A HOLISTIC BEREAVEMENT MODEL TO COUNSEL AIDS PATIENTS

by

Sherry Potter

Proposal For A Master’s Research Project Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Arts

OTTAWA UNIVERSITY

January 1995
A HOLISTIC BEREAVEMENT MODEL TO COUNSEL AIDS PATIENTS

by

Sherry Potter

has been approved

December 1994

APPROVED:  

Donald G. Froehlich

Sherrin L. Snyder

ACCEPTED:  

Sherrin L. Snyder

Director of Graduate Studies
ACKNOWLEDGMENTS

I would like to thank my husband Allan, and my children Karin and Scott, for their patience, understanding and encouragement during my continuing education and career change. I also want to thank my parents Edmond and Evelyn Klauber, and my parents-in-law Reverend Claire and Doris Potter for their continuous support and belief in higher education.

My special thanks go to the clients and staff of the New Arizona Family, for all of the varied and stimulating experiences during my two years of counseling in this residential setting. I also wish to thank the patients and staff at Phoenix Shanti for confirming my desire to make grief and loss counseling my specialty.
# TABLE OF CONTENTS

Chapter

1. THE PROBLEM........................................................................................................1
   Introduction ........................................................................................................1
   Background .........................................................................................................1
   Purpose ..............................................................................................................2
   Research Questions ............................................................................................3
   Rationale and Significance of Study ..................................................................3
   Definition of Terms ..............................................................................................7
   Assumptions and Limitations .............................................................................10
   Organization of Remainder of Study ................................................................11

2. LITERATURE REVIEW.........................................................................................12
   Introduction ........................................................................................................12
   Dealing with Ongoing Loss .............................................................................12
   Lack of Social Support Systems .......................................................................15
   Potential Grief & Pain Therapies for AIDS ......................................................17
   Spirituality .........................................................................................................17
   Alternative Medicines ......................................................................................18
   Pain Control .......................................................................................................19
   Hypnosis ............................................................................................................20
   Prayer ................................................................................................................21
   Reiki ...................................................................................................................22
   Spirits ...............................................................................................................23
   EMDR ...............................................................................................................23
   Summary ............................................................................................................24
CHAPTER 1

THE PROBLEM

Introduction

The focus of this study was to examine existing methods of bereavement and expression of loss for victims and survivors of AIDS. Counseling geared to treat families of persons dying of other diseases does not address all problems associated with AIDS. Because of the social stigma associated with this disease, sources of help are not always evident. A new bereavement model was proposed that took into account the disenfranchised grief that is experienced when the death of a loved one is not socially supported.

Background

Many therapists are untrained to deal with bereavement in general, and bereavement of people with AIDS (PWAs) and their survivors in particular. PWAs and survivors are often blamed by an ignorant public for exposing others to this disease. As a result, they are left with feelings of abandonment and guilt. Many have been ostracized from the mainstream population their entire lives because of their lifestyles (Horn, 1993). But like other bereaved persons dying or grieving the loss of a loved one, PWAs and survivors need to talk, cry and share their emotions in order to heal.

Many PWAs and survivors have utilized spirituality as a guide to find the solace and acceptance denied them in relationships. There is evidence that counseling in groups and sharing emotions with others in similar circumstances helps to improve an individual's self-esteem, personal relationships
and quality of life (Wofelt, 1992).

These groups plus self-help, and individual sessions of psychotherapy can assist one in reaching a stage of acceptance and freedom that comes from within. PWAs may then be able to transcend grief and move to an expression of love, acceptance and sharing.

Grief is not something to get over, it is a constant expression of having loved someone. The passion and rate of frequency of grief may vary with time. However, it is a natural expression of loss that survivors need to become comfortable with, even to welcome, in order to heal.

Grief helps one to remember the past rather than to deny having had meaningful things that are no longer there.

Remembering and reaffirming is important. Assimilating the past with the future is healthy. . . . Healthy grief can help us to remember, preserve and affirm the past while allowing it to become the past. Grief allows us to continue our journey. It gives us permission to live and reach out for new meaning in life. (Clayton, 1991, p.43)

Healthy grief allows one to continue the cycle, rather than to be stuck in pain, loss or anger. Compassion allows one to identify with the pain of the whole species so that grief is no longer alien or undesirable. Experiencing grief is the result of having loved and being loved. PWAs and survivors must not be denied this healing (Wofelt, 1992).

Because counseling for dying patients and their families does not address all problems associated with AIDS, a new model of bereavement has been proposed in this research project to deal with grief that is often unshared and unsupported.

**Purpose**

The purpose of this study was to create a new bereavement model that can be taught to counselors and medical staff for therapeutic use with PWAs and survivors. An exploration of existing methods of grieving were combined with new methods designed to work with disenfranchised and perpetual grief,
that is, grief that is not supported and leaves no time to heal because of its epidemic proportions.

This study has examined nontraditional methods of therapy, some ancient and some new: rituals used by ancient cultures, symbolism, creative memorialization through action and art, touch, energy and bodywork. Better known methods that could be utilized more efficiently such as hypnosis, visualization, groups, confrontation, closure and authenticity were also examined.

This study has attempted to integrate models and theories into a workable prototype that can be followed by professionals working with this population.

Research Questions

The focus of this project was to find a bereavement model for counseling PWAs and survivors. Methods of therapy that would be most valuable to PWAs during various stages of the disease were described for caregivers. This allows caregivers to assist patients in sharing their grief and mourning in a manner that will allow them to move on with living. The following questions address this problem: Can holistic health care, which includes healing of the mind, spirit, emotions and physical body, be effective in work with PWAs and survivors? How does lack of social support affect the health of PWAs and survivors? How can experiential therapies expedite healing and ease dying? What should be the content and structure of a therapy designed to heal all aspects of a person, including the physical, emotional, mental and spiritual?

Rationale and Significance of Study

AIDS has broken all the rules of modern dying and permits no time to
move through the traditional stages of grief (Horn, 1993). Many PWAs are
dying pathetic, lonely deaths, and their survivors are facing isolated, often
shameful periods of mourning. Survivors' reentry into productive society is often
prolonged and traumatic because of guilt, shame, anger and regret. As this
disease progresses into the population at-large, so will chaos, tragedy and
victimization. Health care workers, mourners and those not yet personally
effected must learn healthier ways to express loss, and to support those who
are dying and experiencing personal loss.

In the 70's, "the death-awareness movement," (Kastenbaum, 1977)
headed by Elizabeth Kubler-Ross, started in this country. A major focus was on
hospice care, inspired by Dr. Cicely Saunders at St. Christopher's Hospice in
London, England. The article Living with Dying (1978) states that hospice is
founded on the concept that the most important needs of the dying are pain
relief and close contact with loved ones.

Death has become a more personal and lonely experience than it was
even 100 years ago.

Early Western humanity accepted death as familiar, ordinary and
expected. Death was a public ritual organized by the dying person in his
bed chamber with friends and relatives. . . By the mid-20th. century
modern medicine was prolonging life and robbing death of its social
significance. Families learned to control grief and mourn only in private.
(Living with Dying,1978, p.2)

Hospice recalls the concept of "the good death," where one's life ended
surrounded by family and friends, forgiving and being forgiven for grievances.

Death education, although still lacking in many areas, is being taught at
universities and in some primary and secondary schools. Because children are
more afraid of what's kept hidden, death has been brought into some
Films are shown, personal experiences are shared, and different burial customs are discussed. Older children may be taken to funeral homes to view coffins and cremators if they wish (Living with Dying, 1978).

California’s Center for Attitudinal Healing, founded by Gerald Jampolsky, was instituted in 1975 to aid dying children and their parents.

The center was founded on the belief that more is involved in health than the physical, that healing has emotional and spiritual components. Participants learn to look at death from a different perspective, as a natural part of life. They affirm that being well is being happy and peaceful inside no matter what is happening outside. Healing takes place when there is love, and there is love when there is no fear. (Jampolsky, 1979, p.12)

This includes letting go of the past and not anticipating the future, but focusing on the “now.” Both humor and honesty are used along with chemotherapy and surgery (Stacy, 1987).

The woman in charge of the children’s programs at the center lost two children from unrelated illnesses within one year of each other. Although multiple losses like this have been fairly rare until recently with AIDS, they were commonplace in the 19th century. At that time families had many children and lost many before adulthood. Possibly because of the absence of these multiple childhood deaths in our own time, we have grown less prepared for them (Stacy, 1987).

Research on specific interventions with PWAs and survivors is virtually nonexistent. References to the psychosocial effect of AIDS on patients and families were rare in professional counseling until very recently. Williams and Stafford (1991) note that even as the tremendous emotional and psychological damage to PWAs has begun to be recognized, the damage to families and loved ones remains largely unrecognized in lay and professional circles.

Lovers of PWAs are an at-risk population. They face the grief and problems that are present within the general population with the loss of a
spouse but with none of the support systems, mainly family and religious institutions. An additional effect on partners is "survivor guilt," which is about possibly transmitting the disease and not having it yet oneself. Spiritual crises may need to be dealt with at having to face one's own death through the loss of a loved one and the injustice of death at a relatively young age.

Many of these dying men had not disclosed their sexual orientation, so their families now must deal with the loss of their "normal" son along with his impending death.

AIDS changes intimacy patterns for PWAs and families. Even innocent avenues of intimacy such as hand holding, hugging and kissing may be restricted by ignorant health care workers. An additional barrier is frequent disregard for boundaries of permanently committed homosexual couples. This is seen both with health care workers and immediate families of PWAs. Legal status as a spouse may not be recognized for these couples, leaving the partner excluded from treatment and burial decisions, and without rights in community property disbursement (Williams and Stafford, 1991).

Grief groups for gay men are one of the few safe places for homosexual survivors to express feelings without fear of stigma or reprisal (Klein & Fletcher, 1987). Other successful forms of intervention are peer groups, grief work, and reinforcement of existing coping skills.

Questions to ask for future counseling research agendas include: Is there a difference in effectiveness between self-help groups and practitioner-led groups? Are groups who are limited to specific relationships with the PWA more effective than mixed groups? Would the development of treatment teams from various medical and mental health disciplines be more effective than seeing individual practitioners? (Williams and Stafford, 1991, p.424)

There is an opportunity in the midst of chaos with this disease to reunite and reconcile families. It is the family that is mostly called upon to provide the physical and emotional care and nurturing required in the course of this
disease. Helplessness and powerlessness are common reactions to the deteriorating condition and eventual death of the PWA. This powerlessness felt by both families and PWAs can serve as a spiritual catalyst to bring them together in the face of death. It may also act as a healing of old wounds and realization of things that truly matter in life. This path may eventually lead to a spiritual transformation for all involved (Williams and Stafford, 1991).

Counseling involvement for PWAs and survivors is critically important to their ultimate health, wholeness and quality of remaining life. Also of importance is the development and sharing of quality interventions among professionals as this crisis spreads to every population in the world.

**Definition of Terms**

**AIDS.** Acquired Immune Deficiency. A life-threatening condition characterized by serious impairment of the immune system, leaving the person defenseless to infection and malignancies. There is no known cure, and the mortality rate is 80%.

**ALPHA.** A state of consciousness and awareness.

**ANTICIPATORY GRIEF.** “The phenomenon encompassing the process of mourning, coping, interaction, planning and psychosocial reorganization that are stimulated by the awareness of the impending loss of a loved one and the recognition of associated losses in the past, present and future” (Rando, 1986, p. 115).

**BEREAVEMENT.** To be deprived of or destitute from loss.

**BIOFEEDBACK.** Electronic equipment that helps people to recognize signs of physical stress and the patterns that lead to them. Then they learn relaxation skills that help them reduce the stress.

**CHAKRAS.** Energy points inside of the body.
COLON THERAPY. A flushing of the intestinal tract to cleanse the colon of toxins.

DIS-EASE. Holistic term for the body being out of balance either physically, emotionally, mentally or spiritually.

DISENFRANCHISED GRIEF. Grief that is not recognized or supported by society.

ELECTRO-ACUSCOPE. A device that analyzes the health of tissues from an electrical perspective.

EMDR (Eye Movement Desensitization and Reprocessing). A technique for reprocessing trauma and anxiety by using repetitive eye movements directed by a trained therapist.

ENERGY WORK. Therapy done with the energy aura surrounding the body and the electrical energy within the body. This is done both manually and with electrical equipment.

ETHERIC BODY. A much lighter body that cannot be seen that surrounds the physical body and is the same shape. An energy body.

EROS. The Greek god of love and life.

ETA THERAPY (ELECTROMECHANICAL THERAPEUTIC APPARATUS). A device used to balance the electromagnetic energy field of the body.

EXPERIENTIAL THERAPIES. Therapies other than psychotherapy. This can include any form of art, drama and movement. It emphasizes action rather than exchanging words.

HIV. Human Immunodeficiency Virus. A retrovirus transmitted through bodily fluids, mainly blood and semen.

HOLISTIC HEALTH CARE. Care in four areas of human health; spiritual, emotional, physical and mental.

HOSPICE. A facility for the terminally ill where treatment is on a personal level.
The primary concern of staff is to relieve pain of patients and allow them contact with loved ones.

MOURNING. The recognition of a deeply felt loss.

MYOPULSE THERAPY. Stimulation that increases circulation and muscle relaxation with a device.

NLP (NEURO LINGUISTIC PROGRAMMING). An explicit model of human experience and communication (Andreas and Andreas, 1989).

OMEGA VECTOR. A national organization that held free workshops for self-development.

ORACLES. The medium in which deities were consulted in ancient Rome and Greece.

OUT OF THE CLOSET. Slang for a person revealing his or her homosexuality.

PERPETUAL GRIEF. Loss that leaves no time to heal because of its epidemic proportions.

PSYCHONEUROIMMUNOLOGY. A form of medicine that helps to heal the mind, the nervous system and the immune system together.

PWAs. People with AIDS.

REIKI. Energy work to remove blocks within the etheric and physical bodies.

SHAMANISM. Spiritual and medicinal work done by indigenous healers.

SUBTLE ENERGY. Energy that surrounds the body and cannot be seen.

SURVIVOR GUILT. Guilt about possibly having transmitted HIV to lovers and not yet having it oneself.

SURVIVORS. Family and friends of PWAs; lay caretakers.

SWEAT CEREMONY. Used by American Indians as a ritual for cleansing and healing.

SWEAT LODGE. Place where sweat ceremony is held.
TEMPLE BEAUTIFUL. A program of healing at the A.R.E. Clinic in Phoenix Arizona for serious and chronic illnesses. The name is taken from one of the sacred temple programs in ancient Egypt.

THANATOS. The Greek god who stood for death.

THETA. The deepest altered state one can experience in sleep or hypnosis.

UNIVERSAL HEALING. A term used by New Agers for shared healing of the world and everything in it.

VISUALIZATION. A form of hypnosis or relaxation.

Assumptions & Limitations

The basic assumption of this study is that present bereavement models are not wholly adequate for PWAs or survivors. The bereavement model presented is a combination of resources and therapies that are known to be effective with other populations. Because descriptive research lacks predictive power, it is only assumed that these therapies will also work with this population.

The model is based on holistic teachings and therapies that may have better results with persons already in touch with the spiritual part of themselves, and are willing to suspend traditional belief systems.

The number of therapists interviewed is limited, as is their location, Arizona. This limitation may result in favoring therapies more accepted in the Western portion of the United States.

A lack of statistical application or other experimental methods may discourage other researchers or consumers. All data included in this study are qualitative.
Organization of the Remainder of the Study

Chapter Two provides an introduction and organizational structure of the literature review. The literature review integrates existing bereavement theories with the work of practitioners utilizing new methods. These methods will hopefully assist PWAs and supporters to gain understanding and peace through their crises. Responsibilities of professionals and lay persons in administering to this population are discussed along with a review of coping devices that will hopefully allow the highest standards of personal and professional efficacy.

Chapter Three provides an introduction reviewing the purpose of the study and a description of methodology used. Information addressing the research design, source of data and other procedures follows.

Chapter Four provides a synopsis of the interviews with non-traditional therapists who treat clients for loss and grief. This chapter also looks at those techniques and modalities most useful to working with AIDS patients.

Chapter Five is the Bereavement Model.
CHAPTER 2
LITERATURE REVIEW

Introduction

The extensive literature related to death, dying and bereavement suggests that a process is involved (Kubler-Ross, 1969). The commonly accepted prototype of a griever is one who moves through the various stages, resolving each one, and emerging with an acceptance of the loss. Various theories focus on different stages, though not necessarily following a step-wise pattern (Biller and Rice, 1990).

For many survivors of AIDS, however, grief is complicated by society’s unwillingness to support their grief. Not only have members of the homosexual population lost friends and loved ones, but they have witnessed the destruction of entire networks and communities through multiple deaths over a brief period of time.

The focus of this study was to collect information and data that have enabled a bereavement model to be developed that addresses more than the traditional problems experienced with loss of a loved one. Because of the severity and complexity of AIDS-related bereavement, a different construct than the old stage-model approach is necessary. This chapter introduces material that is current and clinically related to bereavement counseling for PWAs and their survivors. There are two sections dealing with loss and death and one section on possible interventions.

Dealing with Ongoing Loss

Comparisons have been made with survivors of multiple loss from other
situations, such as survivors of the Holocaust where six million Jews and numerous others were sent to their deaths in concentration camps. The survivors experienced demoralization, disorientation, loss of self-esteem, depression and a loss of connection. (Erikson, 1976, p.302)

These survivors also experienced a loss of meaning in their lives due to living through an experience that contradicted all the fundamental rules which had previously guided their lives. In the aftermath of these tragedies, survivors grieve for their personal losses as well as for loss of the culture and community at-large. This multi-level loss is also experienced in the gay community where AIDS has indiscriminately taken its toll (Schwartzberg, 1992).

Bereavement issues specific to loss are more common in persons with greater numbers of losses. Homosexual men in particular fit into this category. The above researchers speculate that two processes operated to minimize depressive symptoms. . . First, the scale of the epidemic at that time meant that the untimely deaths of all of these people were becoming the norm in this population. Second, that growing numbers of community social support systems were being utilized by and helping to protect these men against depressive reactions to multiple deaths... Interventions for depression may be less necessary in multiple deaths, interventions specific to loss may be more necessary. . . (Newgebaurer, et al., 1992, p.1375)

An additional study done by Biller and Rice (1990), found that the unwillingness of society to validate the gay identity and the lack of time between losses led to a severe impact on self-identity and self-esteem. “It is commonly believed that loss reminds people of other losses; thus, when gay people deal with the grief of someone dying, they are reminded of the grief of coming to terms with their own self-identity” (Siegal and Hoefer, 1981, p.520). Thus their present grief is compounded by the past grief of dealing with the thought of themselves as being second-rate citizens.

Kastenbaum (1977) coined the phrase “bereavement overload” in reference to the elderly who experienced many friends’ deaths within a
relatively short time. This concept was reinterpreted by Lehman and Russel (1990) to apply to those dealing with multiple loss with AIDS. Comparisons were made to disaster situations where havoc was wreaked on thousands in a community. “Stripped of the support they received from their community, they became apathetic and seemed to have forgotten how to care for one another” (Erikson, 1976, p.303).

Professionals must come to understand what the overwhelming aspects of multiple loss means to the gay community. By recognizing their struggle to validate their identities and by accepting the disaster theory also applying here, practitioners can learn to apply appropriate intervention.

Questions related to avoidance elicited confirmation of not having ample time to grieve, because as soon as one friend died, subjects moved on to taking care of someone else. They felt no freedom to lean on any friends for support, believing that they too (friends) would be dying soon.

Confronting the epidemic by volunteering to help others and learning from friends' deaths gives some the ability to begin their own grieving process. There is not enough time to work through the many feelings in the grief process which may have long-term, irreparable effects. The post traumatic effects of crises, when not dealt with properly last the rest of one's life. (Typhurst, 1951, p.766)

The enormity of loss in the gay community creates a climate of communal loss as well as personal loss. Community members speak of “being surrounded by AIDS” due to the proliferation of AIDS news in the media, at conferences, seminars, fund raisers and memorial services (Amelio, 1993). Grief is magnified beyond the limits experienced in other types of death. The overwhelming magnitude of these multiple losses demands special awareness and sensitivity from care givers and practitioners (Wofelt, 1992).

It is of interest that survivors would further grieve their most significant loss after each new loss. Recent losses were minimized and the wounds for the most significant loss never healed. Support groups should be used to replace support systems no longer functioning and allow
participants to tell their stories over and over. (Biller and Rice, 1990, p.285)

**Lack of Social Support Systems**

As mentioned before, the grief from AIDS is complicated by society’s attitude regarding the disease.

Bereaved family members often shroud the cause of death with secrecy and mourn alone. Those who were estranged from the one who died may be paralyzed with guilt, shame and self-recrimination. (Horn, 1993, p.81)

In addition to daily care taking, family members may also be dealing with anticipatory grieving, issues of self-mortality, fear of communicability, and lack of financial, emotional, and physical support. Often families report conflict between providing a supportive environment for the patient and responsibility for maintaining the general health of the family.

All the issues normally associated with the death of a spouse or partner are exacerbated by guilt over one’s own survival, fear of one’s own death and exhaustion in caring for someone in a prolonged dying process, by partners of PWAs.

Children of PWAs are at high-risk for psychological problems not only because of prematurely losing their parents, but are often unable to receive support due to the stigma attached to AIDS (Williams and Stafford, 1991).

Stigma and isolation are commonly felt emotions by PWAs and survivors. These are equally relevant to heterosexuals as well as homosexuals. Other concerns of spouses and partners are whether or not to be tested themselves. For those already tested positive, there is fear from knowing what is in store for themselves.

For homosexuals who are not yet out of the closet, there is the difficulty of public mourning. Bosses, co-workers and family members may be unaware of the sexual orientation of these survivors, and letting them know may be
hazardous to becoming unemployed and ostracized. Having to hide the cause of death can prolong grief and cause unnecessary guilt (Amelio, 1993). AIDS bereavement is correlated strongly with post-traumatic stress syndrome symptomatology, and other adverse psychological reactions such as demoralization, sleep problems and suicidal ideation.

Another situation facing PWAs that does not usually effect other terminal patients is a sense of helplessness and seeing themselves as toxic, stigmatized outcasts. . . . Counseling involvement . . . is critically important to their eventual healing and wholeness. The development and sharing of quality interventions among professionals can enable people to develop a new equilibrium in the midst of the crises of AIDS. (Williams and Safford, 1991, p.425)

AIDS family caregivers, who can provide the best support, suffer from a sense of untimely and unjust death. They may face existential questions about death and their own mortality. The anticipatory grief of these caregivers can be particularly painful. This is especially true for parents, since the death of a child, regardless of age, is considered the most acute form of grief (Sanders, 1979). These caregivers discover that their lives have been and will continue to be permeated with loss that is greater than the lives of the average person. Gone are their dreams for the future, their personal freedom, their previous lifestyles and relationships. Loss pervades their personal, professional and recreational lives. There is a blur of constant activity and demands.

Rando (1984) states that a healthy step in facing loss, is wanting to discuss feelings and grief with the PWA. He adds, however, that often there is guilt and distancing from worry about these conversations making the PWA depressed or worried about the caregiver. When both parties are ready to discuss their grief, this becomes an important source of support for all. His conclusion being that sometimes talk about death becomes an intimate and fulfilling part of caregiving.
For those caregivers within the gay community, multiple loss is a major challenge for caregivers and also provides substantial support in coping with loss. An important healing aspect of all of this is living fully in the present. Time together becomes a precious thing and life can take on an intensity unfelt before. As PWA's lost their ability to move, speak or see, caregivers reported that being present was a major priority. The long hours together were time to review and evaluate the experience, the PWA's life and the relationship. The intensity was unsurpassed (Brown and Powell-Cope, 1993). Anticipatory grief during a terminal illness can increase the intimacy and involvement in a relationship by drawing people together (Rando, 1984).

Health care services may need to become responsive to families who do not plan for the future together and instead live one day at a time. Anticipatory grief does not replace the necessity of grieving after the PWA's death. This too becomes complicated because of stigma and communicability of HIV infection. Thus the lack of usual support and sympathy (Murphy and Perry, 1988). AIDS family caregivers are particularly vulnerable and would benefit from support and counseling in anticipatory loss and grieving.

Potential Grief and Pain Therapies for AIDS

Spirituality

Spirituality has been a vehicle for grief for those who use their losses for transformation. People respond to abuse and neglect in different ways. Some shut down, closeting themselves in airtight systems of beliefs that may give birth to even more negative and harmful behaviors. Others who make use of their grief and loss more positively, allow themselves to open and release with alternative ways of being in the world. They find patterns of resilience and transformation that connects them deeply to other cultures and to the earth, thus
experiencing connection with all of humanity (Lifton, 1993).

Those in the gay community experiencing loss of self and allowing themselves to emerge from the darkness of their experience, can create a unique transformation of creative emergence. Coming out of injustice and suffering allows some to express themselves creatively and compassionately (Ritter and O’Neill, 1989).

Often persons responding to personal suffering in a healthy manner, reveal that what evoked their sympathy and concern the very first time was themselves. They transform their own experience as victim into a commitment to combat victimization of others. They make constructive use of their own pain and confusion (Lifton, 1993).

Ritter and O’Neill (1989) reference specific ways of coping with one’s own trauma and connecting oneself positively with the world. In their article they refer to other researchers’ writings on the integrating power of dreams and Lifton’s recommendation of reconnecting by telling stories. They also refer to work on reconceptualizing spirituality by connecting with prepatriarchal religious expression. These themes can allow spiritual rebirth in the gay community. By appreciating the richness of gay clients’ spiritual questing, their counselors can facilitate “wholeness.”

**Alternative Medicines**

The research shows that some institutions specialize in working with certain populations. A clinic that has a specialized program for seriously ill people is the A.R.E.(Association for Research & Enlightenment) Clinic in Phoenix, Arizona. This eleven day residential program is named after an ancient healing center of great renown, the Temple Beautiful. Each patient has an opportunity to enjoy a serene and supportive environment through the
closeness of a small group.

Participants have a choice among many modalities of treatment. After a complete physical workup with the help of a primary therapist, a specialized program is planned for each person. This program may include herbal and energy medicine, massage, spinal manipulation, colon therapy, diet, exercise, group and individual counseling, biofeedback training, visualization training, meditation, prayer and dream interpretation (A.R.E. Clinic, 1992).

Complementing conventional medicine, this program has allowed its patients to experience holistic healing.

Pain Control

Morphine has been used by doctors to control severe pain. The question of how much morphine is too much may be irrelevant for those with terminal diseases and chronic pain, such as AIDS. However, more often than not the prescribed dosage does not keep the patient pain free (Stanko, 1994).

Much interest has been paid to "high-dose morphine" to relieve cancer pain. The only reason to limit a morphine dose is to prevent adverse reactions such as extreme sedation, respiratory depression, nausea and constipation. But a typical daily dose of morphine is 5 to 20mg. every 3 to 4 hours. This is only adequate for short-term, postoperative relief, not for chronic relief for those with terminal illness (Fulton and Johnson, 1993).

The best way to relieve chronic pain is to prevent it. To do this, the patient needs a constant, baseline level of morphine for continuous relief and a breakthrough dose for severe pain, occurring usually at bathing, eating, or moving. The breakthrough dose should be one-quarter to one-third of the daily baseline dose. Also the morphine can be combined with other analgesics as appropriate (Fulton and Johnson, 1993).
A patient receiving morphine for extended periods may have to increase the dosage to achieve the same effect. This is known as tolerance. Physical dependence, like tolerance is a physiologic phenomenon. If the morphine is suddenly discontinued, physical symptoms will appear within 6-12 hours. This can be avoided, however, by slowly tapering the dose, decreasing it 15-20% a day (Fulton and Johnson, 1993). Addiction, which is craving the drug for physiologic reasons rarely occurs in patients taking morphine for pain.

In the past, interest in heroin for pain relief was shown by the National Cancer Institute and members of the House of Representatives. In a major study, the National Institute on Drug Abuse was to test the Brompton Cocktail at Sloane-Kettering Hospital. This drink is a widely used pain reliever used in England. It contains heroin, cocaine, gin, and phenothiazine, which is a tranquilizer. It’s all mixed with a chloroform water base. The combination keeps patients pain-free and alert. But because of a deep rooted fear and negative reaction to heroin by the general public, the medication never took hold in this country (Satchell, 1977).

Hypnosis

Ancient medicine men induced hypnosis with tribal drumbeats. Modern hypnosis has been known for about 200 years, but professional use of hypnosis by therapists and doctors has primarily developed since World War 2 (Francis, 1990).

When used appropriately and knowledgeably, hypnosis can accomplish much that could be useful for those in chronic physical or emotional pain. Hypnosis can reduce pain and stress, improve relationships, overcome insomnia, help one to understand oneself, stimulate change in thought patterns, and learn creative visualization. When one becomes absorbed in anything, a
book, a hobby, driving, one is in a hypnotic state. They all access unconscious resources in different ways (O’Connor and Seymour, 1990).

Anyone can learn self-hypnosis from a hypnotherapist and use it the rest of his or her life for any purpose. Conscious minds handle reasoning and logic, while unconscious minds receive and retain information from everywhere without judgment (Francis, 1990). Through hypnosis, persons can achieve insight into the subconscious and use this awareness to grow spiritually and emotionally by listening to and learning about themselves.

Prayer

Cancer patients have helped to heal themselves through channeling their spiritual energy by using prayer (Creno, 1994). Some patients diagnosed with terminal cancer years ago are surviving and thriving. Their doctors just view them as having beaten the odds, but they believe they’re still alive because of their faith. Those interviewed by Creno weren’t especially religious, but at some point decided they had nothing to lose by turning to spiritual guidance and hope.

Creno (1994) cites scientists in psychoneuroimmunology who say prayer can be powerful medicine. She quotes Dr. Carl Hammerslag who says that prayer inspires hope, and hope changes the nature of the immune system. She state that Dr. Jeffrey Zieg, director of the Milton Erickson Foundation, was surprised that anyone would doubt this phenomenon. He believes the mind and body cannot be separated, that they work in a synergistic way.

Creno (1994) also cites religious leaders who believe that everyone who prays for healing is healed, but not necessarily physically. This includes the belief that healing can take place on different levels, physical, spiritual, and emotional. If someone has cancer or AIDS, he may not be physically healed,
but may be reunited with family, reconciled to dying, or helping others to grieve similar circumstances. This would be a spiritual and emotional healing. Although a physical healing would not necessarily be out of the question either. Some physicians Creno interviewed do not mind if their patients use alternative healing methods, as long as they don’t cease going to the doctor. They believe that prayer, as part of an overall positive attitude is helpful, as it helps people tolerate their therapy. Some think that fewer patients would seek out alternative therapies if their doctors would just listen to them compassionately.

Reiki

Reiki is a Japanese healing technique that means universal energy and was brought to the United States after World War 2. It opens the natural healing channels which allows more energy to flow through (Creno, 1994). Reiki is one of the recently renewed, popular healing techniques brought from the Orient to the Western part of the world. These techniques help to heal one’s emotional as well as physical state of being and are learned by so-called New Age Healers. They practice their healing arts on a growing number of people who are searching for remedies and cures that more conventional medicine cannot produce 100% of the time.

Dr. Andrew Weil (1994), University of Arizona College of Medicine Professor, has studied alternative methods for over two decades. He thinks that belief alone can elicit medical cures and that no system of treatment has a monopoly on cures. Dr. Weil says, “New systems of treatment work best when they first appear...Gurus and healers best inspire the disciples with whom they work. After a few generations, the efficacy of the healing system declines” (p.E3).
Spirits

Ancient Greeks descended into caves for as long as thirty days to consult oracles who helped them to see images of the dead in mirrors and pools of water. This helped to unburden themselves of grief.

In modern times, Dr. Raymond Moody (1993), has written a book about his experiments with contacting the dead as a way of relieving unresolved grief. Like the Greeks, he uses a mirror to reflect the images. Moody claims that those entering his prepared room made contact with their dead loved ones and sometimes even dead others.

Two therapists who were trained by Dr. Moody opened a training center in Scottsdale, Arizona, for health-care professionals interested in a new form of grief therapy. Several groups of health-care professionals have done intensive one day workshops. They claim the main benefit from this is the lifting of grief for the participant. This workshop also helps prepare the person for his own death. A Phoenix resident said the experience helped her deal with her grief over her son's death. She said she felt calmer afterward and didn’t see him as being in as much pain as before. She felt very thankful for the experience (Brinkley-Rogers, 1994).

EMDR

EMDR (Eye Movement Desensitization and Reprocessing) is a fairly new technique. While mainly used in therapy for trauma, therapists have found it useful in treatment for distorted thinking and its manifested behaviors, painful memories, physical sensations and anxiety. All of these have been problematic for clients with unprocessed grief. This technique shortens necessary therapeutic time for relief of symptoms (Cowley and Biddle, 1994).

The exercise, which consists of sets of repetitive eye movements guided
by the therapist, is speculated to trigger an innate mechanism that files away painful memories. Psychologist Clifford Levin is quoted as stating that, “EMDR may be effective because it reinitiates the kind of natural information processing cycle found in REM sleep” (Cowley and Biddle, 1994, p.70).

EMDR’s developer, psychologist Francine Shapiro (1994), has the philosophy that EMDR is a natural process moving toward self healing in an accelerated fashion. She says that trauma causes a pathological change in the neural system, and the incident is frozen in its original anxiety producing form. Incapable of being processed to completion, the information continue to reappear in pathologies such as intrusive thoughts and flashbacks. The repetitive eye movements that are part of EMDR may serve as an automatic desensitization which inhibits anxiety and restores neurological balance. Thus, when processed and integrated, there is nothing negative to return to.

Ideally, the effect of this technique is to address the original incident that established the dysfunctional framework, elicit the trigger that stimulates the maladaptive response, and install a desirable cognitive or behavioral response (Shapiro, 1993)

Summary

Although there is a tremendous amount of literature on AIDS, there is little information on bereavement therapy specifically for people with AIDS and survivors. The research and predictions of a future holocaust with this disease support the need for additional knowledge concerning bereavement aide for all those involved.

This chapter gave information concerning AIDS and the differences in treating it from other fatal illnesses. It also showed a void in treatment of the grievous aftermath for survivors of AIDS. Also presented in this chapter were
treatments, that like the disease of AIDS, are quite different from anything experienced by people living in this century.
CHAPTER 3

METHODOLOGY

Purpose

The purpose of this study was to create a new psychosocial-experiential model for bereavement that can be taught to counselors and medical staff for their therapeutic use with PWAs and survivors. In this study are nontraditional methods of grief work, some ancient and some new. This includes disenfranchised grief, grief that is not supported by society and leaves no time to heal because of its epidemic proportions. The importance of spirituality in healing, compassion, love and acceptance are prominent in this study.

Design of Study

This descriptive investigation deductively inquires into modalities of loss and bereavement therapy in order to propose a new model for therapists who work with PWAs and their survivors.

The relationship between existing bereavement therapy and newer models of holistic health care were examined. The outcome of this investigation provides a bereavement model for PWAs and survivors.

Data Collection & Methodology

Data are qualitative and collected by unstructured interviews. The interviews focused on specific therapeutic practices used by various health practitioners to facilitate the mourning of losses. Unstructured interviews were held with these professionals in order to collect pertinent data. Notes were
utilized to document these interviews when allowed. Questions pertaining to facilitation of psychosocial intervention were asked in order to determine which are most helpful. Questions asked: What techniques do you specifically use to deal with loss or grief? What type of holistic treatment do you use in therapy?

The sample of health care workers consisted of Phoenix area professionals who work with clients on grief and loss, not necessarily with death.

**Sample of Professionals**

1. Susan Stanko, B.S., R.N. Therapist and Nurse Practitioner.
2. Daniel Eckstein, Ph.D. Psychologist and Professor.
4. Sandy Longbotham, Licensed Massage Therapist.
5. Eloise Cole, Director of Center for Grief Education.
7. Jane James M.A.(c), Certified Hypnotherapist.

**Instrumentation**

The validity of results depended on this researcher’s interviewing skills. Since all of the therapists interviewed use varying modalities, exploring all possibilities was facilitated by using an unstructured format. Much of the information was ‘emotionally loaded,’ necessitating this type of format. The authenticity of responses elicited in this manner greatly enriches the study.

Background information of therapists such as sex, age, years of experience, and professional degree was not important in this study. The sole
characteristic of professionals to be interviewed for this study was to be a health care worker participating in grief or loss therapy. The information from the interviews and the literature have been evaluated and assimilated to form a bereavement model.
CHAPTER 4

PRESENTATION OF THE DATA

Interviews

Nine therapists who help their clients or patients to process loss were interviewed. The interview information is presented in this chapter in the chronological order in which the interviews were conducted: Susan Stanko, Daniel Eckstein, John McGarey, Sandy Longbotham, Eloise Cole, Susan Paull, Jane James, Kathy Kessler, and Linda Deane.

The first interview was with Susan Stanko. Susan uses acupuncture, Reiki, and psychotherapy with her clients. She most recently worked at Desert of the Valley Hospice and with Omega Vector as the facilitator for Omega 1. She was trained in acupuncture at the Traditional School of Acupuncture in Baltimore, Maryland. Susan’s sessions with her clients in her office are two hours long. She uses whatever modalities and techniques she feels are needed and intuits what the client needs at the time. She also determines what the client wants to happen, as she believes each client knows what he or she needs for himself or herself at some level.

This researcher personally experienced Susan’s modality of therapy. Her use of acupuncture is for the emotional and mental bodies of a person rather than for physical healing. In treating these areas, however, a patient may notice a removal or lessening of pain in the physical body as energy blocks are removed.

Because of her work with the dying at the hospice, Susan believes in giving enough medication to keep the patient comfortable at all times. She found that too many times the doctor is fearful of the patient becoming addicted
to the medication, mainly morphine, in spite of the fact the patient is soon to die. Therefore, the dosage prescribed was seen by her as far below the amount needed to eliminate the pain. She said it was also below what some in the AIDS field consider to be a safe maximum dosage.

Susan’s apprenticeship in Shamanism with a Native American healer, emphasizes her belief that the physical body responds to all healing processes. Susan has built a sweat lodge on her property and holds weekly sweats for anyone wanting to attend. She believes that this activity has purifying and healing properties. She finds that each person attending responds in his or her own unique way, just as each one’s reasons for attending the sweat may differ.

To many Native Americans, a sweat ceremony is a spiritual ceremony that affects the whole person. Some persons who attend these ceremonies do so to experience healthy change in various aspects of themselves, the physical, mental or spiritual, thus making it a “holistic” experience. Many participants utilize this ceremony regularly (weekly), to maintain balance and health. Others come only when feeling the necessity of regaining health, just as some see a doctor upon feeling ill. Susan’s sweats are open to anyone, not just her clients. This is another way for her to share ‘universal healing.’

The next interview was with Daniel Eckstein. This took place where he works at the A.R.E. Medical Clinic, which stands for Association for Research and Enlightenment. See literature on A.R.E. in Appendix A. The clinic espouses the views of Edgar Cayce, the sleeping prophet. Cayce was a lay person who lived in the earlier part of the 20th century, and who while in a trance state, was able to diagnose and prescribe for ill people from all over the world. The clinic employs traditionally trained medical and psychiatric staff who have a belief in holistic healing including the beliefs of Edgar Cayce. Daniel also is on the teaching staff of several universities. He works in the department of energy
medicine at the clinic.

Many of Daniel's patients at the clinic have serious and chronic diseases. The clinic has an eleven day program called the Temple Beautiful, to work with seriously ill patients in a holistic manner while they live on the premises. In addition to using conventional medicine, the various staff members practice massage, hypnosis, colon therapy, biofeedback, group and individual counseling, visualization, meditation, prayer, dream interpretation, spinal manipulation and energy therapy which includes electroacuscope/myopulse therapy, and ETA therapy. See Appendix B for more information on these therapies.

Electroacuscope/myopulse therapy is impedance-monitoring microamperage electrotherapy that helps to repair tissue and relieve pain. Some users feel that any condition involving nerve or muscle tissue can be improved. Thus muscle spasms, herpes infections, surgical incisions and hematomas, all of which can be seen with AIDS, can be aided with this equipment.

ETA (Electromechanical Therapeutic Apparatus) is applied directly to the body by revolving the patient on a platform in a vertical circle, creating energy interactions between the patient's body and ambient environmental fields. A stimulation of the inner ear is also produced. The effects reported have been of stress reduction, pain relief, relief from insomnia, accelerated healing of cuts and burns, and increased efficiency in left-right brain hemisphere coordination resulting in greater learning ability. The use of diet, exercise, herbs and relaxation methods are also included in this well-rounded program.

Daniel's therapeutic theories include Freud's philosophy on Eros and Thanatos. He is informed on and in agreement with the principles of psychoneuro-immunology. Daniel believes diseases such as cancer can be
caused by anger and AIDS by self-hatred. He recommends that patients and colleagues read The Tibetan Book of Living and Dying by Sogyal Rinpoche (1992) and Bill Moyer’s book and TV show Healing and the Mind (1993). The main point in both of these books and in Daniel’s work is that of treating all components of a human being with many of the treatments aforementioned. Some are applied to the body, others to the mind, but the desired result is the same, the healing of the whole person.

Whereas meditation and visualization is applied directly to the mind, its beneficial physical effects have been relief from stress and pain, reduction of high blood pressure, and better physical functioning. Each patient receives his or her own treatment regime from Daniel or another doctor or therapist. Treatment staff do not just treat a malignancy or a symptom. The well being of the whole person is the treatment plan.

Another staff person at the A.R.E. is John McGarey. His background includes working with PWAs at Mesa General Hospital. Here he works in the Pain Center with those in chronic pain.

John prefers using biofeedback and counseling. Like the well known cancer doctor, John Simonton of Texas, John utilizes relaxation and imagery to effect a trance state. He says this has a beneficial effect on glandular response in the immune system.

Sandy Longbotham, massage and colon therapist, also works at the A.R.E. Clinic, as well as having her own practice. She practices her art on many patients in the Temple Beautiful Program as well as out-patients at the clinic. Through the years, her techniques in massage have evolved. At the present she includes music, aromatherapy and energy therapy in her massage. A session with Sandy not only feels good, but also stimulates the immune and circulation systems of her clients.
Eloise Cole, Bereavement Counselor, does her counseling at Grimshaw Mortuary. She counsels with families of those who have died. Sometimes this begins before the death when the family has contacted the mortuary for burial information. Most of the time, however, it is done after the burial has taken place. Eloise contacts families for up to one year after the loved one’s death. She does this through the mail, in a newsletter, and also in an untraditional manner. See newsletter in Appendix A. Eloise has an annual potluck dinner at the mortuary in one of their attractive receiving rooms. Bereaved families come together, not so much to memorialize their dead, but to give support to each other.

Eloise says it is always a memorable affair with a little participatory entertainment, gentle talk and music. In addition, she sends out a monthly newsletter with bereavement advice and information. When asked what this does for her clients, she explained that for those going through the normal bereavement stages, it allows them to continuously remember that death is only a part of life, and that while one misses the dead, they can be remembered in more ways than sadness, depression and loneliness. Her work, which includes a weekly bereavement support group, allows her clients to be in touch with other mourners, so as not to feel alone with their losses. She sees long term social support as extremely important in healing.

Eloise is just one of the interviewees who believe that creativity helps to overcome the helplessness that people feel over death. She has had clients erect Christmas trees and have birthday parties at grave sites to memorialize their dead on special occasions. Personalized rituals such as reading letters to the deceased and symbolic music and poetry readings at funerals are more of her suggestions to clients. Some clients then begin to think of their own meaningful ways to remember and celebrate the lives they once shared. One
client sent up hundreds of balloons at a funeral. Others have had memorial tables at their loved ones’ funerals and handed out personal items of the deceased to those who were there.

Eloise reminds her clients that pain does not lessen with these rituals, but they give meaning to the loss and emphasize the love and happiness that was in the relationship. This seems to help people survive the death of a loved one. It has also been known to renew faith in life and lessen anger because it decreases feelings of helplessness. Many learn much about life when they fully experience and learn to accept death.

Another benefit of active and personalized mourning, suggested by Eloise, is realizing the fragility of life and not worrying so much about material things. Instead, noticing others and administering to their needs increases one’s own self-esteem and sense of belonging. All of this hopefully renews a sense of wonder and appreciation for life. Add a little dash of humor (or a lot), and loss becomes easier to bear.

Susan Paull is a certified movement therapist in private practice. Her movement techniques decrease blocked energy in the body, which is caused by not acknowledging the emotions of anger and depression. As a psychotherapist, she may counsel her client for the causes of these emotions. As a movement therapist, she goes directly to the consequences in the body.

She finds that many of her clients are not in touch with their own bodies because of suppressed memories and emotions due to trauma. Movement, which is created for each client, helps to move the energy and allow feelings to be expressed. Often times clients are able to understand for the first time why they are angry or depressed, or even that that is what they are feeling. They may remember abuse from childhood or realize that they never mourned certain losses.
Identifying feelings may result from several techniques Susan uses. She has clients utilize props while moving, which often makes it less embarrassing for them. These may be sticks, wands, scarves, balls, pieces of material or anything the client might wish to use that is not harmful. Susan also has her clients do artwork, imaging and relaxation. She utilizes music, although the movement need not be done with it and is not structured. Children respond well to movement therapy because they can express physically what they may not be able to verbally. Adults also find relief and release from physical as well as emotional pain during movement therapy. This therapy is done in groups as well as with individuals. When done in groups, members process their feelings afterwards.

Jane James uses hypnotherapy to help clients express their emotions while moving through the death experience. She works with AIDS patients who live in private homes where they are cared for with others who have the same disease. This social support system is invaluable to the healing of their emotions and accepting their deaths. She feels that hypnosis helps patients to move beyond their natural resistance to their upcoming “metamorphosis”. They are then in a position to release pain and confusion and to transition in peace. See Appendix C for hypnosis and visualization techniques.

When the patient is close to dying, she covers his face with a cloth, sits at his head and breathes slowly with him. When he is in a relaxed state, either Alpha or Theta, she asks him what he sees when he leaves his body. If he see nothing, she gives suggestions of experiences by others, and he then chooses what he wants to see. She encourages him to see a light and go to it. Many have seen loved ones, who have already died, coming forward as if to meet them. She applies gentle touch to keep the patient relaxed and to reassure him as he moves on.
Her techniques include music, journaling, brain integration, humor, sandtray, movement and touch. She encourages patients to plan their own memorial services and to leave meaningful items for loved ones. Her main purpose with her clients is to help them die with serenity and dignity.

Kathy Kessler works with many women who have survived sexual abuse and have life threatening eating disorders. She finds that their major losses have been of family and family connectedness. She uses journaling, writing fairy tales about their own lives, EMDR (Eye Movement Desensitization and Reprocessing) and NLP (Neuro Linguistic Programming). Both of these latter techniques help to reorganize thinking and have been accepted by insurance because they facilitate brief therapy. Kathy also uses sandtray and other art forms. A helpful technique she uses is to have the client make a box and decorate it inside and out. Often the outside and inside differ completely, which allows her to understand things about the client who may not have been able to verbalize the feelings. She encourages her clients to get in touch with their bodies and their senses since some cannot tell when they are hungry, thirsty or tired. She uses Eriksonian hypnosis to do this.

Linda Deane works in conjunction with other therapists. She does an intake with her client and then decides what techniques and modalities would be best. She uses psychotherapy and hypnosis herself but refers her clients to others for body therapy, energy work, nutrition, exercise and diet consultation, acupuncture, lymphatic therapy, breathwork and fasting. These professionals work together in the same school and find this to be very convenient for the client as well as for themselves.

Although Linda was trained in traditional counseling and massage, she has integrated her knowledge with many nontraditional modalities in order to beneficially affect clients' physical, mental, emotional and etheric bodies.
Linda believes that AIDS is connected to guilt about one's own sexuality and being different. Because of this, the immune system is affected by feelings of shame, guilt and fear, which is an unconscious death wish. Healing is found through adjustment to loss and being willing to continue to love. She assists clients to reevaluate their belief systems in order to help heal themselves. Linda believes that the physical body is the last part of the person to be affected by dis-ease.

In addition to counseling AIDS patients, Linda also works with incest survivors on their feelings of loss. These clients, she finds, have lost their own identities and thus are spiritually disconnected. She uses hypnosis and regression so that they can journey into their own bodies to heal their illnesses. Linda recommends reading Many Lives, Many Masters by Brian Wise, M.D. (1988). Her methods of counseling and her beliefs about human functioning are spiritually based.

Linda also teaches classes at the Southwest Institute of Myotherapy. A new class she is offering is concerned with subtle energy bodies and chakras, and the blockages that occur and prevent people from true self-expression. This class is recommended for persons doing healing work with others.

Conclusion

The information gathered through these interviews was analyzed and integrated into the model of bereavement therapy which appears in the following chapter.
CHAPTER 5
THE BEREAVEMENT MODEL

Introduction

The purpose of this bereavement model is to assist clients in discovering their “authentic or higher Selves,” so that healing can come from within. The first question the therapist must ask is, “Am I able to ‘love’ this client?” If the answer is yes, then spiritual healing is possible. Self-doubt, self-hatred, low self-esteem, or lack of acknowledgement of the authentic Self, are all reasons for dis-ease. If people learn to accept love, in a spiritual sense from others, then they in turn can love and accept themselves. The therapist, in this model, is a guide through one of life’s most exciting journeys.

All of the included techniques were used because of their healing powers. But by far the most important element of this model is found in the relationship between client and therapist. When therapists are able to accept and support their clients unconditionally, then spiritual healing is capable of happening.

The information received in interviews was incorporated within the following eight stages. The stages need not be followed in order, and some may be skipped entirely according to each client’s needs. Some clients may not include each modality within their belief system and may wish to exclude one or more. Each stage may require more than one session to reinforce it within the holistic system. Following is a summary and explanation of the purpose of each stage of the model.
Stage One - Introduction

When a PWA is introduced to this model, the therapist should assess what stage of AIDS he is in. If this is a survivor, the therapist should note when the patient died. The therapist may then move forward following the same steps for PWA's and survivors. The assessment should include the physical condition of the client to determine if movement and touch can be tolerated in therapy. If not, stage four should be skipped.

The therapist assures the client that she will be working closely and empathetically with the client. The client should be told that he has the right to refuse any of the stage therapies. Unless the therapist is trained in all stage techniques, she must inform the client that he will be referred to other therapists who will work closely with her. When both client and therapist are comfortable with the agreed procedure, move to Stage Two.

Stage Two - Spirituality

The client and therapist discuss the client’s idea of spirituality. The therapist should continue to reinforce and support the client in his beliefs throughout the model. In this stage, any spiritual process, such as prayer, meditation, chanting, drumming, channeling, visualization or any other method the client uses to reinforce a connection with his idea of a higher power is used in therapy. The therapist may wish to design a schedule with the client so that the process may be practiced as many times as the client feels comfortable. They may also continue this practice together in therapy.

Stage Three - Drugs & Alternative Medicine

The therapist should ascertain whether the patient has any painful or uncomfortable symptoms. If so, she should let him know that she will work with
him and his physician to make him as comfortable as possible. In this stage the therapist should call the physician and inform the physician of what she (therapist) will be doing. If possible, it is best to work in conjunction with the physician in the patient’s best interest. She may need to give the physician information on high-dose morphine as she will not be able to prescribe it. Discussion should include all possible support programs for the patient, including hospice, family support or nonsupport, nursing, day care facilities, group homes (available in some cities), or any other alternative.

**Stage Four - Relaxation Methods**

These methods could include hypnosis, visualization, imagery, meditation, self-hypnosis, music, rhythmic sounds, breathwork and dream work. They not only serve to relax the client for deeper work, but contribute to therapy by bringing a sense of trust and peace into the relationship. This may be the first time the client experiences this. Chosen methods should be taught so the client may practice them on his own as well as with the therapist.

**Stage Five - Body Therapy**

A major reason for this stage, is to allow the client touch from a safe person. It is a latter stage in order to give time to the client to feel safe with the therapist. Only then can he permit and benefit from touch. Chances are this client has been deprived of benign physical contact with others. This serves to promote disease. Safe touch allows love to flow within the body. The following stage will help it to flow without blockage.

The therapist may suggest massage, whirlpool, exercise, movement, dance, psychodrama, yoga, spinal manipulation or any other type of movement and touch therapy. She should schedule the chosen therapies with the client.
She may be present for support if she is not doing the therapy herself. A regular routine is important for the client both physically and emotionally.

**Stage Six - Energy Therapy**

The physical body is the last to feel the effects of stress and turmoil. The body has its own memory pattern and can hold memories of abuse and trauma from past years when the conscious mind has forgotten.

Therapies could include Reiki, Jin Shin Jyutsu, Therapeutic Touch, Polarity Therapy, Acupuncture and Acupressure. All help to remove blockages within the body, due to stress from many different causes both past and present.

Therapists who are untrained in these various modalities need to refer their clients to those who are trained. When first applied, the client may feel ill. These therapies work much the same as stirring a pot of muddy water. The sediment has settled and upon initially stirring, the whole bowl becomes cloudy and dirty. After repeated cleaning and sifting, the water once again becomes clear. Therefore, it is important to continue these therapies on a regular basis.

Some, but not all of these therapies, include touch, which as noted before, is healing if the client is open to it.

**Stage Seven - Creating Empowerment**

The client should now be ready to work on himself with improved self-esteem and the ability to create new choices. Cognitive-behavioral counseling as well as creative processes is used in this stage, to assist clients in changing inappropriate patterns, establish clarity, restore a sense of humor, and create a sense of well-being.

EMDR and hypnosis are behavioral techniques that could be used at this point to instill and fix healthy thought patterns in the client's mind. Artwork and
movement could add creative intention to this. Although the therapist will administer the technique, she needs to follow the client to his intended destination. If therapy has been successful up to this point, the client will now be the guide.

Stage Eight - Self-Acceptance & Tranquility

At this stage, all techniques and modalities discussed in Chapters Two and Four have been applied. At this time the patient may also be closer to death. This does not imply failure. There are times when it is impossible to change one’s destiny, even when the present feels difficult or negative. To accept and do the best one can is sometimes all one can do. But surprisingly when this happens, a feeling of tranquility and serenity can be felt that leaves one quite undisturbed with all eventualities.

The more the client works with these processes with a trusted therapist, the more this feeling of acceptance with one’s destiny occurs.

Conclusion

Healing can take place on the emotional and spiritual level even if not possible on the physical level. If the client feels a sense of personal empowerment, peace and an ability to make choices, even at death, then therapy has been successful. If the client feels joy, love and compassion for others, where he once felt unexpressed grief, loss and separation, surely this is success. If the client is less stressful and feels that past and present trauma is healing, this also is success. When the client has discovered his authenticity and is able to freely express who he is without fear of loss, this is seen as positive movement in life’s journey for both client and counselor. To achieve these successes is the purpose of the model.
REFERENCE LIST


Parchin, Victor. Seven ways to reduce the stress of being alone. Grief relief, 5-6.


APPENDIX A
COUNSELING BROCHURES
Welcome ... to the A.R.E. Clinic, where the healing concepts of the Edgar Cayce readings are used to complement conventional medicine, providing a unique, hopeful, and exciting approach for regaining and keeping health!

The A.R.E. Clinic seeks to provide an opportunity for people to experience holistic healing — that is, healing which involves the body, the mind, and the spirit.

Each patient may choose the program and services closest to his or her individual needs. However, if you are suffering from a serious or chronic health problem, we suggest that you try one of our Special Programs. These programs represent our most comprehensive efforts toward achieving total, holistic health.

If you wish to find out more about our programs and services, or to make arrangements for a visit, feel free to phone us at our main number, (602) 955-0551. Our operator will direct your call.

SPECIAL PROGRAMS

The Temple Beautiful Program

This program is named after an ancient healing center of great renown: the Temple Beautiful. The program is residential, and the participants spend eleven days at the Clinic's spacious Oak House. Through the closeness and caring of small group interaction, and under the personal direction of Dr. William A. McGarey, each person has the opportunity to enjoy a beautiful and supportive environment. More than one hundred and fifty of these programs have been conducted by the Clinic over the past decade, and most people report that these few intensive days at Oak House have changed their lives. We strongly recommend this program for serious or chronic health problems.

Those who participate in this program will experience healing through the use of herbal and energy medicine, massage, spinal manipulation, colon therapy, diet, exercise, group and individual counseling, biofeedback training, visualization training, meditation, prayer, and dream interpretation. Each person receives a unique series of treatments based upon the results of their physical examination, which includes a complete history and laboratory workup.

For more information, please call the Temple Beautiful Program Coordinator at (602) 957-1533.

The Neurological Improvement Program

This program is non-residential, and is designed toward correcting difficulties of a neurological nature, including learning disabilities, stroke, seizure disorders, cerebral palsy, spinal cord injury, autism, and more. Each program is tailored to the needs of the individual, and so is of different length, involving a different selection of treatments. Those who accompany the patient will be given the tools to continue the treatment program at home.

Adults with neurological difficulties may also consider a combination of the Temple Beautiful and Neurological Improvement Programs, to receive the maximum healing effect.

For more information, please call the Clinic’s Patterning Center at (602) 954-9096.
MEDICAL SERVICES

Medical Care
In addition to conventional medical services, we offer sports medicine, herbal and homeopathic remedies, naturopathic manipulations, acupuncture, nutritional counseling, and more. We also provide a special emphasis on women's health maintenance.

Phone Consultations
We realize that many people cannot take the time to visit us or spend the money required for travel to Phoenix. Indeed, many situations (especially those regarding the Cayce readings) involve questions that can be answered over the phone. Of course, with a phone consultation the physician does not have the advantage of examining the patient's physical condition, and cannot give precise judgements, but many times general advice is all that is needed.

All phone consultations must be arranged by appointment.

To schedule an appointment, or for further information, please contact our Medical Office at (602) 955-0551.

THERAPIES

Massage Therapy
Therapeutic healing through touch is a modality recommended in Edgar Cayce's philosophy for balancing body energies. Proper massage affects the physiological, mechanical, reflexive, and psychological aspects of health by increasing lymphatic flow and circulation, thereby speeding the elimination of stress and diet-related toxins. It helps restore health to the skin, muscles, blood vessels, lymphatic system, nerves, and internal organs. "One massage," the Edgar Cayce readings state, "is equal to four hours of sleep."

Massage techniques employed by the Clinic therapists include:

- Cayce Lymphatic Massage and Neuromassage
- Massage to Music and Swedish Massage

Colon Therapy
Colon therapy involves a flushing of the intestinal tract. While this may seem unusual, it makes sound medical sense, for toxins can easily build up in the colon and leak into the rest of the body, producing the conditions for illness. Because of this, colonics are frequently recommended as a means of bringing the body back into balance so that healing can begin.

Physically, colonics hasten the elimination of bowel contents, including undigested food particles, harmful bacteria and their waste products, excessive mucus and gas, parasites, and impacted feces. Colonics also strengthen the bowel walls and stimulate the liver, pancreas, and stomach. Local blood flow and lymphatic circulation are improved, and these act to reduce the stress of colon tissues, allowing them to function more normally. Colonic cleansing also produces conditions more favorable to the growth of helpful bacteria.

Colon therapy rapidly reduces the amount of stress toxins in the whole body. In fact, many people report that a colonic brings them an immediate and lasting psychological sense of relief.
Other therapies offered through the Therapy Department:

- Cranial-Sacral Release Work
- Acupressure and Reflexology
- Polarity Therapy
- Herbal Body Wraps and Whirlpool Bath

To schedule an appointment, or for further information, contact our Therapy Department at (602) 954-9096.

ENERGY MEDICINE AND BEHAVIORAL RESOURCES

Stress Management Program

This comprehensive program focuses on relieving many symptoms of stress, such as high blood pressure, headaches, ulcers, asthma, muscle spasms, chronic tension, fatigue, and other illnesses. It also aims to provide concrete tools to help manage stress on a daily basis, with the goal of preventing stress symptoms from recurring or reappearing in another form. After an initial evaluation, a program utilizing counseling and electrotherapeutic modalities is implemented according to individual needs.

Counseling

An integral part of the therapy program, counseling is available for individuals, couples, and families. We find that counseling will often provide the key to breakthroughs in patient therapy, either by bringing to light supposedly unrelated medical factors, or by assisting the patient to adopt a more healthful approach to their problems. It is our belief that illness is a result of the many stresses encountered in life, and much stress can be relieved through counseling and increased self-awareness.

Biofeedback

Biofeedback is a simple and effective way of showing people the affect that their mind and its moods have upon the body. With the help of sensitive, electronic equipment, our patients learn to recognize the signs of physical stress and the patterns of thought that lead to them. Then they learn relaxation skills that help them to reduce this stress. Biofeedback is exceptionally helpful in relieving muscle tension, reducing pain, improving circulation, and reducing high blood pressure. These biofeedback techniques are skills that once learned can benefit you for the rest of your life.

Electro-Acuscope Therapy

The Electro-Acuscope is a device that analyzes the health of tissues from an electrical perspective. The instrument sends out a mild electrical charge (less than a trillionth of house current), in a waveform designed to supplement the failing energy of toxic cells. This enables the cells to progressively eject more of their toxins and so regain their natural health. Patients often report immediate partial relief from chronic pain and tension, and many chronic symptoms are substantially improved in just a few treatments.

The Electro-Acuscope can also be used as a method of auricular therapy, reflexology, and acupuncture, and is an effective tool for stress management.

Myopulse Therapy

The Myopulse is a device that stimulates increased circulation and muscle relaxation. It is frequently used in conjunction with the Electro-Acuscope to help reduce tissue toxicity.
Myopulse treatment is recommended for:

- prevention of tissue atrophy
- muscle retraining and relief of spasms
- increasing range of motion and circulation

**Non-Surgical Facial Recontouring**

Like any other part of the body, the face is subject to aging, injury, and illness. Mild electrical stimulation, as provided by the Electro-Acuscope and Myopulse can be used to restore a more youthful health to facial muscle and skin.

A short program of treatments can produce visible and lasting results. This method is a safe, relaxing, and gentle way to:

- reduce wrinkles, tighten sagging skin, eliminate bags under eyes
- release facial tension and improve complexion

**ETA Therapy**

ETA therapy has been recommended by Clinic physicians to hundreds of persons over the past several years, many of whom have reported numerous benefits. The ETA (Electromechanical Therapeutic Apparatus) is an unusual device believed to enhance and balance the electromagnetic energy field of the whole body. The electrical current used is unnoticeably small, but effective.

Reported benefits include:

- Relief from stress and pain
- Reduction of hypertension and high blood pressure
- Deep relaxation and feelings of well-being

To schedule an appointment, or for further information, contact our Energy Medicine and Behavioral Resources department at (602) 955-0980.

**PATTERNING CENTER**

The techniques of our Patterning Center come from a variety of sources, including the Cayce readings. *Patterning* is an approach to neurological disorders that emphasizes the ability of the nervous system to adapt to stimulus, and — through this ability — recover proper function if given the proper stimulus. The A.R.E. Clinic has used these techniques successfully for the past decade to obtain improvement of many different kinds of neurological conditions, from epilepsy to muscular dystrophy. Our patients have included children diagnosed with autism, hyperactivity, Down’s Syndrome, and learning disabilities, as well as mature persons who have suffered from strokes, memory loss, and confusion. We also work with those who have received an injury to the brain or spinal cord.

Our primary message to people in these situations is: *don’t be discouraged*. We have many times seen remarkable improvements occur in adults and children where others had thought no improvement was possible.

For more information, contact our Patterning Center at (602) 954-9096.
FOR THOSE OF YOU OUTSIDE ARIZONA

Appointments
When writing the Clinic for appointments (other than the Special Programs), please address your correspondence to the attention of the Reception Supervisor, A.R.E. Clinic, Inc., 4018 North 40th Street, Phoenix, Arizona, 85018, or call (602) 955-0551. Our Reception Supervisor can help you find the appointments best suited to fit your individual needs.

If it should become necessary to cancel these arrangements, it must be done at least 96 hours (4 days) prior to the first scheduled appointment.

Medical Records
If you have recently had a physical examination and/or laboratory tests, you may want to have your doctor send us copies of this information. Records should be sent to the attention of the Reception Supervisor at the Clinic’s address. This additional information is always helpful, and it may result in preventing the duplication of certain tests and be a savings to you.

Weather, Environment, And Clothing
The Phoenix area is known as “the Valley of the Sun.” The lifestyle here is in keeping with the informality of the Southwest. Summer temperatures rise to over 100 degrees, and lightweight clothing and casual attire is acceptable under most circumstances. From October through April, you should be comfortable in moderate-weight clothing, although a sweater or jacket will be helpful at morning and evening. Midwinter temperatures may drop to 30 degrees at night and rise to the 60’s during the daytime.

Cost, Insurance, And Financial Arrangements
The cost of the services at the Clinic are comparable with those of other outpatient medical facilities and therapies. Most of our medical services will be covered under most insurance plans, however this will vary according to the insurance that you carry. It is advisable to check with your insurance representative prior to your arrival to clarify what services offered here are covered.

Thank you for your interest in the A.R.E. Clinic. We hope to be of service, and we look forward to seeing you in Phoenix.
Grief over the loss of a loved one is personal and devastating. Although each individual responds to loss in their own way, Shock, Anger, Guilt, Resentment, Depression, Inadequacy, Denial, Loneliness, and a feeling that life just can't go on; are some of the overwhelming, yet normal, feelings associated with the death of someone close, whether it be a spouse, child, parent, or friend. These informal meetings will explore the grieving process and methods of positively coping with these emotions which few of us know how to handle. Please feel free to come and learn with us about the grief process.

Our Lending Library featuring over 250 books about death, dying, recovery and personal growth. Books may be checked out for a period of two weeks. To obtain your copy of our lending library list, just stop by the mortuary, or for information, contact Eloise Cole or the Mortuary Office at 249-2111. Grimshaw Mortuary provides the library as a community service.

Please ask about our helpful brochures on helping adults and children cope with their grief.

**WHEN:** Tuesday, September 14, 1993:

**Speaker:** Eloise Cole, Director of Death Education/Grief Support Services at Grimshaw Mortuaries

**Good Grief:** Understanding grief and healing. When someone we love dies, life becomes very different. Common actions and reactions to death and grief will be discussed.

**LOCATION:** Grimshaw Bethany Chapel • 710 W. Bethany Home Road • Phoenix, Arizona 85013

**BEGINNS:** Program and speaker begins at 7:00 p.m. followed by support group.

**INTRODUCING A NEW SUPPORT GROUP!**

Brown Bag Lunch Group • 4th Tuesday of each month • 12:00 - 1:30

The very first meeting of our new support group will be September 28, 1993

Call Eloise Cole at 249-2111 for more information.

**Visit Our Lending Li-bear-y**

Sometimes it helps to have a hug. Visit our lending "Li-bear-y" and borrow a bear or other stuffed friend, to give you a hug during the tough times.

ALL GRIEF SUPPORT SERVICES THROUGH GRIMSHAW MORTUARIES ARE PROVIDED WITHOUT CHARGE.

Articles and poetry in this newsletter are from the March/April, 1989 and July/August, 1991 issues of Bereavement Magazine and are reprinted with permission from Bereavement Publishing Inc., 8133 Telegraph Drive, Colorado Springs, CO 80920.
DEAR FRIENDS

Dear friends, if you were to ask me to measure the love I have for any member of my family, I would be hard-pressed for an answer. Surely my love is higher than the mountain tops and deeper than all the oceans and broader than all the deserts of the world. So too is my love for my loved one who has died.

How can I be asked to pack away mementos and memories and not speak his name?

No one can crate the depths of the ocean or the breadth of the deserts nor can my love be boxed and carried away.

Dear friends, please do not set limits on my grief. Neither my love nor the depths of my sorrow can be measured. I am unable to heal on a timetable set by another. Weeks and months have no meaning when set against the measure of my love. Walk with me please, this difficult road of recovery, I promise you I indeed will heal, when I have grieved enough for me.

ELOISE COLE
Director-Center for Death Education and Grief Support Services
Grimshaw Mortuaries

"We alone can grieve, we cannot do it alone."
Mary Brown Ph.D.

Dear Friends,

As we walk life’s road, each of us will face a time when we will need to say goodbye to someone we love.

At the time of the death, many of us are supported by family and friends. As the weeks and months pass, we sometimes have less support from others.

Each of us grieves in our own way and in our own time. The types of information and support we need, varies with each individual.

It is our wish to support you through the pain of grief. Our grief support services are available to anyone at no charge. It is our hope that having these resources will soften your way through griefs path as you find renewed strength and hope.

JACK BYRD
Chairman of the Board

GARY WILLIAMS
President, Grimshaw Mortuaries

Additional Information on Next Page
OUR SERVICES INCLUDE:

LENDING LIBRARY . . . We have over 250 books on grief for adults and children. Included in the library are resources for healthcare professionals and the clergy. Our library is located in our hospitality room. You may come in Monday - Saturday, 9:00 a.m. to 5:00 p.m. and check out books.

NEWSLETTER . . . Mailed monthly, September through May, our newsletter contains helpful articles and poetry. Announcements about our support groups and special programs are included in our newsletter.

SUPPORT GROUPS . . . The second Tuesday of each month, September through May, at 7:00 p.m., our support group meets. Each month we feature a special speaker or program.

The fourth Tuesday of each month, our brown bag lunch group meets from 12:00 to 1:30 p.m. This is a time to bring your lunch and sit and share with others.

INDIVIDUAL GRIEF SUPPORT . . . Our Bereavement Specialist, Eloise Cole, is available for one on one grief support. Sometimes it can prove very helpful to have someone with rich experience in the dynamics of grief, help during the tough times.

TREE OF REMEMBRANCE . . . While the first holidays can be difficult, it is also a time to remember and celebrate the lives of those who have died. Our Tree of Remembrance dedication is offered in memory of those who have died.

For further information about our support services, please call: Eloise Cole. 249-2111.
APPENDIX B

ENERGY APPARATUS
Description of E.T.A.

The Electromechanical Therapeutic Apparatus (ETA) is a device invented in 1974 by David Graham, a Canadian engineer. It has been patented and approved for use by the FDA.

It consists of a platform like a cot on which the patient lies. An electric motor rotates the platform in a vertical circle approximately 9 inches in diameter, keeping the platform level. The rotation rate of 10 revolutions per minute (rpm) moves the patient in a rhythmical cycle through the electromagnetic and gravitational fields of the earth, creating energy interactions between the patient's body and ambient environmental fields. A repetitive, gentle stimulation of the vestibular mechanisms of the inner ear is also produced.

In addition, a pulsating sinusoidal electrical field is generated on the platform. This field flows around the patient from head to toe, projected by a sine wave generator of 125 hertz producing 1.5 to 2 volts in the head piece. The patient is insulated from the head piece (a copper hemisphere 31 centimeters in diameter), but his/her feet are electrically grounded.

The brain is stimulated simultaneously by electrical induction and by the vestibular mechanisms affected by the rotation of the bed. This produces effects upon hemispheric coordination and neurological function.

Therapy sessions last from 30 to 60 minutes and are scheduled consecutively at weekly or other intervals. Counseling, visualization and therapeutic physical exercises are frequently provided in conjunction with ETA treatments, depending upon the condition being treated.

A scientific rationale for this therapy is found in the extensive literature of theoretical and clinical research concerning the use of low frequency, low voltage electromagnetic fields, as well as the use of body rotation for brain and neurological stimulation.

Two types of effects have been reported to result from ETA therapy: 1) Improvement of various physiological processes (including stress reduction, relief from pain, relief from insomnia, improvement of chronic back problems, accelerated healing of cuts and burns, and improvement of neurological disorders); and 2) Alteration of states of consciousness (including beneficial alterations in brainwave patterns and greater efficiency in left–right brain hemisphere coordination resulting in greater learning ability).

Further inquiries should be directed to the Department of Energy Medicine at the A.R.E. Medical Clinic, 4018 N. 40th Street, Phoenix, Arizona 85018, (602) 955-0551.
The Electro-Acuscope/Myopulse System: Impedance-monitoring microamperage electrotherapy for tissue repair

BY K.M. LUCERO

Golf legend Jack Nicklaus, runners Joan Benoit and Mary Decker, and football players Freddie Solomon and Terry Bradshaw are among the many athletes who created public awareness of the dramatic improvements produced using Electro-Acuscope/Myopulse treatment. Media coverage of their injuries and recoveries, however, illuminated neither the modality’s mechanisms of action nor its vast range of clinical applications, in part because the system was referred to as the “miracle machine” and the “magic box.” Worse, these terms led many to believe that this equipment, established for more than a decade, was experimental and mysterious. Confusion with more primitive forms of electrotherapy also was common.

Unfortunately, the misconception that all electrical stimulation therapies are alike persists. Those involved in the use and further development of these modalities, however, point out that various types of electrotherapy have in common only their noninvasive nature and their use of electrical current. For example, TENS is intended to remove or reduce the patient’s perception of pain, while galvanic stimulation produces muscle contraction and hence a strengthening effect. While these modalities certainly have their place, they differ radically from the Electro-Acuscope/Myopulse system both in mechanism and effect. Using microamperage rather than milliamperage current, with the wave form continuously adjusted according to measured tissue impedance, the Electro-Acuscope/Myopulse accelerates tissue repair. Pain relief, though commonly experienced by patients, is a secondary effect of the stimulus; muscle contraction is not produced.

Because of its profound effects on tissue repair, the Electro-Acuscope/Myopulse system can be applied to a broad range of clinical conditions successfully. Early in the application of this technology, this wide utility was sometimes misconstrued to the system’s detriment. Those who had not pursued the literature on the cellular effects of Electro-Acuscope/Myopulse technology mistakenly assumed that the diverse conditions for which the system was heralded as treatment indicated that its effect was largely psychosomatic. Fortunately, the reverse is true. As accelerated tissue repair is beneficial in a vast array of clinical presentations, the system benefits patients due to its physical, rather than psychological, effects.

Though awareness of the mechanisms involved in tissue repair gained a constantly growing audience, further informational efforts will be needed in order to eradicate persistent myths. As a family practitioner with a subspecialty in physical medicine, Steve Center, MD, of San Diego has noted that, “Even some of the physicians who refer patients to me for Electro-Acuscope/Myopulse treatment still confuse this technology with TENS, despite my efforts to educate them. This modality does not block the nerve signal, this treatment is corrective.” Furthermore, the current is generally below the patient’s sensation threshold, so that the tingling or burning sensations typically noted during less sophisticated forms of electrotherapy are not produced.

Though much public awareness of the Electro-Acuscope/Myopulse system has been created, based on the testimonials of athletes and other public figures, evidence to support this modality’s usefulness is far from anecdotal. Neither is this system experimental. Many well documented comparative studies, per-
ments of cellular physiology, and that is why I find it so effective," Center says.

In addition to its tissue repair effects, the Electro-Acuscope/Myopulse system differs from other forms of electrotherapy in two particulars affecting primarily the practitioner rather than the patient. Training is required for proper use of the instrument, and treatment is generally active. "This is in no way similar to galvanic stimulation, where you can put on probes and walk way," explains Joan Shrum-Brown, PT, owner/director of Marguerite Physical Therapy Clinic of Mission Viejo, Calif. "This takes skill and knowledge to apply correctly." Surgeon George Godfrey, MD, founding member of the American Trauma Society of the American College of Surgeons and medical director of Atlantic Industrial Medical Physicians' three-location group practice in Atlantic City, reports an additional favorable effect. "Patients who have had problems for any length of time become extremely appreciative of the fact that a person is treating them actively," he says.

While training is definitely required, it is also easily obtained. User groups receive extensive training on-site, and in-depth courses and seminars are also offered by Electro-Medical, Inc in Fountain Valley, Calif. Courses typically begin with a thorough grounding in the system's physiological effects on both cellular and organ system levels, followed by clinical applications coverage and the provision of treatment protocols for conditions most commonly treated. Shrum-Brown advises, "The physiology portion of the course is phenomenally helpful for understanding Electro-Acuscope/Myopulse technology and what it does. Even those who are not yet using the technology should gain an understanding of its actions and history, for which reason I would recommend this course very highly." For new system users who prefer less physiological background, hands-on training over the course of several days can be provided. Herr Schneider, ATC, head trainer for the Chicago White Sox, recalls, "The distributor spent eight days with us, providing very practical training and treatment protocols." He appreciated the fact that training was tailored to suit his needs, which rarely encompass the theory and mechanics involved in treatment. "Frankly," he jokes, "I don't care if there is a little mouse spinning inside to power this system. It works.

In the case of the Electro-Acuscope/Myopulse System, impedance monitoring and waveform adjustments are the means through which stimulation is constantly modified to induce optimum tissue repair.

To date, the Electro-Acuscope/Myopulse system is the only device that adjusts its waveform continuously in response to the tissue impedance that it monitors. If the low-frequency impedance value of the area being treated differs from a designated value, the waveform will be adjusted accordingly. In addition to delivering the best possible waveform for a given tissue, Shrum-Brown notes, this feature provides the person administering treatment with valuable information. "Impedance monitoring helps you locate the area that you need to treat," she says. "You get constant readouts on tissue impedance that let you know which areas are not conducting.

Though Shrum-Brown has evaluated several types of electrotherapeutic equipment in her practice, including other microcurrent devices, impedance monitoring has induced her to keep four Electro-Acuscopes and three Myopulse units in constant use. "Naturally, we checked out the cheaper systems," she says, "but I find this system most refined and productive of better results."

Because the number of conditions that can benefit from accelerated tissue repair and secondary pain relief is immense, the use made of the Electro-Acuscope/Myopulse system depends heavily upon the user's experience. Shrum-Brown, as one of the system's earliest users, feels that any condition involving nerve or muscle tissue can be improved. She has noted only four reasons that response may be delayed or absent: "Treatment was not given properly, the patient's condition requires surgery, bone is impinging on a nerve, or the patient is defending secondary gain." Shrum Brown also stresses the system's importance as an adjunct to therapeutic exercise, body mechanics, and especially mobilization. "After Electro-Acuscope/Myopulse treatment, the patient is relaxed and pain-free. In mobilization, that is when you can really create change." She uses the system most frequently for patients with muscle spasms, temporomandibular joint disorders, bursitis, arthritis, surgical incisions, sprains and strains, herpes zoster infections, dysmenorrhea, and hematomas.

According to Mark Kana, PT, supervisor of physical therapy for Southwest General Hospital and its Sports West Clinic in Middleburg Heights, Ohio, "the best response depends not on the specific diagnosis, but on the skill of the user. The modality's applications are limited only when the user is not employing the full spectrum of treatment." Over the past three years, Kana has used the Electro-Acuscope/Myopulse system to treat a variety of conditions involving the neck, back, hip, knee, ankle, and shoulder.

Schneider uses the systems primarily for acute injuries. "We have been known to treat a sprained ankle within three minutes," he says. "We have just about excluded ice and the routine treatments for sprains and bruises, and we treat injured players immediately as they come out of the game.

"I use the Acuscope predominately for acute and chronic pain," Center says, "mainly of musculoskeletal origin: automobile accidents, lumbosacral sprains, shoulder strains and rotator cuff tears, and sports injuries." Center also uses the Electro-Acuscope/
Myopulse system to treat herpes zoster neuralgia, local skin infections, decubitus ulcers, post-CVA spasticity, chronic fatigue syndrome, migraine and verteobrogenic headaches, and carpal tunnel syndrome.

Godfrey says, "The most impressive results are found in the severe muscle contraction headaches associated with injuries to the muscles of the upper chest, upper thorax, and neck. At times, the headache is gone within 30 seconds." He also employs Electro-Acuscop/Myopulse treatment for chronic problems produced by strains and sprains, carpal tunnel syndrome, acute joint injuries, acute neck injuries, whiplash, trauma, skin ulcerations, arthritis, and the palliative care of ruptured disc patients who are either unable or unwilling to undergo surgery.

Though most users consider the Electro-Acuscop and the Myopulse as a single, integrated system, the two devices differ in their applications. The Electro-Acuscop is effective in treating acute and chronic conditions, inflammation, edema, and pain. The Myopulse is particularly effective in treating muscle and connective tissue. The two devices are often used sequentially for several conditions. In sciatica, for example, Shrum-Brown first conducts Myopulse treatment to reduce muscle spasm and then turns to the Electro-Acuscop to decrease nerve irritation.

Occupational medicine's uses for the system have been particularly gratifying. "We have relieved pain, restored motion, and gotten patients back on the job a lot more quickly," Godfrey says. Employers whose staff members have been treated note similar results. As Martin R. Daniel, ATC, manager of rehabilitation and safety for Walbro Corp of Cass, Mich, reports, "The Myopulse and Electro-Acuscop have paid for themselves many times over...Our workers' compensation costs have been decreased by over 50% since adding these two modalities to our in-house rehabilitation program." Given the system's effectiveness in treating carpal tunnel syndrome, its utilization in such settings is expected to grow in proportion to the increase in reported cases of CTS.

Practitioners have noted that patients often display a strong preference for Electro-Acuscop/Myopulse therapy over other forms of treatment. Kana reports that none of his patients have expressed any trepidation or resistance to his recommendation of Electro-Acuscop/Myopulse treatment. "I generally begin by describing the optimum environment for cellular repair and how this system produces that environment, giving patients as much information as possible. I also give them reprints of articles concerning this modality so that they can learn more about the treatment between visits." Patients not only educate themselves, but often become enthusiastic proponents of the system and begin "referring" friends and relatives for treatment. Often, Kana says, "They get up off the treatment table shocked at the immediate improvement. Many are able to walk comfortably or tie their shoes, for example, for the first time in months or years."

Patient satisfaction is produced by several factors. First, the treatments are not only painless but generally imperceptible. Second, the patient is not left alone in a room as with so many other modalities. Third, the secondary effect of pain control often lasts for an extended period after treatment. Finally, effectiveness is obvious and immediate. "We have gotten used to seeing contusions dissipate before our eyes during treatment," Schneider says. "As soon as they are injured, players now call for and expect Electro-Acuscop/Myopulse treatment."

In at least one instance, patient enthusiasm motivated a practice to institute Electro-Acuscop/Myopulse therapy. When Godfrey's group practice hosted a three-day demonstration of the system, patients who had undergone only one treatment contacted Godfrey repeatedly with requests that the modality be made available to them. "The reason that we purchased the equipment was that our patients were feeling so much better that they were seeking me out to tell me," he says. "That is very unusual. I have never seen patients go to such lengths before."

The reasons users state for their adoption of the Electro-Acuscop/Myopulse system naturally vary, but they share a common element: The system is able to fulfill needs left unmet by any other form of treatment. Shrum-Brown began using the Electro-Acuscop/Myopulse system 11 years ago because no other therapeutic regimen was suitable for her nursing home patients. "Geriatric patients could not tolerate electrogalvanic stimulation because of pressure from muscle contraction," she says. "I got much better acceptance with the Electro-Acuscop/Myopulse system because it does not produce discernible sensations in these sensitive patients."

The previously unsatisfied demands met by the Electro-Acuscop/Myopulse system can be societal as well as clinical. As Center reports: "It really concerns me that there are so many people on habit-forming medications in this country, with no attempts made to correct their underlying problems. Now that I am providing
Electro-Acuscope/Myopulse treatments. I rarely prescribe narcotics and muscle relaxants. I have very few patients on habit-forming medication, which to me is a great benefit," Center adds that the Electro-Acuscope/Myopulse system can save patients and their third-party payers large sums by making extensive diagnostic testing unnecessary in many instances. "When I get a patient with a rotator cuff strain, for example, I could do $1,500 worth of tests before I begin treatment, as many physicians would. By instituting Electro-Acuscope/Myopulse treatment immediately, I both conserve health care resources and avoid exposing the patient to diagnostic testing radiation. It would help both patients and payors if medicine could employ this type of early intervention more often," he continues. "Though I still treat many patients conventionally as well, in some cases I am able to begin Electro-Acuscope/Myopulse treatment before doing a workup."

In many instances, the results noted by patients following Electro-Acuscope/Myopulse treatment are striking—one reason that the system’s use in the treatment of world-class athletes has garnered so much attention. Because their ability to compete often depends upon perfect physical function, athletes have traditionally been among the most aggressive in demanding Electro-Acuscope/Myopulse treatment for their injuries. Even in locales without professional teams, athletes seek practitioners who provide Electro-Acuscope/Myopulse treatment. As Godfrey reports, one such athlete provided him with dramatic evidence of Electro-Acuscope/Myopulse treatment’s effect. Marathon swimmer Paul Asmuth sought Godfrey’s aid for myositis and capsulitis of the shoulder only days before a 21-mile marathon swim that included a punishing final stretch against the tide. “After five Electro-Acuscope/Myopulse treatments, Asmuth was able to outrace a swimmer ten years his junior, finishing second and proving how rapidly his shoulder condition had improved,” Godfrey says.

Center also has treated marathon athletes, in his case twin runners, with impressive results. He sees equally dramatic improvements in non-athletes, however. “In 1986, a patient who had experienced severe headaches three times a week for 20 years consulted me. I performed two Electro-Acuscope treatments. Ever since those initial treatments, this patient’s frequency and severity of headache have dropped to a mild occurrence every six to eight weeks; she has a maintenance Electro-Acuscope treatment every two months.”

Since the Electro-Acuscope/Myopulse system’s effectiveness has been both impressive and well-documented over the course of 12 years among thousands of patients, why is this treatment not available to every patient? Several answers to this question suggest themselves:

• Health care providers sometimes exhibit a tendency to ignore therapies outside the realm of their current research or interests.
• As a whole, the medical profession is slow to accept change.
• A considerable body of research on electrotherapeutic action focuses on cellular effects and is thus published in physiology journals, given the volume of medical information published, these journals are not widely read among those involved in active patient treatment.

Because the Electro-Acuscope/Myopulse system’s actions are neither chemical or thermal, they constitute a radically different approach to physical medicine. In addition, the modality does not fit the traditional pattern of surgical and pharmacological intervention that characterizes Occidental medicine.

Twin sister triathletes Barbara Alvarez, PhD, and Angelika Casteneda, 48, were both able to resume active competition after undergoing Electro-Acuscope/Myopulse therapy. Casteneda was treated for tibiais anterior tendinitis one week prior to participation in a 100-mile race. Alvarez’s condition, after receiving 3-5 treatments for a hamstring strain, improved rapidly, enabling her to return to competition.

- Because the devices are noninvasive and can be operated by nearly all health care practitioners, their endorsement by physicians might threaten medical control of the therapeutic process.
- Beyond basic TENS and muscle stimulation, electrotherapy is very rarely included in medical school curricula.
- When compared with the ease of writing a prescription for medication, Electro-Acuscope/Myopulse treatment may seem time-consuming, even though the benefits are obviously greater.

Though such biases and educational deficits remain to be remedied, those who now offer Electro-Acuscope/Myopulse treatments will continue to see gratifying results, both for their patients and for their practices. Center had expected Electro-Acuscope/Myopulse treatment to be a useful but limited adjunct to his practice, but finds that “Now, it has taken over half my practice.” While this places him in an enviable position, he hopes that more physicians and other health care practitioners will soon join him in providing their patients with superior results. “I think that every doctor should have an Electro-Acuscope/Myopulse system in the office,” he concludes, “right next to the microscope and the centrifuge. This treatment should, for the benefit of patients everywhere, become that common.”
APPENDIX C

EXERCISES & TECHNIQUES
GRIEF RELIEF

Seven Ways to Reduce the Stress of Being Alone

By Victor M. Parchin

On January 31, 1983, Sally, a twenty-two-year-old woman, was robbed, abducted and murdered. Almost exactly six months later, the grandmother who had raised Sally since she was a year old, died. Those who knew the family said the grandmother died of a broken heart.

The medical reality is that grief is very stressful. Every loss has a tremendous psychological and physical impact. Researchers have noted that heart disease and mortality rates are consistently higher for divorced, single and widowed individuals of both sexes and all races.

The news, however, for those in grief is not all bad. While stress is always a by-product of loss, one should not feel totally helpless when dealing with grief. It is possible to reduce tension and help fight off the effects of stress. Here are seven suggestions for breaking the cycle of stress:

IMAGE POSITIVELY

Imaging is a term which has recently come into vogue. It involves forming a mental picture or visualizing an ideal situation one would like to experience. The theory behind imaging is that what you see is what will be.

A 24-year-old woman who had been in a coma for three months was visited by her primary physician and an intern. The physician said to the intern, “Don’t waste your time on her. She’s never going to wake up.”

A few weeks later, the woman came out of the coma and was asked if she could remember anything during her comatose state. She replied, “I remember hearing that doctor say I’d never get well. I made up my mind to show him he was wrong.” Imaging involves channeling the emotions and mental attitudes in ways that break cycles.

BALANCE YOUR TIME

It is vital to balance work and play, leisure and labor, activity and rest. EV-
everyone needs space, variety and a change of pace. If a situation is wearing you down, seek ways to equalize and lighten your life.

One woman, whose husband died suddenly and prematurely, was overwhelmed by her loss. Her grief was almost unmanagable as was her stress level. Finally, she was able to overcome her anxiety through balancing the load by adding pleasure to her pain.

First, she took over her husband’s business—an involvement she had previously never had. Then, she got a dog, something her husband had never agreed to. She also began to travel, and she took up tennis. “If I can’t have Paul,” she said, “I’m doing to do everything I couldn’t do when he was here.”

EXERCISE REGULARLY

A variety of studies provide ample evidence that physically fit individuals have the edge over others in dealing with stressful life events.

A study that tracked the health habits of 17,000 Harvard graduates for 12 to 16 years, found that individuals who exercised habitually, suffered fewer heart attacks and significantly increased their overall health and longevity.

The exercise does not need to be rigorous, just regular. It is not necessary to become a long-distance jogger or marathon swimmer. Daily walking at a comfortable pace delivers great benefits in stress reduction. One 80-year old man took up bicycling after his wife died. “I wouldn’t miss my daily bike ride for any reason,” he says. “It clears my head and puts things into perspective.”

WRITE OUT THOUGHTS AND FEELINGS

Anything which objectifies experiences is generally healthy. During stressful times, many people begin to write in a journal. It can be a therapeutic way to get in touch with deep feelings and emotions. Keeping a daily record allows you to spot the main stresses in your life. That knowledge, in turn, can help you respond better.

Martha, whose husband died of cancer at the age of 58, writes an ongoing letter to her deceased spouse. In it, she tells of the day’s happenings, insights she has received as a result of his death, and sometimes she expresses her anger toward him for leaving her prematurely and causing her present pain.

SHARE YOUR WORRIES AND CONCERNS

Seek out someone who can listen and be non-judgmental. Good friends whom you have come to love, trust and respect can be very helpful when stress is tearing you up. Don’t hesitate to tell them that you need to talk. They may not automatically realize that.

Support groups can be valuable as well. James’ wife of forty years died one night in a hospital. The first time he attended a support group meeting, he could not get through the details of his

Stress resulting from loss cannot be avoided, but it can be managed and minimized.

By applying these techniques, you will be rewarded with better health and more enjoyment of life.

wife’s illness and death without breaking down in tears completely. For several months the members of the group listened to him tell and re-tell the story, and with each recounting, he shed some of that night’s pain. Sharing of sadness always serves as a catalyst for healing and growth.

ACCEPT YOUR FEELINGS

After a loss of any kind, we do not choose our emotions, they choose us. It’s important to let the feelings flow naturally. Robert, who lost both his wife and oldest daughter in an automobile accident, writes: “I’ve had my share of tears and sadness over my tragedy. And I’ve had my share of a whole flood of other feelings too: anger, helplessness, hopelessness, fear, guilt, loneliness. I’ve learned that it does no good to fight such feelings. Pushing them down only seems to make them come back with even greater fury. But when I have embraced them as part of me, and normal, then I’ve been able to ride the crest of that wave of emotion to a new place in my recovery process.”

MAINTAIN ADEQUATE NUTRITIONAL BALANCE

Following a loss of any kind, people often suffer from eating disorders, the majority of them finding meal times unpleasant and even impossible. However, grievers need to be extra careful about providing themselves with important nutrients. As much as possible, every attempt should be made to eat daily portions from the four basic food groups: meat, fruit and vegetables, grains, dairy products.

It is also important to maintain an adequate fluid intake because it is easy for the griever to override a sense of thirst. Additional fluid intake should be encouraged while avoiding caffeine and alcohol.

Stress resulting from loss cannot be avoided, but it can be managed and minimized. By applying these techniques, you will be rewarded with better health and more enjoyment of life.
CO-MEDITATION

This exercise is used by Jane James with her patients. This exercise was developed fifteen years ago by Richard Boerstler, a psychotherapist. It is a modern off-shoot of an ancient Tibetan meditation technique to clear and quiet the minds of dying lamas. The technique today is highly effective in cases of anxiety and fear as it eases the dying process, reduces stress, lessens physical pain (with accompanying anguish), and releases, reduces and redirects anger. It is a physiological approach that uses the body (the autonomic nervous system), to affect a change in mind. Co-meditation has proven to be a powerful tool in recovery.

This exercise is unique in that both the client and the counselor reach a non-stressful, relaxed demeanor as a result of the process. Co-meditation, as the name suggests, requires both the counselor and client for active participation. The relaxation that results dissolves tension and is a means of centering one’s own consciousness and opening the way for deeper communication. The client need not do anything but be as he or she is, and enter into what is given:

The client is asked to rest on the couch or floor (with adequate support pillows for knees and neck). He is asked to lie comfortably with his eyes closed as he simply listens and breathes. Covering your client with a light blanket gives a sense of security and warmth from possible cold drafts.

Sitting next to the client, the counselor suggests that he or she is going to breathe along with him. The counselor watches the rise and fall of the client’s abdomen so as to tune into the client’s breath rhythm. As the counselor tunes
into the rise and fall, she adjusts her respiration rate to the client's. As a few mutual breaths have been established, instruct the client to allow an "ahhhh", to escape with each simultaneous exhalation. Each time the client breathes out, the counselor sighs a deep and audible "ahhhh." The client need do nothing, although most clients begin to express "ahhhh" once the discomfort of verbal expression has passed. The exercise continues until four to five mutual exchanges of "ahhhh" and breathing patterns are shared. Sometimes this does not occur for twenty minutes. What is important for the counselor to recognize is that the client has been given a technique to reduce stress and tension in conjunction with the counselor. As a shared experience, most resistance is broken to sharing feelings, trust is established and there is more space in which to share his predicament. It is a wonderful bridging technique for overcoming client shyness and reticence.
THE STAR IMAGE

Exercise Goal

This technique is utilized for persons dealing with grief, separation, disappointment, confusion, and the inability for "letting go" of the past:

Time - 5 minutes - Step-by-Step Process

On a quiet, still, clear night, position yourself in a comfortable chaise lounge or chair with an unobstructed view of a star (preferably the brightest, and largest in the sky). Do a progressive relaxation technique for calming and tranquility. When you are able to do so, begin to imagine that the star is the person or object of frustration. Begin a dialogue by talking to the star (out loud is best) as if it was a real person or object. Literally, tell it all that you are experiencing and feeling; tell it all the things you have ever wanted to say from your heart and could not express; allow your emotions to pour out of you as you imagine these emotions going across time and space to the star. With each emotion "landing" on the star, imagine that the star gets bigger and brighter. Give yourself permission to let go of all your emotional holdings, and grasplings. Allow yourself to "tell the truth" to the star. Do this for as long as you feel you have any negative emotions or unanswered questions left within you.

When you have expended all emotional energy into the star, allow yourself to feel the peaceful response of released, negative energy; allow yourself the recognition that you are only human, and have needs, also. Know that whenever you need to express your emotions, all you need to do is to go outside and "talk" to the star; or imagine you are outside talking to the star. When you are completely finished, acknowledge your range of feelings, change of emotional balance, and formulate a conclusion for positive change. Try asking the star for answers, and wait for the answer (often, the answer will come within three days during your dream or reverie.
Conclude your star exercise on a positive note for well-being, serenity, and inner peace.
IV. Pace and Lead Statements

Pace Statements - what they are doing that you want them to notice that is "trancelike"

You are sitting in the chair.
You are breathing in and breathing out.
You can hear the sounds in the room.
You can feel the sensations in your right hand/left hand
You have a conscious mind.
You have an unconscious mind.
Your eyelids are beginning to flutter.
Your breathing is getting deeper.
You can notice the sensations in your (body part)

Lead Statements - what experiences you want them to develop

......and you can..............

bemome more absorbed in your experience.
feel more comfortable
begin to understand things more deeply/clearly/comfortably
become more aware of certain things
(body part) can feel heavier/warmer/
reflect on important things
go further inside
really begin to let go more and more
develop that floating feeling

Ratification Statements- statements that reinforce and support the clients hypnotherapeutic process.

that's good
that's right
very good
excellent
yes!
Protocol # 1

INDUCTION SCRIPT - FACE/LEAD INDUCTION

Orient----Pace-----Lead----Ratify-----Pace----->>>>

1. Orientation:

______(Name)______, you might take a few moments to just begin to relax there in that chair .... to make yourself comfortable .... take a few nice breathes .... good! And as you do, you can allow your eyes to slowly....close. And that can help you to begin .. to really feel even more comfortable .... that's good .... At first .... you may become more aware of some things than you were before. And since you are here.... and hearing... the sound of my voice, you might feel a sense of comfortable curiosity about the things you may learn... because today.... learning is so very important.

______(Name)______, you might notice... some of the other sounds in the room ... that's it! .... and because you can notice things.... slowly and easily.... the important thing is that your conscious mind can really pay attention to some of the interesting elements of your own personal experience.... Most of the time our conscious minds can be so busy with the thoughts and problems of the day.... but now... you can just take the time to really learn ... very good!

2. Pace----Lead-----Ratify:

You might become more aware of your own breathing and the way you take things in... fully.... hold them .... and the way you can just slowly... let things go.... good! And you might also notice how things are beginning to change.... because you really want to understand your own comfort .......

Your conscious mind might focus on the sensations in your right hand..... your left hand..... that's it ! ! ! ....... Or the ways in which you see yourself sitting there in the chair.... images that drift into the mind automatically.... because with your eyes closed it becomes easier and easier, to become more and more aware... of a variety of things that might otherwise be overlooked or ignored completely.
Thoughts, feelings, sensations... and the gradual alteration of awareness... as the mind begins to experience that gradual... letting go. Letting go even of the effort it take to be aware of exactly where the arms are positioned or the hands or the fingers... even of the effort it takes to be aware of which leg seems to relax more quickly, or completely than the other... may seem to be too much effort to bother making.....but it takes time to experience that nice feeling of letting go..... Your own time in your own way..... that's it.

Now, (Name) , as your mind begins to flow down... toward that place of quiet awareness... even as the sound of my voice or the meaning of my words just move... in and out.... because you really don't need to pay attention..... to anything....., but those feelings of deeper feeling... of your own experience.... just really allowing yourself to drift more easily into that experience...... good.

As your conscious mind may notice those sounds and sensations inside..... while your unconscious mind really... allows you become even more easily absorbed in moving down..... into that quiet personal place where you can really let go......and learn more about hypnosis...... comfortably........ that's it!!!!!!!

.................................................................................. good........................................ that' right!
..........................................................................................

3. Reorientation

And now ....... As I begin to count up from one to five, you can just pay attention to your breathing as you begin to slowly re-orient

One...... becoming more aware..... and breathing...... that's good. Two...... your conscious mind attending to your body and how it begins to change slowly and steadily..... Three......... recognizing that it can be so nice to learn things through your own interesting experiences..... Four.... almost all the way back now, because you have a conscious mind and an unconscious mind... Wondering how your eyes will feel as they open and the right amount of tension moves back into your muscles.... that's right... and five.................opening your eyes and just being here for a few moments before you begin to think about things in another way........ Good !!!!!!!!!!!
Protocol # 5 - Sample Intervention Script

Regression & Metaphor/Story

Orientation:

[Name], We are going to spend some time helping you to make yourself more comfortable and to beginning to develop some important changes in the ways you can experience things. You might begin by taking a few nice breaths and really starting to clear out any of those thoughts or concerns or tensions that you may notice and just... really starting to move your awareness more toward your own personal experiences as we proceed together.... That's good.

Now, as you just allow your eyes to... slowly close, you can begin to move inside and notice things in different ways..... in those ways that have become more familiar to you.... today.. that's it! Because you really do want to learn to make those important changes, comfortably .... and you really can.... learn, unconsciously... how hypnosis can develop.. things for you.

Induction:

Pace-Lead:

You may be aware of certain sounds in the room and those can help you to move down even more into your own experience. You might be aware those feelings in your eyelids.......and of the colors or forms or images that you can see with your eyes closed....... or right now, you might be aware of something else that can be easily absorbing....... good !

You can notice the rhythm of your breathing and pay attention to the ways tension moves in and out as things change.......because you have a right side to your body.....those sensations in your foot...... your hand.....your shoulder.......that's right! and left... too... The inhale....... and the exhale..... while you really let things go ...... fully.....
Regression:

Your conscious mind can learn to really enjoy those feelings of comfort..... your unconscious mind can now really drift back to a memory of being in school, maybe in the fourth or fifth grade..... ....good. Your might remember some of the things in the classroom,... the desks, ....the teacher, ....some of the other children....... even some of the sounds of being in school ... ........good.

Now, __name______, You can also remember your house or apartment, at that certain time in your childhood..... and you can just take the time to begin to notice things that can interest you .....now.......back there ... good! ... and because you have and unconscious mind... you can ..... really remember.......and you can become absorbed in the experience.

And you really could also move to a time where change was so very important for you....... just taking your time to move around inside ...... in your way........ that's it ! .................

Because it can be important to go back.... and to make the changes that are important to you....... easily and unconsciously.

While your conscious learns in certain ways....... your unconscious mind is so powerful and is a vast reservoir of resources for learning and making those changes in its own way.

Metaphor/Story:

Now.......you can be really be there........ and you can be here, hearing me also so that unconscious experience and the conscious experience can be very interesting........... the ways in which they blend and change......

So as I begin to tell you about..............orient to story or metaphor ........ you can understand things on many different levels and just allow the those changes to develop in their own ways......

---------------

INSERT STORY AND/OR METAPHOR
ReOrientation:

____ Name _______, you can take a few more moments to allow those important things to really settle in.................... because the unconscious mind works in that way............ that's right...........................................................
........................................................................

and then..... you can begin to come back to this time and to this place slowly....... just allowing the transition to be enjoyable and steady.......just paying attention to your breathing as you move back toward the count of 10.

one..... you may remember certain things, but it is important to really forget things....... two...... and allow your unconscious mind to dream its own dreams now and tonight....... three, 30 % of the way back....... that's good. Four........ 40 %..... and Five, half-way back............ That's it.

Six....... beginning to come back even more...... hearing the sounds of the room, and becoming aware of your own body...
Seven.... 70 % of the way back. Eight...... that's good...
Nine.......... almost all the way back now...... allowing the right amount of tension to return to your body.......and getting ready to open your eyes.......... and TEN !!!!!!! All the way back.

............... very good !!!!!!!

11
The Gnat Namouss—and the Elephant

Once upon a time there was a gnat. His name was Namouss, and he was known, because of his sensitivity, as Perceptive Namouss. Namouss decided, after reflection upon his state, and for good and sufficient reasons, to move house. The place which he chose as eminently suitable was the ear of a certain elephant.

All that remained to do was to make the move, and quite soon Namouss had installed himself in the large and highly attractive quarters. Time passed. The gnat reared several families of gnatlets, and he sent them out into the world. As the years rolled past, he knew the usual moments of tension and relaxation, the feelings of joy and sorrow, of questing and achievement which are the lot of the gnat wherever he may be found.

The elephant's ear was his home; and, as is always the case, he felt (and the feeling persisted until it became quite permanent) that there was a close connection between his life, his history, his very being and this place. The ear was so warm, so welcoming, so vast, the scene of so many experiences.

Naturally Namouss had not moved into the house without due ceremony and a regard for the proper observances of the situation. On the very first day, just before moving in, he had cried, at the top of his tiny voice, his decision. 'O Elephant!'—he had shouted—'Know that none other than I, Namouss the Gnat, known as Perceptive Namouss, propose to make this place my abode. As it is your ear, I am giving you the customary notice of my intention.'

The elephant had raised no objection.

But Namouss did not know that the elephant had not heard him at all. Neither, for that matter, had his host felt the entry (or even the presence and absence) of the gnat and his various families. Not to labour the point unduly, he had no idea that gnats were there at all.

And when the time came when Namouss the Perceptive decided, for what were to him compelling and important reasons, that he would move house again, he reflected that he must do so in accordance with established and hallowed custom. He prepared himself for the formal declaration of his abandonment of the Elephant's Ear.

Thus it was that, the decision finally and irrevocably taken and his words sufficiently rehearsed, Namouss shouted once more down the elephant's ear. He shouted once, and no answer came. He shouted again, and the elephant was still silent. The third time, gathering the whole strength of his voice in his determination to register his urgent yet eloquent words, he cried: 'O Elephant! Know that I, the Gnat Perceptive Namouss, propose to leave my hearth and home, to quit my residence in this ear of yours where I have dwelt for so very long. And this is for a sufficient and significant reason which I am prepared to explain to you.'

Now finally the words of the gnat came to the hearing of the elephant, and the gnat-cry penetrated. As the elephant pondered the words, Namouss shouted: 'What have you to say in answer to my news? What are your feelings about my departure?'

The elephant raised his great head and trumpeted a little. And this trumpeting contained the sense: 'Go in peace—for in truth your going is of as much interest and significance to me as was your coming.'
THE CHAMBER OF HORRORS

On one important evening in the life of the Dalai Lama, his masters came to him with great sympathy and told him as gently as they could that it was time for him to be locked into the chamber of horrors, for he had been heard crying out in his sleep.

They explained that he could not be a wise king until he had learned to overcome his fears and better understand his strengths. The ancient gods of Tibet were to be his guides into courage. These gods would appear to him in the masks of his various earthly and illusory fears, upon which he must meditate nightly until fear was cast out by the love of life.

The king was taken down a narrow passageway to a door opening upon darkness. He was told to enter the room and sit on the floor. A very dim lamp was placed next to him. The masters withdrew, closing the door and locking it from the outside.

At first the Dalai Lama saw nothing but a barren altar, then hideous faces began to loom out at him. He shrieked, sprang up and threw himself at the door. When the teachers finally opened it, the limp body of the king slid out and slumped at their feet in a dead faint. They carried him to bed and sang him lullabies all night long to ease his terrible dreams.

The next night he was taken to the chamber of horrors once more. This time he sat there with eyes shut tight. Though trembling violently, he managed to stay in his place until released.

Months passed before he dared open his eyes in the chamber of horrors again. But, once he had understood that he would no longer be allowed the quest for truth without passing through terror and that his cowardice would only condemn him to a lifetime of returns to this dreaded place, he began to peek briefly and, finally, with wide-open eyes at the horrifying personages.

Many years later when the Dalai Lama was forced to leave Tibet and escape into India, he visited the chamber of horrors last of all, to bid good-bye to the beautiful masks of the gods.
Sherry Potter was born in Chicago, Illinois, on September 18, 1945. She attended Governor's State University in Illinois, and received her Bachelor of Arts Degree in 1982. She moved to Scottsdale, Arizona in 1987 with her husband, and began her work there in the therapeutic field. She entered the Master of Arts program at Ottawa University in 1992, and will receive her Master of Arts Degree with an emphasis on professional counseling in January, 1995.

Sherry is a member of the Arizona Group Psychotherapy Society, the American Counseling Association and the Arizona Counselors Association. She has received national professional certification from the American Academy of Bereavement, and is eligible for Arizona state certification in counseling.

Sherry is currently doing group therapy with domestic violence as a contractor with the Diversion Programs of Scottsdale and Phoenix, Arizona. She also does bereavement therapy with people with AIDS and survivors, and is dedicated to dignifying death and grief from AIDS.