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Churchill Fellow 2023

What It Means To Be Human:

contemplative & psychedelic approaches to existential wellbeing within palliative care.

For Lilian & Alistair

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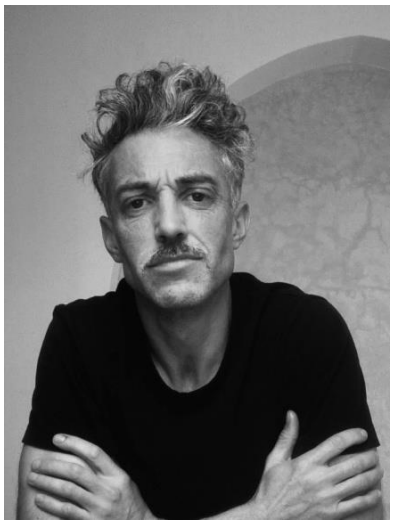

About the Author

Dr Dave Bradley is a GP in Palliative Care within NHS Borders, Scotland. He has a Postgraduate Diploma in Systemic Theory & Practice and has qualified to teach mindfulness-based approaches through Mindfulness Scotland. He lives in Edinburgh.

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Fear

(by Khalil Gibran)

It is said that before entering the sea
a river trembles with fear.

She looks back at the path she has traveled,
from the peaks of the mountains,
the long winding road crossing forests and villages.

And in front of her,
she sees an ocean so vast,
that to enter
there seems nothing more than to disappear forever.

But there is no other way.
The river can not go back.

Nobody can go back.
To go back is impossible in existence.

The river needs to take the risk
of entering the ocean
because only then will fear disappear,
because that's where the river will know
it's not about disappearing into the ocean,
but of becoming the ocean.

Preface

"We do not become fully human until we give ourselves to another in love."

Thomas Merton – *Love and Living*

Most of us, I would imagine, would prefer not to contemplate our own death. It is, after all, a rather morbid subject, despite its inevitability. *"Man is a creature who tries to deny his creatureliness,"* declared the anthropologist, Ernest Becker (Keen, 1974; p.71), underpinning the theory that our fear of death is the motivational force behind all our behaviour (Solomon & Greenberg, 2019). Yet is this really what it means to be human – to live in constant fear of death?

Among those I care for who are facing the prospect of dying, my sense is that what truly lies at the heart of any such fear is the absence of love; that death signifies the end of all life's relationships behind which lies a meaninglessness into which we will disappear irrevocably.

There are, of course, many times in life, too, when love is absent; when our endeavours to love or be loved leave us wounded. For many of us, these existential wounds remain unhealed, when the insight or resources needed to respond may not be abundantly available. Yet, as meditation teacher and chaplain, Kirsten DeLeo (2016), reminds us in her essay *More Than Just a Medical Event, "everything we have not dealt with in life, we are confronted with in death*" (p.188). As we care for those approaching the end of their lives, we must choose how to respond to the suffering such unhealed wounds inflict.

While love feels intuitively at the heart of what it means to be human, we seem to have inquired so little into the role it plays in suffering and healing. Love is not a word we often hear in palliative care (Rosa, 2021); to speak of love in such contexts may feel unexpected, uncomfortable, even unscientific. Experience tells me, however, that the people for whom we care are more than happy to share their experiences of love and its presence in their lives. The difficulty lies in knowing how to respond to its absence.

Palliative care has always sought to attend to the suffering of those whose disease medicine cannot cure by focusing on the healing of their personhood instead. The immortalized words of Dame Cecily Saunders (1976) – *'You matter because you are you'* – came from her holistic recognition and understanding of who someone is beyond their suffering and the multifaceted dimensions of human existence. Death tasks us all with making sense of our mattering.

In keeping with the approach that palliative care is as *"a blend of modern science and sensitive compassion"* (Doyle, 2005), this report gathers the same threads that run through contemplative traditions and psychedelic practices to weave together a viewpoint that to be human is to be a relationship; that each one of us is not simply a human being, but also a human belonging whose well-being flourishes in love.

The learning that constitutes this report comes from conversations with clinicians, neuroscientists, monks, professors, chaplains, researchers, and even a mycologist, while visiting Canada and the United States of America in October 2023 and May 2024.

It begins by exploring the existential nature of *Suffering* in the context of palliative care, broadly defining it as the negative emotional experience of losing one's sense of self, before proceeding to consider *Healing* as the transcendence of such suffering that emerges from a sense of connection to something larger than one's self and a shift in how we respond to our experiences of both life and death.

Being draws on the mystical awe of psychedelics and the Buddhist teachings of the bardos to point to the awareness that exists within and beyond our bodies. The role of compassion in changing our relationship to suffering is discussed in *Belonging*, highlighting the powerful role each of us has in witnessing each other. *Becoming* brings together the idea that meaning is created from a deepening of both our awareness and compassion to create the conditions conducive to life, even within the dying process.

The report concludes with the suggestion that attending to these three existential parts of the human condition constitutes the practice of *Love* and how, from this perspective, we might envision a system of healing where we mutually flourish in our care of the dying.

My hope is that what is offered here will allow each of us be a compassionate presence to others at a time of deep suffering, when it is all too easy to shrink from the fullness of being alive. Perhaps this is what it means to be human, not simply within our healthcare systems, but in the larger belongings in which we find ourselves increasingly disconnected from each other and the world in which we live.

It is my belief that the will to love is at the core of our existence. Therefore, to borrow the words of the Rev. Dr Martin Luther King (2015) in his 1967 sermon, *Where Do We Go From Here?: "I have also decided to stick with love, for I know that love is ultimately the only answer to mankind's problems."*

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Glossary of Key Terms

Contemplative care: a relationship-centred approach that draws on the contemplative practice of the caregiver as the primary source of loving action.

Contemplative practice: a set of psychological or spiritual processes relating to the nature of reality (including *self* and consciousness) and their role in human suffering and well-being.

Existential: relating to the meaning of existence, often interpreted through philosophical or spiritual lenses.

Healing: a return to wholeness or well-being through the transcendence of suffering.

Mindfulness: the awareness that emerges through paying attention to the unfolding of present moment experience without judgment or evaluation.

Psychedelic: a substance that alters perception and expands consciousness (from the Greek, meaning *mind-revealing*).

Palliative care: the active, holistic care of those with life-limiting illnesses to alleviate suffering and improve quality of life or well-being.

Self: a psychologically and socially constructed narrative of individual identity.

Transcendence: the sense of temporarily fading of one's sense of self into the experience of unity with something larger.

Suffering: a negative emotional experience of a loss of sense of *self*.

Well-being: a condition of being unhindered, open to, and ready for everything.

Suffering

If you want to know the truth about the universe, about the meaning of life and about your own identity, the best place to start is by observing suffering and exploring what it is. The answer isn't a story.

Yuval Noah Harari – *21 Lessons for the 21st Century*

At the age of eighty-seven, Marilyn Yalom was diagnosed with multiple myeloma from which she would go on to die within a short period of months. "*Even if I am not afraid of death itself,"* she reflected in the book she penned alongside her husband of sixty-five years, *"there is no cure for the simple fact that we must leave each other"* (Yalom & Yalom, 2021; p125).

Referring to how our love for others shapes our sense of self, Marilyn had poignantly written some years prior, *"If you cease to care for the person you love, you will give up a vital piece of your identity"* (Yalom, 2012; p.273). Love and loss are deeply embedded in the human condition and her death, she understood, would not simply be hers alone.

There may be few who have worked with and written so extensively about the existential fear of death as Marilyn's husband, the psychiatrist, Dr Irvin Yalom. His dynamic approach of *Existential Psychotherapy* focuses on the inescapable parts of a human being's existence in the world – namely death, groundlessness, isolation and lack of meaning – the premise being that our awareness of the senseless void of loneliness within these existential givens leads to an experience of anxiety and the psychopathology that comes from trying to defend against it (Yalom, 1980).

In a similar vein, the cultural anthropologist, Ernest Becker (1974), believed that our deep-seated fear of death and subsequent denial of our mortality is one of the primary motivators of human behaviour. His posthumously published book, *The Denial of Death,* sets out the theory that we build our character and culture around shielding ourselves from the underlying helplessness that comes from the terror of our inevitable death (Keen, 1974). Becker's ideas went on to inspire experimental social psychologists, Sheldon Solomon, Jeff Greenberg and Tom Pyszczynski (2015), to formulate their Terror Management Theory (TMT) which states that bolstering our self-esteem in the pursuit of maintaining an illusion of immortality through systems of cultural beliefs, such as religion, class or

capitalism, helps us transcend the fleetingness of our existence by imbuing our reality with a sense of order, meaning and permanence.

Of course, the moment we come face to face with the reality that our life will soon be coming to an end often hits us like an *"existential slap"* (Coyle, 2004), when all sense of order, meaning and permanence dissolve and the terror we had so carefully guarded ourselves against comes rushing towards us. No wonder we succumb to depression, despair and distress when our motivation has always been to keep on living. Yet following Becker's (1974) observation "*to be free of the anxiety of death and annihilation…we must shrink from being fully alive*," Dr Yalom (1980) suggests we must move in the opposite direction: *"though the physicality of death destroys us,"* he writes, *"the* idea *of death saves us"* (p.40).

The notion that we can attend to the anxiety and terror that comes from death by contemplating on its inevitability might appear somewhat paradoxical. One can imagine that thinking about your death might do more harm than good. Yet in order to lead a more fulfilling life, Dr Yalom advises bringing such ideas into our conscious awareness so that we can develop more choice around how we respond and, in turn, experience life more fully: *"I feel strongly…that confronting death allows us, not to open some noisome Pandora's box, but to re-enter life in a richer, more compassionate manner"* (Yalom, 2008; p.9).

How does confronting death allow us to re-enter life in a richer, more compassionate manner? The answer lies in suffering.

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The physician and bioethicist, Dr Eric Cassell (2004), wrote that *"the test of a system of medicine should be its adequacy in the face of suffering"* (p.iv). Yet despite palliative care's approach of preventing or alleviating suffering to improve the quality of life of those facing a life-limiting or life-threatening illness (WHO, 2002), the suffering that arises from our existential concerns remains problematic.

While some have previously called for the profession to move beyond a specialty of 'symptomology' to one that more fully explores the deep personhood of human nature (Kearney, 1992), others have suggested that *"suffering from losses, lack of love, existential doubts…are not medical issues, and the response to them is not necessarily the responsibility of any healthcare discipline"* (Ahmedzai, 1997). Yet love and loss undoubtedly do impact upon 'medical issues', as Dame Cecily Saunder's (1964) observed in her syndrome of *total pain – "the suffering of a whole person who is part of a network of relationships that will soon be left behind"* (Krawczyk, et al, 2018; p.3). Furthermore, confusion around an exact definition has impeded access to effective interventions (Boston, et al, 2011), and many within palliative care still see existential suffering as being a problem that evades medicalised

approaches and a common experience that is insufficiently treated within our current therapeutic frameworks (Niles, et al, 2021).

Perhaps it is helpful to think of existential suffering as a syndrome – one of distress, grief or helplessness due to the persistence and finality of a life-threatening illness that can manifest in a variety of debilitating symptoms, namely anxiety, depression, demoralisation or the desire for a hastened death (Dee, 2021; Kissane, 2012; Vehling & Kissane, 2018). Such symptoms have recently been shown to exist in over one-third of those receiving palliative care, contributing to a rise in hospitalisations, carer burnout and poor quality of life (Kissane et al, 2022) and prompting calls to improve our understanding and approach to existential suffering (Philipp et al, 2021; Yeh & Chernicoff, 2023), both for the benefit of those within our care as well as our own profession (Dauchy 2023; Maffoni, 2019).

Yet maybe all suffering is existential. Dr Cassell (1982) offered his own definition of suffering as "*a state of severe distress associated with events that threaten the intactness of the person"* (p.640), where the person is an interconnected relationship between all aspects of the body, mind, and socio-cultural identities. While some might argue about certain nuances within Dr Cassell's statement, most would agree that suffering has two fundamental components – *a negative emotional experience* that stems from *a loss of sense of self* (Tate & Pearlman, 2019). It is not hard to imagine how losing one's sense of self feels like dying, with the sense of groundlessness, isolation and meaninglessness that comes with it.

Those within palliative care have been addressing existential suffering through a number of approaches that primarily help people make sense of their lives and create a more meaningful response in the context their mortality; *Existential Psychotherapy* (Yalom, 1980), *Logotherapy* (Frankl, 1988), *Dignity Therapy* (Chochinov,2016) and *Meaning-Centered Psychotherapy* (Breitbart, 2018). More recently, *Managing Cancer and Living Meaningfully*, or CALM, has emerged as *"an evidence-based intervention…to help patients and their caregivers effectively manage the challenges, tasks and crises triggered by advanced disease and to live their lives as meaningfully as possible"* (Rodin & Hales, 2021; p.2).

Designed as a form of brief psychotherapy, CALM builds upon three psychological pillars – self-esteem, attachment security, and the sense of meaning in life – to address the challenges and opportunities that arise from living with advanced cancer. Having spent some time with Dr Gary Rodin and his team at the Global Institute of Pscyhosocial, Palliative and End-of-Life Care at the Princess Margaret Cancer Centre, Toronto, I saw how valuable and effective such a structured and well-embedded approach is in reducing symptoms of depression and death-related distress (Rodin, et al, 2018).

The aim, Dr Rodin explained to me, is to support what he terms *double awareness,* the ability to simultaneously engage in life alongside planning for the limitations that come as we approach its end (Rodin & Zimmerman, 2008). Key to this is the process of mentalisation – the capacity to symbolise meaning, take multiple perspectives, and connect feelings, thoughts and beliefs to

behaviours – all of which serve to expand our view of the possibilities for living while facing the prospect of dying (Rodin & Hales, 2021).

I had wondered about the need for such an approach with my own mother twenty years prior who, at the age of fifty-eight was unexpectedly diagnosed with advanced metastatic cancer. Not veering from the graceful determination with which she had lived her whole life, she refused to consider the prospect that she might die from this, despite the onslaught of physical complications that bombarded her. Then just two months after starting treatment, being told it had made no difference whatsoever, she changed her mind and asked to go to the park.

My mother had always loved trees and, being autumn, she wanted to sit beneath their falling leaves one last time. That morning, she hauled herself out of the bed and dressed herself, something she hadn't done in weeks. She sat waiting for us as we arrived into her hospital room. The day prior, she had barely kept her eyes open for more than ten minutes, but that day, I don't think she blinked for nearly two hours as she took everything in – the copper tones rustling in the gentle breeze, the hazy glow of warm sun on her face, the delight of children kicking their way down leaf-strewn paths. Maybe she even caught a glimpse of the tears I tried to hide.

That evening, I watched my mother fall into a peaceful sleep and kissed her goodnight. She died the following day.

Of course, I can't be sure, but that afternoon in the park it seemed my mother had found a way to make sense of dying that I can't imagine she would have been able to do through talking alone. I wonder if she instinctively knew she needed to feel her loss in such a way that would not overwhelm her, then somehow found the means to do it, surrounded by those she loved and loved her back. What my mother showed me that day forms the basis, all these years later, of the approach contained within these pages in attending to the suffering of those who fear death.

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I started my fellowship another sunny, autumnal morning outside a Toronto coffee shop waiting for a certain Associate Professor of Psychology to arrive on his bicycle. Dr Norman Farb studies the neuroscience of identity and human emotion. In his doctoral thesis, *To Which of Thine Selves Be True?*, he demonstrated how our well-being can be improved by changing the way in which the brain evaluates our experience and shapes our emotional reactions (Farb, 2011). Importantly, Dr Farb's work tells us we're not who we think we are.

The historian and philosopher, Yuval Noel Harari (2019), writes that humans are story-telling animals: *"When we look for the meaning of life, we want a story that will explain what reality is all about"* (p.313). Stories are how humans make sense of things; how we organize, account for and attach meaning to the seemingly vast disarray of our experiences and the roles we inhabit to create

a sense of a cohesive whole. According to the developmental psychologist, Daniel Stern (1990), *"the human mind needs to select meaningful details out of this disarray and pull them together into the most coherent, comprehensive, consistent, commonsensical, and simple organisation possible"* (p.133). Stories do just this.

Neuroscientists have discovered an area of our brain, known as the Default Mode Network (DMN), where we pull together the stories of who we are. The DMN habituates our patterns of thought, emotion and behaviour by making comparative appraisals with our autobiographical account of ourselves in the world (Davey, et al, 2016; Raichle, et al, 2001). Some even suggest it forms the basis of our what we might call our *ego* (Carhart-Harris & Friston, 2011). Essentially, the DMN forms the basis of who we *think* we are and makes sure that how we behave follows the cohesive narrative our lives, going to great lengths to defend the consistency of its stories, even if this means repeating painful patterns of the past and closing ourselves off from exploring new meaning (Sprevak & Smith, 2023; Swann & Behrmester, 2012).

Interested in exploring how the DMN impacts on our susceptibility to depression, Dr Farb devised an experiment in which participants were asked to think about themselves in response to certain words they were shown – for example, *honest, cowardly, loyal* – while their brains were being scanned in a fMRI (Farb, et al, 2007). Sure enough, the DMN lit up, demonstrating it was working hard to compare these descriptions with the way participants thought of themselves.

Next, participants were shown the words again but this time, rather than judging themselves against these descriptions, they were asked to directly sense how they felt in their body – perhaps some fuzziness in the chest, tension in the stomach, or tingling in the face. Looking at the fMRI images, activity in the DMN was reduced, meaning it wasn't working as hard as when they had to think about themselves. Yet, more importantly, a completely different part of their brain was had been activated, one that senses our internal experience and, when Dr Farb looked at how this correlated with any depressive symptoms, he found that people who are better able to sense directly into the experience of their body, without making comparative judgments about what this means, are less prone to episodes of depression.

At first, this seemed paradoxical – doesn't suffering come from experiencing an overwhelming amount of negative feelings? Why would being better at *feeling* make someone less likely to suffer from depression? To answer this, Dr Farb conducted another experiment where participants were shown a series of sad film clips during which, again, the DMN was particularly active. But when participants were asked to sense into their experience rather than think about it, the area of the brain responsible for sensation simply shut down during the sad clips. The more anxious or depressed people reported themselves to be, the more the brain suppressed their ability to sense into their experience (Farb, et al, 2010).

Of course, when we're in the midst of difficult life experiences, it makes sense to try to avoid unpleasant feelings or sensations in the moment but, as Dr Farb says, this comes at a price further down the line: *"By getting rid of the dynamic mixture of momentary sensations, only the certainty of one's sadness remains, unruffled by other feelings"* (Farb & Segal, 2024). The more our brains shut

down our ability to feel sensation, the more likely we are to develop depression in the future (Farb, et al, 2022).

The problem here, Dr Farb explained, is that the brain prioritises thought over sensation. Each of us has our own internal model of our reality, let's call it our *sense of self*, through which we interpret what is happening around us and predict what will come next (Pezzulo, et al, 2022). If our sensations don't match our expectations, our brain tells us to take action but, for whatever reason, if our actions fail to change our experience, we suffer – we have a negative emotional experience of losing our *sense of self,* with all the groundlessness, isolation and meaninglessness that Dr Yalom tells us comes with it. Yet, as another existential psychiatrist, Dr Viktor Frankl (1988), discovered, "*When we are no longer able to change a situation – just think of an incurable disease such as an inoperable cancer – we are challenged to change ourselves"* (p.116).

This is what Dr Farb suggests we do, that we change the habit of deferring to the expectations of our *sense of self* and instead find ways to expand ourselves in the sensation of the present moment; that we get out of our stories and into our body. Throughout his studies, what Dr Farb has been demonstrating is how the practice of mindfulness helps us do just this, exploring our senses to find alternative ways to having to change a situation and justify our expectations. *"The art of questioning, of negotiating with our representation of the world",* he says, *"lies at the heart of contemplative practices"* (Farb & Segal, 2024; p.87). For many, these are simply practices in the art of dying.

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With a deep sense of stillness, I opened my eyes, gradually gathering myself and coming back to my senses. It felt like a moment of rebirth. For the preceding thirty minutes, I had been guided through a meditative journey into my own dying process – a Tibetan Buddhist practice known as the *dissolution of the elements after death*.

At times brutal in its honesty and vividness, the practice takes the meditator through the dissolving of those aspects of their subjective experience that constitute our *sense of self*: the five *skandhas* of form, feeling, perception and mental formations and consciousness. Visualising their dissolution in elemental form – earth, water, fire and wind, space – is one of the initial meditations learned by monks in their preparations for dying.

Getting up from the meditation mat, I made my way out of the *zendo*, the temple at the heart of Upaya Zen Center, and into the crisp morning air. It felt like I was experiencing life for the very first time – the intricacies within a leaf illuminated in the sunlight, the gentle caress of the wind on my face, the rapturous birdsong filling my ears. I, like everyone else, was enthralled by these seemingly new-found sensations that, in those moments, felt like cherished gifts that deserved our utmost gratitude and care.

I remember thinking during the practice that my death seemed so very real. Now, life seemed so present – an aliveness in the body, an awakening of the senses, a clarity and curiosity to a vast wonder not present before. I sensed a renewed love for life and although death still felt real, in that moment, there was no way I could possibly fear it.

Contemplative practices originated from our need to address the role of the *self* in human suffering and our relationship with death (Chödrön, 2022; Davidson & Dahl, 2016). While such practices are common throughout many religious and Indigenous traditions, mindfulness was introduced into the field of Western medicine by the physician, Dr Jon Kabat-Zinn (1982), who took inspiration from Buddhist teachings. Conceptualised as *the awareness that emerges through paying attention to the unfolding of present moment experience without judgment or evaluation* (Kabat-Zinn, 2003), mindfulness has been shown to alter the way the brain functions, leading to improvements in many physical and mental health conditions, including depression, pain and immune function (Teasdale, et al, 2000; Davidson, et al, 2003; Zhang, et al, 2021).

Buddhism has its own existential givens, or *Marks of Existence*, that characterise each of our lives – *impermanence*, *suffering* and *non-self* – that is, everything that exists is impermanent, including our sense of self, and any attempt to view life otherwise will result in suffering. "*Suffering is seen as the result of particular configurations, or patterns of mental processes that interact in ways that keep the whole configuration going…The maintenance of such configurations depends on the re-creation of a particular set of conditions, from one moment to the next, over and over again"* (Teasdale & Chaskalson, 2011; p.104). According to Buddhism, the origins of suffering lie in wanting things to be different.

The aim of mindfulness, then, is to relieve suffering by changing the conditions that give rise to the patterns that keep us wanting things to be different – if we can learn to relate more skilfully to any unpleasant experience then we can learn to avoid suffering by changing what the mind is processing, how the mind is doing so, and changing our view of what is being processed (Teasdale & Chaskalson, 2011). This means letting go of our tendency to identify with what our experience tells us to be true and understanding our broader relationship with the vastness of reality – processes known as de-reification and de-centering (Dahl, et al, 2015; Dunne, et al, 2019). Mindfulness changes both the nature and quality of our experience so that losing our sense of self doesn't have to be the negative emotional experience we fear it is.

Yet let's not get ahead of ourselves. The aim of this report is not to make everyone expert practitioners in mindfulness, as much as I would encourage it, but rather to show how such contemplative practices point to the set of conditions that allow us to confront death and re-enter life in a richer, more compassionate manner; how, rather than being overwhelmed by our suffering, we can learn to transcend it.

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Healing

We can experience union with something larger than ourselves and in that union find our greatest peace.

William James – *The Varieties of Religious Experience*

"I sensed a light radiating from Rolf's face. It pulsated in concentric circles, spreading outward, touching us as we leaned in with slightly bowed heads. The chatter in my mind, clasping words about the stages of colon cancer, new treatments, lymph nodes, and survival rates, faded. I could sense a force around his body pulling him away. And questions in my mind. What is Rolf thinking? What is he feeling? What does it mean for him to die? A voice in my mind said: I feel awe" (Keltner, 2023; p. xxii-xxiii).

Dacher Keltner has spent his career researching and teaching others about finding the good life, recognising that emotions such as compassion, gratitude and love lead to a life enlivened by meaning. Yet, he came to recognise that behind all of these was an emotion that has the power to unite us, even in death. FIND AWE, he says (Keltner, 2023).

I met Dr Keltner at his downtown Berkeley office, surprised at his enthusiastic response to my request to meet, but he graciously reassured me that he had a lot of time for people working in palliative care, particularly after the death of his brother, Rolf, from colon cancer. I was curious, having written so eloquently about his own journey of coming to terms with his grief, how could finding awe be so healing?

It turns out that Dr Keltner's work provides the scientific underpinning to what prominent physicians within palliative care have always believed. When Cecily Saunders, Elizabeth Kubler-Ross and Eric Cassell were asked what healing was, their responses contributed to its definition as *the personal experience of the transcendence of suffering* (Egnew, 2005). To heal, they said, is not to fix or solve our suffering, but to transcend it; to go beyond the negative emotions of losing one's sense of self. Awe just happens to be the emotion of transcendence.

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At the age of sixty, the humanistic psychologist, Abraham Maslow, suffered a near-fatal heart attack. Having spent much of his life exploring the subject of human motivation and the farther reaches of human nature (Maslow, 1971), Maslow discovered that the highest purpose in life might simply be a reconciliation with death (Maslow, 1979). In a letter to a friend, he wrote: *"The confrontation with death – and the reprieve from it – makes everything so precious, so sacred, so beautiful, that I feel more strongly than ever the impulse to love it, to embrace it, and to let myself be overwhelmed by it"* (May, 1969; p.99).

Maslow speculated that if it were possible to give others a similar experience of death's reprieve, not only might they learn not to fear it, they might actually flourish (Cleary & Shapiro, 1995). *"If you can transcend the fear of death,"* he said, not long before his fatal second heart attack, *"your life today, at this moment, would change. And the rest of your life would change. Every moment would change. I think we can teach this transcending of the ego"* (International Study Project, 1972).

Maslow's earlier work had been to develop a 'hierarchy of human needs' whereby the goal was to move towards a state of self-actualisation with the desire *"to become everything that one is capable of becoming"* (Maslow, 1954, p.46). At any given moment, Maslow suggested, we have the choice to move towards growth or remain in a state of fearful defensiveness. Yet, perhaps as a means by which to come to terms with the impending likelihood of another heart attack, Maslow became interested in what he had once described as *"going beyond and above selfhood"* (Maslow, 1961; p.105). He began to see that the desire to transcend one's self was as much an aspect of human nature as our more basic needs, the denial of which might be just as harmful to our survival.

Defined as a transient mental state marked by both a decrease in one's sense of self and an increase in feelings of connectedness, a self-transcendent experience is one in which *"the subjective sense of one's self as an isolated entity can temporarily fade into the experience of unity with other people or one's surroundings"* (Yaden, et al, 2017; p.143). Self-transcendent experiences show us that losing one's sense of self does not necessarily lead to negative emotions. A diminished sense of self can, in fact, be meaningful and contribute towards our growth. As psychologist, Jonathan Haidt (2006) points out, *"Anything that shrinks the self creates an opportunity for spiritual experience"* (p.200).

So what makes the difference between a negative experience of losing one's sense of self that results in suffering and a more meaningful one that creates an opportunity for healing?

There are two distinct, yet synchronous, components of self-transcendent experiences, *"as when a raindrop falls into the ocean it simultaneously ceases to be a single drop when it becomes part of the ocean"* (Yaden, et al, 2017; p.150). The first, *annihilation,* occurs when there is a dissolution of a bodily sense of self and its boundaries. On its own, this can create a sense of depersonalisation which has been associated with certain states of psychopathology. So for a self-transcendent experience to be considered a meaningful one, it also requires there to be a second, *relational* component, where there is a sense of connectedness or oneness with something larger than the self.

As I discovered in the Tibetan Buddhist practice of the *dissolution of the elements after death*, this can be achieved through certain meditation states. But there is also another way to experience, as Maslow put it, this transcending of the ego.

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"I was alone in a timeless world with no boundaries…Life reduced itself over and over again to the least common denominator. I cannot remember the logic of the experience, but I become poignantly aware that the core of life is love. At this moment I felt that I was reaching out to the world – to all people – but especially to those closest to me. I wept long for the wasted years, the search for identity in false places, the neglected opportunities, the emotional energy lost in basically meaningless pursuits.

"As I began to emerge, I was taken to a fresh windswept world…All noticed a change in me. I was radiant, and I seemed at peace, they said. I felt that way too. What has changed for me? I am living now, and being. I can take it as it comes. Some of the physical symptoms are gone. The excessive fatigue, some of the pains. I still get irritated occasionally and yell. I am still me, but more at peace. My family sense this and we are closer. All who know me well say this has been a good experience" (quoted in Grof & Halifax, 1978; p.23-24).

Gloria was in her early forties with incurable metastatic breast cancer which had given rise to deeply debilitating symptoms of depression and anxiety. Prior to this, she had happened to be working within the research team at Spring Grove State Hospital in Baltimore, Maryland, investigating the effects of the psychedelic, lysergic acid diethylmide (LSD), in those with alcohol addiction. It was 1965.

A psychologist within the team, Sidney Wolf, suggested Gloria might benefit from LSD-assisted psychotherapy, given the relief he had observed in the psychiatric patients he had treated. With permission from her physician and family, Gloria agreed, and went on to have an experience that changed her relationship with, not only her cancer, but also with herself and those she loved before she died peacefully five weeks later. Wolf (1965) went on to write about the role of LSD in the anguish associated with death, suggesting that it *"may one day provide a technique for altering the experience of dying"* (p.69).

Nine years later, under the guidance of psychiatrist, Dr Stanislav Grof, and medical anthropologist, Joan Halifax, Spring Grove had already enrolled more than one hundred persons dying of cancer in their psychedelic-assisted therapy programme, which they describe in their book, *The Human Encounter With Death* (Grof & Halifax, 1978).

Dr Grof's work with LSD first began in his home country of Czechoslovakia where he observed an improvement in the psychiatric symptoms of those within his studies. Many of the participants

stated they had experienced a kind of death and rebirth, followed by feelings of something they described as cosmic unity. Dr Grof, however, also noticed something else: *"Many individuals… independently reported that their attitudes towards dying and their concepts of death underwent dramatic changes. Fear of their own physiological demise diminished, they became open to the possibility of conscious activity after clinical death, and tended to view the process of dying as an adventure in consciousness rather than the ultimate biological disaster"* (Grof & Halifax, 1979; p.20).

It was this that later motivated Dr Grof to explore the possibilities of LSD as a treatment of physical and emotional suffering in those dying of cancer and other chronic diseases at Spring Grove. Both he and Joan Halifax saw the experiences of those taking LSD as a rite of passage that could help prepare for actual physical death by serving to realize the impermanence of our bodily existence while providing insight into the transcendent nature of consciousness. Results predominantly showed an improvement in physical and emotional symptoms, though perhaps not with the scientific rigor of today's standards (Yensen & Dryer, 1992).

Yet the program suddenly ended in 1976 given the political backlash from the US government's *War On Drugs,* effectively putting a halt to all research into the therapeutic use of psychedelics globally (Hall, 2022). Described as the world's foremost researcher in psychedelics who *"has therefore seen a vaster panoply of human experience than anyone in history"* (Walsh & Grob, 2005; p.119), Dr Grof later lamented: *"In removing [psychedelics] from the hands of professionals, the government has taken away the most promising research tools and the most powerful therapeutic approach that psychiatry has ever had"* (p.142).

Now, thanks to the patience and persistence of those who followed in the footsteps of Sidney Wolf, Stanislav Grof, Joan Halifax and many others, there has been a psychedelic renaissance (Sessa, 2012) and it is once again possible, with the scientific rigor modern medicine now demands, to investigate the promising and powerful insights that psychedelics have to offer those who face the existential suffering of fearing death through the healing nature of self-transcendent experiences.

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Dr Charles Grob might be one of the most patient people I have met. Having dropped out of college in his junior year, while figuring out what to do with his life, he ended up working in Stanley Krippner's Dream Research Laboratory in Brooklyn, New York. While there, he discovered Dr Krippner's vast library of literature on psychedelics which he began to read his way through during the overnight sleep studies. As he became fascinated by the potential of psychedelics to understand the brain and help people with mental illness for whom conventional treatments were not sufficient, Dr Grob realised this was what he wanted to do with his life. So, having promised his father that he would tell him once he had come to a decision, he phoned him…at 3am. Himself a prominent physician and researcher, his father, perhaps sleepily, told him that if he wanted to be taken

seriously then he needed to go back to college and "get his credentials." That was 1980 and any research into psychedelics had already been outlawed.

Dr Grob told me this over lunch in his favourite Chinese restaurant, just across from Harbor-UCLA Medical Center where he is now Professor of Psychiatry & Behavioural Sciences. The reason I wanted to meet him is that Dr Grob was the first to study the use of psychedelics for the treatment of anxiety in those with advanced stages of cancer in over thirty years and, despite the small number of subjects, his double-blind, placebo-controlled pilot study showed that, in this case, psilocybin was both safe to use and had the potential to lower anxiety levels (Grob, et al, 2011). Dr Grob's patience had paid off and the stage was set for psychedelics to once again be studied as *a technique for altering the experience of dying.*

"The possibility through self-transcendence, to not solely identify with the failing body, but to connect to something more enduring, is a profound gift and offers spiritually transformative and therapeutic potential," writes Dr Anthony Bossis (2021; p.15), Clinical Assistant Professor of Psychiatry and co-principal investigator in New York University's subsequent clinical trial of psilocybin-assisted therapy in advanced cancer (Ross, et al, 2016). Together with the study by Johns Hopkins University (Griffiths, et al, 2016), they showed the extent to which alleviating the symptoms of existential suffering may be possible (see also the Cochrane Review by Schipper, et al, 2024). Since then, others have begun to study the effects of psilocybin-assisted therapy in broader settings (Beaussant, 2025; Ross, et al, 2025) and, while these results have been more mixed, they point us towards a greater understanding of the role psychedelics can have within the care and healing of personhood and existential suffering (Beaussant, et al, 2021; Rosa, et al, 2022; Ross, et al, 2022; Schuldt, et al, 2025).

Elsewhere, as Dr Grob was obtaining the appropriate approvals for his pilot study in the United States of Amercia, Dr Rael Cahn had travelled to Switzerland to complete his doctoral thesis on the effects of psilocybin on brain waves. Now Clinical Assistant Professor of Psychiatry and Director of the University of Southern California's Center for Mindfulness Science where is researching the neurophysiology of transpersonal states of consciousness, Dr Cahn has devoted his career to the exploration of what meditation and psychedelics have to teach us about the self and healing.

Dr Cahn is somewhat of an expert in electroencephalography (EEG) and the changes in brain waves during the self-transcendent states and his studies clearly show that, with meditation and psilocybin, there is greater attentional focus on sensory information and reduced automated cognitive processing; that is, our brains are less prone to the habitual reactive thought patterns and ruminative processes of our DMN, and more able to focus on the sensory experience itself (Cahn, 2007; Cahn & Polich, 2008; Cahn, et al, 2013). As Dr Cahn says, our brains become clearer mirrors of our sensory surroundings.

Yet Dr Cahn has shown that something else happens to our brain waves during self-transcendent states – they begin to slow down so that the time taken from detecting a sensory stimulus to evoking a response increases, from around 100 to 300 milliseconds. Two hundred milliseconds might not seem a very long time but, for our brains, it may well be all the time we need to remain open to

the possibility that our experience might be different to what we think. This might be all the time it takes for us to change our mind, moving from a negative emotional experience of losing our sense of self to one that gives us meaning.

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Two decades ago, Drs Balfour Mount and Patricia Boston, conducted a series of interviews with people with an incurable illness to explore the causes of existential suffering and what that might allow them to transcend it. Their study, *Healing Connections* (Mount, et al, 2007), discovered two factors which allowed participants to move from a state of suffering to experiencing one of wellbeing despite their illness.

The first was what the authors termed a *response shift* – an ability to change one's internal state from one characterised by loss of control, victimisation, or crisis of meaning to one of openness and choice towards one's attitude and sense of meaning in the present moment. The second was *connectedness* to something beyond one's sense of self – be that a higher Self, others, the phenomenal/sensational world or ultimate meaning, however one might define these. In their concluding remarks, the authors note, *"It was not meaning, per se, that brought the person alive but the underlying experience of being part of something greater and more enduring than the self"* (Mount, et al, 2007; p.383). Meaning unfolds in the context of relationship, they said.

This brings us back to awe – the emotion we feel in the presence of something that transcends our current understanding of the world; a feeling of vastness and the need to make sense of it (Keltner, 2023; Keltner & Haidt, 2003). Most of us would be familiar to feeling awe in the presence of a beautiful sunset, a rousing piece of music, or the birth of a baby, but as Dr Keltner points out, awe may also be experienced in response to another's courage or compassion, a sudden epiphany, even in the process of dying: *"In experiences of awe…I learned that there is more to our existence than what ends with the last breath of the body"* (Keltner, 2023; p.236).

Awe reminds us that losing our sense of self doesn't have to be the negative emotional experience we fear it might be. Instead, awe quietens the conditioned habits of our DMN, interrupting our configurations of self-centred stories, ruminations and judgements that lead to mental states of suffering. It shifts our response from being closed to being open to the vast potential of possibilities that exist in the present moment by connecting us to something much larger than our individual sense of self where we can create a more meaningful story of our existence.

This, Dr Keltner told me, is the healing nature of awe. Awe allows us to transcend our small self-understanding of our place in the world and integrates us into the larger systems of life which he beautifully introduces us to as *entities of interconnected relationships held together by qualities that unite around a unifying purpose* (Keltner, 2023). Here, too, meaning unfolds in the context of relationship: *"awe has taught me that the evolution of our species built into our brains and bodies an*

emotion, our species-defining passion, that enables us to wonder together about the great questions of living" (Keltner, 2023; p.250).

One of our great questions of living is what it means to be human in the context of suffering and death. Contemplative and psychedelic practices, both of which induce the transcendency of awe, allow us to explore this question in more depth and ponder how they might connect us to a larger system in which those who are suffering can lead a richer, more compassionate life. If suffering is the negative emotional experience of losing one's sense of self, then awe is the meaningful emotional experience of that same loss, where such meaning unfolds in relationship to something beyond our sense of self.

Towards the end of his life, Maslow became more and more interested in what lay beyond the self, suggesting that at the heart of human motivation is the need for self-transcendence (Kaufman, 2021). Borrowing Maslow's terminology, then, when I began exploring the question of what it means to be human, a pattern emerged of three core needs that constitute our sense of self: *Being, Belonging and Becoming*. Perhaps these are the existential stories each of us needs to make sense of. Looking through the lenses of contemplative and psychedelic approaches, we will see that, given the right conditions, suffering itself can be a healing process.

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Being

A human being is a part of the whole, called by us "Universe," a part limited in time and space. He experiences himself, his thoughts and feelings as something separated from the rest – a kind of optical delusion of consciousness. This delusion is a kind of prison.

Albert Einstein – letter to a friend

At 4:40pm on 10th March 2021, in the foothills of the Indian Himalayas, an 86 year-old Tibetan monk took his last breath. Having dedicated his life to the Tantric tradition of Buddhism, the monk was renowned for his artistic skills and ritual performance that formed such an integral part of his meditative practice, often going into silent retreat for long periods, sometimes lasting years. As is customary in such circumstances following confirmation of death, the monk was left undisturbed, yet after seven days, he looked as serene has he had before he died, *"with the eased expression as if he had just laid down for a nap"* (Tidwell, 2024). The monk was in *Tukdam*.

Documented in detail in *The Tibetan Book of the Dead* (Evans-Wentz, 1957), *Tukdam* is a revered meditative state achieved at the time of death, in which the practitioner seeks ultimate realisation into the fundamental nature of the mind. It is characterised by a maintained suppleness and elasticity of the skin, a radiance of complexion and warmth, particularly around the heart, and often with the presence of a fragrant odour. Most notably, there is a suspension of the normal process of decomposition.

Tibetan Buddhists believe that, although the *coarse* mind and body have ceased to exist, there is still a very *subtle* mind that is maintained within a *subtle* body, an energy centred around the heart. Practitioners will have cultivated such skilful awareness of this subtle mind throughout their lifetime that it persists beyond what Western science calls death, until they finally release their meditation and everything dissolves into luminous emptiness. It is only then that the body starts to emit the putrid smell and accompanying signs of decomposition one would expect. For the monk described above, this took thirty-seven days.

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What is it like to be a human? This was essentially the question posed by philosopher, Thomas Nagel (1974) in his seminal paper on the nature of consciousness entitled, *What Is It Like To Be A Bat? "Most of the neobahaviourism of recent philosophical psychology results from the effort to substitute an objective concept of mind for the real thing,"* he contends (p.445). Again, we humans like to separate our ideas about reality from our experience of it.

For much of recent human history, the predominant paradigm for human consciousness has been dualism – that the mind and body are two distinct and separate entities. This was famously enshrined by the seventeenth-century philosopher, Rene Descartes, who said, "I think, therefore, I am," effectively placing the care of the body into the rationale hands of science and medicine while laying any concerns of the mind solely at the feet of philosophy and religion. This, they called, *The Enlightenment.* Yet contemplative traditions, such as Buddhism, have always maintained a non-dualistic view of the relationship between the mind and the body. For them, enlightenment is seeing reality as it really is, and science has started to take notice.

In 1992, neuroscientist Dr Richard Davidson was tasked by His Holiness The Dalai Lama to use the tools of modern neuroscience to study the nature of the mind for the cultivation of well-being and the relief of suffering. The Center for Health Minds at the University of Madison-Wisconsin was founded five years later and continues to expand the science of human flourishing as a public health concern (Davidson, 2019).

Previously aware of the Center's research around how contemplative practices impact the experience of pain (Wielgosz, et al, 2022), as well as their broader approaches to wellbeing (Dahl, et al, 2020), I was keen to explore how these might be applied within the context of palliative care. But then Dr Robin Goldman, the Center's Director of Research Support, thought I might also be interested in their investigations into *Tukdam*. She was right.

Now in its eighteenth year, *The Tukdam Study* is being led by Dr Tawni Tidwell, a biocultural anthropologist and Tibetan medicine doctor, and to date has recorded over fifty cases in which there is no recordable heart, lung or brain activity and yet normal decomposition is significantly delayed (Lott, et al, 2021; Tidwell, 2024). While both enthralled and baffled at how this might point to the relationship between consciousness and the body, a subject that has always intrigued me, this improbable phenomenon of *life suspended in death* also helps us understand how we might transcend the suffering that arises when facing the prospect of dying.

∞

It is difficult to imagine such profound changes happening in such a small room. Dr Rick Zeifman, Adjunct Assistant Professor, is showing me round New York University Langone's Center for Psychedelic Medicine and we have come to the therapy suite. Here, participants in the centre's clinical trials take a psychedelic drug, lie down for several hours with an eye mask on and listen to a

curated playlist of music through headphones. Two therapists are present throughout, providing reassurance and, if needed, some gentle encouragement to *go inwards*.

Having been carefully screened and prepared for what might happen, each participant is provided with support following the session to help integrate their insights that will, hopefully, improve whatever condition has brought them here which, so far, has included major depressive disorder, alcohol use disorder, and existential distress. It is what Stanislav Grof had referred to as psychiatry's most powerful therapeutic approach and it all takes place here in this small, rather unassuming room along a windowless corridor in downtown New York City.

So when twenty-nine people with a life-threatening cancer diagnosis came out of this room having *gone inwards* with the help of a psychedelic, what happened for most to rank it as one of the top five most meaningful experiences of their entire life? Furthermore, sixty to eighty percent of them became less anxious and depressed, even six months later, while eighty-seven percent reported increased life satisfaction and well-being attributed to their experience (Ross, et al, 2016). The authors conclude *"a potential psycho-spiritual mechanism of action: the mystical state of consciousness"* (p.1177).

The substance given to participants in this study was psilocybin, a naturally occurring, psychoactive chemical present in what most might know as *magic mushrooms*. Used ceremonially for centuries by Indigenous cultures as a way of healing through the altering of consciousness and union with the sacred, these mushrooms were once referred to as the *flesh of the gods* by the Aztecs due to their ability to induce mystical experiences. Now, in a vastly different setting, nearly seventy percent of people going into that windowless therapy room had a full mystical experience which positively correlated with the improvement in their anxiety and depression, a consistent finding across similar studies (Griffiths, et al, 2016; Ross, et al, 2016).

Having coined the term *mystical experience*, the nineteenth century philosopher and psychologist, William James, went on to write*: "Our normal waking consciousness, rational consciousness as we call it, is but one special type of consciousness, whilst all about it, parted from it by the filmiest of screens, there lie potential forms of consciousness entirely different. We may go through life without suspecting their existence; but apply the requisite stimulus, and at a touch they are there in all their completeness, definite types of mentality which probably somewhere have their field of application and adaptation"* (James, 1902).

Building on James' four defining features of such experiences, others have gone on to develop the *Mystical Experiences Questionnaire* to assess the quality and extent of such occurrences (Barrett, et al, 2015). Thirty questions explore four domains: *Mystical* (feelings of unity, ultimate reality, eternity, etc); *Positive Mood* (sensations of amazement, tranquillity, ecstasy, etc); *Transcendence* (a loss of sense of time and space); and *Ineffability* (the sensation that the experience cannot be adequately described in words).

I wonder if James had imagined that the *"probably somewhere"* in which these experiences of altered consciousness have their *"field of application and adaptation"* would include this small room

in downtown New York. Whether he did or not, such settings are increasingly becoming frontiers for the therapeutic use of psychedelics in a whole host of conditions and, while having a mystical experience itself was not shown to be of statistical significance in reducing the fear of death in this particular study group, what participants said was just as affirming of the existential benefit of James' prediction (Swift, et al, 2017).

"I was not here anymore; I was not in my body…I thought to myself that that is death, and it was scary, but I remember I said to myself, "Oh if this is death, it's not that bad – at least there is something."…It was exotic and unknown, mysterious, something I would not mind being in because I would love to explore that" (p.499).

"[The psilocybin] just opens you up and it connects you…it's not just people, it's animals, it's trees – everything is interwoven, and that's a big relief…I think it does help you accept death because you don't feel alone, you don't feel like you're going to, I don't know, go off into nothingness. That's the number one thing – you're just not alone" (p.499).

"In my abdomen, that's also where part of my cancer was…I kinda felt like that was my umbilical cord to the universe and that this was where my life would be drained from me some day, and I would surrender it willingly when my time came, and that was just so profound…it was just really comforting, you know, it kinda reaffirmed what I believe, that, you know, we're all kind of a greater whole and that you go back" (p.499-500).

They were, of course, experiencing a kind of death or dissolution of the ego through which one transcends the boundaries of self (Letheby & Gerrans, 2017), a consistent theme throughout Stanislav Grof's work with LSD, where the *"loss of boundaries between the subject and the objective world…is the main objective of psychedelic therapy"* (Grof, 1980; p.35). Yet beyond this annihilation of the self, Grof also intuited a relational component – a sense of perpetual unity with something larger: "*I can not say that I am absolutely sure,"* he would say later, *"but I feel it is pretty plausible that when my body dies, this will not mean the end of conscious activity; that my consciousness and existence will in some form continue beyond death"* (Walsh & Grob, 2005).

As with *Tukdam,* psychedelics present us with the challenge of making sense of the self-transcendent or mystical experiences they provide and the ways in which they change our relationship with death. Of course, this makes them both a promising research tool and powerful therapeutic approach for those experiencing existential suffering. In referring to psychedelics, Dr Keltner (2023) remarks, *"I don't think there is another experience that produces mystical awe with such reliability except, perhaps, watching the birth of a child, nearly dying, or dancing with the Dalai Lama"* (p.215).

∞

I am not sure if Yongey Mingyur Rinpoche has been at many births, or even danced with the Dalai Lama, but he has certainly nearly died. For obvious reasons, there are no first-hand accounts of what it is like to be in *Tukdam*, but Mingyur Rinpoche's (2019) near-death experience, which he describes in his book *In Love With the World,* is about as close as we might get.

Shortly before midnight on the 11th June 2011, Mingyur Rinpoche slipped out unnoticed from his Buddhist monastery in Kathmandu, Nepal. His plan: discard the trappings of his privileged lineage and position to embark on a three-year retreat, wandering like a Hindhu sadhu and living free from both worldly belongings and concerns. His purpose: to understand the true nature of self.

As the son of an esteemed meditation master, from a young age, Mingyur Rinpoche would have been well schooled in these teachings and practices of the *Satipatthana Sutta,* the foundations of mindfulness laid out by the Buddha as a path of liberation from suffering. Though extended retreats are common occurrences for an abbots like him, Mingyur Rinpoche wanted to experience life without the privileges he had been afforded and go beyond the sense of self that identified with these labels. So he followed his father's advice: *"Don't tell anyone where you are going, including our family members. Just go, and it will be good for you"* (p.xx).

Yet within a couple of weeks, Mingyur Rinpoche had fallen gravely ill from food poisoning, becoming so frail that he curled up in the dirt and resigned himself to dying. As a young monk, he had learned to regularly practice the *dissolution of elements* meditation and the teaching of the *bardos*, the intermediate states that exist between death and rebirth (Chödrön, 2002). Between the *bardo of dying* and the *bardo of becoming* is the *bardo of dharmata* – the true nature of phenomena, or being-ness. It was in such a state that Mingyur Rinpoche thought to himself, *"What happens when the body dissolves? Can I stay conscious enough to find out?"* (p.208).

"Suddenly…boom!...awareness and emptiness became one, indivisible, just as it always is…The entire universe opened up and became totally unified with consciousness. No conceptual mind. I was no longer within the universe. The universe was within me…I was no longer bonded to any sense of a distinct body or mind. No distinction existed between me, my mind, my skin, my body, and the entire rest of the world…As a drop of water placed in the ocean becomes indistinct, boundless, unrecognisable, and yet still exists, so my mind merged with space…No separate me loved the world. The world was love. My perfect home. Vast and intimate. Every particle was alive with love, fluid, flowing, without barriers…the bliss of love and tranquillity" (p.225-7).

Then, without any sense of reason or will, Mingyur Rinpoche slowly returned to his body and reoriented himself to where he lay in the dirt. After several hours regaining his senses, he attempted to stand but blacked out and collapsed. It was only then that someone found him and brought him to a hospital where he was able to recover and eventually resume his wandering retreat, *"free to live without fear of dying"* (p.240).

What did he learn about suffering? *"I finally discovered the only reliable liberation from suffering: not trying to get rid of the problem*" (p.92).

∞

What is it like to be a human – an entity of interconnected relationships we call body and mind trying to make sense of our existence? This is the view of the poet and philosopher, David Whyte (2024):

"Body might be a word that represents something more miraculous than even the mind that can contemplate the body's miraculousness. Perhaps the central and unchanging difficulty for human beings in remaining healthy, physically and psychologically, is that the mind cannot fully contemplate, appreciate or understand the body's thousands of interlocking inter-dependent connected systems, and the way those hidden systems connect with the world: the way the body's never ceasing beating, pumping, circulating, breathing in and out busyness, all combined with its inner restful autonomic guidance, needs no act of will or effort or management on our part to keep it going. The mind unanchored in the body is always trying to be something or somebody, the mind is always attempting to control the body: the body exists in its own form of freedom, always under the gravitational influence of something far beyond the mind's understanding" (p.37).

The mind unanchored in the body is always trying to be something or someone. We favour thinking over feeling. Yet what happens when we embody our present moment awareness and let go of thinking things should be different from the way they are? This is what contemplative practices and psychedelics allow us to do.

When describing his own mystical experiences with psychedelics, the writer and philosopher, Aldous Huxley (1954), famously quoted William Blake's poem, *The Marriage of Heaven and Hell*, in which Blake concludes: *"If the doors of perception were cleansed every thing would appear to man as it is, Infinite. For man has closed himself up, till he sees all things thro' narrow chinks of his cavern."* This is, of course, what our DMN does, *"interpreting situations and experiences in a way that bolsters a sense of self, ultimately seeking to acquire things deemed pleasurable for the self and to avoid things distressing to the self"* (Condon, et al, 2019; p.104).

Contemplative practices, such as mindfulness, developed as a way of alleviating our suffering by deconstructing the delusion that we have an enduring, autonomous sense of self, but instead of trying to get rid of it altogether, mindfulness brings a greater awareness of the larger reality in which we exist so *"one can retain the recognition that the self is…ultimately a story"* (Condon, et al, 2019; p.104). Through processes of *decentering* – being able to disidentify with thoughts by observing them objectively – and *dereification* – experiencing thoughts as mental events rather than reality itself – we can expand our sense of self beyond the delusion of our stories and into the awareness of our bodies (Dahl, et al, 2015; Dunne, et al, 2019). It's not that there is no self, just not one that exists in isolation.

The mystical experiences induced by meditative states and psychedelics reveal that when we lose our sense of self in connection to this larger reality, our awareness extends beyond the normal

limitations of our understanding (Millière et al, 2018; Nour & Carhart-Harris, 2017). Perhaps this is the mystery that makes death so full of awe. As with *Tukdam*, there is a miraculousness about how awareness resides in our bodies, even when the beating, pumping, circulating, breathing in and out stops.

Yet, dying can also be painful, not just physically, but mentally, socially, spiritually, all of which we feel in our bodies. The pain of loss is not just in the mind, it seeps into our bones, gets under our skin, wraps around our chest. Understandably, these are feelings we spend our lives trying to avoid. So why feel them now? It is my experience that avoiding such feelings only heightens our suffering by keeping us from making sense of them. As Dr Farb's work shows us, when we try to get rid of our feelings, only the certainty of our suffering remains.

So how do we allow ourselves to feel what we need to feel in order to find meaning in our experience of it? How do we transcend our suffering? The first step is coming into an awareness of the reality of the present moment by cleansing the doors of our perception. By getting out of our stories and into our bodies, we begin to see the patterns and configurations of our fear, not as something we must defend against but something we can be with.

Yet awareness on its own is not enough to allow us to feel what we fear to feel but, here too, the body has another miraculous ability – we call it compassion.

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Belonging

Ultimately, the reason why love and compassion bring the greatest happiness is simply that our nature cherishes them above all else…However capable and skilful an individual may be, left alone, he or she will not survive.

His Holiness, The Dalai Lama – *Compassion & the Individual*

The bell rang. I entered the room, bowed and knelt before the teacher. This was *dokusan,* a Zen tradition whereby the student gets to ask a question or explore their practice in more depth. It lasts five minutes and I wondered what I could possibly learn about contemplative care in such a short period of time. I had prepared my questions but arrived at the retreat in the midst of my own loss, the effects of which I felt welling up within me as the days went by. In an unexpected deviation from my script, I opened the *dokusan* with the words, "Hi, my name is Dave and emotion is not far from the surface."

The Zen teacher looked at me in a way that reminded me of a loving, wise grandmother, with his expression so full of compassion and curiosity; his eyes, to borrow the words of St John of Kronstadt, *burning brighter than the sun.*

"What would it be like not to have to hold on to that?" he asked. So I didn't.

I knelt there sobbing, tears rolling down my face, looking every which way – out the window, up at the ceiling, down at my hands. The Zen teacher, still with his grandmotherly gaze, then asked, "Why are you looking away?" as if offering the invitation, *I'm here, look at me.* So I did.

We stared unblinkingly into each other's eyes and slowly something began to change within me. The emotion started to dissipate, my breathing began to slow, my shoulders relaxed, my sobbing eased. "Who's holding this space for you?" he asked.

"Not many, not here," I replied, his gaze continuing to draw me into his presence where we both just sat in silence.

The bell rang again. I got up, bowed and left the room knowing that something had deeply changed. I was a different person to the one who had entered just a few minutes before. No explanation on my part of what was behind the upwelling of emotion. No attempt from the Zen teacher to understand or analyse it. No advice given. Just compassionate curiosity and the unwavering gaze of his loving presence. I realised that in this moment I had learned just what contemplative care is.

The New York Zen Center for Contemplative Care was founded in 2007 by Koshin Paley Ellison and Chodo Robert Campbell as a means to transform the culture of care through contemplative practice, meeting illness, aging and death with wisdom and compassion. They define contemplative care as a relationship-centred approach that draws on the contemplative practice of the caregiver as the primary source of loving action (Koshin & Weingast, 2016). To get a glimpse into how this might look in practice, I had attended their annual retreat at the Garrison Institute in upstate New York, where the theme was *Turning Fear Into Courageous Compassion.*

In his book, *Untangled*, Koshin (2022) writes*, "The suffering we feel is rooted in how tangled up we are. Many of us feel tangled by our fears, our resentments, and our stories about ourselves and others. We feel controlled by behaviours we can't change, thoughts we can't stop, feelings we don't want to feel. We feel tangled in confusion, or in misperception, or in traumas we haven't learned to heal"* (p.2). Contemplative care invites us to untangle our suffering by bringing awareness to our fears, resentments and stories, then offers us something else to which we can belong.

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When Dr Stephen Ross published the results of his clinical trial into the effects of psychedelic-assisted therapy on the psychiatric symptoms of existential distress (Ross, et al, 2016), the news generated a lot of excitement. *"A dose of a hallucinogen from a 'magic mushroom,' and then lasting peace,"* wrote one reporter in the New York Times (Hoffman, 2016).

Yet despite subsequent headlines that *"The Psychedelic Revolution is Coming*" (Jacobs, 2021), when I sat down with Dr Ross to discuss the future of psychedelic-assisted therapy within palliative care, he admitted there are still a lot of questions to be answered. One of which, importantly, is knowing just what is responsible for the reported changes in symptoms: is it the drug (Carhart-Harris & Nutt, 2017), the therapeutic context (Carhart-Harris, et al, 2018), expectation bias (Szigeti & Heifets, 2024), or a combination of all of these?

Psilocybin, or rather its active metabolite, psilocin, is a serotonergic agonist that acts on 5-hydroxytryptamine type 2A (5-HT2a) receptors in the brain, resulting in the disinhibition of control mechanisms within the pre-frontal cortex (including the DMN) and the subsequent hyperactivity of other sensory parts of the brain (van Elk & Yaden, 2022). What unfolds is an increased connectivity of different brain regions that lead to changes in sensory perception, altered emotional states, and

increased psychological flexibility. Essentially, we become more open to our experience as it is, without the judgmental influence of our normal conditioned patterns of thought.

When participants in Dr Ross's study were asked what effect their experience with psilocybin had on how they viewed their cancer diagnosis, one put it this way: *"One of the really vivid images that I had was a sketch of a dinner table—it was almost this round circle that represented a dinner table—and at the table was cancer, but it was supposed to be at the table. And the feeling I had was cancer is a part of everything. It isn't this bad separate thing; it's something that's part of everything, and that everything is part of everything. And that's really beautiful. It was just a sort of acceptance of the human experience"* (Swift, et al, 2017).

The way in which psilocybin, and psychedelics in general, have been proposed to effect change is through a model called *Relaxed Beliefs Under Psychedelics* (REBUS; Carhart-Harris & Friston, 2019). The suggestion is that the usual beliefs underpinning how our brains appraise what they think *should* be happening are suppressed, allowing us to become more aware of the fullness of our experience as it *actually* happens. This opens us up to the possibility of forming new beliefs about our experience, be that about our self, our past, our relationship to others, or our cancer.

Again, these changes were found to persist well after the study (Agin-Leibes, et al, 2020), supporting the idea that psychedelics increase the neuroplasticity of our brains and help us maintain new beliefs long after their effects are out of our system (Agnorelli, et al, 2025). In a model now termed *Revised Beliefs After Psychedelics* (REBAS), Dr Zeifman and his colleagues (2025a) have shown how this ongoing revision to our beliefs, particularly the negative ones we hold about ourselves, is linked to an improvement in our well-being.

What is it that allows us to relax and revise our beliefs? For some time, researchers have been focusing on the mystical experience as the catalyst for change (Griffiths, et al, 2006; Griffiths, et al, 2016), believing that the intensity of the mystical experience predicted the improvements seen (Romeo, et al, 2025), but Dr Ross and Dr Zeifman are among those beginning to discover it might be something else (Carhart-Harris, et al, 2021).

"When examined alongside mystical experience or positive mood, self-compassion was consistently a significant predictor and mediator of mental health outcomes while mystical experience and positive mood were not. This suggests that while the dissolution of one's sense of self, a primary feature of the mystical experience, may be important, its importance may be dependent upon concurrent or subsequent experiences of altered attitudes or emotional expression towards one's self. In other words, it may not be the breakdown or collapse of one's self-model alone that matters, but the co-occurrence of self-compassion alongside this process or with the eventual reemergence of the sense of self" (Zeifman, et al, 2025b*;* p.17).

While recognising some of the study's limitations, Dr Ross and Dr Zeifman suggest that the presence of self-compassion helps shift deeply entrenched negative beliefs about oneself and direct the therapeutic process of meaning-making, allowing individuals to make sense of their suffering more fully. This seems to confirm what we already know about self-transcendent experiences, that it's not

so much the annihilation, dissolution or loss of our *sense of self* that matters, but more how we relate to it – whether we fear it or can learn to be with it compassionately. So whether it's the drug, the therapy or the presence of a therapist, what allows us to transcend our suffering is the quality of our relationship with it. Perhaps we shouldn't be surprised, since the origins of the word *compassion* literally translate as *being with suffering.*

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To better understand the transformative role of compassion, I went to spend time with Joan Halifax. Now in her eighties, Roshi Joan, as she is better known these days, has lived a rather remarkable life. Following her work at Spring Grove with Stanislav Grof, to whom she was briefly married, she became involved in the civil rights movement, protested against the Vietnam War, cared for those dying in the AIDS crisis, and continued her work as an anthropologist, at one point even driving a VW van alone across the Sahara desert to witness the Dogon people's seven-year rites of passage that happens only once every fifty-three years. Roshi Joan knows something of being with suffering.

Having taken refuge in Buddhism, Roshi Joan has continued to integrate anthropology and social activism into compassionate action. Her Upaya Zen Center sits beneath the beauty of Cerro Gordo Mountain just outside Sante Fe, New Mexico. Housed within the traditional adobe style buildings common to the area, it is a centre for practice, training and social action. It was there I got to join Roshi Joan on *Being With Dying*, an immersive training program for healthcare professionals around the psycho-social, ethical, existential and spiritual aspects of illness and dying, that she has continuously taught for the past thirty years (Halifax, 2008).

Roshi Joan has spent decades caring for those who are dying. From an early standpoint, she recognised the *"need to develop ways to teach care givers and dying people how to have a more realistic and open approach to the experience of dying"* (Halifax, 1995; p.16), translating her experience into a form that can be learned through contemplative practices and teachings.

Being With Dying serves three intentions: to develop a foundation of mindfulness that provides the stability of mind and emotions to support clinicians to engage more deeply in addressing the reality of living and dying; to support clinicians in developing the self-awareness needed to recognise their own difficulties and commit to addressing their own suffering; to directly cultivate compassion as an integral part of the provision of holistic end-of-life care (Rushton, et al, 2009). *"Compassion calls forth our best human capacities,"* writes Roshi Joan, *"in a way that no other response does"* (Halifax, 2018; p.206).

During our eight days together, I and around sixty other nurses, doctors, chaplains, and therapists took a deep dive into the neuroscience and practice of *enactive compassion* (Halifax 2012). As Roshi Joan teaches, compassion is an emergent process of embodied and participatory sense-making in response to suffering. She is very clear that compassion is not a feeling, nor is it a habitual, one-size-

fits-all approach to suffering. Instead, compassion is an unfolding response adaptive to the context of our experience; a relationship between our awareness of the present moment, our attitudes towards our experience, and our altruistic intention to act. While compassion is not something that can be learned directly, these three components can each be cultivated through mindfulness training (Shapiro, 2006).

Yet, Being With Dying is not simply an impartation of knowledge, it is also an exploration of our own fears around death and an opportunity to enact compassion in response. *"It has become clear to me that the issue of one's own death stands at the centre of this work. There is often a great need for support and processing around personal issues care givers have in relation to working with dying people and their feelings about death, suffering and loss"* (Halifax, 1995; p.16). As Roshi Joan pointed out, while our explicit intention might be towards compassion, our unconscious motivation can still be tangled up in our own stories of what death, suffering and loss mean to us. Until we attend to these, we risk adding to the suffering of those for whom our intention is to care.

We humans have an uncanny ability to mirror each other's emotional states through our capacity for empathy. Empathy provides us with the means to cooperate and bond in our social contexts by resonating with shared emotional experiences and understanding something of each other's perspective (Decety & Jackson, 2004; Lamm, et al, 2007; Preston & de Waal, 2002). There is even the suggestion that empathy allows us to interpret the intentions of others (Hamilton & Grafton, 2008; Iacoboni, et al, 2005). We can sense another's motivation to protect against their own fear or suffering, which only adds to our own. This is why Roshi Joan is so interested in compassion because it is distinct from empathy in that it carries with it the intention to help; *"compassion is feeling* for *and not feeling* with *the other"* (Singer & Klimecki, 2014; p.875)

In her well-known experiment with Buddhist monk, Mathieu Ricard, the neuroscientist, Dr Tania Singer, was able to show that empathy and compassion utilise different networks in the brain (Singer & Klimecki, 2014). When we witness another's pain or suffering empathically, our brains experience this as if we are feeling the pain or suffering ourselves (Lamm, et al, 2011). Yet when looked at through the lens of, what Mathieu Ricard calls, *altruistic love,* empathy leads to the presence of compassion (Ricard, 2023).

Awareness of another's suffering is not enough to generate a compassionate response, often leading to what is known as *empathy distress fatigue* – an overwhelming, self-focused reaction to another's suffering (Klimecki & Singer, 2011). Compassion, on the other hand, gives suffering something to belong to through another's intention for us to heal. Compassion restores us, as Roshi Joan so beautifully puts it, to *"an unbroken, intimate relationship with existence itself"* (Halifax, 2008; p.13).

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How do we turn fear into courageous compassion? Here's what I learned from my *dokusan* experience with Koshin.

Koshin knew nothing of the story behind the welling up of my emotion. He had no inkling of the circumstances around my loss, grief and distress, and he didn't need to. Had I spent an hour talking about my feelings, the circumstances by which they had come about, and what I could do to feel better, I am convinced it would not have had the same effect as spending just a few minutes staring into the eyes of a compassionate presence. Koshin's simple invitations to let go, look at him, and feel held within that space, were all I needed in the moment. No explanation, no advice, no content. Just compassion.

Here was the lesson: the content of our experience is not really that important; it is the quality of our relating to it that matters. Having a sense of awareness allows us to more fully experience the nature of our suffering but it is compassion that allows us to untangle from it, connecting us back to a selfless intention of care. Compassion not only allows us to feel all our experiences more fully, it provides us with the means to make sense of them and, sometimes, all it takes is to see it in the eyes of one who looks upon us with *eyes brighter than the sun.*

Later, I asked Koshin, if it's true that the content of our experience is not that important, then what's the role of the story? Without hesitating, he beamed, "To flourish!" He then asked me what *I* thought.

"Up until now," I replied, "I would have said the role of the story is for it to be resolved."

"And how's that going?"

With a knowing sigh of resignation, I admitted, "Not very well."

Our stories are the lenses through which we perceive our experience, configurations of mental processes that we use to inform our behaviour choices. Yet our stories can also keep us stuck, tangled in our need to reach some resolution we think might relieve our suffering. The role of the story is not to find resolution but to bring awareness, to both ourselves and others, for the need to let go and be in the presence of compassion. It is then we can enter a space where new meaning takes form in the vastness of the present moment, where our sense of self is transcended and we are gifted the opportunity to tell a new story, one that is not concerned with the content of our experience but rather our relationship to it; and once we do, we get to share it with others so that all can share in the flourishing. That's the true role of the story.

"Why is it we love to listen to our teachers and elders tell a story?" Roshi Joan once asked. *"Because it's a way that we can find ourselves in a landscape that offers a new and deeper perspective on who we really are. Stories are medicine because they teach us about and prepare us for the experience of change. Through the story, we may connect to a more realistic vision of who we really are"* (Foehr, 1997).

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Becoming

The person who is…more able to live fully in and with each and all of his feelings and reactions…makes increasing use of all his organic equipment to sense, as accurately as possible, the existential situation within and without…He is completely engaged in the process of being and becoming himself.

Carl Rogers – *On Becoming a Person*

Overlooking the coastline of Point Reyes National Seashore, amid sixty acres of rolling, Californian hills, Commonweal is dedicated to the healing, resilience and justice of the community of life on earth. The work of Commonweal is about connecting humans back to our roots as creatures of the earth. *"We heal in community,"* writes its co-founder, Michael Learner (Weller, 2015; p.xiv).

Following the diagnosis of his father's life-threatening cancer, Michael went on a global search for an array of integrative therapies that might offer a holistic approach to cancer treatment. From the learning he gathered, Michael resolved to create an intensive program at Commonweal for people living with and dying from cancer. Now thirty years on, the Cancer Help Program has hosted over two-hundred residential retreats that focus on the holistic dimensions of deep, intentional healing.

On a sunny, spring morning, I met Ladybird Morgan, one of Cancer Help's facilitators, to go for a walk around the Commonweal ranch. Both a registered nurse and a social worker, Ladybird has over twenty years' experience in palliative care, including co-founding the Humane Prison Hospice Project, being co-investigator and therapist for a trial of psilocybin-assisted therapy, and now completing a PhD in existential psychology. Her work, she says, is shaped by her dedication to contemplative practices and inner freedom.

We traced our way through woodlands and shrubs, coming across the small wooden chapel where notes to absent loved ones are placed in gaps between weathered clapboards. We sat on bluffs high above the Pacific Ocean, listening to the sounds of seabirds. We walked past abandoned buildings that once housed radio transmitters and explored the sand-tray where figurines and objects are placed to signal of our inner landscapes. Finally, we came to the retreat house where participants spend time making sense of these little rituals and symbolic acts of remembering.

Our conversation soon turned to grief, the emotion of loss, and the importance of giving it space to be fully expressed and fully experienced, while also recognising the conditions needed for this occur. Ladybird believes that grief is never ours to bear alone; it is carried within our communities, not only by those with whom we are intimately connected, but also in relationship with our cultural societies and the more-than-human world of animals, plants, water, earth and space that surrounds us.

Commonweal is situated on the Indigenous land of the Coast Miwok tribe and as Ladybird and I ambled our way back along the path towards our cars we could see the outline of an animal slowly walking towards us. As it got closer, Ladybird pointed out that it was a coyote and yet, seemingly undeterred by our presence, it continued its purposeful walk towards us. As we warily stepped to the side, the coyote nonchalantly passed within a few feet, giving us only the slightest of glances before continuing on its way.

Later, I discovered that for the Coast Miwok, the "Old Man Coyote", or *Wuyoki*, is a central figure in their mythology, appearing as both their creator god and ruler of the afterlife. He symbolises change and transformation and, there at Point Reyes, the Coast Miwok believed the souls of the dead would jump into the ocean and follow the "golden thread" of the setting sun and live in peace with the *Wuyoki* forever. Rituals, of course, were paramount to aid these souls on their journeys of transformation. Rituals have always been how humans create the conditions needed to let go and find meaning in times of grief and loss.

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I've always been struck by the view of the British anthropologist, Gregory Bateson, that *"the major problems in the world are the result of the difference between the way nature works and the way people think"* (Bateson, 2011). So it was, I found myself sitting on a back porch somewhere north of Los Angeles with mycologist, Anne Laforti, talking about the way nature works.

Anne Laforti is a scholar of *biomimicry* – the science of studying and learning from nature to inspire designs and processes that solve human problems – a term coined by the biologist, Janine Benyus (1997). Taking the viewpoint that nature has been continually researching how life flourishes for the past 3.8 billion years and that we, as human beings, are just as much a part of nature's experiment, biomimicry supposes that the answers to the world's major problems are found in *"the conscious emulation of life's genius"* (Benyus, 1997; p.2). Nature has already figured out what works, what is appropriate and what lasts.

So, together with Anne's friends – Devorah Brous, grief counsellor and soil scientist, and Dina Kuperstock, chaplain and spiritual care artist – we excitedly discussed what nature can teach us about grief and, as Anne so beautifully put it, the *overly generous reciprocity of letting go.*

One of the key concepts within biomimicry is that *life creates the conditions conducive to life.* Change, loss and death have always been an integral part of nature's evolution and, as such, are embedded in processes of renewal, growth, and vitality. Everything is held together in a larger ecosystem of reciprocity. Botanist, Robin Wall Kimmerer (2020), writes, *"all flourishing is mutual"* (p.21). So how then does nature let go? Citing the example of pecan trees, where bumper crops of nuts are released simultaneously only when conditions are most suitable for their survival, she tells us it is with communal abundance.

For humans, letting go is not an easy task, often eliciting painful and debilitating emotions, not least, that which we call grief. So what might be life's genius in the purpose of grief? From an evolutionary perspective, some have argued that grief is maladaptive*, "a by-product of the way in which biologically important close relationships are maintained"* (Archer, 1999; p.62), where the costs can be viewed as a trade-off with the benefits such relationships confer.

Others have highlighted the ways in which grief actually helps us adapt by signalling our need for care and reassessing our goals, plans and other significant relationships (Nesse, 2005). An example from nature would be zebra finches who vocalise their distress at being separated from their bonded pair and engage in searching behaviour that brings about their reunification. Grief, then, can be seen as a form of searching behaviour and a natural signal of our need for connection (Butterfield, 1970; White & Fessler, 2017).

If grief serves an evolutionary purpose to signal our need for connection, then it follows that nature would also provide a solution to our problem of isolation, and so, caring behaviours evolved in response to the stimulus of suffering that comes from our fundamental needs not being met (Gilbert, 1989). As already discussed, our capacity for empathy allows us to become aware of the emotional signals of others, yet it is compassion that leads us to respond in a way that benefits both the carer and the one being cared for.

The founder of Compassion Focused Therapy, Professor Paul Gilbert, says that the goal of compassion is to feel the quality of *safeness* – the degree to which we can regulate our response to threat and explore our freedom to grow (Gilbert, 2020; 2024). This is distinct from *safety*, which we often equate to the absence of threat. Safeness comes from letting go of wanting things to be different, being in the awareness of how things are, and feeling the presence of compassion that invites us into the overly generous reciprocity of letting go. As Paul Gilbert has said, *"Compassion is the courage to descend into the reality of human experience."*

How, then, do we solve the problem of suffering by letting go of the way we think and embrace the way nature works? How can we flourish even in the presence of our grief? We come back to ritual.

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Sitting outside Roshi Joan's house at Upaya Zen Center, I caught up with Dr Tony Back, a faculty member on *Being With Dying* and Professor of Medicine at the University of Washington, to gather his insights into the role of psychedelic-assisted therapy to address the existential fear of those who are dying.

Dr Back has now published the results from his clinical trial of a group psilocybin retreat for people with metastatic cancer and associated symptoms of anxiety or depression. Over three days, groups of up to eight participants were led through a secular ritual-based group facilitation model during which they received a single dose of psilocybin with the intention that the structured sequence of ritual acts within a group setting would provide the *"narrative architecture that helps participants integrate intense or transcendent experiences into coherent stories of self and meaning"* (Back, et al, 2025; p.3),

Rituals are the means by which traditional wisdom cultures have been transcending suffering for millennia – *"intentionally structured, symbolic acts that embody and reinforce shared meaning and guide participants through experiences that may otherwise feel unbounded or overwhelming"* (Back, et al, 2025; p.3). Acknowledging the use of psilocybin in such ceremonial contexts, Dr Back sought guidance from such wisdom holders to avoid cultural appropriation within the retreat setting (Gerber, et al, 2021; Celidwell, et al, 2023), an ethical step in considering a framework of conduct and reciprocity in psychedelic therapies (Spriggs, et al, 2023).

Following the retreat, and comparable to other study contexts, participants had a significant reduction in symptoms of anxiety and depression which was sustained six months later. Yet it was the qualities of the retreat facilitators that Dr Back wanted to draw attention to, qualities which support the emotional regulation, orientation and meaning-making of participants by embedding them within a communally shared field of intention and care.

Firstly, p*resence* – the embodied awareness and intentional availability that creates a receptive interpersonal dynamic to foster the participants' sense of safety and openness. Then there is *relational sensitivity* – the ability to resonate with the somatic, emotional and relational dynamics of individual participants and the group, allowing for adaptive responses in each moment. Both of which are held by *containment* – the capacity to sustain presence and relationality while maintaining clear interpersonal and structural boundaries that give participants the felt sense of safeness needed to allow experiences that can be unexpected, threatening or intense.

"Ritual is able to hold the long-discarded shards of our stories and make them whole again," writes the psychotherapist, Francis Weller, another member of Commonweal's Cancer Help Retreat. *"It has the strength and elasticity to contain what we cannot hold on our own, what we cannot face in solitude"* (Weller, 2015; p.82). For nearly thirty years, Francis has been offering grief rituals where participants are able to make the repressed visible and provide compassionate witnessing to the forgotten or denied stories of loss that have given rise to their grief; practices that, Joseph Campbell (2004) taught, allow us to become *transparent to the transcendent*.

One of the gifts of ritual, Francis writes, is that it allows us to enter a self-transcendent state he calls *derangement. "Derangement is necessary because our current emotional 'arrangement' is not working. We often find ourselves clinging to control, self-conscious, hyper-vigilant, and fearful of showing our emotions to others. This carefully 'arranged' relationship with life denies us the freedom to receive the support we require from our community at times of loss"* (Weller, 2015; p.86).

I've heard Francis speak a few times and people often ask him how grief rituals work. He is the first to say there is something unknown and mysterious that occurs but, when our grief finds its belonging, it begins to transform. *"There is a strange intimacy between grief and aliveness,"* he writes, *"some sacred exchange between what seems unbearable and what is most exquisitely alive"* (Weller, 2015; p.1). Rituals provide the crucible for such alchemy to occur within a container of compassionate presence. It is then that we can begin to find meaning in our suffering, by becoming transparent to the transcendent.

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"It is the making of meaning that makes us human, that makes us capable of holding something as austere and total as the universe, as time, as love without breaking," pens the author, Maria Popova (2025; p.15).

Meaning in life has been described as *the extent to which one's life is experienced as making sense, as mattering to the world, and as being directed and motivated by valued goals* (George & Park, 2016). Professor of Psychology, Dr Crystal Park (2022), suggests *the meaning made* emerges from the relationship between *global meaning* – our deeply held beliefs, values and goals regarding reality, control and identity – and *situational meaning* – our understanding of the current circumstances in which we live. Each of us is continually appraising and monitoring for the discrepancies and differences between our expectations and our experience. These appraisals determine our reaction to events, whereby the more unpredictable, unfair and uncontrollable an event is, the stronger our reaction will be.

Yet, what is particularly interesting here is Dr Park's suggestion that the distress we experience is not due to the meaning we derive from the situation itself but from wanting it to be different. We suffer not from the loss of our sense of self but from the extent to which it violates our expectations. *"This violation-distress is painful, motivating people to try to alleviate it,"* writes Dr Park (2022; p.2). We do so by reducing the discrepancy, either by changing the meaning of the situation or adopting a new way of understanding the world and our beliefs, values and goals. We transcend our suffering by making sense of it.

To understand how we do this, we can go back to the work of Dr Farb. Having found that mindfulness confers its benefits through our perception of sensation, he also showed that it reduces violation-distress, when our experience fails to match our expectations (Farb, et al, 2007; Farb, et al,

2010). *"Exploring our senses to discover something unexpected or ignored provides an alternative to always having to fix the world to justify our expectations"* (Farb & Segal, 2024a). Instead of trying to get rid of our distress, he suggests we allow ourselves to be surprised by it.

Dr Farb calls this *sense foraging – the practice of intentionally engaging with sensation and welcoming its ability to update our models and expectations of the world* (Farb & Segal, 2024b). Sense foraging creates a sense of presence; the feeling that comes when we no longer want things to be different. By connecting back to the awareness of our senses and witnessing our sensations through the relational sensitivity of compassion, the experience of losing one's sense of self turns from one that causes distress to one that surprises us. From here, there is a vast potential of possibilities from which to create new meaning. It has always been our nature to be creative beings, we just need to learn how to think the way nature works.

"Those in whom we witness healing," writes the palliative care physician, Dr Michael Kearney, *"are those in whom nature has been allowed to do her work. We may remove the obstacles and create the right conditions but the ultimate move is not ours. In her own time and in her own way, nature brings the healing"* (Kearney, 2000; p.109).

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Love

Fearlessness is what love seeks…Such fearlessness exists only in the complete calm that can no longer be shaken by events expected of the future.

Hannah Arendt – *Love & Saint Augustine*

Gathered together in the front room of Michele Chaban's Toronto townhouse, everyone took turns reflecting on their experience of death and dying, and how their various contemplative practices had served them both personally and professionally, but mostly personally. Amongst the group were nurses, psychotherapists, a psychologist, a lawyer, social workers, a Reiki and yoga practitioner, all of whom have, at one time or another, been taught, supported or mentored by the woman who had so generously extended the invitation to share an afternoon with me. The following day, Michele expressed surprise at how quickly each one had spoken so deeply from their personal experiences of caring for loved ones at the end of life. *"I guess they wanted to share what suffering 'worked with' looks like," she wrote. "It is their most sacred story – it is their motivator."*

Now retired and in her seventies, Michele has had a remarkable career spanning four decades, working with an approach she now calls Mindfulness-Informed End-of-Life (MIEOL) care. Having originally been educated in humanities and theology, Michele says she was searching for a framework of human spirituality. *"Is there something that joins us all in our humanity? I was asking what practices make us human."* It was from here she went on to obtain her masters in social work, train in family therapy, and eventually find her way into hospice and palliative care.

"Palliative care is relationship-based work, no matter how you practice it," Michele explains. *"By the time patients got to me, they'd had experiences of failure: failed interventions, suffering unattended to, socialized into demoralisation due to medicine's relationship with their data, symptoms and disease, not their personhood or their social context."* Noticing that the dying and their family caregivers were exhausted, Michele intuited that she needed to find a model for replenishment that worked with the body. *"I was in search of what practice allowed the dying some form of therapeutic relief other than pain management and talk therapy."* She started to introduce mindfulness into her work.

As Michele passes her wisdom on to subsequent generations now tasked with caring for those who face death, she summarises her approach this way: *"Love practiced does not displace one's grief but it surely does transform it, especially around some of the sharper edges of sorrow. It essentially takes the grief and does something with it rather than ruminate on it. It takes one out of helplessness and hopelessness into compassion in action."*

Michele generously told me about her own experience of living with decades of pain following a car accident in her early twenties that resulted in several spinal fractures. Yet, she will be the first to recognise that her own relationship with suffering has given rise to the contemplative philosophy of the approach she now teaches – the *phenomenology* of our suffering, the *epistemology* of how we come to understand its origins, the *ontology* of being in relationship with it, all of which give rise to the *teleology* of its purpose, that is, to flourish. Suffering has a surprising and valuable role.

Dying too has value and, for Michele, its purpose is to make subsequent generations healthier than the one before: *"In this way, the dying person takes on the social role of healer and works to help those who are suffering around them through the reciprocity of care."* If the fear of death is deeply embedded in the human condition, then so too is our capacity to love.

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In her book, *All About Love*, author and activist, bell hooks (2001) suggested that *"our confusion about what we mean when we use the word 'love' is the source of our difficulty in loving"* (p.3). The word love means different things in different contexts: I love ice-cream, I love hanging out with my friends, "I love you."

Like hooks, I have always found the psychiatrist, Scott Peck's (1978), definition of love to be a helpful benchmark: *the will to extend one's self for the purpose of nurturing one's own or another's spiritual growth*. We could argue whether ice-cream has any bearing on spiritual growth but most of us would agree, I'm sure, that we use the word *love* to mean the relational quality that helps us be most fully ourselves. As Viktor Frankl (1973) reminded us, it is our spiritual dimension that makes us human, where spiritual might be considered an *"orientation toward or experience with the existential features of life"* (Harris, et al, 1999; p.414).

Referring to the existential features of life, the German philosopher, Hans-Georg Gadamer (2018), defined health as *"a condition of being in the world, of being together with one's fellow human beings, of active and rewarding engagement in one's everyday tasks"* (p.13). This is why we love, to nurture our sense of being, belonging and becoming. Yet the enigma, Gadamer suggested, is that health becomes evident only in its absence. For most of us, it is the only when we are threatened with its loss that we are compelled to contemplate our existence. As many of the anthropologists, psychologists, psychiatrists and philosophers written about here have stated, we seem hard-wired to be motivated more by fear than love; we would rather defend our sense of self than transcend it.

Buddhism calls these defences *hindrances* - mental states that hold us back from flourishing by wanting things to be different to how they really are. These are the stories of our past when love was absent, the lenses through which we view and appraise our present moment, the expectations that determine our behaviour, that motivate us to either shrink back in fear or move towards growth. That fear may once have served us well, protecting us from threats that would indeed have overwhelmed us without the protection of love, but in the present we are challenged to recognise when it also holds us back and to find ways of bringing a compassionate presence to our current experience.

Buddhism tells us the path to alleviating the suffering that our hindrances bring is to mindfully work with them, to embody an awareness of how we relate to our experience, knowing this matters more for our flourishing than any content. Hans-Georg Gadamer (2018) agreed. Rather than defining our well-being as a destination to be reached or a set of conditions to be met, well-being is a state *"of being unhindered, open to, and ready for everything"* (Gadamer, 2018; p.73), one that can no longer be shaken by events expected of the future. It is fearlessness that love seeks, irrespective of events expected of the future.

"There are paths to health that do not have to do with the 'elimination of illness,' but by relating to suffering in friendly, caring, and accepting ways, both in others and in oneself" writes the Norwegian psychologist, Per Binder (2022; p.3). How might we design a health-care system for those who are suffering and dying that allows us to find a path to health by cultivating a state of well-being? How do we create a container for compassionate presence within which we can work with what might otherwise feel too overwhelming? It is through the reciprocity of care contained within the ritual of compassionate presence.

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Founded in San Francisco amid the AIDS epidemic of the 1980s, the Zen Hospice Project pioneered a compassionate approach to end-of-life care which they termed *an appropriate response* – a simple act of finding practical ways to work towards the goal of alleviating suffering. Combining spiritual insight with practical compassionate care, the project emphasised presence and listening as *"a mutually beneficial relationship between caregivers and people who are dying"* (Ostaseski, 2009).

Having opened a six-bed guest house, then later partnering with Laguna Honda Hospital to provide hospice services, the Zen Hospice Project closed its doors in 2018 due to regulatory challenges and the lack of sustainable funding. Yet its focus on caregiving as a deeply meaningful human activity continues as the Zen Caregiving Project, providing training and education in compassion-based approaches that support mindful-caregiving. A recent study of their four-session training to family caregivers showed a significant improvement in depression, anxiety, caregiving burden and well-being (Juberg, et al, 2023).

During my fellowship trip, the project's volunteer program manager was Alistair Shanks, who had been involved with the Zen Hospice Project since 2004 and is now program manager for training at the Humane Prison Hospice Project. To get up close and personal with death, he told me, we need to create sacred spaces grounded in the spiritual, that is, our human need for meaning and connection with something larger than ourselves. *"Meaning-making is the essential mandate of spirituality,"* he told me, *"which requires a certain quality of presence towards those who are dying so they are heard and seen and understood."*

This is what the Zen Caregiving Project teaches through its mindful-caregiving courses. To explore what this might look like in practice, I spent a morning with Roy Remer, the project's Executive Director, and members of the palliative care team at the YoloCares hospice in Davis, California. Together they shared their experiences of creating sacred spaces, *"setting the table"* by modelling openheartedness and curiosity, so people can tell their story. They recognised the desire many have to know that as they approach death their story will have meaning by being heard and understood. As one grief specialist reflected, being the recipient of such stories and witnessing them with compassion offers a sense of belonging as *"each word that they're speaking, I'm sharing it too."*

This is the essence of mindful-caregiving, says Zen Hospice Project's founding director, Frank Ostaseski (2009), to listen *"to the dying person's story, their emotional upheaval without needing to change the other in some way, and without needing to either cheer up falsely with empty hope or turn away from someone who is trying to reconcile their life. That is the healing power of presence*."

While standardised approaches to mindfulness in the form of six- or eight-week courses have been studied in the context of palliative care to varying degrees of success (for example, Jaffray, et al, 2016; Gianotti, et al, 2019; Poletti, et al, 2019; Mosher, et al, 2024), what makes the difference, whether in managing pain, reducing caregiver burden, or reframing the meaning of an illness, is the quality of our relationship to our experience. Instead of being viewed as a threat, cultivating a compassionate presence towards any challenging experience allows it to become a meaning-focused opportunity for growth (Garland, et al, 2015; Yela, et al, 2020). The counselling psychologist, Dr David Shannon (2020), summarises his own research into the practice of mindfulness for those in hospice care this way: *"When approached with mindfulness, even the most challenging aspects of human experience appear to be workable"* (p.94).

"Putting a dying person through an eight-week course is taxing, draining and depleting and often ends in failure to participate in full," says Michele Chaban. This is why she and those at the Zen Caregiving Project, the New York Zen Center for Contemplative Care and Upaya Zen Center teach the healing power of presence to those who are at the bedside, necessitating our own work around our feelings towards and experiences of death, suffering and loss.

For those of us who care for the dying, then, the invitation is to be fully present to the unfolding of our own experience as much as that of others. As Frank Ostaseski (2009) continues: *"I understand that in order to work with someone else who is dying, I have to do a kind of individual exploration. I have to look at my own relationship to sickness, old age and death. While I'm working with someone, I'm also investigating my own fear, my own grief. In Buddhism, we recognize that someone else's*

suffering is also my suffering. So when I take care of myself, I care for others; and when I care for others, I am taking care of myself."

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When I first began working in palliative care, I was introduced to the writings of Dr Michael Kearney and immediately felt a resonance with his approach of attending to the existential distress of those who are dying. *"If we can find a creative way of responding to the challenge of soul pain,"* he writes, *"it may open up a path to the very heart of living, even in the shadow of death"* (Kearney, 1996; p.15). When we become disconnected from the deepest and most fundamental aspects of our human nature, *soul pain* is our fear of the unknown. For Dr Kearney, this provides us with an opportunity to become more fully alive.

Having become disillusioned with medicine and considering leaving the profession, Dr Kearney had been advised to visit St Christopher's Hospice in London, described to him as *a place of healing. "While there I encountered patients who, despite the fact that their bodies were frail and dying, seemed to be among the most real and complete human beings I had ever met. I too felt more alive in their presence"* (Kearney, 2000; p.xix). With his faith restored in human nature and medical care, Dr Kearney returned to train under Dame Cecily Saunders and has spent his career exploring the nature of healing and its place within healthcare. So when Dr Kearney, who now lives in Santa Barbara, California, invited me to spend an afternoon with him and his wife, Radhule Weininger, a clinical psychologist and meditation teacher, I jumped at the chance.

Dr Kearney has always been open and honest about his own experiences of empathy fatigue and burnout, recognising that the quality of our lives affects the quality of life of those under our care. Acknowledging the work of psychoanalyst, Michael Balint, *"If we are the most powerful medicine we will ever give our patients, then who we are as persons matters as much as how knowledgeable and skilled we are as professionals"* (Kearney & Weininger, 2011; p.109).

Defined as *"a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job"* (Maslach & Leiter, 2016; p.103), the prevalence of burnout among palliative care staff can be as high as sixty percent (Abraham, et al, 2025; Gomez-Urquiza, et al, 2020; Kamal, et al, 2020). It is characterised by a syndrome made up of three broad categories of symptoms: emotional exhaustion, depersonalisation and feeling a lack of accomplishment, all which of sounds remarkably similar to the symptoms of existential suffering and the groundedlessness, isolation and meaninglessness that accompany it.

Yet others argue that burnout is really something more akin to the *moral distress* that stems from the challenge of simultaneously knowing the care that needs to be given but being unable to provide it due to constraints beyond our control (Dean, et al, 2019). Whether we call it burnout or moral distress, both have serious and specific consequences on individuals, but their causes lie beyond the

responsibility of those they affect, reminding us that we are part of a system we call healthcare; that is, an entity of interconnected relationships held together by qualities that unite around a unifying purpose.

The title of this report, *What It Means To Be Human,* arose amid the Covid pandemic when, like so many of us working in healthcare, I struggled to make sense of our response to the incessant threat of death that had pervaded our lives. In my search for some way to help alleviate this threat, I came across a conversation with Michael West, Professor of Work & Organisational Psychology and the author of *Compassionate Leadership* (West, 2021), in which he makes the point, *"If you lead an organisation in ignorance of what it means to be human, it will not work"* (The Kings Fund, 2019). Comprehending the interconnectedness of our relationships is important. Understanding the quality of how we relate to our experience matters. Being motivated by a common purpose that benefits all is essential for everyone to flourish. Leading an organisation or providing care in ignorance of this will not work.

This is what Dr Kearney (2025) now teaches to others working in healthcare through his Deep Resilience programme. Influenced by his own contemplative practice, he recognises that healing comes from an embodied awareness that we are rooted in something beyond our individual sense of self and that by remaining open to the flow of compassion, we can find renewed meaning and purpose in helping others do the same. All flourishing is mutual.

Contemplative traditions have long understood our interconnectedness and its role in sustaining well-being. *Contemplative Medicine,* the integration of contemplative practices into a physician's personal and professional life, is now being taught by the New York Zen Center for Contemplative Care and has since been shown to reduce clinician burnout, cultivate well-being, and actively develop the skills needed to sustainably practice compassionate medicine (Kennard, et al, 2023).

The role of psychedelics in the treatment of clinician burnout has also been explored by Dr Tony Back and Ladybird Morgan who, in setting up a randomised-controlled trial to look at the effects of psilocybin-assisted therapy on the psychological morbidity experienced by frontline healthcare staff following the COVID-19 pandemic, showed a significant and sustained reduction in symptoms of depression and, while not statistically significant, a reduction in the symptoms of burnout (Back, et al, 2025). The insight of one of those participants is worth noting: *"I learned how important it was for me to understand that I, at best, help identify what is distracting someone from what is in them and how to help connect them with what they already are. That what I do, really, is connect people with their own healing"* (Back, 2024).

To help connect others to their own healing, we must first learn to do the same in ourselves. As I learned from Dr Kearney, we must become wounded healers. *"The wounded healer is one who holds her own pain while staying present to the other in theirs, knowing that this, more than anything else she may do, is what awakens the inner healer in the other"* (Kearney, 1996; p.146). Within the safe containment of a compassionate presence, suffering allows us to reconnect with the deepest, most fundamental aspects of our human nature. Suffering worked with becomes our most sacred story – it becomes our motivator.

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This report began with the question, how does confronting death allow us to re-enter life in a richer, more compassionate manner? The answer, as the psychologist Abraham Maslow once suggested, lies in self-transcendence. Following his near-fatal heart attack, Maslow discovered that everything was so precious, so sacred, so beautiful that he felt the impulse to love, embrace and be overwhelmed by the prospect of his death rather than fear it.

Throughout this exploration into self-transcendence, I have been curious about the repeated mention of love. There was Gloria with advanced metastatic cancer who, during her psychedelic experience at Spring Grove, came to the realisation *"that the core of life is love"* (Grof & Halifax, 1978; p.23). Mingyur Rinpoche felt in the midst of his near-death meditation that *"every particle was alive with love"* (Rinpoche, 2019; p.226). Then one of Dr Back's retreat participants who said the following of her psilocybin experience: *"I objectified my cancer. I wanted to be angry at it, to yell and scream, and then started laughing at how absurd that was. So I gave it a hug and loved and forgave. I wrestled with the idea of death but it didn't seem possible. It seemed like my body could die but my feelings could never die, and I know that sounds silly but I realised death is love"* (Back, 2024).

What is it about the nature of our existence that when we lose our sense of self in the absence of fear, we call it love?

Exploring this question through the approach of contemplative practice always felt like the natural place to begin given my own experience of how mindfulness has enriched my life. Contemplative traditions have, for millennia, taught us the nature of our impermanence and how to be with loss through cultivating an awareness of our connectedness that extends beyond our sense of self. Whenever I would think I was drowning in my own stories, mindfulness offered me a way of feeling held in letting them go.

I then discovered the emerging research around psychedelic-assisted therapy, much of which had is beginning to address the existential domains of suffering within palliative care and, through the tools of modern neuroscience, confirming what contemplatives have been telling us all along. If, in my limited practice, mindfulness allows me to feel like I could breathe beneath the waves, then psychedelics have the potential to make me feel like I am the ocean itself.

There is now an increasing body of evidence to support the synergistic relationship between meditation and psychedelic experiences (Griffiths, et al, 2018; Millière, et al, 2018; Smigielski, et al, 2019; Eleftheriou & Thomas, 2021; Payne, et al, 2021; Qiu & Minda, 2021; Jyllkä, et al, 2025). Both bring an awareness of being in relationship with something beyond our sense of self; both open us to a quality of compassion that calms our emotional experience; both provide insights allowing us to transcend our current understanding and create new meaning. While there are many questions still to be answered about how best to offer these practices to those in our care, they have the potential

to powerfully alleviate the suffering of those confronting death and greatly improve the quality of life of everyone involved. We need to be asking these questions.

Underlying both contemplative practices and psychedelic experiences is awe – the emotional experience of vastness and the need to make sense of it. Awe transforms how we see the essential nature of the world by connecting us to something larger than the self (Keltner, 2023). It places us within the larger systems of life, within entities of interconnected relationships held together by qualities that unite around a unifying purpose – communities, nature, culture, epiphanies through which we mark life as sacred. Yet, when Dacher Keltner was researching what motivates us most to feel awe, he discovered it was *moral beauty* – the witnessing of other people's acts of courage, kindness, strength or overcoming, *"marked by a purity and goodness of intention and action"* (Keltner, 2023; p.11).

Moral beauty changes the way we respond to fear in the region of our brains called the amygdala. It stimulates the vagus nerve, part of our nervous system responsible for feelings of calm, and induces the release of oxytocin, a hormone linked to social bonding. All of which create a sense of safeness, of being held in a larger belonging, while activating parts of our brain where our emotions translate to ethical action to create the sense *"that we are part of a community appreciating what unites us"* (Keltner, 2023; p.83).

We are not simply human beings, we are human belongings, and it is my belief that at the heart of what it means to be human is the will to love: *"Love is the unrecognised invitation in every relationship"* writes David Whyte (2024; p.161). We suffer when love is absent and yet it is through the practice of love, of expanding one's self for the purpose of our mutual flourishing, that we come into an unhindered, intimate relationship with existence itself.

We can explore the role of mindfulness and psychedelics in alleviating the suffering of those who are dying, and I believe we should, as there is much to explore. After all our exploration, however, I am sure we will find that the most effective "cure" we have for the existential distress that comes from our fear of death is the ritual of compassionate presence. By doing our own work, through our own acts of courage, kindness, strength and overcoming, those for whom we provide the safe container of compassionate presence are invited to witness their own moral beauty, and in turn become wounded healers for others. *"The sacred nature of the human community is the weave within which the dying individual finds him or herself…It is this very factor that can make the loss of individuality experienced in dying less painful"* (Grof & Halifax, 1979; p.5).

We do not become fully human until we give ourselves to another in love.

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Epilogue

"I would love to live like a river flows,
carried by the surprise of its own unfolding."

John O'Donohue – *Fluent*

One bleak February morning, part way through my fellowship year, I suddenly woke with an odd but distinctly clear thought in my head, as if someone had spoken to me from the foot of the bed: *the last paragraph of Andrew Mullen.* I knew of no such person and, being unaccustomed to such thoughts waking me up, I was immediately curious about the significance of the impartation.

Who was Andrew Mullen? And what was contained within this paragraph? The name sounded Irish and my mind turned to love letters, last wills and testimonies, secret messages - stories that inspired the imagination of where I grew up. Yet it wasn't until a few days later, when travelling to visit family in Ireland, that I thought to google the phrase. It immediately brought me to a thesis written by Father William Dempsey, entitled, *Father Andrew Mullen 1790-1818: a study in early nineteenth century spirituality*, in which he recounts the miraculous circumstances around the death of a young Irish priest two-hundred years prior.

Andrew Mullen was born in a small town in County Offaly in 1790 and entered seminary aged nineteen. By all accounts, he was a devout and virtuous man, serving as a curate in the parish of Clonmore. From what is known of his spiritual training, he would have been instructed in a form of contemplative practice; balancing prayerful meditations with engaged acts of service, cultivating an awareness of the divine in all things, and freeing oneself from attachments to make choices based on love.

However, in 1818, following a short illness described as bilious fever, Andrew Mullen died at the age of twenty-eight. The custom would have been for his body to be returned to his hometown of Daingean but, for reasons unknown, he was buried in the church yard at Clonmore. So five weeks later, members of his family travelled the sixty miles from Daingean and dug him up in the middle of the night to bring him home. Upon opening the coffin to check it was him, they discovered that

remarkably his body was not decomposing. Describing it as *incorrupt and flexible,* they brought him back to Killaderry Cemetery where news spread of this miraculous occurrence.

Taken as a sign of his holiness and entry straight into heaven, Andrew Mullen's grave became a shrine and, to this day, many still visit to pray for healing. The thesis by Father Dempsey was an attempt to petition the Vatican to bestow sainthood by chronicling the life of Andrew Mullen and the miracles that had occurred since his death, yet without success.

What of the last paragraph? Within his thesis, Father Dempsey included the only surviving letter of Andrew Mullen, written to his mother during his time in seminary. It begins, as most letters do from nineteen-year-olds to their mothers, by apologising for not writing sooner, telling her not to worry about him, that he's keeping well and eating enough. He goes on to ask after aunty so-and-so and to say hello to various folk within the town, but then tells his mother to *"give my love and humble regards to Mr O'Reilly and tell him I am following his counsel punctually"* followed by the Latin words, *remenebo semper quod sum deo adjuvante* – I will always remain what I am with the help of God.

I remember sitting there on a train in Ireland completely baffled by how I had been led to such a story by waking up with the very specific words, *the lost paragraph of Andrew Mullen.* Yet beyond this, I was amazed at the similarities to what I was researching at the time, the phenomenon of *Tukdam* and what it means to be human, seemingly contained within the death of this Irish priest and his motto, *I will always remain what I am with the help of God.*

Two weeks later, I went to visit Andrew Mullen's grave and had arranged to meet with the current parish priest, Father Declan. Despite having only recently arrived in Daingean, Father Declan was well aware of the story of Andrew Mullen and the fervent interest of a remaining few to make him a saint: "Sure, don't I have to scrape them off the ceiling sometimes," he told me, with a honest humour only permitted in someone with his years and lilting accent. "I'm not interested in those kind of miracles," he continued. "The miracles I'm interested in are the ones of human kindness."

I spent the afternoon listening to the stories of Father Declan's life as he studied the contemplative teachings of Thomas Merton, held the hands of those dying of AIDS in whose rooms doctors and nurses were too afraid to enter, continuing to apply the salve of human kindness to many who suffer heartache and grief. "I'm writing a book to help people prepare for dying," he told me.

It all seems too much of a coincidence and yet I can't explain how Andrew Mullen entered my mind, how those words led me to his story, its connection to my exploration of what it means to be human, meeting Father Declan and our shared purpose of helping people prepare for dying. Yet perhaps this is the point; that the meaning is within the mystery. We will always remain what we are with the help of the unknown.

Death, too, is a mystery; *an ocean so vast that to enter there seems nothing more than to disappear forever*, wrote Khalil Gibran in his poem *Fear*. Yet, it continues, there is no way back. The only way to overcome our fear is to enter the ocean and to realise that death is not an act of disappearing but an

act of becoming. What carries us is not the certainty of any outcome but the surprise of our unfolding. This capacity for surprise, for giving ourselves the space and time to welcome the unknown and transcend the meaning of our loss, is what helps prepare us for dying.

The choice to explore existential well-being through contemplative and psychedelic approaches was largely influenced by my mindfulness teacher. Dr Alistair Wilson was a psychiatrist who, through his own contemplative practice, had gone on to teach me, and so many others in healthcare, the benefits of cultivating a more compassionate presence. Always the pioneer, Alistair had wondered about the synergy between mindfulness and psychedelics, given their similar effects on the brain.

At the same time, Alistair was also preparing for his own death from advanced cancer, and while there wasn't the opportunity to explore the role of psychedelics, he was able to tell me how his mindfulness practice had greatly helped him. He told me of being able to accept what is, about being present in the moment rather than falling into ruminations about the past or present, about being compassionate towards his own experience of incremental loss that allowed him to let go without falling into resignation.

While I would have loved to have shared this completed report with him, I have a sense Alistair already had a deep and intimate knowledge of what I have written, and so, in helping others prepare for dying, the last paragraph belongs to him and the words he wrote to me a couple of weeks before he died:

"I have a growing sense of my own impermanence and a strong sense of connection with a deeper reality of flow. Our existence is like an eddy in a river – it forms and dissipates. Within that flow is a sense of compassion or kindness. The challenge is to go beyond the illusion of permanence, the invitation is to connect with the flow of compassion."

Fellowship Itinerary

1st – 8th October *Toronto, Canada*	**Gary Rodin** *Director, Global Institute of Psycho-Social, Palliative & End-Of-Life Care & Professor of Psychiatry at University of Toronto* **Norman Farb** *Associate Professor of Psychology, University of Toronto* **Michele Chaban** *Founding Director of Applied Mindfulness Meditation & Mindfulness-Informed End-of-Life, University of Toronto;* with Kelly Butler, Celina Carter, Lee Freedman, Karen Ghelani, Fabio Fernandes, Shari Stein, Moustafa Abdelrahman **Daniel Rosenbaum** *Psychiatrist & Co-founder UHN Psychedelic Psychotherapy Research Group*
9th – 10th October *Madison, Wisconsin*	**Center for Healthy Minds** Tawni Tidwell, *Research Assistant Professor, Tukdam Project* & Robin Goldman, *Director of Research Support*; with Brendon Panke, Carmen Alonso, Tulku Tashi, Dekila Chungyalpa, Andy Karlson, Lily Smith, Simon Goldberg, Teri Pipe
11th – 15th October *New York, New York*	**NYU Langone's Center for Psychedelic Medicine** Stephen Ross, *Associate Director & Clinical Professor of Psychiatry,* Kelly O'Donnell*, Associate Clinical Professor of Psychiatry,* Richard Zeifman, *Adjunct Assistant Professor* ***Perspectives on Psychedelics*** **Conference** *Horizons* (cancelled) **Craig Blinderman** *Chief of Supportive Care Service, Memorial Sloan Kettering Cancer Center* **Bradley Lewis** *Associate Professor, New York University (narrative medicine)*

16th- 17th October Boston, Massachusetts	**Thich Nhat Hahn Center for Mindfulness in Public Health** Dawn DeCosta, *Executive Director* & Jade Conway, *Communications Manager*
18th – 22nd October Garrison, New York	**New York Zen Center Contemplative Care Retreat** Chodo Robert Campbell, Koshin Paley Ellison & Pamela Ayo Yetunde
27th April – 4th May 2024 *San Francisco, California*	**Psychedelic Culture Conference** *Chacruna Institute for Psychedelic Plant Medicines* **Dacher Keltner** *Professor of Psychology & Director of Greater Good Science Center, University of California, Berkeley* **Zen Caregiving Project** Roy Remer, *Executive Director* & Alisdair Shanks, *Volunteer Program Manager* **YoloCares** Chris Erdman, Renee Avalos, Debra Chapman, Elisa Stone, Amy Meie, Leia Gaspar, Robert Englund **Ladybird Morgan** *Cancer Help Program, Commonweal* **Phillipe Goldin** *Professor & Director of Clinically Applied Affective Neuroscience Laboratory, University of California, Davis*
5th – 9th May 2024 *Los Angeles, California*	**Charles Grob** *Professor of Psychiatry, UCLA-Harbor Medical Center* **Rael Cahn** *Clinical Associate Professor of Psychiatry & Director of Center for Mindfulness Science, University of Southern California* **Michael Kearney** *Palliative Care Physician, Santa Barbara & Co-Founder of Mindful Heart Programs* ***Biomimicry*** Anne LaForti, Devorah Brous, Dina Kuperstock
10th – 17th May 2024 *Santa Fe, New Mexico*	***Being With Dying,* Upaya Zen Centre** Roshi Joan Halifax, Tony Back, Cynda Rushton, Holly Yang, Mary Taylor, Corrina Chung, Wendy Dainin Lau