

# The Journal of Process Oriented Psychology

**Bodydreaming: Illness, Coma and Death Processes  
At the Edge of Process Work**

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# A Comparison of the Medical/Nursing and Process Work Approaches to Coma: a journey through the minefield of unconsciousness

by Kay Ross

In this article I compare the medical/nursing and Process Work approaches of working with those in comas. My background, first as a nurse in intensive care, and more recently as a Process Work student, has enabled me to develop my thoughts and ideas. Arnold Mindell's interventions and research have challenged my long-standing beliefs about how to support those who are unconscious. As a nurse, I was taught that the best thing to do for someone in a coma was to wake them up. The whole medical treatment and management program was geared towards waking people up, and this was my goal as an intensive care nurse. Looking back, I realize that I missed many signals and clues as to what was really going on with those I was caring for. Some of them just wanted to be left alone in their own private worlds, while others wanted to be allowed to die. I hope that the following ideas will challenge some of you as I myself have been challenged!

## Background

I trained as a nurse twenty years ago and have worked in adult and pediatric intensive care units in Australia for ten years, caring for many people who

were unconscious or in comas. The Process Work definition of a coma is "... profound states of apparent unconsciousness where one cannot respond to any verbal or non-verbal approaches."<sup>1</sup> The medical definition is "... a state of depressed cerebral function."<sup>2</sup> The emphasis in medicine has been on keeping those in a coma alive and arousing them. There has not been any acknowledgment that some people might want to be in a coma for reasons known only to them. Despite consistent negative feedback, such as people going deeper into their comas whenever they were approached or when medical personnel would try to arouse them, in a medical setting we would try everything possible to "get them to wake up." It wasn't only the medical profession that encouraged this; the first question relatives would ask when visiting was, "are they awake yet?" The media also sensationalizes those who come out of comas with headlines such as "...wakes up after four months in a coma." No wonder there is such an emphasis on "waking up." Mindell points out that people sometimes need the inner time in the coma to work on themselves.<sup>3</sup> He says that those in a coma are "... wakeful human beings going through one or more meaningful steps in

<sup>1</sup> Arnold Mindell, *Coma: Key to Awakening* (Boston: Shambhala 1989).

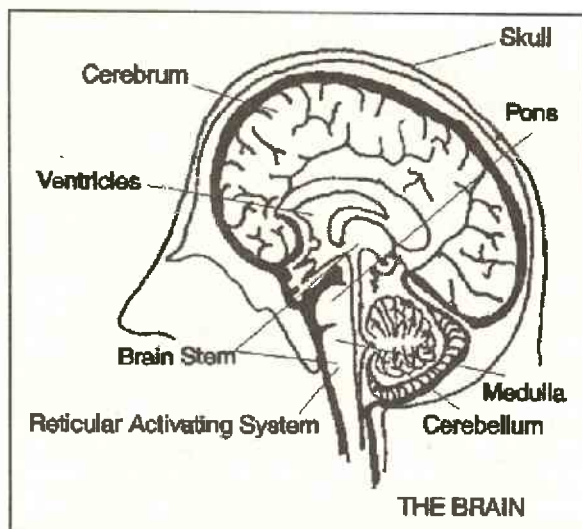
<sup>2</sup> C.J. Binniger, P.F. Healy, N.L. Polts, and D.E. Wilson, *American Review for NCLEX* (Pennsylvania: Springhouse, 1992) 445.

<sup>3</sup> Mindell, *Coma*.

their process of individuation.”<sup>4</sup> He goes on to say that “Most dying people need assistance to experience fully the powerful events trying to happen.”<sup>5</sup>

### A brief medical overview of coma

The skull is a bony, rigid structure containing solids (brain and spinal cord) and fluid (cerebrospinal fluid [C.S.F.] and blood). If there is any swelling or increase in the contents, i.e., C.S.F. (hydrocephalus), blood (hemorrhage) or brain tissue (tumors, abscess) there is nowhere for the swelling to go. The swelling therefore impinges on the brain itself and causes brain damage due to edema and lack of blood and oxygen supply. Medical care is aimed at preventing and reducing brain swelling (cerebral edema) and any increase in the skull's contents (raised intracranial pressure).



The cause of unconsciousness is when this swelling presses on the reticular activating system (R.A.S.), which is a network of neurons and tracts that extends from the lower brain stem into the pons, mid-brain, thalamus and cerebral cortex. Any disruption to the R.A.S. will reduce the level of consciousness and lead to coma. The cerebral cortex controls the content of consciousness while the R.A.S. is the on/off switch.<sup>6</sup> The R.A.S. receives information

from all the sensory functions of the body. The messages are sorted and then sent to the cortex to be acted upon to maintain a normal state of functioning and activity.

Measures to prevent cerebral edema and increased intracranial pressure include: body cooling and sedation to decrease the brain's need for oxygen; ventilatory support to assure an adequate supply of oxygen and to decrease the levels of carbon dioxide; sitting upright in bed at 30 degrees to ensure venous drainage and steroids to decrease inflammation and swelling. Patients' fluids are severely restricted to limit the amount of circulating fluid and thus decrease the amount of body fluid and cerebral edema. Nutritional requirements are met with either intravenous replacement or intragastric feedings. All of these measures are also geared towards the patient waking up from whatever is causing the coma. Additional specific treatment includes draining the blood if there is a brain hemorrhage, antibiotics if there is an infection, removal of a tumor if one exists, and shunting of C.S.F. if there is hydrocephalus (accumulation of C.S.F. in the ventricles of the brain). General nursing care of the unconscious patient includes keeping the stomach empty via a nasogastric tube (vomiting and aspiration increase intracranial pressure), bladder catheterization, oral and eye hygiene (to stop the formation of corneal ulcers) and side-to-side turning to prevent the formation of decubitus ulcers (pressure area sores).

One of the most common causes of unconsciousness in acute care settings is cerebral edema and increased intracranial pressure, where the brain swells because of trauma (just as your arm would swell if it were badly bruised). Often these people are young and have been involved in automobile, motorcycle or sports accidents. Other causes of cerebral edema include hypoxia (lack of oxygen to the brain), metabolic disturbances (i.e., high or low blood sugar levels in diabetes mellitus), poisonings, electrolyte imbalance, etc. Aggressive treatment is aimed at preventing further swelling and decreasing

<sup>4</sup> Mindell, *Coma* 5.

<sup>5</sup> Mindell, *Coma* 10.

<sup>6</sup> A. Stolarik, "What the comatose patient can tell you," *Registered Nurse* April 1985: 28.

the swelling that already exists. It is not possible to drain this fluid because it is contained within the brain cells themselves.

### Neurological observations

One of the major ways to assess the patient's condition is to assess her/his response to verbal and painful stimuli, the pupils' reactions to light and the spontaneous movements. The patient is "graded" according to a scale (response to verbal/painful stimuli, pupil response to light, limb movement, etc.). The higher the score, the better the chance of recovery. Thus, a patient's prognosis is based on the score. This scale is referred to as the "Glasgow Coma Scale." Patients score points for their highest level of functioning in 3 different categories (see Appendix 1). The highest possible score is 15, and a score of 5 or less is seen as indicating a bad prognosis. In one study, 85.2% of those with a score of 3-5 died or were in a persistent coma two weeks after the onset of the coma.<sup>7</sup> The outcome for those in a coma is mainly dependent on the initial coma grade. The duration of coma and advanced age are also viewed as negative factors influencing the outcome.<sup>8</sup>

Brain damage is a broad term which describes the loss of function due to an assault on the brain. Signs of brain damage can include moans and groans, sucking on fingers, inability to respond to simple commands, abnormal posturing and uncoordinated or involuntary movements. These signs are seen as "evidence" of brain damage, "proving" that the person has suffered trauma to the brain. Often there is no attempt to follow the signals and to unfold the patient's inner process.

Process Work postulates that whatever is happening to a person is a meaningful expression of the dreaming process. The process worker encourages people to experience whatever is happening for them, to unfold it and to believe in its potential meaningful-

ness. Thus, if a person appeared to not be responding as they had previously, the process worker would understand their lack of response at that time as meaningful and necessary for them. The medical profession, however, tends to see that something is wrong if there is a deterioration in the patient's condition and would try to correct it by increasing medications or looking at other ways to rectify the problem.

We do need Western medicine, especially for acute emergencies, fractured bones and bacterial infections, etc. However, not everybody who is in a coma wants to wake up. I will discuss some of the people I have cared for to demonstrate this point. I do want to assert that without the medical profession, we would not have the opportunity to work with those who are unconscious; they would not have survived the initial onslaught of the coma without intense medical intervention.

### Brain death, or "what is dead?"

The question, "What is dead?" has inspired a long and continuing debate.<sup>9</sup> Thirty years ago, this question simply did not arise: when a person's heart ceased functioning there was no means to resuscitate them, and they just died. Today the available medical technology enables us to save many who, in the past, would not have made it. Mechanical ventilators will pump oxygen into the lungs and thus provide a continued oxygen supply to vital organs such as the brain, heart, liver and kidneys. Medications will keep the heart pumping and the kidneys functioning. But the question arises; if the person has no brain function, are they still alive? The medical and scientific community has answered the question with; if there is no evidence of brain function above the brain stem, then the person is declared dead, and ventilatory support may be terminated. Lack of brain stem function is determined by the following criteria:<sup>10</sup>

<sup>7</sup> R.L. Sacco, R. VanGool, J.P. Mohr and W.A. Hauser, "Nontraumatic Coma. Glasgow coma scores and coma etiology as predictors of 2-week outcome," *Archives of Neurology* Vol. 47 (11), Nov. 1990: 1182.

<sup>8</sup> R. Kalff, W. Kocks, J. Pospiech and W. Grote, "Clinical outcome after head injury in children," *Child's nervous system* June 1989: 156-59.

<sup>9</sup> C.M. Fisher, "Brain Death—A Review of the Concept," *Journal of Neuroscience Nursing* 5, Oct. 23 1991: 330-33.

<sup>10</sup> J. Lynch, *Brain Injury: Tapping the Potential Within* (Melbourne: Hill of Content Publishing, 1992): 457.

1. absence of spontaneous movement
2. absence of any response to painful stimuli
3. absence of spontaneous breathing
4. pupils fixed and dilated
5. absence of caloric reflex
6. absence of gag response
7. absence of brain activity as evidenced on ultrasound or scanning.

This all seems straightforward except for the fact that there are many examples of people who have been pronounced "brain dead" or profoundly brain damaged, have had their life support discontinued, and have continued to live, despite medical pronouncements that this is impossible. Karen Quinlan is a much publicized example of this.<sup>11</sup> After a prolonged court battle, her parents won the right to have the ventilator turned off. It was assumed that she would die without ventilatory support. According to the medical profession, Karen should have died when her life support was terminated. She defied the doctors by spontaneously breathing on her own.

There are now many studies which question the concept of "brain death." Turog and Fackler<sup>12</sup> extrapolate that brain death may be accompanied by retention of central nervous system activity in the form of spinal reflexes and evidence of environmental responsiveness. Studies such as these raise the question, "should we terminate life support when "brain death" is diagnosed?" The many stories of people "waking up" as well as the research raise the possibility that these people may not be dead. This is an area where Process Work could be utilized. If we were able to work with "brain dead" people, I imagine that we would be forced to rethink our concepts of life and death. Ethics aside,<sup>13</sup> deep democracy demands that we support people in whatever state that they are in.<sup>14</sup> This includes

those who are clinging to life by the means of life support.

I nursed a young boy who had been dragged out of a swimming pool after being immersed for over 20 minutes. "Timmy," 18 months old, was rushed to the local hospital where he was resuscitated, placed on a life support system, and transferred to the Children's Hospital. He scored 3 on the Glasgow Coma Scale (the lowest score possible), and had no response to any stimuli. Two days later his parents were told that there was no hope of recovery, that his brain showed no activity and that his life support systems would be terminated. When his ventilator was turned off, Timmy started to breathe on his own. He remained unconscious for another two weeks, and then started to respond to his environment. After intense rehabilitation, Timmy learned to walk and talk. Two years later he was placed in a normal kindergarten. He shows some signs of clumsiness, and he has slightly slurred speech. Mentally he appears to be at the expected level of development for a child his age. This is despite the fact that he was pronounced "brain dead." The medical profession looks on cases such as Timmy's as "mistakes," assuming that somebody missed something. Another point of view is noting the fact that he met all of the criteria for brain death and survived despite this.

### Living wills

Living wills are relatively new. A living will is a mechanism by which patients can communicate their desires for medical treatment at the end of life.<sup>15</sup> Most states have adopted legislation that allows patients to designate, by advance directives, the type of health care they would like to receive if they should become incompetent while suffering from a terminal illness.<sup>16</sup> Some health profession-

<sup>11</sup> See P.W. Armstrong and B.D. Colen, "From Quinlan to Jobes: the Courts and the PVS Patient," *Hastings Center Report* (18)1, Feb.-Mar. 1988: 37.

<sup>12</sup> R.D. Turog and J.C. Fackler, "Rethinking Brain Death," *Critical Care Medicine* 12, Dec. 20 1992: 1707-709.

<sup>13</sup> F. Miedema, "Withdrawing treatment from the hopelessly ill. Part I: The ethical case," *Dimensions of Critical Care Nursing* (1993): 40-45.

<sup>14</sup> Arnold Mindell, *The Leader as Martial Artist* (San Francisco: HarperCollins, 1992): 5.

<sup>15</sup> H.J. Silverman, J.K. Vinicky and M.R. Gasner, "Advance Directives: Implications for Critical Care," *Critical Care Medicine* 7, Jul. 20 1992: 29.

<sup>16</sup> J. Sugarman, M. Weinberger and G. Samasa, "Factors Associated with Veteran's Decisions about Living Wills,"

als push people to sign a living will which directs the type of care they will receive if they are critically ill or suffering from a debilitating, chronic medical condition.<sup>17</sup> Ely et al<sup>18</sup> surveyed a large number of physicians regarding their decision making process about feeding tube placement in an 89-year-old man who could not swallow or communicate after a stroke. Here it was assumed that because the man had lost his verbal skills and did not nod yes or no, he was unable to make a decision about his own life. The study showed that had he made a living will prior to suffering the stroke, the doctors would have followed his wishes.

This brings up a major problem with living wills. What if someone changes his/her mind? It is all very well to talk about what someone's wishes are prior to an incident, but this does not take into account changing circumstances. Mindell<sup>19</sup> points out the importance of establishing contact with those in a coma and asking what their wishes are in that moment. I believe that this is the only ethical way to establish whether the patient wants to live or die. Living wills take away the person's right to change his/her mind.

### People's experiences of unconsciousness

There are many stories of people's experiences of waking up after being in a coma. Some talk of "near death" experiences, while others relate stories of imprisonment and deep sensory experiences.<sup>20</sup> Most reported near-death experiences include profound feelings of peace, joy and cosmic unity. However, even these experiences can be interpreted as unpleasant or frightening.<sup>21</sup> Near death experiences are associated with surviving a critical illness, and they have been reported by children as well as

adults.<sup>22</sup> These studies prove that unconsciousness is a process that people experience differently. Care of those in a coma should include relating to them, responding to their signals and encouraging them to believe in the meaningfulness of what is happening. Gone are the days when those in comas were relegated to the back wards and left to vegetate. These people are undergoing profound experiences unique to them. As supporters of this process we need to accompany them on their journeys without any judgment or criticism.

I looked after a young girl who was 10 years old. "Mandy" was hit by a car on the way to school and received massive head injuries. She was rushed to the nearest hospital where she was resuscitated and placed on a life support system. She was then transferred to the Children's Hospital where a CAT scan (computerized axial tomography, a 3 dimensional X-ray) showed that she had a cerebral hemorrhage. She had surgery to drain the blood from her brain, and was returned to Intensive Care in critical condition. Mandy was diagnosed as "brain damaged" fourteen days later after not responding to treatment. For two weeks Mandy was totally dependent on the ventilator to keep her alive, and her parents kept a bedside vigil, waiting for her to wake up. It was finally decided to terminate all treatment and it was explained to her parents that there was no hope of recovery, that Mandy would not wake up and that she would be a vegetable for the rest of her life.

During this time I had a gut feeling about Mandy. I noticed that Mandy would open her eyes and appear to look straight ahead. She also moved her mouth in a sucking motion and whenever I carried out oral hygiene, she would suck on the swab stick.

*Archives of Internal Medicine* 2(6), Feb. 15 1992: 325.

<sup>17</sup> J. Hare and C. Nelson, "Will Outpatients Complete Living Wills?," *Journal of Geriatric Internal Medicine* 1, Jan.-Feb. 1991: 43.

<sup>18</sup> J.W. Ely, P.G. Peters, S. Zweig, N. Elder and F.D. Schneider, "The Physician's Decision to Use Tube Feeding," *Journal of the American Geriatrics Society* 4(5), May 1992: 471-75.

<sup>19</sup> Mindell, *Coma* 100-101.

<sup>20</sup> P. Tosch, "Patients' Recollections of their Post-traumatic Coma," *Journal of Neuroscience Nursing* 20(4), Aug. 1988: 224-26.

<sup>21</sup> B. Greyson and N.E. Bush, "Distressing Near-death Experiences," *Psychiatry* 55(1), Feb. 1992: 96.

<sup>22</sup> M. Morse, P. Castillo, D. Venecia, J. Milstein and D.C. Tyler, "Childhood Near-death Experiences," *American Journal of Diseases of Children* 140(7), Nov. 1986: 1111.

These signs were seen by the medical profession as evidence of severe brain damage. Looking back, I now know that these were signals of what Mandy was experiencing. Unfolding these signals might have led to a greater understanding of her process and what she was going through at the time. I was surprised that she was still alive despite the extent of her injuries. I talked to her constantly, telling her what day it was, where she was, and what had happened, as well as news about her family and friends. I also encouraged her parents to talk to her, because I believe we can always assume that hearing may be present.

The morning that the decision was made to stop all treatment and to terminate life support, I was caring for Mandy. Turning away from her bed to get something from her bedside locker, I heard a noise. A voice said, "I'm hungry." I turned around to find that Mandy had pulled out her endotracheal tube and was chewing on it like it was a banana (the endotracheal tube is an airway tube which is connected to the ventilator). She was fully conscious! Mandy made a full recovery despite her injuries and the predictions of the medical staff. Afterwards I asked what she remembered about being sick. She said "...it was like a dream where I was very tired and I needed to have rest." She added that she "...got angry about people poking her and telling her to wake up; she was too tired!" She also remembered some of the things that people had said to her, including the fact that her dog had had puppies while she was unconscious. The fact that she did not "respond" did not mean that she was not aware of what was going on around her. It meant, in this case, that she chose not to respond.

In medical terms, Mandy had an "unexplained full recovery from devastating head injuries." In process terms, the coma was meaningful to her; she needed time to rest while she experienced her own process. Attempts to wake her up did not work because, as Mandy said, she "... needed to sleep." Prior to the accident, Mandy's parents described her as a very active child who was always doing something. She worked hard at school, attended ballet classes, played basketball and was a member of the girl scouts. After her recovery, Mandy appeared to slow down and take things easy. Her parents and doctors thought that this was because of her physi-

cal injuries, but I wonder whether her "rest" also influenced this.

I also nursed another young girl who was unconscious after contracting meningitis (a bacterial infection of the covering of the brain). "Sue" was eight years old and had been in the hospital for 6 weeks. During this time she remained unconscious, with very little response to treatment. The doctors finally told her parents she would probably remain like this for the rest of her life. Sue's moans and groans were seen as "evidence" that she was brain damaged. In those days I didn't know anything about Process Work, so I did not explore these sounds and movements. When it was decided that Sue was not going to recover, she was sent to a medical ward where she received nursing care but no attempts were made to "wake her up." Ten days later Sue sat up in bed and announced that she wanted to go home. She said that she'd been to a "nice holiday place," where she could do what she wanted. She hadn't had to worry about doing what she was told because "...they finally left me alone." I wondered if she was talking about the previous ten days, when she was left alone because the medical profession had decided that there wasn't much point in continuing to try to wake her up.

Of course, not everyone who is in a coma will wake up; some will remain unconscious, and others will die. Again and again I have seen people in prolonged comas because their loved ones are unable to let go, or because they have unfinished business.

"Steven," 21 years old, was involved in a motorcycle accident. He received massive head, chest and abdominal injuries, as well as fractured limbs. Two months later he was still unconscious, with no response to verbal or painful stimuli. He was being fed by an intragastric tube, was breathing on his own, and did not appear to be aware of his surroundings. His relatives had been told that he had no hope of recovery; brain scans showed irreparable brain damage. Steven's wife, Nancy, would come in every day and tell him how much she needed him, that she couldn't live without him and to hurry up and get well. After each visit, Steven would become very agitated; he would scream loudly and would thrash about in bed. Finally, a nurse had a long talk with Nancy. She explained that it might be time to start letting go of Steven and to look at ways she might be able to say good-

bye to the man she had married. A few days later, Nancy told Steven that she still loved him, but if he needed to go, then she wouldn't stop him. She said her good-byes and sat with Steven. At first there was no response, then Steven opened his eyes, looked straight into Nancy's eyes, smiled, and slipped into unconsciousness. Two hours later he died peacefully, with Nancy at his side. It seemed that Steven just needed to know that Nancy would be all right before he could leave.

Stories such as these raise the question for the medical profession, "should we assume that everyone in a coma wants to wake up?" My answer is "no, some people want to be left alone; they need to be unconscious." A process worker would follow a comatose person's process, unfolding the signals and believing that everything that happens is potentially meaningful. From this perspective, a coma is something that needs to happen. By believing in the process we are able to let go of expectations of waking, being cured, etc. Medical professionals are trained to heal, and if someone is in a coma, then their response is to wake that person up by any means possible. My vision is that the medical system will work with process workers; together we can develop new approaches to supporting those who are unconscious.

### Coma arousal therapy

A controversial approach to working with those who are unconscious is Coma Arousal Therapy (C.A.T.). Hunter<sup>23</sup> states that "It cannot be proven that there is no potential for recovery following brain injury, even in the most severe cases... because there is no diagnosis that can scientifically demonstrate that recovery of function will not occur... (therefore)... every attempt should be made to tap this...." C.A.T. is a "... planned series of activities aimed at arousing a person from a coma."<sup>24</sup> It consists of stimulating all the senses of the comatose patient,<sup>25</sup> and aims to activate the reticular acti-

vating system. It is a time consuming, labor intensive program where teams of people take turns systematically stimulating the person in a coma.

Methods include: shining a light in the person's eyes (visual); placing strong tasting substances on the tongue (taste); holding aromatic substances in front of the nose (olfactory); stroking/touching the skin with objects such as feathers (touch) and making loud noises (hearing). The person's movements are also stimulated by moving the limbs in a passive range of motion exercises, placing the person on a tilt table and lying the person supine or prone over a large ball and rolling them around the floor.

In process terms, most channels are being accessed by the team of care givers. My concern, however, is that it is done without any acknowledgment from the person who is unconscious. They are stimulated whether they want to be or not. Another difference is that a process worker attempts to follow the patient's signals which are happening and not impose stimulus on the person from the outside. Wilkinson<sup>26</sup> talks about her own son who underwent C.A.T. after nearly drowning. She describes his response as "...he could push things away from you if he didn't like the stimuli you were giving him." C.A.T. depends on this stimulus, and so Wilkinson's son continued to be stimulated despite his protests. He died a week after she made that statement.

Baker<sup>27</sup> states that "...Facial grimacing is an indicator that the taste sense is working." She does not acknowledge that the grimace might be an attempt to communicate that the person does not want those tastes placed on the tongue! She goes on to say "...smell... stimulus has been achieved if the patient grimaces or attempts to withdraw." Again, there is no attempt to follow the person's feedback.

### Some points to remember

If you are working with or visiting someone who is unconscious, it is easy to forget that this person is a

<sup>23</sup> I. Hunter, *Brain Injury: Tapping the Potential Within* (Melbourne: Hill of Content Publishing Company, 1986): 46.

<sup>24</sup> J. Baker, "Explaining Coma Arousal Therapy," *Australian Nurses Journal* 17(11), June 1988: 8.

<sup>25</sup> J. Wilkinson, "Coma Arousal Therapy: Is There a Need?," *Australian Nurses Journal* 5, Nov. 16 1986: 45.

<sup>26</sup> Wilkinson, *Coma Arousal* 45.

<sup>27</sup> Baker, *Explaining Coma Arousal* 8.

living human being. All too often care givers and visitors treat the person as if he or she is not there and talk about them in their presence. Here are some tips I have drawn up after caring for those in comas, as well as talking to people who have regained consciousness:

1. Always knock and ask permission before entering the room. Introduce yourself. Explain why you are there and what you are going to do. Remember that for someone who is confined to bed, the bed and the room become extensions of the self. Do not abuse them by entering without announcing yourself, sitting on the bed, moving objects around in the room, opening/closing windows, etc. Always be aware of feedback and proceed slowly.

2. Talk to the nursing/medical staff before starting. Find out the best times for visiting. You may have to negotiate. Do not assume that you will be the only one who wants to see the person. Remember meal times and doctor's rounds, as well as any visits to X-ray, physical therapy, etc.

3. Tell the nursing/medical staff what you are doing. Invite questions and comments. Expect a hostile reception if you don't inform them of your visits. Any negative feedback is often because they are uninformed and are concerned for their patient's well being. Imagine what it would be like if someone came into your workplace and appeared to take over a vital task! Offer them reading materials and (if you feel confident enough) a teaching session. Expect them to come in and see what you are doing. Remember, they have the ultimate responsibility for the welfare of their patient.

4. Talk to the person you are working with. Always assume that they can hear you. Do not shout; speak clearly in a normal tone, close to their ear. Tell them everything, especially if you are going to touch them.

5. Expect to feel foolish when you are talking to the patient. We are conditioned to communicate on a verbal level, and when we do not receive verbal feedback, we feel one-sided and at a loss. This is an ideal opportunity to fine-tune our ability to notice minute signals.

6. Do not give the patient anything to eat or drink without checking with the nursing staff. The patient may be on fluid restriction or a special diet.

7. It will be easier to work with someone who is close to death if you have faced your own mortality and beliefs about death. Ask yourself if you

believe in reincarnation, life after death, heaven/hell? What is the purpose of life? What are we doing here? These questions and more will be raised as you work with this special population.

8. If you have any queries about nursing/medical treatment, please ask. Do not go ahead with something if you are uncertain. Some medical equipment is vital to sustaining the patient's life. Don't touch anything without checking first what it is and what it does. Read up about your client's condition. Understand any medical terminology—some people use complicated terms to describe simple procedures.

9. Always keep relatives informed of what you are doing. Do not raise their hopes inadvertently. Select your words carefully; remember that they will cling to any hope that you give them. Do not use words like "...cure, wake up, get better, heal." Explain what you are doing and why you are doing it. Talk about what you expect, i.e., "I am following what Joey is doing. See how he is moving his hand? Well I am touching his hand so that he knows that I am here. I don't know what it means but I believe that it is important somehow for Joey. Let's see what else is happening."

Keeping these points in mind will make it easier for you to work with those who are unconscious. Remember, always respect them and their process.

## Conclusion

In this article I have attempted to outline the differences in the medical and Process Work approaches to working with someone who is unconscious. I have briefly outlined the medical paradigm and suggested additional ways that we might support those in comas. I hope that this has allowed you to appreciate their world and to acknowledge that "while there is life, there is hope."

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## Appendix 1 Glasgow Coma Scale

Response	Score
<b>Eye Opening</b>	
spontaneous	4
to verbal command	3
to pain	2
none	1
<b>Motor Response</b>	
obeys	6
localizes to pain	5
flexion - withdraw	4
flexion - abnormal decorticate rigidity	3
extension - decerebrate - one	1
<b>Verbal Response</b>	
oriented and converses	
disoriented and converses	4
inappropriate words	3
incomprehensible sounds	2
none	1