Coma Work-
Pathway to Transformation

Gary Reiss

If I were to tell you that I had a method of psychological work and body work that could improve your sex life, deepen your relationship skills, and get you closer to the main reasons you are alive, would you ever suspect I was talking about working with people in comas? I say this because most people don't think learning about comas would be relevant to them. I have told people that the percentage of people who have a coma sometime during their life is quite high, and especially right before death. Yet this doesn't seem relevant for most.

However, I often grab their attention when I say that I don't know any form of bodywork that helps you develop as sensitive a touch and that this can be great for your sexual life, or that the listening and feedback skills you develop can help turn your relationships around. So while this article is mostly about working with people in and recovering from coma, this work also applies to relationships in general. It is especially effective reaching those who are hard to reach, including people in coma and severely withdrawn states, such as dementia and Alzheimer patients, but can facilitate reaching any of us when we need to be related to in an especially aware and sensitive manner.

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Traditional medicine, neuropsychology and other fields involved in treatment of coma often include physical stimulation as the only interactive approach between patient and practitioner. A great deal of work is done to rehabilitate the physical body, but the role of psychology and spirituality ignored. The director of a large coma unit described the traditional method of psychological work with the patient as, 'Taking care of the body the best we can, and doing nothing while seeing if anything happens by itself.' Process-orientated coma work in contrast, working alongside the treatment of the physical, concentrates on the internal experience of the person in coma. The coma worker doesn't just wait for nature to heal, but facilitates the natural tendencies trying to come forward in the person's subtle signals and experiences. The coma worker is a mind/body worker who supports the client's internal wisdom in healing.

'Anyone can learn the basic interventions'

The Method

Talking to someone in a coma usually doesn't achieve strong results. Since the client can't verbally respond, much of their response is through movement and touch. This is one of the main differences between process work and traditional psychotherapeutic work; that the therapist often needs to touch the client to communicate and to access information. The touch is made safe by the training of the therapist, and is constantly monitored by the family, as well as doctors, nurses, physical therapists, occupational therapists, and by other staff coming in and out of the patient's room. Which introduces another difference in process-oriented coma work; that one almost always works with a coma patient while the family is present.

Process-oriented coma work is based on the theory that the comatose state itself is meaningful to the patient, and every signal in this state is potentially full of expression and meaning. Therefore, process work explores the minimal cues present. Each twitch, eye movement, sound made, sigh, change of skin color, and blood pressure shift provides an opportunity to sensitively reach in and facilitate the person's process.

For example, I was working with a man in a coma, for whom the hospital had given up hope of any change and had recommended to

the family that they end life support. I noticed he moved his leg the slightest bit. I moved his leg until movement began in the other leg, then in one arm, and finally in both arms. At this point his breathing began to improve, as measured by the monitoring equipment.

We worked with him for five days in a row, using minimal cues. The first few days we worked mostly with his body movements. He began moving his legs, his arms, and rubbing his stomach. We also worked with the positioning of his legs. On the second and third day we began to try and establish a binary feedback signal. We were able to work with him so that he would lift his finger to indicate 'yes', and leave it down to indicate 'no'. I asked him several times if he wanted to live, and he always answered 'yes'.

On the night of the third day, I did a family therapy session working on problems around the father's care and between themselves (comas and other life threatening situations often bring unresolved family issues to the surface). The next morning I told him that I had had a great session with his family, and that they were working things out. He began to cry. I said every emotional statement I could, and he cried and cried. A short time later, his wife called, and I put the mobile phone up to his head. He suddenly talked, and asked her when she was coming to see him. An hour later, still talking, he fed himself at the lunch table. This man, who had been considered brain dead, was suddenly eating and communicating.

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Results of coma work are not always that dramatic. However this story illustrates that minimal signals, when interacted with, may give strong feedback. It also illustrates the use of binary feedback loops to allow 'yes' and 'no' answers to be signaled and the importance of family therapy interventions. In *Coma, A*

Healing Journey, Dr. Amy Mindell presents these and other methods in an accessible fashion. Anyone can learn the basic interventions.

The central idea is that the experiences associated with a comatose state are potentially meaningful for the individual's development. The coma is, not just about what is often a terrible tragedy for the family but, what Dr. Arnold Mindell, founder of this work, describes as a key to awakening. In his book *Coma, Key to Awakening* Mindell says of this work,' We need to learn a form of communication that appreciates and understands the smallest signals, the most minimal cues of our depths and joys. Once we succeed in communicating with people in strongly altered states, life after death appears as a timeless, eternal reality trying to manifest itself in the present.' (1989, p.4)

Mindell continues, 'Comatose states are very special dreams attempting to facilitate our drive for self-knowledge. In this blackest hole of life, the processes that have been waiting inside of us our whole lives seek completion and realization. In the light of this idea, life appears to be the search for self knowledge.' (1989, p.102). Part of our job as coma workers is to help unfold the meaning in people's states. This is the bigger picture. In the smaller picture, every signal is meaningful, no matter how small, how reflexively defined etc. Every eye movement, swallow, arm posture, breath, change in machine beeps, everything is an expression of something physical and beyond.

This is a huge shift from the medical model, which only defines the return to normal behavior as significant. For example, in the first case I worked with, the neurologist said that, 'When Sadie sits up and plays cards again. Then her progress will be considered meaningful.' On another occasion a man, who had been given no chance of recovery, sat up and spoke. However the neurologist deemed it insignificant until he had spoken three consecutive sentences in rational order.

These views bring up an important discussion about what consciousness is: modern medicine defines consciousness as ordinary consciousness. That is being who you were before the coma. This method of coma work says that consciousness is a continuum, and that the person in coma is aware. From one point of view, they are less aware than those in ordinary consciousness. While, from another perspective, they could be considered more aware because of having access to altered and marginalized states of consciousness.

Like all extreme states, which stand beyond the norms of society, coma represents a part of the shadow or unlived parts of society. These deep vegetative states may be present in coma patients because

the rest of us don't have time for them during the busy lives we lead. Thus I can almost predict the kind of pre-comatose life someone has been living by looking at them in the comatose state. Those who were compulsive workers tend to look like they are on holiday. Many who were never angry look like they are fighting. A mother, in an extroverted family that has regular parties of more than sixty people and where people were always talking, looks like the Buddha meditating quietly.

It seems that comatose states may offer a way of integrating those parts of our lives that are marginalized by our families, our culture, and us. In coma, people become these split off parts, and no one can force them out of being where they are. The coma state is both one that we have the least control in, in terms of our physical body functions, and the most control in terms of our freedom to be in altered states. For example, a dad comes up close to his son's face and tells him he has to get up out of the coma and go back to work. John gazes far off into the distance, and smiles. Part of him is just where he needs to be, and he knows it.

There are many different ways of integrating the lessons of the comatose state in order to be our whole selves. There are many possibilities. Perhaps the only path is to live out these needed parts of us by staying in the comatose state. A second path would be to come out of coma, and with support, bring back these parts and live them out in ordinary life. So that those in coma who are meditating would not just return to being busy all the time but, also make space to meditate and, possibly teach others how to integrate meditation into their lives. Another possibility is to touch and know these states through coma and feel free to let go and die. All are important paths to development.

Ethics

The belief system behind this approach firstly states that it isn't ethical to leave people in altered and extreme states for long periods of time without any psychological intervention. We wouldn't let someone we knew who was lost in the woods wander about for days or years without trying to help them find their way, and yet we do this with hundreds of thousands of coma patients worldwide. It is very rare to find any kind of psychological or mind-body component present in any of the treatment programs for people in coma despite the interest of family members. Many people lie in hospitals, rehabilitation centers, nursing homes, and in home care with little, if any, of this kind of intervention.

Based on the reports of several people I have worked with, who have come out of coma, these states can be very lonely and frustrating. Patients are often left without any stimulation because of

the belief that the patient needs to be quiet. Often the families think they just need rest, views that mainstream medical opinion often support. While this is often true at the beginning, it may not be so true after a period of time once physical healing is proceeding. It is possible that much of our treatment is actually keeping the person in coma.

A second part of the ethics of coma work is that we should value people in all states of consciousness. For instance, if medical systems don't tend to value the person in coma enough, they tend to write off their ability to make progress after a certain number of months. Families often stop interacting with the person because they don't know how to relate to someone who doesn't talk, or act like they used to. If we have a broader view of the value of all states of consciousness, then every state from fully dead to fully enlightened is a state that has meaning, for the person, for the family, and for the wider world.

Most medical systems and families have a goal of bringing the person out. This is an important, understandable and valuable goal. However, it is not my goal as a coma worker. My goal is to meet them where they are. I tell them that they will show me the best way to work with them, and that I will follow their process. In a system where everyone around them is controlling all aspects of their life, I tell them that I am there to follow them; I am there to facilitate their journey, and if they come out of the coma, then so much the better. If not, that their journey may be improved with the coma work as part of their experience.

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In my experience people who do come out of coma with this work, tend to be more intact and make quicker recoveries than those who don't receive this method. I am currently involved with a group setting up research to document some of the effectiveness of this work with people who do come out of coma; looking at the level of change present between those who do and don't receive the treatment.

A third ethical aspect of coma work is that people have the right to make decisions about their death in more than one state of consciousness. Mindell says, 'Learning how to give the comatose individual access to his or her own depths and communicative abilities should be, I hope, a contribution

to a new 'Thanatos ethics', an ethics capable of giving the individual the opportunity to make a clear and conscious choice about life and death, thereby rendering legal debates about life and death obsolete.'(1989,p.4). For instance, people often have signed a living will saying they don't want to be kept alive if they go into coma. As coma workers we need to ask them, while they are in the coma, if they feel the same way. People have often indicated that they felt very differently.

Skills of a Coma Work Therapist

This method of coma work takes a great deal of training and hands on experience and requires teamwork skills, as this work is too difficult to do alone. The coma worker needs to have strong observational and interactive skills, as well as be able to open up to all the dreamlike and altered states inside of themselves that come up when working with someone in these states. They need to know how to do bodywork, movement work, work with sound and voice, and work with seeing in order to orientate themselves to the multitude of possible signals and feedback. Likewise since most people in comas have loved ones involved, and many of the interventions involve not only the patient but also their family, the coma worker will need to utilize the skills of relationship and family therapy.

Summary

This article introduces some of the basic ideas and practices involved in working with comatose people. It is my hope that someday the hundreds of thousands of people in these states will be met through methods like this, spending less time alone, and more time facilitated on their journey. It is very hard to move through extreme states like this without a guide, and those of us willing and interested need to learn more about how to be guides through this land of transformation we call coma. In learning these methods, we also learn more about how to work on ourselves, particularly when we are in altered states. We also learn skills that can improve our contact with others, so this whole path of knowledge is truly a healing journey.

Further Reading

Mindell, Amy. Coma: a Guide for Friends and Helpers.Portland, Or:Lao Tse Press, 1999.

Mindell Arnold. Coma, Key to Awakening. Boston: Shambala, 1989.

Reiss Gary. Vital Loving, to be published spring 2004.