Original Paper

Training program about the therapeutical intervention "relaxation, mental images and spirituality" (RIME) for re-signify the spiritual pain of terminal patients

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Abstract

Background: This article presents a training program for a therapeutic intervention involving relaxation, mental images and spirituality (RIME), which can be administered to help terminal patients to resignify their spiritual pain. **Objective:** Analysis of a training program based on the understanding of the experience of professionals in the use of RIME intervention and of patients in their resignification of spiritual pain, as revealed during the administration of RIME by trained professionals. **Method:** The participants were a nurse, a female doctor, three psychologists and a volunteer alternative therapist, all experienced in or studying palliative care; they were invited to participate in the training program and were later in charge of caring for eleven terminal inpatients in public hospitals of Campinas, Piracicaba and São Paulo. The theoretical and methodological basis of the study involves action-research and phenomenology. Qualitative results were analyzed by the content analysis utilizing the thematic analysis technique. Quantitative results were analyzed descriptively using the Wilcoxon Test. **Results:** In the analysis of the professionals, experiences, five categories and fifteen sub-categories were found. In the analysis of the constitution of spiritual pain, we found the idea of fear of death to be the most prevalent, either expressed by negation of the gravity of the clinical prognosis or by the perception of this gravity. After the administration of RIME, statistically significant differences in perceived level of well being ($p < 0.0001$) were expressed after sessions of RIME. **Conclusion:** The proposed training program proved to be effective in preparing health area professionals for the use of RIME intervention, qualifying them to provide spiritual assistance within an academic perspective. The results suggested that RIME promoted the resignification of spiritual pain in terminal patients..

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There is a Greater Love. There is a Greater Goodness. There is a Greater Power. Our mind is linked to the universe. We are not an isolated part of the universe. We are a part of it, along with all the other parts. We participate in the same respiration — the Great Respiration. The limited respiration of our lungs is only illusory. Our movement is illusory. Our real movement is mental, spiritual. All that we can see of everything that surrounds us depends on the level of our consciousness. (Celso Charuri).

Introduction

Based on the elements suggesting transcendence cited by patients who have undergone near death experiences (NDE) (Greyson, 2000, 2003; Kübler–Ross, 1998, 2003; Moody Jr, 1989, 1992; Morse and Perry, 1997; Parnia and Fenwick, 2001; Van Lommel, 2004; Van Lommel et al, 2001), the senior author developed one intervention for seriously ill and terminal patients denominated relaxation, mental images,

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and spirituality (RIME) to be administered by health care professionals (Elias, 2001; Elias, 2002; Elias, 2003; Elias, 2006; Elias e Giglio, 2001a; Elias e Giglio, 2001b; Elias e Giglio, 2002a; Elias e Giglio, 2002b). A training program was then designed to prepare health care professionals to use it in therapeutic intervention (Elias, 2005; Elias et al 2006a, Elias et al 2006b, Elias et al 2006c).

The expression NDE was coined by Moody Jr (1989; 1992) to describe the experience of individuals whose clinical death had been declared, yet they returned to life and remembered having experienced some or all of the following states:

- sensation of being dead;
- sensation of floating outside their bodies;
- peace and absence of pain;
- positive emotions;
- capacity for movement at the speed of thought to a desired location;
- capacity to hear what doctors and family members were saying from a perspective which would have been impossible if they had been in their supine bodies;
- movement through a tunnel, attracted by a bright white, gold or blue light, or the visualization of beautifully decorated bridges or gates through which they passed to another dimension or to a spiritual world;
- meeting with deceased friends or relatives;
- contact with spiritual beings, denominated as Beings of Light (or Communication with Light) by these individuals; these beings irradiate unconditional love, assistance, comfort and protection;
- entrance into extremely lovely places, often with flowering gardens, forests, and lakes surrounded by a very bright light;
- review of their life, not as a judgment, but as a form of understanding who they truly are and the true meaning of life as the learning of unconditional love and the acquisition of knowledge, especially self-knowledge;
- positive reformulation of personality due to the contact with the "Light" (Communication with the Light);

According to Van Lommel (2004), such events may also be reported by those who have been in a deep coma, as well as by those who have had "visions in their death beds" or have survived highly dangerous situations where death seemed inevitable, although in the end they escaped unscathed (such as accidents while mountain climbing or automobile accidents); these situations are known as "fear of death".

RIME intervention was developed over a period of seven years by the senior author. Concerned by the extreme psychological and spiritual suffering of the children and adolescents with terminal cancer with whom she was working, she was led to look for a means of minimizing this suffering, and the presentation of a documentary about NDE (Moody Jr., 1992) gave her the idea of trying to induce the visualization of those elements described by those who had experienced a NDE in her young cancer patients to reduce their suffering (Elias, 2003). Further study and development after the enrollment in the graduate program of the Faculty of Medical Sciences [at the State University of Campinas] increased the efficacy of RIME intervention, culminating in her master's thesis on the qualitative evaluation of the efficacy of the procedure (Elias, 2001), widely reported in a series of articles and chapters in books (Elias, 2002; Elias, 2006; Elias e Giglio, 2001a; Elias e Giglio, 2001b; Elias e Giglio, 2002a; Elias e Giglio, 2002b), which showed that it led to an improved quality of life during the process of dying. The next step was the development of a training course to prepare other health care professionals to use it; these results were reported in her PhD dissertation (Elias, 2005) and are summarized here.

RIME intervention consists of the integration of mental relation techniques and the visualization of mental images with elements which represent the issue of spirituality based on the reports of NDEs, spirituality understood as the relation between an individual and the more transcendental area of his/her psyche and the changes which result from such meditation (Jung, 1986), as well as the experience of unconditional love (Charuri, 2001).

In the revision of literature about studies related to the spirituality and death, we have highlighted two articles. Barham (2003) reported a case study using a Buddhist technique for experiencing the process of death, which promotes symptom control during the final 48h of life. That author observed that aspects related to spirituality, serenity, peace, and love were very important for the sensation of security necessary for a "good" trip to the spiritual world. Papathanassoglou and Patiraki (2003) provided a hermeneutic and phenomenological perspective, focusing on the interpretation of dreams of individuals after hospitalization in an intensive care unit. The research explored the meaning of having been critically ill. Eight individuals reported their dreams in semi-structured interviews. Using the language of the unconscious, they were able to find the symbolic meaning of their experiences, being critical illness conceptualized as a phase leading to transformations in the "self" by awakening spirituality and personal growth. According to the authors, nurses in an intensive care unit should be prepared to help patients to experience the described process.

In a review of the literature involving complementary intervention, various studies promoting intervention of some sort were found, but only a few specifically

involved terminally-ill patients. Generally known as complementary or alternative therapies, these interventions involve the promotion of the quality of life during the process of dying through the use of music therapy (Hilliard, 2005) dignity therapy, which consists of care for the patient focusing on his/her level of cognitive and functional independence and the control of physical and psychological symptoms (Chochinov, 2004), hypnosis (Elias, 2005), and the application of religious or spiritual intervention, prayer and conversation with a clergyman or meditation and directed imagination, (Millison e Dudley, 1992). Among the papers involving meditation and directed imagination, there is the work of Birnbaum and Birnbaum (2004), who described an innovative therapeutic intervention in group work with survivors of suicide attempts and mental health professionals. The techniques used included relaxation and concentrated meditation, accompanied by directed meditation in a search for internal wisdom. Many participants related an important positive experience, including access to internal knowledge, which was highly relevant for them at that moment in their lives. For some, these introspections were felt to be coming from a deeper part of the patient's own self (internal source), whereas for others, the source was felt to be a spiritual guide or presence (external source). The results indicated that directed meditation might be a powerful resource for therapists and their patients, including suicide attempts.

The methods used by many of these therapies resemble that of the RIME intervention, although the latter involves the specific induction of visualization of those elements described by patients who have passed through NDE. In this paper, we report a course for training health care professionals on the use of RIME. Despite the growing importance, which health professionals have given to the question of spiritual assistance, training designed to minimize spiritual suffering has not been previously reported in Brazil.

Medical practitioners can no longer ignore alternative practices. We must recognize that certain alternative treatments may be more effective for a specific patient than the traditional allopathy, and such practices must be made available for use under appropriate circumstances. Curriculum planners must thus include such information during medical training. It will then be up to the health care professional to select the truly best possible options in his/her treatment of the population (Silva, 2005).

The training program of RIME intervention developed here may provide such an option for the curriculum and this preparation for dealing with terminally-ill patients could provide a contribution to the education of future health care professionals who will eventually have to work with such patients.

Objective

A training program was designed to prepare health professionals for the use of RIME intervention. The results were analyzed to explore the experience of these professionals in the utilization of this intervention and that of the patients in their redefinition of spiritual pain during the administration of RIME.

Subjects and methods

This is a study in action research and phenomenology. According to Amatuzzi (1996), phenomenological research is generally defined as a study of what is lived and its meanings. The presupposition is that what is experienced is an important path to the truth and decisions which must be taken. It works on the level of intentions, and the analysis of this experience can be made in general (describe the nature of the experience) or specific (describe the meaning of specific experiences for a given individual or group of individuals), but it can also be concerned with the establishment of relationships of meaning. In this study, specific experiences were analyzed, i.e., the experiences of both patients and professionals administering RIME were investigated, as well as the nature of spiritual pain and its redefinition. According to Amatuzzi (1996), there are various kinds of phenomenological research; the thesis presented in this article is based on empirical phenomenological research involving the application of phenomenology to psychological research based on empirical data. Action research, on the other hand, presupposes joint participation of the researcher and the subjects (Bogdan e Biklen, 1994); in this study, such collaboration involved the senior author and various health care professionals who were taught RIME, so they could help terminal patients to transform their interpretation of the meaning of spiritual pain.

The qualitative results were subjected to content analysis involving semi-structured interviews, a structured questionnaire and a diary. According to Bardin (1994), content analysis can be conducted by the investigation of a specific theme, as well as by other techniques, and consists of separating a text into units, i.e., discovering "nuclei of meaning" which constitute the communication, and which may, by their frequency, mean something in relation to the analytic objective involved; afterwards, these affirmations (statements) are grouped in relation to a specific subject. The analysis can be presented graphically by means of words, phrases or a summary.

The quantitative results were analyzed by a descriptive method using data collected by the Analogical Visual Scale of Well Being model with colored facial expressions. This model, which consists of a scale of six colored faces expressing a range of suffering, from total absence to intolerable suffering, with the scale including a blue face representing the lack of

suffering (10), a greenish blue face showing slight suffering (8), a green face expressing moderate suffering (6), a yellow face revealing discomfort (4), an orange face expressing intense suffering (2), and a red face showing intolerable suffering (0), was used because the presence of color and expressions were felt to permit a better identification of the intensity of patient fears, as well as their guilt, feelings, and emotions, since faces have a certain play format in their presentation which could be beneficial at a time when, given the clinical circumstances, the terminal patient was generally emotionally withdrawn. The scores at the beginning and end of each session were compared on the basis of averages, using a Wilcoxon test for non-parametric data.

Six health care professionals participated in the training program and later administered RIME to terminal cancer patients; they included a nurse (responsible for the nursing team of the cancer sector in a university hospital specialized in the treatment of women), a doctor (coordinator of the program for palliative care in a public hospital of the state of São Paulo in Brazil and president of the National Academy of Palliative Care (ANCP)), three psychologists and an alternative therapist. Two of the psychologists and the therapist work in the area of Palliative Care in the two hospitals mentioned above, and the third psychologist, "trained" as a Jungian analyst, had vast clinical experience and had studied palliative care.

The patients were eleven individuals with terminal stage cancer. They ranged in age from 27 to 76, and had an educational level ranging from high school to a university degree. Their religions included Catholicism, various Protestant denominations, and Spiritism. They were selected by the professionals because the possibility of cure had been discarded by the medical staff responsible for their care and their suffering in the face of dying was so evident. Only a single patient could have recovered, based on the clinical picture, but the nurse in charge observed that her condition rapidly worsened and the fact that she was suffering tremendously; in fact, this patient actually died during the early morning hours after the administration of RIME.

A two-day preparatory course for RIME Intervention was developed and administered by the first author during the first semester of 2004 in a public university in the city of Campinas in the state of São Paulo in Brazil. RIME Intervention involved three stages: the first was the identification of symbolic pain of death, which was determined in a semi-structured interview. The second involved the transformation of the data about spiritual pain expressed in the interview into symbolic images, and the third consisted of orientation in the use of techniques of mental relaxation and the visualization of mental images to induce the elements which constitute spirituality. Complementary sessions for the orientation of family members were also recommended as part of the therapeutic intervention (Elias, 2001; Elias, 2002; Elias, 2003; Elias, 2005; Elias, 2006; Elias e Giglio, 2001a; Elias e Giglio, 2001b; Elias e Giglio, 2002a; Elias et al 2006b).

The pedagogic strategies used (expository classes, group discussions, and direct experiences) are included in the outline of the course presented in Table 1. The content information of the course was supplied in the form of a 100-page booklet.

The use of the procedure by the professionals was followed up by semi-structured interviews focusing on three themes: management of the therapeutic tie, management of therapeutic intervention using RIME, and the nature of the emotions and feelings of the professional during therapeutic sessions with the patient. The professionals also filled out a structured questionnaire and kept a diary of their reactions to the use of RIME. This questionnaire provided specific data about the number and length of sessions, the patient well-being before and after RIME administration, and relevant aspects of the clinical history of patient's identification of spiritual pain, experience with reinterpretation of this pain, and dreams of both professional and patient (and relatives), as well as any experiences of a spiritual or transcendental nature.

Results

Analysis of experience of professionals in utilization of RIME Intervention.

Qualitative results were obtained for both the experiences of the six professionals administering RIME intervention and the eleven patients treated. Data to evaluate the experience of health care professionals in the use of RIME methodology were collected from structured questionnaires, semi-structured interviews and diaries. The analysis revealed five categories, with a total of 15 subcategories. The categories identified and the number of professionals making reference to that category at least once, are presented in Table 2.

Analysis of effect of RIME intervention on redefinition of spiritual pain by patients

Six categories and eleven sub-categories referring to spiritual pain were identified. These are presented in Table 3, and examples of the redefinition involved are reported in Table 4.

Table 1. Outline of course for health professionals for therapeutic intervention with terminal patients.

Class	Contents	Duration	Strategy
Presentation of group	Reception, warm-up, and member introductions	30 min.	Experience
Presentation of training program	Structure of course and signing of informed consent	30 min.	Orientation, oral and multimedia presentation
Techniques of mental relaxation and visualization of mental images: theoretical aspects	Definition of mental relaxationInduction of mental relaxation Considerations of interaction between soma and psyche Definition of mental image visualization Short history of the utilization of image visualization in medicine Recent considerations in use of mental image visualization	30 min.	Oral and multimedia presentation
Experience (relaxation and visualization)	Projection of images of beautiful scenes Relaxation and visualization exercises based on images chosen	30 min.	Oral and multimedia presentation
Theoretical foundations of spirituality adopted in the study	Presentation of theoretical background of program. Reference to the meaning and dimensions of spirituality Near Death Experiences (N.D.E.) Spiritual needs of the terminally ill Dreams and experiences of a spiritual nature related to the terminal phase of illness	30 min.	Oral and multimedia presentation
Elements involved in the issue of spirituality (studies of Near-Death Experiences (NDE))	The spiritual world, death, and post-death, as reported in NDEDescription of elements commonly encountered when passing through NDEIdentification of possible changes in [attitude?] after NDEPhilosophical and spiritual considerations based o studies of NDE	30 min.	Oral and multimedia presentation
Documentary video	Reports of 6 patients about NDE	60 min.	Presentation of video
Dreams and experiences of spiritual nature related to terminal phase	Definition of experiences and dreams of spiritual nature Symbolic data of dreams and spiritual experiences of patients, family members and the first author, collected during MSc thesis and interpreted based on Jungian references and elements of spirituality	60 min.	Oral and multimedia presentation
Synthesis of day	Identify main aspects brought up in classes of training program for the day	60 min.	Reflection and group conclusion
Therapeutic intervention: relaxation, mental images and spirituality (RIME)	Main aspects of relationship management and therapeutic work Verbal and non verbal symmbolic language Structure of therapeutic intervention Family orientation	90 min.	Oral and multimedia presentation
Symbolic pain of death/ Spiritual Pain: case reports	Concepts of pain, total pain and spiritual pain. Presentation of cases, including description of spiritual pain identified and operationalized during RIME	90 min.	Oral and multimedia presentation
Exercises of relaxation, visualization and spirituality	Exercise based on the main elements to be worked on with patients: beautiful scenes, symbols of transformation and beings of light Exchange of participants experiences	90 min.	Verbal orientation for visualization and listening to music Report of group experiences
Explanation of instruments used in the research	Objectives of the study. Method and instruments for collection of data	60 min.	Presentation via multimedia
Summary of training	Summary of the aspects covered in the group and sharing of experiences during the preparation course	90 min.	Group work of reflection and conclusion

Table 2. Summary of categories found and number of professionals referring to the theme at least once, as well as quotations of some these professionals.

Category	Number of professionals (n = 6)	Some examples of professionals' quotations
1) Facilitation in managing therapeutic relationship	6	**Psychologist 1:** "I felt the establishment of a relationship on the basis of the confidence and serenity expressed by the patient while choosing images and listened to music, and when they were involved in visualization. The family of one patient nicknamed me the "music girl". **Doctor:** In a case when the patient could no longer communicate, the elements for the administration of RIME had to be chosen based on information furnished by family members, but during the administration, the patient reacted positively, as I could see from his respiratory frequency and facial expressions. **Therapist:** "I felt like an angel carrying the patient when using the procedures of RIME; the special care this intervention allows to the professional express favours the creation of a positive link with the patient".
2) The frequent feelings, perceptions and emotions aroused in the patient by the use of RIME suggest psychospiritual maturity of the health professional	6	**Psychologist 2:** "The only truth in the world is the manifestation of love. By administering RIME to a patient, I am transmitting love to that patient". **Psychologist 3:** "I felt transformed during the administration of RIME. The professional is helping a patient, but is also relaxing. Moreover, each time I administer RIME, I feel good for both reasons. I have also learned not to have prejudice against feeling compassion". **Nurse:** "I felt good when I realized that I was actually helping someone at an extremely difficult time. I felt at peace when I administered RIME, and that feeling of peace was extended to a peaceful resolution of other conflicts in my job as nursing team supervisor, and I have observed an increase in my self esteem because I feel I am doing good for my patients."
3) Feelings and experiences of spiritual and/or transcendental nature reflecting love and peace or the occurrence of intuitive dreams	6	**Doctor:** I felt vigorous after administering RIME, differently from other days routine when I would feel exhausted. I also had an intuitive perception of the presence of beings of light in the environment, both during and after the administration of RIME, and I felt safe and protected by this presence." **Psychologist 1:** "I had dreams reflecting extra-sensory perception which made it easier to introduce the suggestions of RIME and to deal with the difficulties of patients; when I left the sessions, I had palpable feelings of love, a lot of tranquility, peace, and lightness, and I understood these as "really strange", coming from the presence of Beings of Light around me". **Therapist:** "During the administration of RIME, I felt the intuitive perception of the presence of Beings of Light, as well as a feeling of transcendence, of lightness, as I experienced my own spiritual issues".
4) The use of RIME sometimes arouses negative feelings, emotions and perceptions in the health professional	4	**Psychologist 2:** "In the beginning, when I saw the first patient, I was afraid of losing control because the experience with the procedures of RIME visualization was extremely real; the feeling was that there really was Light, that it was not the fruit of my imagination. With the second patient, I couldn't sleep, I felt a strong fear of death and had nightmares after the first two sessions using RIME; I considered these experiences as a result of the contact with the energy of patient's fear of death". **Doctor:** "I felt exhausted after administering the first session to the first patient, and I had to sleep when I got back to the hospital. This exhaustion was due to the incorporation of the patient's fear of death".
5) RIME is a concrete, clear and feasible proposal that offers positive results in palliative care	6	**Nurse:** "RIME brought serenity and trust to the patients, and this was perceived by their relatives. After this experience, I found that my professional actions extend beyond physical care providing psychic and spiritual relief, as well as the administration of a technique which brings both psychic and spiritual peace to the patient". **Psychologist 3:** "The administration of RIME contributed greatly to my personal and professional development allowing to present a complete positioning in both areas besides developing a security and peaceful feeling face to the death-life dichotomy. I have also learned not to have prejudice against the feelings of compassion/sympathy". **Doctor:** The professional mourning is real and spiritual and RIME is also a way to enable the professional to cure this mourning. I have also noticed that it was important to administer RIME to one patient with whom I had already established a link in order to understand that the inclusion of spirituality in conventional medical care does not interfere with clinical treatment or with the professional position of trust towards the patient, but rather strenghthens it. After this training and the RIME administration, I have concluded that the care focusing only the physical needs of terminal patients is no longer satisfactory.

Table 3. Analysis of the patient experience with spiritual pain and its redefinition identified six categories and eleven subcategories, which referred to spiritual pain. These are presented in Table 3 along with the number of patients who reported each at least once.

Category	Subcategory	Number of patients reporting at least once (n=11)
Fear of death expressed by negation of gravity of clinical stage.	-Difficulty in accepting diagnosis and clinical care -Attachment to concrete and material world	5
Fear of death expressed by perception of gravity of clinical stage.	-Concern with physical suffering. -Non verbal expression of tension, fear and panic. -Aggravation of clinical symptoms.	5
Fear of after-death based on negative experience in spiritual dreams.	-Visualization of terrifying or very frightening images.	2
Fear of after-death expressed as negative affective feelings of disintegration, non-existence, or being forgotten.	-State of heightened alertness. -Anxiety of separation. -Doubts about Divine Love.	5
Negative ideas and concepts about the meaning of life expressed by absence of feelings or feelings of existential emptiness.	-Previous negative experiences of affective or productive nature.	4
Negative ideas and concepts of spirituality caused by experience of affective abandonment projected to spirituality.	-Difficulty in transcendence and trusting spiritual beings.	2

Quantitative analysis of spiritual pain

Data about "well being" manifested by patients before and after RIME sessions are presented in Table 5 and Figure 1. Although eleven patients were submitted to RIME intervention, only eight were considered in the quantitative analysis, since the other three could no longer communicate verbally when RIME intervention was initiated; the process of redifinition of spiritual pain for these three patients could only be evaluated qualitatively by means of non-verbal communication. The difference in the scores before and after each session was based on the averages, using a Wilcoxon Test for non-parametric data. Statistically significant differences ($p < 0.0001$) were obtained, i.e., after RIME sessions, patients reported a greater level of well being.

Discussion

The professionals involved observed that the procedures of RIME (the attractive images of nature, music, visualization of places suggesting peace, tranquility and harmony, and reference to spiritual beings transmitting love, goodness, serenity and protection) favored the establishment of the relationship between professional and patient. The emotional climate in the therapeutic setting also favored the development of this relationship, since it favored the transcendental/spiritual representation of love and safety (through reference to the presence of Beings of Light, angels, etc.).

Therapeutic listening is an important instrument in the area of health; this can be effected by means of adequate professional intervention, as pointed out by Fiorini (1991). We have observed that the administration of individualized RIME, considering the personal history of the patient and his/her selection of music for relaxation facilitated the establishment of therapeutic listening. This therapeutic listening then facilitated the context of visualization, as well as the specific images of nature, Beings of Light and other symbols, which are personalized so that the definition of spiritual pain is unique for each patient.

The benefits of RIME accrued for both patients and professionals. There is a constant battle between the energy of life and death until the organism eventually gives up and is reduced to inorganic matter (Freud, 1975). When the energy of love is present, however, the energy of life will be victorious as long as it has completed the construction of an action of fecundity, identified in the feelings, perception and emotions referred to by the professionals.

RIME was found to be a feasible approach for the induction of the equivalent of a NDE in terminal patients. Since the NDE is known to lead to a loss or reduction in the fear of death, it contributes to a serene and more dignified death, and such a benefit was also observed here. Moreover, not only the terminal patients, but also

Table 4. Examples of how categories of spiritual pain were identified and how they were redefined.

Category	Patient information	Spiritual Pain	Redefine process
Fear of death by negation of seriousness of clinical picture.	Patient E.O.G (female, 74, cancer, catholic, housewife).	Expressed by difficulty in accepting care from nursing staff.	Patient became more friendly with nursing staff and died peacefully when she suffered respiratory failure after vomiting.
Fear of death by perception of seriousness of clinical picture.	Patient S.G. (male, 62, cancer and upper vena cava compression (SCVCS); spiritism religion, electrician).	Expression reflected extreme anguish before administration of RIME intervention.	When the doctor approached the patient and invited him to take a trip on a boat in the sea, he became upset, as if he wished to say something. Little by little, he calmed down. Despite a rasping breathing, breathing became calmer. But the greatest change was in his expression showing serenity and peace during and after the administration of RIME, which was also perceived by his relatives (sister, oldest son, and daughter-in-law). The patient stopped breathing in the presence of the doctor twelve minutes after the conclusion of the administration of the RIME. His heart stopped beating about three minutes after the respiratory failure; patient's sister immediately perceived how his expression was totally calm and peaceful.
Fear of after death due to negative spiritual experiences or dreams.	Patient Z.B.O. (female, 52, lung cancer, catholic, teacher and lawyer).	During the first sessions of RIME, visualization of a dead landscape; nightmares about monsters and giant bees.	The patient was able to visualize a lovely and attractive scene where she felt comfortable, as well as the meeting with a guardian angel, which she named Gabriel, and she remembered having received a guardian angel from a student. She also reported having visions of her deceased parents and that she was no longer afraid, despite not having had a good relationship with her relatives.
Fear of after death due to fear of being forgotten affectively.	Patient N.J. (female, 55, uterine cancer, catholic, teacher).	Need to feel connected to the spiritual world, beautiful, protective, and receptive.	During administration of RIME intervention, the patient not only visualized Beings of Light and felt surrounded in their love, but also reported having seen these beings in the room where she was; she interpreted them as young archangels. At this time, she reported to the psychologist administering RIME that she was no longer afraid.
Negative ideas about the meaning of life due to absence of feelings and existential emptiness.	Patient M.V.C.S. (male, 30, testicular cancer with metastasis in lungs, protestant of Assembly of God, motorcycle delivery boy).	Guilt in discourse when referring to what he had done during his life, especially in relation to the family.	The issue of family was worked with, both verbally and in RIME visualizations. The psychologist asked the patient to visualize his whole family surrounded by light (children, parents, all of those he loved); they were happy because the love of God was coming to them as well, and in this way, the [patient could] prepare himself to leave his family. Near to the actual moment of death, the patient conversed with his ex-wife, terminating some unfinished business and completing what the psychologist called a fantastic review of his life.
Negative ideas about spirituality due to feelings of abandonment projected to spirituality.	Patient M.S.S. (female, 27, uterine cancer with invasion of vertebras and bladder, protestant, of cleaning assistant).	In the first session of RIME, visualization of a woman who could have help her while drowning, but who did nothing to save her.	The patient started to visualize images such as a green forest, waterfalls, rivers, and an illuminated path. The psychologist always used images which the patient believed in: the presence of angels, the love of a caring, non-judgmental God, and pardon for wrongdoings. She was encouraged to pay attention to the Light and feel loved; the patient showed she was able to do so, because she changed when the psychologist started to speak about this; the psychologist who worked with her said it was impressive, as if she was really leaving her body and letting things go.

Table 5. Well being score of patients (n=8) using Visual Analogue Scale (VAS) before and after RIME intervention.

Patient	Number of sessions evaluated	VAS well-being at beginning of session	VAS well-being at end of session	Number of sessions with improvement
E.O.G.	3	Score = 4, 2, 2 Total = 8 Mean = 2,6 Median = 2	Score = 8, 8, 10 Total = 26 Mean = 8,6 Median = 8	3
P.M.	5	Score = 0 + 0 + 0 + 0 + 0 Total = 0 Mean = 0 Median = 0	Score = 4 + 4 + 8 + 4 + 0 Total = = 20 Mean = 4 Median = 8	4
M.S.S.	4	Score = 4 + 2 + 0 + 2 Total = 8 Mean = 2 Median = 0	Score = 6 + 6 + 6 + 10 Total = 28 Mean = 7 Median = 6	4
N.J.	3	Score = 2 + 8 + 10 Total = 20 Mean = 6,6 Median = 8	Score = 10 + 10 + 10 Total = 30 Mean = 10 Median = 10	2
Z.B.O.	4	Score = 5 + 5 + 6 + 6 Total = 22 Mean = 5,5 Median = 5,5	Score = 5 + 5 + 6 + 7 Total = 23 Mean = 5,75 Median = 5,5	1
M.L.C.I.	1	Score = 0 Mean = 0 Median = 0	Score = 10 Mean = 10 Median = 10	1
M.A.S.	2	Score = 6 + 2 Total = 8 Mean = 4 Median = 4	Score = 8 + 8 Total = 16 Mean = 8 Median = 8	2
M.V.C.S.	11	Score = 6 + 6 + 6 + 6 + 6 + 6 + 6 + 6 + 6 + 6 + 6 Total = 66 Mean = 6 Median = 6	Score = 10 + 10 + 10 + 10 + 10 + 10 + 10 + 10 + 10 + 10 + 10 Total = 110 Mean = 10 Median = 10	11
Total	**33**	**Total score = 132** **Mean = 4** **Mediana = 5**	**Total score = 263** **Mean = 7,96** **Mediana = 10**	**28**

TWilcoxon Test - p < 0.0001.

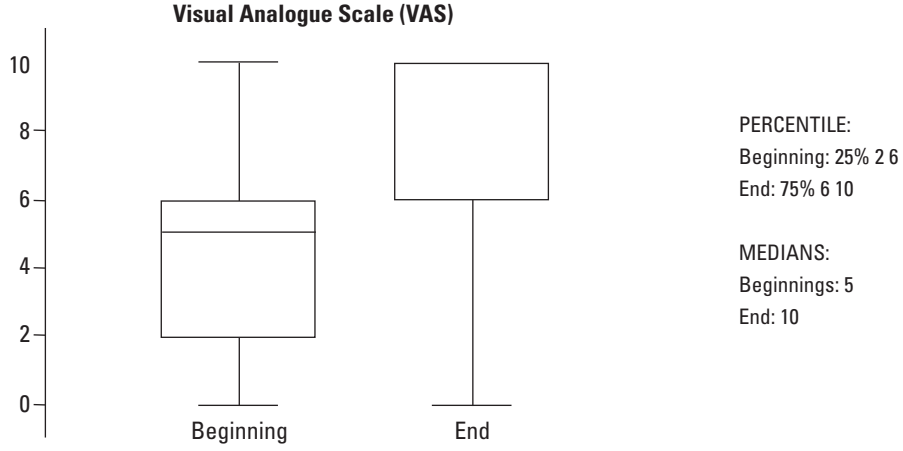

Figure 1. Blox Plot scores of well being reported by patients using Visual Analogy Scale (VAS) of Well Being before and after RIME sessions

the professionals administering RIME, benefited from the experience, and the latter reported they had integrated the relevant aspects into their lives in a healthy and constructive way.

Based on the experiences reported by these professionals, including those of the senior author herself, we can affirm that during the administration of RIME there is a psychic insertion of the professional into the limit between the physical world and the "spiritual world"; moreover, the "essence" or "spirit" of the professional and that of the patient become closer, or in psychoanalytic terms, there is an unconscious approximation of therapist and patient. We realize that RIME is not easy to administer; since it unites therapist and patient in a single feeling, it requires the commitment of the professional to this involvement.

We also observed that some of the professionals reported that some patients were extremely afraid of death at the beginning of the sessions. When these professionals listened to the patients speaking about such spiritual pain, they felt similar sensations themselves and reported feelings of impotence and frustration in the face of the resistance of their patients. Since RIME involves therapist and patient in a single relationship of unconscious approximation, these feelings are understandable. Once the elements of RIME have been experienced, these negative emotions disappear. All of the professionals considered RIME to be a feasible intervention procedure which provides positive results in the treatment of patients in the stage of palliative care.

In the first phase of the study, a second nurse participated in the training course, but she was unable to administer RIME to any patient during the stipulated period. Since this professional was quite experienced in the area of palliative care and participates in the home services program of a public hospital, we interviewed her to discover what had happened. She reported that she felt incapable of facing the criticism of colleagues and other professionals who thought that she should be concerned only with the biological aspects of her patients, rather than psychological and spiritual aspects. We feel that these observations are pertinent; since administration of RIME intervention may require special courage from the professionals in order to confront the resistance which may be encountered during this period of paradigm shift (Kunh, 1996).

Nine of the eleven patients revealed a fear of death, with this aspect of spiritual pain being characterized as the most prevalent and responsible for most of their suffering during the terminal process; this is in agreement with the results of previous studies (Elias, 2001). One of the patients in an intermediate stage of negation/perception was oscillating between the two positions, but revealed aspects of the fear of death in both. Seven of the patients, including the two who did not mention a fear of death itself, reported fear of the after life. It seems that an understanding of such representations of spiritual pain is very important, since professionals, especially nursing technicians, often take the attitudes of patients personally, which generates unnecessary professional stress, as well as contributing to inadequate assistance in meeting the needs of the patient.

In both qualitative analysis and quantitative analyses, RIME intervention facilitated the redefinition of spiritual pain. The quantitative analysis revealed a statistically significant difference ($p<0.0001$), between the level of well-being at the beginning of sessions and at the end. The redefinition took place gradually over time, although these feelings worsened during the interval between sessions. It is thus recommended that the interval between sessions be as brief as possible.

RIME intervention minimized the suffering during the process of dying for a diversified population of patients with some sort of cancer. Patients of both sexes with educational level ranging from a minimum of formal education to a university degree were treated successfully and age does not seem to make a difference, as RIME was effective for people ranging in age from 27 to 76, and during the pilot project we also worked with children and teenagers, also with good results (Elias, 2003). Moreover, the effectiveness was not compromised by religious beliefs, as it was successful with Catholics, Spiritism people, and various Protestant sects.

At no time during the seven years of development and experience with the use of RIME intervention has it proved to be contraindicated, although it has only been administered to those who believe in a spiritual after-life and by professionals who also believe in such a spiritual life. Thus, we do not know its effects on either patients or professionals who are atheists or have a religion which does not believe in a spiritual life after death. Since NDEs, however, have been known to turn atheists into believers (Kübler–Ross, 1998, 2003; Moody Jr., 1989, 1992), RIME should be tested in patients who are non-believers in life after death.

The experiences stimulated by RIME intervention have been found to be similar to those described by patients who have gone through a near-death experience, and this is true for both professionals and patients; this suggests that the visualization of images is an individual experience going beyond the simple imagination prompted by suggestion.

Conclusion

The training program proposed here has proved to be effective for the training of health care professionals (nurses, doctors, psychologists, and therapists) in the administration of RIME, and this treatment increased the well-being of terminal patients by improving the quality of their lives during the process of dying, as well as facilitating the redefinition of their spiritual pain. The result of this intervention was greater serenity and more dignity in the face of death, and the reactions of

both professionals and patients to the use of RIME were overwhelmingly positive. Limitations of this study include the fact that the research design did not include the utilization of a control group to compare the results of RIME with other types of intervention, although in the future we intend to include a control group. Moreover, the sample was too small to permit generalization. Although the results obtained were significant and were collected using a rigorous methodology, the number of patients and professionals involved was minimal. New studies involving more individuals are called for to develop a better understanding of the experience of professionals administering RIME intervention, especially the spiritual aspects of this experience, as well as that of redefining the spiritual pain of patients.

Moreover, the study involved only patients with terminal cancer, but it is recommended that research be conducted to evaluate its applicability in other situations, such as pre- and post-surgery, the diagnosis and accompaniment of cancer, and the treatment of psychosomatic illnesses, as well as the therapy of patients who have attempted suicide. Its beneficial effects for the treatment of family members and the caretakers of such patients should also be investigated.

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