Comprehensive Cancer Care: Integrating Complementary & Alternative Therapies
Remarkable Recovery
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I want to thank Jim Gordon and all of the folks he has acknowledged here. This really is a landmark conference, and a wonderful opportunity for all of us to deal with one of the most difficult and perplexing questions of the human condition: cancer. Why do we get it? How do we cure it? How do we survive with it?

Jim said that this is a topic about something miraculous. Things happen. Wondrous things happen. It is about this great mystery, about the sense that there is something about our ability to heal that has caused the human being to wonder and to question, to engage in a deep and wonderful mystery. It is with this sense of mystery that I invite all of you to come together with me to think deeply about some of the questions that we have before us. I like to think of all of us as sleuths, with pieces of a clue that may help to reveal something about the overall pattern of how healing happens.

As we are here together with the idea of exploring something that is deeply mysterious, we also sense that there are no easy answers. There is a sense of great mystery, awe and wonder. It is in this sense of the mystery that I quote Albert Einstein, who said, “It’s the most beautiful experience we can have. It’s the fundamental emotion, which stands as the cradle of true science.” I might also add as the cradle of true integral medicine for the future.

This cartoon says, “By God, for a minute there, it suddenly all made sense.” I put this up as a way of acknowledging at the beginning of this talk that we really have more questions than answers. I would say that, in terms of where we are with our understanding of something like remarkable recoveries, we are not even sure of the right questions to ask. As we engage in this

conversation this morning, it is with deep humility that we should all begin to wonder and to engage in questioning about the fundamental nature of what it means to be human, and what it means, as a human being, to be able to overcome adversity.

What we do know is that when all is well, our body behaves like a finely tuned instrument. We have this capacity somehow to self-regulate, an ability to perform like a well-tuned instrument that keeps us functioning, day in and day out. The question is, "What happens when the instrument goes out of tune? How do we begin to tweak it again, so that we can play in perfect harmony?" What I want to talk about today is something called the "healing system," with this hypothesis in mind: Perhaps, like we hear about the immune system or the nervous system or the endocrine system, perhaps there is something called a healing system, and it is in the context of this healing system that we may begin to understand something about how remarkable recoveries occur.

Norman Cousins was one of the first people in contemporary times to articulate the notion of a healing system. He noted that one item of medical knowledge never changes. The physicians need to tap the patient's powers, recognizing them as the primary force to work with. It is not about a doctor doing something to a patient. It is not about a healer doing something to a patient. It's really about a collaboration, where what we're trying to do is liberate some innate capacities within ourselves that allow us to become fully healthy and fully functioning. What would we do if we wanted to study something like the healing system? Here's a quick quote from Mark Twain: "Nature heals and the doctor sends the bill." Maybe he was a little bit more cynical than Norman Cousins. I don't know.

In order to begin to understand this question of the healing system, and to begin to look for pathways, or clues, following my metaphor of the detective or the sleuth, where would we

begin to find the clues that may lead us to some understanding about the nature of the healing system? I'd like to outline some of those areas very briefly and then go more deeply into one specific domain of research.

We find that there are a number of different perspectives, or areas, where we can begin to look at the healing system in exceptional healing instances. Take, for example, hypnosis. There is something about the plasticity of the body, and its relationship to the mind, that remains a mystery. How is it that a person in ordinary consciousness has a certain physiological reaction, and yet under hypnosis, through some kind of dissociative experience caused through hypnosis or other altered states, they can have remarkable recovery from burns, for example, or they can resist pain to a level that can't be accommodated in their ordinary state of consciousness? This is really a remarkable thing.

Another pathway, or another possible direction for finding clues about the healing system lies in the area of multiple personalities, again dissociation. Here we find instances in many case reports of people who have in one personality a particular kind of condition – for example, they may be diabetic, needing a high level of insulin – while in another personality, they seem to need less insulin, or none at all. One personality may be allergic to cats; the other isn't. There is more and more evidence that there is something about this plasticity of the body and its relationship to the mind and to consciousness that has yet to be accommodated within the conventional medical model. More work needs to be done on this. The area of multiple personalities, and particularly the health implications of it, is very preliminary, mostly anecdotal. It represents one of the most promising directions for future research.

Consider the placebo. We know what placebo is. It's that part of medicine that we want to get rid of when we want to test something. It's that thing that we're always trying to exclude

from our experimental trials. Harris Dienstfrey, editor of the wonderful journal, *Advances*, another landmark journal in the area of mind-body medicine, recently wrote an essay for us about the mysteries of the mind. In particular he looked at the placebo as the great unquestioned assumption of modern medicine. How is it that we can take an inert substance, and this inert substance knows not only how to heal us, but where to go in the body to bring us back into perfect harmony? This is just remarkable. Instead of pushing it to the sidelines, it's something we should bring into the forefront.

I put this slide up to remind me about placebo. There was a great Native American shaman at the turn of the century. He noted that he was a healer because he was a great shaman – he wasn't a great shaman because he healed. In other words, it was his feeling that because people came to him with the belief that he was a healer, he had the capacity to liberate their innate healing abilities. Again there's this notion that our expectations, our consciousness, our state of mind, our beliefs – in the system, the healer, ourselves, the meditation, the visualization, whatever the mechanism is for us – are powerful. There is something very powerful about a belief system that may provide clues to what we mean when we talk about a healing system.

Miraculous healing is an area that we hear a lot about. The tabloids love to talk about miraculous healing. There has been very little research. This is a picture from Lourdes in France. Every year about 5 million people visit the miraculous healing waters of Lourdes. What is that about? Why do we choose to make pilgrimages? There are more pilgrimages to Lourdes than any other pilgrimage site in the world. There is something deeply mysterious, something profoundly compelling about our need to understand the healing journey. People frequently report miraculous healing as a result of taking the waters of Lourdes.

Lourdes has set up very rigorous criteria for evaluating miracles. Not everybody can have a miracle. They are very cautious about who they allow to make such claims. Over the years, fewer and fewer people have been passing the test. In the history of Lourdes, there have been 65 proclaimed miracles. This is determined through a series of steps. People have to have very elaborate medical records before and after. They have to go through a series of medical exams before, during, and after. It isn't trivialized. It represents stories of hope. It represents indications that in fact these miraculous healings from every different kind of medical condition, most of them cancer, have happened. It doesn't happen very often. But it happens.

Frequently in medicine we think about the probability distribution. We think about what is normal. We talk about those factors that maybe cause disease. We think about the pathological variables. We think very little about those outliers, those people who represent the tail ends of the probability distribution. They are real. Some people die earlier than expected, and some people live longer than expected. What can we learn from these tail ends of the probability distribution that may help us to mobilize and catalyze a healing response within everyone? What happens when people believe enough, make a pilgrimage, even if it's to their physician, their alternative practitioner, or their own meditation shrine in their house, that may be catalyzing for their own healing response?

The Institute of Noetic Sciences has had a long-standing interest in this issue of the healing system. We are particularly interested in looking at areas where we might begin to pinpoint indicators of the healing system, and collecting cases of those remarkable recoveries that don't seem to fit within the normal probability distribution. These are the outliers. These are the exceptions. This isn't the norm by any means, but it represents a possibility. It is within the context of possibility that we are engaging this mystery of healing.

Jim mentioned Brendan O'Regan. Brendan was a biologist by training. He was also a futurist and a visionary. He had a very strong commitment and belief in the powers of healing. He himself had a terminal illness. He spent a long time doing research on every aspect of the healing system, from the most mundane to the most profound. He was very interested in looking at biochemical changes. He was a pioneer in the area of psychoneuroimmunology, acting as a synthesizer, bringing together people who 20 years ago had only a glimmer of an idea that there was something that could become psychoneuroimmunology or psychoendocrinology. Twenty years ago, the notion that there was a link between mind and body was largely heresy. It was within the context of forging some new frontier, beginning to develop clues about the nature of the healing system, that Brendan put together a program on the inner mechanisms of healing.

He was particularly interested in collecting cases of spontaneous remission. At that time, and even today, there's a lot of criticism of spontaneous remission, or remission generally. Critics suggest that it doesn't exist, that it's a misdiagnosis, that it must be so rare that it's not meaningful. They say they're just random outliers, statistical flukes, and that therefore we shouldn't bother to take them seriously. It's not as important as looking at something like the normal aspects of the bell curve. These are very limited assumptions. Rather than accepting that we live in a box and that the box defines what our possibilities are, maybe it's time to throw open the box and step out. Maybe it's time to begin to question those unquestioned assumptions about who we are and what we're capable of becoming.

In this context, and in order to begin to address some of the challenges that face this area of remission, Brendan began to collect cases of spontaneous remission. Working with Caryle Hirshberg, who was the co-author, with Marc Barasch, of the book *Remarkable Recovery*, we compiled a book called *Spontaneous Remission*. It's an annotated bibliography of all the

medical literature up to a couple of years ago in the area of spontaneous remission. Over 3,500 case reports were collected. These came from many different journals – 830 medical journals were surveyed.

A variety of search terms were used, because spontaneous remission is just one way of describing this. Regression, remission, exceptional survival – there are a variety of different ways of conceptualizing this. Most cases were of cancer, although there are a variety of other illnesses that are documented in this book. It was an attempt to address the first question, which is whether or not remission exists. Well, if it doesn't exist, there are a whole lot of physicians who have written case reports about something that is pure fantasy. As you begin to collect more and more of these anecdotes it becomes a database for something that can begin to look like science.

This led to a series of television shows for Turner Broadcasting called *The Heart of Healing*, and a companion book. In both the video series and the book, you'll find wonderful documentation of these kinds of healing systems and the various clues.

I want to talk mostly about some work that we're doing currently in the area of extended survival, a project started about 15 years ago under Brendan's direction. This was an attempt to challenge the conclusion that remission and long-term survival are really a fluke, or a misdiagnosis, or some fantasy that we might hold as wishful thinking. Brendan and a woman named Eva Glazer, who is a social epidemiologist, went into the Bay Area tumor registry. They did a search of all people who had distant site cancer, metastatic cancer, and who were still alive 10 years later. While the numbers were small relative to the overall database, they identified 118 people within the database who were still alive 10 years after their initial diagnosis. This suggested that there really was something there.

The second problem was, although you found evidence that there are people who claim to have extended survival from a terminal diagnosis, maybe it was an initial misdiagnosis. What do we know about their medical records? Eva found the original pathology reports for 88 of these 118 people. They took these pathology records to an independent pathologist, who had no connection to the study. They asked this pathologist to review the records and to either confirm or refute the initial diagnosis. In 100% of the cases, the pathologist confirmed the initial diagnosis. This suggested not only that remission and extended survival exists, but that it's not due to misdiagnosis, at least not in those 88 cases for which we were able to obtain the pathology records.

I came into the picture about 5 years ago. I thought this was very interesting. We were now 20 years out with these patients. Wouldn't it be curious to go back into the registry to see how many of these initial people were still alive? We did this. The people at the registry were very cooperative. For them, it seemed as though this was a unique opportunity to look at something that is largely unquestioned. They deal mostly with pathology. They deal with the causes of disease. Rarely have they had the opportunity to look at the opposite side of the question. What causes survival? Does survival exist? How is it that some people are able to beat the odds? It was with great cooperation that they provided us with these records. We found actually more cases at 20 years than Brendan and Eva Glazer had found at 10.

This is one of those mysteries. In going through and trying to figure out how this could be: there are now more advanced search capacities, the computer technology is better, the demographics of the Bay Area have grown rapidly. A number of factors may explain why there are more people within the database generally that would allow us to find even more people within the 20-year survivor group than had been in the 10. One of the problems with these

databases (for anyone who works with the SEER registry or any of the other tumor registries) is that there are often motivations for keeping people alive on paper – social security, or a variety of other kinds of compensation for the family. You can't completely trust these numbers.

Again, we became sleuths. We put on our detective hats. We actually hired a firm to help us identify how many of these people were still alive. We found a good deal. Approximately 50 of these people had some kind of phone number, address, had registered to vote recently, had a driver's license, had records that indicated that they were still alive. We found their phone numbers. First we sent a letter. Then we called them.

The next step was to begin to do interviews with these people, to hear from them about their own stories. What was important to them about their remarkable survival? To reiterate, these are people who have had a diagnosis of distant site cancer. This is not any kind of homogeneous group. These are people from many different types of cancer populations. The point is that they have had some kind of distant site, metastatic cancer, and are still alive 20 years later. Those were the criteria we used in beginning this expedition.

We were able to contact a number of these people, and we found 20 who were willing to engage in interviews. Two of my colleagues helped. Nola Lewis is a biologist by training who has been working on this project since the beginning, with Brendan and Caryle Hirshberg and a number of others, and then with Moira Killoran. Moira is a medical anthropologist who has become deeply engaged in this project. She has gone out and done the interviews with each of these people and has developed relationships with people. In this process she herself has become transformed. Whilst we see cancer as one of the scariest and most fear-ridden diseases, the people who have had the experience themselves, these 20-year survivors, don't find it remarkable at all, and aren't fearful of it. It is ironic to me, given the title of this talk, remarkable

recovery, that when we actually start looking at the data, these people don't find anything remarkable about their recoveries at all. They just are. They're just living.

What do you do with these kinds of data? Clearly this isn't a well-controlled study. I'll talk a little bit about some of the criticisms that can be raised about the kind of project we're doing. The first question was definition of the cohort. The second was verification of their status. We did this by looking at the pathology records. The third was going in and attempting to look at their own narratives, their own stories about what's important to them in their cancer survival. In terms of limitations, there's a 20-year hiatus. How much can we learn from people whose disease happened 20 years ago? Memory is a funny thing. People have a way of constructing their experience as different than it was 20 years ago. Recall bias is a serious concern.

There is no control group for this population. Try as we might, we have not really been able to come up with an adequate control group. We've decided to honor these stories at face value, and learn from these people what we can about their experience of survival. We hope that we may glean patterns across the various respondents. We also hope that we may be able to formulate formal hypotheses that can be tested in more population-based, epidemiological studies in the future.

We're also very interested in looking at possible biological markers of remission and extended survival. In particular, we're interested in looking at whether or not survival occurs in families, if there is any indication. We're working with David Eisenberg at Harvard who has some relationships with the people there doing population genetics. They are very interested in the possibility that if we could find familial relationships, there may be a genetic marker for

extended survival. That may help us to extend this population from those tail ends of the probability distribution into something that becomes more part of the normal bell curve.

We have engaged in this topic of narrative, and looking at the stories, and looking at what people themselves think are important. There is a lot of concern amongst people who are quantitatively oriented that this kind of qualitative data collection is unreliable, or that perhaps it doesn't provide the kind of rigor and sophistication we might get from a more quantitative approach. I argue that any adequate hypothesis-generating quantitative-oriented study needs to be qualitatively based. Otherwise you're developing a survey instrument based on a set of questions derived from the researcher's expectations, not from the experience and the lived reality of those people who actually know how to formulate the questions. I had lots of conversations with people, researchers, to talk to them about my concerns about our method, and about the reliability and validity of the kind of work we're doing.

Rachel Naomi Remen, who wrote a beautiful book called *Kitchen Table Wisdom*, is a member of our scientific advisory committee. Rachel, being a dear friend and a great coach, said something to me. Many of you who know Rachel know how poetic she can be. She said, "Understanding how people turn pain into wisdom is not something we can easily quantify. We can only learn this by listening deeply to the stories of individual people and finding the right questions, which will enable them to identify what they let go of and what they took hold of in order to move in the direction of integrity. This is not the kind of research that's easily fundable. It's not hard research, but then things that can be expressed in numbers are often not as meaningful as things that can only be expressed in words, and sometimes the most important things can never be expressed at all, but only experienced." This was off the top of Rachel Remen's head.

This provides a justification, and I could give many quotes that justify the importance of narrative. Listening to the life history stories of these people, looking at the ways in which they are constructing the meaning of their cancer experience within their own lives, has been remarkably informative to us in understanding something about the nature of the cancer experience.

Most of these people did not see anything remarkable about their experience. The mean population age of these people is about 70. These people had generally a lack of knowledge of and/or a disbelief in the severity of their illness. The majority claimed that they either didn't worry about the diagnosis and prognosis, or weren't told anything that led them to worry about it. This raises some really important questions about the kind of culture we live in now, where we're very concerned about disclosure, and about the negotiation within the medical culture about giving patients all of the hard facts, when in fact these kinds of hard facts act as a deterrent to their own ability to maximize their survival.

I have a wonderful case study from an oncologist who came into a meeting we had recently at the Institute. He told a story about a lung cancer patient of his who had been diagnosed with terminal cancer and sent home to die. The man went home to die. He went to bed, and a week went by. Then another week went by, and then a couple of months had gone by. Finally, after about three months of this, he thought, "Well maybe I'm not dying after all." He got up out of bed, and he went back to the doctor. He said, "You know, I feel fine." He decided to go to the Caribbean. He went on a scuba diving expedition. Two years later, the man was still alive.

There are all kinds of exceptions. There are no easy answers to what's happening. I hear a lot of people talk about the cancer type personality. I find so many exceptions to the cancer

type personality. We talk about the fighting spirit. This man gave up, and somehow his body was able to recover. There are all kinds of exceptions. It is about keeping open the questions rather than presuming that we have the answers, even though sometimes that's a very frustrating experience. This sense of disclosure may kill hope. We live in a medical culture in which autonomy and control and fighting spirit are really valued. We need to think about some of the insights that we've gotten from these long-term survivors who didn't have a lot of information about their diagnosis.

We are very much in a preliminary stage of data analysis in these interviews. Those of you who know anything about qualitative research know how overwhelming qualitative data can be. We have reams of data. We have hired another person, Nancy Lund, who has been really helpful in going through the data. We're doing content analysis and looking for patterns.

Spirituality is an important variable. These people are talking about something that has been transformative in their lives. We find an example from an interview. This is a woman in her eighties, who had been diagnosed with distant site breast cancer 20 years ago. She says, "I just kept believing in my faith, and what God can do, and I was sure that there is a force in this world for life to go on. The power of that tiny green leaf that grows between the cracks of cement, and it finds a way to come up and grow. Golly, if God can do that, then there is a part of nature, I don't care what you call it, but I do believe there is a power in the universe that is more than man." It's a sense of adherence. Stories about faith and some kind of surrender to a greater authority came through all of the interviews.

Relationship. The social support that comes from family was also important. This woman had ovarian cancer. "I just felt that it wasn't my time to die. I loved my job. I loved my husband. We were having a very nice life. Also I have a very strong faith in God. I really

prayed that God would let me live longer. He let me live 25 years longer. My prayers were answered." Again, here we find the reference to spirituality, a deference to a higher authority, but also the sense of sociability, social support. A number of people described their relationships as important. Sometimes it was relationships to family. Sometimes it was relationships to their doctor. A number of people really had a strong faith and conviction that their doctor would help them.

Transcendence. This has been one of the most powerful aspects of the interviews – how people can take something that is so detrimental, the most fearful thing that we can confront in our culture, and turn it into the most positive experience they've had in their life. This woman, 83 years old, had breast cancer. The diagnosis was like a rebirth, because it made her faith become stronger. A number of people reported that it was the most positive experience they had ever had in their life. There was something in the experience of having had the cancer that allowed them to face their mortality, to come to some terms with their relationships, to question the kind of lifestyle that they'd been leading.

These are the minority, the far ends of the probability distribution, the people who don't fit. This isn't everybody. But these represent stories of hope, of possibility. There are people who have survived, who have beaten the odds. They then have reframed their experience in such a way that it is transformative and in some sense is transcendent. This is a beautiful painting by a woman who was under treatment for lung cancer.

Where do we go next with this? It's a very challenging area. There are lots of questions to be asked. We are trying to identify patterns in the data. We'd like to make some predictions. Our goal ultimately is to begin to develop some kind of longitudinal program. We have put together a research protocol, but have not yet raised the funding to support it, for prospective

studies of women with Stage Four metastatic breast cancer. The idea would be to develop some kind of naturally emerging control group. If we could identify people immediately after diagnosis, and then follow them through the study period, we may be able to gain better control over the research variables.

The kind of survey questions that we would ask them would be derived not only from our own data, but from the data of others who have attempted to do qualitative research in this area, and whose results are very similar to our own. Warren Berland has done a wonderful study where he found that people were reporting that there was nothing exceptional about their survival per se, but that the cancer experience involved a profound sense of spiritual connection, that family relations were important, and that the experience of cancer was transformative. We would ask a number of questions about the experience, and in this way begin to operationalize these variables in a more systematic way.

Beside our own work, the Institute of Noetic Sciences has been very pivotal in helping to stimulate, feed and fuel a field that has largely been neglected, with contempt oftentimes, by the mainstream medical community. There are all kinds of glimmers that this field is growing and maturing in a way that is very encouraging. There are several web sites available on survival, and last year the First International Congress on Spontaneous Remission was held in Germany. The German government has begun to think about setting up a remission registry that would be a nationally based registry. A number of people in the United States are beginning to set up registries where you can write in and report your remission, just like we have the SEER registry for cancer. If we could have a SEER equivalent for extended survival, then we may begin to learn more about the nature of this other end of the probability distribution, what it means to survive.

The Heidelberg conference was a wonderful experience. There were people who represented epidemiology, biology, who were beginning to develop models for trying to integrate the various psychosocial and biological factors in a way that may allow us to make predictions about remission and extended survival. These are some of the things – biology, nutrition, lifestyle, psychology, social support, and the transpersonal and spiritual dimension. All of these issues came up in the course of the conference. There were a number of researchers from different places in the world who are beginning to ask serious questions about this work.

A new Office of Survivorship has just been established at the National Cancer Institute. This is an important development for the progress of this field. For people who are interested in information, there are a number of web sites. The Mayo Clinic has a web site on people who are survivors. You can write in. OncoLink is also a place to go for information. The Institute of Noetic Sciences has a web site, and the remission bibliography is about to go online on the web site. We have brochures about that. We also have an information packet that provides materials on most of the studies and most of the popular articles that have been written on the field. It provides an opportunity for people.

Where do we go? Norman Cousins again: "The great tragedy of life is not death, but what dies inside us while we live. This is another way of saying that human potentiality is the greatest untapped force on earth. We're still an unfinished species." To end the way I started, we are on a quest. This is a great mystery. We are detectives, and it is our job to find the clues, rather than assuming we have the answers, rather than assuming that we'll even find the answers in our lifetime. It's about engaging in the mystery in a way that brings our full authenticity, our full presence and being, to one of the deepest challenges of our time, of our species. It represents a possibility for us in terms of fully developing our human potential. I'll end there.

Maureen Redl is somebody who has had her own experience with cancer, who has been able to stimulate a group of people who have had cancer experiences to come together in story circles, because of the power of telling stories. She has begun to produce a beautiful documentary recording these stories of both cancer survivors and people who haven't survived, but who have used the cancer experience as a transformative event in their lives. I'd like to ask Maureen if she would reflect a little bit for us on some of her own experiences and observations. Thank you very much.

Ms. Redl: How do you follow that? It's really wonderful to hear Marilyn say the things that she has said. I found myself resonating over and over and over with many of the words. I was diagnosed with metastatic ovarian cancer in 1989, so I'm very grateful to be here, in many ways. The questions, the questions, the questions. I don't have answers, but we certainly have clues. I want to say right at the outset that all is not what it appears to be. Sure, my life broke down. My body broke down. Everything broke down. Everything that I knew as me died. Yet the reality is that in the crisis truly is the opportunity. That's a piece that we hear over and over and over. I hope for each of us as both practitioners and people who may face our own illness, or do face our own illness, that we hold that awareness.

A cure is way too small a goal, way too small. This may be a strange place to say that, but if we only look for the cure, a cure for the physical symptoms, and miss the experience of what illness can bring us to, we have missed the point. (Applause.) Thanks. I'm so glad to hear that recognized. I was not sure. I thought this might be a very dangerous place to say that.

The other piece is that I couldn't agree more with the notion that this is not nearly as remarkable or as extraordinary to heal. Whatever the healing looks like, I want to suggest that

something extraordinary is going on. That is, I don't know the word, something that is trying to happen in many, many, many of us. In our story circles we say, "Anything is possible, even as nothing is certain." Those are our bywords. We hear the stories. I want to suggest that there is something happening in our consciousness, in our collective consciousness, in which this kind of healing is trying to happen.

I want to suggest that all of us who have the experience of illness, who feel this healing that is trying to happen, will go wherever we need to in order to find practitioners who will support us in that process. It does not make any difference whether it is traditional medicine or as untraditional as we can imagine. We will find the people and the opportunities to support the healing that is trying to happen in us.

I want to suggest that healing is much bigger than cure. We all have healing, not only of body and mind but psyche and soul. It's in the breakdown, when the old rules no longer work, that we begin to find the clues. We help each other. We help each other find the healing within ourselves. I had the great privilege of working with Rachel Naomi Remen. When I heard what Marilyn quoted of her saying this morning it brought me to tears, tears of appreciation, tears of recognition, tears of knowing the rightness of those words. Marilyn, would you quote Rachel again?

Dr. Schlitz: Sure. "Understanding how people turn pain into wisdom is not something we can easily quantify. We can only learn this by listening deeply to the stories of individual people and finding the right questions which will enable them to identify what they let go of and what they took hold of in order to move in the direction of integrity. This is not the kind of research that's easily fundable. It's not hard research, but then things that can be expressed in

numbers are often not as meaningful as things that can only be expressed in words, and sometimes the most important things can never be expressed at all, but only experienced."

Ms. Redl: It's all right there. We can only look for the clues and listen to the clues, and help each other. There's a saying, and Jim used it in his book, "The way that can be described is not the way." I don't know what that means for us when we're looking for answers or trying to do research. I'm not a researcher. I'd like to challenge each of you who is to find new ways. The old ways, the old questions, don't give us the answers. Let's listen for the clues and help each other to heal. Thank you.

Dr. Gordon: Thank you, Maureen and Marilyn. This is exactly the place for you and for what you said. The tools that we're looking at very carefully with our scientific method are not the masters. They're in service to healing, and this whole conference is in service to that healing.