Psychosynthesis Research Foundation, Inc.

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February 1, 1971

Dear Colleague:

The fifth meeting of the 1970/71 series of Psychosynthesis Seminars (held on the third Friday of each month) will be on Friday, February 19th at 7:30 P.M.

Our speaker will be Dr. Bertha P. Rodger, Valley Hospital, Ridgewood, N.J.; her subject will be: "The application of psychosynthesis to my work as anesthesiologist." Following Dr. Rodger's talk will be the usual group discussion.

We hope it will be possible for you to be with us at this meeting.

Cordially,

JACK COOPER, M.D. 914-669-5105

FRANK HARONIAN, Ph.D. Plaza 9-1480

DATE & TIME OF MEETING: Friday, February 19, 1971 at 7:30 P.M.

PLACE: Directors' Room, Mezzanine floor, Park Sheraton Hotel, 7th Avenue & 56th Street, New York City. (Please consult notice-board in hotel lobby in case of room change.)

SPEAKER: Bertha P. Rodger, M.D.

SUBJECT: The application of psychosynthesis to my work as an anesthesiologist

PSYCHOSYNTHESIS SEMINARS

1970-71 SERIES

Fifth Meeting: February 19, 1971

Speaker: Bertha P. Rodger, M.D.
Valley Hospital
Ridgewood, N.J.

Subject: The application of psychosynthesis to my work as an anesthesiologist.

Participants:

Jack Cooper, M.D.
Rena Cooper
David Gaines
Peggy Griffin
Frank Haronian, Ph.D.
Frank Hilton
Hilda Hilton
Alex Imich, Ph.D.
Joan Kellogg
Russell Kellogg
Thomas A. Mikula
Birger M. Salberg
Frank J. Shames
Shirley Winston, Ph.D.
William Wolf, M.D.

Psychosynthesis Research Foundation
Room 314
527 Lexington Avenue
New York, N.Y. 10017

THE APPLICATION OF PSYCHOSYNTHESIS TO MY WORK AS AN ANESTHESIOLOGIST

BERTHA P. RODGER, M.D.

It is a great pleasure to be invited here tonight. I feel doubly honored because I was asked to speak to you in March, 1968 on: Does Hypnosis Have a Place in Psychosynthesis? This was a particularly happy meeting, as far as I was concerned, because it opened up a whole new field. I had been in some contact with psychosynthesis before, but I had been searching for more. Now I came full tilt into the midst of it. In preparing for this meeting I have had an opportunity to look at what has happened in between times, and to see how much I have really learned from the psychosynthesis movement and the people who are involved in it. It has given enormous reinforcement to the work that I was already doing through hypnosis.

For one thing, it gave reassurance of latent energies. I knew they were there. I have watched them being called forth in patients or coming forth spontaneously, but Dr. Assagioli's diagram, with the levels of consciousness, those higher energies that are available and the methods of reaching through to them, have been really fascinating. So, it has brought me better ways of calling them forth with little need for preliminaries, just going straight to it.

The task of an anesthesiologist is to take care of the patient while the surgeon takes care of the diseased part. The emblem of the Anesthesiologist is a lighthouse standing guard over the mysterious waters of the unconscious. Dr. Wesley Bourne an anesthesiologist published a book in 1955 called Mysterious Waters to Guard. He includes, in addition to the mysterious waters of consciousness (and unconsciousness), the waters within the cell and the waters by which the cells are bathed. How can you influence these?

Drugs are a partial answer. We have adrenergic drugs that mimic that part of the autonomic nervous system. We have chlorinergic drugs that mimic blocking agents and so forth. But this is only a partial answer. The waters within the cells and surrounding the cells are very much affected by feelings which call for sympathetic and parasympathetic actions. Drugs alone can certainly not keep them adequately calm. If they diminish responses, they can also diminish the circulatory and the respiratory responses, which can cause great difficulty. There is need for someone to guide the patient along, step by step, in constructive ways of coping with the situation. Because the situation of anesthesia and surgery is simply another feeling or experience, the patient brings to it the same ability to deal with feelings that he does for any other situation.

Even the most well-adjusted and stable person often finds some little pitfall in store for him that he hadn't anticipated. I can take the anesthesia situation with great equanimity when it's somebody else. When it's me, this is different. But learning to cope better with feelings in one situation is transferable, so that you can use it for others. Sometimes this needs to be pointed out.

There is a great need for allaying anxiety between the time when decision for operation is made and the time that the operation actually comes about in elective surgery and even in emergency surgery. This may seem like a very long time. Settling into a new and strange situation, the picture that you hold in your mind of what you anticipate makes an enormous difference. When a patient is concerned with anxiety, apprehension, and pain, these take over that field of awareness. There isn't really much room for anything else. I have found that in trying to use hypnotic techniques with these patients often it's very difficult to get their attention off the pain, or off the anxiety. I may have to intensify this before I can help them to get control and change the channels, as it were.

As part of the work that I have been doing in the last few years with the Joint Commission on Religion and Health of the Episcopal Church, I wrote up a little background information, and some ways of coping with this, as a little pamphlet which is now available. It's called "For Those in Hospitals,* with a subtitle "Patience for Patients."* It has to do with the effects that thoughts and ideas have upon physiology, how important relaxation is, and with ways of changing the image, of focussing attention on something else. These are meditative experiences.

The patient comes with all sorts of ideas, like the patient who spoke to me when I was making a pre-operative visit. He was to have a hemorrhoidectomy the next day. He said, "Oh yes, I'm just waiting for that first time the body is beginning to function afterwards. A friend of mine told me that that first bowel movement feels exactly as though you are passing a very large rosebush with the thorns all around it." I told him, "This is a vivid picture, and whether you think so or whether you don't think so, whether you believe or you don't believe that this is what is going to happen, you're very likely to respond in the light of the image that you hold before you." So, then we had to go to work and replace this image with another image. It took a little bit of working. But it's worthwhile, because peace of mind is reflected in maintaining optimal physiology in the pre-operative period, during maintenance, and post-operatively.

Most often the experiences of anesthesia and surgery seem rather awful to patients. This can turn to something else. Last fall I presented at a scientific meeting a paper under the title "Awful to Awe-full". I gave this title to a group of patients and asked them to write something of their experiences. One patient transposed the title without knowing that she did so - "Awful to All Full." She was totally fed up with the overflowing problems she was facing. She had a long-term illness. Her husband was very annoyed at her for being sick. He didn't think she was as physically sick as she was. The process of diagnosis was a very prolonged one, with symptoms that came and went. But in the process of writing up her response, she showed very clearly that she was beginning to work her way through problems and come to something else.

Ancient wisdom has told us over and over again "The fear of the Lord is the beginning of wisdom." Webster, in his second meaning for "awe", gives "powerful reverence, solemn wonder." This kind of awe comes when fear or terror is faced. These two, fear (or terror) and awe, may be considered as being related, though they are of a different order, in a vertical direction.

There is an Irish proverb you have probably heard, that a ghost con-

*"For Those in Hospitals--Patience for Patients," by Bertha P. Rodger, M.D., .20 cents. Forward Movement Publications, 412 Sycamore Street, Cincinnati, O.45202

fronted runs away. It's always the one from which you run that chases after you.

I have among my friends someone who came as a patient first. She is a surrealist painter, and for a long, long time she has painted her dreams and her fantasies. Only now she is beginning to understand them in a different way. She allows me to use pictures of her paintings and slides of them in working with patients as individuals or working with groups, to show visually--and this is much faster than a long verbal discussion--how people can come from the depths of darkness, anxiety, fear and distress, up to a higher level of understanding and so of performance, bringing out these inner resources.

I brought a couple of prints, which I'll pass around for you to see. The first one is called "Five Rooms and a Bath." It shows the darkness of a long corridor with several rooms opening off it. The general feeling is somewhat drab, although the colors are very beautiful. This picture doesn't anywhere near do it justice. The blues, the purples and the greens are just exquisite colors in the actual painting. But despite this, there is a sort of drab feeling to it. It portrays vividly a concept that life is like a corridor with doors opening off it, most of them closed. There's one door that will open. If you take a look at it, you see that there is a door in the distance, open a crack, with bright golden light streaming from it. That light is reflected in the foreground in the water that has overflowed the bath and come down the corridor; and it's shining through the transom above the outside door.

Ethelyn Woodlock is a person of very great talent as a painter who has shown nationally as well as locally. Her work is full of that golden light. It shines like hope in the distance or through the arches she loves to paint, like this next one that I'll pass around to you.

This is a dark alleyway with light at the end. This is one of Venice. She accompanies her paintings with little poetic writings which she says just come to her sort of like automatic writing. She just writes them down.

This one says:

Five Rooms and a Bath
Venezia

A voice spoke in English,
"Why, in Venice,
are you sketching a
dirty old alley?"

But there was love at the end,
fresh yellow paint
and blue,
flowerpots and
a washline blowing
and a little old lady
going
HOME.

In depression or discouragement the patient may feel that he is at the bottom of that dark, dark pit from which there is no egress. When he is encouraged

to take a look, to shut his eyes and look inside, and to persist in looking, he can find at least a pinpoint of light toward which he can move. Then he finds it isn't a pit at all but a tunnel through which the therapist is willing and able to lead him a step at a time. When he accepts this, a giant step has been taken. You can really work with him. But it's sometimes rather difficult to bring him to this point.

What is an anesthesiologist's interest in all this? Patients with pain problems are often so very sunk in despair and depression that any unpleasant sensation which reminds them of this situation, of their physical condition or of the way in which they interpret the situation in which they find themselves, becomes intolerable. Pain is magnified, and it's the painful thinking that is most disturbing. Only when the higher resources of hope are stirred up can they begin to respond more favorably to drugs, to hypnosis or to techniques of psychosynthesis.

One of the most helpful things I've found is the Dis-identification and Identity Exercise which Dr. Assagioli has in his book. I have modified this slightly to suit my needs and mimeographed it. I often go over part of it with patients, introduce them to it, then give them the mimeographed copy to remind themselves that "yes, of course, you have pain and when you have pain it tends to take over that little field of awareness." I draw them Dr. Assagioli's diagram of the ovoid with the field of awareness, the conscious self, and the levels of the unconscious, and point out that the conscious self is the observer, as in a dream. "You're both the dreamer and the actor or actress in the dream, and so you are the controller. You may not have known it, but you actually do have control, and you can re-establish it when it is lost."

This comes to many people as a totally new idea. They had no idea they could have control over what comes to them. So, we talk about the idea of the field of awareness being like a television screen on which various scenes are recorded. "If you don't like the program, why don't you change the channel? How do you do it? You can do it through psychosynthesis techniques, like the guided waking dream which you can do very quickly right now." We go through alternative ideas for different approaches.

This is very vivid and they respond very well. Symbols accumulate psychic energy, and they direct it. "This is the way you plan anything," I tell them. "This is the way you worry. You're very good at worry. Look at what you've worried yourself into now, the state that you're in!" They understand this very readily.

"What happens when you worry? You think of something that might possibly happen. Maybe it's very improbable, but the more you think about it, the more possible it seems. Then you're all set for it to come about because you interpret everything that comes to you, every feeling, every sensation, in the light of this picture that you hold."

"So how do you want it? Do you want a picture of the worst things or would you like to picture something a little bit better? How much better can you get it than that? Play with it awhile in your own spare time. I showed you how." This really makes a change of response.

I use what I call the venetian blind technique, suggesting to them, "Suppose you think about yourself as if you were at the center of a control tower like the control tower on an airfield. Here you are up in this plexiglas tower.

You can see outside and follow what goes on. You have all sorts of radar and ways to monitor what goes on all over, inside the field and outside the field, planes coming and going, and all the rest of the traffic. Imagine it surrounded by venetian blinds. When the sun gets too bright in one place, you just close the venetian blinds. If it's too dull in another place, you open a little way. So, you can screen out whatever you want and still monitor it on your instruments within." I find if I help patients tune out pain too completely, they get worried lest it lose its diagnostic significance. Some of the surgeons have been worried about this too. So, this is comforting to everybody concerned. They can monitor the pain, and turn the venetian blind so they can peek out to see if it's still there; but it doesn't bother them; it's still outside. They can pull the blind down fast again.

"Or if you don't like this technique, maybe you'd like to build a wall of numbness. You might build it out of cinderblocks or you could build it out of ice. Ice numbs things beautifully. You build up the threshold of pain so the pain can't jump over it to bother you. Yes, it's there. But what is pain? We build up a library of pain. We respond in view of our previous understanding of it or our present understanding. Not all sensation is pain. You may not like it, it may be uncomfortable, it may be unpleasant, but it isn't necessarily pain. Whatever it is, whatever it comes from, up here in the mind is where it registers and up here is where you respond to it. The best place to block it is in the mind, and you're the only one that can do this.

"I can tell you how to do it, how to go about it, but you are the one to do it. You can play sort of a game with yourself to see how well you can do."

When I was here last time in 1968, I was talking about this sort of thing and the way I used hypnosis. One person in the audience afterwards said that she had had very bad migraine headaches and that one time after doing the dis-identity exercises she had realized that her body, her sensation, her headaches, weren't all there was to herself and that maybe she could just put them outside what she had considered herself. She took her headaches and put them outside the big circle. She would still have them, but she was able to function and they no longer bothered her.

This is a very important thing because so much is tied up in pain. Headaches and various symptoms become part of the psychic economy. It's better to allow the patient to keep it but not allow it to bother. There's a big difference between that and taking away a crutch. "All right, if this is what you need. Let it tie up this energy, let it keep you from something else, but don't do it to the extent it has to stop you from functioning."

There was a patient who came with paresthesias of the legs, pain sensations in the legs that were most annoying to her. She said that she felt like a pin cushion with great big long hat pins, sticking into her. She also felt emotional pricks from the remarks that her husband would drop, because he didn't understand what was going on within her. He thought that she was goldbricking. After the exercise in dis-identification she deliberately decided that she would no longer mind the sensations and the feelings.

This is what she wrote: "A pin cushion never minds the pricks and jabs. It doesn't cry nor run away. It simply absorbs them calmly. Each unpleasant idea or sensation, unkind word or discomfort need not send me into a tizzy. I can relax,

gather strength and move on about my business." From that time on she had very much less difficulty with these sensations and also with the pricks of the spoken word or the looks that her husband would give her.

The same artist who painted these lovely pictures had a great deal of trouble with arthritis, a high degree of pain with it. I suggested to her one time that she might take a look at her joints, see what they looked like and see what color the bones and joints were; and if she didn't like them, to just paint them to suit herself, in her mind's eye, with her beautiful colors. This is what she wrote some time afterward in her automatic writing:

Painting Prescribed

I know a wondrous
most beautiful soul
who told me to go
into my pain-wracked
joints
and paint them
with my beautiful
colors.
I must try to
heal myself.

Bones are usually
white.
If I walk around
in just my bones
with all of these
colors on them
what a strange sight
I'll be to all the
other souls walking
with just their
bones showing.

So I will paint
my left hip a
deep purple.
The right hip
will be sea green,
banded with gold.
My left knee will
be hot pink.
Sometimes bones
are cold and gray.
Then they must be painted
with hot pink. Gay.

Bones are the solid
parts of my coat.
I wear a coat of
many colors within
and without.

I choose these colors.
I must select
those that are
most suited
to the
situation.
I must keep the
angry colors
away from my coat.
I must keep the
gray illness
away.

On second thought
I must change the
hot pink to
cool ice blue.
This will take out
the hurt better than
a hot color.
Pain is hot.
I must think
only of the
happy colors.

Most of the
deep colors are
not good.
Deep bright red
is gay, but
deep dull red
is very bad.
Deep blue is
very sad,
BUT, deep purple,
ah, there's a
color that is
truly mysterious
and SO beautiful.
It is mystic.

Ethelyn Woodlock
1970

She has had a lot of fun painting her bones and painting her joints, and she has gotten very effective pain control. She informed me, not too long afterward that now she could float down the stairs from her third floor studio to the first floor to pick up the phone on the third ring. When I tell somebody else about this success which she had, they may look at me oddly at first. As they begin to think about it they wonder, is she kidding or is she serious? So, I leave it with them. Sometimes when I come back I tell them, "You can do what you like about it. They're your bones. It's your pain. Keep it. Give it away. Give it up as slowly or as rapidly as you're willing to. I can only tell you how to go about it." Here is where the will comes into play.

So often we see patients coming into the hospital determined to be a good patient. This is particularly true of nurses and doctors, and it's true of mothers and others. They want so much to be good patients, to do just what is expected of them, to cause no trouble, to refrain from upsetting their family in the time between the decision for hospitalization and the time they are left in the hospital. They are determined not to use a narcotic or a sedative for pain or for sleep.

I bring forth to them the idea that this is fine, only it soon reaches a point of no return. It takes excessive tension and tightness. As soon as you say, "I'm going to do this," you just tighten up all over and then you're all set to feel pain much more intensely.

When you turn to the aspect of willingness rather than determination, you find latent power from inner resources is freed. It may consist of a willingness to get better, to deal with the situation just a little bit better, to give up some of the symptoms, to accept health, to respond more creatively and comfortably and constructively or to live with what's unavoidable until such time as it can change. The key to rehabilitation is always to do what you can with what you have. This unlocks the next step. The patient's willingness is crucial, his willingness for actual participation in therapy, to allow the medication to work, to allow the other therapies to work, and to establish a better inner climate for healing. What we are doing always in medicine and surgery is establishing the climate in which healing can take place.

I never healed anybody in my life and neither did any other doctor. Ambrose Pare knew this and said, "I dress the wounds, God does the healing." We can supply the raw materials for healing by prescribing the products of endocrine glands or vitamins or proteins. We can establish fluid balance, give blood transfusion, put bones together so that they can heal in better alignment, or put a part at rest. We can knock them out with drugs, but it's the patient who does the resting. So a willingness and the establishment of a better inner climate for healing makes an enormous difference.

There's the indignity of being ill, the total dependency on other persons. I think particularly of a patient whom I saw a month or so ago who has been in the hospital for six weeks with her leg in traction following an accident in which her leg was broken. There was so much swelling, so much edema, that they didn't want to put a cast on. She was just deteriorating. Her behavior had become very, very childish. She was the despair of the nurses. When they heard I was coming in, they said, "We just can't do anything with her. Nothing we do is right. We put the elastic bandage on the leg as we're instructed to do, and three minutes later it's killing her. She has so much sensation in there that she just can't put up with it."

She herself recognized that her behavior was childish. She didn't like the way she was responding. She was a woman in her sixties, one of the Grey Ladies at the hospital. She didn't want to be this kind of patient, but she just couldn't help it. She had gotten into this state, and things seemed to be getting worse and worse, a vicious circle. We see so often this pathological circle of thought. Something happens, some symptom or some feeling which gives rise to considerable anxiety. Every time you're reminded of this anxiety or this feeling, you say, "Oh, we're not going through all this again, are we?" And that makes you very tense and tight. That makes the symptom worse or the feelings, and so you go around and around and around in a very vicious circle.

If you can break that circle in any way, by changing the picture or by muscular relaxation instead of tension, you send it in the other direction. As you quiet down the anxiety or relax the physical tension, that quiets the anxiety. That quiets the symptom a little bit. You can begin to sort things out and see whether you're over responding or whether you're justified or if something else needs to be done about it.

Some time ago an English physician published in the American Journal of Clinical Hypnosis what he called the analeptic circle of thought. I made out a diagram (see next page) which I had mimeographed to use with patients. It starts out with the idea that as you learn to relax even a little bit, then your body functions more smoothly and efficiently. You feel better and stronger and so you can cope a little better with things. You get a little mastery, a little confidence, so you can relax more and so on, round and round, a deepening. That is the basic idea. This healing circle of thought replaces the vicious one.

With this patient, one of the first things I did with her was to show her Dr. Assagioli's diagram and to point out that she could get mental control of bodily processes. She already had some, but she could put it to use much more. It was more important than she realized. It was evident that we were already beginning to reach up to the higher levels, because she perked up in just 15 minutes,now that a different kind of help was presented to help her get control. Already hope was there. When you stir this hope, it's a vital factor. She was beginning to accept the concepts presented.

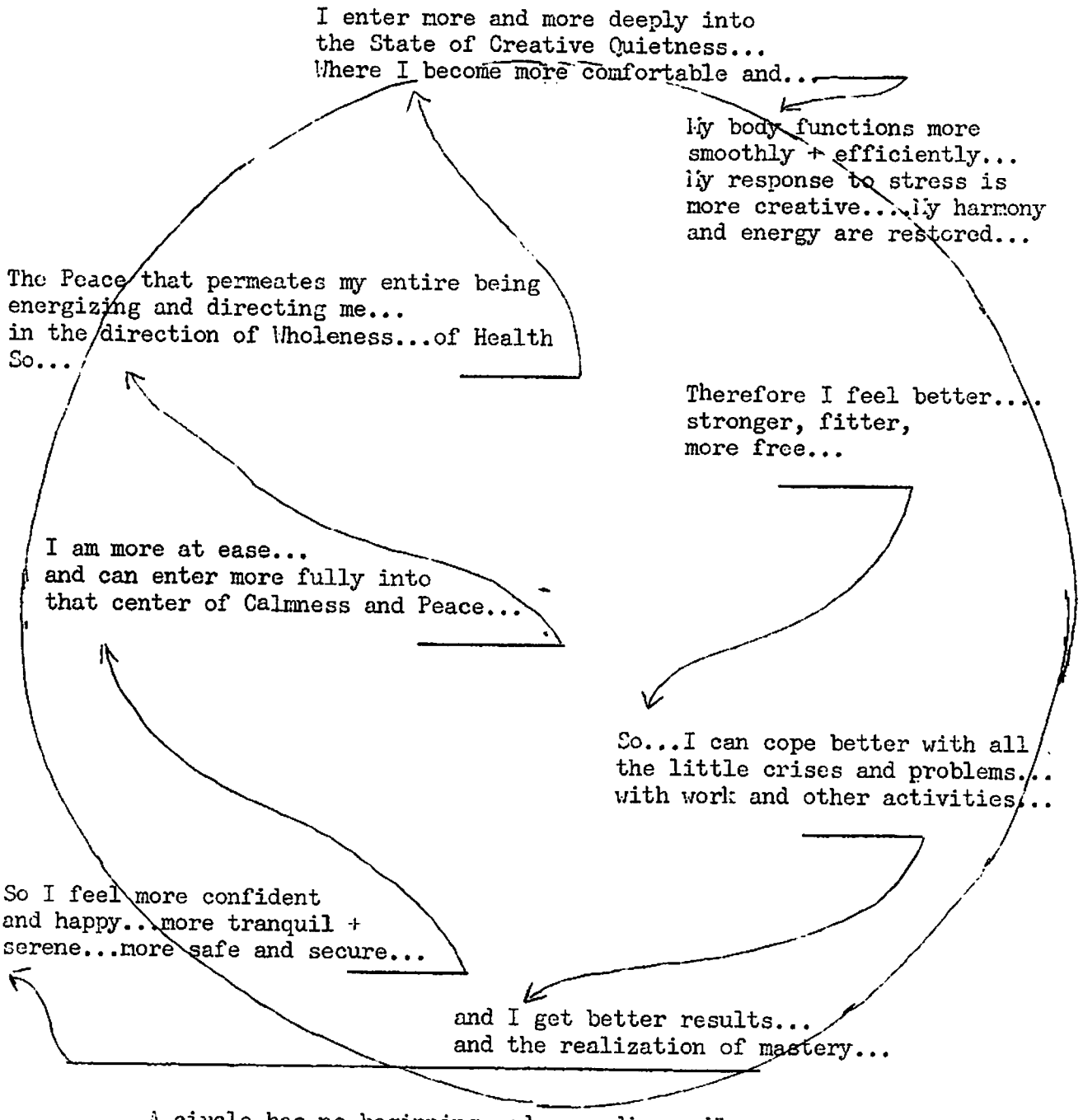
She had taken that first giant step of being willing to cooperate, willing to listen, willing to go along and see what would happen. I could only speak to her for short periods of time. I saw her about 15 or 20 minutes at a time. But I presented this to her very early so that she could get some idea of what was going on. Then I went through the dis-identification process with her to dis-identify her from her pain and sensation and from her feelings. Next I used with her the exercise of the blossoming of the rose, the development and opening of the spiritual self. She was delighted with it. She began to really be convinced that there was much more within her that could really open up and she could put to use. I used the analeptic circle. Then we went into various methods of pain control. She began putting these things to use right from the start.

I put some of this on tape for her, because she was kind of fuzzy with tranquilizers. It took her awhile before she could go off these and really feel she was grasping what was going on. So, she would play these tapes for herself.

We talked about the idea of willingness in putting up with the inevitable and in cooperating with therepy. Another patient was referred because of post-

The Cultivation of Quietness
Basic Course April 1969
Bertha P. Rodger, M.D.

ANALEPTIC (HEALING) CIRCLE OF THOUGHT



A circle has no beginning and no ending. Whenever any of these ideas comes to you--whether by chance, by association with other thoughts, or by deliberately entering into the State of Quietness--you can think around and around the the whole circle as many times as you like. Each time you do so you re-activate it so that it re-energizes itself and becomes self-perpetuating. It lifts you out of the old dis-ease-producing circle of pathological thought. It is as if its energy lifts you on a spiral, ascending until you come to abide in that Circle of Peace, the center of power from the Source of all Power, capable of complete transmutation to Wholeness.

Adapted from The Analeptic Circle
Dawes, A. Charles
American Journal Clinical Hypnosis
Vol. 11:167, January 1969

operative anxiety which was upsetting her physiology. I was asked to quiet it through hypnosis.

She was a most interesting person, but difficult to reach at first. It was possible to approach her through this diagram "The Secret of Silence" (see next page). It is a series of concentric circles. The outside circle is labeled "Your responses to the alarms that come from outside." From our outside world we are constantly being exposed to the chaos, the turbulence and the anxiety that is in the world at large and all the stresses of our own personal world. These things keep jamming in on us, particularly on hospitalized patients. They come pressing in all the way around all the time. We keep fighting back against them, making our responses to the alarms from outside. The kind of response that we most commonly make is the kind a cat makes when it sees a dog. It's all ready for fight, in anger or flight, in fear. This is fine when it's something that you can respond to physically. But what do you do when it's pain? What do you do when it's an operation? You can't punch an operation and you can't run away from it for very long or you'll run into more serious difficulties.

Inside the outer circle is another, or onion ring, if you like to consider it that way, where we find the "Sense of Ignorance." You really don't know all you want to know or would like to know. You have a sense of unawarenesses. You know there is more to you than you put to use and recognize your inadequacies.

Inside that is a third ring. This is where you have a longing for peace, for calmness and for spiritual understanding. Inside that is the smallest ring of all, the hole in the donut, so to speak. This is the "Center of Calmness," the "Center of Peace." It seems very, very small, but when you get into the center you find it's like the horn of plenty. It's connected to the ocean of peace. This is a reaching through to your inner resources, to your higher resources.

I showed the patient this and showed her that sometimes we find ourselves spontaneously in the center when things just get too much for us. There are many ways in which we can enter it. We can enter it through hypnosis, through the autogenic type of training, going through the circles of the onion ring or through religious means, meditation. It's a source of great strength.

When I spoke about this, her eyes began to brighten up and she was all intense interest. I knew a little bit about her background, but didn't know what her response would be. She had been several years in a Japanese prisoner of war camp, and had been horribly tortured. Part of her difficulty now was that the number of injections, intravenous fluids and so forth, administered, reminded her so vividly of her concentration camp experience. They would inject her with various drugs before they tortured her. She said she managed to deal with her feelings enough to go through the operation because she knew she needed it. She put up with it, but she sort of fell apart afterwards.

When she heard that you can deliberately enter into the center of peace, she was most intrigued. She said she had found her way into that spontaneously when things got just too bad and she couldn't stand it another second. She found she was somehow removed; she knew nothing of what was going on to her body or anything that was said to her. She just was somewhere else. But she could never get there until it got beyond a certain point of terrible torture. She would put up with an awful lot before she got there.

She learned very readily, through a guided waking dream, to imagine herself going into this, into the stillness that lies beyond silence. It was a fascinating experience to work with her.

The writeup on the back of the diagram called the "Secret of Silence," comes from "Letters of the Scattered Brotherhood," edited by Mary Strong. These are letters written by mystics of various ages and creeds scattered throughout the world. The similarities of approach, the pictures they draw, their ways of speaking are like a common language that transcends all differences. It speaks very directly to me.

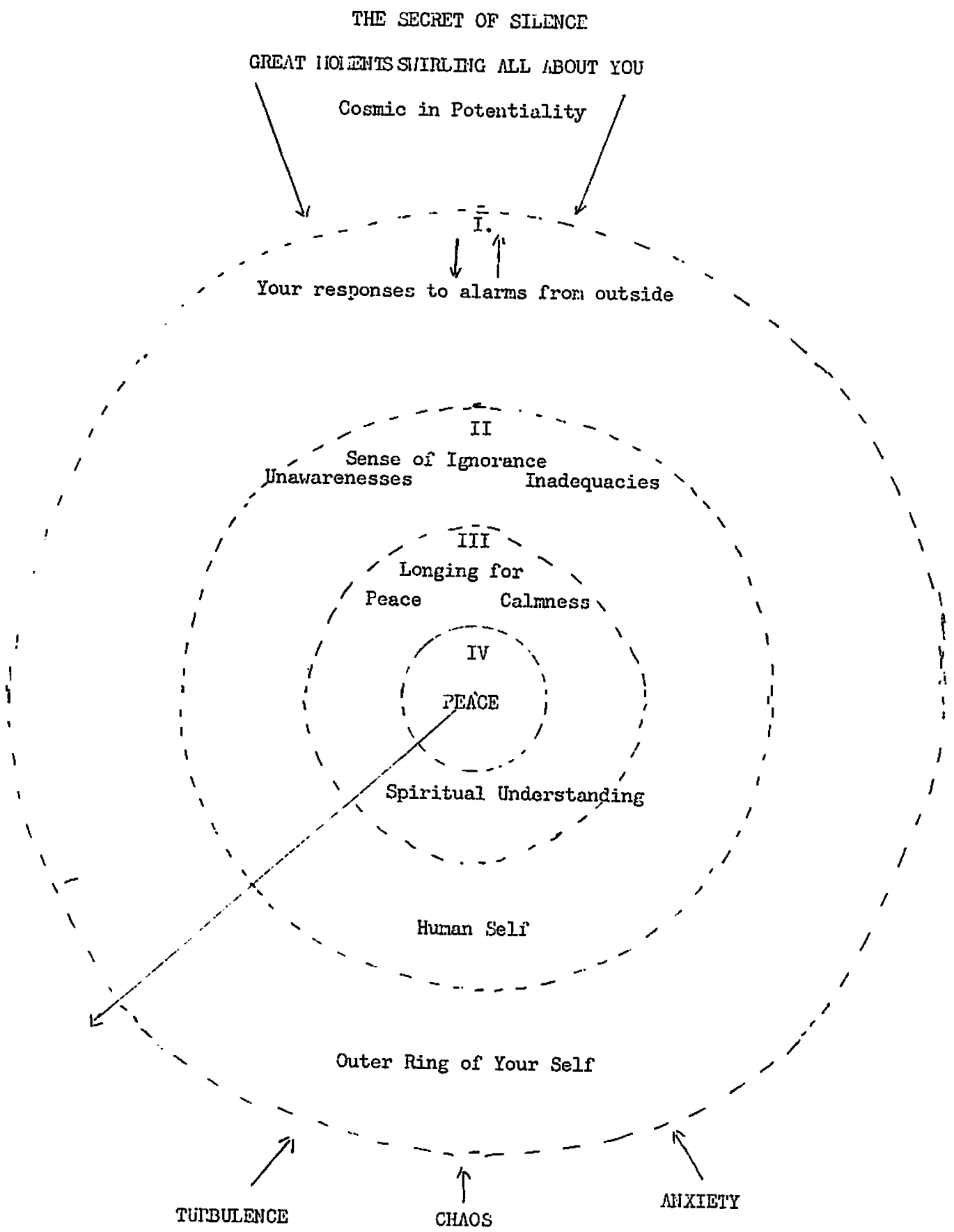
In that outside circle where we respond with the autonomic nervous response of the adrenal glands, making the body ready for fight or flight, is one way of responding. Another way is to withdraw. Instead of withdrawing to that center of peace, one can withdraw through addiction, through tranquilizers or sedatives or narcotics, but in withdrawing in this way you block yourself off not only from the outside stress, but from the inside peace too. It's well worthwhile learning some other way of doing.

When you go deliberately--or by any other means into that center of peace--then it's as if you're opening up the apertures of consciousness for peace to flow through <u>all</u> the layers of being. Something happens when you reach those inner resources. You're never quite the same again. It is a way of dealing with feelings that is very different from repressing them and pushing them down into the deeper parts of the mind, even of locking them up in that hypnotic technique of locking up painful thinking in a safe place until such time as you need it. Here is something that really transmutes it. It's a little bit like the seagull that picks up all the garbage and you think, "What's going to become of this poor creature," but it turns it into pure seagull.

You can't help the feelings that come to you. But what do you do with them? Do you keep them in your field of awareness? Do you repress them or suppress them? Or do you let them be changed, made into something else? Do you digest them, so to speak? Spiritual digestion is a fascinating idea to play with and to think about.

Dr. Assagioli points out to us that we do live in a psychically septic atmosphere, in constant contamination from it. The negative feelings of anxiety, frustration, hostility and resentment are rampant everywhere, and they are very contagious. We can neutralize them. We need to protect ourselves and our patients from them. We can do this by deliberate cultivation of positive emotions and qualities of the psyche and by freeing these latent resources. He points out that modern advertising takes a word or a phrase and ties it to a symbol or a color, a tune, a rhythm, and flashes it constantly before us on TV, on the signboards, long in the distance on a highway. On the Garden State Parkway, for instance, you see the sign of a gas station without stopping to read it; it just flashes at you. Without even being conscious of it, you're alerted to be ready to pull in there when you need it.

It's a subliminal influence, which speaks to us on both the conscious and the unconscious level. You're familiar with his Technique of Evocative Words, putting on a card the word or the quality you want to evoke, talking about it, thinking about it, and then just putting it anywhere, even upside down. You're reminded of it each time you see it.


THE SECRET OF SILENCE
GREAT MOMENTS SWIRLING ALL ABOUT YOU
Cosmic in Potentiality
I.
Your responses to alarms from outside
II
Sense of Ignorance
Unawarenesses
Inadequacies
III
Longing for
Peace
Calmness
IV
PEACE
Spiritual Understanding
Human Self
Outer Ring of Your Self
TURBULENCE
CHAOS
ANXIETY

THE SECRET OF SILENCE

"There is an outer ring of yourself surrounded by turbulence, chaos and anxiety; great moments swirling about, cosmic in potentiality. Within this ring is another circle outside of which are your responses to all these alarms and insistent shocks, excitements and dismays. Inside this ring is another ring. This is a place where you sense your ignorances, your unawarenessses, your inadequacies. Here is where you are sorely tried, for this is your human self. And so these rings get smaller as you near the center where you find a place in you that longs for peace, calmness and spiritual understanding. Finally there is the center which seems to the imagination within a very small circumference. Here is where you are, here is a place where you decide; here is where you are yourself. Most people seldom find it except in great moments; this is the peace promised to those who seek. For this center lifts you high and clear of all the rings into eternal omniscient vision; here, when your mind is fastened to it and all your thoughts and all desires are pointed toward it, is the Spirit that will lead you through the valleys of the shadows of death, violence and hates and all the confusion that beset you and your country and your world at this time.

"Hold to this center. You can only reach it in silence, you can only keep it in quietness, you can only feel it in serenity; this is the place of the pearl of great price. Carry the silence of your guarded center with you, guarded by the thoughts you have accepted. This is the way of a son of God. Every man in ordinary life presents a character which is instantly felt; everyone is revealed sooner or later, the vagaries of the human personality betray us. But the quietness of the realm I speak of is a steadying strength not of our making though of our accepting, and what is given forth from it is felt also. Remember always to acknowledge this; 'of myself I can do nothing.' What you have done is to seek the kingdom and having found it your task is to hold it, and that is a task indeed, for emotions, personalities can steal you away out among the outer rings; your thoughts instead of being pointed toward your center, race away into the mad dance.

"Come back, come back and in holy stillness be lifted high above all this! Your dominion over yourself and the circumstances of your life can be glorious if you will keep your center clean, illumined and still in immortal silence. Here is selflessness, here is revealed true knowledge, wisdom, power and courage; the dignity of courage which is loyal to that which is not your human self. You will be given divine strategy in dealing with seemingly hopeless difficulties. The hates, criticisms, annoyances, the instinctive dislikes. . . keep them in the outer circumference. Turn your face away, turn it within toward that which is shining there. This is the kingdom of heaven. This is the task most needed now for yourself, for your loved ones, for your time. Each one anchored in this omnipotent stillness strengthens the soul of your nation.

"'I never leave thee nor forsake thee, thou art in my keeping.'"

"Letters of the Scattered Brotherhood
Edited by Mary Strong

He also suggests putting it in a design; and I've been working with this idea. Here's a circle design that has some bright gay colors and a flower motif. The words on it are "quietness, confidence, courage, and trust." These are qualities pre-operative and post-operative patients,or any hospitalized patients, need in large supply.

There are various symbols that came out here. There are crosses in the center; here are vibrations or waves, stars, stylized flowers. I don't know what these are - picket fences, maybe. I made up one of these designs to give to the patient in traction I referred to earlier. It reminded her that she could develop quietness, that there was confidence available for her, and that it was growing. She put it up on the traction bar and looked at it.

On the back of the design I have a mimeographed sheet of explanation.

One patient couldn't seem to picture anything. I was trying to work with her with hypnosis. I had worked with her before, but she now was in such a state - with a cardiac condition,that her physician called me to say, "See if you can do anything for her. Tranquilizers aren't doing a thing." I tried to get some pictures of pleasant places to distract her. She couldn't picture anything, not even any quiet colors. I just couldn't get a handle to take hold of. So, I went home and made one of these designs to put up for her and said, "Okay, you couldn't think of anything. Take a look at this. Let's see what that brings to your mind."

I knew she loved flowers and I made a design which reminds me of our plac in Maine, with a wild rose at the center. I put in the spruce trees, the flowers, the rocks, the waves and the blue sky meeting the waves. She put it up and when I came back to see her the next day she said, "You know, I went to sleep last night. I looked at that picture and all of a sudden I started thinking about the ocean waves. I just seemed to see them and I watched them, and the first thing I knew I was asleep."

Here is a nebulous sort of thing; where something is starting up. Sometimes they don't want anything too specific. I often hold up or bring in two or three of these designs and let them choose which they want. "Would you like to take one of these? It'll remind you of the things we've been talking about, and you can put them up. They're a great conversation piece." For somebody who has been in the hospital for quite some time, has gotten thoroughly bored and now bores others - like that patient who got so childish - this was great. All the nurses and the nurses' aides came in and talked to her, whereas they'd just run the other way as fast as they could before.

I have used these things in teaching because they are good visual aides. Sometimes when I talk about the blossoming of the rose, which is indicative of the spiritual self opening up, I use this design of the golden rose opening. Mrs. Kellogg, who is here tonight, started me doing these some time ago. I've had such fun with them. As you can see, I am not an artist, never was and never will be. But I do love colors. I try to get my patients to do some as feedback. A few do but not many.

It's very difficult to assess just what goes on, but when you see something happen, something good, when a turn in a different direction happens over

and over again, you have a significant method developing.

This is an idea of some of the ways psychosynthesis has been an enormous help to me. It has been very exciting working with patients. I might say one more thing, and that is that there was a physician, James Porter Mills, who was head of a hospital for neurological diseases in Chicago some time during the end of the last century. He left his work there to go into teaching what he called a new order of meditation, which is Contemplative meditation. It means simply using a brief phrase each time the mind wanders. You quiet the body down and tie up the mind with a brief phrase like this primary meditation: "Abide in me and ye shall find Wisdom, Strength and Peace for all your needs." Each time the mind wanders you bring it back with this meditative sentence until it goes deeper and deeper into that center of peace.

He said that we most commonly think of ourselves as being creatures of opposites. He listed three columns of words under the heading:

Existence	Death	Life
pleasure	pain	Joy
accuracy	error	Truth
attachment	hate	Love
cleverness	foolishness	Wisdom
confidence	fear	Faith
concord	discord	Harmony (Peace)
ease	disease	Health (Wholeness)
virtue	evil	Goodness

The third column, the Words of Life, he says, resolve the division of the other two. They constitute the highest potential of man and he can deliberately turn in this direction by concentrating on the Words of Life and by recalling them each time he becomes aware of their counterparts in existence or death. The system he developed on Contemplative Meditation is a direct and potent method of cultivating this kind of Life.

Sometimes I tie these up with the mandalas. The healing potential, I think, is vast. It's a way that one can reach through to patients one can't reach verbally. Sometimes patients are so bound up in their anxiety or their depression that they can't listen to what I have to say to them. Sometimes they are so heavily medicated that I really can't get through too much to them. They are not ready for hypnotic techniques or psychosynthesis techniques of other kinds. I sometimes just put up one of these designs and say, "Here's a joy wreath for you. Just put it up and take a look at it. We'll talk some other time." It's not long before they're ready to talk and we go on from there.

This is the way in which I use psychosynthesis. Now let's see what you have to say.

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DISCUSSION

MRS. COOPER: Dr. Rodger, did you say that you don't use hypnosis anymore?

RODGER: No, I do use hypnosis. But for a long time, even before I came in contact with psychosynthesis, I began using hypnosis in a much more subtle way than the formal induction techniques; but recognizing the hypnoidal state and using it. And I still use it.

In talking with Dr. Cooper before the meeting, he was saying that he spends a lot of time dehypnotizing people. I said "Yes, that's exactly what I do." People have hypnotized themselves into accepting the wrong suggestions, the negative suggestions, the bad images. What I am really doing is dehypnotizing them from these illusions so we can go on to a picture of reality.

WOLF: I think it was one of the most delightful lectures I have heard in a long, long time. As I was listening, I was trying to see if I could come to some sort of common denominator which is being applied here in a very constructive and really artistic manner. If one imagines a patient who is to undergo an operation or the things they have to do during a long illness, obviously there is a great deal of anxiety in many people - "Am I going to have pain, what is going to happen, is it going to be successful, is it going to do something to my family, or whatever?" The anxiety is a tremendously diffuse thing.

The longer the state goes, the more diffuse it becomes. One could say, perhaps, that the technique of, for example, the concentric circles, and other things of that kind, brings the mind to a focus whereby anxiety automatically is reduced by the very fact that it comes to a focus. And that focus is preferably in a peaceful place, or the focus of putting the pain from one place to another place, which then focusses pain into a spot.

Then, with these beautiful mandalas and colored pictures, you go from that focus, it seems to me, into a pleasant diffusioning. I was wondering whether one can look at this whole thing - that is, the various techniques that you're applying whether done by hypnosis or by persuasion or by imagery - as a sort of an hourglass picture. You bring it down to a focus, to a point, to a narrow area, and then with these beautiful, colorful, peaceful pictures, you sort of let it diffuse a little, but in a more constructive manner. I wonder if that sort of thing would in any way be operative there.

RODGER: That's very interesting, and this reminds me of an experience I had with a patient last night. It's a patient who has had a good deal of pain and discomfort. She has lupus, which means that she has symptoms that come and go. For awhile they thought that she was a psychiatric patient because they just couldn't tie it to any particular disease. She has been through quite a bit, and she was very distressed. I had just a brief time with her, but I had been working with her before with hypnosis. So, I worked to develop a deep trance state to let her be quiet and let things sort themselves out. She said afterwards, "That was the most fascinating experience, because when you were suggesting that I go deeper and deeper I found myself at the age of 15 jumping off into darkness. I wasn't afraid but I didn't know what was coming. I went way down. I seemed to go way down to the bottom. When I got way down at the bottom, God came and picked me up, way up on high."

In a sense, it's the same kind of thing. It's a focusing; you focus down first, and then through to the other side. That's a little bit like this drawing I've used for some classes, of the rainbow bridge. Michal Eastcott in her book The Silent Path, an Introduction to Meditation speaks about the rainbow bridge between the conscious and the unconscious, between the self and the higher self. It's the same sort of thing. You focus and go through and come to the higher, the true self.

Mrs. KELLOGG: Do you use hypnosis in connection with this?

RODGER: Sometimes I do, but usually that would be a more or less formal hypnotic technique, and I don't. I simply let them look at it and let it say what it will to them.

I have used it as a hypnotic induction, but mostly with office patients and not so much with the anesthesia patients that come specifically for this.

Mrs. HILTON: Dr. Rodger, last time you were talking to us you mentioned that you had dealt at that time with quite a few terminal cases. Are you still using this same type of technique, or do you have a further, deeper one?

RODGER: It's more of the same. It's painful thinking that is more disturbing than actual pain. And they'll readily agree. If I say to them, "If you had this much pain in your hand, you could handle it, couldn't you?" They respond, "Yes, I could."

Sometimes with a hypnotic technique we show them that you can transfer pain and feel it in one place instead of another. So, "Move it to your hand where you can handle it." I work with them in much the same way I worked with this patient who was in traction. I don't really have a set procedure that I use. I just see where I can get a handle to work with, where their interest lies, where we have a common understanding. I listen and look to see what little cues I can pick up to find out what they need and then help them.

Mrs. HILTON: There would be a difference, would there not, if the patient knew it was terminal or not?

RODGER: Not necessarily, because the patients always really do know. I often use a confusion technique with them deliberately, pointing out that - "Today is Friday, that means yesterday was Thursday and tomorrow is Saturday. When Saturday comes, yesterday is Friday, and Sunday is tomorrow. And you have pain - and you know that you have pain - and you know that you know it. But what you do not know is that you also have no pain - and the areas with no pain and the times of no pain are really even more important than the times of pain. There are some things you know that you know that you know. There are some things other people know, and you know that they know, but you don't want them to know that you know. And you want to say no to pain, but you want your no to be a good no...." So, we go on with all kinds of ideas. I haven't said specifically anything about what you think or I think, that you know or I know. We all know there are things below the surface. So, if somebody wants to keep quiet about it, let's let them. The patient will be very, very patient with relatives and doctors who are afraid to approach this and will not let them know that he knows.

Nobody gets all of this kind of rigamarole of therapy, surgery, X-ray,

chemo-therapy, etc., without having a pretty good idea they've got something that's pretty serious. It's all written up in the magazines. When they are given an opportunity to talk about it, they do.

It's a fascinating thing that hopes change. Our hope in working with patients is that they will get well, that the disease will be controlled if not cured. We're well people. We are healers and want to work with this. As the disease progresses and the patient recognizes this is serious and begins to come to terms with it, he goes through various stages in acceptance. First, there may be, helpfully, a denial of it. "This happens to other people; it can't happen to me." Then there comes a recognition, "But it is happening to me." Then they're very angry, and they're angry at everybody. "Why on earth are you walking around when here I am sick? I'm dying and you are healthy. Get out of here!" And they're mad at God, "Why does God let me have this terrible thing? I'm no worse and no better than this other person who is walking around. Why should I have this?" So, they're furious. This is a difficult stage to deal with.

Then they come to an acceptance. "What's the use. I'm not going to get better and I can't die. I'm stuck in between." It's like sea sickness. First, you're afraid you'll die and then you're afraid you won't. So, here they begin to get the hope that maybe death can be not too difficult. Then they can come to full acceptance of it.

We had a wonderful experience last May in London. We spent the afternoon with Dr. Cicely Saunders who has set up what she calls St. Christopher's Hospice, which is a place where people can go to learn to accept death. It's an experiment that she started, and it is having widespread effects. We came away after three hours there up on cloud 99. She helps the patients to work through to this acceptance in many ways, helps them to speak about it, listens to how they feel. She spoke at the Symposium on "Catastrophic Illness in the Seventies" that Cancer Care put on in New York last fall and showed slides of the stages. Elizabeth Kubler-Ross also pointed out these stages and the way people accept them. (WOLF: Where is this place?) Dr. Saunders' is in Sydenham outside London. But she comes to this country sometimes. She is brought over for special lectures or workshops.

COOPER: There is a course now at Columbia, given by Prof. Carse, on dying which was over-subscribed. I think they had room for about 200 people and 500 applied for the course. And there are a number of organizations now devoted to Thanatology.

RODGER: Dr. Saunders doesn't like this kind of emphasis on death. She says "It's not 'terminal patients' we're talking about. We're talking about <u>people</u>. They're going to live all the rest of their lives - and they ought to live them to whatever extent they can, they are <u>persons</u> right up to the very time of death. They need to be considered as persons."

One of the things that most interested us was that the rooms there are set up so that they do have a few private rooms, but not many. Most of them are in cubicles that can be curtained off. There are four or six cubicles facing each other. When a patient is actually dying, they pull the curtains back so that the others can watch. Someone always sits there - either a member of the family or one of the staff - right beside the patient, frequently speaks to them or touches them so they know someone is there. They have whatever medication they

need, to keep them comfortable. But they respond very well to medication. They don't get confused.

COOPER: Do they require large doses?

RODGER: No, they often don't; but even when they do require large doses, they don't get the side effects of it and the blurring and confusion, just a quieting effect. The curtains are lovely bright yellow. There are flowers on the window and it's beautiful. And she encourages the family, even the baby, to come often.

COOPER: Do they have music?

RODGER: Yes, they do; but not all the time, not constantly, not drowned out. And they encourage patients, if they wish to, to pray for the other person. It's an immensely supportive situation; so they know that when their time comes there will be somebody there and a hand to hold. This is very important.

HARONIAN: In that situation, in that setting, do they find an unusual amount of paranormal experiences at death?

RODGER: I don't really know. I'd be interested in knowing about that; but nothing came up about it. I'm sure if they were very aware of it, something would have. (COOPER: The situation is paranormal.) Yes.

COOPER: The paranormal is a kind of support from your unconscious. If you have the support of the people around you, then you don't need it.

RODGER: And there were some marvelous psychosynthetic paintings there. She had the most exciting things. There were several painted by a Polish artist with beautiful blues and golden light. They have a chapel with a tryptich by him. I can't remember what they all are; but there is one of Christ healing. And the central figure has this light coming out.

Down in the morgue, they have a room down in the basement where, if the relatives are not there at the time of death, they put the patients; they tuck the patient up in bed as if he were living. It's a narrow bed at the further end of the room. The room is very plain, painted in light colors. At the back there is a lovely soft bright yellow curtain. On the shelf over the bed there are bright fresh flowers- there were jonquils the day we were there. The patient is here in bed as if he had just gone to sleep. The relatives can come and take leave, say good-bye, recognize that there is death and this garment is no longer needed. When they're ready, they leave.

Coming out, they pass through a door facing a wall; they turn left to go up the stairs. But on this wall, facing the door is this beautiful painting. It's all blue, with quite a bit of white. It's the Christ ascending, the resurrection; and it just lifts you right up out of that place. I get thrilled every time I think of it. I live it over again.

These attitudes are very different from the attitudes with which physicians and nurses commonly approach death. Death is a failure as far as doctors and nurses are concerned, and it's pathetic. But having classes with the nurses, telling them about these psychosynthesis ideas and a little bit about these experiences, has made changes in some of their attitudes. We've had quite some discussions on how you work with a dying patient. So, this attitude spreads.

We have a series of therapeutic conversations with our recovery room and delivery room nurses and with the nurses who work with surgical patients or with the long-term illness, intensive care and coronary care units.

WOLF: Do they suggest to the dying patients that they go to a better level, a brighter world and so on - this rather oriental type of orientation?

RODGER: I don't know; I don't think Dr. Saunders specifically does this. (WOLF: In other words, to make it a pleasure.) I think a great deal more ought to be done with helping people through the experience of dying. I frequently tell my patients little anecdotes. I wait until they bring it up. I respond only to what they bring up. I don't push much on them, although I'm alert to come out with my little "goodies" when it's appropriate. But one of the things I like to tell them is the story of a Sunday School class that was asked to transpose into their own words the story of Enoch's translation. One little girl wrote: "Enoch and God were great friends, and they used to take long walks together. One day they walked further than usual, and God said to Enoch, 'Enoch, you must be tired. Won't you come into my house and rest?'" So, this can come in with a light touch.

Ralph Sockman wrote a book on pain and suffering. A patient asked, "What's it like to die?" The person he was quoting was a physician who was sitting with a dying friend. The doctor said he didn't know what it was like to die; but here was his friend all alone and the doctor was the only person close enough to come and stay with him. He thought "How on earth can I tell this person what it's like to die? I don't know anything about this. I never thought about it." Just then he heard the dog scratching at the door. He brightened up and said, "It's like that dog scratching at the door. He doesn't know what's on the other side. He knows his master is in there. It's all right."

Dr. Elizabeth Kubler-Ross is a psychiatrist in Chicago who has been doing a great deal of work with theological students, listening to patients who are in terminal illness and hearing what they have to say. She has made some very interesting videotapes of these interviews and what the patients tell them. She speaks of one patient who asked her a question, about what it is like to die. She was rocked back on her heels because she never really thought very much about this; so she said, "What do you think about it?"

The patient replied, "Well, I think it's kind of like transplanting a plant from my garden to God's garden."

So, as you collect these little things, metaphors, analogies and pictures, you can present them to others. You can bring them into conversation, half seriously, half laughing, and let the patient accept them or not - think about them, bring up something further or just forget them for now. But it's there.

HARONIAN: Do you do any work in obstetrics?

RODGER: Yes. In fact, this is my main work because I'm in charge of delivery room anesthesia and have been since the hospital opened.

HARONIAN: The reason I asked, I wondered if you experienced any opportunities there for the use of psychosynthesis - the birth end rather than the death end. A nurse that I worked with recently, who specializes in obstetric nursing, has a very strong feeling about the value of the birth experience, particularly for the mother and for the father too, as a potential self-realization experience.

RODGER: One of the things that I started using long ago when I was employing more formal techniques of hypnosis was the idea that here's an experience that makes you a co-creator with God, bringing new life into the world. "You feel a contraction; you may not like it; but your body knows how to go through labor and delivery. You don't have to <u>like</u> it; you just have to <u>do</u> it." I suggest to them that in labor is a good time to review "all the little bits of love that make up the mosaic of your understanding of love,all the way back from your own birth, love of parents, relatives, friends, boy friends, fiance, husband, the children you already have." Very interesting feedback comes from this.

Said one patient, "I never thought of it like that. Time went by so fast. I remembered incidents I hadn't thought of for years!"

HARONIAN: Do you get peak experiences out of these suggestions or in these experiences of birth?

RODGER: I don't really see patients enough for them to give me very much feedback. I do go around and make post-delivery rounds on them, but oftentimes the patient is busy or they'll call me for the delivery room while I'm in the midst of a visit. I think there would be a great deal more if I had a little more time to pursue it.

HILTON: Dr. Rodger, earlier in your talk you mentioned that you used a variation of the dis-identification exercise. I was wondering if it was one specific variation or whether you varied it from patient to patient.

RODGER: At the end of the Stage Two ("I recognize and affirm myself as a center of pure self-consciousness. I realize that this center not only has a static self-awareness but also a dynamic power and is capable of observing, mastering, directing and using all of the psychological processes and the physical body. I am a center of awareness and of power") I often suggest at this point that this awareness comes from the Source of all awareness, and the power comes from the Source of all Power. So, the implication is - and sometimes I put it into words - that whatever you do through this, you're not just dependent on your own poor little self, but you're drawing on Infinite Power. It's there, and it's there for you.

IMICH: I heard rumors that in Russia hypnosis is used extensively in painful childbirth. Do you know anything about that?

RODGER: Yes, this is true. There have been reports coming back that they are using it extensively. They use a very authoritative approach, I understand, because people in that part of the world are used to obeying orders, and they like orders. They're trained to this. This is true all over Europe to some extent, more than it is in England and the United States.

Someone pointed out that in most of the European countries the people will obey commands, that in England people will allow themselves to be persuaded, and in this country we can be permitted to do better - so whatever meets the patien need, you use. We don't find in this country that the authoritative approach is very valuable. It's all right with a limited number of people. You can use it, for instance, under army circumstances where people are trained to carry out orders. But you have an awful time with most people if you try to give them orders. They'll go the other way just out of spite.

HICH: Yes, but does hypnosis necessarily involve very authoritative approaches?

RODGER: No, it doesn't. And more and more we are using it permissively as a presentation of ideas.

HARONIAN: Doesn't it at that stage then become very much like the guided waking dream? (RODGER: Yes, exactly. It's the same thing.) You ask the patient if he is willing to accept ideas and images and then follow them through?

RODGER: Exactly. It's the same thing. It's an interpersonal relationship where you're offering your ideas, your experiences, your inner resources, and a recognition that they are in you and in the patient. So, you're encouraging them and calling them forth. It is enormously supportive and encouraging, and this is the way we use it.

HARONIAN: As I listen to you I am reminded of a friend of mine who does psychic healing and who tells me that she always enjoys the experience tremendously herself, and she has a need to keep doing it. I wondered if there isn't a secret behind all that you're telling us to the effect that as you do these things yourself, you're enjoying it and getting quite a bit of healing effect yourself.

RODGER: That's right. Somebody pointed out that a channel or an irrigation ditch that brings water from the source of water to the garden that needs it, always has flowers and things blooming along it, because it's watered by the same water, and this is true. When you find this self that we look for as the center and recognize the self, it's not only your own self, but it's all selves. And the true Self at the top of Assagioli's diagram is in contact with all other selves. The healing of one is the healing of all. To whatever extent one is healed others are healed too in this situation. If you go back to - well, for instance, the miracles that Jesus performed. - When He told his disciples to go out and do this sort of thing, he always said to them, say to the person that you have healed the "Kingdom of Heaven has come nigh unto you." It's within you.

Lambourne, who is a physician in England, wrote a book for his theology degree, "The Church, The Community, and Healing." He points out that in the healing situation the patient is the protagonist. He's the one who dramatizes the illness in all of us. We're not perfect. There is lack in all of us. It's in the healer as well as in the patient and in the community, the relatives, the friends and so forth. Anyone who sees this healing, recognizes it and accepts it,is healed too. The mechanism at work is that of right relationship with God, the Source of all power and the Source of all awareness, the Source of all healing. This sets one into right relationship with others and with the self. As you recognize this, you have a different frame of reference.

HARONIAN: Now you are getting into the whole area of psychic healing, spiritual healing.

RODGER: Spiritual healing is only an approach from a spiritual point of view. It's the same as medical healing when approached from a medical point of view.

HARONIAN: With regard to your arthritic patient who had imagined painting her joints different colors, was there any subsequent clinical evidence of improvement in the arthritic condition subsequent to the use of this kind of imagery?

RODGER: The swelling in her joints did go down and she was able to move them very much more readily. No, it didn't happen immediately. It came about rather slowly at first, then much more rapidly. It had been getting worse and she herself put the mental painting as the turning point. She felt there was a definite change, and it somehow seemed to mobilize her resources for healing.

HARONIAN: My concept of this kind of healing would include a parallel healing of the psyche, if you will; a real change in the person's outlook and interpersonal relations, as well. Did you observe that, aside from the relief of pain?

RODGER: Yes, this is true. She came to recognize that certain kinds of psychological stress and her response to it had been responsible to some extent for episodes in the past and that she could make some changes in her response and she did. In one guided waking dream, she saw a vampire sucking blood. She found out who that was and recognized here was something important going on. Then she decided she wasn't going to be bugged by this and fed the vampire with something that would satisfy it but not use up her own blood. (HARONIAN: You used the Feeding Technique?) Yes. In fact, I read her part of your article. Very handy, very nicely put. Thank you kindly.

IMICH: Did you find among your patients any who are not afraid of operations?

RODGER: Oh, yes, certainly. And these people don't need much time; but even they have the right to be patients and I simply point out to them, "You have a right to be a patient, you don't have to like everything, you just have to put up with it. Any time you need help, we'll help you." Just leave it open. Physicians and nurses especially need to be treated like any other patient and to have some basic points to hang their hats on. For instance, I tell them, "From the time you get your medication until you're back in your room again, you need to pay attention only when someone speaks directly to you." They never really thought of this, but it tunes out extraneous conversations and bad post-hypnotic suggestions that they might pick up on the way. (HARONIAN: In the operating room?) Right. (HARONIAN: Under anesthesia?) Even under anesthesia. You're so right.

Even the most stable and best adjusted person can run into little pitfalls along the way, come against something they really didn't anticipate and don't quite know how to cope with, particularly if they had some medication and there's a little blocking; they're not quite able to cope the way they would ordinarily.

So, if you have a few pegs to hang things on, then you can respond more creatively. Or you can put it aside knowing that there's somebody you can ask about it, with whom you can work it out at a future time if you want to.

SHAMES: Do you ever use hypnosis as the sole anesthesia for major surgery?

RODGER: It is used for major surgery. I don't ordinarily; partly because the surgeons are too afraid of it. We have done some operations, and frequently do

them with a minimum of anesthesia, just enough to reinforce the ideas that are presented.

HARONIAN: It has been said, if I recall correctly, that if you use hypnosis, you can use a fraction - perhaps a fifth or a quarter - of the chemical anesthetic that you would otherwise need and that you thereby can eliminate totally the incidence of accidental death from anesthesia.

RODGER: You can. You can often talk them out of cardiac arrest. You can talk them out of vomiting. You can talk them out of a lot of things.

COOPER: You can laugh them out of it too, which helps a whole lot, bringing up jokes, laughter, etc.

RODGER: That's right. And our recovery room girls are doing a wonderful job. The head recovery-room nurse a week or so ago said, "You know, Dr. Rodger, I found that in the last few weeks I can talk these patients out of laryngo spasm." She discovered she could do it now herself.

You tell them to take a deep breath. They'll do it. Even under deep anesthesia they'll do it. I rarely see laryngo spasm now. We used to see it frequently, particularly with pentathol. There is a tendency to go into spasm and it's sometimes difficult to break. Just tell them to breathe: "Take a deep breath." If they don't do it, tell them again. If they don't, tell them again; they'll always do it with the third one if they haven't before. We're trying to teach anesthesiologists this also. They're awfully hard to teach.

COOPER: When I was an intern in neurosurgery and the patient would be under local anesthesia the neurosurgeon, who was quite bombastic and loudmouthed, would say, "Don't suck there, you'll suck out the whole brain." Or, "There's the thing, Jesus, where I can't get to it!" Needless to say his death rate was large. This impressed me and I wouldn't work with him.

HARONIAN: I would like to ask again about the paranormal situation. Stan Krippner, when he was here last month, pointed out that the incidence of ESP and various kinds of paranormal communication are always greater during shifts in states of consciousness. You are dealing with that all the time in your business, particularly as an anesthesiologist. So, I am curious as to whether you are especially aware of the possibilities of and circumstances under which paranormal communication occurs.

RODGER: This would be a fascinating thing to follow up, and there is a marvelous opportunity. This was suggested some time ago to anesthesiologists: that they observe and log any changes in states of consciousness. But, for one thing, we use such rapidly acting anesthetics that they just go from here to there in a matter of seconds.

I use that time to give them post-hypnotic suggestions for relaxation, to orient them to what I want to come next. The same thing is true in returning from consciousness. If I could spend more time in the recovery room, I could do this. But this is a problem, that our schedules are tight. It would be fascinating if you had more time with them.

COOPER: I might emphasize that paranormal experience occurs more frequently in a situation where the patients don't receive help from the environment in the death

scene. It's a response on the part of the individual themselves rather than it being, as we think it might be, other entities coming over. In a hostile death situation, you'll see more of the paranormal experiences, e.g. in accidents, on the battlefield, where there is no one to help out.

In my experiences with over 800 casualties, with some 80 deaths, if I was present and could help them in the dying situation - many of them, you know, you hold, or you're with them - there was no paranormal experience. But if a corpsman would report an unattended death, then he might report something paranormal.

I don't think that we are going to find very many paranormal experiences.

HARONIAN: You're suggesting that if the dying person is in communication with another person, there is no need for a paranormal type of communication? (COOPER: Yes.) Which suggests that there is a need for some type of communication at death perhaps for those who are isolated from others. (COOPER: Yes.)

KELLOGG: I've read so often that dying patients, even in the most supportive environment, will still at the moment of death or shortly before imagine their relatives coming to them. I certainly call that paranormal. I think this occurs even if the physician is holding them. I still think they will take leave of the physician. Do you rank that as paranormal?

HARONIAN: Yes, I would. Karlis Osis, of course, has done study on this.

COOPER: The Karlis Osis deathbed observations on some 600 cases were done and some 200 responses were given by the physicians and nurses who were observers and not participants. The report opened up an avenue for further research. Osis still wants more observations.

RODGER: I have been only rarely with people at their death.

COOPER: I have. I have spent quite a lot of time in professional life in assisting people and you just don't see the paranormal if you're there. But I get reports of it where patients die, say, during the night. Then the nurse that's on will say, "Yes, he was talking to Aunt Susie. He was completely out of his head at the point of death." But if I'm around -- (KELLOGG: They talk to you instead.) -- and talking with me, no great problem. They go out very quietly.

HARONIAN: That suggests that the person who was there, other than you, who was witnessing the death was not really in communication with the dying person. (COOPER: Not supporting the individual.) Just observing; and at the time the patient wasn't really aware of his presence--

COOPER: They had to bring out this kind of experience to support themselves at this particular point.

KELLOGG: So, the relationship should be just as supportive as the doctor present at birth. (COOPER: Right, even more so.)

RODGER: Yes, it is a kind of birth.

COOPER: It's a birth into another dimension - and we need to have a team, a

nursing team, people-oriented; just like they're doing in England at the present time. I'm quite sure in the English situation they are not going to find very much of anything resembling paranormal experiences. It certainly hasn't been brought to their attention up to this point. They tend to be dramatic when they do occur.

WOLF: I think it would have to be done with a one-way mirror or something like that so they would think they're alone.

RODGER: There is so much more we could do with patients dying, to develop teamwork and train teams. There is such a desperate need for it.

COOPER: When teaching medical students, I'd present at least one or two dying patients, and I would tell them beforehand we were going to speak about the care of dying patients. The students would in a facetious way remark. "That's the last thing I want to talk about."

WOLF: Dr. Rodger, do you use autogenic training at all in your pre-operative work?

RODGER: Yes, not as much in the pre-operative as I do in other work that I do. It's an excellent approach for an anesthesiologist because the things that bother patients often are somatic complaints, pain, tension and so forth. When I do use it pre-operatively I give them just the first basic exercise. (WOLF: Heaviness and warmth?) Yes. And that no sound need disturb them; and I add to that no feeling need disturb them. I point out it can be physical feeling or sensation or it can be emotional feeling. It helps to turn down the volume control of this response. Frequently, when I haven't had opportunity to have a pre-operative visit with a patient in an emergency situation, or if I have been off the day before and somebody else has pre-medicated him, I'll see him that morning and very briefly go through this little exercise.

WOLF: I mean a prolonged thing. For instance, you have the patient in the hospital a week or two before - (RODGER: We don't usually know who is going to give the anesthesia until the day before.) Do you think there would be any way to bring the individual into a neutral state so that whatever suggestions to be given would be much more powerful from that neutral state?

RODGER: Occasionally I have patients referred to me ahead of time, and I'll see them once or twice anywhere from a week or a month before operation. But that's seldom. Mostly they are patients who come to me on their own because they know something of the work I'm doing. There are very few referrals from physicians, I might add. I tried to get our anesthesia department interested in doing this and in setting up some classes that would be open to patients who were going to come in for hospitalization; you could do it so simply, so easily and inexpensively, and it would make such an enormous difference. The nearest I got to it is getting a few of the doctors to put some of these pamphlets in their waiting rooms, "Patience for Patients." They report favorable responses to this, but it's only a drop in the bucket.

COOPER: The climate is not too favorable yet. They are still too interested in brain transplants and techniques. I worked with Mike DeBakey for a number of years, and as soon as we started talking along this line, the residents would leave; but they would spend hours removing bandages and looking at sutures and talking about techniques. They're not ready yet for this sort of thing.

Somewhere about the junior year in medical school, their interest goes out the window. I worked intensively with freshmen and sophomore students, and we could get a lot over to them. But by the time they became juniors and seniors, they were too wrapped up in technique. At that stage they began carrying bottles of urine and feces and peering through microscopes or seeing what remained of a patient; and they were not concerned with the patient as a person. It doesn't return until four or five years after they finish their residency; and then only a small percentage will begin asking questions.

RODGER: Many of the referrals that I get - to work with patients in pain problems or any kind of difficulty, tension problems, stress problems - come from the nurse saying to the doctor, "Why don't you call Dr. Rodger in for that?" If she keeps at it long enough, then they may do it, when they can't think of anything else to do. By that time it's kind of hard to work with them because they have pretty much given up.

But this is a place where groups come into being and are enormously helpful. There is much that you can do through groups - autogenic training, for instance, in groups is great - particularly when you combine it with psychosynthesis.

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