two principles, make a genuine effort to bring about the best decision even though they may fail to find it there and then. Yet the effort itself was good and the resulting situation should be accepted as the only reasonable one in the circumstances."

(4) "I would urge that we promote the idea of benemori, a dignified death, in the dying patient. There is no need to prolong the dying process, nor is there any moral or medical justification for doing so. Euthanasia, that is the employment of direct measures to shorten life is never justified. 'Bene mori' that is, allowing the patient to die peaceably and in dignity is always justified."

...4/-

<u>EUTHANASIA</u> : Etymologically the word means "dying well". But the word has now come to mean "easy dying", for it implies medical intervention to cut short life by causing death. We must distinguish between euthanasia which is claimed as a legal right, and euthanasia as a moral option.

(a) <u>Legal euthanasia</u>: Advocates of euthanasia as a legal right of every citizen can be understood to speak of euthanasia in two senses:

(i) <u>In the strict sense</u> : i.e., "to cause death (or to assist in causing death) to a conscious, certainly incurable patient who requests that his agony (physical or psychical suffering) be terminated by a calm and painless death".

(ii) <u>In a wider sense</u> : This would include: (a) to cause death, at the instigation of pity, to an unconscious dying person, to monsters, the seriously insane, etc.; (b) to cause death, for the sake of society, to a socially dangerous person, and in general to persons who cannot live morally useful lives within society (the so-called 'eugenic deaths', and disposal of useless persons e.g. the aged, mentally retarded etc.)

The judgement on this has been succinctly formulated by Pope Paul VI when he wrote to the International Federation of Catholic Medical Associations: "Without the consent of the person, euthanasia is murder. His consent would make it suicide."

(b) <u>Euthanasia as a moral option</u> : Here it is customary to distinguish between (i) <u>Direct or positive euthanasia</u>: i.e. the rendering of assistance in order to cause death, This can never be allowed. (ii) <u>Indirect or negative euthanasia</u>: i.e. the administration of treatment, e.g. for the alleviation of pain, which has as a side effect the acceleration of death. Here, we could also include the stopping of those procedures which only prolong the process of dying, while they hold out no hope for life. This should better not be called euthanasia at all, and in fact is morally licit.

<u>FINAL SUMMARY</u>

We can summarize all that has been said above, in an organized way, by quoting extensively from a lecture given by Dr. G.B. Giertz at a Ciba Foundation Symposium on ETHICS IN MEDICAL PROGRESS: with special reference to transplantation. He writes: "The subject of euthanasia poses now problems in medical ethics. The central point is whether we can establish the moment when life ceases to have any human value; this is essentially the same central problem as in abortion, although it is then a question of deciding the time when life begins to have human value. Both problems force us to face up to the question of whether man can draw such a boundary that he can disregard the obligation to protect life. There are essentially two possibilities. One is to leave the duty to protect and preserve human life unconditional. Such a view implies that man lacks the

right to determine the length of life and to judge what is a valueless life and what a valuable one. The second possibility is euthanasia, for which there are strong advocates in Sweden. A professor of practical philosopy asks: "Is the physician's virtuous skill in repairing damaged individuals and sending them back to so-called life, blind or deaf, with grave changes in personality, with poor sight or deprived of the power of locomotion, actually a gain from the aspect of the value of human life"? In this connexion the economic factor has been mentioned. Is it in fact intended that we shall provide the medical services with resources for furnishing life supporting measures for every individual who might qualify for it, even when the prospects of securing a recovery are negligible? Should we not accept that man shall decide what is fit for life and what is not, and direct our resources to the former?

More recently a third factor has entered this discussion, namely the question of the dignity of life and death. My own attitude is that in the treatment of the hopeless case we should try to act so that the patient, in spite of everything, can live as normal a life as possible and is freed from pain as far as possible. Much of our medical effort is concerned with achieving these ends. We choose the path that appears to us to be the wisest from the human and medical aspects, and thus do not limit our consideration to probable survival time. But when shall we give up the struggle? In most cases it is not difficult to decide. So long as we are not convinced that all hope is gone we should as a rule fight with all the means at our disposal. But when we have been able to establish that the end must soon come, then we should take this into account in our action. In this situation death is a natural phenomenon and should be allowed to run its course. The thought that we physicians should be obliged, for instance, to keep a patient alive with a respirator when there is no possibility of recovery, solely to try to prolong his life by perhaps 24 hours, is a terrifying one. It must be regarded as a medical axiom that one should not be obliged in every situation to use all means to prolong life. Such an obligation would rapidly lead to an untenable situation and spell disaster to our hospital organization. The point is that these considerations are purely medical ones - no step is taken with the object of killing the patient. We refrain from treatment because it does not serve any purpose, because it is not in the patient's interest. I cannot regard this as killing by medical means: death has already won, despite the fight we have put up, and we must accept the fact. Only the recognition of this limit can enable us to solve the problem that for many has made the thought of death an agonizing one - the fear of an artificial prolongation of life when it has already been bereft of all its potentialities.

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A recent article on power sharing by George Prince in the "Harvard Business Review" suggests a series of probing questions which any chairman might want to ask before the group meets again:

Must you call all the shots? Or would using cooperatively the various talents available within the group be better?

Must you protect your power to make decisions? Or would the best decision emerge if you combined your power with that of those who eventually must implement decisions?

Must you decide every course of action where you have the authority to decide? Or should you enlist courses of action from others and then contribute your own thoughts as matters progress?

Must you exercise all the autonomy your power permits? Or should you use your power to help others develop their own autonomy?

Should you use your power for your own growth? Or should you share your power so everyone grows?

Must you motivate the group? Or should the group's accomplishments motivate the group?

Must you review, oversee, and control the group's efforts? Or should you use your experience, power, and skill to aid the group in accomplishing these efforts?

Must you take credit for the group's results? Or should you clearly recognize the accomplishments of individuals within the group?

Must you spot all flaws and have them corrected? Or, to achieve results, should you help others to spot and overcome any flaws?

Must defining the group's mission be your sole responsibility? Or is your role to facilitate the discovery of the mission by the organization itself?

Should you make judgments about the group's actions while decisions are being carried out? Or is your task to join the group to make sure decisions are carried out?

Handling these questions will allow you to keep in check three essentials for any organization: getting the job done, maintaining the integrity of the group itself, and making sure each member has an opportunity for purposeful growth.

FZ
5/78

To Dr Ravinarayan 32.5

ROLE OF HYPNO-THERAPY IN THE MANAGEMENT OF INTER-PERSONAL RELATIONSHIP

Short course is given on the role of hypnotherapy in behavior and management. This stresses hypnosis as a particular kind of interpersonal relationship in which the individual permits increasing restrictions on his sensory intake. He excludes all extraneous stimuli except those that are brought to his attention. What is important is not the depth of participation. In the behavioral modification and successful management, the degree of rapport is an important parameter. In every day management conviction of hypnosis leads to better suggestions. The important factors for successful management are motivation, belief, expectation, imagination and the subsequent restructuring of the individual reality percepts.

32.5

ROLE OF HYPNOTHERAPY IN BEHAVIOR AND MANAGEMENT

I. WHAT IS BEHAVIOR?

Behavior as a pre-conditioned mind-Free and hindered behavior-learning process and behavior pattern-positive and negative suggestions-behavior related to physical and mental conditions-Religion and behavioral modification.

II. ANALYSIS OF BEHAVIOR AND SELF-MANAGEMENT

Psychoanalytical aspect of behavior-Symptom removal and behavioral management-Emotional needs and control of behavioural changes-Role of habits in behavior behavioral dependency-Behavior in a multiple personality.

III. ROLE OF BEHAVIOR IN AN OCCUPATIONAL FRAME

Beliefs and faith-Attitude towards ethical and legal aspects of work- Comparative evaluation of self participation in group and team work- Expectancy and behavioral changes- Failures and psychosocial implications.

IV. ALTERATIONS AND MODIFICATIONS OF BEHAVIORAL PATTERN.

Laws of suggestions and hypersuggestibility - Hypnodial state and hypnotic state - Concentration and distractions- Self dissociation and depersonalization- Hypnotherapy in management.

* * * * * * *

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BAN...

RN
9/12

DAY 1 : MIND & BODY

DAY 2 : SELF MANAGEMENT

DAY 3 : GROUP ~~[illegible]~~ MANAGEMENT

DAY 4 : USE OF HYPNOSIS IN MANAGEMENT.

3²-4

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32.4

COMMUNITY HEALTH CELL
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BANGALORE 560 001

SUGGESTIBILITY TESTS
CHEVREVUL'S PEDULUM
TESTS

When and how to perform, ?

To perform Chevrevul's Pendulum test, one must have a heavy ring or a glass ball on a string, which the individual holds in his hand, arm outstretched, over a piece of paper upon which is drawn a circle about 8 or 10 inches in diameter with a cross inside. The subject is told not to make any concious attempt to help or hinder the movements of the ball (Or ring), but that the ball will move spentaneously by just thinking about it. He is informed that the mere concentration upon the balls moving from left to right, forward or backward, clockwise or counter clockwise, will cause it to swing in accordance with his thoughts.

The subject is instructed to let his eyed travel around the circle, or up and down the cross, or from one side to the other of the horozental line. It is again suggested that he will not be able to control the swing of the ball. If the ball follows the operator's suggestions, this indicates a positive suggestibility. When the swing is well developed, the subject is asked to concentrate on the ball's swinging in a clockwise direction. After this has been accomplished, it is suggested that it might swing in a counterclockwise direction or up and down.

OTHER TESTS

1. The thermal test
2. Olfactory test
3. Kohnstamm test
4. Disguised tests.

(A) NORMAL INDIVIDUAL

1. What is behavior?

2. Is it related to mind or body?

3. Where is mind? Is it some part of CNS?

4. Is there any thing like animal behavior in man? If so how to diffrentiate it from normal behavior?

5. Is there any influence of aging on behavior? What is the difference in physical and mental age as regards to behavor

6. Is it possible to define the undividuals behavior in a given set up? and how?

7. What circumstences activate hindered and free behavior in a normal undividual? How to differentiate them?

8. Can we say behavior is an outcome of only preconditioned mind, How does it happen.

9. Is it possible to measure the intensity of preconditioned state of mind? in terms of behavioral changes?

10. Learning influences behavior. true or false

11. Is behavior due to suggestion or persuation?

12. Religion and behavior in terms of interactions, how to explain?

13. Confidence and behavior; any relationship?

(B) NORMAL INDIVIDUAL WITH ABNORMAL BEHAVIOR.

32 . 6

R E A C H

REDEMPTORIST ACADEMY OF COMMUNICATION & HOMILETICS
TELE:578631

RICHARDS TOWN, P.B.532
BANGALORE 560 005

"COMMUNICATING WITH THE SICK"

21st-28th Nov.1978

A Second Training Course

TOWARDS A TOTAL HEALING MINISTRY

IN PURSUIT OF WHOLENESS

COMMUNITY HEALTH CELL
47/1,(First Floor) St.Marks Road
BANGALORE - 560 001

I. Exploring Wholeness

A. Our Life - Self-gift from the Father

Man as he came from God, possessed the wholeness, the fullness of perfection which has eluded man since Adam's fall.

Before the world was created, God alone existed. Existence was with God. God had all perfection; He is all perfection of being. In creating us God extends Himself, as it were and bestows life on us. Our life is SELF-GIFT of the Father.

B. Theories of Being

1. World-Self Dimension (William A. Luijpen, a philosophical anthropologist's view)

Man is viewed as conscious-being-in-the-world. This implies that man encompasses two dimensions: the material world and the non-material interior life. Man's existence is basically a "standing-out" in his world. (World for the Psychologist means people, events and situations that make up my day to day experience)

Man would not be man without the world. The world would not be the world, as we know it, without the conscious subjectivity of man who discovers meaning and establishes relationships in the world.

Man is a conscious-being in the world, therefore as well as a meaning-giving presence in the world. That which man is, defines his task. Luijpen puts it this way:

"Man is a task, a task-in-the-world. As long as man is man, his being is, and is essentially, a task. . . True, man can disregard the task-like character of his being-in-the-world, but then he disregards himself as a man. He then gives himself the mode of being a thing: for a thing, being is not a task because it is not a subject, not free."

(William A. Luijpen, Existential Phenomenology rev., ed; Duquesne University Press, Pittsburgh, 1969, p.199)

2. Man as body-ego-spirit (Adrian van Kaam, existential-psychological approach)

Man is an integrated whole. The body is that part of my whole self which is most accessable to my awareness. It is tangible, material and most immediately felt when I interact with my world.

Dr.William Kraft speaks of my body as rooting me in my world. He says without my body I am nowhere, no-one and no-body!

Related to my bodily self is my vital self. On the vital level I am endowed with a basic pattern of temperament and emotionality which I cannot readily change without doing violence to myself.

My ego is that aspect of my personality which enables me to interact with the world in a practical, organized manner. It empowers me with the ability to manipulate, control and influence my relationship with others and the world.

For the most part my ego is task oriented and problem solving. However, even when I perform a task that requires problem solving it is possible to conduct myself in such a way that my behaviour is more than just body-ego performance. The something else that comes through, van Kaam calls spirit.

My spirit is not a skill or ability. It is a certain "quality" which permeates the rest of my personality. It is the spirit which enables me to open to a realm of existence beyond the limits of my material body and the performance of my ego.

C. Reflecting Upon Man Through Literature and Life

1. Concretizing the self-theories through literature
We reflect upon the story of the renowned German novelist, Herman Hesse entitled Narcissus and Goldmund. The story centers around the two extraordinary persons, Brother Narcissus and Goldmund, the title characters. Narcissus is a young, handsome Greek teacher who is loved by many and resented by some as well because of his superb self-control and reserve. Goldmund is a delicate youth who has enrolled for study in the cloister school.

Each of the characters stand out as conscious-beings in the world; as persons possessing an interior life of consciousness with which he can be conscious of himself and as meaning-giving presences in their particular world.

. And exerpt from Mauriac's book The Inner Presence: Recollections of My Spiritual Life (New York: The Bobbs-Merril Co., 1965) p.1 concretizes the body-ego-spirit theory.

> "A book I intended to read stands open before me, but unread. I tried in vain to read it; my attention was not held. A new record has not been played; it has not even been taken from its envelope. A certain chill is creeping over me and making me afraid. No, it is not anything or ANYBODY: it is merely that I have lost interest in everything except the fact of my being alive; from now on this is enough to occupy my mind. My hand on my knee is still warmed with the red tides of the sea throbbing within me, but those tides will not ebb and flow eternally. My world is nearing its end and sometimes I can think of nothing else during these last moments before the final one."

2. Concretizing the Self-theories through the Experience of Sickness.

Sickness provides an opportunity to re-evaluate our "world".

The nature of a person's illness will influence his response to it. In physical suffering the bodily dimension of man is called sharply into focus.

The vital dimension (emotions) are called also into play.

The ego self is rendered almost totally inactive.

The Gestalt principle is at work in the case of illness. This principle operates such that when one aspect of a thing comes to the fore other aspect move into the background.

D. Characteristic Trends Which Seem to Indicate Authentic Becoming or Growth into Wholeness

Carl Rogers, an American psychologist, has listed four criterion of wholeness. 1) openness to reality 2) trust in one's organism 3) an internal locus of evaluation and 4) a willingness to be a process.

A person who is open to reality is able to relate realistically to himself and to the reality outside of himself. This quality is the openness "to what exists at this moment in one's self and in the situation."

Trust in one's organism basically means thatan individual comes to know that his organism, unique as it is, is a suitable organ for encountering the world.

The third principle effects a strengthening of one's personality. Such a person radiates a wholesome attitude of self acceptance. Choices and decisions become more personal and more permeated with a sense of accountability and responsibility. A person who realizes, believes that the "locus of evaluation lies within himself" will not be easily swayed by popular opinion.

Roger's fourth principle, that of "willingness to be a process" is opposed to the product mentality. The product mentality is characterized by fixed and absolute goals. While it is true that in the process of becoming an authentic self we do have goals, we do not become fixated on achievement.

Life and growing into wholeness is a task of integrating, growing and achieving. The task-like nature spoken of by Luijpen remains. From birth to death the self is always emerging. We are always-on-the-way.

"Man dies before he is fully born."

II. On-the-Way: Surrendering to the NOW

Bill Atkinson is an example of a person who is really on-the-way. The art of surrendering to the NOW eludes many of us.

Our very nature strives for self realization. Under favorable conditions our energies are directed to realizing our potential.

Under stress, suffering or sickness, we may be alienated from our real selves.

Neurotic persons find it impossible to accept themselves: therefore he is unable to realize or utilize his ability or potential.

To become as fully as possible one's self (defined here as originality) demands a certain amount of maturity. If what I really am, what I "think" I am, what I want to be and what I ought to be exist in a fairly close relationship. I have a good start. A neurotic or a psychotic person (a schizophrenic) lives in a world of unreality. The tines of the self-concept are a great distance apart.

Facticity (all the elements of my past life over which I had no control) influences my life, but it doesnot determine it. Through my development I gradually become aware that the "world" reveals me to myself. Just as others are present in my experience, so too, I am present in theirs. The principle of co-constitution is a being-through-others.

We depend on others for the fulfillment of our basic needs: security, love, belongingness, respect etc. We live however, in a pre-reflective way--mostly unconscious of the need that we have or each other.

Ordinarily the interaction between man andhis world is not consciously entered into. Yet, we do have th ability to be responsive. It is this characteristic of "responsiveness" that distinguishes me from the lower levels of creation.

Responsiveness is a threefold movement:
1) self-presence
2) self-expression
3) self-affirmation

Another small passage from Mauriac's autobiography demonstrates this quality of responsiveness.

> "Everything went well for me on two rosters, eternity and time. I had just published The Viper's Tangle which had been praised to the skies. The dome of the Institut began to emerge from the mist beneath my prudent gaze. And then one day in 1932. . .
>
> Suddenly, I lost my voice. . . and was sent to Combloux for treatment. What followed I shall not tell, although that clap of thunder in a sky serene as mine had been made a break in my life and created another sky and another earth." (Mauriac, op. cit.)

Self-presence = I become present to what I am experiencing. It is as it were "owning" my feelings... joy, satisfaction, anxiety, a sense of accomplishment...

Self-expression = I am able to tell someone how I feel. Perhaps I only commit my feelings to paper. I may tell a friend or share with a loved one. In the example from Mauriac the self-expression comes in the form of an exerpt from his autobiography.

Self-affirmation = This is a kind of saying "yes" to what I have been aware of and what I have expressed.

When I begin to understand myself, my view of the other is broadened also.

B. Some Basic Psychological Principles that May be Applied to the Healing Ministries (Cf. Maher, S.J.)

1. Every individual exists in a continually changing world of experience of which heis the centre.
2. The individual reacts as an organized whole to the phenomenal field of experience.

   Note: The term "field" in psychology refers to an area of reality here and now perceived or experienced by the person.
3. The indivudual has one basic tendency and striving - to actualize, maintain and enhance the experiencing organism or the self.
4. Behaviour is basically the goal-directed attempt of the individual to satisfy its needs as experienced, in the field as perceived.
5. The best vantage point for understanding the behavior of another is from theinternal frame of reference of the individual himself.

C. Faith as Integrating

From the principles above we see that being-through-others is exemplified. Sickness, however can help me to realize that there are some elements of dis-integration in all levels of my being--elements which no person can totally eliminate or integrate.

This realization can motivate me to seek thehelp of Someone other than a human.

Paul Tillich says:
"The integrating power of faith...is dependent on...the degree to which the person is open for the power of faith and how strong and passionate is his ultimate concern."

With Jesus' help there is no limit in my way of becoming.

Thomas Merton insists that Christianity has the potential to enhance and transform even the mystery of suffering.

Suffering (sickness, tension) accepted in faith involves the rhythm of losing and finding ourselves in Christ. Merton says that nothing so easily becomes unholy as suffer ng.

Merton says that suffering puts the question to us, "who are you?" He says when this happens we must be able to say our name. By this Merton means that we must be able to express the very depths of what we are.

Pain very often, or rather rur responre to it, is a good indicator of the level of our wholeness. Yes, realities are often found in contradiction to one another!

In your work as healers then, I conclude with the words of Jurgen Moltman: You are called to help others realize their wholeness as far as it is possible.

In a world of commerce
where the soul becomes lonely,
faith must address itself
to the inner existence of man
and provide reaning and direction
for personal life.
It must create for the inside
What is missing on the outside:
warmth, security,
receptivity, transcendence.

(from Lift Up Your Heart,
F.J. Sheen, p. 103)

Sister Mary Germaine Hustedde, PHJC

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REACH

REDEMPTORIST ACCADEMY OF COMMUNICATION & HOMILETICS
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"COMMUNICATING WITH THE SICK."

TOWARDS A TOTAL HEALING MINISTRY

" PATIENTS ARE PEOPLE "

Duplicate

We can sometimes classify paitents as diseases or diseased parts of the anatomy. We can be efficient in cleaning wounds, making beds, injecting arms and giving enemas ...where we prod, pull, turn over, cauterize diseased parts of bodies. But the feelings of the patient... feelings of fear, anxiety shame, helplessness, frustration, anger, self pity, despair, hurt, grief can all too easily be overlooked when there are a whole big number of temperatures to be taken, pulses to be felt and blood pressures to be taken. Nurses too are people and have their own feelings. You are not machines. Yourrelationships with your Communities, successes and failures can put into moods of sadness, frustration and so on.

So you have people dealing with people. Does this mean that you go round reflecting back feelings, empathising, consoling and comforting the whole time? Blood tests have to be taken, wounds have to be dressed, stitches have to be removed, temperatures have to be taken. All this is required plus T.L.C. (tender loving care). Sometimes it is expressed with a smile, a compassionate glance, a gentle touch, a word of understanding, a fluffing up of pillow, a little prayer...that communicates respect, understanding, concern for the patient.

All of us live under stress: There are different types of stress:

Frustration, Conflict, Pressure.

We cannot always obtain the goals we want in life. It may be because of prejudice, inflation, lack of opportunities, physical handicaps, lack of needed cmpetencies and so on. For some people frustrations can cause a lot of stress.

We also face a lot of conflicts in life. A man wants to get married for sexual, social and security reasons and yet he fears the responsibilities of married life and loss of personal freedom. Or it may be he cannot decide between present satisfactions and future ones and this is very stressful. Or he feels caught between the devil and the deep blue sea...hemmed in whichever way he turns. Conflicts cause stress. Stress may also arise from pressure to achieve particular goals or to behave in particular way

Many of us learn to live with stress, to adjust, to cope with the situation, to release tension in acceptable ways. If I have built up personal resources and have situational resources that will help me cope, adjust, live with the stressful situation, then I may be O.K. Again, on a biological level, if I have a healthy constitution, a good diet, available medical aids, I may be able to deal effectively (resist and destroy) invading viruses. So good stress tolerance (frustration tolerance) may help me not to be incapacitated biologically and psychologically.

In this seminar, we know that sickness is of the whole person... not just of the lungs or of the psche. We have been hearing of psychosomatic disorders. Emotional factors can lowet the resistence of a tuberculosis patient and thus contribute to the onset of the disease

Will a patient cooperate with treatment or welcome death as a solution to his problems? Will he fight the disease with a determination to get well?

Flanders Dunbar, a pioneer in the field of psychosomatic medicine (1943) concluded that "It is often more important to know what kind of patient has the disease than what kind of disease the patient has."

Peptic ulcers, tension headaches, high blood pressures are usually brought

2/-

on in large part by sustained emotional tension.

I do not want to repeat what I am sure Doctor has already covered in classifying various psychophysiological disorders (caused and maintained primarily by psychological and emotional factors rather than organic ones) e.g. skin, respiratory, gastrointestinal etc.

Graham (1962) found the following attitudes and coping patterns to be fairly typical.

Ulcers: feels deprived of what is due to him. Wants to get what is owed or promised and to get even.

Migraine.... feels something has to be achieved, drives self to reach a goal and then feels let down.

Asthma... feels unloved, rejected, left out in the cold, and wants to shut the person or situation out

Eczema... feels he is being frustrated, but is helpless to do anything about it except take it out on himself.

Hypertension.... feels endangered, threatened with harm, has to be ready for anything, to be on guard.

However his findings are not definitive. I am merely stating this to show how emotional factors can play a large part in causing stress that affects the patient adversely.

So we have this worried, anxious patient brought to a hospital or a Nursing home for treatment. He goes through admission, examinations, tests of various sorts, his temperature and pulse are taken regularly, he is given injections and invalid food. People with solemn faces look at him. Relatives of other patients peer curiously into the room and shake their heads sadly. There is a smell of antiseptics pervading the room and everything cries out "Hospital." Instead of an atmosphere of relaxation, it is often an atmosphere of fear, anxiety, pain. If he is taken to the Cornorary care unit or theIntensive care unit, there is the heavy silence, the whispers, the aweseome array of dials and machines to monitor his heart beats etc. The drips and tubes and wheel chairs and white starched uniforms are like the Navy on parade. This is what it looks to someone from outside the medical world. I think that it only serves very often to increase the fear, the tension, the helplessness, the frustration, to increase the anxiety and the threat to the patient. Two other features that can cause irritation are (1) the round by the barra sahib. You are yanked into upright position, your bed clothes are straightened, your file produced, you wait for the sound of his footstepsas the Doctor-in charge enters with his entourage. A few questions perhaps, a little whispering between the Doctors, a new set of pills and the inspection is over. (2) The other irritating thing is when you become a specimen to be studied by a group of medical students who crowd round your bed while Doctor spells it all out for them in big terms that sound frightening. They are inspired and awed and you are frightened and anxious and irritated.

Coleman and Hammen (1974) tell us of some "built in" psychological coping and damage-repair mechanisms which operate in all of us. They appear to opearate automatically and to be part of our coping resources. Be aware of them.

Crying it out

This is a common means of alleviating emotional tension and hurt. We see it in children who have been frustrated or hurt. When you loose a loved one you cry to gain emotional equilibrium. Woman cry. Men may curse or swear but are generally not allowed to cry (cultural training). How do you react tp people crying it out? Can a man be allowed to cry alone if he is embarassed with out it being noticed?

Taking it out

When you undergo a traumatic experience you have the need to repetitively tell others about it. This is one way of allevating tension, desensitizing yourself to the point where the traumatic experience can now be accepted as something that occured in the past and is integrated into the self-structures. Are there people to talk to and to listen? (Retired sisters/ Legion)

Laughing it off

Some view setbacks and hurts with a sense of humour and try to joke about them and laugh them off. It helps to alleviate emotional tension and also helps the individual see the experience in a broader perspective.

Seeking support

A child clings to her mother in times of stress to get protection and support. Critically ill patients need affection and companionship. Even in less critical situations, patients turn to others for emotional support until they can gain their own equilibrium.

Dreaming and Nightmares

People who have undergone traumatic experiences often report repetitive dreams or nightmares in which they relive the traumatic experience. As in the case of repetitive talking, this pattern appears to desensitize the individual to the traumatid experience so that he can accept it as something in the past and integrate it into his self-structure without undue disruption. (Seen more in people babies..Accept. Help those who can to talk). These built in reaction apatterns may be used in varying degrees and combinations depending on the individual, the social setting and the nature of the traumatic event which resulted in the psychological hurt or damage.

RELAXATION TRAINING: Shivasana, Controlled breathing as tension release, (Inspiration 1-6. Hold 1-6 Expiration 1-6 Hold 1-6) shoulder and neck massage, relaxing eye-balls, tongue, jaw, breathing in Lord incrase my faith, breathing out...Praise to thee O God. Jesus prayer take away the focus from my fears, my problems, self-pity, anxiety and put the focus on the Lord.(the storm at sea, Peter's focus of Jesus and onthe waves)

Comapre this with the over use and habit forming tranquilizers, pain killers, sleeping tablets so often used. Forgiving onself "The Father is very fond of me" I do not have to earn his Love. It is a gift, (Irish priest meets old man. Walk together. Shelter from rain, old man takes out book and reads aloud, Priest: you must be very close to God. Old man: Yes the Father ... of me).

I do not need to go more into the healing of memories and prayer of healing. So much mentioned already. John Powell's "He touched me" story of the neurotic woman he had been counselling.

A nurse then is more than just a serving woman who knows how to dress wounds and give injections. She has to be a therapeutic person who is entrusted with a healing ministry.

Nurses aids. Marian Helpers (L.S.P.) Counsellors, Chaplains etc. etc.

Lay ministers of the Eucharistic in Methodist Hospital, Brooklyn, Couples and disturbed children. Ministers in the church/Listening/Feelings.

Biofeedback training: In May, I was with a friend in L.A. who suffered from migrain headaches. He used to go for biofeedback training. Suppose you are learning to play tennis, the tennis coach gives you feedback that can help you correct your behaviour accordingly. There are new biofeedback devices that can monitor automatic functions like heart rate andbrain waves and convert the information into signals like lights or sounds that the individual can readily perceive. As more sophisticated biofeedback devices and procedures are develeped, it may become possible for the individual to control many automatic functions...heart rate, blood pressure, stomach acid secretions; -- -

He sees threatening things on the screen e.g. flowers, trees, fields of grass, dust which threaten an attack of asthma are flashed on a screen. As the patient reacts, light and sound signals speed up, when he was relaxed, he only heard slow, lethargic clicks, Over a series of session, the patient learns to keep the patient coming at a slow rate by keeping the tension down. It gives the patient more control over the situations and reduces the number and severity of the attacks. Since faulty utonomic responses can be learned they can also be unlearned.. through feedback, reinforcement and such learning principles. Can we be creative enough to help people discover the causes of tension-listen to themselves and deal with this even if we do not have biofeedback derives. Recalling situation and circumstances of each attack. Is ther a pattern? Sam derive used in healing m of memories.

Aurvedic medicines? Herbo-nature cures-Overspecialisation? G.P. & Mid wife in the village clinic (Barefoot Doctors) Treatment in the home or local area.

Half way houses/systems theory-Cure a person and put him back into a sick environment-Treat the person and enviornment (Conjoint family counselling)

Sociocultural : Alleviation of severe stress in the individual's life situation. Social workers on the team. N.F.B Programmes, non-formal education, supplementary incomes, better sanitation.

Hospital social workers meet the family of the Patient, look at situation and circumstances causing tension-suggest methods of reducing or alleviating it specially in chronic cases, suicide attempts etc.

Therapists are people also

Doctors and Nurses are people also. Like their patients they also have feelings, moods, fears, likes and dislikes, prejudices, shortcomings, abilities and talents.

Doctors, and Nurses are called to be helpful people and heal ing people but they must realize that they cannot help and heal everyone and always, There are so many factors beyond their control. Does the patient want to remain sick or get well ? Have they got the required drugs, medication facilities? Even if they are creative and can improvise and substitute for what they lack, they still may be helpless and hopelessness in such cases? They are not omnipotent. They cannot practise bilocation. They only do have two hands and need to sleep sometimes. So can they say to themselves:" I tried my best in the circumstance." Or do they feel irritational guilt and keep blaming themselves, thereby missing the present moment to give of their best.

I am reminded of a story I saw on Televsion,A girl is going up an escalator. There is a candle on the railing next to each step. She is supposed to light as many candles as she can. As she is ascending, she lights one candle after other. Now she misses a candle. She is worried and in trying to light the candle she passed already, she misses the candle that is the same level as her. Then she becomes greedy and starts light-ing the candles that are above her level. But in doing so, she again misses the candles on her own level. She finally realises that she would concentrate always on the candle that is immediately level with her, without panicing about the future or worrying about past. In that way she scores best. People who are always worrying about past mistakes are living still in the world of yesterday while the world of today passes them by, so also ..ththings that will never happen. A certain amount of planning and foresight is good but the present moment is when we should be fully alive. We learn that we are falliable and liable to make mistakes.

--5/-

Some Nurses and Doctors are like Martyres. They kill themselves because they cannot say No, sorry, I am too exhausted to help. Sure there are crises when special efforts are required. But when this happens all the while and one cannot get adequate rest, leisure, time to read and update oneself, then one has to ask why? Man is not a mchine. Even machines crack up if not serviced regularly. Can a Doctor or Nurse accept the fact they are human like everyone else and they can only serve a certain number of people and nomore? When they are sick, troubled, worried with their own domestic problems, then they are also taking that to work with them. May be they need a day or week off or some time to reflect and be healed themselves.

Physicians heals thyself first.

Many of your are living in religious communities. Your communities-life and relationships in the community will affect the way that you function.

A Doctor who had domestic problems needed marriage counselling in order to continue practising effectively. A certain young Doctor was himself taking drugs and needed help before he could continue practising Surgery A priest who absolve people needs absolution himself from time to time.

Doctors and Nurses do not need to have all the answers or to pose as if they do. They can say: Let me see, I have to take some tests. Or I, have to ahve a consultation. They have to listen carefully to the patient's past history and not rush in where angels fear to tread.

The Doctor and the Patient are both people in an inter personal relationship. The initial contact is important. The smile, the respect, the concern of the Doctor or Nurse for the patient helps establish the beginings of a healingbond. I know of a certain sister who every morning in her meditation would prepare herself for her patients. She would ask Jesus to help her bring joy, comfort and peace to His sick brothers and sisters she would meet that day. She knew the names andailments of each patient in her ward and she prayed to the Lord about these people, asking Him to let her be an instrument of His peace to them that day. So you can well imagine how she went to her day's work with anticipation and motivation to heal.

As the relationship between the Therapist and the Patient widens, Transference takes place. Transference can be of feelings of affection or dependence on to the Therapist, perhaps perceiving him as a loving helpful Father, A negative transference is when the patient projects his feelings of aggression or hostility. Sometimes the transference can change from symptoms and yet feel fearful and resentful for having told "ALL" or for having expsoed his perceived weakness. Or when he does not receive the reassurance or advice he expects, his positive transference may change to negative feelings.

The Doctor or Nurse must understand and make allowances for this, remembering that the defensive behaviour seen in repeated criticisms, unrealistic expectations, aggressiveness, resistance and irritability is a way of testing the Therapist's sincerity by the patient. He may gradually drop this defensiveness and change his perception of himself and with others. Ways of dealing with this are

Simple acceptance: You are feeling angry and helpless.

Clarifying questions-regarding the form of anxiety the patient seems to be manifesting. You seem to be restless. Why do you suppose this is happening?

Reflecting back the Feeling: You are feeling uncomfortable?

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I accept you, the person with these feelings, is what the Therapist tries to put across to the patient.

There is also such a thing as counter transference.

We can classify them into four types of anxiety patterns that the Doctor or Nurse experiences.

a) Unresolved personal problems of the Therapist
b) Situational Pressures
c) Being overly sympathetic (Empathic)
d) Wants to be liked at all costs.

Unresolved personal problems of the Doctor or Nurse:

I must not let my own pet hangups interfere with my diagnosis and treatment of the patient. If I am prejudiced against a certain type of person I must be aware of letting that come in the way I relate to this unique patient.

Situational Pressures:

A Therapist may feel responsible to see that the patient improves. Or he may feel that his professional reputation is at stake if he fails with this patient. His anxious feelings can be transmitted to the patient, who in turn feels anxious and frustrated that he is not coming upto Doctor's expectations.

Being overly sympathetic: A certain emotional detachment is necessary to be objective and really help the patient. Otherwise I can be so moved subjectively that I cannot function effectively.

Fear of displeasing the patient:
Though a relationship is built on respect and cordiality, the therapist must risk the patient's admiration by firmly yet gently insisting upon what is considered necessary.

Yes indeed Doctors and Nurses are people also. So self awareness and self acceptance are important. In clinical pastoral experience, medical personnel and hospital chaplains undergoing the course are required to keep along in which they write verbatim reports of their interviews with their patients. This helps them to take a look at themselves through analyzing the way they responded or acted.

For example: Why did I become so emotionally involved with the patient who felt so unloved and unlovable? Could it be that I too still feel unloved and unlovable?

Why did I make this particular response to this Patient's remark? What was behind it?

What was I reacting to when making this remark?

Why did I ask that question? Was it related to helping the Patient?

Was I merely curious? Was I really being judgemental by asking the question? Why did I feel impelled at this point to give advice?

Was it because I felt that the patient expected me to have allthe answers? And did I respond by being all wise?

Am I using the patient for my needs or am I letting him use me? Do I give assurance because of my own needs for assurance?

e.g. I feel so tense I feel like throttling her to death.

It is alright to feel that way. After all thinking of killing is not the same as murder. (Would arouse more anxiety inclient)

Sometimes feelings do seem hard to control and we feel an urge to let them go at times. Perhaps you would like to mention some experience what makes you feel this way? (Recognize the feeling & deals with the problems) What kind of people make you very defensive? Which are beyond your level of competence? e.g. Hostile, aggressive women, irritate me, I refer them to someone etc. I try to resolve my own feelings with a counsellor.

Galieleo said: "You cannot teach a man anything. You can only help him to find it in himself."

The Doctor is a teacher who is himself a humanbeing, fallible and subject to human weakness. He also has to struggle to make adjustments to life. There are some who are emotionally more mature and others less mature. Many hide anxiety and insecurity. Some have little patience and retort with childish behaviours when confronted with it.

A doctor voluntarily choose a life of dedication, yet how many can live upto it, day after day?

Yet people expect Doctors to be super human, magicians, wonder workers. They find it hard to believe that he has the same anxieties and conflicts the same alternating hopes and depressions as other men. They do not think about the dilema the Doctor can be in when confronted by the need of his patients and the needs of his own family.

Yet a Doctor has to serve his fellow human beings. He has to be dedicated. He cannot afford to indulge in impatience or intolerance. He cannot make moral judgements on his patients' behaviours. He is there to help and to heal.

The doctor or nurse may learn medicine from Books but the practice of medicine, they learn from patie nts.

The doctor needs to combine the findings of science with heal-ing. Both elements are imprtant. He has to teach his patint how to be well. Most patients talk about "My Doctor" not just a Doctor. There is the element of relationship, trust in which the patint's dignity, self respect and self esteem are maintained.

When you learn to love and accept yourself, it is easier to love and accept each patient also.

Fr. Peter D'Souza
C.Ss.R.

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R E A C H

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4/1/79

"COMMUNICATING WITH THE SICK"

21st-28th Nov.1978

A Second Training Course

TOWARDS A TOTAL HEALING MINISTRY

IN PURSUIT OF WHOLENESS

Duplicate

I. Exploring Wholeness

A. Our Life - Self-gift from the Father

B. Theories of Being

1. Man as conscious-being-in-the-world

(William Luijpen - a philosophical anthropological approach)

2. Man as body-ego-spirit self

(Adrian van Kaam - an existential approach)

C. Reflecting upon man through literature and life

1. Concretizing the self-theories through literature

2. Concretizing the self-theories through the experience of sickness

D. Characteristic trends which seem to facilitate authentic becoming of growing into wholeness. (Carl Rogers)

1. Openness to reality

2. Trust in one's organism

3. An internal locus of evaluation

4. Willingness to be a process

Duplicate

* * * * * *

II. On-the-way: Surrendering to the NOW

A. Originality - "being and becoming as fully as possible one's self."

1. Factors involved:

a) facticity - all the elements of my past life over which I have had no control.

b) co-constitutionality - "being-through-others"

c) responsiveness: a three fold movement

1) self-presence

2) self expression

3) self affirmation

B. Some Basic Psychological Principles Applied to the Work of the Healing Ministries (Trafford Maher, S.J.)

C. Faith as Integrating

1. Christ the One who totally integrates

2. Building up the Kingdom through Suffering

Sister Mary Germaine Hustedde,

R E A C H

REDEMPT[illegible] & HOMILETICS

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"COMMUNICATING WITH THE SICK AND COMMUNICATING WHOLENESS"

17th – 26th Jan

~~20th – 29~~th NOVEMBER 1977

COMMUNICATION SKILLS

I. Therapeutic

II. Non-Therapeutic

I. Therapeutic Technique of Interpersonal Relationship:

		Examples
1. Using silence	:	– –
2. Accepting	:	Yes, Ah, Mum I followed what you say Nodding
3. Giving recognition	:	Wishing (Good morning Mrs.S.) You have combed your hair You have made a kerchief.
4. Offering self	:	I will sit with you a while, I will help you with this work, I am interested in your comfort.
5. Giving broad opening (especially useful for hesitant and uncertain patients)	:	Is there something you like to talk about? What are you thinking about? Where would you like to begin?
6. Offering general leads	:	Go on And then? Tell me about it.
7. Placing the events in time or in sequence	:	What seemed to lead up to? Was this before or after? When did this happen?
8. Making observations	:	You appear tense. Are you uncomfortable. When you----? I notice you are twisting your hair. It makes me uncomfortable when you----?
9. Encouraging description of perceptions	:	Tell me when you feel anxious. What is happening? What does the voice seems to be saying?
10. Encouraging comparison	:	Was this something like? Have you had similar experience?
11. Restating	:	Patient: I can't sleep, I stay awake all night. Nurse: You have difficulty in sleeping?
12. Reflecting	:	Patient: Do you think I should tell the Dr.?
13. Focussing	:	This point seems worth looking at more closely.

	Technique		Example
14.	Explaining	:	Tell me more about it. Would you describe it more fully? What kind of work?
15.	Giving information	:	My name is .... Visiting hours are .... My purpose of being here is ....
16.	Seeking clarification	:	I am not sure that I follow. What is the main point of what you said?
17.	Presenting reality	:	I see no one else in the room. That sound was a car back firing. Your mother is not here I am a nurse.
18.	Voicing doubt	:	Isn't that unusual? Really? That is hard to believe.
19.	Seeking consensual validation	:	Tell me if my understanding of it agrees with yours. Are you using <u>this word</u> to convey the idea?
20.	Verbalising the implied	:	<u>Patient</u>: I can't talk to you or to any one It is a waste of time. <u>Nurse</u>: Is it your feeling that no one understands?
21.	Encourage evaluation	:	What are your feelings in regard to ...? Does this contribute to your discomfort?
22.	Attempting to translate into feelings	:	<u>Patient</u>: I am dead. <u>Nurse</u>: Are you suggesting that you feel lifeless? Or Is it that life seems without meaning?
23.	Suggesting collaboration	:	Perhaps both of us can discuss and discover what produces your anxiety.
24.	Summarising	:	Have I got this straight? You have said that........? During the past hour we both have discussed.....
25.	Encouraging formulation of Plan of Action	:	What could you do to let your anger out harmlessly? Next time this comes up, What might you do to handle it?

II. <u>Non-Therapeutic Techniques of Interpersonal Relationship</u>:

	Technique		Example
1.	Reassuring	:	I would not worry about....... Every thing will be alright. You are coming along fine.
2.	Giving approval	:	That is good. I am glad that you........
3.	Rejecting	:	Let us not discuss......... I don't want to hear about.......
4.	Disapproving	:	That is bad I had rather you would not.....
5.	Agreeing	:	That is right I agree.
6.	Disagreeing	:	That is wrong. I definitely disagree with. I don't believe that.
7.	Advising	:	I think you should Why don't ...?

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... Probing	:	Now tell me about......... Tell me your life history.
9. Challenging	:	But how can you be the Prime Minister? If you are dead, why is your heart beating?
10. Testing	:	What day is this? Do you know what kind of hospital this is?
11. Defending	:	This hospital has a fine reputation. No one would lie to you.
12. Requesting an explanation	:	Why do you think that? Why do you feel that way? Why did you do that?
13. Indicating the existance of an external source	:	What makes you say that? Who told you that you are Jesus? What made you to do that?
14. Belittling feelings expressed	:	<u>Patient</u>: I have nothing to live for... I wish I was dead. Nurse : Every one gets down the dump or I have felt that way sometimes.
15. Making stereotyped comments	:	Nice weather we are having. It is for your own good. Keep your chin up. Just listen to your doctor and take part in activities. You will be home in no time.
16. Giving literal response	:	<u>Patient</u>: I am an Easter Egg? <u>Nurse</u> : What shade? or You don't look like one.
17. Using denial	:	<u>Patient</u>: I am nothing. <u>Nurse</u> : Of course you are something Everybody is something <u>Patient</u>: I am dead. <u>Nurse</u> : Don't be silly.
18. Interpreting	:	What you really mean is .... Unconsciously you are saying ....
19. Introducing unrelated topics	:	<u>Patient</u>: I would like to die. <u>Nurse</u> : Did you have visitors yesterday?

Reference: Hays and Larson, <u>Interacting with Patients</u> (1964)
Macmillon Co., New York, Page 7-37.

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"COMMUNICATING WITH THE SICK"

TOWARDS A TOTAL HEALING MINISTRY

Facial Expression & Body Language

The Science of Facial Expression is the diagnosis of the New Science of Healing. It is only those who have thoroughly mastered the principles of the latter, who will be able to fully understand the new method of diagnosis. I would therefore advise everyone intending to make a study of the Science of Facial Expression, to first ask himself whether he is perfectly acquainted with the doctrines of New Science of Healing and whether he has really grasped the principles on which it is based.

1. There is only one cause of disease, although the disease may manifest itself in various different forms and in different degrees of severity. The particular part of the body in which the disease chances to make its appearance, and the external form in which it expresses itself, depended upon hereditary influences, age, vocation, abode, food, climate etc.

2. Disease arises through the presence of foreign matter in the body. Such matter is first deposited in the neighbourhood of the orifices of the abdomen, whence it is distributed to the most various parts of the body, especially to the neck and head. This morbid matter changes the shape of the body, and from this change the severity of the disease can be observed. Upon this fact the Science of Facial Expression is based. To deny that foreign matter accumulates in this manner, is to dispute the truth of the Science of Facial Expression. But the fact that the state of the body can really be ascertained from changes in the form, is scarcely to be seriously contested; and this, indeed, is the soundest proof of the correctness of my whole theory of disease.

3. There is no disease without fever and no fever without disease. The entrance of foreign matter into the body and the formation of deposits there, marks the commencement of the struggle between the organism and the morbid matter; and it is through this internal activity or friction, that fever is produced. Everyone knows from experience, how the smallest particle of an external foreign substance entering the body - e.g. a little splinter in the finger - immediately causes discomfort in the whole system. A kind of fever is set up and does not abate until the foreign substance is removed. In a similar manner, the foreign matter in the interior of the body causes fever. At first the fever is often but slight and runs its course internally (chronic fever); should sudden changes take place in the body, however, or violent fermentation of the foreign matter, caused by change in the weather, mental excitement, etc., the fever may break out with great violence. It is always erroneous to speak of any disease as being unaccompanied by fever.

After this short epitome of the principles of the New Science of Healing, I will proceed to the question, "What is the Science of Facial Expression?"

It is the scienceof diagnosing from the external appearance, the internal condition of the body. From what has been already said, it will be seen that what we have to do is neither more nor less than

1. To observe how far the body is encumbered with foreign matter and in which parts the latter is deposited.

2. To draw conclusions as to the symptoms resulting and to those which must result in the future.

It is, not, however, the task of the Science of Facial Expression to minutely describe every little external or internal bodily change and to determine the various forms of disease, furnishing each with a special name after the manner of so-called medical science. On the contrary, the object in view, is to examine the state of the system as a whole, in order to detect whether the organism is healthy or diseased; and in the latter event, to determine how far the disease has progressed or has still to progress, and what chance of recovery there is.

And it is precisely in the possibility it presents to us of ascertaining the condition of the entire body, andof deciding whether we have a severe case before us, or whether the patient can be cured with but little trouble, that the high value of the Science of Facial Expression lies.

In order that we may be in a position to clearly judge of its worth, let us first submit the diagnostic methods of other systems of healing to a short criticism.

METHODS OF DIAGNOSIS

Allopathy, the medical system recognised by the State, and the one still generally dominating, sets a high value on a minute diagnosis. For this purpose a thorough study is made of anatomy, principally by dissecting dead bodies i.e. corpses. The allopath must know the name of every particle of the body, be thoroughly acquainted with the precise position of every organ, and also understand how to judge the internal organs from their operation. He therefore percusses, palpates and ausculates the body, and from his observations deduces the state of the organs.

A detailed medical examination thus consists of a number of separate observations, only incidentally connected. He feels his pulse, percusses and ausculates chest and back, to determine the condition of lungs and heart. Next the region of the liver and stomach is palpated and the genitals examined. This general examination may be followed by a more detailed inspection of individual organs, such as the eye and ear, though this is usually referred to specialists. And what is the doctor's final pronouncement? The patient is told that this or that organ is perfectly healthy, another slightly affected a third perhaps in a still worse condition. Any opinion as to the state or disposition of the body as a whole, as to the autopathic vitality, is rarely given. Or should, as an exception, such an opinion be expressed, it will be less the result of the examination, than of the general impression produced upon the physician by the outward appearance of the patient, and perhaps also by remarks made by the latter himself. For the physician, like everyone else, e.g. nurses, who is much occupied with the sick, in the course of years acquires a certain sharpness of subjective perception.

FACE IS THE INDEX OF THE MIND

The appellation "Science of Facial Expression" only designates one feature of the new method of diagnosis. This is usually the case when one attempts to find a concise expression or title to characterize something, and had I chosen some Latin or Greek word, nobody would ever have remarked it. The Science of Facial Expression concerns itself with the whole organism. But as the face is the part most readily examined, and since here not only all mental, but also internal physical processes are, as it were, reflected, it is the facial expression that must before all be observed. Hence the name given to the new method of diagnosis.

As already remarked, there is no such thing as disease affecting solely one particular part of the body. In every case of illness, the entire system suffers. The whole body changes in form and colour, but this alteration is only sufficiently pronounced for clear observation at certain places. The deportment also becomes another, but this change is not noticed until the alteration is very marked. A body which is encumbered also performs its functions in a different

manner from a healthy body, and hence the state of health can likewise be determined from the bodily activity. The Science of Facial Expression takes all these facts into account: the form of the body, the carriage, the colour, the movements, all these are carefully noted. In order, however, that we may be able to clearly recognize deviations, we must first study the healthy man.

The Healthy Man

It is no easy matter to depict a healthy human being, for perfect health is rarely to be found to-day. Amongst wild animals, health is the rule and disease the exception, and it is therefore easy to discover the normal form; with civilized man, however, it is just the reverse. It was only by degrees that I succeeded in drawing a picture of a normal human body. I first of all inferred from the bodily functions what the state of real health must be. For a healthy body must perform all its functions - and properly perform them - without trouble, without pain and without artificial stimulants. Firstly come those functions which are necessary for maintaining life, such as the absorption of food and the explusion of refuse material. The healthy man experiences a feeling of real hunger, which is fully satisfied by the consumption of natural foods. The feeling of satisfaction occurs before there is any uncomfortable sensation of fulness, and the process of digestion goes on so quietly that one is not conscious of it. All discomfort after eating, the desire for highly seasoned foods and strong beverages is un-natural and indicates disease. To quench the thirst, the only desire should be for water.

The urine, the secretion of the kidneys should cause no pain on leaving body, nor be of an unduly high temperature; it should possess an amber colour, and never be colourless, bloody, black, cloudy nor flocculent. Neither should there be any gritty or sandy deposit. The odour should neither be sweetish nor sour.

The faeces of a healthy person are of cylindrical form, firm but not hard. They leave the body without soiling it. As a rule they should be brown in colour, not green, gray nor white. They should never be watery, nor bloody, nor contain worms. Thin evacuations are always a sign of disease, just as are hard, spherical blackish dejections.

The skin in health should should not emit an unpleasant smelling exhalation, as, for instance, does the skin of carnivorous animals, and particularly that of carrion feeders. The skin should be moist, but not wet; it should have a warm feeling and a beautiful smooth, elastic surface. The hairy parts should be well-covered with beautiful, full hair; baldness is an indication of a diseased body.

The lungs in a healthy organism perform their functions without any difficulty. The air should be inhaled through the nose, which is their natural guardian. The custom of keeping the mouth open, whether during the day or in sleep, is a proof of disease.

In any exertion, the healthy body always gives due warning, by a feeling of fatigue, of approaching excess. This sense of weariness is by no means a painful one, it is even pleasant, causing us to rest and finally sleep. The sleep of a person in health is soft, quiet and un-interrupted. On waking such a person is cheerful, bright and contented; neither languid nor irritable.

Should a healthy person experience deep mental suffering, he will recuperate quickly. Not in vain, has Nature given us tears, the true alleviator of mental anguish.

All these indications can readily be observed with the senses, most of them being obvious to the eye, without the use of any artificial apparatus.

The observations have all been made on living persons and can be confirmed at any time. To make a corpse the subject of observation is of no real purpose.

Anyone proving to the possession of perfect health by fulfilment of the above conditions, must necessarily exhibit a correct bodily form; his body must be free from all foreign matter.

The Normal Figure

I. Form. The normal form is one of fine proportion throughout.

In the normal figure the head is of moderate size; the neck is round and neither too short nor yet too long. No prominences are to be noticed on it and in circumference it is about equal to that of the calf of the leg. The chest is arched, the abdomen is not prominent, nor is the trunk prolonged downwardly. The legs are strongly built and bowed neither inwardly nor outwardly.

The following characteristics of a normally healthy person have also to be remarked. The forehead must be free from wrinkles, smooth and display no adipose cushion. The eyes must be clear and free from veins. The nose is in the centre of the face, is straight in form and neither too full, nor yet too thin. The mouth is always closed, both during the day and when asleep; the lips are a beautifully formed covering and must not be too thick. The face itself is oval, not angular, and there is a clear line of demarcation exactly below the ear. It is this sharp division that gives symmetry and grace to the human visage. Most people remark instinctively the beauty of such a face, but are unable to clearly explain wherein the handsomeness consists.

The chin must be rounded, by no means angular. The back of the head should be divided from the neck by a clear line.

II. Colour. The colour of the face should be neither pale nor yellow nor yet unduly red. Above all it should not present a shiny appearance. The natural complexion of a European is a pale pink. The face should be fresh and animated until old age.

III. Mobility. In judging the condition of the body, the mobility is also of importance. If any natural movement is arrested, it is a sign that the body is not normal and that foreign matter has accumulated in it, exerting an inhibitory action. The movements of the head especially, are of particular significance in diagnosing according to the Science of Facial Expression. There should always be the capability of turning the head freely left and right. There must be no tension at the throat when the head is raised; nor any tension at the nape of the neck when it is lowered.

It is, therefore, according to the form, colour and mobility that we judge the physical condition.

If the form or colour of the body is no longer normal, or if the mobility is arrested, it is a proof that the body is encumbered with foreign matter. This encumbrance must be caused by matter, for it is only such that alters the bodily shape. The question now arises; how does this matter - which does not belong to the body, and must therefore be designated foreign matter - enter into the human system? It can only find entrance into the body in the same way that any other matter whatsoever is admitted.

Matter enters the body through the stomach, the lungs and the skin. Through the lungs and skin we inspire air, through the mouth the body takes in solid and liquid nutriment and condusts it to the stomach. So long as we follow nature, foreign matter cannot obtain access to the body; or if it accidentally does, it will soon be again expelled, for nature has provided precautionary means for removal of any injurious substances.

Intestines, kidneys, skin and lungs in a healthy body are continually at work, removing from the system everything that is of no service, or no longer of service to it. If, however, too much foreign matter is

introduced into the body, the system is unable to deal with it and part of the matter remains in the body.

Most persons are encumbered with foreign matter even in the prenatal state, often to such an extent that they are sickly from birth. A large percentage of such children die in youth.

Theforeign matter accumulates at first at the exists of the body, and may be expelled for a certain length of time by means of small crises, such as diarrhoea, profuse perspiration and copious discharges of urine. In this manner, indeed, even large deposits of morbid matter are sometimes excreted. Nevertheless there is generally some residue left, or new matter is deposited. Intense heat arises at the parts where the deposits are, this being the direct cause of the diarrhoea and also the reason of a certain transformation of the foreign matter. Fermentation ensues, and geses are generated. These latter are carried through the body and are partly excreted by the skin, but partly also deposited again in solid form. It is these deposits that form the encumbrance of the body. The encumbrance may be of various kinds, depending upon the direction which the deposits have taken.

If stomach and bowels are once weakened and permeated with foreign matter, then even natural, wholesome food can no longer be properly digested. All such in-sufficiently assimilated material, however, likewise becomes foreign matter. If once morbid matter commences to accummulate in this manner, the process proceeds rapidly, and disturbances of the system, as above mentioned, usually occur repeatedly. This is the explanation of the numerous diseases of children, the sole purpose of which is to expel foreign matter from the body.

Sometimes the body itself forms artificial outlets for the effete matter, such as open sores, haemorrhoids, fistulae, sweating feet etc, In such cases the rest of the body may appear to be healthy, since the encumbrance does not inconvenience. These outlets, however, only form when the body is already considerably encumbered; for they are, so to say, self-operations performed by the system itself, and this only happens when there is an active exciting cause.

WHAT CHANGES ARE CAUSED BY THE PRESENCE OF FOREIGN MATTER IN THE BODY?

As already mentioned the foreign matter seeks out suitable places to deposit itself. Such deposition of matter starts in the abdomen, in the neighbourhood of the exits. As soon, however, as the process has even commenced, the morbid matter begins to make its way to more distant parts, such as the head and limbs. In the absence of any special circumstance, this distributive process goes on very slowly. The matter usually shows a tendency to travel to the extremity of the body and in doing so must make its way through the narrow passage formed by the neck, where the deposits are most easily to be seen. They appear first as an enlargement of the part, then taking the form a swellings or lumps. Later on they wholly conceal the underlying organs and there is desiccation and shrivelling of the parts. As unskilled observer can here be easily deceived and think that there is no encumberance. Examination, however, will always show hard streaks causing the neck especially to appear irregular. In particular, the movement of the head in such a case will be abnormal. The colour will also be unnatural, being usually grey or brown or unduly red.

Frequently even the general form is sufficient to enable us to judge with tolerable exactitude as to the nature of the encumbrance. In other cases, however, every point must be carefully observed before the disease can be clearly pictured.

The swelling form in the neck and head in the same manner as in the abdomen, and increase in both parts uniformly. Sometimes, however, the abdominal deposits decrease, whilst those at the neck increase, the water treatment, on the other hand, causes the cervical deposits to decrease, those at the abdomen increasing correspondingly.

The path which the foreign matter follows in passing from the abdomen to the head is by no means always the same. It is probably dependent upon the vitality of the various organs which have to be passed, and also partly upon the position in which the person usually lies when sleeping. Thus the foreign matter may predominate in front of the body, or at one side, or at the back. We accordingly have three kinds of encumbrances:

1. Front Encumbrance,
2. Side Encumbrance and
3. Back Encumbrance.

The side encumbrance can, of course, be either at the right or left side.

Generally speaking, we do not find one kind of encumbrance alone, there being usually a complication of such. For instance, there may be front and side, or side and back, or sometimes general encumbrance of the whole body.

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C O M M U N I C A T I O N W I T H T H E S I C K

TOWARDS A TOTAL HEALING MINISTRY

HEALING THE WHOLE PERSON.

COMMUNITY HEALTH CELL
47/1,(First Floor)St. Marks Road
BANGALORE - 560 001

A. Activating event

Someone unfairly and harshly criticizes me and professes dislike for me.

B. Belief System

I must be loved and approved by everybody or I lose all sense of my own worth.

C. equentEmotions - Self pity, Depression, Sadness

D. Dispute the distorted, irrational misconception in the belief system.

I don't have to please everyone, to be loved and approved in order to retain a sense of personal worth. My critic has the proble,, not I.

E. Event or experience is transformed by reinterpretation and re-evaluation, which makes possible the elimination of the misconception.

Different emotional reaction, Continued self-confidence, personal peace and compassion for the critic.

A. Activating event of failure (School, work, plan not carried out)

B. Belief that failure indicates something is wrong with me. My personal value is undermined and permanently damaged by failure.

C. Consequent sadness, depression, discouragement.

D. Dispute of misconception. I reevaluate and emphatically deny that failure in an expose of personal worthlessness. Failure does not diminish my person. The only real mistake is the one from which we learn nothing. My efforts may have resulted in failure. But I am not a failure. Everyone fails. The successful person is one who profits from failure.

E. Event of failure has been reevaluated and transformed into a profitable experience and time of growth. Because of the change d interpretation of the event, the emotional reaction is likewise changed from a "This is the end" depression to a "Wait till next time" eagerness and enthusiasm."

Treatment for Neurosis

10 principles of full human living. J. Powell "Fully human,fully alive"

Write or describle to a friend-confident somewhat lengthy answers to the questions. The "Why" at the end asks you to explain your answers in terms of your belief system.

1. Principle: Be yourself. Don't wear a msk or play a role

Question: In what circumstances do you find it most difficult to be honest and open about what youthink and feel? WHY?

2. Principle: Experience fully and express freely your true emotions

Question: With which emotions are you most uncomfortable? Which emotions do you feel free to express? Why?

3. Princple: Do not let fear of hurting another's feelings interfere

3. Principle: Do not let fear of hurting another's feelings interfere with your decisions or prevent you from doing or saying what you think you should.

Question: Are there special persons or types of persons or special circumstances or situations in which this fear of hurting another's feelings is criplling and painful to you? WHY?

4. Principle: Assert yourself. You have a right to be respected to think your own thoughts and make your own choices. You should be listened to and taken seriously, Insist on this right.

Question. When and with whom do you find it hardest to be assertive?

To demand respect for your person and your rights ? WHY?

5. Principle: Do not bend yourself out of shape trying to please everyone all the time

Question - Do you feel compelled to please all people or at least certain spe cial people all the time? In certain circumstancey? WHY?

6. Principle: Do not attempt to make yourself look better by attacking cutting down or gossiping about others.

Question: Do you feel threatened by the succes of others? Of those with whom you work? Of the same or opposite sex? Do you feel compelled to point out their limitations? Why?

7. Principle: Look for what is good in others, enjoy and praise others for their good qualities and deeds.

Questions: Do you tend to be more aware of other's irritating and obnoxious qualities or their good and pleasing qualities? Is it true of any particulare individual or group, that you tend to fix upon their limitatiqns, failures? WHY?

8. Principle: Think of yourself in positive terms. Become aware of all that is good in you.

Questions: Are you uncomfortable in describing your achievements? In admitting the things you really like about yourself? Within yourself? When talking to others? WHY?

9. Principle: Be gentle and understanding with yourself, as you would like to be with others.

Question: What weakness in yourself most exasperates you? WHY?

10. Principle: Do not judge another's accountability and subjective guilt. Forgive wherever necessary. Bearing a grudge is self-destructive.

Questions: Is there something that people do that you cannot forgive? WHY? Is there someone you cannot forgive ? WHY?

~~What are the causes of Alchoholism~~

Physiological Many Alchoholics seem to have nutritional deficiencies. This gives rise to a craving for alchohol. What they need is vitamin therapy and a good diet. But there is no unanimity in the views about whether people inherit metabolic patterns that result in this nutritional deficiency or not

Psychological a) High level of anxiety in interpersonal relationships b) emotional immaturity 3) Ambivalnce towards authority, 4) Low frustration tolerance 5) grandiosity 6) low slef esteem, 7) feelings of isolation, 8) perfectionism 9) guilt, 10) compulsiveness, There are present in enlarged proportions in the active lchoholic. Persists a diminished form even after they become sober.

X Successful vision therapy is based on repetition. Just as we repeatedly thought the distorted thoughts until they become habitual distortions in your vision, so must we now think the right thoughts, the rational and realistic thoughts, until they become new attitudes replacing the old distortions.

Go back to your five basic misconceptions (NumberII) and write out the positive, rational thoughts that would be an appropriate corrective for each misconceptions. Try to verbalize these corrective thoughts into a motto or resolution which you can repeat internally on those occasions when the old delusions would have crippled you and destroyed your peace. e.g "I am a good person whether everyone approves of me or not."

John Powell "in fully human, fully alive" page 128 ff

enumerates the list of specific distortions or misconceptions that he has found to be at the root of most neurotic sufferings.

1) I have received so much that I have no right to have any faults.
2) I have only myself to blame.
3) I cannot be angry at anyone but myself.
4) My physical dimensions are the measure of my viility or feminity.
5) Nobody could really love me.
6) I don't deserve to be happy.
7) Loving yourself or admitting your talents is egoistical and conceited.
8) What really matters is ME! I am a special person.
9) Self forgiveness is self indulgence
10) I am a born loser
11) Laughing at yourself is stupid and self-demeaning.
12) I have to bury forever many of my memories, they would make me too angry or too sad.
13) If I begin reflecting on my past, it will be a Pandora's box, it is better to leave well enough alone.
14) If I ever begin to release my emotions, I know I will lose control
15) Keep your mouth shut and you won't get into trouble.
16) People make me mad or afraid.
17) Stupidity makes me angry
18) Hurting the feelings of others should always be avoided
19) My thoughts and feelings would really shock you.
20) Keeping the peace is the most important thing in a relationship
21) You can't really say what really you think or feel
22) You can't really trust anyone
23) My parents were ideal in every way
24) I know that if people get to know the real me they will not like me.
25) I must play a role in order to be accepted by others
26) I have to be the centre of attention or I don't enjoy myself.
27) Because I play roles in front of people to impress them, I am phoney and therefore no good at all
28) My parents are to blame for me.
29) Marriage is only a piece of paper.
30) Love does not last.
31. Do your thing Baby! you are the only one who counts
32) You can always tell a hypocrite.
33) You have to give in.. to compromise yourself...in order to get along with others.
34) If someone comes to me with a problem, I must do more than just listen and discuss the problem.
35) Love is all sweetness and light, when a person has found love, it

Record in writing (a journal?) the strongest negative emotion which you you have experienced recently Describe the activating even and your consequent emotions.

1. studey your verbalization of the even. e.g the electric current fails You can either say :"This is an inconveninee but I'm sure it will all work out." Or you can say:Oh my God! What on earth can I do. My day is ruined. Study the words you choose to describe the event and your emotional reactions.

2. Ask yourself what there is in your vision of reality that resulted in your precise emotional reaction. Is there a distortion of misconception in your vision that threw the whole event out of focus?

++11++ Try this experience with a friend-confidante. Both of you write what you would guess are your own five basic misconceptions.e.g. I have to be approved and loved by everyone in order to retain a sense of personal worth." Then both write what you would guess are the five basic misconceptions of the other person. Finally, share and discuss what you have written.

Note: Do note proceed with this experiment if therr is the attitude: I've been waiting a long time to lay this on you." Review and revise the distortion under that hostility before attempting this exercise. Such guessing and sharing have to be acts of love or they are counter-productive.

iii Take an area of current negative emotions, especially of anger and fear.e.g I get furious while driving if someone cuts in ahead of me." or "when people disagree with me on an important issue, I get very upset and stay very upset for a long time."

Ask yourself about your inner vision. What is in you, makes this situation so disturbing? E.g.I see all other drivers as my competitors. If someone cuts in on me, is superior. Or " I think I am a special person I do not consider that he may be on his way to hospital with a sick paitent."

"When people disagree with me, I always suspect they do not like me. If they liked me, they wouldn't disagree with me."

IV 10 Principles (p.t.o.)

V Write a verbal portrait of your illusory self, the public image or person you would like others to see, believe in, be impressed by, but which is not the real you.

Why does this person appeal to you?

VI Evaluate yourself on these five common personality problems by listening them in the order in which you most painfully experience them.

OVERSENSITIVITY...RECENTFULNESS ....SUSPECIOUSNESS...BEING OVERLY CRITICAL.

Then take the first two and try to describe in terms of your basic vision, why you are most troubled by these two problems.

VII What is your basic mind-set or question is approaching life, the persons and events of life? Describe it precisely. e.g. What do I have to fear? Explain it in terms of your basic vision.

N.B. Do this either in your journal or with a friend confidante

VIII Do you tend to live (think, daydream) more in the past, present, future? WHY? (Do this in journal or with friend confidante)

IX Describe the person you would like to be. If you were asked why you haven't become this person, how would you answer? What is your vision or belief system that keeps you from realizing this idea?

is tne endof all struggle and suffering.

36) What willthe neighbours say? We have to look good.
37) Perfect love is the only kind of love.
38) I do not need others
39) I know what is best for you.
40) Love is doing whatever the beloved wants
41) If you want something done, you have to do it yourself.
42) I know your whole trouble
43) I'll get even if its the last thing to do
44) You can't praise others too much. It will go to their heads.
45) Love isblind
46) I have to please others to satisfy their expectations of me
47) No commitment can be for life
48) This is the way I am and always will be
49) I just can't decide
50) It's no use trying
51) I just don't have the will power; I can't
52) It's easier just to give in
53) Where there's a will there's a way. You can do anything you really want to
54) I have to prove myself
55) Life is one damn thing after another
56) A true ideal should always be just out of reach
57) I must win them all. I have to be the best
58) Life is easier if you don't stop to think about it
59) Good people do not suffer. Virtue always triumphs in the end
60) Those were the good old days
61) You only live once. Grab all you can for yourself
62) We are for time, not time for us. We must keep moving and producing to justify our existence
63) You cannot set your sights too high
64) Whateer you do you should do it perfectly
65) Never give up
66) A thing is either black or white. To make distinctions is always confusing.
67) Beauty is in the eyes of the beholder
68) The world owes me a living
69) I can't waste time taking a walk, reading a book or puttering in a garden
70) Every problem is solvable
71. The world belongs to the young. Oh. to be young again'
72) Failure is failure and all failure is final
73) I'm too old to start now
74) Who needs God?
75) Prayer is for the weak.

WE CAN CHANGE OURLIVES ARE TO A GREAT EXTEND IN OUR OWN HANDS. WE ARE NOT PRISONERS OF THE PAST BUT PIONERS OF AN EXCITING FUTURE. WE CAN, TO A GREAT EXTENT, ACCEPT PERSONAL RESPONSIBILITY FOR OUR DESTINY.

Fr. Peter de Sousa C.Ss.R

S. Gerosa

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R E A C H

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21st - 28th Nov. 1978.

"C O M M U N I C A T I N G   W I T H   T H E   S I C K"

TOWARDS A TOTAL HEALING MINISTRY

Counselling skills in Hospital Visitation.

Caring Your attitude of loving regard for the Patient whether expressed by unconditional warmth or challenging the Patient to be fully who he is.

Ego strengthening Helping the Patient to develop his own thinking, feeling, and perceptive ability so that he can cope with life more effectively.

Encountering Providing the experience of active encounter in which both Therapist and Patient express their real feelings.

Feeling Helping the patient experience in a phychologically safe relationship feelings which he has hitherto found too threatening to experience freely.

Interpersonal Analyzing How can you analyze the Patient's perceptions or manipulations of your relationship with him and therefore of the Patients other interpersonal relationships in life.

Pattern Analysis Analyzing unworkable patterns of functioning and helping the patient develop adaptive patterns of functioning.

Reinforcing How do you reward behavious that is growth enhancing as well as socially adaptive and punish behavious that is negative or self defeating.

Self disclosing Are you aware of and in some cases able to talk about your own adaptive and defensive patterns of living which can encourage the patient to do the same thing.

Value Reinforcing Can you help the Patient look at his assumptions about himself and others and his world and re-evaluate them?

Re-Experiencing Can you help a patient recall and re-experience the past and help him in disensitizing the sick effects of those past learnings on his present functionings?

These are some 10 ways that different people use? Which is your style of functioning? What need you to learn or grow in?

Fr. P. deSousa C.Ss.R.

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"COMMUNICATING WITH THE SICK"

TOWARDS A TOTAL HEALING MINISTRY

The Nurse & Human Relations

Mrs.Mammaen, Nursing suptd of the T.B. Hospital in Delhi writes that one of the functions of any Hospital is to care for the sick and restore them to health. Patients look for courreous, considerate and gentle care, for security, for cleanliness and for personal understanding. The Patient's welfare and interest must be of paramount consideration, since hospitals, Nurses and Doctors are there for that purpose.

Patients are dissatisfied for various reasons.

1) The changed environment Large Institution. Mercy of strangers. Something unpleasant done to them.

2) Discomfort, irritation and anxiety due to their illness
3) Certain rules and regulations required of them and theirrelatives. They may be ignorant about customs and the geography of the place (lavatories)
4) Noise of stretchers and trolleys. Hospital staff going up and down. Patients being woken up for medicines. Sharing wards with convalascent and chronic Patients and acutely ill people. Lack of privacy.
5) Food served may not be to their taste
6) Frequent treatment and medicines. May not like to be disturbed.
7) Lack of proper care
8) Lack of confidence in the hospital Staff
9) Undesirable attitude of hospital Staff
10) Most Adults value their Independence and hate to be dependent on others
11) Family Problems..children, earning member, look after home
12) Nurses too busy and too overworked to meet the total needs of the Patient.

Mrs.Prem Mishra

The average patient is frightened and insecure about hospitalization. Relatives become anxious about his welfare and financial loss. Certain amount of anxiety to his recovery. The bed side nurse can allay his fears and help to satisfy his need helping him to rest and relax.

She should give him safe and effective physical care
Asses patient's needs, keeping the priority needs in mind
Make individual nursing care plan for each patient
provide emotional support during painful procedures by giving explanation and stay on with him
Interpreting the line of treatment to the patient and his relatives to alley fears and anxiety of the unknown
Developing confidence of patients and relatives in the doctor and the hospital treatment
observing, reporting and recording Patient's physical and mental state.
Imparting health education to patients and relatives to prevent disease and to promote health in the community.
Listening to patients and relatives to asses their needs
Assisting in bringing about best interpersonal relations in the team members
Informing the patient about hospital and community resources for some special problems during the hospitalization or rehabilitation.
The nurse is a link between the patient and members of the medical team. But she needs the support and backing of the medical team as well.

Mrs Malhotra says: "The Nurse is not primarily to serve the Docter"- She is indeed a bridge between the hospital and the Community, the patient and the Doctor, But she is the most priveliged member of the team, having the most direct and close relationship with the Patient and members of his family who visit him. She can help them adjust to hospital conditions, understand the cause and treatment of his illness

and achieve sufficient knowledge of health practices to return home and remain well, or improve conditions.
She should know the medical and social service facilities available in the Community and help the patient plan for the future. Recognise and accept the Patient as his and on his own level.
Are too many nurses forced to spend too much time in non nursing duties like keeping Registers, making out admission and discharge slips, Lab requisitions, writing Doctor's orders, counting linen and counting drugs? How can she find time for nursing care?

With over crowding, poor working conditions and poor hospital design, there may be lack of adequate facilities, supply and equipment, Nurses aids, Sweepers and ayahs.

Communication with and Treatment of Class IV employees

In some cases Patients speak well about the Doctors and Nurses but is is the Nurses aide or Orderly who may cause anger and discontent. Sometimes there is fear of these people going on strike and of the Union. Their wages, hours of work, other benefits are things that management has to go into. So also the training and professional pride everyone should have, no matter whether it is to do with serving meals or washing corridors.
May be the problem lies with the fact that few people give these employees any respect when speaking to them. How many say Please and thank you and express admiration, appreciation and gratitude. When Patients are discharged all the fuss is made of the Doctor or Nurse. But who is grateful to the sweeper, pharmacist, cook, laundryman, clerk, X-Ray technician?

Many of these are behind the scenes jobs or lower, somellier, dirtier, hard manual labour type of jobs that are paid less than other jobs, as compared to other countries where their corresponding slary is higher-

Dr.Sahni spoke about Japan and the planning review that takes place between people of all levels. He also mentioned the sense of Mission in a hospital where shift workers gathered together for a half hour prayer and meditation and singing to start their day together to heal God's people.

Is there any practical thing you can do to motivate others to work better?
How can you get cooperation from others, specially Nurses aides?

All this cooperation can change the environment of the Hospital and help you to create an atmosphere of healing in which you nurse back people to health.

S. Gruosa

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"COMMUNICATING WITH THE SICK AND COMMUNICATING WHOLENESS"
~~20th - 29th November 1977~~ 17th - 26th Jan 79

WHATSOEVER YOU DO ....

Yellappa has come in for abdominal surgery. He is 72 years old. Lives in Begur village. Farmer. Someone did magic on them. He thinks a spell was cast. Doctor is going to take out all my inside tubes as I cant eat and digest food. Frightened. Anxious. Helpless. Angry.

Mathew aged 10 years old had an accident. Both legs are broken. Multiple fractures. He has been he e 6 weeks and will be here another 6 weeks perhaps. He cries when he receives treatment. Bored. Restless. Scared. Frustrated.

Teresa aged 46 years has just had a total hysterectomy. She is worried about the secondary effects of having her Ovaries removed. She was depressed and crying when she did not want to cry.

Fr.Thamburaj is in for a rectum prolapsis. He has had several operations in the past. He had 5 enemas this morning alone. He is fed up. He has several lecture in Theology to prepare. Next time he is not coming to hospital.

C.C.U. Margaret, heavy woman, 50 years old. Heart attack. Cheerful sort. Her worried husband sits nearby. She must not talk. He does not want to talk. You come in.

Sam, Air Force pilot. Slipped and fractured 3 ribs. Needs help to move in bed. He is laid up when he wants to be on the move.

Sr.Loretta is dying of cancer. She is offering her sufferings for the conversion of Russia. She is in terrible pain. Everyone whispers and people come to venerate her.

Justin is 19 years old. He got burned and is worried about his looks. He is embarrassed with all the treatment he receives. His friends come in and try to cheer him up.

Mr.Mascarenhas is 84. Old school Catholic. Cranky, tough, stubborn and holy. He asks the Sister in a sari where her husband is? He is incontinent and has to be changed like a baby every little while. Clings on to his Rosary and crucifix.

Daisy aged 5 has a hair lip. She is in for an operation. She hides her face from you. She is stiff and rigid and all alone. Should you go away?

Jose 28 tried to commit suicide. He is pale, thin, edgy. His wife ran away and he has lost his job. He stares into space. Does not notice you.

Miriam just lost her twins. She is 36 years old. They were her firstborn and were 6½ months premature. She says: "God does not love me".

Lester 46 looks pale and anemic. He had an E.C.G. but they must have been false pains. He has pains in his kidney now. In the last 2 years he has been in and out of hospital for many tests and complaints.

- Fr.Peter de Sousa,CSSR

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REACH

"COMMUNICATING WITH THE SICK AND COMMUNICATING WHOLENESS"

~~20th-29th-November 1977~~ 17th 26th 79

PASTORAL CARE AND COUNSELING IN GRIEF AND SEPARATION

by Wayne E. Oates

	PATIENT REACTION	FAMILY REACTION	MEDICAL INTERVENTION	PASTORAL INTERVENTION
1.	Denial. Disbelief. Isolation. The decision to share or not to share his/her feelings.	Shifting roles. Quest for a support community. Need for "stress-breaks." Decisions whether or not to communicate such facts as are known. How to "break the wall of silence."	Physician's certainty of diagnosis. Need for consultation. Sustaining interest in a dying patient; combating boredom. Establishing an open relationship with family and patient. Helplessness. "Busyness."	Awareness of the patient shock and need for denial. Debriefing after diagnosis. Encouragement of medical consultation. Reenforcement of health maintenance presumptions.
2.	Anger. Finding adequate targets for anger. God is most adequate. Catharsis.	Sharing of anger as injustice, without taking too personally or patronizingly the anger of the loved one directed at them.	Absorbing anger directed at him/her and carefully protecting the patient's needless running from the doctor to doctor by suggesting consultations.	Creation of an "OK" feeling about anger, especially toward God.
3.	Bargaining. Review of past infidelities to man and God. Reversion to the image of self as a "luckt" or "unlucky" person.	Review of past conflicts in the light of the new situation. Renewal of marriage vows, for example. Repentance for overwork and neglect.	Could money buy better treatment? Could it all be psychological? Should a psychiatrist be called in?	Rededications to God. Vows to enter religious work. Vows to attend church more. Let's live each day at a time.
4.	Despair. Depression. Mourning at the loss of parts of body, changes in appearance, disability. Despair over excessive costs of care. Loss of job.	Avoidance of cheerleader role. Frank weeping with the weeping patient. Assurance of loving steadfastness. Avoidance of suspicion of marital unfaithfulness.	Possible use of medication to control anxiety and/or depression.	Encouraging the expression of sorrow. Avoiding overreassurance. Sitting with the person in silence. Touch. Prayer.
5.	Acceptance. Extending the amount of sleep- exactly the reverse of decreasing it as with a child. "A final rest before a long journey." "I have fought all I can."	Restricting visits only to persons intimately known by or asked for by the patient. Being with the patient & keeping alert for leave-taking messages, verbal & nonverbal. Elimination of all family infighting.	Being sure that the patient is not forgotten. Being alone with the patient at eventide. Close consultation with the family about the use of artificial means to extend life.	Regular visiting according to previous patterns. Listening for confession good & bad. Listening for last requests, funeral wishes, estate planning. "Nothing can separate us."

A helper is a "therapeutic person", a "healer", one in relationship with whom a person derives a heightened sense of his own worth, competence and overall well-being.

Characteristics of a good professional therapist are:

1. Trustworthiness: He is of good will and one can depend on him to keep his word.

2. Openness: He communicates his feelings and reactions fully to the other person.

3. Respect for differences: He shows the courage to recognize his differences in opinion and attitude from those of the other person.

4. "Letting be": He shows willingness to permit the other person to be himself.

5. Empathy: He has the ability and willingness to see the world from the other person's point of view.

6. Not afraid to like: He permits himself to experience and express positive feeling for the other person.

..... page 3

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32.10

7. Positive regard: He displays honest acceptance of the other person in all his differences.

8. Tact: He has enough sensitivity to avoid threatening the other person.

9. Permissiveness: He avoids judging or evaluating the conduct or experience of the other person.

10. Faith in man's potential: He is profoundly committed to the belief that people can change and grow.

a) Therapists listen: Providing a receptive, permissive, empathic and understanding audience. Listening not merely with the head but with the heart as well xx in an effort to enter into the patient's world and feel with them.

b) Therapists reflect and interpret: Reflection means restating the "FEELINGS" that were implicit or explicit in the patient's last remark ... describing a feeling back "Is like a paper caught in the wind, blowing this way and that without control - Is the kind of feeling you have?

INTERPRETING a remark or a series of episodes to find patterns, connections similarities that will foster increased insight in the patient (WARNING - not to be done by untrained or unqualified persons).

C) Therapists reward healthy behaviour: Praise, encouragement, expressing delight, showing agreement to reinforce such behaviour may also be shown in not showing displeasure where the patient may have expected it for being honest and so is reinforced in being frank and honest because of Therapist's acceptance.

d) Therapists directly or symbolically satisfy many of the patient's needs: The Therapist attempts to discern what the patient needs in order to feel secure, trusted, accepted and in some way through the counselling relationship, indirectly provide for these needs. However such transference should only be temporary.

e) The therapist respects his patient for his uniqueness and individuality. Does not pressure the patient, nor does the therapist put conditions on his attention, affection and interest in what the patient is saying.

f) The Therapist does not USE the Patient's traits as a means for reaching personal or private ends. He strives to act in ways that will provide growth.

g) The therapist encourages and permits free emotional expression: The patient is encouraged to vent fully all his feelings about all of the significant persons in his life, including the Therapist. The Therapist accepts the expression of feelings and tries to help the patient to see why such feelings were repressed earlier and not acknowledged.

h) The Therapist tries to understand the Patient and to promote self-understanding in the patient: Helping the patient to understand how he came to be as he now is and to know and "accept" how he now is.

i) Therapists inspire faith and hope in patients: The Therapist inspires confidence and trust and offers hope that the patient can ultimately transcend his difficulties and get on with more effective living. It inspires the hopeless to keep on trying and not to give up. It helps the worried to relax and allow themselves to be healed.

(Notes taken from CURRENT CONCEPT OF POSITIVE MENTAL HEALTH by Marie Jahoda.)

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R E A C H

REDEMPTORIST ACADEMY OF
COMMUNICATION & HOMILETICS
PHONE : 578631

MT ST ALPHONSUS, RICHARDS TOWN,
BANGALORE 560 005

"COMMUNICATING WITH THE SICK AND COMMUNICATING WHOLENESS"

17th ~~20th-29th November 1978~~ 26th 1979 January

THE PSYCHOLOGICAL REACTION TO SICKNESS

INTRODUCTION

1. Definition of Disease, Homeostasis
Levels of Homeostasis. Miller's 5 levels cell, organ, individual, community and cosmic Inter-relationship of these levels.

Human Personality - Body, mind & spirit

a) Body resistance and thresholds of tolerance to discomfort, pain and malfunctioning - inherited, acquired through training or nature of the illness.

b) Mind - level of mental health. Tolerance to stress. Attitudes, Motives, Meaning of life.

c) Spiritual : Relationship with God
Concept of death
Life after death

Dynamic Reaction of all factors.

2. Illness as a Stress

The degree of disruption of life due to illness depends on

a) the individual
b) the situation in what the illness occurs, &
c) the nature of the illness.

The individual : (1) Perception of the illness - how he/she evaluates it - especially in relation to his ability to cope with it.

a) The severity of the illness - physical
psychological
b) His tolerance to stress-previous physical & mental health, his adjustment to life situation. Previous illnesses.

External supports: Lack of support - especially emotional support, make the illness more severe and also lowers the individual's resistance.

Adjustment to the illness depends on:-

1) Severity & duration of the illness
(acute > < chronic illness)

2) Multiplicity of demands
A number of stresses at the same time
e.g. Heart attack loses his job distressing news).

3) Unfamiliarity Invalidism
hospital surroundings

4) Anticipatory fear - death etc.
Understand the illness
Knowing how long it will last and its effects and residual effects, preparing for eventualities, will help to adjust to it and lessen its effects.
Illness may be a crisis to a person's life.

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3. Reaction to Sickness

Personal sickness / sickness of others

a) Reaction is individual - no two people react the same.
b) Normal /abnormal reaction

What is normal. Wide variation/range

(1) Common Reactions

a) Acceptance - Hope and confidence in being cured
b) Neglect - not to worry, minimising the danger
c) Anxiety - Many factors - Death / disability
Invalidism - burden to the family
Economic and financial loss
Disruption of work, activity and plans
Effects on others' plans and work.

4. Escape through illness - Perpetuates /prolongs illness.

a) Escape / withdrawal from unpleasant life situation - "I am sick, so I cannot do this." Honourable escape - relief by being wounded.

b) Attention seeking - comfort, love, respect.

c) Regression to childhood - need for mother, instinctual needs.

d) Punishing others, "getting one's own back by being sick."

e) Self-punishment - atonement for guilt.

f) Malingering - conscious simulation of illness from ulterior motives.

5. Illness is a sign - (Projection & Rationalisation)

a) Of God's displeasure
b) Of evil forces - jadoo, witchcraft, spells.

6. Other Reactions:

a) Denial of illness - non acceptance
rejection

"This cannot happen to me. I have never had this before."

b) Anger & Rebellion - Why should it happen to me?
Why should I suffer. What evil have I done? Where is justice? God is injust."

c) Depression - Hopelessness. Loss of will to live.
Desire to die - requost for euthanasia.

d) Gain - compensation neurosis.

e) Spiritual reaction. "God wants me to bear the cross."

Complications : Physical complications - cerebral hypoxia
avitainosis
hypoprotienaemia
cerebral amines
Loss of will to live - suicide
Superstitous practice - Satan's hold.

7. Reaction to Treatment

a) Fear of treatment, operation, results.

b) Rejection - I know better (than the doctor etc).

c) Over dependance - invalidism.

d) Disproportionate demands, attention, time (insecurity)

e) Drug dependance and habit-formation.

Psychosomatic & Somatopsychic Reactions - Body - Mind - Relationship

a) Perpetuation of illness through psychological factors - "secondary gain," "target organs," "body language," e.g. asthma, hypertension, dyspepsia, ulcers, etc.

b) Effects of ill health on the mind-

i) on personality esp. in childhood, dependance, overprotection.

ii) chronic malnutrition

iii) chronic ill health

Illness may be a crisis in a person's life
Out attitudes towards the Patient
Care and concern - compassion
Respect - for his feelings
as an individual - right to know the truth.
for his rights - to privacy
as a child of God
No condemnation or rejection
No over optimism/over pessimism
No lies - till the truth. If necessary prepare for death - set things in order material and spiritual.
Bring Christ to the ill person
Be a channel of God's love.

- Surg Commodore T.D'Netto,
I.N.

....

SGurssa

32.13

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REDEMPTORIST ACADEMY OF COMMUNICATION & HOMILETICS
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"COMMUNICATING WITH THE SICK"

An Intensive Pastoral Care Seminar

TOWARDS A TOTAL HEALING MINISTRY

CELEBRATING THE HOLY EUCHARIST AND WHOLENESS.

1. No man is an island, - a well known song -
"No man stands alone.... We need one another, so I will defend. Each man is my brother, each man is my friend"
We need other persons, the world to attatin wholeness
At the Holy Eucharist, we meet as a community of persons, who need one another, who will need healing in order to attain wholeness.

We are still broken, we are not yet a community, when we celebrate the Holy Eucharist, we stand, as it were, on our toes, we arise above what we really are. Thus we draw heaven towards the earth. The Eucharist is a pre-figuration (an incarnate reality!) and a guarantee of the world to come. Since we are pilgrims towards that community of wholeness, in which everyone can fully be his/her precious self in his/her relationships with others, the liturgy, especially the Eucharist, "is the summit towards which the activity of the Church is directed, and at the same time the fountain from which all her power flows" (Const.on the liturgy, No.10.)

2. We can probably say that Jesus Christ was instituting the Eucharist all his life. He was very fond of meals and picnics. Why? Because then the heavnly communion became most palpably visible and within the realm of human experience. There brokenness was reduced to a minimum, and healing raised to an earthly maximum. The climax of all Jesus' community sayings and celebrations was the Last Supper, which cannot be understood independent of Jesus' crucifixion. What he did sacramentally at the last supper, giving himself, breaking himself for the life and wholeness of the community, He did literally on the Cross, pouring out his blood, spending his life for the wholeness of the community of mankind.

How to make this an experience for all participants?

3. The great responsibility of the celebrants, the responsibility of all the participants, who co-operates, external participation, expression of the internal participation.

4. Growing towards wholeness through the penitential rite, by the review of life in the light of the readings, leading to a resolution that refers as concretely as possible to one's professional milieu.

5. God's Word and wholeness - a real listening to the Good News, will often involve or rather presuppose preparation.

6. The Offering: one further step towards wholeness. Taking part in the preparation of the altar for the Eucharist (Offortory procession) is only relevent and authentic, when it signifies our preparation for surrendering ourselves with Christ to the Father for the healing and liberation of mankind. This surrender should be as concrete as possible and every time new and fresh in the light of the (New) Word that was proclaimed. Then every Eucharistic celebration becomes an always deeper realisation of our Christian (religious) commitment: "Father into your hands I commend my spirit!" Preparing the altar for the Eucharist is preparing myself for putting myself through and with Christ in the hands of the Father on the altar of the world, it implies and signifies that we become more faithful and sensitive to God in our daily work.

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7. Thanksgiving (Eucharist) leads to greater wholeness. During the Eucharistic prayer we complete our response to God's Word by offering ourselves and our lives "with Christ to the eternal Father in the Holy Spirit" (Directory for Masses with Children, No52). With Christ we thank the Father for all he did and is doing for us now, in our history, in our lives. Our joining in the great thanksgiving Prayer of the church is only meaningful and fruitful and an on-going contribution to our wholeness, if we live out our thanksgiving in our daily life, if we acquire and constantly deeper a thanksgiving spirituality. This implies:
   i) the acknowledgement that all that we have and we are is God's gift.
   ii) God has given us our gifts and abilities to use them for the purpose he has given them: the fulfilment of his plan. The best thanksgiving to use them well.
   iii) The thanksgiving spirituality makes a content and joyful and challenge us to put an end to unfair competition and career making at the cost of others that tears the world and many Christian communities apart.

8. Living the meal character of the Eucharist means working for the wholeness of every person, communi ty and all communities. The Eucahrist as a thanksgiving memorial and sacrificial family meal is not only sign and expression of the unity and love in God's family, but it should also constantly strengthen and foster that unity. The meal character expresses that we are quite conscious of the fact we are still have to become a true family, even though w we agree to sit at the same table. Every mass is , therefore, a "walking on our toes." and we know how tiring this is in the long run. Yet the longer we are able to do so by living throughout the day as brothers and sisters, the more we live as Christ wants us to live, prefiguring the future, eternal communion by sharing already in the community life of God himself, Father, Son and Holy Spirit.

Conclusion: The Holy Eucharist is a celebration of life, if our life is a celebration of the Eucharist, a eucharistic life. Only then it is the summit of the Christian's striving for wholeness and the fountain from which all his/her power to work towards that wholeness flows.

Gerwin van Leeuwen o.f.m

For further reading: Gerwin van Leeuwen o.f.m., "Liturgy as Catechesis," in Vidyajyoti, May 1977, 205-219

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THE SACRAMENT OF RECONCILIATION

Entrance Hymn

Opening Prayer: O God,/ most merciful Father,/ we have come to confess our sinfulness before you,/ before the whole court of heaven,/ and before one another. You remember that we are dust/ and you know our weakness./ Have mercy on us, O Lord,/ for we do not know how we stand before you,/ whether guilty or innocent,/ in the security of your jealous love./ We humbly bow before you and say:/ Spare your people, Lord./ Purify our dedication to your service./ Remove the barriers that divide us,/ the shortcomings that spring from our human weakness./ Teach us to forgive/ and to bear with others/ as you forgive and bear with us./ Let our hearts of stone/ become hearts of flesh/ sothat there may be no obstacle/to our love for you/ and for one another.

First Reading: Daniel 9:4-17 (Pause for reflection)

Response: (Daniel 9:17-19): And now, our God,/ listen to the prayer and pleading of your servant./ For your own sake, O Lord,/ let your face smile again/ on your desolate sanctuary./ Listen, my God/ listen to us./ Open your eyes/ and look on our plight/ and on the city that bears your name./ We are not relying on our own good works/ but on your great mercy,/ to commend our humble plea to you/. Listen, Lord;/ Lord, forgive!/ Hear, Lord, and act!/ For your own sake, my God,/ do not delay,/ because they bear your name,/ this is your city,/ this is your people.

Second Reading: Mathew 9:2-8 (Pause for reflection)

Response: O Lord Jesus Christ,/ you forgave the sins of the paralytic/ because of his great faith in you./ Give us a genuine faith in you;/ in your power and willingness/ to forgive our sins./ Let us too arise/ and walk in the strength of your grace/ and the support of your friendship./ All praise to your heavenly Father/ who has seen fit to give such power to men.

Litany of Pardon: The response will be : HAVE MERCY, LORD, CLEANSE ME FROM ALL MY SIN.

1. If we say we have no sin, we deceive ourselves, and the truth is not in us. (I John 1:8)
2. With Peter the apostle, we say: Depart from me, Lord, for I am a sinful man. (Lk 5:8)
3. Mindful of Mary Magdalen, Peter and the thief on the cross, we come to you in confidence.
4. You, O Christ, remain our advocate to plead our cause before the Father. (I John 2:1)
5. You, O Lord, the Most Holy, have taken our sins upon yourself; in your body you bore them on the wood of the cross. (I Pet 2:24)
6. You are compassion and love. You wash us clean and make us white as snow, if only we admit our guilt before you.

(Examination of Conscience)

Public Confession: I confess to almighty God,/ and to you, my brothers and sisters,/ that I have sinned through my own fault/ in my thoughts and in my words,/ in what I have done and in what I have failed to do;/ and I ask blessed Mary, ever virgin,/ and all the angels and saints,/ and you my brothers and sisters,/ to pray for me to the Lord our God.

Prayer of Contrition: Our Father,/ you have chosen us,/ and given us the wonders of human life./ You have loved us forever,/ and shared with us your divine life./ And yet,/ we know we are still human;/ we acknowledge our sin,/ our sickening selfishness,/ our refusal to love and to give./ We beg you now,/ to forgive us,/ to give us new life,/ to free us from all in our lives/ that is

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less than human and Christian./ We beg forgiveness from all our brothers and sisters/ whom we have used,/ with whom we have not shared our love./ Our Father,/ restore us to life,/ make us new,/ make all things new,/ through Jesus Christ,/ your Son, our Lord./ Amen.

(Confessions)

(Penance: For all who have received the sacrament, besides any penance imposed privately, your penance will be to recite Psalm 31. All present, moreover, are invited to share the penance with those upon whom it is imposed and to pray for their perseverance and spiritual improvement in the Lord.)

Psalm 31 : Happy the man/ whose sins are forgiven,/ whose transgressions are pardoned./ Happy is the man/ whom the Lord does not accuse of doing wrong,/ who is free from all deceit./ When I did not confess my sins,/ I was worn out/ from crying all day long./ Day and night/ you punished me, Lord;/ my strength was completely drained,/ as moisture is dried up/ by the summer heat./ Then I confessed my sins to you;/ I did not conceal my wrongdoings./ I decided to confess them to you,/ and you forgave all my transgressions./ So all your loyal people/ should pray to you in times of need;/ when a great flood comes rushing,/ it will not reach them./ You are my hiding place;/ you will save me from trouble./ I sing aloud of your salvation,/ because you protect me./ The Lord says:/ "I will teach you the way you should go;/ I will instruct you and advise you./ Don't be stupid/ like a horse or a mule,/ which must be controlled/ with a bit and bridle,/ to make it obey you"./ The wicked will have to suffer,/ but those who trust in the Lord/ are protected by his constant love./ All who are righteous,/ be glad and rejoice,/ because of what the Lord has done!/ All who obey him,/ shout for joy!
Glory be to the Father/ and to the Son/ and to the Holy Spirit;/ as it was in the beginning/ is now/ and ever shall be/ world without end./ Amen.

(Absolution: God, the Father of mercies, through the death and resurrection of his Son, Jesus Christ, has reconciled the world unto himself, and sent the Holy Spirit among us for the forgiveness of sins. Through the ministry of the Church, may God give you pardon and peace, and I absolve you of all your sins, in the name of the Father, and of the Son, and of the Holy Spirit. Amen.

Closing Hymn

THE REVOLUTIONARY PIONEERS

DR. NAND KISHORE SHARMA N.D. & DR. SAVITA SHARMA N.D.
CANCER & HEALTH SCIENCE EXPERTS
Chief Physicians– Daulatram Nature Cure Centre

The First Physicians in Indian Natural Healing Field.

- Having done extensive work, study & research in Natural Cancer Management.
- TREATED (More Than 4800) & CURED LARGE NUMBER OF CANCER CASES and has gained wide Recognition from Press, Public & Prominent Personalities.
- Formulated the Most Simple "Natural Cancer Therapy" there by establishing the greatness of Nature & Supremacy of SELF HEALING POWER.

Dr. Sharma Couple are solely dedicated & devoted to the upliftment of suffering humanity & science of Natural Hygine. They have brought up their two children almost on Natural Food Preventing them from hazardous Vaccination & Childhood disorders. This is their Best Contribution towards creating a Healthy Future Generation.

NO CURE! NO HEALTH ! WITHOUT OBEDIENCEY TO THE LAWS OF NATURE

BENEFIT IS DEFINITE— AT ANY STAGE OF ADVANCEMENT

No Sooner one Surrenders to the Natural Healing System all unexplicable PAINS SUFFERINGS & DISCOMFORTS definitly Turns into Ease-Peace and Comfort. Which No Drug and therapy has yet achieved.
Enough Vitality in patient can overcome any stage of cancer, patient with low immunity Survives very Peacefully.

(1) THE INEVITABLE FAILURES OF RESEARCHERS:- The ignorant scientists and laymen are searching NON-EXISTING 'HEALTH' & 'CURES' in everything EXCEPT NATURE'S LAW, RIGHT FOOD & RIGHT LIVING., Ignoring & maintaining the root cause. Therefore they are bound to fail.
(2) DRUGS AND THERAPIES NEVER CURE:- All existing drugs and therapies have no relation at all with "Health & Healing" they are absolutely symptomatic & suppressive, making the suffering a lavish luxury and eventually prove more harmful- THEY NEVER CURED & WILL NEVER CURE.
(3) BODY (CANCER) HEALS THYSELF:- Healing Powers cannot be improved upon by any out side Aids, Drugs and Therapies on the Contrary they are abuse and interference in Natural Healing process. The inherent Tendency of the Body is always towards Health and Perfection if the right needs are supplied and causes of ill health is avoided Body Heals itself
(4) GOOD IMMUNITY NEVER TOLERATES CANCER:- HEALTH is created only by Natural Food and Living Health creates Immunity & Immunity kills the Cancer (Don't fool yourself by artificial immunity). Care for HEALTH! NOT for DISEASE.

THE MOST DREADFUL DISEASE TREATED THE MOST SIMPLE WAY

THE METHOD OF CARE:-

- THE CAUSES OF THE DISEASE ARE CORRECTED (UNNATURAL WRONG NUTRITION AND LIFE STYLE).
- THE NORMAL NATURAL NEEDS ARE SUPPLIED (FRESH AIR-SUNSHINE-PURE WATER-REST. WHOLESOME FOOD - MENTAL POISE & RECREATION)
- BODY IS DETOXIFIED (BY VARIOUS CLEANSING PROCESSES)
- POSITIVE SPRITUAL ATITUDES ARE DEVELOED (BY MEDITATION – HEALTHY VISUALISATION & SELF RECOGNITION)
- YOGA & EXPERCISES:- (TO STIMULATE DETOXIFICATION SECRETIONS & ABSORPTIONS)
  FINALLY THE KEY OF WHOLE SUCCESS - IS WHOLSOME UNCOOKED FOOD FOR RESTORATION OF NORMAL BLOOD CHEMISTRY AND METOBOLISM
- RAW JUICES OF GREEN LEAVES, FRUITS, & VEGETABLES
- SALADS OF FRUITS & RAW VEGETABLES
- SPROUTS OF CEREALS & PULSES • SOAKED NUTS, SEEDS & ITS MILK
- HONEY & HERBAL TEAS AND VERY LITTLE WHOLESOME COOKED FOOD

ORGANICALLY GROWN FOOD BRINGS THE FASTEST RESULT

STRICTLY AVOIDED (THE CANCER PROMOTERS)

NO MILK & MILK PRODUCTS - NO ANIMAL PRODUCTS
NO. SALT, SUGAR, TEA, COFFEE, TOBACCO ALCOHOL
NO. REFINED CEREALS - NO COOKED & FRIED FOOD
NO. CHEMICALS - NO MEDICINES

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- **EXPECTING A CURE ! WITHOUT REMOVING THE CAUSE OF DISEASE-& LIVING HEALTHFULLY IN ACCORDANCE WITH THE LAWS OF NATURE) IS GREATEST FOOLISHNESS PRACTICED BY PATIENT & DOCTORS.**

DONT DISAPPOINT ! NATURE DOSE HAVE A REMEDY

Creating Love, Hope and Miracles

Paula Anne Hinson R.N. C.H.C.

Introduction: by Gerald G. Jampolsky, M.D.

Music: by Dr. Steven Halpern

Dr. Jerry Jampolsky, it is with great love and respect this personal acknowledgement is written for you. Thanks for your pioneering spirit, courage and great faith in starting the first Center for Attitudinal Healing in Tiberon, California. You are deeply loved and appreciated. Your spirit of cooperation and the inspiration you generate is making a difference throughout the world.

The composition "Starborn Suite" played throughout this tape series was generously given by Dr. Steven Halpern, composer, recording artist, and producer. Steve is a pioneer in contemporary music and an acknowledged authority on the healthful effects of sound and music. He is the author of "Sound Health" (Harper & Row) and "Tuning the Human Instrument", and widely sought as a public speaker and seminar leader. Special thanks from all the kids and their families from our Jacksonville Center for Attitudinal Healing.

"My attitude and relaxation techniques helped me through chemotherapy, the stress and hurt of losing my hair, pain of surgery, and negative thoughts about death. This tape series has made my life so much better, it gave me the emotional and physical strength I needed. You can do anything you want when you put your mind to it, "says Melinda, who is now planning a bright future. Age 17

Shawn, who just turned six and has T-cell Leukemia, was haunted by nightmares when scheduled for spinal taps until he began using the tapes. "He was only 5 years old and had never experienced pain or discomfort and the spinal taps are very painful, "says his mother, Maria. "After working with the tape, he was able to cope with the spinal tap and was more relaxed. He also has one to use when he has to have chemo and his whole attitude had changed even though he is very young. The tapes have helped tremendously." Age 5

Paula Hinson is an expert on the healing that Love, Hope and Miracles can bring about. Helping many children, adults and their families overcome the challenges of a life-threatening or catastrophic illness is Paula's life purpose. Paula is an ordained minister, registered nurse, counselor and founder of "The Jacksonville Center for Attitudinal Healing". She has worked in the medical profession for more than 15 years. The therapeutic value of her work has been recognized by the American Cancer Society, Candlelighters, the Florida Prison System, Sports Illustrated Magazine, and she has received numerous honors and awards.

TAPE ONE introduces the whole family to Paula and Jerry and supports the parents, brothers and sisters in letting go of the fear, anxiety and hopelessness associated with the diagnosis of a family member with a life-threatening illness.

THE SECOND TAPE will bring the listener into a peaceful and positive attitude, helping to decrease and manage pain, fear and side effects of spinal taps.

TAPE THREE continues the positive imagery and relaxation techniques of the previous tapes while helping to decrease pre-anxiety and manage the side effects of chemotherapy.

Paula Anne Hinson, R.N., C.H.C.
Prudential Drive, Suite 208, Howard Doctors Building, Jacksonville, Florida 32207

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Proceeds go to Aslan House, The Jacksonville Center For Attitudinal Healing helping kids and their families with a catastrophic illness.

ASLAN HOUSE

The Jacksonville Center for Attitudinal Healing

Programs for
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ASLAN HOUSE

The Jacksonville Center
for
Attitudinal Healing

Programs for Children and Adults
with Life-Threatening or
Catastrophic Illness.

JACKSONVILLE CENTER FOR ATTITUDINAL HEALING

Aslan House is named for Aslan, the powerful lion who symbolizes strength, hope, faith and encouragement in C.S. Lewis' famous "Chronicles of Narnia". Aslan's goal is to help others, and like our namesake, Aslan House is dedicated to helping individuals and families in their times of need.

Our programs offer a variety of support groups and resources, all designed to help and encourage those facing the challenges of a chronic or catastrophic illness. These programs are offered free, to both the individual experiencing illness and their family members and loved ones.

Aslan House supplements traditional health care and its emphasis on the physical/physiological aspects of illnesses. We believe that true healing also includes a spiritual and emotional component that must be addressed. We provide emotional support services that promote attitudinal healing. Attitudinal healing is the process of letting go of painful, fearful attitudes. When we let go of fear, only love remains. At Aslan House, our definition of health is inner peace, and healing is the process of letting go of fear.

The principles of attitudinal healing include universal, nondenominational and spiritual truths, which individuals use to fit their own needs and purposes. The purpose of Aslan House is to enable individuals to let go of the emotional pain and fear that usually accompany an illness or death and thus begin to lead a more fulfilling and peaceful life.

All of our support groups offer a time for people to connect with others facing similar life-threatening situations, for learning they are not alone and for joining with others who really understand.

In an atmosphere of unconditional support and caring each person is given the opportunity to learn from others and help others, directly experiencing "as we help each other we help ourselves".

Our group process is a warm and lively one, with trained adult facilitators joining in as friends and equals. In the words of a group participant "I know I have to do it myself, but I don't have to do it alone".

SUPPORT GROUPS

CHILDREN'S GROUP
Ages 6-16, with a life-threatening illness, have dinner together, then move into a time of sharing-giving love and support to one another.

SIBLING'S GROUP
Brothers and sisters of children in the Children's Group join and have dinner together. Common fears and anxieties are shared and discussed in a safe, supportive atmosphere.

TEENAGE/YOUNG ADULT GROUP
Young adults age 16-26 come together in supportive groups to let go of fear and anxieties to experience inner peace. Program includes frequent outings and social activities.

PARENT GROUPS
Parents of children participating in the children's programs meet while children are meeting in their groups. It is an opportunity to share the concerns and fears families must face during the challenges of a life-threatening illness and exchange loving support for one another.

SONS AND DAUGHTERS GROUP
Children age 6-16 meet to give and receive support as they share feelings about having a parent who is experiencing a life-threatening illness or who has already died.

ADULT GROUP
For any adult with a life-threatening illness. Groups provide a safe environment in which to explore fears and to experience love and support.

ADULT FAMILY SUPPORT GROUP
For spouses, significant others and friends of those facing a life-threatening illness. This gives you a chance to meet your own needs as well as that of the life-threatened person.

ADULT LONG-TERM ILLNESS GROUP
For people with long-term illnesses that are not immediately life-threatening but can threaten the quality of life.

PERSON-TO-PERSON GROUP
Designed to provide individuals seeking personal opportunity for self-awareness, stress management and enhancement of communication skills for making positive changes in attitudes.

PROFESSIONAL'S SUPPORT GROUP
For any physician, nurse, social worker, clergy, educator and mental health professional involved in meeting needs of patients and their families with a life-threatening illness. Designed to provide personal opportunity for self-awareness, stress management and enhancement of communication skills through peer support.

SENIORS PROGRAM
Our center facilitates attitudinal healing groups weekly for seniors at nearby retirement homes to help those who wish to enhance their lives.

LOSS AND RECOVERY PROGRAM
The emphasis of this program is on you. Loss is a natural process and recovery can be enhanced by discovering positive resources and coping skills in a non-judgemental atmosphere after experiencing the loss of a loved one.

HOSPITAL AND HOME VISITATION PROGRAM
Our center staff will visit group participants in hospitals and homes to extend loving support to the entire family. Meeting with physicians, social workers, nurses and teachers who work with children and young adults is an important element of this program.

EDUCATIONAL OUTREACH PROGRAM
Our public speakers bureau gives professional presentations to civic, church and business organizations within our community.

VOLUNTEER PROGRAM
Volunteers are a vital component of all our services. The Center provides a training program for all our volunteers before working in the programs and on going in-service and facilitator training for active volunteers.

PHONE PAL PROGRAM

Those who are unable to receive support from Aslan House because they are disabled or live to far away, may participate in the MICROTEL HELPLINE program. Through the use of the fiber optic long distance network donated by Boca Raton-based MICROTEL, "phone pals" facing life-threatening illnesses can call each other free of charge on the telephone and share their feelings, frustrations, and hopes openly so that they can move ahead with their lives. The program is available to anyone in need, regardless of age. Each HELPLINE applicant is matched up with someone who shares a common experience, disease or phsycial disability.

"We learn that yesterday is memory, tomorrow is a vision, and today is faith. We're learning about faith. You've got to have that, not fear."
-Patient at Jacksonville Center for Attitudinal Healing

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BANGALORE - 560 001
45 .16

ASLAN HOUSE
Jacksonville Center for
Attitudinal Healing
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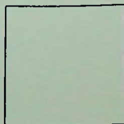
Jacksonville, Florida 32201
(904) 353-HELP



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INDIAN MEDICAL ASSOCIATION

BANGALORE BULLETIN

Editor
Dr. G. K. RAMACHANDRAPPA

MONTHLY

Executive Editors
Dr. R. SRINIVASA
Dr. VINOD CHEBBI
Dr. (Mrs)USHA SRINATH

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Editorial

HOLISTIC MEDICINE : NEED OF THE HOUR

Present aim of the medical education and the practising physician is the right diagnosis and treatment of a case. In order to make a diagnosis more precise and treat the patient better, the doctors are branched into specialities and super-specialities. The rapid strides in electronic and nuclear science have been successfully harnessed in the field of medicine to provide precise knowledge of the disease and its treatment. The achievement in the pharmaceutical field is not small either; hundreds of new drugs enter the market every year making a wide therapeutic choice for each patient. With all this, one can conclude that the diagnosis is made easier, and the treatment better. But the surprising fact is that it is not so.

By the number of the investigations carried out per year on a problem-patient it is quite discernible that all of them show nothing abnormal, but the patient's suffering continues. The reason behind this is that there are many obvious facts that fail to get the attention of the doctor. The patient's problems emerge from not just by physical abnormalities, but more so from social and psychological maladjustments with his immediate environment. Problems of interpersonal relationship, behaviour disorders, neuroses and a host of others plague the patient. Major life events leave an impact that may simulate a disease. Human emotions are expressed in terms of an illness. When the patient carries all these to a doctor and wants to unburden with him, the doctor, honest to his professional training of medical college, attempts to diagnose the disease. The doctor's communication with the patient on human-to-human level is absent. Thus the Homo sapiens is lost in the thick of the electronic gadgets.

The present day medicine has another drawback: since it is disease-oriented, the patient is prescribed drugs with the hope to cure or manage the medical condition. These drugs may have harmfı effects in the long run. Thus the patient may escape a disease, but becomes a prey to drugs.

In order to serve better, the disease-centred approach must be changed over to the patient-centred approach. The patient must be understood to have three dimensions-physical, psychological and social. Any change that takes place in one of them certainly influences the other two dimensions. Besides, a patient's needs at different times of his life-cycle are different and these must be recognised by us. Many times we have to anticipate a problem and prepare the patient to face it. We have to plan with the patient to keep him healthy in physical, psychological and social contexts, not merely aim to cure him from the disease. Sometimes the patient is advised to change his life-style. Thus we have to aim at the total welfare of the patient. This calls

(*Continued to page 2*)

For **IKEBANA** for spouses of doctors see page 3

for understanding, education and counselling from our side, for which we are ill-equipped.

When we combine the whole-person pathology with preventive care and continuing care and practise it, that is Holistie Medicine.

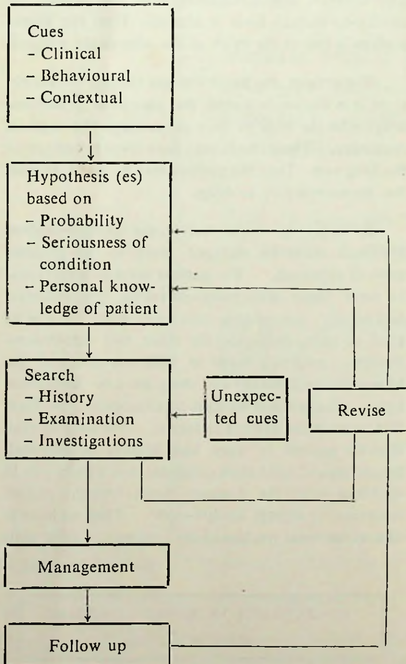
Are we doing this? —Dr. Vinod Chebbi

Family Medicine

PROBLEM-SOLVING AND DECISION-MAKING Part-II

Dr. VINOD CHEBBI
Family Physician
Bangalore

The last issue saw how the conventional inductive method of diagnosis taught in medical colleges was not useful in family practice. The problem-solving process in family practice is as follows :



This method is hypothetico-deductive, in which cues help to make a hypothesis, one or more, at a time. Then a search is undertaken through history, examination, investigations and treatment to prove or disprove a diagnosis.

Cues : A cue may be defined as an item of meaningful information. When a Family Physician is confronted with a lot of data of varying values, from the most significant to the irrelevant, he has to select the cues which give him an idea about what is wrong with the patient. Cues can be single, but usually are multiple, forming a pattern. There are varieties of cues — symptom cues, sign cues, behavioural cues and contextual cues. Symptom cues and sign cues need no explanation. Sign cues are rare in family practice, so a FP has to rely on symptom cues heavily. Also important is the patient's significance to a particular symptom even if the FP does not think so. Patient's anxiety, depression, hostility, acting out are all behavioural cues. For instance,the statement, "This makes me feel depressed" gives a cue about his emotional state. Contextual cues are those that spring from some incongruity the FP senses in the whole pattern of a consultation. For instance, "Why is this patient coming to me for a minor problem again and again?", "Why does her mother-in-law accompany her to every consultation?", "What type of a life is this woman leading?" and "Why is that young man waiting to come in as the last patient?" are some contextual cues.

Hypotheses : Taking the cues into account, a FP formulates a set of hypotheses which are usually two to five in number. These are based on three factors : probability of a condition, seriousness of a condition and personal knowledge of a patient. The hypotheses, once formulated, are arranged in order of their common occurrence. If, for instance, the cues point out that the patient is weak and has lost weight recently, of the three hypotheses, namely, diabetes, thyrotoxicosis and cancer, diabetes comes first in the list since it is more common. However, it does not mean that a rare condition should be entirely ignored; its place is the last in the list. But if a rare condition is also a serious one, then it secures a place before others since its early recognition and treatment is rewarding. A hypothesis is

(*Continued to page 4*)

Programme for April 1990

World Health Day Celebrations:

7.4.1990 — Slogan for the year : *Our Planet Our Health; Think Globally Act Locally.*

SCIENTIFIC MEETINGS

14.4.1990

Subject : Acute Abdomen
Speaker : Dr. R.H.N. Shenoy, Surgeon

15.4.1990

10.00 a.m. to 5.00 p.m. — General health check up and immunisation camp
Inaguration : Dr. B. Ranganath, Vice-President, IMA B'lore Br.
Venue : Harohally village

CME ON COMMON SKIN PROBLEMS

In collaboration with I.A.G.P.
20.4.1990

3.00 p.m.
Subject : Generalised Itching
Speaker : Dr. D.A. Sathish
4.00 p.m.
Subject : Use of Topical Steroids
Speaker : Dr Gopal, K.I.M.S.

21.4.1990

3.00 p.m. to 5.00 p.m. — Discussion on Common Skin Problems
Moderator : Dr. N. R. Nagabhushana, M.S.R.M. College

22.4.1990

10.00 a.m. to 4.00 p.m. — Family health check up and gynaecology camp
Venue : Ramanagar High School Organised by IMA Ladies' Wing

Inauguration : Dr. M.S. Shilpa, Convener, IMA Ladies' Wing Committee

28.4.1990

3.45 p.m. — High Tea
4.00 p.m. — Attractive Ikebana Demonstration Flower Arrangement for the Spouces of Doctors By Dr. Uma Sheshgiri, Organised by IMA Ladies' Wing Committee

Special Cartoon Film for Children accompanying the spouses

Donate Liberally

Indian Medical Association intends to give yearly donations towards feeding Endowment Scheme of Sri Venkateshwara Dharmashala, Kidwai Memorial Institute of Oncology on July 1st to be observed as "Doctors' Day" all over the country. We personally appeal to all the members to donate liberally for the cause.

News from Headquarters

Prof. R.J. Singh, President of IMA Headquarters writes:

"Immunisation to be the programme of the year;

Every member to enroll one new member;

Every branch to conduct at least one CME in a year".

Every State Branch should set up at least ten immunisation centres in the clinics of the practitioners having a refrigerator. They can procure vaccines, vaccine-carriers, immunisation cards and other inputs from the Government authorities or UNICEF offices; instructions for maintaining cold chains can be had from the latter.

A Family Welfare Cell has been established at the HQ to popularise FW programmes, especially spacing techniques and the oral pill. All the Gynaecologists and other practitioners can have their quota of oral pills to be distributed among the patients from the HQ through their local branches.

(*Continued from page 2*)

based on the personal knowledge of a patient. For instance, when a patient known to be suffering from attacks of bronchial asthma comes to his doctor breathless, the first hypothesis is bronchial asthma and not cardiac asthma. Personal knowledge also includes the personality of the patient, his behaviour, his interpersonal relationship with the people around him, the way he lives and his relationship with his FP.

Search : Once the FP makes a list of hypotheses, he looks for any evidences to prove or disprove them. He gathers these evidences from the history, examination. investigations and sometimes, treatment. It is not wrong in family practice to make a diagnosis after the treatment. For instance, it is easy to differentiate the chest pain of dyspepsia from that of cardiac origin by giving the patient a course of H_2 blockers or beta blockers. This is less expensive, safer and surer method of diagnosis than subjecting a patient to a battery of investigations. Risk, benefit and cost calculation must always be kept in mind when tests are chosen. The expected benefit is not only the usefulness of the test in validating a hypothesis but also the extent to which the results of the test will change the management plan. If a FP has already planned a line of management which does not change by the result of a test, then it is better to avoid the test. Conversely, a test which has the sole benefit of reassurance to the patient may be carried out even if the FP may feel it is clinically unnecessary. (*to be continued*)

You Said So !

"Wither Specialist Practice"

Despite the present trend of medicine towards extreme specialisation, a real specialist should view human ills from the standpoint of "the person affected by an illness" rather than "the illness affecting a person". A specialist nevertheless must have a knowledge of general practice.

Dr. N. GANDHI, Pathologist

Kudos to Dr. Naresh Shetty's article ! It is interesting and thought-provoking. Today's GP is a 'stepping stone' before becoming a specialist. He is called only in emergencies, to be forgotton soon. His life is miserable. The breed of GPs will soon disappear and society will be the sufferer. If I make my son a GP, it will be the greatest sin and blunder that I can commit.

Dr. V. L. GANAPATHY, General Practitioner

I have observed that students who have come from the families of doctors, nurses and even ward–boys developing themselves into good doctors. If at least 50% seats could be given to such students, at least half the medical world could be expected to be kind.

DR. D. P. JAYARAM, Dermatologist

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Oncology News

From this issue onwards, the page of the Bulletin will carry **NEWS** item on oncology sponsored by Bangalore Cancer Research foundation. Any person/ Institution willing to contribute **NEWS** to this page may send it to

Dr. B. S. Ramesh
Bangalore Cancer Research Foundation
C/o Bangalore Cancer Hospital
44/45, Raja Ram Mohan Roy Extension
Bangalore-560 027 Phone: 225644, 225698

C.M.E. In Oncology was conducted on 20th and 21st January 1990 by A.R.O.I. Karnataka Chapter at Bangalor Cancer Hospital.

It was inaugurated by Prof. D. Shankar Raj, Principal, B.M.C. Presidential address was delivered by Prof. G. Kilara, Bangalore Cancer Hospital.

Congratulations!

Dr. M. Krishna Bhargava
Director, K.M.I.O.

In sincere appreciation of his unstinted hard work and determination to the cause of Cancer Dr. Bhargava has befittingly been awarded **Padmashri.**

Our Hearty Greetings.

Forthcoming vEents

Karnataka Cancer Society has constructed a new premises at Viyalikaval, Bangalore and, will be inaugurated shortly.

Endowment Oration

Karnataka Chapter of ASI has decided to conduct Dr. A. J. Narendran endowment oration in Oncology.

Advertisement

The Chairman and Members of the Governing Council, Principal, Staff and Students of **Dr. B.R. Ambedkar Medical College** offer Best Compliments and wish you all Happy New Year.

Kindly refer your patients to Dr. B. R. Ambedkar Medical College Teaching Hospital for free and advanced medical care with latest well-equipped departments and well experienced staff in the following specialities:

Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Skin and Venereology, Ophthalmology, Otolaryngology, Radiology, Laboratory Diagnosis, Psychiatry, Cardio-Thoracic Surgery.

CME Programmes will be arranged as per stipulation for the benefit of postgraduates.

Sri H. S. Shivaswamy
Chairman

Dr. C. Madaiah
Principal

Dr. B. R. Ambedkar Medical College, Bangalore

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CHRISTIAN MEDICAL ASSOCIATION OF INDIA
Plot No.2, A-3, Local Shopping Centre, Janakpuri, New Delhi 100 058

CMAI Day of Prayer: February 4, 2004
Healing Ministry Sunday: February 8, 2004

The CMAI invites you to celebrate Healing Ministry Week and Sunday 2004

Theme: "Your Faith has healed you"

What is Healing Ministry week?

CMAI is the official health arm of the Churches in India. It serves the Church in India, remaining as a related agency of the National Council of Churches in India based at Nagpur. It brings together 300 plus mission hospitals and about 5500 Christian Health professionals to a fellowship and encourages them to be effective in the ministry of healing. It is ecumenical and interdenominational in nature.

CMAI gives leadership in the healing ministry week celebration every year in the second week of February. Till 1986, the Healing Ministry Sunday was celebrated as Hospital Sunday. This week gives every congregation an opportunity to create awareness on issues related to health, healing and wholeness. We believe this will help members, churches and local congregations to get involved in health and healing initiatives. Local congregations are the signposts of God's healing presence in this world.

This week I am sure will bring a lot of new stimuli to our churches and local congregations celebrating and pronouncing the healing ministry. We hope you will use this week to be a time of discussion on health and healing issues. Please make it a great celebration, since God's healing power is available to this world through His children and the church.

1273
1311

To

All Bishops, Pastors, Heads of Institutions and members of CMAI

Dear Partners in the ministry of healing,

Greetings to you in the name of Jesus Christ, who is our source of healing. It is my privilege to bring this booklet, containing an Order of Worship to be used on the Healing Ministry Sunday and a Sunday school lesson plan for use on the Healing Ministry Sunday. In the same envelope, you will also find the poster depicting this theme. Faith in Jesus Christ alone heals us, transforms us and leads us to God Himself. I am sure this theme in its rich tone can give a lot of insights to life and its challenges.

The Christian Medical Association of India is celebrating the Healing Ministry Week along with the Catholic Health Association of India and the Commission for Healthcare Apostolate of the Catholic Bishops Conference of India. This broader partnership will enable many more congregations to learn about the healing ministry.

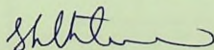
The week will be celebrated from February 2-8, 2004. February 4th 2004 is a special day of prayer and February 8th will be the Healing Ministry Sunday. Many congregations have earmarked the Healing Ministry Sunday collections to be sent to us in the past years and I take this opportunity to thank you for this partnership.

We would like to record our appreciation to the contributors for our Bible Study. Our grateful thanks to Ms Grace Matilda, Mr AP Berry, Ms Eunice Rao (CMAI staff), Ms Esther David, New Delhi and Rev Job Jeyaraj, CSI, Bangalore.

We are interested in knowing how you celebrated the Healing Ministry Week and Sunday in your Churches, congregations, institutions and health centres. We would appreciate your suggestions for strengthening this partnership, so that we can continue to have meaningful celebrations in the future.

With best wishes and prayers,

Yours in Him,



Rev Sharath David
Senior Programme Co-ordinator
Chaplains Section

Healing Ministry Sunday : Order of Worship

February 8, 2004

Theme: **"Your faith has healed you"**

Call to Worship: *Heal me, O Lord, and I will be healed; save me and I will be saved, for you are the one I praise.* Jeremiah 17:14

Opening Prayer: O eternal God, our heavenly Father who alone is the healer of all mankind. We bless your holy name that brings healing to us as a body of Christ, the community, the family and individuals. Heal us O God and help us receive the wholeness in our life.

We humbly beseech you to grant to all of us your grace, and healing mercy. That we may henceforth obediently walk in Thy holy commandments; and leading a quiet and peaceful life in all godliness and honesty. We may continually offer unto Thee our sacrifice of praise and thanksgiving for these Thy mercies towards us through Jesus Christ our Lord. Amen.*(adapted from common prayer book)*

Opening Hymn : *'O God our help in ages past'*

Praise and Worship

Minister : Father, we thank you for the unlimited healing possible in your name.

All: **Praise you God for your steadfast love.**

Minister : We thank you for the healing properties planted in each of us and your creation.

All: **Praise you God, the Holy Spirit, who enables healing and comfort.**

Minister : We thank you Lord for entrusting us with resources that brings healing.

All: **Praise you Lord Jesus for your touch.**

Minister : We thank you, triune God, for the promise of healing and restoring all of us.

All: **Praise to thee, O God the Father, the Son and the Holy Spirit.**

Confession

Leader: Let us humbly confess our sins to Almighty God.

All: **Almighty God, Father of our Lord Jesus Christ, Maker of all things, Judge of all men; We acknowledge and protest our manifold sins and wickedness, which we from time to time, most grievously have committed. By thought, word and deed against Thy Divine Majesty, provoking most justly Thy wrath and indignation against us. We do earnestly repent and are heartily sorry for these our**

misdoings, the remembrance of them is grievous unto us. The burden of them is intolerable. Have mercy upon us, O merciful father, for Thy Son our Lord Jesus Christ's sake, forgive us all that is past and grant that we may ever hereafter serve and please Thee in newness of life. To the honour and glory of Thy Name; through Jesus Christ our Lord. Amen.

Minister: May the Almighty and merciful Lord grant us pardon and remission of all our sins, time for amendment and the grace and comfort of the Holy Spirit. Amen.

The Word: **Jeremiah** 17: 5-13

Psalms 30: 1-12 (Responsive reading)

Epistles I Peter 2: 18-25

St. Mark 5: 25-34

Sermon: **Topic** " Your faith has healed you"

Scripture St. Mark 5: 25-34

(Suggested outline available on page 6)

Intercession of Healing (A health professional leads the congregation in intercession)

***Leader*:** That it may please Thee to bless and keep all Thy people;

We beseech Thee to hear us, good Lord.

***Leader*:** That it may please Thee to give to all nations unity, peace, and concord;

We beseech Thee to hear us, good Lord.

Leader: That it may please Thee to illuminate all bishops, priests and deacons, with true knowledge and understanding of Thy Word; and that both by their preaching and living they may set it forth and show it accordingly;

We beseech Thee to hear us, good Lord.

Leader: That it may please Thee to give us an heart to love and dread Thee, and diligently to live after Thy commandments;

We beseech Thee to hear us, good Lord.

Leader: That it may please Thee to give to all Thy people increase of grace to hear meekly Thy word, and to receive it with pure affection, and to bring forth the fruits of the Spirit.

We beseech Thee to hear us, good Lord.

Leader: That it may please Thee to bring into the way of truth all such as have erred, and are deceived;

We beseech Thee to hear us, good Lord.

***Leader*:** That it may please Thee to strengthen such as do stand; and to comfort and help the weak-hearted; and to raise up them that fall; and finally to trample down Satan under our feet;

We beseech Thee to hear us, good Lord.

Leader : That it may please Thee to preserve, heal all sick persons and young children; and to show Thy pity upon all prisoners and captives;

We beseech Thee to hear us, good Lord.

Leader : That it may please Thee to defend and provide for the fatherless children, and widows and all that are desolate and oppressed;

We beseech Thee to hear us, good Lord.

Leader : That it may please Thee to have mercy upon all men; and it may please Thee to forgive our enemies, persecutors and slanderers, and to turn their hearts;

We beseech Thee to hear us, good Lord.

Leader: That it may please Thee to give and preserve to our use the kindly fruits of the earth, so as in due time we may enjoy them;

We beseech Thee to hear us, good Lord.

All: **O God, who in Jesus Christ called us out of darkness into your marvelous light; enable us always to declare your wonderful deeds, thank you for your steadfast love. We praise you with heart, soul, mind and strength, now and forever. Amen.**

Song: *Just as I am without one plea ....*

(Offertory)

(If the Eucharist is celebrated, kindly continue the liturgy of the communion service.)

Concluding Prayer

Healing God, our heavenly father. We thank you for blessing us in your presence. For the healing we have received that you may remain perpetually in us making our life and witness relevant. Abide with us throughout our journey and may your grace protect and heal us always. As you have commended to the lady, "Your faith in me has healed you," so help us to put our faith and hope in you to receive our healing from you. Amen

Benediction

Minister : **"Go! It will be done just as you believed it would." And his servant was healed at that very hour.**

May the grace of our Lord Jesus Christ, Love of the father and the fellowship of the Holy Spirit remain with us now and always. Amen

Closing hymn: *My Hope is built on...*

Acknowledgement: *Prayer of confession and intercession taken and edited from the book of Common Prayers.*

Sermon : Topic **"Your faith has healed you"**
Scripture: St. Mark 5: 25-34

Aim

To help understand that all healing is from God. God in Christ is our source of healing. When we exercise our faith in Jesus He heals acknowledges us and makes us complete.

Goal

- To have faith in Jesus that God heals us and we can run to Him at any time in our life
- To help congregation understand that God's intention is to help us have wholeness in life providing healing to any sickness.
- To know the heart of God concerning people and to understand His love t them in their times of need.

Suggested Outline

Introduction

- **God heals us because of His love and our faith in Him.**

The woman's faith in Jesus and His love matched and the result was healing. Faith appropriates healing. Faith helps us to receive God's healing. Faith is the anchor to receive God's healing, without faith one cannot receive healing. This brings blessings to our life.

- **God wants us to acknowledge the healing we receive.**

Every healing proceeds from Jesus. He is the author of our life. Whether the healing is through a medical intervention or through prayer, it is God who ultimately heals. All He wants us to do is acknowledge that we have received from Him. We cannot be silent/passive to God's intervention of healing in our life. God wants us to celebrate and praise Him for the healing we receive from Him enormously.

- **God wants healing to make us whole and spiritually united with Him.**

The healing helped the woman to have a conversation with Jesus who is the source of all healing. The woman received her healing. She returned whole, complete and restored as a human being who can enjoy the life in its fullness. She met Jesus personally that day which means she renewed her relationship with God, God wants to re-establish a personal spiritual healing relationship with Him which brings an end to our search of our healing. God, who is our Alpha and Omega, is our source of every healing.

Conclusion

"Your faith has healed you"

Healing Ministry Week Celebrations

February 2-8, 2004

CMAI Day of Prayer

February 4, 2004

Healing Ministry Sunday – Sunday School Corner

February 8, 2004

The Lesson Plan

Aim: To tell children that Jesus Christ is our ultimate source of healing.

Goal: To help them understand that having faith pleases God and it brings healing.

Memory Verse

'And make straight paths for your feet, lest that which is lame be turned out of the way; but let it rather be healed'. Heb. 12:13 (KJV)

The Story

A long time ago in the land where Jesus lived, there was a lady who had been ill for many years. She went to see lots of doctors and they couldn't make her better.

One doctor said, "Try using this ointment. That might make you better." But it didn't.

Another doctor said, "Try taking this medicine. That might make you better. " But it didn't. Another doctor said, "Try drinking some tonic. That might make you better. " But it didn't.

Each doctor told her to do something, but none of them could make her better. At last the lady had spent all her money and still she wasn't better. "I'll never get better now," she thought.

But one day Jesus came to the place where the lady lived. She had heard about Him and she thought, "Jesus can do wonderful things. I'll ask Him to make me better. " But then she thought, "There would be lots of people near Jesus and they will all listen if I talk to Him. I am afraid to ask Jesus to help me if all those people will be watching and listening. Oh dear, what shall I do?" She thought and thought. She was quite sure that Jesus could make her

well, but she was too frightened to ask Him to help her. She knew that all the people would be watching and listening.

Then she had an idea. "I know what I'll do," she said. "I'll creep up quietly behind Jesus and just touch the bottom of His cloak. I' m sure that if I do that I shall be made well and nobody will know what I have done."

So she walked out of her house and down the road until she found the crowds of people who were following Jesus.

The lady began to push her way through the people. "Excuse me, please" she said and went a little way. "Excuse me, please," she said again and pushed a little further. It took her a while to get to Jesus, but at last she did.

She saw some of Jesus' helpers standing close to Him. Then she saw a man asking Jesus to help Him. Jesus listened and then began to go somewhere with him. 'Jesus is going to help that man,' she thought. 'I want Him to help me too'.

She managed to get quite near to Jesus. "I must just touch the bottom of His cloak," she thought, " that's all I need to do."

So she quickly stooped down and touched the bottom of Jesus' cloak. As soon as she had done so, she felt better. She knew that she was quite well again. Then she turned round to hurry away.

But as she turned she heard Jesus say, "Who touched me?" Then Peter, one of Jesus' helpers, said, "Master, there are lots of people all around you. They are all crowding in and touching you. Why did you ask who touched you?"

Jesus answered, "Somebody has touched me for a special reason. Somebody wants me to help them."

"Jesus knows what I have done," thought the lady. She felt very shy. But she knew that she must tell Jesus that it was she. She was so frightened that she was shaking all over but she knelt down in front of Jesus and said,"It was I, Sir. I touched you because I wanted to be made better. Then she told Him how she had been trying to get better for years and years and how none of the doctors could help her."

Of course, Jesus was not at all angry. Instead He smiled at the lady and said, "Because you believed I could help you. Go home now. I am glad you are well."

So the lady turned round and went home. She felt better and she was very happy.

Prayer

Thank you, Lord Jesus, for helping the lady who touched your cloth. Teach me to remember that you will always help me, whatever situation I may be in. Amen.

Activity

You can act out the story by choosing the twelve children as disciples and one boy as Jesus. One girl can enact the part of the lady. The other students in the class can be part of the crowd.

CHRISTIAN MEDICAL ASSOCIATION OF INDIA
Plot No. 2, A-3 Local Shopping Centre, Janakpuri,
New Delhi - 110 058

"Your faith has healed You"

Bible Studies

Healing Ministry Week Celebrations

February 2-8, 2004

CMAI Day of Prayer

February 4, 2004

Healing Ministry Sunday

February 8, 2004

To All Bishops, Pastors, Heads of Institution and Members of CMAI

Dear Partners in the ministry of healing,

Greetings to you in the name of Jesus Christ, the name from which every healing proceeds. It's my privilege to bring two booklets to you, containing six Bible studies to be used during the week of celebration and an Order of Worship to be used on the Healing Ministry Sunday and a Sunday school lesson plan for use on the Healing Ministry Sunday. In the same envelope, you will also find the poster depicting this theme. Faith in Jesus Christ alone that heals us, transforms us and leads us to God Himself. I am sure this theme in its rich tone can give a lot of insight to life and its challenges.

The Christian Medical Association of India is celebrating the Healing Ministry Week along with the Catholic Health Association of India and the Commission for Healthcare Apostolate of the Catholic Bishops' Conference of India. This broader partnership will enable many more congregations to learn about the healing ministry.

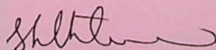
The week will be celebrated from February 2-8, 2004. February 4th 2004 is a special day of prayer and February 8th will be the Healing Ministry Sunday. Many congregations have earmarked the Healing Ministry Sunday collections to be sent to us in the past years and I take this opportunity to thank you for this partnership.

We would like to record our appreciation to the contributors for our Bible study. Our grateful thanks to Ms Grace Matilda, Mr AP Berry, Ms Eunice Rao (all CMAI staff) and Ms Esther David, New Delhi and Rev Job Jeyaraj, CSI, Bangalore.

We are interested in knowing how you celebrated the Healing Ministry Week and Sunday in your congregations, institutions and health centres. We would appreciate your suggestions for strengthening this partnership, so that we can continue to have meaningful celebrations in the future.

With best wishes and prayers,

Yours in Him,



Rev Sharath David
Senior Programme Co-ordinator
Chaplains Section

FAITH ENLIGHTENS YOU

"This, the first of his miraculous signs, Jesus performed at Cana in Galilee. He thus revealed his glory, and his disciples put their faith in him." John 2:11 (NIV)

Faith brings light and dispels darkness. It helps us to be sure and not guessing in life. Faith is the result of one's own knowledge and the conviction we have concerning God. As a result of this, the gap is narrowed and in due course of time, the gap has no place thereafter as we learn to trust God. The attitude changes and we work in close fellowship with God.

The disciples learned that day what God can do when we take a problem to Him. All things are possible when we put our faith in God. We need to be more sincere and prayerful to know God. We should pursue learning from Him, which will take each one of us from darkness, open our mind to receive Him fully and act according to the will of God. He then will enlighten all the concerned and heal them as well.

Faith is the guiding light for such transformation to take place in an individual or in a group. This helps us to follow God implicitly, till the end.

God can help us to put our faith in Him in all its fullness, receive a mind to understand the purpose of creation and draw closer to Him. We should help fellow human beings and live an enlightened life for God, till our end.

Questions for reflections:

1. How distinct is our faith in God from the humans?
2. How many milestones have we crossed towards the transformation?
3. How open are we to the faith and steps of transformation of people of other faiths?

FAITH LEADS YOU TO WHOLENESS

"And one of them, when he saw that he was healed, came back, He glorified God and he fell upon his face at Jesus's feet, giving Him thanks; he was a Samaritan. And Jesus asked, "Were not the ten cleansed?" But where are the nine? Were there none found that returned to give glory to God, save this stranger? And he said unto him, arise, and go Thy way: Thy faith hath made thee whole." (ASV)

Wholeness could mean totally flawless with not even an iota of imperfectness. Faith and healing with thanksgiving leads to wholeness. The man with the Hansen's disease (Leprosy) that become whole thanked Jesus profusely for what He had done. He acknowledged the healing with thanksgiving.

Learning experiences lead to light and it helps oneself to be out of darkness/ignorance. To have absolute faith in God one requires determination and discipline to the utmost.

When the desire to attain totality increases constantly and continuously, God in His faithfulness helps them to grow and draw closer and closer day by day, and fills us with a new experience to reach the wholeness in our creation.

A perfect God alone can help us to have and grow with the desire to become flawless and whole, and fulfill our desire to establish a whole humanity.

Questions for reflections:

1. Does our faith lead us to the knowledge of God's totality?
2. Have we recognised anyone deeper in faith and with knowledge of totality by now?
3. Does our faith embrace God's one-piece humanity?

FAITH INITIATES NEW LIFE IN YOU

"They told Jesus about her. So he went to her and took her hand and helped her up. The fever left her and she began to wait on them."

When Jesus went to the house of Simon and Andrew, Simon's mother-in-law was down with fever. This matter was brought to the knowledge of Jesus. Why? This is because they had immense faith in Jesus. Through their faith they were sure that Jesus can heal her.

When Jesus heard about it He went to her with compassion, held her hand and made her sit. As soon as He touched her, she was healed of her sickness. She immediately got up and started serving them.

Instead of worrying or losing heart, they looked upto Jesus and believed that He would surely heal her and once healed she began to serve. Through this we conclude that:

- We are asked to develop faith
- We should be sure to be healed
- We are asked to serve Him

God can restore us with new activities and actions and help us to lead a fruitful and a witnessing life.

We are supposed to bring to the knowledge of Jesus when someone is sick or grief stricken, which is what we call as a faithful prayer. When we inform Him, He will heal and empower them with a new initiative, which will bear fruits.

Questions for reflections:

1. Do you take it in prayer when something goes wrong?
2. Do you have faith that Jesus can put things right?
3. Do you agree He can put new energy, spirit and power to your life to achieve new goals?

FAITH TRANSFORMS YOU

Many of the Samaritans from that town believed in him because of the women's testimony. John 4:39

It was about a woman and the transformation which she received that made the whole village to turn to Christ.

It all happened near a well where Jesus came to get some rest. It was a hot and humid afternoon, Jesus sat down beside the well. He saw a woman coming to draw water. Jesus knew her whole life yet asked her for water to drink. The request was simple but the woman was taken aback because she knew that Jews have no dealings with Samaritans. Jesus said, "If you know who I am and what I can give, it is you who would be asking me for living water."

Jesus revealed her whole life and made her know about Him. She believed in Christ at that moment. The great change took place in her. She was filled with joy and received power to be bold. Then she ran to the village and brought many people. Through the Samaritan woman many started believing Him. Transformation of one woman led to transformation of many people in that village.

Transformation is a continuing process. As the sun rises the darkness goes away; when the transformation takes place the darkness of our life departs. Faith in Jesus can result in transformation in the following dimensions in each one of us.

- It enables us to see the glory of God (John 11:40)
- It makes us a righteous person (Rom.10: 10)
- It brings us salvation (Rom.1: 16)
- Never puts us in shame in any trials (Rom 9:33, Rom 10:11)
- Helps us to get our prayers answered (Matthew.21: 21, 23)
- Brings healing in us (Matthew 9:22)
- Fills us with joy (Rom.15: 13)

May God help us to have faith in Him to get a transformed life, which leads us to see these blessings.

Questions for reflections:

1. Who is our source of transformation in this life?
2. How can faith in Christ induce transformation in us?
3. What can happen to us when we get transformed?

FAITH LIBERATES YOU

"The Spirit of the Lord is on me, because he has anointed me to preach good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed"

"Come to me, all you who are weary and burdened, and I will give you rest."

Experiencing God's love through faith endows us with liberation for all of us living under the slavery of this world. Faith in Jesus Christ liberates us. Liberation means we are set free from every kind of bondages like sin, sickness, poverty, fear and death.

Sin is the rebellious, disobedient nature in us to displace God from our life. Romans 3:16 "Sin separates us from God and keeps us far away from experiencing God's love." The Bible says the blood of Jesus Christ cleanses us from all our sins and we are forgiven and made whole.

Faith in Christ Jesus brings complete healing into our lives. We are set free from every kind of disease and sickness. Liberation is being set free and once we experience it, it is our responsibility to share this good news with others. People are living under various kinds of fears and bondages like unemployment, drug abuse and poverty. They are suffering from unbearable pain and mental turmoil and there is no peace in their lives, in the family and in their surroundings, the poor and marginalised have lost hope and are living in despair.

In the midst of all these, God has placed us as an agent of healing to proclaim freedom to the prisoners and to release the oppressed. We are called to be liberators and to become a channel of healing, restoration and peace to the people around us.

Do we feel responsible for those who are still in bondages from which we need to be set free? Let us bring them to the feet of Christ Jesus, who alone can take all our burdens and set us free. It is by freedom that Christ has set us free. Let us have complete faith in Jesus Christ for the 'Lord is the Spirit, and where the spirit of the Lord is, there is freedom' (2 Cor.3: 17).

Questions for reflections:

1. Have we experienced true freedom in our lives?
2. Note down some of the bondages from which we need to be set free?

FAITH RESULTS IN SPIRITUAL RENEWAL

Jesus said to him, Salvation has come to this house today...
Luke 19: 9(a)

A man called Zacchaeus wanted to see Jesus. He ran ahead and climbed on a tree to able to have a glimpse of Jesus. The desire to see is so strong that he climbed upon a tree. The result is Jesus came to Zacchaeus' house.

The events that followed during the interaction of Zacchaeus with Jesus:

- Total transformation and rectification of the past mistakes.
- Those who were earlier cheated by Zacchaeus were able to see in him, the signs of spiritual renewal.

The life and spiritual renewal must be witnessed in our thoughts and actions. Christ brings about spiritual renewal, which brings about spiritual growth and development. The fruits of the spirit are love, joy, peace, patience, kindness, and goodness. Let us demonstrate a life of spiritual renewal and maintain an attitude of dependency on God. ,

Questions for reflections:

1. What are the signs of spiritual renewal?
2. Are we enabling spiritual renewal or obstructions?
3. How can we generate spiritual renewal in our working place?

USE OF A MODEL OF `SOCIETY - HEALTH CARE INTERACTION' IN HOLISTIC CLINICAL TEACHING IN INTERNAL MEDICINE

A 4-element multidimensional model was designed at JIPMER to illustrate the theme of `Society and Health Care'. The model was used to stimulate residents to have a holistic view of a patient and his/her illness.

The model was designed by the author and refined by peer-review and feedback. The model (see annexure) was explained to a group of residents of internal medicine; they were asked to review the cases under their care using the model and see if they could find it of any use. Nine cases were reviewed by them and presented before a panel of faculty members from Medicine, Pharmacology and Social Medicine.

OBSERVATIONS

1. The residents said they could comprehend the complex inter-relationships and influences of various factors in a simple looking Doctor-Patient interaction.

2. The residents could unravel atleast a few more important points in each of the nine cases reviewed by them, which were initially missed by the conventional case record writing.

3. The model was wide in scope and content but flexible enough to permit its use in all types of clinical situations. However, in some cases, not all the elements were applicable.

4. Both the faculty and the residents felt that the model started where conventional case record ended and thus was complementary in nature, adding depth and width to the case discussion.

5. A write-up on every chronic case using the model may help plan management more tailor made to suit the patient and his/her place in society.

SUMMARY

A 4-element, multidimensional model on Society and Health Care was found to be useful in getting a holistic perspective in case discussions. Further studies are needed to assess its use in clinical teaching of holistic medicine and (drug) therapy.

ANNEXURE.1 The Model.
ANNEXURE.2 Some points unraveled by the residents using the Model.

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ANNEXURE.2

Some of the points elicited by the residents:

1. Malaria in a 19 year old male.
   - the patient was aware of malaria as a disease caused by mosquito bite but was not aware of its symptoms
   - health education posters in his village were about guinea worm but not about malaria
   - there was no control procedures in operation against mosquito in his village
   - under these circumstances `cure' of malaria as recorded in the case record became meaningless.

2. Typhoid in a 45 year old female, a housewife.
   - unaware of typhoid or its endemic nature at her place
   - lack of simple hygienic measures at home; open air toilet
   - failure of administration to provide potable water or control houseflies
   - even if the patient was cured and sent home, typhoid would persist in her locality.

3. Miliary TB in a 23 year old man in a TB - prone family.
   - while the family knew about cavitary pulmonary TB, all were ignorant about non-pulmonary forms of TB
   - failure of primary health care to even suspect TB as a possibility in this man who presented as a PUO
   - media do not inform public about non-pulmonary TB
   - any persistent symptom in a contact of TB could be extra-pulmonary form of it. This needs stress in curriculum.

4. Hypertensive nephropathy in a 55 year old fireman.
   - unaware of hypertensive complications and of the need for regular therapy
   - media do not inform the public about common and important non-communicable diseases.

5. Para suicide using yellow oleander seeds by a 27 year old man.
   - society perceives para suicide as a mechanism of solving problems or of resolving conflicts in the family
   - media hype (TV and Movies) propagates these myths.

SETHURAMAN.KR 1

DOCTOR-PATIENT COMMUNICATION AT THE OUT-PATIENT LEVEL

AIM OF THE STUDY

To assess the extent of problems in doctor-patient communication using patients' understanding of four parameters, viz.
(1) nature of the illness,
(2) drug effects,
(3) drug dosage, and
(4) side-effects to watch for.

SUBJECTS & METHODS

Fifty patients coming out after consulting a faculty staff and fifty patients coming out after consulting a first year resident were selected for this survey. Armed with the results of the survey, the doctors were asked why the communication failed in majority of cases.

OBSERVATIONS

Patient characteristics revealed that the residents saw more of rural, illiterate and low-income group of patients. The time spent per case varied from 10-25 minutes for a faculty while it was 3-5 minutes in the residents' hall (See Table.1)

Almost all the patients seen by the faculty were informed verbally or in writing, the nature of illness and the dosage of drugs. However, 52% were not told about the effects of the drugs or about the adverse reactions to watch out for (See Table.2)

The resident performed poorly in all four areas with majority of the patients ignorant about the illness or the drugs issued. The responses of 78 cases who were not satisfied with the communication are recorded in Table-3. The majority of them centered around lack of time, non-communicative nature and language barrier.

Two faculty staff and eight residents cited the following reasons for ineffective communication:

1. Pressure of work (8)
2. Boredom of repeating the same instructions (6)
3. Patient illiteracy (5)
4. Use of technical words without translation (5)
5. Some cases especially females, not taking charge of their problems (2)
6. Garrulous patients who keep on talking if given a chance (1).

It was apparent that both modifiable and non-modifiable factors operate in the failure of effective communication. Alumni of JIPMER had earlier pointed out that `ability to effectively communicate with patient and relatives' is the most important skill not taught in medical school (See Annexure)

TABLE-1. PATIENT CHARACTERISTICS

	Male	Urban	Literate	Low income	Total (n=)
Consultant	32	29	41	8	50 - Group A
Resident	34	14	27	40	50 - Group B

TABLE.2 PATIENT ASSESSMENT OF THE INTERVIEW

	Explained Understood a.	Explained Not understood b.	Not explained OR do not know c.
Group A (n=50)			
Illness	19	28	3
Drug effect	13	11	26
Dosage	27	22	1
ADR	6	10	34
Group B (n 50)			
Illness	3	16	31
Drug effect	0	2	48
Dosage	9	13	28
ADR	1	2	47

TABLE.3

PATIENT RESPONSES ON REASONS FOR INEFFECTIVE COMMUNICATION (n=78)

1.	Too little time to talk	37
2.	Non-communicative or rude doctor	26
3.	Language barrier	21
4.	Use of medical jargon	18
5.	Non-communicative nurse/pharmacist	13
6.	Self-deprecatory remarks	4

SELF ASSESSMENT OF PRESCRIBING HABITS AMONG ALUMNI OF JIPMER

AIM

To record the self-assessment of JIPMER Alumni on their usage of non-essential (NE) drugs and the reasons for doing so.

SUBJECTS & METHODS

During the Annual Alumni Meet of August 1991, 46 alumni agreed to give a feedback by filling up a proforma (See Annexure-1). Their responses were tabulated and analysed.

OBSERVATIONS

Alumni profile: 42 were practising and 4 were not practising clinical medicine. There were 10 primary care, 39 secondary care and 3 tertiary care physicians/surgeons.

Average drug usage: Varied from 1-4 per case, with a mean of 2.8 (or 3). This corresponded to the mean of 3 drugs per prescription at a PHC and at a pharmacy reported by us.

Cases sent back without a drug was marked on a Likert type scale. Ten felt that no case was sent without a drug. Only two, who were academicians, felt that most of their cases were sent without a drug. The other responders (28) felt that a few of their cases were sent without a drug.

Usage of NE drugs: 33 out of 39 responders (85%) perceived themselves as not prescribing only NE drugs in most cases. This again corresponded to out objective assessment at PHC and at pharmacy wherein 2% and 14% cases were given only NE drugs.

Overall use of NE drugs: 29 out of 34 responders believed that they prescribed only a few NE drugs. 3 responders, who felt that they do not use any NE drugs were academicians. 4 responses were incompatible with their earlier responses and were discounted. In our objective analysis, the percentage of NE drugs used was 31% in PHC and 41% in pharmacy sale - somewhat more than what our alumni felt they did.

Reasons for using NE drugs: The most common reasons reported were: 1. placebo value (27) 2. patient expectancy 3. patient demand (21) 4. desirable action of the drug (17) 5. to justify the consultation fee (2).

An insight into patient behaviour was reported by some alumni. The patient behaved in a hospital, the same way as in a temple of worship, where they get `prasad' (holy offerings). For them, hospital was a temple, the doctor a priest, and the drugs were `prasad' to be sought after. If they were denied the `prasad',then they felt cheated in a government hospital and disappointed in a private hospital/practice. To conclude, the self-assessment feedback given by the alumni was revealing and useful.

A STUDY OF PRESCRIBING HABITS IN PRIMARY HEALTH CENTRES (PHC) AND IN PRIVATE PRACTICE

AIMS

1. To collect 50 consecutive drug prescriptions in a PHC and in a retail pharmacy for detailed analysis.
2. To estimate the average number of drugs prescribed, the percentage of non-essential (NE) drugs used and study irrational use of essential (E) drugs.

METHODS & OBSERVATIONS

Fifty consecutive drug prescriptions were collected from a nearby PHC. No case was sent back without a drug. No case was asked to buy a drug from outside.

In the retail outlet, 62 self-order drug sales were recorded by the time 50 prescription drug sales got completed. The extent of self-order sale, by no means restricted to over the counter (OTC) drugs, is to be seen to be believed.

A comparison of the two groups of data is given below:

Observations made	Group A (PHC)	Group B (Pharmacy)
No. of drugs - total	146	145
" - range per case	1 to 5	1 to 5
" - average	3	3
No. of injections	19 (13%)	n.a.
Cases with E drugs only	18 (12%)	11 (8%)
Cases with NE drugs only	1 (0.6%)	7 (5%)
No. of Essential drugs	101 (69%)	86 (59%)
No. of NE drugs	45 (31%)	59 (41%)
No. of E drugs used irrationally	10 (30%)	n.a.

COMMENTS

The number, range and average drug per prescription are all remarkably similar in both the groups. But the proportion of NE drugs is more in group B. Even if E drugs were used, they were irrationally used in 30% of instances. The volume of self-order drug sale was more than prescribed drug sale. The implications of the last two comments are obvious and need further studies and elaboration.

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OPINIONS OF PATIENTS AND PHYSICIANS ON A D R

AIM

To interview some known patients and physicians regarding adverse drug reaction (ADR) and gain insight into various aspects of the problem.

SUBJECTS & METHODS

Personal interviews with 20 patients (12 rural and 8 urban) and 6 physicians were conducted in a loosely structured format. The points were then culled and summated for presentation.

OBSERVATIONS

Rural patients: Out of the 12 interviewed, 5 were illiterate and 7 had done some schooling. Talking to them revealed the following points:

1. Most of them relate illness and drug effects to the ancient principles of `heat, cold, bile and air'.

2. Most of them felt that modern drugs were powerful and fast acting due to excess heat or cold properties and this may produce side-effects. Such effects were acceptable to them if the symptoms were not severe.

3. Whenever they felt any such effects due to a drug, they reduced the dosage or stopped it altogether. Only two consulted their doctor before doing this.

Urban patients: Of the 8 interviewed, all had atleast school level education. Talking to them revealed the following points:

1. Most felt that ADR meant `allergy'. One had Ayurvedic concept like the rural folk.

2. Allergy, according to them meant any undesirable effect or action of a drug or even non-drug.

3. Allergy generally meant personal dislikes also. Six gave examples like `allergic to x movie star' to explain their concept of allergy.

4. Five had experienced `allergic symptoms' like gas, vomiting, itching or rashes and all had stopped the drugs. Four changed their doctors and one reported back to the same doctor.

SUMMARY: The lay persons' concept of ADR was bipolar - either Ayurvedic or a confused understanding of allergy. Self-made therapeutic decisions were taken and feedback to the doctor concerned was absent in most instances of ADRs.

OPINION OF SIX PHYSICIANS:

Drugs avoided were analgin, oxyphenbutazone, aspirin in high doses, injection penicillin for outpatients and injection streptomycin.

Drugs in restricted use: Chloramphenicol, analgin, penicillin and tetracycline (obsolete).

1. All were aware of side effects, adverse reactions and special precautions of commonly used and established drugs but not of newer and rarely prescribed drugs.

2. If a mild ADR was reported, only reassurance was given but if potentially serious are causing discomfort, the drug was withdrawn. all of them had seen some `problem hypochondriacs' who always got ADR before the major drug effect.

3. All were conscious of the fact that severe ADR usually meant a patient lost to other doctors in the vicinity.

4. Severe ADRs encountered in their practice included the following:

- Steven Johnson Syndrome (drug unknown)
- Aplastic anaemia - analgin related
- Anaphylactic shock - analgin, penicillin and oxytetracycline related
- Sudden cardiac death following inj. aminophylline.

ADR MONITORING

There were no reporting or monitoring agency known to any of them except a local government doctor. There was a mechanism of reporting serious ADRs to Director of Medical Service, Pondicherry who could ban the use of the suspected drug or the batch of drug.

ADR information: Since it is vital not to lose a patient, all the physicians informed their cases, either orally or in writing, common side effects, e.g. headache following nitroglycerine use, or urine color change after taking rifampicin. At the same time, too much of stress was not made on ADE for fear of making the patient more afraid of the disease rather than the disease. A physician who saw mostly illiterate rural poor said that his patients expected him to make all the decisions for them, even non-medical ones!

SUGGESTIONS ON ADR INFORMATION TO PATIENTS

1. The drug industry could keep a package-insert for lay persons.

2. ADR reports must have follow-up action and also feedback to the reporting doctor.

3. While herbal remedies ofter with no proper scientific proof were being trumpeted as safe miracle cures, the openness of modern medicine was exploited by quacks and practitioners of alternate medicine to their advantage.

4. Drug combinations made it more difficult to pinpoint the drug causing ADR.

OPINION OF SOME PHARMACISTS

Pharmacists felt that they were only `vendors' and ADR info and reporting was the duty of the treating doctors. These were Govt. employed and qualified but reluctant. In contrast, private sector `pharmacists' were unqualified. The official qualified one was often a `Phantom' pharmacist!

PROS AND CONS OF PATIENT EDUCATION ON A D R

FOR	AGAINST
Educated patients should be told of risk/benefit in treatment. Saves problems if ADR occurs later.	Most patients, especially illiterates cannot handle ADR info. The doctor should decide for them.
ADR information to patients is a must - on ethical and and practical grounds.	Patients query at odd hours on ADR symptoms and signs.
Serious ADRs need to be warned.	Patient may become more afraid of the drug than the disease.
Doctor-patient interview should include ADR information.	It takes a lot of time to explain all ADR and reassure them.
ADR information promotes `patient autonomy'.	`Paternalism' is promoted by the doctor deciding for the patient.
Therapeutic trials may be taken more seriously if ADR is known to the patient.	Therapeutic nihilism may be promoted by over-emphasis on risks.
ADR info contributes to scientific clinical practice.	Fear of `modern medicine' may push the patient into the hands of quacks and charlatans.
May prevent self-medication and over-medication.	
Knowledge of ADR improve efficacy.	

The above list was compiled with the help of the physicians.

SUMMARY

Though ADR information is an important area, many problems need to be addressed if it has to become effective.

Lay persons' perceptions on drug effects and ADR, forces that act against ADR reporting and monitoring and a general lack of administrative action in the matter of ADR should all be considered while formulating any corrective strategy.

-DR. K.R. SETHURAMAN, M.D., JIPMER, PONDICHERRY, INDIA.

SAMPURNA

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PROGRAMME

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Keep your mind going, keep a new lease on work by career switching if necessary. Human beings do not simply exist, but always decide what their existence will be.

To make your retirement fruitful, start investing on yourself. Look for unmet needs, define your goals and analyse your skills; now is the time to do what you really wanted to ... and experience new spiritual horizons.

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General Information

For the courses you wish to join, please write to :

The Director
Montfort College
Old Madras Road, Indira Nagar
Bangalore - 560 038

Courses begin in the morning of the given date of commencement (the date of arrival is the previous day) and conclude by the tea time on the last day of the course.

Mathew Pannathanath, SG.
Director

SETHURAMAN, KR

DRA-9.

HOLISTIC MEDICINE

"Holistic is a buzz-word today - different persons interpret it in different ways. However, holistic perspective in medicine has been advocated by ancient physicians like Hippocrates and Charaka.

Hippocrates has said "I would like to know what kind of person has a disease rather than what disease that person has". Just think about it! Even today, it is difficult to improve upon this simple and yet accurate view of holistic perspective. Consider the person with a real or perceived health problem as a whole - his/her personality, attitude to life, knowledge, socioeconomic and cultural standing etc. in order to understand the illness from a holistic view point.

Charaka said this in a more abstract manner: "A physician who fails to enter the body and mind of a patient with a lamp of knowledge and understanding can never treat rationally". Perhaps the sage Charaka could foresee the current culture of taking `a pill for every ill' and getting treated in a mindless fashion.

If Medicine had such a `holistic' view, then when and how did it degenerate to be a dehumanised profession? As medical sciences advanced, we could understand more and more about the causation of diseases - Malaria which was thought to be due to "foul-air" was proved to be due to a blood parasite carried by a mosquito. Similar revolutionary discoveries and progress were made in the field of medicine and therapy.

Our attention shifted more and more to the biological sciences at the expense of behavioural sciences. In order to cope up with the advances, specialisation became order of the day. As a cynic had said it, "specialist doctors knew more and more about less and less until they knew everything about nothing". Dr. K. White has coined the term "Ignorant Savant" for

this breed of specialist doctor who are well informed in their own limited field but are ignorant of patients lifeworld. T.S. Eliot asked us "where is the wisdom we have lost in knowledge? Where is the knowledge we have lost in information?"

The information loaded medicine or `infomedicine' as it is called, is based on biomedical model and simplistic in approach.

A causative agent or factor produces disease in person who consults a doctor. With the help of clinical and laboratory medicine, the disease is diagnosed and a drug is advised to control or cure of the disease. This works well on paper and in text books. But in real life, two-thirds of cases seen in general practice have symptoms that do not fit into any of the diagnostic label of the biomedical model.

During the past decade, concerned physicians around the world have realised this anomaly. Many models and new paradigms of biopsychosocial models have been proposed.

I would like to explain to you our own multidimensional model of health care which we believe represents a holistic approach to health care in the context of a teaching hospital.

There are four icebergs (or pyramids, if you like) and two circles linking these four icebergs (Fig.1) The patient is the apex and is part of a family which is part of a community . The patient carries the knowledge, attitude and practices of the community and the family. He/she also reflects the literary, social, cultural and economic status of the family and the individual. These hidden parts of the iceberg have to be considered to get a comprehensive picture of the patient.

Similarly, the disease iceberg has the following components - the illness (what the patient perceives), the disease (what the doctor perceives), the internal environment and causative

agent/factor, and finally the external environment and facilitating factors.

The third iceberg has doctor who is the most visible to the patient. He is supported by health care team and diagnostic facility. Health care system at primary, secondary and tertiary levels functioning at the locality and the country are at the bottom. Alternative systems of medicine forms another face of the iceberg.

The fourth is the treatment iceberg: the visible part is the drug and non-drug therapy advised by the doctor. Availability, accessibility and affordability of these therapies form the midportion. Production and procurement at a macro level forms the bottom of this iceberg.

Any changes in the hidden parts of these icebergs affect the visible parts. Finally these four 'elements' are linked by communication and transport. Media form part of the communication. These are acted upon by activist and professional organisations and regulated as well as acted upon by the Government.

As long as Indian mileu permits stray pigs to act as biological amplifiers, we cannot eliminate epidemics of brain fever (viral encephalitis). If facilities for training in Yoga are not available, what is the use of a "holistic doctor" prescribing Yoga for a patient?

This model may sound complicate enough to be an acceptable paradigm of holistic health care. But is it useful especially to a teaching hospital?

Our experiences at JIPMER with a group of trainee doctors has been given to you as a background paper. I'll just quote two examples:

1. Rasheed, a diabetic patient was a difficult case to control. He was on tablets and insulin injections. His family doctor repeatedly referred him for better control. Our intern interviewed him and discovered that Rasheed never took the injections for he believed that the insulin was derived from pork. His religion proscribed pork. He was reluctant to disclose this on his own for fear of ridicule.

2. A 15-year old boy had fever for 2 months. He had disseminated tuberculosis (TB). In spite of his family having had two cases of TB lung, none of them suspected TB in this boy "because he had no cough or blood spitting". On review, our intern found that none of the educational campaigns on TB stress on TB of other organs. Hence the community is generally aware of only the lung TB.

After using the model for one month, the interns opined thus:

The conventional history elicitation covers a lot of personal and family details. The use of the health care model added newer dimensions in understanding a case, especially a chronic one.

RELEVANCE TO THIS WORKSHOP:

As you can see, this model incorporates all the elements that influence health and health care either directly or indirectly. The academician, the health activists, the drug industry, the diagnostics, the government, the media - all find mention. Each of them can contribute to improving the health status of the people.

HOLISTIC APPROACH TO CONSUMER EDUCATION:

We, the members of EQUIP believe that health education and consumer empowerment is a multidimensional and holistic process. Many agencies and activists have to co-ordinate to achieve the common goal. Our logo for the workshop consisting of six interlinked arms denote this belief. The emblem of EQUIP itself reflects our belief that doctor-patient relationship is a fragile one based on trust. It is fiduciary in nature and health care is not a commodity to be purchased by a consumer who has the means to do so. The central frame represents this trusting relationship which is under considerable strain for various reasons. It is for the government, the industry, the consumer activists and the media to promote and protect the doctor-patient relationship. These four elements are shown as two arms protecting the flame in our emblem.

Our common goal is better health care for all. To achieve this objective, a start has to be made. During this workshop, let us put our heads together, consider various aspects of the health care system as it exists in India and find some ways and means of improving the matters. We aim to release our consensus in the form of Pondicherry Declaration on 4th December. This Declaration will also contain Charter of rights and responsibilities of health professionals and consumers of health care. Of course, this will have no official sanction at present, but hopefully it will initiate a national debate and lead to positive action by various interest groups. This has happened in Malaysia on 1st March 1993. There is no reason why it cannot happen in India by next year.

We are aware that many workshops end up with passing of resolutions and nothing beyond that. In fact, Swami Vivekananda has said "an ounce of practice is worth tonnes of promises". I hope that we would commit ourselves for some definite follow-up action during the next year or two. Thank You!

Dr. K.R. SETHURAMAN MD
PRESIDENT – EQUIP.

BHAGAVAD DHARMA

Sri Sri Bhagavan's Way to Liberation

(A monthly news–letter from the TEMPLE OF SRI SRI BHAGAVAN, Bangalore)

Recommended Price Rs. 5/- Issue : 3 October 1993 For Private Circulation

SPECIAL ISSUE ON HEALTH

The Divine healing of Sri Sri Bhagavan

Many participants have experienced miraculous cures of their ailments during our Spiritual Intensives. This issue has excerpts of the conversations in which Sri Sri Bhagavan has made reference to health related issues. Some of the insights revealed to the sadhaks by Sri Sri Bhagavan during meditations have also been included.

* Health is a very complex thing to understand and it is not required to understand all about health-in order to remain healthly. Every human being intuitively knows everything that he/she is required to know.

* All theories are models and can never fully-capture experiential reality. So any theory of health should be used with intuitive wisdom of the healer. A theory should be treated as a supporting technique and not as the truth or fact of human processes.

* There are essentially two approches to healing

1. Natural healing

This includes leave it alone healing, faith or religious healing.

2. Artificial healing

This includes the use of magical potions, empirical medicine and the modern medicare (casual or analytical approach)

The view of disease is entirely different in the two approaches. In the first approach disease is seen as a condition with a Divine message. In the second approach disease is seen by a person as an undesirable condition which has to be got rid of somehow. Also the second approach nurtures a hope of understanding the physiology of the human body and other associated mechanisms in order to eventually be able get an upper hand over disease and perhaps even on death. No such hope exists among the votaries of the first approach and hold that life is essentially has to lived - it can never be understood. Mahathma Gandhi very forcefully makes a case for the first approach in his book HIND SWARAJ.

* In Faith healing the essential key is to be able to receive the Divine message contained in the disease (in general any sorrow). For this a person has to fully experience the dis-ease, pain or sorrow and be in it–until he gets a mystical or a Divine experience. The experiencing of the sorrow or pain or dis-ease fully is an art that can be acquired through Sadhana or practice. The process of acquiring this skill is greatly hastened by praying to a Spiritual Master like Sri Sri Bhagavan. The Divine experience can assume many forms. It can be Descent of Sri Sri Bhagavan in an effulgent form into your heart or it can be a brilliant vision of the Light of GOD or it can be a flash of understanding accompanied by bodily convulsions or even a powerful dream where you get a Divine message of healing. There is never an iota of doubt left after having a Divine experience. Any healing which is not associated with such an experience generally does not have a profound effect.

Sri Sri Bhagavan often tells us that an individual is his relationships. Minus these relationships or securities there is no individual. The primary relationships of a person are with his parents, spouse, and children. Every person is seeking unconditioned love in these relationships. But unfortunately everbody is only getting a cheap substitute viz. conditioned love. It is sufficient for a person to receive unconditioned love for a small duration of time and be completely satisfied for

ever. Conditioned love however is never satisfying and a person keeps on craving for more and more of it without ever getting fulfilled. When he does not get love, he indulges in games which often involves falling sick and even dying. A person cannot die if atleast there are two persons cannot die if atleast there are two persons (including himself) who really want him to live and pray to that effect.

* The following poem illustrates the point discussed above :

We become unhappy only to share
it with our fellow beings
We become sick only to trouble our
family members only
We become unsuccessful only to
punish and pain our parents
Only by forgiving all and ourselves
can we be liberated

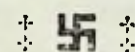
* The patient's family has to be involved in the healing process if the healing has to be lasting.

* The diseases which have been seen to have been cured are

1. Headaches 2. Migraines 3. Body Aches 4. Arthritis 5. Acidity and Ulcers 6. Eye defects 7. Skin ailments etc.

There does not seem to be a clear correlation between which diseases are more amenable to cure. If a person is able to get Divine experience then he will certainly get cured irrespective of what he is suffering from.

* The Spiritual Intensives are not conducted for the purposes of healing. Healing happens to be entirely a beneficial side effect in the path of spiritua growth.



Some Case Studies :

1. Dr. CHITHRA PRASAD, aged 60 years, Salem, Tamilnadu.

" In 1985 I underwent total hysterectomy, After one month I developed severe cholic pain. constipation and distention of the abdomen. As the months passed by the severity of pain as well as the frequency increased. Normally the pain used to last for about 10 hours during which I used to vomit and have bowel movements atleast ten times. The ailment was diagnosed as post operative complication - a subacute obstruction in the intestines due to adhesions. My condition continued like this till I attended the Spiritual Intensive in Somangalam, Madras in April 1992. There I had the last attack of my cholic pains which lasted for about four hours. I was healed there with the Divine grace of Sri Sri Bhagavan. After that I never have had such an attack.

2. Mrs Sarvanammа, aged 55 years, mother of Dr Murulikrishna, Director M. R. Hospital, Madras.

Her previous condition : A congenital defect in the heart. Her heart beat was 55 per minute. She used to get very tired and was incapable of any kind of even light strenuous work like climbing stairs etc. The Healing : Through the Divine Grace of Sri Sri Bhagavan she got a new pace maker and her heart beat was restored to the normal of 72 per minute. (Please not get confused that a artificial pace maker was installed, No Scissors were used and the whole healing took just four minutes). Dr. Anandan leading a group of devotees invoked the Grace of Sri Sri Bhagavan and also witnessed the operation being performed on the subtler planes with the help of his Avirbhava of Sri Sri Bhagavan inside his heart. Dr. Mayilvahan another medical doctor witnessed the whole phenomenon on the physical plane and personally watched the miraculous cure. Her present condition is completely normal.

3. Mrs Vanita K. Bhat, Director Balalok School, Virugambakkam, Madras, aged 50 years.

A patient having persistent migraine, very high B. P. 110/180, and hypo thyroid used to consume 28 tablets a day. Now she is completely normal and has not taken any medicine since she has received the Divine Avirbhava (The holy spirit) of Sri Sri Bhagavan in September 1992

4. Mrs Parvatiamma, 60 years, ritired teacher was operated for retinal detachment in Vijaya Health

Centre, Madras. The operation was not successful resulting in total blindness. After healing by means of a Divine surgery Sri Sri Bhagavan restored her vision. Within minutes she was able to walk unaided and after 15 days she was able to read the newspaper.

Most of the Divine Surgeries were witnessed by Dr. Anandan who is a leading surgeon in Madras with the help of the Avirbhava or the Holy Spirit of Sri Sri Bhagavn.

5. Chi. Vijayaraghavan aged 15 years, student of Balalok School. He was limping with a lot of pain for the last 6 years after an accident involving multiple fractures. After the Divine Healing of Sri Sri Bhagavan he is playing basket ball.

6. Chi Ashirroy Dinesh aged 16 years, student of Balalok school used to develop sudden breathlessness and his windpipe used to get blocked. The emergency treatment given to him was to put him on oxygen. The ailment was diagnosed as anxiety attacks and was put on sedatives as preventive medication (valium 3 times a day and some other medicines). Ashirroy began to lapses in his memory as a side effect. Again with Dr Anandan headed a group of devotees prayed to Sri Sri Bhagavan and invoked His Grace and completely healed the boy. All medication has stopped and the boy is leading a completely normal life.

7. Dr. Shirdi Prasad Tekur is a pediatrician. He happened to examine a 4 day old baby which had jaundice. The attending pediatrician had felt that the baby was in a critical condition and had suggested total blood transfusion as the only means to keep the baby alive. However the moment Dr. Shirdi Prasad saw the baby he felt that Sri Sri Bhagavan is there in the baby so he immediately took the parents into confidence and told them not to go in for blood transfusion. The attending pediatrician got annoyed and told the parents to legally cover themselves in case the child was harmed and a legal document was prepared to that effect and signed by Dr. Shirdi Prasad. Sri Sri Bhagavan then told him to discharge the baby immediately when the baby was brought home the baby completely recovered and started smiling.

MONTHLY ACTIVITIES:

The Temple of Sri Sri Bhagavan, Bangalore has the following regular activities.

* Satsang will be held at the Temple premises on every Sunday between 10-30 a. m. and 1-00 p. m.
* The spiritual Intensive will be held once in every month. Such of those desirous of participating in this programme may kindly contact the centre for further details.
* In order to spread this movement you may also organise Satsangs at your premises inviting atleast 10 people. Some of the Bagavad Dasas will address the satsang on prior intimation to them.
* You can visit the Centre on any other day to discuss and clarify issues that may by important to you.

Bangalore Temple : Dr. SHEKAR R. BORGAONKAR
163/B, 5th Main, 4th Block, Rajajinagar, Bangalore-560 010 Phone : 352834

Other Contact Points : S VISWANATHAN Phone : 354198
R. SOMANATH Phone : 355971

ಶ್ರೀ ಭಗವಾನ್‌ರ ಆಧ್ಯಾತ್ಮಿಕ ಶಿಬಿರದಿಂದ ಜಿ. ಶ್ರೀಧರ್‌ರವರ ಆರೋಗ್ಯದ ಅನುಭವಗಳು

ಶ್ರೀಧರ್‌ರವರು ಪ್ರಿಂಟಿಂಗ್ ಪ್ರೆಸ್‌ನ ಮಾಲೀಕರು. ಇವರಿಗೆ ಎರಡು ವರ್ಷಗಳಿಂದ "ಸೋರಾಸಿಸ್" ಎಂಬ ಚರ್ಮವ್ಯಾಧಿಯಿಂದ ನರಳುತ್ತಿದ್ದರು. ತಲೆಯಿಂದ ಕಾಲಿನವರೆಗೂ, ಚರ್ಮದ ಬೊಬ್ಬೆಯಿದ್ದು ಸುಲಿದು ಬೀಳುತ್ತಿತ್ತು. ಇದರಿಂದ ಅವರ ತಲೆಯ ಮೇಲೆ ಕೂದಲು ಇಲ್ಲವಾಗಿತ್ತು. ಬಟ್ಟೆಗಳು ಮೈಗೆ ಅಂಟಿಕೊಳ್ಳುತ್ತಿತ್ತು. ಇವರು ಸೈಂಟ್ ಜಾನ್ಸ್, ಕೆಂಪ್ಸ್ ಮತ್ತು ಮಾರ್ತಾಸ್ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ಅಡ್ಮಿಟ್ ಆಗಿ ಉಪಚಾರ ಪಡೆದಿದ್ದರು. ದಿನಕ್ಕೆ ಮೂರು ಬಾರಿ ಮಾತ್ರೆಗಳನ್ನು ತೆಗೆದುಕೊಳ್ಳುತ್ತಿದ್ದರು. ಅವರಿಗ ಮೈಕೈ ನೋವು ವಿಪರೀತ. ಒಂದೆರಡು ಕೆ.ಜಿ.ಯಷ್ಟು ಭಾರವನ್ನು ಹೊರಲಾಗುತ್ತಿರಲಿಲ್ಲ ಹಾಗೂ ನಡೆಯಲಾಗುತ್ತಿರಲಿಲ್ಲ ಮಂಡಿ ಮುಂತಾದ ನೋವು.

ಇವರು ಜುಲೈ ತಿಂಗಳ ಆಧ್ಯಾತ್ಮಿಕ ಶಿಬಿರಕ್ಕೆ ಪಾಲುಗೊಂಡರು. ಇವರು ಶಿಬಿರಕ್ಕೆ ಬರುವೆನೆಂದು ಅಂದ ಕೂಡಲೇ ಇವರಿಗೆ ಅವರ ಖಾಯಿಲೆ ಗುಣಮುಖವಾಗಲು ಶುರುವಾಯಿತು. ಶಿಬಿರದ ಮೊದಲೆರಡು ದಿನ ಅವರಿಗೆ ತೊಂದರೆಯಿತ್ತು. ಆದರೆ ಇಂದು ಅವರಿಗೆ ಚರ್ಮವ್ಯಾಧಿಯು ಪೂರ್ಣವಾಗಿ ಗುಣವಾಗಿದೆ. ಮಂಡಿಯಲ್ಲಿ ಮಾತ್ರ ಸ್ವಲ್ಪ ತೊಂದರೆಯಿದೆ. 5 ಕೆ.ಜಿ. ತೂಕವನ್ನು ಸರಾಗವಾಗಿ ಹೊತ್ತು ನಡೆಯುತ್ತಾರೆ ಮತ್ತು ತಲೆಯ ಮೇಲೆ ಕೂದಲು ಬೆಳೆದಿದೆ. ಅವರ ಮಿತ್ರರೆಲ್ಲರು ಅವರನ್ನು ನೋಡಿದಾಕ್ಷಣ ವ್ಯತ್ಯಾಸವನ್ನು ಗುರುತಿಸುತ್ತಾರೆ. ಹಾಗೂ ಅವರು ದಿನಕ್ಕೆ 60 ರೂಪಾಯಿ ಔಷಧಿಗೆ ಖರ್ಚು ಮಾಡುತ್ತಿದ್ದ ಅವರು ಈಗ ಕೇವಲ 10 ರೂಪಾಯಿಯ ಔಷಧಿ ಹಾಗೂ ದಿನಕ್ಕೆ 1 ಬಾರಿ ಮಾತ್ರ ಮಾತ್ರೆಯನ್ನು ತೆಗೆದುಕೊಂಡು ಗುಣಮುಖರಾಗುತ್ತಿದ್ದಾರೆ. ಇವರಿಗೆ ಆವಿರ್ಭಾವ ಆಗಿಲ್ಲ ಭಗವಾನರ ಮಹಿಮೆಯ ಬಗ್ಗೆ ಸಂಪೂರ್ಣ ನಂಬಿಕೆಯಿದೆ.

ಶ್ರೀ ಭಗವಾನ್‌ರನ್ನು ಪ್ರಾರ್ಥಿಸುವ ಕ್ರಮ

ಬನ್ನಿರೋ ಬನ್ನಿರೋ ಕುಣಿಯೋಣ ಬನ್ನಿರೋ
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ಅವನ ಕೃಪೆ ದೊರೆಕಿತೆಂದು ನಿನ್ನ ಮನಕೆ ತೋರಲು
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ನಂಬಿಕೆಯೇ ದೇವನೆಂಬ, ದೇವನುಡಿಯ ನೆನೆಯಿರೋ
ಓಂ ಭಗವಾನ್, ಓಂ ಭಗವಾನ್, ಓಂ ಭಗವಾನ್ ಅವನ ನಾಮ
ಓಂ ಭಗವಾನ್, ಓಂ ಭಗವಾನ್ ಅವನ ನಾಮ ನೆನೆಯಿರೋ

Spiritual Intensive Conducted at Central Jail, Bangalore on 9th, 10th and 11th September 1993

A Spiritual Intensive was conducted for the inmates of the central Jail, most of them serving life sentence In all about 50 persons participated. Many had powerful Divine experiences while all of them developed tremendous 'Bhakthi'. The sharing of experiences during 'Samalochana' was stunning and even the Superintendent of jail, who had given the permission for the programme expressed the uniqueness of the programme He said that if he had refused the permission for the programme, he would have cheated the inmates of something invaluable We have been given an open invitation to organise Satsangs and Spiritual Intensive as frequently as we can make it. The love, authenticity and the goodness of the convicts was an experience for the Bhagavad Dasas. We intend to conduct many such intensives in schools, colleges, orphanages etc. All of you are requested to take initiative in organising them.

Book-Post

To.

Embodiments of Divine Atma!

It is most essential to observe the principle of moderation in food habits, work and sleep. The Buddha, preached the same principle of moderation to his disciples. "Be always moderate, never go to excess." proclaimed the Buddha. In fact moderation is the royal road to happiness.

The modern man who flouts the principle of moderation in every aspect of life, endangers his health and well being. The food consumed by man should be proper, pure and wholesome. But nowadays people eat whatever they get and wherever they get it from, and thereby spoil their health. Food plays a major role in the upkeep of health. Care should be taken to see that the food consumed does not have much fat content, for, the fats consumed in large quantity are detrimental not only to one's physical health but also affects the mental health, whereby he loses human values. Meat and alcoholic drinks take a heavy toll of man's health, causing many a disease in him.

The symposium scheduled, has for its theme "The Heart and its ailments". Also in the agenda the discussion about the preventive aspects of diseases as well as the treatment and the effects of heart diseases find a place. Questions are raised about the efficacy of Cardiac Surgery and related effects. The heart is a special organ in the human system, for it is pulsating ceaselessly unlike the other organs. The heart surgery involves complexity for the surgery has to be performed without arresting the heartbeat at the same time the functioning of the lungs should also be kept up. The medical men of genius invented the heart lung machine in 1956 to carry out the activities of the heart as well as the lung during the cardiac operations. The machine takes upon itself the function ensuring the purification of blood and keeping up circulation of the blood. The details of the functioning of this heart-lung machine is well known to the doctors. The tube which is fitted connecting the heart and the machine should be airtight, and should be fixed with great care, for any lapse in the fitting of the tube may cause air bubbles which will endanger the patient's life. The power supply is most crucial for the success of the operations, for any interruption in the power supply will stall the operation. Therefore we have to depend on generators for ensuring uninterrupted power supply during the course of the operation.

Questions are posed if the heart surgery ensures permanent cure. Cardiac surgery is helpful, for it enables man to carry on his daily schedule and lead a normal life. But, it is wrong to conclude that surgery is the only way of curing heart diseases. Some of the diseases can be cured even by medicine. In my opinion it is the primary responsibility of every individual to prevent becoming victims of heart disease, by regulating the food and other habits. Prevention is better than cure. There will be no room for cardiac ailments if your food habits are properly controlled and regulated.

Research has revealed that non-vegetarian and alcoholic addicts are more prone to heart ailments than vegetarians. If the vegetarian food consumed should be balanced and wholesome, it should contain liberal doses of vitamin C and vitamin E, which are available in vegetables like carrot, for, the presence of these vitamins prevents the heart ailments in a large measure. Every effort should be made to keep the human body healthy. Health is wealth. Acquisitions of wealth cannot be enjoyed by a person with poor health. Health is more important because it gives physical and mental strength to a person.

The birds and beasts do not suffer from any cardiac and digestive ailment, as man suffers from. The cause can be traced to the natural food which the animals consume unlike, the human beings who are

indulging in taking all sorts of fried and cooked items of food being slave to the tongue. The modern man has come out with many artificial food stuffs and a variety of alcoholic drinks, which highly endanger man's health. The birds and beasts lead natural lives, whereas, the artificial life styles of man today takes a heavy toll of his health. When man observes moderation in diet he can be saved from diseases. In the entire range of God's creation man alone is endowed with the faculty of discrimination. It is this faculty of discrimination which sets him apart from the animals. Man should exercise his discretion and discrimination in regard to food habits.

The progress of man ensures the progress of the universe. When man prospers, the universe too prospers. Any amount of development in the areas of scientific, economic and social set up of man is not of much use without mental transformation. It is only the mental transformation of man which can confer perfect health and well being.

How can we bring about this transformation in the mind of man ? The transformation of the mind of man can be brought about by restraining passions and emotions. Since mental tension is most detrimental to man's health, man should learn the art of controlling his passion and emotions, for unbridled emotions strain the mind of man. It is also essential that we keep our mind serene and peaceful while eating food. We should not indulge in discussions of topics which will arose our passion and excitement and disturb the mental peace while we are taking food. Mental tension is responsible for ill health. We should also avoid viewing TV, video etc while eating food, as they cause mental disturbances.

Now there is pollution in every thing such as the air that we breathe, the water we drink, the sounds which are jarring to the ears and food we consume. Because of this all round pollution, man's health is affected. Apart from this, man's mind is also polluted making him susceptible to diseases. Man should make earnest endeavor to lead a serene and pure life. Man should realize the truth that troubles and turmoils are temporary, like passing clouds. There is no scope for agitations to arise in you if you realize this truth. The person who realizes this truth will not allow his mind to be swayed away by the passions of anger, cruelty, etc. Passions yield only temporary satisfaction but causes emotional disturbances. Hence, it is imperative on the part of man not to yield to any unbecoming passions while taking food. The observance of the three 'P's namely, purity, patience, and perseverance, vouchsafes permanent happiness and good health free from diseases.

It is not only the unbridled passion which damage the health of man, the consumption of foods like meat, liquor etc also cause equal damage. Living on ill-gotten money also causes ill-health to some extent. The living made by unjust means causes many unknown diseases to take root in us. It is said,

As is the food, so is the mind;
As is the mind, so are the thoughts;
As are the thoughts, so is the conduct;
As is the conduct, so is the health.

Man today is a victim of worry. What is the cause for this worry ? Lack of contentment is the cause for worry. The rich man is not contented in spite of the accumulation of wealth. A discontented man loses, whereas, a contented man gains. Worry causes hurry and both of them together bring about ill health. So Worry, Hurry and Curry (fatty foods) are the root cause of cardiac ailments.

Presence of large quantities of fat is the cause of Cardio vascular diseases. Doctors advise against the consumption of fatty food stuffs which cause increase in weight resulting in ~~resulting in~~ susceptibility to cardiac diseases. The presence of toxins also inflicts equal damage. So man should eat in moderate quantity of the right type of food and avoid intoxicating drinks to safeguard his health.

The intake of food should be gradually reduced after crossing 50 years. Some people consume food indiscriminately unmindful of the calorie content of the food taken. For example, people eat pappads fried in oil (thin circular flour preparations) which have high calorie content. People also consume 'ghee' which is also a high calorie food. A single pappad has 100-150 calories of energy, whereas a single spoon of ghee also has 100 calories of energy. Even when the quantity of food intake is reduced, reductions in the calorie content is not ensured.

There are some doctors who advise the patients against smoking and addiction to alcohol, but they themselves smoke and drink! This gap between speech and practice raises doubts in the mind of patients about the sanity of the medical advice given by them. Such doctors who do not observe the harmony of speech and practice, mislead the patients.

Embodiments of Love! You have high degrees such as MD, FRCS, MRCP, etc., as a result of your sincere striving. But it is a mistake to think that you earned these degrees. In fact these high degrees have been conferred on you for your study, skill, memory power and knowledge. These degrees will truly belong to you on the day you apply this knowledge in practice.

But unfortunately, in this modern age all activities and professions are tainted by a commercial outlook and greed for earning money. Even the sacred profession of a doctor has degenerated into a business deal. A doctor should reflect the triple qualities of sacrifice, love and compassion in treating his patients. But some doctors do not have these virtues at all! They misuse their divine and sacred knowledge for the sake of money. Money is important, but we must exercise discretion in this regard. You can charge the correct fees from the wealthy, but be kind and considerate while dealing with the poor. Try to give free treatment to the poor. You should not charge the millionaire and pauper alike! It is said 'Vaidyo Narayana Harihi'. (The Doctor is equal to God). As the Lord has love and compassion, the doctors too should have these divine virtues of the Lord. A doctor devoid of these virtues is not a doctor at all!

Doctors should win the minds of the patients by talking to them with compassion and concern. The diseases are half cured when the doctors win the minds of the patients by talking to them with love and consideration. The sick and the diseased respond favourably to your treatment once you start talking to them with love and a smile on your face. But if you purse your lips and wear a grim expression on the face, the patient loses heart. The doctors should administer the injection of courage and encouragement as is calcium administered to the weak. So it is most essential that doctors should have these sterling virtues of love and compassion. Compassion is more important than money.

How to lead healthy life? Let me tell you about my own health. I am sixty eight years old and believe it or not, my weight for the last 54 years has been the same 108 pounds only. It never went up to 109 pounds or touched down to 107. You can lead a healthy life once you achieve this kind of balance and moderation. I never eat even a little bit excess. I observe the principle of moderation whether I am invited for food by a millionaire or by a pauper. Even though I am sixty eight years, my body is in perfect trim!

I do not suffer from aches and my heart is as sound as a rock. There is none who can work like me and exert himself as much as I do! The secret of my sound health is my regulated food habits. This is how one has to achieve the unity and harmony of food, head and God.

The foremost quality of a doctor is sacrifice. We have organized this Symposium to explore ways and means of rendering help to the sick and the diseased. We have in India some doctors who lead lives of sacrifice like Dr. Venugopal, Dr. Bhan, and Dr. Sampath from All India Institute ofMedical Sciences. These doctors who are committed to the cause of service come to our hospital without even charging the traveling expenses. Their sacrifice contributes to the sanctity of this Institute of Higher Medical Sciences. There is an atmosphere of infective joy and good cheer which pervades our hospital. Every body is in smiles, the patients, their relatives, the nurses, the doctors, every one! They are all like flowers in full bloom. But it is not the same with other hospitals.

The essential mark of a hospital is its cleanliness. Clean toilets are index of the cleanliness of a hospital. Our hospital is as clean as a mirror, for it is kept always clean by the team of dedicated sevadal volunteers who relentlessly work hard with a spirit of service and sacrifice. It is not the service of one, but the service of the many which contributes to the prosperity and the rapid development of our hospital! A single flower cannot make a garland. All the people - the patients, doctors, workers, every one work with the spirit of harmony and unity. It is this sense of unity which contributes to purity and this purity of heart secures Divinity. This hospital is a direct proof for the presence of purity, unity and divinity. It is our fond hope that such purity, unity and divinity should prevail in other hospitals as well!

Unity is most essential in all fields of activity - moral, scientific and spiritual. Purity vanishes in the absence of unity. Divinity will be extinct when there is no purity and unity. People pin their faith in 'community' in utter disregard to unity, purity and divinity. We should never encourage communal feelings for we should believe in the fatherhood of God and brotherhood of the man. Humanity will be healthier and better if doctors resolve to render two days of free treatment every week.

Some doctors wonder how we are able to give free treatment, free operation and free meals to our patients in our hospital. To be frank, there should not be any scope for wonder in this regard. You can work wonders with purity of heart. Any work which is started with purity of heart is bound to succeed. Money flows if your work is suffused with love and sacrifice. People will volunteer with munificent funds to support any noble endeavour.

The land of Bharat (India) has been a Punya Bhoomi, (land of sanctity), Tyaga Bhoomi (land of Sacrifice), Yoga Bhoomi (land of spiritual austerities) and Karma Bhoomi (land of righteous action). In fact there is no dearth of money in India. Sacrifice (Tyaga) ultimately secures for oneself all kinds of bhoga (opulences).

Good people eat moderately, people who practice spiritual austerity fill only half of their stomach; the noble ones eat only for living; the fools live only to eat.

What is the cause for poverty in India? The cause is only one fourth of the population work and three fourths of the population lead lazy lives. It is a serious blunder to entertain the notion that

India is a poor country. The cause for India's poverty is due to the laziness of her people. We should work without frittering away even a moment, when alone our nation will be rich and prosperous.

Who is the poorest man in the world? He who has many desires is the poorest man. Who is the richest man? He who has much satisfaction is the richest man. Man can have desires, but there should be a limit for one's desires. Desires which exceed all limits will be disastrous in the end. Accumulation of wealth robs one's sleep, which in its turn brings many a disease in its trail. Doctors should strive to cultivate contentment. Enjoy this contentment and try to share the joy of contentment with others.

Sacrifice secures immortality. What is the way to immortality? The removal of immoralities is the only way to immortality. We should make earnest endeavour to control the evil passions of anger, ego, jealousy and hatred. Today the quality of envy has become a disease.

Doctors envy doctors; Wealthy people envy other wealthier people. We must rid ourselves of envy and nourish human values. We should cultivate good manners, behaviour and discipline. What is manners? Who is man? The proper study of mankind is man. One must achieve the harmony of thought, word and deed to be called a man. Your conscience is the witness to your feelings and thoughts. Any work performed to the satisfaction of one's conscience is bound to be a success. Our hospitals and educational institutions prosper since we work for the satisfaction of our conscience.

We entertain neither fear nor grief though some people harbor evil intentions about us. We do not depend on others, we pin our faith on our own purity and conscience. None can shake us as long as we stand on the rock head of purity. Purity is the human quality which we should try to cultivate, the rest are only quantities. Of what use is quantity without quality? What is the use of barrels of donkey's milk? One spoon of cow's milk is much better than barrels of donkey's milk.

It is for the fostering of the human quality that we are all struggling day and night. Doctors should first and foremost have faith in spirituality. Faith in spirituality alone can bring in transformation of humanity. What is spirituality? Spirituality is not the celebrations of festivals, nor even performance of rituals. True spirituality is the earnest endeavour to eradicate all animal qualities. Today humanity has descended to such a degrading level that men see evil in good, without trying to see good in evil.

Doctors who are eminent experts in their fields have come to participate in the symposium here. Sincere efforts should be made to put your great talents and skill to good use. The climes and countries from which you have come may be different. But all of you have one thing in common: noble feelings. These noble feelings are God's gift to man and come by Divine grace. Harmony and adjustment are easy to cultivate by dint of understanding. Treat the patients as your own kith and kin, as your own brethren. The help which you extend in good faith to your patients will be rewarded in course of time. Diseases attack all, they do not distinguish between a millionaire and a pauper. You should show compassion to all without any distinction.

Doctors! deliberate in these three days as to how you can provide total cure for all heart ailments so that no one would suffer from this dreadful disease. It is my wish and blessing that you will have useful discussions, come out with ways and means of helping mankind to be free from heart ailments. With this I bring my discourse to an end.

- sSs -

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HOLISTIC MEDICINE, VOL. 4, 61 (1989)

EDITORIAL

I always wonder whether it is a good idea to publish conference proceedings. Even if the speakers actually produce their manuscripts on time, the words on the page may be well out of date by the time that they are published. And the written word never recaptures that sense of excitement that one feels at a really interesting meeting.

Last October the BHMA devoted its annual conference to *Energy in Medicine*, and we decided to go ahead and publish the results. I hope you find them rewarding. The ideas they embody were certainly intriguing when we heard them.

After a brief plea by myself that we should be careful how we use words like 'energy' lest we compound our confusion, there follows a paper by Pietroni *et fils* on breathing and how it is controlled. Our breath is essential for any energy change that occurs in the body, and Eastern medicine has much to say about 'the breath of life'.

So too does it say things about the aura, the 'subtle energy body' which it believes to surround the physical body. Changes in the aura are thought to presage physical illness. But most Western doctors simply don't believe in it. Here Julian Kenyon explains the extremely important research that his group is doing to try to establish the existence of subtle energies by objective methods.

Finally, Stanley Jacobs faces the daunting task of talking about the *Philosophy of Energy*. He contrasts many models and shows us how restricting our views to the conventional Western approach may seriously limit our perspective. In his opinion Ayurveda presents perhaps the most comprehensive picture of energy, as it relates to human nature. And Eastern approaches certainly give us the best opportunity to 'be still . . . and know that the other and the self are one'.

Another excellent article by Malcolm Pines entitled 'Psychological Aspects of Energy', was also presented at the conference and will appear in a later issue of *Holistic Medicine* because of shortage of space.

CLIVE WOOD

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PAPER

The Physical Nature of Energy in the Human Organism

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To get even close to any understanding of the physical nature of energy in the human organism sounds like a daunting task. Fortunately it isn't. Indeed, it is very simple. All human activity – physical and intellectual – depends on solar batteries.

Physical energy

In physics, *energy* is the capacity to do work. And *work* itself is done when we move a force through a distance. The horsepower of your car engine is measured in units that originally depended on how much weight a horse could pull up a mineshaft. So for the physicists, energy has a very precise meaning and it is measured in exactly defined units called, for example, foot-pounds, or calories or joules or watts.

There were originally many different units because there are different forms of energy – mechanical, electrical, chemical and so on. One of the most basic and exciting findings in physics is that all of these forms of energy are interconvertible.

This is not a new discovery. Two hundred years ago an American-born, inventor noticed that drilling out gun barrels made them too hot to touch. Mechanical energy was being converted into heat energy. And we have known for over a hundred years that passing a metal wire through a magnetic field produces a flow of electricity – the principle that operates the dynamo on your bike, or the generator in a power station. In a nuclear station, atomic energy is turned into heat, which is turned into mechanical energy to drive the turbine. So energy is a unity and, of course, matter and energy are also interconvertible. Einstein's equation

$$E = mc^2$$

describes the huge amount of energy that we create by converting tiny amounts of matter.

Living on solar power

Living systems run on energy as well, in this case biochemical energy. Plants 'fix' the energy of sunlight; animals use the energy stored in the chemical

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bonds in their food. Both shunt it into their own energy-rich molecules and most of the processes of life depend on the biochemical energy that is released when a particular molecule (technically called adenosine triphosphate or ATP) which the organism creates for itself as an energy store, is split into simpler structures. Since animals eat plants (or other animals which eat plants) all biochemical energy comes from sunlight – solar energy which gets converted into the energy of chemical bonds. So we all live essentially by solar power.

Laws and equations

Although energy exists in so many interconvertible forms they all obey the same physical laws. So we can be confident in using a single label to describe this whole series of similar (indeed basically identical) qualities or 'things' that we call forms of energy. We recognize energy by the effects it has and the forces that it creates. These effects are both predictable and measurable and we have instruments to answer questions like 'how much?' or 'how strong?'.

We also have equations that relate forms of energy and forces to each other. For example, when work (W) is converted to heat (H) there is an exact relationship between the two given by:–

$$W = JH$$

When two bodies attract each other, the force between them (F) depends directly on their combined masses, but inversely in the square of the distance between them:

$$F = M_1 \times M_2/d^2$$

The precise equations don't matter for our purpose here. What matters is the fact that they exist.

It has taken over two centuries to establish these laws and, contrary to some popular beliefs, the coming of relativity, quantum theory and the new physics hasn't shaken them. They describe the reality of our lives to an accuracy of at least one part in a thousand million – close enough for us to catch the next bus or send a space-probe to Saturn.

Back to Babel?

But a problem may arise when more recently discovered 'things' (more recent to scientists at least) are also called 'energy'. For example, we hear about *biodynamic energy*, about the energy in the acupuncture meridians and about the *subtle energy body*. To call these things energy, to use this particular label, implies that we *know* that they follow similar laws to, say, heat or electricity, or at least that they follow *some* laws that allow for their measurement and allow us to predict the effects they are going to exert.

It seems to me that these 'subtle energies' have not yet been shown to obey the same set of rules (or indeed any set of rules) as electricity or magnetism. Now there is absolutely no reason why they must. It is possible, though I think unlikely, that they may represent a quite different order of reality. Such a discovery would be immensely important. But until we have this information I suggest that we use a word other than 'energy' to describe them, some neutral, non-value-loaded term. Otherwise, we risk being back in the Tower of Babel. The same is true for psychological energy (as opposed to brain energy, which depends on ATP) not to mention spiritual or healing energy.

It may seem arrogant that physicians and hard scientists – those who live by numbers – should seem to usurp a commonly used word and keep it for themselves, and I don't expect this to be a popular suggestion. But unless we do keep the different categories clear in our heads, and only classify them together when they have been *shown* to go together, we may do just as much harm to the idea of subtle energy, say by lumping it with electricity, as we do to ATP by confusing it with the life force.

What's yours called?

But of course, this whole question of how orthodox scientists use words and whether they agree or not with the world of 'unorthodox' medicine is totally irrelevant to the vast majority of the population. Most people simply *know* what *they* mean when they talk about *their* personal levels of energy. They don't need the scientific experts from either camp to tell them.

But just what do they mean? I started to ask this question a couple of years ago and I was amazed to find that there has been almost no research on the way that people perceive their energy, and how they experience it when it is high or low, let alone what they do to maintain it on good days or boost it when it flags. Even less has there been any attempt made to measure people's levels of energy before and after some activity that is 'supposed' to energize them, like say a burst of exercise or a session of acupuncture.

The lack of this research is due to the fact that most scientists (even medical scientists) spend most of their time considering what can go wrong with our energy systems. I myself spent years teaching stress research – the way that distress leads to dysfunction and eventually to disease. But I came to the conclusion that it would be at least as important (and a lot more fun) to carry out a series of studies on how people experience their personal energy and what they do to boost it. Such research should also try actually to *measure* people's energy levels over days and weeks, and to chart the way it varies following changes in their lives. But it should be broader than that. Feeling vigorous is just one aspect of feeling good about yourself and your world. What we really want to know is what makes people feel alert or enthusiastic about what they are doing and satisfied with themselves for doing it.

And so began the Oxford Energy Project, a three-year study in which we

hope to get answers to at least some of these questions. It is based at Linacre College and the Department of Physical Anthropology at Oxford and has the interest and support of people in various parts of the University. The Project is currently setting up a nation-wide network of people who are interested in taking part, either as research collaborators, or as volunteer subjects. As part of the study these volunteers will get a chance to monitor their own energy levels. And just as importantly, the network will bring people together to exchange their own ideas about energy and how it relates to areas like achievement, health and well-being.

If you are interested in having further details, or perhaps even becoming involved, simply write to Dr Clive Wood, Linacre College, Oxford OX1 3JA.

Joining the network doesn't cost anything and any results that people provide about their own energy levels will be completely anonymous. The Project should mix two vital components that characterize the best type of research. It should create new and interesting information. And it should be invigorating for all of these involved.

HOLISTIC MEDICINE, VOL. 4, 67–79 (1989)

PAPER

Respiratory Mechanisms and Clinical Syndromes

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Summary: A review of respiratory mechanisms is outlined and the links between sympathetic and parasympathetic discharge are described. The links between respiratory rhythms, autonomic modulation and the clinical syndromes of hyperventilation and obstructive sleep apnoea are delineated.

Keywords: Breathing Autonomic nervous systems Hyperventilation Sleep apnoea

Introduction

Breathing is one of the fundamental processes of living. If we stop breathing we die. In the last 20 years, Western medicine has become aware of some of the traditional medical practices of the East. To the surprise of many, they have not proved easily dismissible on the grounds of sham or placebo. Disciplines such as Ayurvedic medicine have claimed to show ways of using breathing to achieve shifts in normal and abnormal physiological states. This paper is a review of the current Western understanding of respiratory mechanisms as they are linked to distinct clinical syndromes. In a subsequent paper, we shall review the Ayurvedic understanding and describe the link between physiological descriptions of the body and Eastern Yogic practices.

I. Physiological mechanisms of breathing, with special reference to the autonomic nervous system

Breathing is one of the very few continuous physiological functions that can be controlled both voluntarily and automatically. Voluntary breathing is under cortical control, whilst automatic breathing is under the control of structures within the brainstem. The spinal cord is the meeting place of these two systems, as both use the same respiratory muscles. We can consciously control our breathing to such an extent that important changes in the concentrations of carbon dioxide and oxygen (P_{CO_2}, P_{O_2}), and acidity (pH) of the blood can occur. This cortical control is separate from brainstem control. There is a more direct pathway from the cortex and other higher centres via the cortico-spinal tract, to the spinal neurons that control the muscles of breathing.[1]

The diaphragm is the muscle of quiet breathing. When the diaphragm

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contracts the two domes descend. This creates a partial vacuum, sucks down the lung bases, and draws in air. The descent of the diaphragm causes passive protrusion of the abdominal wall. Expiration is produced by passive recoil of the lungs and chest, and by the contraction of the abdominal wall muscles. This is known as *diaphragmatic* or *abdominal breathing*. When increased pulmonary ventilation is required (e.g. during exercise) *thoracic* or *chest breathing* occurs. Contraction of the external intercostal muscles and the interchondral fibres of the internal intercostal muscles elevate the ribs. This causes the chest to expand and suck in air. The lateral fibres of the internal intercostal muscles slope in the opposite direction to the fibres of the external intercostal muscles. Their action is thus to produce expiration. Full inspiration can be produced by the diaphragm and the intercostal muscles alone. However, increased pulmonary ventilation requires rapid breathing. For this, the accessory muscles of inspiration are required – sternomastoid, scalenes and, if the arm is fixed, the muscles which attach the upper limb to the chest.

The 'respiratory centre' lies within the brainstem. It consists of several groups of widely separated neurons which are found bilaterally in the *medulla oblongata* and *pons*. The dorsal and ventral respiratory groups are located in the medulla. The dorsal respiratory group is mainly involved in inspiration, controlling the respiratory movements of the diaphragm. The ventral respiratory group is involved in both inspiration and expiration. It controls the respiratory movements of the thoracic musculature.[2] The *pneumotaxic centre*, in the upper pons, helps control the rate and pattern of breathing. An *apneustic centre* has also been described, but its function under normal physiological conditions is not known with certainty (see Table 1).

Inspiration during quiet breathing is controlled by the dorsal respiratory group (DRG). Expiration is passive, by the elastic recoil of the lungs and chest. An increasing signal, known as the 'inspiratory ramp', is produced by

Table 1. Relationship between location, function and information processing of respiratory centres

	Location	Function	Incoming information
Pneumotaxic centre	Pons:– Nucleus parabrachialis	Control of the rate and pattern of breathing	Pulmonary stretch receptors (PSR) VRG
Dorsal respiratory group (DRG)	Medulla:– Solitary tract nucleus	Inspiration – Quiet breathing	Central and peripheral chemoreceptors (PSR)
Ventral respiratory group (VRG)	Medulla:– Nuclei ambiguus and retroambiguus	Inspiration and expiration – Forced breathing	Various
Apneustic centre	Pons	?	

the dorsal respiratory group. This causes a steady inspiration, slowly increasing the lung volume. The key to the rhythm of breathing is the 'turning off' of this inspiratory ramp and, thus, the end of inspiration.

There are several mechanisms involved in this process. The pneumotaxic centre sends a continuous signal to the dorsal respiratory group. This controls the end-point of the inspiratory ramp. A strong signal from the pneumotaxic centre decreases the duration of the inspiratory ramp, causing not only shallow breathing, but also rapid breathing. Another mechanism for limiting inspiration is the Herring-Breuer reflex. Pulmonary stretch receptors (PSR), located in the lungs, feed back to the dorsal respiratory group via the vagal nerves. When the lungs are stretched, this feedback ends inspiration. However, in humans the lungs are rarely full during inspiration and this reflex probably functions more as a protective mechanism than as a primary cause of the end of inspiration.

The ventral respiratory group is almost totally inactive during quiet breathing. When the respiratory drive increases (e.g. during exercise), impulses from the dorsal respiratory group 'spill over' to the ventral respiratory group (VRG). The ventral respiratory group then provides an increased drive, both to expiration and inspiration. It is the drive to the expiration that is the more important, however, since there cannot be rapid, deep breathing without forced expiration. Thus the ventral respiratory group acts almost as an overdrive unit (see Figure 1).

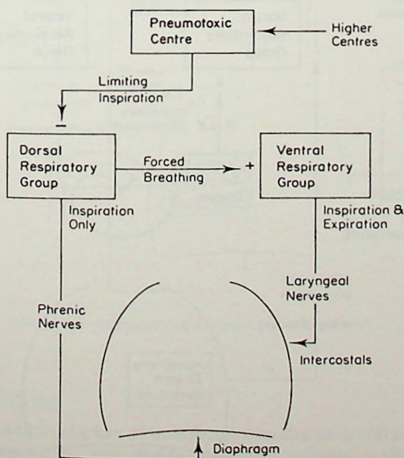

Figure 1. Brainstem control of respiration

The overall rate of respiration is controlled by central and peripheral chemoreceptors, which monitor the concentrations of oxygen and carbon dioxide in the blood P_{O_2} P_{CO_2}, as well as the blood acidity (pH). Control of these levels is one of the most important functions of respiration. Peripherally, the carotid and aortic bodies monitor these levels. The carotid bodies are located at the bifurcation of the carotid arteries; they feed back to the area of the dorsal respiratory group via the glossopharyngeal nerves. The aortic bodies are located along the arch of the aorta; they feed back to the same area via the vagal nerves.

The peripheral chemoreceptors are primarily sensitive to the arterial concentration of oxygen – blood pH and P_{CO_2} have a larger and more rapid effect centrally. The carotid and aortic bodies receive their own blood supply and, as the drop in oxygen tension across them is minimal, they are effectively measuring arterial blood concentrations. Their maximum response is at an arterial P_{O_2} of 30–40 mm Hg, at which levels haemoglobin saturation becomes dangerously compromised (see Figure 2).

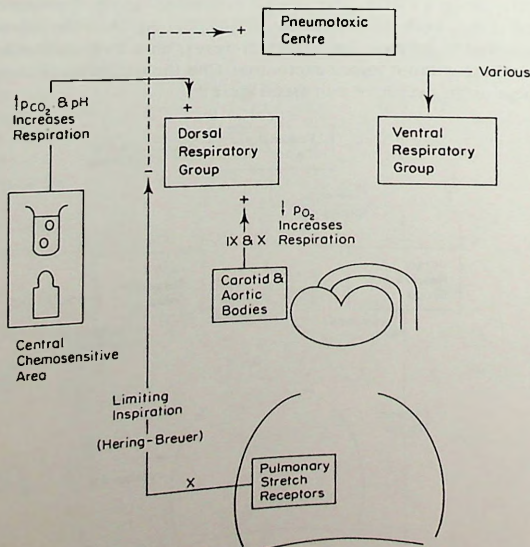

Figure 2. Respiratory feedback mechanisms

Centrally there is a chemosensitive area in the region of the respiratory centre in the medulla. This area is sensitive to blood pH and P_{CO_2} and can cause a very strong drive to inspiration, increasing both the rate of rise of the inspiratory ramp and its strength. In fact blood P_{CO_2} is the stronger of the two stimuli. This is because the chemosensitive area is inside the blood-brain barrier. This barrier can easily be crossed by carbon dioxide molecules, but is virtually impregnable to hydrogen ions (summary Figure 3).

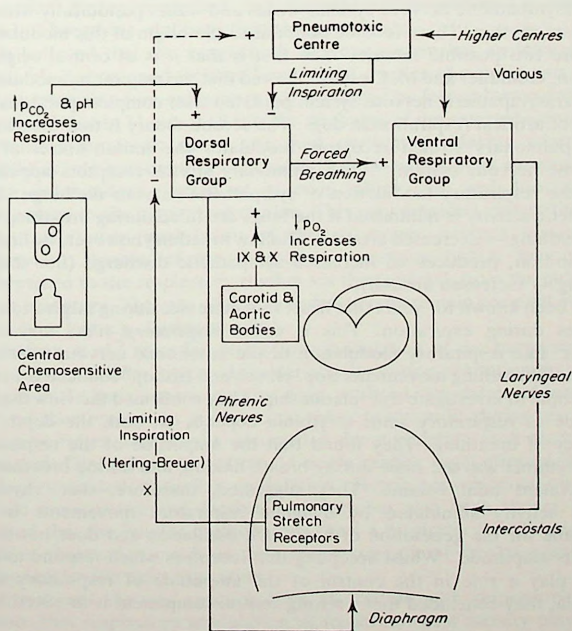

Figure 3. Summary of respiratory control

The Breathing Rhythm

How the fundamental rhythm of breathing is produced is still not completely understood. Berger *et al.*[3] reported that the basic respiratory rhythm can exist without the pneumotaxic centre, and that the medulla alone can produce a repiratory rhythm, although an abnormal one. Later work has shown rhythms

theory is supported by many of the papers previously discussed. The result of the respiratory modulation of the sympathetic nervous system appears to produce a state of greater arousal during inspiration. This arousal is limited by filling the lungs during breathing i.e. by deep breathing.

Finally, in this discussion of respiratory modulation of other systems, it is of note that the respiratory rhythm can itself become synchronized to other rhythms. Bechbache, Chow, Duffin and Orsini[13] reported the entrainment of the respiratory rhythm to exercise rhythm. Zhang reported that if the central nucleus of the amygdala is stimulated with single electrical pulses at a rate slightly above that of the respiratory rhythm the respiratory rhythm will become entrained to the rhythm of the pulses.

In conclusion, it appears that the respiratory modulation of the autonomic nervous system has both a central and a peripheral component. The majority of evidence supports the view that sympathetic discharge is greater during inspiration than during expiration. Parasympathetic discharge is of an opposite phase – greater during expiration than during inspiration. It would appear that inspiration is associated with an increased state of arousal. This is supported by observed respiratory modulation of such diverse areas as reaction time and knee-jerk reflex.

Finally, it has been shown that stimulation of pulmonary stretch receptors inhibits respiratory modulation of sympathetic discharge. Thus, deep breathing which fills the lungs decreases the arousal associated with inspiration.

II Clinical syndromes related to breathing

Obstructive Sleep Apnoea

There are many types of sleep apnoea syndrome. The most common is obstructive sleep apnoea, although central sleep apnoea, resulting from loss of respiratory drive from the brainstem, has also been reported. In fact most sleep apnoeas are mixed, or at least there are contributions from both obstruction and loss of respiratory drive.[14,15] It would appear that the prevalence is about 1% of the adult population. The vast majority are men (90%), and a large majority obese (60%).[16]

The cause of obstructive sleep apnoea appears to be oropharyngeal collapse.[15] During sleep the tone of the pharyngeal muscles decreases, an effect which is not specific to the pharyngeal muscles. The decrease in tone causes narrowing and this narrowing may be enough to cause collapse during inspiration, especially if other predisposing factors are present. Collapse results in apnoea. After a certain time the change in blood gases causes a semi-wakening and a resumption of breathing. Partial obstruction causes snoring and stimulates both the autonomic and central nervous systems.[15] Apnoeic episodes are most common during REM sleep.[17] Remarkably, many patients may be unaware of such apnoeic episodes.[18]

The most common symptoms of obstructive sleep apnoea are daytime

sleepiness and excessive snoring at night, often reported by the spouse. Other symptoms include personality changes, impaired social functioning, intellectual deterioration, anxiety, depression, and problems with erection and ejaculation.[14–17] If untreated, life-threatening respiratory and cardiac complications can arise.

Initially tracheostomy was the treatment of choice, but now is almost obsolete.[16] Other surgical interventions, such as removal of the uvula and tonsils, may be tried. Drugs have not proved of much use.[14,16] Non-invasive techniques such as continuous positive airways pressure, applied through a nose mask or tubes, has been effective. However, long-term use has proved difficult because of the disturbance to sleep once the initial excessive drowsiness has been overcome.[14,18]

Zhu[19] reported the case of a patient who had sleep apnoea and was successfully treated by an electroacupuncture technique involving the transfusion of 'vital energy'. The patient was needled at Zusanli with the anode connected to the needle. His son was needled at the same point simultaneously, the cathode being connected to this needle. The patient and his son held hands to complete the circuit. The treatment was repeated the next day. The patient slept well during his subsequent two days in hospital and a follow-up one year later showed no recurrence of the syndrome.

Hyperventilation Syndrome

Recently awareness of hyperventilation syndrome has increased, as has the number of cases being diagnosed and reported. It is thought to occur in 6–11% of the population,[20] which is very high for a complaint that has been frequently misdiagnosed. One of the problems is that overbreathing can occur during apparently normal respiration[21] if a small but unnoticeable increase in tidal volume (e.g. to 750 ml/min) is coupled with a normal respiratory rate (e.g. 16–17 per min). If undiagnosed, chronic hyperventilation can cause permanent changes in both the psyche and the soma.[22]

The immediate effect of hyperventilation is to blow off CO_2. This results in a decreased P_{CO_2} in the blood, and thus respiratory alkalosis. The usual response to acute loss of CO_2 is renal excretion of bicarbonate ions, which restores the blood pH to normal within a few hours or days. Once the blood pH has been restored to normal the respiratory centre becomes 'reset' to maintain the P_{CO_2} at the current level.

Symptoms occur both centrally and peripherally. Carbon dioxide is the major factor controlling cerebral blood flow. A decrease in P_{CO_2} causes constriction of both the cerebral arteries and veins. This limits cerebral blood flow if cardiac output and blood pressure remain constant. Dizziness, disturbance of consciousness, and hallucinations may occur. Peripherally a muscular tetany can occur, probably by an effect on the nerves, and also cardiac disrhythmias. An increased sympathetic drive is produced by hyperventilation *per se*, with its associated symptoms. This is to be expected since hyperventilation is part of the fight or flight response.[23] Clinically,

fluctuating low levels of CO_2 (hypocarbia), produced by intermittent hyperventilation, can be even more damaging.[22]

Hyperventilation can produce symptoms which mimic many organic conditions and it can exacerbate existing conditions. It is implicated in conditions such as agoraphobia and panic attacks, and although perhaps not the prime cause, it potentiates them. Hyperventilating produces many of the symptoms of a panic attack; these are recognized by the sufferer, which causes anxiety and further hyperventilation, until a full-blown panic attack ensues.[23] Chronic hyperventilation may result from such initial stimuli as phobias, and once the vicious circle described above becomes a frequent occurence the initial stimulus may be completely forgotten.[25]

Diagnosis of hyperventilation is usually by a provocation test. The patient is asked to hyperventilate for a period of about three minutes. If this produces symptoms which the patient recognizes as part of his condition then hyperventilation may be diagnosed.[21,24] Further evidence can be provided by measuring alveolar CO_2 levels after the provocation test. A slow return to normal is common in patients with hyperventilation syndrome.[20] As a result of a study done by Grossman and De Swart[20] a questionnaire has been produced listing the 35 principal symptoms. A score of over 30 indicates a strong possibility of hyperventilation syndrome.

III. Breathing as a therapy

Hyperventilation Syndrome

Lum[22] reported that 99% of the people whom he had seen with hyperventilation syndrome were thoracic breathers. Therapy often involves breathing retraining, that is an attempt to teach the patient to breath with the diaphragm, rather than the chest. Pinney, Freeman and Nixon[25] reported on the use of a nurse counsellor in the treatment of hyperventilation syndrome. Patients who had been diagnosed as suffering from the syndrome, after a routine examination, including a chest x-ray and an ECG to exclude major organic disease, were referred from the Accident and Emergency Department of Charing Cross Hospital. A study of 30 consecutive patients was carried out. The average score on the Grossman questionnaire[20] was 47.

The patients were taught how to use their diaphragms when breathing, were encouraged to practice such breathing for at least 15 minutes, 3 times a day, and generally to monitor their breathing during the rest of the day. They were also told to try to decrease their respiratory rate to 10–12 breaths per minute. Each patient had two or three sessions with the nurse, each an hour long and usually nine days apart. Assessed at the end of their last session 64% reported that they were much better, and only 6% reported no improvement at all.

Grossman, De Swart and Defares[26] conducted a controlled study of breathing retraining in the treatment of hyperventilation syndrome. They

studied a group of 47 people who were randomly assigned to either an experimental group (25) or to a control group (22). Both groups received a form of ventilatory therapy over a period of 10 weeks. The treatment consisted of seven laboratory sessions, together with home assignments. During the laboratory sessions a respiratory device, which made an audible bleep at the rate at which the patient had to breathe, was used to train the patients' respiratory rate. They were encouraged to use their abdomens when breathing. The respiratory rate for the control group was set at the resting respiratory rate of the patient, whilst for the experimental group it was slower by one or two breaths per minute. The experimental group were given portable units to take home and use, whilst the control group were told to spend their home assignments in slowing their respiratory rate and in making inspiration more expansive.

At the end of the course both groups showed improvements in resting respiratory rate, end tidal CO_2, CO_2 recovery after forced hyperventilation, and in self-assessment. The experimental group showed significantly greater improvements in end tidal CO_2 and CO_2 recovery after forced hyperventilation than the control group.

Panic Attacks

Salkovskis, Jones and Clark[27] repeated an earlier study by Clark on the effectiveness of breathing retraining in the treatment of panic attacks. The similarity of the symptoms of hyperventilation syndrome to those of panic attacks has already been noted, as has the role of hyperventilation in the onset of panic attacks. The study was carried out on nine consecutive referrals from both general practitioners and consultant psychiatrists.

The patients had to satisfy three criteria: that they suffered from panic attacks; that they had at least three bodily symptoms indicative of hyperventilation syndrome, and that there was no evidence of a life-threatening or metabolic illness, or previous diagnosis of a psychotic condition. After four weeks of keeping a panic diary the first session took place. This consisted of bag rebreathing, forced expiration and a provocation test. These exercises were used to show the patients the similarity of their symptoms to those associated with hyperventilation. They were then trained in paced breathing at a rate of 12 breaths per minute, using a tape. The patients were given the tape to take away and use daily at home. Further instruction and assessment took place after five days, one week later and then at three months and six months.

A total of nine sessions took place in all. As a result of the treatment there was a significant decrease in the frequency of the occurrence of panic attacks. The resting P_{CO_2} of the patients, which had been low in comparison with age and sex matched controls, returned to normal levels.

Postoperative breathing

Celli, Rodriguez and Snider[28] studied the effects of various breathing techniques on the prevention of pulmonary complications following abdominal surgery. They studied a total of 172 patients who were randomly assigned to four groups, each group contained over 40 people. Group 1 was a control group and received no respiratory treatment. Group 2 received intermittent positive pressure breathing for 15 minutes, four times a day. Group 3 was treated with incentive spirometry four times a day, and Group 4 carried out deep breathing exercises under supervision for 15 minutes, four times a day. The frequency of pulmonary complications varied as follows: Group 1 48%; Group 2 22%; Group 3 21% and Group 4 22%. Further, the patients in Group 3 had a significantly shorter stay in hospital than the patients in the control group.

Vraciu and Vraciu[29] studied the effects of breathing exercises in preventing pulmonary complications following open heart surgery. A total of 40 patients were divided into high risk and low risk groups on the basis of such indicators as whether they smoked, forced vital capacity, and forced expiratory volume. The experimental group contained 12 patients considered to be at high risk, and seven considered to be at low risk. The figures for the control group were 13 and eight respectively. All the patients received routine postoperative care including incentive spirometry every two hours; ultrasonic heated nebulization every four hours; turning, deep breathing and coughing every hour assisted by the nursing staff. The experimental group were seen once preoperatively and twice daily postoperatively by a physical therapist.

The programme consisted of lateral and posterior basal expansion, diaphragmatic breathing, and coughing. The frequency of complications was 38% in the control group and 19% in the experimental group. The results were even more clear amongst those patients considered to be at high risk: 46% complications in the control group and only 8% in the experimental group.

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PAPER

The Dove Project

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Introduction

The Dove Project is aimed at detecting an objective electromagnetic or other field around the body with a view to ultimately developing a diagnostic instrument, which could also be used as a therapy monitor, preferably imaging the field as a photograph or an image on a computer screen. In short, we want to image the aura, and in so doing obtain an insight into what ancient systems of medicine called *chi* or *prana*, and what we are calling biological energy, life force, orgone or whatever.

The project has its roots in systems of complementary medicine which have developed out of acupuncture and homoeopathy, such as bioelectronic regulatory techniques as in the electro-acupuncture according to Voll technique, Vega testing and the segmental electrogram,[1,2] and other related areas such as Kirlian photography.[3]

All these methods claim to measure biological energy from the body via acupuncture points, and also to measure radiation from homoeopathic remedies, all in a more or less objective fashion. All rely to a greater or lesser extent on some element of subjective input from the practitioner.

Background

My fascination with biological energy began as a child initiated by a sense of wonder at the natural world. As an eight year old I was given a child's book on medicine by an uncle. I always remember a diagram of the acupuncture meridians on the inside frontispiece, which must have been very unusual in any book on medicine in the 1950s let alone a lay book for children. Little did I know how important this was going to be for me in the future. In the ensuing years, school work and studying for medicine left no space in my mind for seemingly fruitless and fascinating meanderings into ideas of energy in the body. These ideas resurfaced again when I was researching my MD Thesis[4] when I worked out the embryology of the tympanum. I lost count of the number of slides of embryos I looked at and again my sense of wonderment at the world of nature re-emerged. I spent many hours feeling that there must be invisible energetic blueprints around that govern development and shape in

nature. This is now very reminiscent of Rupert Sheldrake's morphogenetic fields recently proposed by him in his book *A New Science of Life*.[5]

Then by chance I came across acupuncture again – and decided to learn about it. This led to me changing track from my chosen career in ear nose and throat surgery. After completing my MD Thesis I became a principal in general practice and was then able to start using acupuncture in a clinical setting. I really felt I had discovered something so vitally important and that I had to look deeper into it. I remember being fascinated that using the ancient traditional way of looking at acupuncture I was able to be more clinically effective. I then realised that somebody had to look at the body in a research sense as the ancient Chinese had, in terms of energy.

I resigned from the National Health Service over 10 years ago, and went into full-time complementary medicine, adding a number of other techniques such as other methods within acupuncture, environmental medicine and homoeopathy. At about this time I took a part-time post at the Centre for Pain Relief which was part of the Department of Neurology at Walton Hospital, Liverpool. At this time conventional doctors were beginning to think there was something to acupuncture, based on neurological explanations such as Melzack and Wall's *gate control* theory of pain and the endorphin explanations of pain relief.

I felt that with my ideas of circulating chi (biological energy) around the meridians, I was completely swamped by conventional interpretations as to how acupuncture may work. At the time I carried out a double-blind study with a highly sceptical colleague at the Walton Hospital Pain Relief Centre, looking at pain relief following acupuncture.

We took a series of patients, all of them in some degree of pain. I carried out acupuncture on them all, and noted the degree of pain relief obtained. We then injected them intravenously, five minutes after treatment, either with intravenous naloxone (which would be expected to reverse pain relief obtained if it had in any way been due to an endorphin mechanism), or normal saline. The syringes were arranged in the double-blind fashion so neither myself as the acupuncturist or my colleague as the doctor who gave the injection knew whether naloxone or saline was being given.

We found on statistical evaluation of the results (pain relief being scored on a visual analogue scale) that there was no significant loss of pain relief obtained after acupuncture as a result of injecting naloxone. This therefore indicated that endorphins were not an important part of the acupuncture mechanism.[6] This is quite different from the flow of similar papers at the time of our study. However, this particular study was the first of a number of studies reporting similar findings.[7] This strengthened my observation that there really was something to the idea of chi circulating around the meridians.

Later clinical work measuring impedance over acupuncture points as a diagnostic technique using the Voll method also led me to believe that the Chinese were right in that illness starts outside the body, if you like in the aura, and as the auric changes persist physical disease as we know it appears. This was most aptly described to me by one of my many teachers of

traditional Chinese medicine, a Dr Yoo from Korea, who told me the story of Pienchhio.

Pienchhio is regarded as the father of traditional pulse diagnosis. He lived about 200 years before Christ. One story concerns the advice Pienchhio gave to Emperor Huan. Pienchhio felt the Emperor's pulse and said that he had a disease on the skin and that he needed treatment. The Emperor was angry at this and sent Pienchhio away. Five days later Pienchhio returned and requested a further audience with the Emperor, and again he felt his pulse. He told him that he now had a disease of the blood and that the disease process was becoming more deeply embedded. Pienchhio advised the Emperor that he needed treatment, but again the Emperor was angry and sent Pienchhio away. Pienchhio returned for a third time, after a lapse of a few days, and asked for a further audience with the Emperor. Again, he felt his pulse, and said that the Emperor now had a disease in the intestines and the liver, and that he needed treatment. The Emperor responded in the same way and Pienchhio was again sent away.

Piencchio returned a fourth time, but this time ran away. The Emperor called for him and asked why he had run away. Pienchhio told the Emperor that he now had a disease of the marrow which could not be treated. A disease on the skin can be treated with wrappings; a disease in the blood can be treated with acupuncture and moxibustion; diseases in the organs can be treated with herbs, but a disease in the marrow could not be treated. After a few weeks the emperor fell seriously ill and the Imperial Court sent out messengers to find Pienchhio to ask him to come to treat the Emperor. Pienchhio could not be found and the Emperor died soon after.

This story shows that Pienchhio's expertise was largely due to his diagnostic ability as far as the pulse is concerned. He also recognised that illness clearly started outside of the body, or at least on its surface and progressed deeper. Depending on how deep it had got different forms of treatment were required. So in my own mind the idea formed that what was needed was an objective way of looking at the aura – with a realisation that here was a path that many others had trodden unsuccessfully: but why not? So a research proposal was formulated. I realised that we needed a full-time inter-disciplinary team working independently but with some academic affiliations to enable us to look at areas which would not normally be given space in a University situation.

My own experience with trying to do research part-time also showed me that an unhurried careful approach with most of the team being full-time was the only practical way. Generally my idea was thought of as being far too ambitious. I did however receive support from the Institute of Complementary Medicine who did give me some initial monetary support. Then one day a private sponsor offered to fund us for an initial period. My wife and I could hardly believe our good fortune. The next question was where would we base ourselves. But before we had time to ponder on this question we found an ideal building around the corner from my place of work at the Centre for the Study of Complementary Medicine in Southampton. Our benefactor com-

pletely refurbished the building for us, and so we proceeded to our next task of finding our team and giving ourselves a name. My wife Rachel thought of the name *The Dove Project* as a symbol of the spirit. We carried this feeling with us in our project and our weekly project meetings always start with a 20 minute silent meditation, symbolising our common spiritual purpose.

Over a period of six months we formed our team which now consists of seven people. Gradually other associated researchers have come to work with us. I am the project director and I am involved part-time one full day a week. The rest of the time I am involved in clinical work at The Centre for the Study of Complementary Medicine. My wife Rachel manages the project and as well as carrying out management, is involved with integrating our team into a coherent group aiming for a supportive comfortable atmosphere in which we can all work. Our common spiritual purpose and our ability to communicate across the boundaries of our various scientific disciplies is essential to our success.

Dr Roger Taylor is an immunologist of many years standing with his first degree in Veterinary Medicine. He also has an open minded and wide ranging interest in the area that our project is concerned with and brings with him many skills from his years in immunology. Dr Michael Ibison and Ross Edwards are both young electronic researchers. Both are gifted and admirably suited to the project. Our full-time secretary Pamela Stacey has a difficult task of making sure that all runs smoothly in our busy office, and Ann Hold is our part-time clerk and is involved in the office and helping us with the experimental work.

Plan of work

We started work in January 1987 by carrying out an exhaustive search of the literature; both conventional and unconventional. On the conventional side we soon discovered that approximately 4,500 papers per year are published on the effects of electromagnetic fields on living organisms, whereas passive measurements of electromagnetic emission from the body have been almost totally ignored.

On the unconventional side we found that the majority of the papers were badly put together and the quality of work was very poor indeed. Unfortunately the field of complementary medicine has not done itself a lot of good in terms of its research work. Most of it has been carried out on a part-time basis and has been very poorly funded. We have found that the poor scientific background of unconventional medicine is a continuing source of frustration.

Our plan then developed into trying a number of approaches, some conventional, some not, to see which areas would yield the most promising results, with an ultimate aim that the whole project would focus all its resources in one area. Fortunately theoretical models, which have begun to be confirmed experimentally, have recently emerged from advances on the border-line between physics and biology. These suggest that a long range

order, or patterning, can exist in seemingly chaotic random systems, which living systems are.

For a long time there has been the widespread belief that the second law of thermodynamics poses a major barrier to the spontaneous appearance of ordered structures in matter. To put it another way, the non-living universe is running down and basically cooling down (obeying the second of thermodynamics), whereas living systems are going in the opposite direction. This point of view has been shaken when non-linear process, far from equilibrium have been taken into account, and the thermodynamics of irreversible processes has begun to be formulated. It has been recognised that open systems kept far from thermodynamic equilibrium by an external energy source can organise themselves spontaneously, showing definite ordered patterns in space and time.

Ilya Prigogine,[8] a Belgian biochemist and one of the most prominent workers in this field, has investigated a number of general conditions which ensure the possibility of self-organisation in matter. So far as the body field is concerned, its field pattern is not deducible from any knowledge of the physics and chemistry of the body's individual molecules as they might be studied in a test tube, in the same way that the behaviour of human societies cannot be deduced from the study of its individual members. The body field therefore needs to be understood at a higher or more holistic level than is normally considered in medical science. We have a perfectly good explanation of what may be happening in terms of conventional physics. But what we need is a chaotic detector in order to look at the body field.

The study of the body field is likely to be of major importance, not only to medicine but to the man on the street. It will enable disease to be looked at and conceived of in a more holistic sense. When disease is understood only in terms of conventional physiology and biochemistry then the question of causation is difficult to address. It might make more sense to suggest that chronic illness begins as a disturbance in the body field – perhaps many years before medically defined disease appears. We could also expect that we could then be able to push the field back into shape, and thus improve a person's state of health.

We are beginning to suspect that this is what many complementary therapies do. In terms of causation we may be able to define effects such as environmental, emotional or even spiritual factors. This would all have far reaching effects on the way we conduct our lives, both individually and as a society.

Some of the areas we are studying, however, do not seem completely explainable by the new theories of chaotic systems. These are Reich's work[9] with orgone energy, the Delawarr Camera,[10] Reichenbach's odic force,[11] (based upon his thoroughly conducted experiments in Germany over 150 years ago using sensitives with clairvoyant vision who saw biological energy slowly travelling through solid objects) and possibly homoeopathy.

So we are keeping our theoretical door open, to allow that there may be non-electromagnetic explanations of the body field. But this would be

difficult to support as it would fall outside of the cantilevered edifice of modern science. If we were to find there was a stranger explanation then we would have to be very sure that this was so, based on backing from repeatable experimentation.

Photon emission

A small amount of light is produced by all cells in active metabolism, and particularly during cell division or when the cell is dying.[12,13] There are also isolated reports of light being produced by the human body.[14] Popp[15] claims that light is not only produced by the body but plays a role as an internal information carrier. We therefore decided to look at photon emission from the body with the hope that this might tell us something about subtle energies and that its characteristics might bear some relation to physiology and pathology. The first step was to build a light-tight and temperature controlled room, which to our surprise was much more difficult and expensive than any of us had thought. We have, however, a room which must be unique, with a very low background count of approximately 2 photons per second, an extremely black room.

Working with a cooled photon counter (background count about 5 photons per second), with a peak sensitivity (25%) at 410 nanometers (violet visible light), falling to zero at about 615 nanometers (red visible light), we investigated non-living and plant materials. Low level phosphorescence was found in most light coloured or translucent materials (e.g. paper, rice) persisting sometimes for many hours. The phosphorescence of the human hand decayed to zero after 1 hour, after which a persisting luminescence of some 20–130 photons per second was found.

This emission showed a spectral peak around 500 nanometers and contained up to 15% of ultra violet (less than 319 nanometers). We are now proposing to plot the spectra from different subjects and also from the same subject at different times. No definite changes were observed during hyperventilation or apnoea, or when recording over a tensed muscle. Preliminary data from different parts of the body showed highest readings from the finger tips and hand and lowest (about half as much) from inside the upper arm. Emission from the hand (in one subject) showed an approximately two-fold diurnal variation, with a maximum around 8.00 p.m.

Four findings suggest that the light emission is related to the rate of blood flow in the hand:–

1. A correlation was found between photon count and hand temperature.
2. Photon count fell within seconds of applying a tourniquet.
3. The photon count of fresh blood was much higher than from the hand, but only if the blood was well oxygenated.
4. Photon count from a relatively bloodless part of the body (inside of the upper arm) was considerably less than from the hand or face.

We have been interested in the many reports that healing by laying on of hands is associated with electrical 'sensations', and sometimes electrical phenomena. Accordingly we have studied the photon counts (with discrimination between visible and ultraviolet light) from the hands of a number of healers. Comparing results during intentional healing and control periods revealed no gross differences – although there appeared to be a small decline in the visible emission resulting in a greater percentage of ultra violet in the healing periods. We are going to do a further study to see if healers do emit a greater proportion of ultra violet when they are healing. So far the light we are seeing from the body does not appear to be anything to do with chi, prana, or the subtle bodies as in the aura.

We do however, propose to try to record the spectra of the emitted photons, borrowing sophisticated techniques used in astronomy. If we find these photons to be coherent, then this would almost certainly indicate that photon emission from the body carries important information. However, it is early days yet to say whether this is the case.

Our photon emission work at one time nearly lead us astray. We thought we had discovered an inexplicable phenomenon. Light was emitted from a phosphor painted onto a black card. The phosphor was placed facing the photomultiplier tube. When a hand was brought in close proximity to the non-phosphor side of the black card an increase in photon count was recorded on the photomultiplier. This suggested that some inexplicable radiation from the hand was present which was able to pass through opaque material and release light from the phosphor. The graph of photon emission from the phosphor always showed a small initial blip as soon as the hand approached the card, this blip being characteristic for each particular person trying the experiment. We were able to demonstrate that this effect was due to reflection.

After many weeks of painstaking experimentation we were able to show that the photon emission from the phosphor was due to a heating effect brought about by the proximity of the hand. This illustrates the meticulous care we have to take in our project when researching reportedly inexplicable phenomena. We cannot afford to make claims of inexplicable findings unless they are repeatable and we are absoutely sure that no conventional scientific explanation exists, otherwise any scientific credibility we have would soon disappear.

Squid magnetometer experiment

We have built a SQUID (super-conducting quantum interference device) jointly with the Department of Physics at Southampton University. The SQUID is an extremely sensitive magnetometer which uses a super-conducting loop at very low temperatures (minus 269.15 °C) to measure minute changes in magnetic field. At such low temperatures materials lose all their electrical resistance and electric currents flow spontaneously. Professor

Herbert Frohlich, one of our scientific advisers, on whose work our proposed experiment on microwave emission from the body is based, came close to being awarded the Nobel Prize for Physics in recognition of his research into the theory of super-conductors in the 1950s.

We are beginning to use this device to detect any change in the body's magnetic field due to the disturbance of electrical charges within the body resulting from the flow of chi along acupuncture meridians. At the moment we are getting over teething problems with the equipment before we design experimental protocols to look at acupuncture using the SQUID. We have been beset with problems in building our equipment; for example obtaining a satisfactory Dewar cooling flask has taken us nearly nine months. The Dewar is a container in which the super-conducting element is suspended. It is filled with liquid helium and is therefore regularly cooled to extremely low temperatures near absolute zero.

Even the smallest fault in the material of the Dewar can result in cracks opening up and rendering the system useless. Our most recent setback was when we discovered that there was a fault in our superconducting ring, but we are hopeful that this will be overcome shortly. This gives you some idea of how long these experiments take to set up, and also the costs involved if the work is going to be carried out with any degree of thoroughness. The next few months are likely to be very exciting with our SQUID system.

Microwave emission

We are planning to begin a study into microwave emission from the body, funds permitting, a collaborative project with Portsmouth Polytechnic. Our starting point was a claim by a German researcher, Professor Ludwig,[16] that the microwave signature of a subject includes peaks at specific frequencies, which can be related to specific illnesses. One other researcher working in Canada, Bigu del Blanco, has measured peaks at around 100 times the expected thermal background level, which are reported to vary with time.

Professor Frohlich, has developed a theory to explain the apparent trigger effect of low intensity microwave radiation on the development of biological systems.[17,18] One aspect of this theory requires long range interaction to take place between the electric fields of oscillating, highly polarized dipole molecules such as are found in cell membranes, resulting in selective attractive or repulsive forces. Electromagnetic radiation at microwave frequencies might be expected to accompany such an effect.

Our investigation of microwave emission will commence with a mapping of the body's normal emissions over the range 1 to 10 gigahertz (10^9–10^{10} cycles per second). We intend to carry this investigation out on a number of normal subjects. Possible correlations with acupuncture could also be tested.

Our next step would be to investigate subjects suffering from a range of diseases, and in particular patients who are multiply allergic. This is important as work by Cyril Smith and Jean Monro[19] have suggested that

highly allergic subjects who react to allergens at a distance are reacting to microwave radiation emitted from the allergen.

Quantum correlation experiment

We have been interested in psychokinesis (PK), particularly as it is well researched, notably by workers such as Jahn.[20] We therefore consider that this is a legitimate area of study. One of our team, Dr Michael Ibison has devised an interesting experiment involving two radioactive sources.

We plan to count the number of simultaneous emission of electrons from each source (a number of studies in PK have looked at the effect of PK on radioactive decay). We hope to see whether the proximity of a body (or aura) can affect the correlation rate, and whether, if such an effect is discovered, it is more marked the nearer the subject is to the sources, thus obeying some sort of inverse square law. We do not propose to have the subject trying to exert any conscious PK effect on the sources. This experiment will be up and running during the next months.

Unconventional ideas

It has been one of my unshakeable beliefs as the Director of the Dove Project that we must be able to investigate the unusual and indeed the outlandish in an open-minded way. This is something that would be difficult if not impossible to do in a University environment, hence the decision to have an independently based project with some University affiliations. We enact in a microcosm within our project the persisting conflict between science and what scientists currently see as pseudo-science, or at another level, between the intuitive and the intellectual. The unusual areas we are looking at have had and continue to have useful clinical results, so I am convinced that there is something to them, and this is enough in my mind to warrant investigation.

The Delawarr Camera

This is a radionic camera developed by George Delawarr in the 1940s and 50s at his own laboratory just outside Oxford.[21] In simple terms it consists of three cavities, in each of which is a sound source (an electronic buzzer), a small light, a set of 12 rheostats and a bar magnet which can be rotated. In other words each cavity has light, sound and magnetism within it, and each was regarded by George Delawarr as a tuned cavity. The rotation of the magnet and the setting of the rheostat dials was done using a stick pad, a favourite dowsing method of radionic practioners. A 'rate' was the set for the object under investigation.

In practice a blood spot was put on one plate. The other plate had a copper spiral tapped off with a copper tuning fork, again tuned using the stick pad,

and on the third the appropriate rheostats had a rate dialled up according to what you wanted to look at. For example it might be the heart. If there was something wrong with the heart of the patient who gave the blood spot then an image was produced on the photographic plate which was placed below the top section of the camera, the whole thing being built in such a way that no visible light can reach the plate from the specimen.

The camera seems to work on a sort of holographic principle with two reference beams and a third beam from the blood spot. If they do not coincide, then an image is produced. Nearly 12,000 photographs were taken on various Delawarr cameras, and I have examined a number of them. Opinion has been divided in our project. Some of us think they were forged in some way, some of us (including me) feel they were genuine, but the fact remains that we have been unable to obtain an image at the time of writing. We are continuing to try various combinations of settings to see if we can do so. One of our advisers (Dr Cyril Smith) thinks that the camera may be a microwave amplifier, as the operator has to touch the metal on/off switch to obtain an image. We are a little worried about reports that indicate that only certain people are able to operate the camera. So we propose to try feeding the output from a microwave generator into the camera to see if we can obtain a photograph.

Wilhelm Reich – the Orgone Box

Wilhelm Reich and his followers during the 1930s and 40s claimed that an energy, which Reich called *orgone*, can be concentrated inside a box (known as an orgone box) made up of alternating layers of metal and an organic material. Reich claimed that this energy had a variety of physical effects, and also could be used to treat disease. We had the privilege to have a scientist who had worked with Reich, Dr Bernie Grad from Montreal, over to work with us for a week. He gave us some fascinating accounts of working with Reich, including how Reich would make rain for the Oregon farmers with his cloudbuster.

We made a variety of boxes under Bernie Grad's direction, and tested them for the anomalous high temperatures which have been reported. Although we often observed a small temperature difference, controls showed that these were all accountable in conventional terms. Thus, so far we have not proved the anomalous effects reported from orgone boxes. Our boxes have been a maximum of five metal and organic layers. We have been advised that we need a 150 layer box to see any temperature difference. I gave up exhausted on reaching a 50 orgone sandwich. When time, patience, money and ideas permit we will return to Reich's work.

Homoeopathy

Homoeopathy is an important area of investigation for us. It is widely used and its effectiveness is supported by a number of clinical trials.[22,23] It is not,

however, generally accepted by the medical profession or the scientific world, because of the seeming impossibility that water can carry therapeutic activity after every molecule of the substance originally added has been diluted out. In other words it is an anti-intuitive system of medicine. You would not expect it to work.

To support the clinical trials, a number of scientific studies have shown that such non-material dilutions do indeed possess biological activity.[24,25] A particularly impressive study of Professor Benveniste (an immunologist from Paris) appeared recently in *Nature*.[26] He used human polymorphonuclear basophils, with antibodies of the immunoglobulin E type on the surface. When they are exposed to anti-IgE antibodies they release histamine from their intracellular granules and change their staining properties. The degranulation was repeatedly demonstrated at non-material dilutions of anti-IgE. This in a way is curious, because homoeopathic remedies are not reputed to have similar properties when diluted as a homoeopathic preparation, as they have in their concentrated form but in Benveniste's experiment the anti-IgE in dilution had the same effect as the concentrated anti-IgE.

Benveniste's team, in a five-year study, showed that there are successive peaks of degranulation from 40–60% of the basophils depending on the dilutions used. He had hypothesised that, because the dilutions need to be accompanied by vigorous shaking before the effect could be observed, transmission of the biological information could be related to the molecular organisation of water. Unfortunately Professor Benveniste did not make it clear that periods did occur in his laboratory when no such effect was demonstrable, for unknown reasons.

The publication of the paper caused a storm of controversy, and John Maddox, the editor of *Nature*, published Benveniste's work on the condition that he could send an independent team to look at Benveniste's work. The team consisted of Maddox himself, James Randy, a magician, and Walter Stewart,[27] who has been involved in the study of errors and inconsistencies in the scientific literature and with the subject of misconduct in science. This is hardly an open minded team to investigate the unusual findings made by Benveniste's group.

On 'Antenna', (a new BBC 2 programme with a scientific slant), John Maddox said that homoeopathy was dangerous, as serious conditions will be treated by ineffective medicine. He added that this had happened in his own family. Science is not anything like as impartial as we would all like to believe, especially when research into the unusual or the unexplained is involved. The jury is still out on homoeopathy.

But what is going on? I repeatedly observe marked clinical effects from non-material homoeopathic dilutions, and I feel sure that anyone experienced in homoeopathy would agree with me. What are we missing, why can't we consistently demonstrate these effects in the laboratory?

This is one of many thorny questions that we are planning to look at. We plan to examine biological assays such as enzyme systems, in order to repeat the meticulous and thorough work carried out by Boyd[28] in the 1950s. We

also plan to carry out laser Raman spectroscopy of homoeopathic preparations based on the idea that water molecules can take up some kind of vibratory patterning. Although the importance of structuring of water in biological systems is widely realised,[29,30] classical thermodynamics does not give us the means to conceive of how it could hold a virtually infinite variety of patterns, each with such remarkable stability. Some recent theoretical approaches via non-linear dynamics now look promising.[31] However, John Hasted, who has done a lot of work on the spoon benders and whose life interest has been in water, says that he cannot conceive as to how water can hold such patterns.

So what is going on, is it something much stranger than we now think? To begin to answer this we are proposing to mount a series of studies using an advanced technique of Kirlian photography, and amongst other things take pictures of remedies and observe the effects on the Kirlian image from the patient. My previous experiences of Kirlian photography classicially practiced have been very disappointing. The new technique seems to offer much more promise.

Work with clairvoyants

We have done some work with a small number of clairvoyants to try and repeat Reichenbach's work.[11] We recognise three broad types of clairvoyants:

1. KINAESTHETIC MEDIUMSHIP
Alternatively called *clairsentience*, this type of clairvoyance does not require seeing with the eyes but is inner vision. There have been suggestions that this is some kind of seeing through the third eye (thought to be related to the pineal gland).

2. PHYSICAL MEDIUMSHIP
This requires having the eyes open and requires energy from the subject in order to manifest the physical form in three dimensional space. The energy is in the form of so-called ectoplasm coming from the solar plexus area.

3. MIDDLING CLAIRVOYANCE
This is an intermediate state between the other two. The eyes must be open but no energy is required to manifest the form. So far we have found only one subject with reliable physical mediumship.

Our preliminary findings are that objects seem to leave an impression 'in space' after they are removed, this impression remaining for some few minutes. We are still not absolutely clear that the radiation seen has an objective (three-dimensional space and time) reality. An electromagnetic radiation in the physical spectrum can be ruled out as a source, since we have been unable to measure any significant photon emission from crystals and magnets which we have been using, like Reichenbach, with our clairvoyants.

Conclusion

I have tried to give you a snap-shot of some of the work we have been doing. I think you have an overview of our work. We have been in existence for nearly two years and have spent this time unravelling a mass of information, thinking and setting up the experiments I have described. I am not moved to do clinical trials as I do not see any evidence that they change the way medicine is practised. I do see that basic discoveries in science can have more far reaching effects. This is what we are aiming for. The work we are involved in is very long-term and must be carried out with the utmost thoroughness for reasons I have already mentioned.

The project seems to ebb and flow, with periods of great activity interspersed with lulls which were initially nerve-racking. But I believe now I am able to see these as useful gestation periods after which something interesting always seems to follow.

The project was wholeheartedly set up working hand in hand with Christ consciousness. One of the main learning processes for me has been to let go of any distinct outcome and accept that at the end of it all it is only God given, and at the right time and when we are ready to receive new insights, this will come.

I wish to thank all of the team at the Dove Project, and my wife, for their help, ideas and encouragement throughout and also very special heartfelt thanks to our benefactor who has made the whole thing possible. It is appropriate for me to announce that we have just been granted charitable status as The Dove Healing Trust, and our benefactor has nobly and selflessly agreed to a gradual transfer of the project to the stewardship of the charity and its trustees. We are soon to launch a public fund-raising campaign under the slogan; "*Help us to establish natural medicine on a firm scientific footing.*"

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PAPER

A Philosophy of Energy*

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Be still and know thy self
Be active and know the other
Be still in the activity
And know that the other and the self are one

Energy may be thought of as part of a continuum, manifesting in three basic forms: that associated with stillness; that associated with activity; and that associated with accumulation.

Modern societies tend to promote activity and accumulation, while neglecting the first – stillness. The concept of energy has been formulated for many thousands of years, and it has been used, experienced, discussed and applied by adepts for a much longer period. Therefore, one may wonder how and when the word 'energy' came to be taken and applied by modern scientists to refer only to a specific category of observed physical phenomena.

One may also wonder whether the modern scientific views on nuclear and quantum physics which are in accord with ancient teachings on energy have partly arisen from increasing cultural and personal exposure of modern scientists to such ancient teachings.

I should say at this juncture that the views expressed here, although mostly inspired by Indian philosophy, are not intended to represent any official teaching. There are some points that may well be controversial, but I hope that they do not actually contravene the spirit of the teachings from which they came.

Definitions of energy

A spiritual 'definition' of energy could be given as follows: it is that from which the whole manifest universe arises, causal, subtle and physical. It can be *experienced* through its manifestations. It can be *measured* precisely in the physical world by scientific instruments, and measured precisely in the worlds beyond the physical by a direct knowledge of measure itself.

* This article is intended to act as the basis for a small book entitled *A New Guide for the Perplexed – A Holistic Model*.

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Actually, in the ancient teachings, there are no ultimate distinctions made between energy and matter. They are both considered to be aspects of a more fundamental, undifferentiated, principle. This principle is called in Sanskrit *Prakriti*, Nature, or 'that which is before creation', or simply *Awyakriti* – 'the unmanifest'. Differentiation into energy and matter occurs at a later stage.

The matter aspect of this fundamental principle may be considered as critically condensed energy, while the energy aspect may be considered as critically rarefied matter. Similarly, in a more specific medical context, the basic Sanskrit Ayurwedic term *dhatu* means not only a material tissue element, but also its more subtle seed state, as well as a pure stock of energy itself.

The energy of a physical body is measured by the work obtained from it by virtue of its external motion, when it is called *kinetic energy*, or by virtue of its position, when it is called *potential energy*. But there is also a third kind of physical energy. It is that energy associated with the inertia of a body, by virtue of its mass, whether in a vacuum or resting on a surface. This *energy of inertia* can also be thought of as the resistance of an object to movement, or to doing work.

Therefore, I would like to suggest a broader definition of energy that includes both the capacity to do work, and the capacity to *resist* doing work. This definition is certainly well recognized by us in everyday experience!

So, there is potential energy, by virtue of position, kinetic energy by virtue of movement, and inertial energy by virtue of mass. Potential energy and the energy of inertia resemble each other, in that the bodies associated with them are both (relatively) motionless and both need to be set in motion to be able to measure them. However, with potential energy the body is self-motivated – remove the external barrier and off it goes. But the body with the bound energy of inertia requires an external source to move it.

Again from experience we recognize the person who is self-motivated and 'raring to go' and the other one who needs to be constantly cajoled into action. Whenever a force acts on a body causing it to move, work is said to be done. In experience we know that after intellectual work we have moved ideas around and in emotional work we have shifted certain feelings and attitudes around.

Various forms of physical energy are interconvertible. For example, contrary movements cause heat from friction. Similarly, contrary movements in mind, i.e. conflict, cause the experience of mental heat. In experience, we also know that active moving energy can return to still potential energy, or it can be converted into bound or fixed energy through the mechanism of attachment, bonding or identification. We are drawn to certain personalities like magnetism, but repelled by others. And so on. Indeed it could be proposed that the physical phenomena of energy are, perhaps, reflections of the more subtle, psychological ones.

In experience, the quantity and quality of energy can be measured very precisely by the mind. The results are seen in great works of art, skill, graceful movement, and in many everyday activities, as we shall see later. So all in all,

given the different interacting and interpenetrating levels of manifestation – a concept fundamental if we are to understand the broader implications of energy – subtle and physical energy systems do seem to have some significant parallels, and many different kinds of mutual interactions.

What do the words mean?

Before continuing, we need to say a word on terminology and meaning.

Philosophical words such as energy, truth, self, love, and so on, by their very nature have many meanings. This can give these concepts, and their associated experiences, an appearance of seeming to be 'waffly'. Words applied to physical things have much fewer meanings, by their very nature, such as a chair, a table, a pen, and so on. This gives them the appearance of being more precise. Such difference is inevitable, and develops as we move between the spiritual and physical worlds. A diagram may clarify this point.

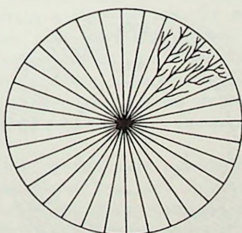

Figure 1. The circle of meaning

As we move from the spiritual centre towards the periphery of the physical world there is an increasing multiplicity of forms and increasing ease of precise definitions and measurements. Quantities become more obvious than qualities. However, as we move towards the centre, there is increasing overlapping, amalgamation, fusion, generalization and final dissolution into unity. This is the spiritual meaning of the word *absolute*.* Therefore, in this centripetal movement qualities become conspicuous and sometimes more important than quantities. In passing, we may note that the diagram can also make clear how spiritual teachings become increasingly similar, and can overlap, as we approach their essences.

Our basic premise is that the very source of energy itself is our own immortal, unchanging self, that centre of pure consciousness, knowledge and

* Sanskrit grammar recognises these kinds of movement by the use of seed words, called 'dhatus', and their grammatical developments into huge numbers of specifically defined words placed in sentences. Indeed, the ultimate seed word is said to be the mystical sound OM, represented in Christian theology as the Word of God. 'In the Beginning was the Word.'

bliss. Such spiritual energy is free, abundant, and everywhere the same. To channel and differentiate this flow of energy, the laws of creation are brought into existence or manifestation, as well as our own individual versions of those laws. The channels so created may result in harmony or disharmony.

Holistic cross-sections

Now, if we outline a holistic dynamic model, we may be able to highlight a few of these phenomena in operation. Figure 2 shows something like 'holistic cross sections' of ourselves – if that's not too much of a contradiction! They are presented from the two opposite or complementary ends of the holistic spectrum, in order that our views do not become fixed in one mode of perception or conception. This model, like all models of course, should be seen just as an exploratory system – a tool to be used, until the knowledge and experience itself have become established.

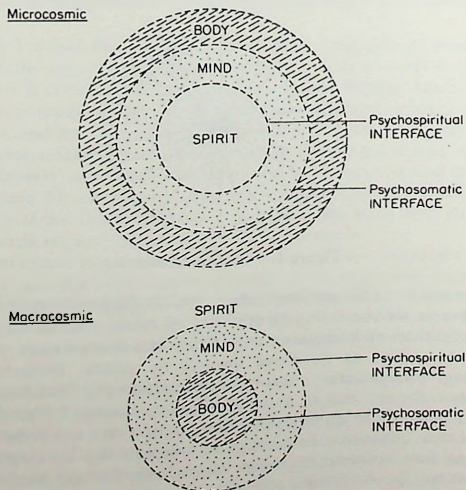

Figure 2. Holistic cross sections of man

Holistic models are usually presented as spirit, mind and body. But what about the actual lines or boundaries themselves that are drawn to distinguish spirit, mind and body – what do they represent? We shall call them here the

psychospiritual interface and the psychosomatic interface. These are only the principal interfaces, for of course there are many others.

Let us now work from the centre outwards.

We begin with that which is beyond beginning – its centre is everywhere. Its circumference is nowhere. Contemplate the two diagrams – gain a sense of this complementarity . . .

'Beyond all sheaths is the self.'

This self is eternally unborn, indestructible, pure and conscious. That is yourself, myself, and the self in all of us. Behind, within, and beyond all phenomena, all differences, all conflict, is unity. It is called by many names such as spirit, love, truth, self, and absolute, to mention but a few. It is the one without a second, beyond all duality, beyond all category. It is the source of all energy.

I think that we have all had some intimation of this unity somewhere within our experience of life. For even when we want gratification from the objects of sense, we are seeking a kind of unity by means of attachment and identification with them. This self is really worth knowing about. It is that within us which is of infinite worth and value. And yet we still believe the most extraordinary things about ourselves – that we are unworthy and unlovable, and unable to give love; that we are incomplete and inadequate, bad or mad; that we have been irreparably damaged by certain experiences of life.

We have lost our sense of wholeness and wholesomeness. In a word, we have lost contact with our real, true, self. But as soon as the message gets home that we can never be irreparably damaged, that we have always been, and will forever be, whole, that our true nature is love, unity, consciousness, knowledge, grace, and many other qualities too, at that very moment, healing energy begins its work from the spiritual level.

We *begin* to be able 'to suffer the slings and arrows of outrageous fortune'. Or in the words of Camus, 'In the midst of winter, I finally learned that here was in me an invincible summer.' Or in the words of Emerson, 'What lies behind us and what lies before us are *tiny* matters compared to what lies within us.'

Those who are well need to hear about the potentiality of this self. Those who are ill need to hear about the wholeness of this self. Those who are dying need to hear about the immortality of this self.

> Death be not proud, though some have called thee
> Mighty and dreadful, thou are not so.
> For those who thou thinkest thou does overthrow,
> Die not, poor Death: nor yet can thou kill me.
> One short sleep past, we wake eternal
> And Death shall be no more.
> Death thou shalt die!
>
> John Donne

The Psychospiritual Interface

There really is only one. But for the purpose of communication, we may consider two or more. This takes us to the inner aspect of the psychospiritual interface, where we first meet *relative truth*; our twofold relative nature; and the first potential differentiation into energy. We also meet here the origin of the principles of relativity and uncertainty, which modern physics has illuminated at the physical level.

Our twofold relative nature has a spiritual side naturally facing towards unity, and a creative side, naturally facing towards multiplicity. Table 1 is a list of many of these complementarities inherent in our relative nature. The list is headed by the equivalent Sanskrit names, Purusha and Prakriti.

I would like to indicate only two basic points here. Firstly, that absolute or objective truth can never be found in the forms of creation. For this truth is none other than our real self or spirit, whose essence is *beyond* creation. Not realizing this basic fact causes great confusion and frustration. For we spend many years of our lives, personal and professional, chasing this *illusion* of truth. We need constantly to remember that created forms are but transitory and partial reflections of Objective Truth. They may serve to indicate, and be enjoyed for a while, but can never act as a permanent substitute.

Secondly, the principle of change in our creative nature confers on all the universe an essentially energetic, dynamic active quality. This is its central feature. Heraclitus said, 'You can't step into the same river twice'. This sea of undifferentiated change is the unifying source of many concepts modern and ancient for the origin of all matter and energy, as earlier indicated.

Table 1. Complementarities inherent in our relative nature

Spiritual nature	*Creative nature*
Purusha	Prakriti
Sentient principle	Insentient principle
Towards unity	Towards multiplicity
Ever changeless	Ever changing
The witness	That which is witnessed
The observer	That which is observed
The enjoyer	That which is enjoyed
The experience	That which is experienced
Ever present	Ever past and future
Being	Becoming
Continuity	Discontinuity
Certainty	Uncertainty
The creator	The stuff of creation
The controller	What is controlled
The embodied self or spirit	The embodiment
The supreme lover	The supreme beloved
The magician	The illusion
Light	Darkness
Spiritual pole	Material pole

'The duality of subject and object and the trinity of seer, sight and seen can exist only if supported by the One . . . Those who see this are those who see Wisdom' (Ramana Maharshi).

Wherever there are two, there is an implicit three, which is the relationship that links or unites them. This takes us to the outer aspect of the psychospiritual interface, and to our threefold relative nature. Table 2 is a classification headed by their Sanskrit names, Sattwa, Rajas and Tamas.

The universal nature appears to be eternally manifesting and disolving, through the interplay of the three primary relative factors in nature. We can call these three factors power, dynamic energy, and matter respectively. In many ways, modern and ancient views coalesce here, not least by stating that power can be seen as energy in extremely concentrated form, and matter as energy in extremely condensed form. Dynamic energy manifests itself through three of the five *Primary Subtle Elements of Nature* – Air, Light and Water.

Table 2. The three primary relative factors of nature. A few of their endless characteristics are listed

Sattwa	Rajas	Tamas
Unity	Duality	Multiplicity
Spirit	Mind	Body
Causal	Subtle	Gross
Power	Energy	Matter
Force	Movement	Mass
Potential	Dynamic	Inertia
Gas	Liquid	Solid
Neutral	Positive	Negative
Conduction	Reflection	Absorption
Sustaining	Creating	Destroying
Potential difference	Current	Resistance
Potential energy	Kinetic energy	Bound energy
Centre	Radii	Circumference
Equilibrium	Expansion	Contraction
Synthesis	Anti-thesis	Thesis
Clarity	Confusion	Delusion
Calmness	Agitation	Exhaustion
Non-action	Action	Inaction
Efficient	Bustling	Lethargic
Satisfaction	Restlessness	Frustration
Affirmation	Aggression	Timidity
Unattachment	Attachment	Bondage
Spontaneous	Cautious	Unresponsive
Equanimity	Optimism	Pessimism
Knowledge	Learning	Ignorance
Wise	Clever	Stupid
Bliss	Pleasure	Misery
Love	Passion	Hate
Awake	Dreaming	Deep sleep
Birth	Growth	Death

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This kind of tripartite formulation, for example, readily accommodates in principle such basic equations as Newton's

$$\text{force} = \text{mass} \times \text{acceleration}$$

and its implied derivative, Einstein's

$$\text{energy} = \text{mass} \times \text{the velocity of light squared.}$$

The basic spiritual equation is: power = dynamic energy × mass.* (We shall see later that dynamic energy is essentially that of an uneven acceleration.)

Compare Newton's equation with the spiritual one.

Physical Formulation		*Spiritual Formulation*
Force	=	Power
Acceleration	=	Dynamic energy
Mass	=	Mass

Now do the same for Einstein's equation

Physical formulation		*Spiritual formulation*
E	=	Power (the energy here may be considered as power because of the huge intense release of energy)
Velocity of light^2	=	Dynamic energy
Mass	=	Mass

We can see that such a 'spiritual' formulation can provide us with a helpful *conceptual* framework to understand, and perhaps to provide, the mental soil for future discoveries.

In the beginning was the word. At that beginning, there was a supreme concentration of centralized power, with immense cosmic forces balanced in a dynamic equilibrium of unimaginable intense proportions. This is the cosmic seed, the cosmic egg of creation, poised in the infinite womb of the undifferentiated universal nature of the creator. Sometimes scientists call the reflection of this spiritual cosmic seed the primeval physical atom, or the original potential state of the physical universe.

Mind originates, radiantly expands and differentiates, from the same potential power centre of dynamic equilibrium, as does the whole universe. Here the dynamic principle of energy comes into operation. As human beings we experience its very first movement, or pulsation in the mind, as that simple feeling of pure, continuous, intelligent existence – before the presence of any specific objects. It is a reflection of pure being, as distinct from becoming. It is, in fact, the experience, the awareness, the reflection of our own true self in creation.

Descartes said, 'Cogito, ergo sum' - 'I think, therefore I am'. But would it be more accurate to reverse the order of this statement to: 'Sum, ergo cogito'; 'I am, *therefore*, I think.'?

* In Sanskrit, Shakti = Prana × Akasha.

Levels of awareness

Why do so many teachings tell us about the importance of coming into the present here and now? It obviously enables us to deal most effectively with any situation with which we are presented. But more subtly, it enables us to experience our own self, because that self, that true identity, only manifests in experience, in the present moment. Once it is established in our experience, we become naturally and straightforwardly self-confident. Our positive aims begin to be realized, and eventually, we discover that most profound truth about life itself – that it is simply here to be lived – from moment, to moment, to moment . . . Children know this truth about life – we see it in their ability readily to forgive and to get over painful situations remarkably quickly – providing, of course, the traumas they face are not too overwhelming. So this ability to live in the present, and to experience their own existence, should always be nourished in our children, as best as we can, in whatever roles we find ourselves.

All 'identity crises' relate to disturbances in this fundamental centre of experience. But if our self-identity is basically true, our emotional field will settle, our mind will become reasonably still, and our body, even when ill, will then follow suit eventually.

This earliest stage of our 'existential identity' is followed almost instantly by a very fine differentiation in mind. For it is now that the great powers of the self first manifest, both spiritually and worldly. Here too are other profound phenomena, such as the universal language, the fundamental measures of the universe, the ideal forms of Plato and the archetypal roles of Jung. In fact, we could say that the 'spiritual genetic material' of the universe – and of the individual – manifests at this very fine level.

Since we are referring here to a very fine level of awareness, I want to consider now what may be called the conscious–unconscious continuum and particularly to concentrate on a view of consciousness.

There are said to be three levels of awareness, and a fourth all-encompassing awareness, which is our true, full unlimited consciousness, or the so-called universal field of consciousness. In our model, these four refer to the functioning of body, mind, nature and spirit, and the levels of awareness may be called sensory, mental, natural and integrated.

The first, sensory, level of awareness is also called the waking state, because it is there that we most readily experience it, when our attention is turned fully outwards and our mind is relatively quiet. Even this first level of awareness, however, isn't all that common. For if we're really honest we do not find it all that easy to give somebody, or something, our full, wholehearted attention. Either we're preoccupied with other things, or we're commenting or criticizing inwardly, or we're just dreaming away about something more pleasant. For example, where is our attention at this instant and what is the quality of it?

The second, or mental level of awareness, includes all specific experiences that occur in the mind.

There is just one point I would like to make here. Concepts such as consciousness, attachment, personal self, the causes of human behaviour, feelings, particularly guilty, depressive, angry and assertive ones, are often viewed in contrary ways by those of us working with spiritual teachings, and those of us working with psychotherapeutic ones. Without going into details, both views are perfectly valid, providing they are understood holistically, by referring them to different ends of a spectrum for growth and development. Or, as we might say in the vernacular, 'we need to know where we are coming from, and where our student/client/patient is coming from'. Failure to find this orientation can lead to great confusion and conflict.

Now here is a poetic description of the *third* or natural level of awareness.

> At the source of the longest river
> The voice of the hidden waterfall
> Not known because not looked for
> But heard, half heard, in the stillness
> Between two waves of the sea
> A condition of complete simplicity.
> T.S. Eliot, Little Gidding

This level of awareness exists where there is a perfect balance in the forces of nature. It is sometimes called the unmanifest, seed, or causal state, because it precedes the other two, and is the substratum out of which they both emerge. It is the level of our nature before and beyond the manifestation of any particular experience. It is, therefore, the world of no-where, no-thing and no-time. It is eternity. 'It is the soul, rapt in oblivion'. In our human experience, it is that level of awareness full of a blissful knowing consciousness. A highly undifferentiated level of being, rather than of becoming. So it has a great significance for us all.

It is the realm of all possibilities, of all spontaneity – it is a desireless state because there are no objects, outwardly or inwardly, to distract. The attention has been withdrawn from the senses and the activities of the mind. The mind is, therefore, profoundly restful and still – so it is sometimes called the state of 'conscious silence'. It is the level of that deep, still, fathomless pool of energy which is not bubbling up to be used, but which is yet totally available for use. It is, therefore, the level of deep nourishment and healing power. (This third level of awareness encompasses the essence of both our two fold and threefold relative natures.)

This realm, and the experiences of adjacent ones, are often described in near death experiences, and in deep childhood regressions. There is often a great reluctance to approach or stay in this level, the twin fears being that of the void of non-existence, or of the emergence of very painful, unacceptable experiences. However, these fears can be negotiated, and when once we become established in this natural level of consciousness, we gain great command over whatever we wish to accomplish.

So, here too is the level of natural control, where we find the freedom, the will, and the power, of the self. But this free-will-power, which is massively

centralized at this level, is to be distinguished from its innumerable paler and weaker reflections within the many sub-personalities of the mind.

From the energy point of view, this level is most important, since it represents the potential, power-concentrated, still state of energy. Because it is a relatively unknown and neglected level, I would like to mention a number of occasions when it may be experienced. Most commonly this happens in deep sleep; in anaesthetic or pathological unconscious states, including fainting and during deep meditative states. Momentarily it manifests in the transient spaces between desires, thoughts, feelings and impulses; during the change-over in breathing rhythms, and during times of sustained attention, when for example we are just listening to someone speaking, or when someone asks us a question. At that very moment of asking, we don't know what they are going to say, and we don't know whether we will know the answer to their question or not. In fact, we are in a highly intelligent state of not knowing – the true wisdom of ignorance. For it is a highly conscious state from where the response comes if needed. It is also in evidence when we catch a glimpse of our own conscious self as it is reflected in that of another person. There are many other interesting occasions when it manifests in everyday life.

This natural, spontaneous, level of existence, in fact, is said to be our very birthright.

Deepening levels of awareness and increasing mobilization of energy is possible through the simple practice of sustained attention. But as simple as the principle is, so the practice can be as difficult. Energy can be tapped from the normally scattered or drifting mind by a straightforward connection of the attention to any one of the senses, or to any chosen symbol in the mind. The attention can also be allowed to penetrate more deeply, to the great reservoirs of energy both in our universal natures and in our particular constitutional natures. Normally, we gain energy through food, sunshine, air, fine sensory impressions, good company, turning from negative to positive thinking (often with help from others), diaphragmatic breathing, deep relaxation, meditation-type practices, and perhaps surprisingly, from simply enjoying our work. At the end of a long day, we can actually feel more refreshed and energetic than at its outset – pure magic!

From the natural awareness we enter into fully integrated consciousness. The consciousness that is fully integrated is rare. It remains the summit of human realization. Such a person experiences total freedom from the snares of the world. Such a person lives permanently in the unshakeable centre of pure love, of pure consciousness, knowledge and existence. And still to such a person the world remains perfectly ordinary – but perhaps not quite so substantial.

We have to learn to live with, to struggle with, to suffer with, the confusing and painful opposites that life presents us with. But how? External changes may well need to be made. Relationships may well need to be sorted out. But from within, our natural awareness gives us the energy, the wisdom and the courage to make the attempt. It provides that third neutral point that integrates and reconciles all things unto itself, and prepares the way for the

final step into total freedom – that fully integrated consciousness that is always present, everywhere – but we just did not realise it.

The Psychosomatic Interface

This is very important clinically. Symptoms such as aches and pains, tiredness, loss of energy and lack of energy, can all present here as the early stage of disorder, before the body produces detectable physical signs, called pathology. Hopefully, treatment can be given at this stage which is 'biotic' rather than 'anti-biotic'.

In passing, there is a general misnomer in the use of the engineering terms, *stress* and *strain* in psychosomatic medicine. Stress is the external factor producing strain in the body. In medicine, we use the word stress incorrectly for both concepts, and perhaps this contributes to some of the confusion that surrounds this subject.

Mind and body have to interact with each other through the psychosomatic interface, crucially through its subtle energy system. From the practical point of view, we are able to gain conscious control over the mind-body system, at the psychosomatic level, through regulation of feelings, senses, actions, and breath, all of which act as vehicles for the subtle energy system, particularly that of breath. Caring for all these aspects is the practical way to achieve a programme for preventative and positive health. Equally, abusing them all is the practical way of achieving ill health.

A few words now about the different areas of the psychosomatic interface.

Feelings

It is perhaps no coincidence that the word 'feelings' can be used synonymously for 'touch'. It really means that we need to be in touch with our feelings. Apart fom the high charge of energy they often acquire, they can act as valuable indicators, like the warning lights on the dashboard of a motor car, alerting us to possible disturbances either in ourselves or in others that may need attention. But while the mind needs 'guarding' from 'negative' feelings, one needs to distinguish that from the suppression of 'painful' or 'unacceptable' feelings which may lead to serious blockages of energy. All created things require their existence to be fully acknowledged at the point of manifestation in experience otherwise they begin to fight back and cause a disturbance.

Senses

We mostly get fascinated and caught up by *the objects* of our senses. So for a change, let us become more aware of the actual functioning of the senses themselves – such as hearing, touching, seeing, tasting, smelling. Yet as useful and as interesting as this practice is, we do spend an enormous amount of energy using our senses just to keep in contact with the outer world. This

can be easily illustrated by just closing our eyes for a few minutes and seeing how restful and refreshing it can be.

A few points now about each sense.

Hearing

In our everyday experience, we all know how energizing it is to be listened to by another with their wholehearted, undivided, attention, and how our energy begins to drain when this doesn't happen. The explanation is simple. When self speaks to self – energy flows. When personality speaks to personality – energy drains. So we need to practise wholeheartedly this undivided attention towards others, for their sakes as well as our own. If we do, something uncommonly interesting happens. A little profound space is created in the mind.

> In this body, in this town of spirit, there is a little house shaped like a lotus, and in that house there is a little space. One should know what is there. What is there, why is it so important?
>
> There is as much in that little space, within the heart, as there is in the whole world outside. Heaven, earth, fire, wind, sun, moon, lightning, stars; whatever is, and whatever is not, everything is there . . . That space is the home of the spirit, self . . . is there.
>
> Taiitreya Upanishad

Our words may give others a profound message that we may never remember or know about.

Touching

Touching (and its associated primary element *air*) is the sense most associated with healing energy. When we are touched by someone, even lightly, it can have an extraordinary impact on the balance and flow of our energy system. This sudden change of flow may be positive or negative, but it does happen. So touch is associated with the most powerful kind of dynamic energy, both at the mental and physical level. The word 'light' is used not only to describe a quality of touch, but also for another powerful form of energy – primary elemental light, which is associated with the sense of sight.

Seeing

This is the sense most associated with beauty, and with distraction. It is said that 80% of our sensory input occurs through seeing. This gives rise to the experience and conviction that only what we actually see appears to be real and substantial to us. From the energy point of view seeing, being so associated with distractability, can result in a most serious loss of vital energy.

Tasting and smelling

This really takes us into the realm of food. Energy seems to exist in three qualities in food. The finest quality satisfies our mind and is absorbed through the act of tasting itself. The next stage begins with chewing one's food well, and with good digestive powers, the more active dynamic subtle energy is extracted through a process described in Ayurweda. The end result is a vital energy called *ojas* which confers the feeling of physical health and vitality, and so it is sometimes known as the physical health aura. It is crucially involved in the maintenance of the immunity system. Thirdly, there is the more familiar extraction of chemical energy.

One last point about the more subtle aspect of food. Physical food obviously nourishes the physical body. But most of our energy, in fact, comes from other sources. We need to appreciate more fully that air and breath are the food that directly nourishes, the energy in our physical bodies. How long can we live without it compared to physical food? And we should further appreciate that sensory impressions acquired from the environment are also even more subtle and powerful energy that directly nourishes our minds. Finally, thoughts and emotions are the most powerful food of all, and nourish our hearts.

Good eating gives us satisfaction; good breathing gives us vitality; fine sensory impressions give us a lively, intelligent mind; and the fine thoughts and emotions that accompany them give us the finest energy of all to experience our own true natures, which is full of wisdom, consciousness and bliss. This is the true nectar of our immortality.

From senses to action

Although the essence of all action first takes place in the mind, it is convenient to discuss this topic here. Actions may be deflected from their original intention by two basic factors – an unconscious one, which is difficult to shift, and a conscious one, which fluctuates and is more open to change. The unconscious factor consists essentially of set mental patterns, and is a mixture of instincts, habits, conditioning, engrams, neurotic responses, early unresolved relationships, unfulfilled desires, deeply rooted attitudes etc. These require intensive work to master or resolve. So it is the factor that is not normally in our conscious control, and this fact becomes very painfully obvious at certain crisis times in our lives – most powerfully at death.

We said that the 'unconscious' and the 'conscious' form a continuum. Conscious experience can be simply forgotten, become a habit, be suppressed or repressed. So also the unconscious can and does make its presence felt indirectly in our experience through many kinds of subtle energy displacements and illnesses, well documented by depth psychotherapy. But there is another interesting way the unconscious makes its presence felt, i.e. by re-presenting to us those significant aspects of our life that in some way or other are still preventing us from experiencing a much happier and freer existence. There are three inter-connected ways in which this may happen: though those events which confront us externally; our usual 'habitual' reaction to those

events and the product of their interaction, which lays down the seed action for future limiting events and reactions.

The conscious factor relates to the everyday work that can be done through the care we give to our breathing, senses, actions and feelings. The simplest and most natural actions are the most efficient and economical ones. So whatever action we're engaged in, just let our attention rest fully on it. If we're listening, just listen. If we're talking, just talk. If we're walking, just walk. If we're eating, just eat, and if we're sitting, just sit . . ..

The quality of our actions is obviously very important. Three kinds of quality can be experienced – natural, superimposed, and inappropriate. They all occur everyday and all the time.

We do some things truly for their own sakes just because they're there to be done. That's the simplest and most straightforward kind of action. It leaves no trace behind it – like a transient ripple on the stream of consciousness. It is precisely measured from start to finish and, amazingly, can actually raise our level of energy by the end of it. It is accompanied by a sense of rightness, peacefulness, enjoyment and an expansion of inner space and awareness. That action can be called a natural one.

Then there are those actions that are quite inappropriate to time and place. These happen out of simple ignorance, or to gratify our personal desires, ambitions or senses, without consideration either for our own well-being or for the well-being of others. This is the conventional selfish action. It may be initially accompanied by a great surge of dynamic energy but inevitably ends up with a loss of energy and a sense of depletion. In our hearts, we can *know* such an action to be inappropriate. It creates a feeling of separation both from others and from our own true natures. The experience of ourselves becomes smaller and darker. This is the real and valuable function of conscience, i.e. the heart working with (con), knowledge (science). Now a selfish action is often confused with an action done for the good of one's own self. But in truth a pure action may be done to meet one's own individual needs, to meet the needs of others, or to meet the needs of everybody in the situation. There is no inherent conflict. What's good for one is good for all. What's good for all is good for one. I salute this version of the musketeers' principle!

The third kind of action is really a mixture of the other two. It's appropriate to some extent, but there's a superimposed desire for something other than what is *actually* relevant to performing the action itself, and that desire may be for oneself or for another.

We need to discover how to prevent ancient habit from short-circuiting our natural responses – which actually arise from that still third level of consciousness. For that level is the level of *real* response-ability. But how *do* we prevent the short circuiting? That's a question we each might like to consider for ourselves.

The subtle energy system

Now what of the subtle energy system itself? The most detailed descriptions are given in tantric yoga and in treatises devoted to Ayurweda. From a supremely power-concentrated potential in the mind descends a vertical spiral motion-force forming the subtle spinal column, and a more distinctly spiral-motion-force that becomes highly concentrated at certain points to form vortices of energy called *chakras*, or wheels, of motion.

These chakras of which there are seven major ones, are really best thought of as *psychosomatic* energy centres because of their crucial strategic position between body and mind, integrating as they do the experiences and forces of both. The three energies of subtle air, light and water described in Ayurweda, – sustain this subtle system from without, complementing and interacting with, the energy sources arising from the inner mental power centre.

Modern instruments have apparently detected alterations in electrical conductivity and resistance along the outer corresponding areas of the physical body, both in relation to chakras and to acupuncture points. While the general skin surface has a resistance of around 300,000 ohms, acupuncture points have 3000 ohms, meridians somewhat more, and chakras have the very low resistance of around 300 ohms.

Two other columns of energy lie astride the central subtle spinal column, and these relate to the breath flowing through the right and left nostrils. They have complementary qualities and functions, one being more related to the active intellectual, left brain hemisphere, and the other to the more passive intuitive right brain hemisphere.

The mental counterparts of the chakras bring us to the interesting area of growth and development, at both the individual and the community level. There is a time for each stage of growth to unfold (but growth can be stunted, accelerated or distorted). Interestingly, it has been said that sometimes pop music and certain types of classical music may excessively activate the lower energy chakra centres, and so prematurely awaken, in the young and the immature, instinctual forces that can't be readily controlled or integrated by their personalities. Chakras can also be applied as a classificatory system, to such subjects as psychology.

We said that there were seven main chakras. The number seven is highly significant. 'On the seventh day God ended his work . . . and he rested on the seventh day from all his work . . . and God blessed the seventh day, and sanctified it.' As we know, the Sabbath day of rest has virtually ended in Western industrial society. So we need to find more subtle ways of creating that rest.

There is a universal law of development known as the law of seven or the law of octaves. It shares an equal importance with the law of three, which we have already discussed as the three primary forces, qualities or energies of nature. The law of three describes the seed state of any phenomena and the law of seven describes the development of that seed. All movement is said to occur by a process of uneven, periodic, accelerations.

In very remote times, one of the esoteric schools applied this law of development to music, and so was obtained the seven-tone natural musical scale – the octave.

Do$_1$ re mi⁓fa so la ti⁓Do^1

There are two crucial intervals where checks in the development of the octave occur. These are at the mi-fa interval, about a third of the way up the octave, and at the ti-Do interval, very near the end of the octave. Any action is vulnerable when it reaches these two points, for unless extra energy is put in, the direction of the action weakens and slows down. (This is the underlying basis to the thermodynamic *Law of Entropy*. Indeed, actions may even begin to move in the opposite direction. The ti-Do interval has a higher frequency than the mi-fa interval, and therefore requires a greater input of energy to cross it.

Fundamentally, all dynamic energy is said to move in accordance with the law of octaves. So it is responsible for creating the universal forms of spiral motion found in all processes, from cosmic nebulae to the DNA helixes in chromosomes, and to the quanta movements in atomic orbits.

But what does all this mean to us at the practical every day level of experience?

Whatever movement we make, whatever desire, thought, or direction we take, is subject to this inner law of development. If energy is not consciously put in at these two intervals, our actions, or desires, will not reach fulfilment, and we will leave ourselves exposed to feelings of frustration, anger, and loss of memory. Also, all the activities in our minds will tend to end and begin prematurely and so overlap and run into each other; this process taken to extremes will result in utter confusion and chaos, and lead us into our darkness.

This lack of energetic input also accounts for the difficulty we have in getting started on jobs, or once started, beginning to flag after a short way on, once we're right in the thick of it. And finally, when we feel either so exhausted or so excited near the end that we almost, or even do, make a mess of it all anyway!

Then, there are the well-known difficulties of partings, and of first meetings, socially and with loved ones. All beginnings and endings are affected, even to the very acts of birth and death themselves. So it is really vital to discover ways of putting in conscious intelligent energy at these critical times. This is another practical question I would like to ask each one of us to address.

Here is a very famous quotation from *Julius Caesar* illustrating beautifully the profound importance of such intervals in life:–

> Our legions are brim-full, our cause is ripe;
> The enemy increaseth every day;
> We, at the height, are ready to decline,
> There is a tide in the affairs of men,
> Which, taken at the flood, leads on to fortune;
> Omitted, all the voyage of their life
> Is bound in shallows and in miseries.
> On such a full sea are we now afloat;
> And we must take the current when it serves,
> Or lose our ventures.

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