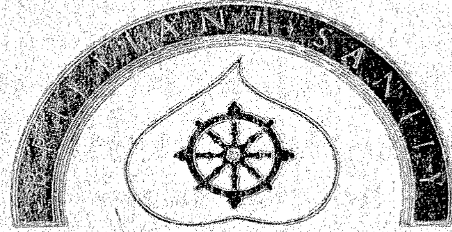

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BRILLIANT SANITY

The emblem "Brilliant Sanity" proclaims the existence of an inherent wakefulness that can be pointed to, recognized, and encouraged through psychological work. This is not metaphysics or metapsychology, nor is it some idealized picture. It is genuine experience that is simple, direct and sane. It arises from clarifying the nature of mind processes. This kind of psychological work involves a progression through discipline, gentleness, and courage, in developing ourselves and in helping others to grow.

The wheel in the center of the emblem stands for the principle of discipline. For the psychotherapist, discipline means that one has the fearlessness to accurately study one's own mind and environment. From that there develops gentleness in one's own life. The bodhi leaf represents the possibility of extending that gentleness to others. The warmth that one expands to others is the necessary environment that allows one to appreciate and truly understand the state of mind of another. The arch represents the courage and daring to help others by any means and beyond our own personal and professional interests.

Psychopathology arises from a failure, for whatever reason, to engage in the personal journey needed to cultivate the wakefulness, precision, and tenderness that is already there. Instead, one falls back to solidification and aggrandizement of the psychological construct of belief in an ego. It is a fragile construction—a homonculus, imaginary companion, double, friend or enemy, object of internal dialogue, a reference point. We continually have hints that ego is a fabrication and that it needs constant maintenance. This gives rise to an anxiety about one's own survival and we call that situation "pathological." It is not pathological at all. It is a true and insistent reminder that we are doing something wrong by attempting to live in a personal mythology that is always falling apart. One then develops habitual patterns and defenses to deal with that anxie-

ty and to further secure the notion of ego. The psychological construction of ego is the primary delusion that we live with. It is the foundation of all neurosis and psychosis, the source of our alienation in accurately relating to the phenomenal world. It is a core issue in the problem of "narcissism."

This is of course, the central insight of the Buddhist experience and the major source of the inspiration for this Journal. From this, there has developed the possibility of working with oneself and others beyond ego. This Journal is a document of that kind of psychotherapy.

We recognize that this is not conventional psychological language, but that is not the main difficulty. The history of psychology reveals that any assertion as to the non-existence of ego has led to an enormous individual and cultural resistance, followed by ignoring and amnesia. The psychological observations and implications of the work of Charles Darwin about the origins of self-consciousness have never been pursued. The analysis of the subtle construction of ego in the work of William James has gathered few students. The early observations of Sigmund Freud as to the maintenance, justification, and rationalization of the "beloved ego" have been distorted and lost. The current work of Jacques Lacan in Paris, regarding the illusion of ego and our imprisonment by that conception, is usually dismissed as impenetrable. The reasons for the fierce resistance engendered by the threatening claims of the non-existence of ego are largely personal and political, but perhaps some of the resistance can be explained by the fact that no consistent psychotherapeutics has emerged from these claims. This Journal will attempt to demonstrate that therapeutic work without the crippling conception of ego is not only possible but is actually being done.

Studying the nature of mind in ourselves and others is the basic training ground for this approach to therapy. Because of that one can understand, clarify and work with disturbed states of mind in a direct and genuine way. At that point the skillful application of the experience of non-ego allows for the workability of many different therapeutic modalities and styles.

When one begins to awaken from the delusion of ego a further connection occurs—a connection with a conscious and unconscious striving for health as well as an urge to be helpful to others. Then one's life can be acknowledged as a meaningful personal journey of development.

THE BOARD OF EDITORS

WORKING WITH THE OLD AND DYING

Ann Cason and Victoria Thompson

Dana Home Care offers an alternative to nursing home care for the elderly and disabled. There is a world of difference between caring for someone in their own home and caring for someone in an institutional setting. People who have been uprooted from their environment are often confused and disoriented, particularly the elderly. Since institutionalism is generally the result of some crisis demonstrating the inability of the person to function independently, the overall trauma is immense. When done properly, in-home care is a much gentler approach. Clients can remain in a familiar environment, and be helped with domestic details they are no longer able to manage. Although the daily routine of dressing, cooking, cleaning, and doctor's appointments are very important in themselves, they also provide a unique opportunity to work with the client's state of mind.

During the last two years a number of concepts have become the ground of our work with old people and dying people. The concepts emerged as we began to discuss what we were doing with our staff.

Usually, when people think about old age and death, they think of these as experiences they have not had yet. Death is something yet to come, mysterious and fascinating, and at the same time frightening. Our approach is that old age and death are actually very familiar. In fact, they are psychological experiences that we have constantly. When you wake up with a hangover and a mouth full of cigarettes, feeling like a chimney sooted over, that jaded quality is old age. It is the sense that experience is not fresh, that there is not any hope or reason to go on. That experience is familiar to all of us. We also experience death constantly when we are separated from people or things that we love.

The care of the old and dying in this country is unique. Medical personnel are the only ones that work with such people. There are a few social service agencies and some other people that are well-intentioned, but the majority of the population does not relate to the aging or dying except as problems they cannot handle. This taboo has come about because people are uncomfortable with the familiar quality of those experiences. Old age and death are not alien—they are right there with us all the time. In our work, going in with some sense of familiarity is the first opening in a genuine relationship. It is tricky, though. While we believe that old age and death are familiar experiences, we have no documented proof to that affect. There is no proof that physical death and what we experience as loss or separation are the same thing. We take a leap of faith, accepting the familiarity of it and at the same time not really knowing, not really being sure. Not knowing is actually a great source of delight and fresh air. If any of us really knew, a computer could do the job. Being able to make a gesture or opening to these situations, treating them as familiar, but not really knowing, is tremendously generous and warm. It comes down to a very ordinary level. When we see an old person huddled in bed, clutching the covers and looking like a corpse, we can feel the presence of death and treat that with friendliness.

This involves us in a recognition of our own mortality. Our own tender beating heart is going to stop at some point, and the blood will stop running through our veins. That sense of mortality we share with the client cuts through the petty concerns and obsessions that we both have. Knowing this enables us to step into peoples' lives with a feeling of having something in common. What they are going through is what we are going through, and so we can work with them.

Another underlying concept that has emerged derives from the Buddhist view of mind. A simple way of describing what mind is, would be to say that we and our world are the same thing. There is no difference. With our clients, for example, we can see from their doilies, their pictures on the wall, their

knick-knacks, their habits, likes and dislikes, that their world and who they are are the same thing. As we step into their world, we are stepping in with our world. We also create an atmosphere—with the way we are feeling, the kind of attitude we take or how we are dressed. We take these things into their world and there is a quality of merging. There is a moment of confusion, not knowing whose world is whose, as well as much uneasiness on the part of the client and ourselves. Nothing is predictable because of this blurred quality. We do not have to focus on our clients as if they were bugs under a microscope. We do not have to examine them in detail in order to know who they are. If we can take their whole world as a message and allow it to give us some idea of how to work with them, within that relationship, both of us can relax. One does not have to be so focused on them, and this creates less of a burden for them to bear.

These underlying concepts have enabled us to go into these situations with the assumption that they are workable. We accept the familiarity of the situation, that death and old age are not alien to us but are part of our experience. We accept goodness and mortality as something that we share. This is our working basis.

Older people can have a great sense of isolation. There is a diminishing or loss of faculties. Eyes and ears no longer work very well, and this cuts the person off from the rest of the world. Mobility is reduced—arms and legs do not work. It becomes harder to go out into the world as well as one did once. When one is over eighty there is a good chance that one has lost a mate, and perhaps, too, friends have gone into nursing homes.

This kind of isolation brings up anger and depression. Your faculties are not working and you are lonely. You know how it is when you have a good friendship—it is sparky and good. When you are old and you have not had that for a long time, it is depressing. Your world becomes smaller and more narrow. You are confined to one house, frequently one room in that house, sometimes even one bed in that room. Yet, as your world becomes smaller and smaller, a strange thing happens. You be-

come highly aware of the atmosphere and all the details within that atmosphere.

There is also a general sense of groundlessness that comes with old age, when you are letting go of your life. There is fear of death and uncertainty about whether you can even make it through the day. This groundlessness and fear are so expansive that a reaction of contraction and solidification occurs. People become extremely attached to their detailed routines, with very strong ideas about the way things should be. This is a very interesting situation. Expansion and contraction are happening at the same time.

When we first go into a person's home, the question comes about, who are we and who are they? We have all kinds of ideas. Old ladies ought to be clean, old men should not drink too much. We have to let go of this a bit. We try to suspend our judgment and take notice of the environment that is there. What is the atmosphere? We look at the drapes on the wall and we hear about how they chose the color scheme forty years ago. We look at all the little doilies, the 1939 World's Fair ashtray, all the pictures of the family, all the books and all the prescriptions. We get to know something about that person and what is important to him.

When we go in we try not to have too much armor. We do not go in as professionals. We do not have uniforms or a lot of notebooks, forms and professional paraphernalia. Without so much armor we can let the situation touch us. We have what you might call a touch-and-go approach. We might go into Eliza's house and sit down. She starts telling us about how bad she feels. Her joints hurt and nobody cares about her. You find yourself sinking into her painful state. Then all of a sudden there is a little reminder and you let go of that state. You can have a sense of humor about it. You just feel her experience, then let go of it a little. You might also feel that Eliza ought to be doing this or that. You can let go of that too.

It is a continual process: going in very gently, paying attention to the environment, being touched, touching and letting go. This happens all the way through the relationship.

In getting to know the person and his or her world, we get some sense of what his personal journey is, what he has been doing all his life, what things have meaning for him. Usually we come into contact with a person when there has been some break in that journey. This may be due to a broken hip or some other physical infirmity, compounded by the severe depression that goes along with old age. We get to know this person and make friends with him. We find out about his journey and what the break in it has been. We find out what the discipline has been and work with that so that his journey can be reestablished. It is very simple. It might be playing bridge with somebody so that her confidence about playing bridge comes back. Then that person might be able to go out and play bridge with her friends once again. We let the situation inform us about what needs to be done.

True friendship allows some relaxation to take place. This comes through appreciation, interest and curiosity about someone sharing who they are and who we are. Friendship is really a very ordinary thing. Many people come to us because they want to work with dying people. They have some idea that working with a dying person is sitting by the bedside, holding his hand and giving him counsel during the last few moments of life. In our experience, this is a romanticized view.

Actually, working with the elderly or the dying is very boring. You are sitting there. They have had their drink of water and you have rubbed their feet. There is not much more you can do, and it is very boring. What you do with that boredom is very important. If you cannot handle it, you scurry around and do all kinds of unnecessary things. The ability to be there with the boredom is the great gift of the meditation practitioner. We are very much used to boredom, so it does not induce as much panic as it does for most health care professionals.

In the same way, we can be straightforward with people about death. When they give us an opening, we do not back away from it. We do not say, "Well, you never know, you might live forever." This is usually the role of the family. The family is always in the role of covering it over, which become very

Kafkaesque. Here is a dying person and everyone is talking about the vacation they will be taking this summer. We can step into that situation and answer, "Yes," when the person asks, "Am I dying?" We can be with them and be sad with them. We take our cue much more from the client than from some formula. We let people talk about their own idea of death. One person might talk about being alone, very alone. There are all kinds of concepts. It is very important for us not to project our own ideas about death anytime during the relationship and especially at the last moment before they die. If one does that, there cannot be any genuine communication because one is too busy maintaining one's own position. So, on our part, there is a sense of respect and gentleness towards a dying person's view.

Our approach is that we honestly do not know what happens after death. There is really no way we could know. We might have our beliefs, but for other people it is not a matter of beliefs; they are going through a door we have not gone through yet. They have to go through it alone. Basically, what we talk about is feeling a genuinely sad parting—that we will miss that person when she goes. It is simply caring for the person the way they are.

Many of our clients have the attitude that, since they are suffering they must have done something bad. This is a problem when one gets old and is going to die. If God had been good, and you had been good, then it should have worked out that you would be immortal. Somehow it turns out that you are suffering and bedridden and falling apart and about to die. It must mean that either God does not exist, or is bad, or else you are bad. A great sense of punishment comes up, an attitude which is very hard on the client. The fruition of our work is when some of this has relaxed. We work towards an appreciation of impermanence on the part of these old people. This can open the way to some humor or even delight in their situation.

We ourselves have to appreciate impermanence too, and be willing to let go of our desires for our clients. Beatrice is a good example of this. We brought her through psychosis and a broken hip. We watched her open up and work with the world.

Now she is starting to decline because she is getting ready to die. We have hoped for a well-received death and a sense of good journey, but we have to let go of that idea too. She is going to die and we have to let go of her. We will not see her anymore.

We must let go of whatever our hopes are for the person. There is always a tendency to want to confirm ourselves and feel that truly we are doing a good job, that people care a lot about us and that we are fine people. Actually, the more intimate we become with people, the more complaints we get. This is very irritating because we think we should be appreciated for the good work we are doing. The more we put into it, the more we think we should be appreciated, yet we are more likely to find that people think we are taking advantage of them, charging too much money, or not attending properly to them. This is frustrating, but it seems to be part of the intimacy. The closer you get, the more their crankiness emerges and the less they are on their "best behavior." You just have to keep going, dealing with that, patiently and attentively.

There are all kinds of reasons not to do this kind of work at all, and yet, somehow, we are doing it and it is fascinating. The reward comes from the intimacy of being so involved with someone else's life. It is like being a servant in a way, having a tremendous presence in someone's life that we would not have otherwise. One has to accept the groundlessness of the situation. We are just there, doing it, and in one sense, there is no real reason why.

At the same time, we do have some kind of feeling for the situation. We have a sense of fruition about dying. One lives as completely as possible and one dies as completely as possible. It is a matter of being fully engaged in experience with as much awareness as possible. In working with clients, the way to approach death is the same as the way to approach life. We present some atmosphere of acceptance and invite the client to take part in that with us. If the client does so, then one has some intuition about what to do and there is some genuine communication. It works for us as well as it works for the client.

CASE PRESENTATION

Beatrice, a 79-year old widow, fell and broke her hip in November 1977. She was living alone in her home at the time, and the accident was quite traumatic. She spent five hours on the floor, dragging herself to the telephone. She was finally able to call her daughter who arranged for her to be taken to the hospital. After surgery and a long period of recuperation and physical therapy, Beatrice and her daughter began to discuss future plans. They were faced with the choice of a nursing home or home care. It was at this point that Dana Home Care was called in.

We first saw Beatrice at the hospital in December 1977. She was seated in a wheelchair, a tiny, yet sturdy-looking woman, alert and pleasant. She had obviously spent a great deal of time "cogitating," as she put it, on whether or not to go home. Even at that first brief meeting, Beatrice seemed far away and somewhat introspective. She is quite deaf, and it was difficult to evaluate how much this feeling of distance was the result of her failing faculties.

The second time we went to see Beatrice at the hospital, we took with us the couple whom we had hired to live with her when she came home. Beatrice greeted Brad and Janet very nicely and said she hoped they would enjoy living with her. Throughout this visit, Beatrice would ask us if she should get up, which chair she should sit in, and so on. She seemed overwhelmed and unable to make the simplest decisions. She did not express this confusion directly, but continued to maintain a social front.

The next day we took Suzanne to see her at the hospital; she was the staff member who would be working with Beatrice. As we came in, Beatrice said, "Don't go near the bathroom. There's bombs in there, and if you go in, they'll explode." She proceeded to tell us a long, rambling story about adding an extension to her house. Very little of what she said made any sense.

Over the next few days, the hospital reported that Beatrice was combative, abusive and incoherent. Her doctor ran tests and found no physiological explanation for her behavior. He then prescribed Haldol, a major tranquilizer, which reduced Beatrice's combativeness but did not diminish her confusion. After prolonged discussion with her daughter, who had visited all the nursing homes in the area, we decided to bring Beatrice home.

We set up a 24-hour care program. Brad and Janet would live in with her, covering most evenings and all nights. Suzanne and other staff members would cover the mornings, afternoons and some evenings. Because of Beatrice's depression, we decided that short shifts of no more than five hours would be best. Our care plan was to get to know her and provide for her basic needs (personal care, meals, house up-keep, etc.).

When Beatrice came home her extreme suffering was very apparent. She was fearful and confused. She did not want to get out of bed, wanting all the drapes drawn and refused to eat because, she claimed, there was metal in her mouth. She "saw double, felt double and heard double." She was terrified of falling and had to be tied into her bed or chair. In the midst of all this suffering there seemed to be a great deal of intelligence. Our task was to create an atmosphere that would allow this basic intelligence to flower, through communication and appreciation.

For the first two weeks, while providing her basic care, we also paid attention to how we handled ourselves and tried to discover the things she cared about by "tuning in" to her environment. There was a bird feeder by the window where birds and squirrels fed. The house was full of books and classical music, and was very tidy and clean. The neighbors told us that Beatrice always had the nicest yard in the neighborhood and that she loved flowers, plants, and trees. Her orderly closet was hung with clothing which reflected a discriminating taste.

At weekly staff meetings we shared our experience of Beatrice, cheered ourselves up, discussed the minutest details of her care and how we could work together.

It seemed that Beatrice had been a hardy person who never did drive, but walked everywhere. She came from pioneer stock and thought of herself as a pioneer type. She had arthritis and was told to keep active or she would be in a wheelchair. Walking and activity were important to her. She loved the outdoors, watching birds, working the soil, helping things grow. She had always been an avid reader and had an interest in music and theater. For yardwork she would dress in a scruffy manner; when she went out, though, she was always stylish and meticulously well-groomed. She was intelligent and sharp, with a salty sense of humor.

As we got to know her better, a plan for her care began to emerge. We started by gently insisting that she get dressed everyday. We combed her hair, put on lipstick and had her stand in front of the mirror to look at herself. Getting dressed made her angry for a long time. One day while helping her dress she began praying, "Dear God in heaven only you know how this woman's mind works. Please protect me. Thank you. Amen." During this period the staff did not get taken in by Beatrice's feeling of incapability, anger or depression. There was a definite sense of feeling her pain but being able to let go, to see through it, even to the humor of the situation.

Suzanne brought in fashion magazines and began looking at them with Beatrice. Janet brought in fresh flowers from the florist, and they had tea parties at four in the afternoon.

The physical therapist came and gave the staff exercises for Beatrice so she could begin walking again. For an active pioneer type, walking was very important. Her whole sense of path or journey, had been broken by not being able to walk. This was also true of reading. The staff began reading to her, providing large-print books and encouraging her to read. This was a busy period for Beatrice and the staff. She had exercises to do, had to walk every day and was encouraged to help with dusting and drying the dishes. She also worked with clay, painted with water colors and frequently listened to music.

Although working hard and making progress, Beatrice started talking about her feelings of emptiness and loneliness. She

did not know what to do with herself. She felt this was a "queer" way to live, and referred to her home as an institution.

One day Beatrice discovered a basket of Christmas cards that had come while she was sick, that she had forgotten. She got busy and read them all, remembered all the people who had sent them and started writing letters. For several weeks she wrote letters and remembered. She began thinking of her life before the accident. As memories began coming back she became very angry.

She alternated between clinging to the staff and getting angry at her situation. This, again, was a difficult time for the staff, listening to her anger, her complaints and "poor me" attitude. Still, there was genuine appreciation for Beatrice, and we could see that she was getting better.

We decided that Beatrice needed encouragement toward more independence and confidence, and so we agreed to cut down her care program very gradually so that she would have some time alone. We started with only 30 minutes alone. She resented this and felt she was being left alone only for our convenience. Gradually she grew pleased with herself and became less fearful. We finally settled on a care program where the live-in couple would fix breakfast and dinner, and provide morning care from 9 to 12:30. Beatrice was now alone afternoons and many evenings.

She gradually moved from confinement in the house to walking outside to long walks around the neighborhood. Soon she went out into the world for shopping, hairdresser and doctors' appointments and occasional meals in a restaurant. On holidays she visited her family in Denver.

There is no true resolution to this case. Beatrice reached her peak several months ago and now is starting to decline. The communication book at her house is full of the details of her life: how her teeth fit and what the doctor said about her toenails or the swelling in her ankles, whether to walk or not, shopping lists and what to eat if constipated. There is some sense of our having made a relationship to boredom and of having slowed down to appreciate the details of life.

Now, with faculties failing more, there is for Beatrice a certain amount of frustration and isolation. She tries to mail letters and forgets to put on the address, then gets frustrated if someone reminds her to do it. She might say, "Well, if you hadn't created so much confusion around here I might have remembered." She thinks there is a little girl who lives in the alley who cries and wants to get in. When something is missing she is sure the little girl took it. There is a feling of sadness watching our old friend decline and get ready to die. Our goal now is not to help her get better, but to maintain the atmosphere of communication and appreciation which will lead to some realism and sense of humor about our common situation. The other day Beatrice said, "People live and get old and they die. There's no sense getting morbid about it."

Naropa Institute was founded in 1974. In 1976 it became an upper division college and graduate school, and was awarded candidate for accreditation status by the North Central Association of Colleges and Schools in July, 1978. Programs include B.A. and M.A. psychology programs, B.A. and M.A. Buddhist studies programs, and certificate programs in dance, theater and poetics. Since candidacy status was granted, a music department has been established and will offer a certificate program in 1981.

The Institute was founded to provide an environment of learning in which students could master the skills of a single discipline as well as develop intuition. Part of this approach has been to complement classroom-based curriculum with non-classroom experience. This is particularly true of the Master's Program in Buddhist and Western Psychology.

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