Aware and Present

A Coaching Manual for Family and Friends of Someone Who Is Dying

Linda A. Curran, BCPC, LPC, CAADC, CCDPD

I write as a trauma specialist. My view of death and dying took shape earlier, as a respiratory therapist who sat on the ethics committee. Those years left me dreaming of a hospice called Morphine & Ice Cream. Given my work in psychedelic-assisted therapy, I would now add mushrooms to the name and the menu.

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Before You Begin

This manual is for the people who love someone who is dying of an illness: partners, adult children, parents, siblings, friends. It is education and coaching, not medical or psychological care. Your person's hospice or palliative team handles the medicine. This manual handles what the medicine doesn't: how to stay present, and how to help your person stay present, while there is still time.

Nothing here is a test. Your person does not owe anyone a conversation, a life review, or a peaceful-looking death. Every exercise, ritual, and conversation in this manual is an offer. Anyone can say no.

For symptoms, medications, and anything sudden or unexpected, call your person's hospice or palliative team. Get their daytime and after-hours numbers now, before you need them. The companion workbook has a contact sheet for this.

If you or the person you are supporting is thinking about ending their life, call or text 988, the Suicide & Crisis Lifeline. If a suicide attempt is underway, an overdose is suspected, or there is immediate physical danger, call 911.

Ask before writing down or recording your person's words, and before sharing them. Permission to record is not permission to circulate.

How to Use This Manual

The other manuals on this site run twelve weeks. This one doesn't, because you may not have twelve weeks. Each module stands on its own. Start with Module 1, then go where you are needed.

- *If you have months:* read the modules in order. Do the exercises. Leave time for Module 6, because taking stock takes time.
- *If you have weeks:* read Modules 1 and 2, then go straight to Modules 6 and 7.
- *If you have days:* read Module 1, then Module 9. Say what you came to say. Keep talking to your person.

The companion workbook holds the worksheets, most with a completed example from a fictional family. Use them if writing helps. Skip them if it doesn't. One sentence on a page counts.

Exercises are done at home. Rituals belong to the family. If your person wants a ritual, they choose a lay witness ~ a friend, an adult child, a neighbor ~ someone who can be present without running the show. Your person's therapist, if they have one, is not the officiant.

Module 1: The Frame

Learning to Fall

Teaching people how to fall and teaching people how to die are the same lesson. Neither prevents the impact. Each teaches surrender. The stiff arm thrown out to stop a fall is what breaks the wrist. Bracing causes the injury. So does its opposite: the person who goes limp hits the back of the head. A good breakfall is organized surrender ~ chin tucked, back rounded, the roll carried through. You give up fighting the ground without giving up yourself.

The Window

The window of tolerance is the state in which a person can think and feel at the same time. Inside it, people can talk, listen, decide, laugh, grieve, and be with each other. There are two ways out.

- *Above the window:* bracing. Fight and flight. Fear runs the show. People argue, rush, push for one more treatment, and can't sit still long enough to say anything that matters.
- *Below the window:* collapse. Shutdown and dissociation. People go numb, foggy, or absent. They may look calm. They aren't there.

Bracing and dissociation are survival solutions. They work when survival is possible. At the end of life, survival is not an option. Organized surrender is the only position inside the window, and the window is where goodbyes get said. It is not a test anyone passes or fails. It is a way to notice where you are.

Exercise: Three Times You Fell

Write down three moments from your own life: one when you braced against something you couldn't stop, one when you went numb or checked out, and one when you stayed present through something hard. For each, note what was happening in your body. Choose memories you can manage today; an ordinary disappointment will do. Leave your hardest history alone. You will use these notes in Module 2.

Module 2: Your Own Window

You can't help your person stay in the window if you are out of it. Supporters brace and dissociate too. Most of the time, they don't know it.

What It Looks Like

- *Above:* heart pounding, jaw tight, talking fast, fixing, researching, arguing with the medical team, unable to stay in the chair.
- *Below:* foggy, numb, forgetting what was said in the last conversation, finding reasons to be in another room, scrolling.
- *Inside:* you can feel what is happening and think about it at the same time. You can stay in the chair.

Exercise: Window Check

Twice a day, and before you walk into your person's room, ask yourself: Am I above, below, or inside? If you are out of the window, come back before you go in.

- Feet on the floor. Feel them.
- Name five things you can see.
- Let one exhale be longer than the inhale. Then another.
- Say to yourself what is true right now: where you are, what day it is, who is in the next room.

None of this is a cure. It is a way back in. Use it as often as you need to. You don't have to be calm to sit with your person. You have to be there.

Exercise: Your Own Breakfall

Go back to the moment from Module 1 when you stayed present. What helped? A person, a place, a practice, your own breath? Write it down. That is your mat. Use it.

Ask for a Break

You will need relief. Ask for it in specifics, and ask someone other than your person. "Can you come at four and sit with Luis for fifteen minutes?" gets a yes or a no. "Let me know if you need anything" gets nothing, so don't wait for it. Before you step out, make sure someone is covering if your person wants company.

If Your Person Hurt You

Not every supporter is sitting beside someone who was good to them. If your person abused or harmed you, their dying can bring the old material back at full strength. The body braces or goes numb the way it did then.

You don't have to be there. You don't have to forgive, reconcile, or say goodbye in person. A letter you never send counts. So does a goodbye from a distance, or none at all. If you choose to be there, decide in advance how long you will stay and who takes over when you leave. If old memories are surfacing, get support for yourself from a trauma-informed therapist. This is the time for it.

Module 3: Recognizing Where Your Person Is

Your person has a window too. Learn to read it, not to manage it. You are not there to move them back in. You are there to notice, to stay in your own window, and to make it easier for them to come back to theirs.

What to Look For

- *Bracing:* agitation, anger, demands for more treatment than the team recommends, refusing to talk about what is happening, an insistence on fighting that crowds out everything else.
- *Collapse:* flat, distant, disconnected from conversation, a calm that feels empty rather than settled, saying "it's fine" to everything.
- *Inside:* able to talk about what is happening and feel something about it. Able to laugh. Able to be sad without disappearing.

Before you call withdrawal dissociation, rule out the body. Fatigue, medication, delirium, and dying itself all look like collapse. Tell the hospice or palliative team promptly about new confusion or a sudden change in alertness.

When Your Person Has a Trauma History

People meet death with the system they already have. Someone who survived earlier trauma by bracing may brace now. Someone who survived by dissociating may dissociate now, and dissociative calm can look a great deal like peace. A trauma history doesn't tell you which is happening today. It is not a character flaw either. It is the body doing what it learned to do. Patience, steadiness, and your own presence help. If your person has a therapist, let the therapist know what you are seeing.

Fighting is not failure. Dylan Thomas wrote to his dying father, *Do not go gentle into that good night*. Some people need to rage before they can rest. Your job is not to talk them out of it. It is to stay with them while they do it.

When Your Person Has Dementia

Dementia can make it harder to think clearly, remember, or put feelings into words. That does not mean your person has stopped feeling. Two things follow. First, offer the work of Module 6 ~ life review, unfinished business, letters ~ early, while your person can take part and wants to. Follow their pace; there is no single right moment for everyone. Second, later on, your presence may matter more than a full conversation. Your person may not know your name. They may still respond to a familiar voice, a song, a hand they trust. Follow their cues about what comforts them. Stay in your own window and show up in ways you can sustain.

Exercise: What You Saw

Keep a short log. Once a day, write down what you observed, not what you think it means. "Ate two bites, asked about the dog, cried when the nurse left" is useful. "Seemed depressed" is not. Note who saw it and what you didn't witness. Over a week, the log shows you where your person spends their time, and it gives the hospice team something concrete.

Module 4: Talking About Dying

We live in a country that denies death. Most families have never said the word out loud to each other. Your person may be waiting for permission to talk about it. So may you.

Opening Lines

You don't need a speech. You need a door. Try one of these, then stop talking and listen.

- "What are you most worried about?"
- "What do you want me to know?"
- "What would make the time we have good?"
- "Is there anything you want to say that you haven't said?"
- "Do you want to talk about this, or not right now?"

The last one matters. Some people want to talk. Some don't. Some want to on Tuesday and not on Wednesday. Asking is how you find out.

When the Answer Is No

"Not today" is an answer. Take it without a follow-up question: "All right. I won't bring it up again today." If your person asks you to stop asking altogether: "I'll leave it to you to bring it up." Then do.

What Not to Do

- Don't rush to reassure. "You're going to beat this" closes the door.
- Don't fill silence. Silence is often where the real answer is coming from.
- Don't correct feelings. If your person is scared, angry, or relieved, that is information, not a problem to solve.
- Don't hand your person your fear. If you need reassurance, get it from someone else.

Exercise: One Door a Day

Each day, open one door. Write down what you asked and what you heard. If the door stays closed, that is an answer too. Try again tomorrow, unless you've been asked to stop.

Module 5: Comfort Serves Presence

Organized surrender does not require pain. Managing pain is what palliative care is for. A person in uncontrolled pain is out of the window ~ braced against it ~ and can't say goodbye to anyone. Comfort is what makes presence possible.

Many families fear morphine. They worry it will hasten death or take their person away from them. Hospice teams use opioids to relieve symptoms, and that fear keeps many people in pain they don't need to be in. Opioids can cause drowsiness, and illness itself reduces alertness. If you are worried about sedation, say so. Ask the team how to balance comfort with your person's wish to be alert for the times that matter most. Follow the team's medication plan. Don't change it on your own.

Questions to Ask the Hospice Team

- What is the plan for pain, and what do we do if it breaks through at night?
- What other symptoms should we expect, and what helps them?
- If my person wants to be more alert for a visit or a conversation, what can we adjust?
- Who do we call, and when? What if nobody answers?

The Ice Cream Part

Comfort is not only medication. It is the food your person still wants, the music they love, the window open, the dog on the bed. Ask what would feel good today. Then do it. Offer small amounts of food or drink without pressure. If swallowing is hard, ask the team how to offer comfort safely. When food and drink are no longer wanted, ask them to show you mouth and lip care.

Decisions and Documents

Families often find out what their person wanted at the worst possible moment. Find out now, while your person can tell you.

- *Health care proxy* (also called a health care agent or medical power of attorney): the person who makes medical decisions when your person can't.
- *Living will or advance directive:* your person's written wishes about treatment.
- *POLST:* a medical order signed by a clinician that tells emergency responders and hospitals what treatment your person wants. Some states call it MOLST, POST, or MOST.
- *DNR (do not resuscitate):* an order not to attempt CPR.

Ask the team which of these your person has, where the originals are, and who needs copies. Keep them with the contact sheet, where anyone covering for you can find them.

Module 6: Presence for Themselves

Presence runs two ways: for oneself, and for the people one loves. This module is about the first. A person who is present for themselves can take stock, finish what is theirs to finish, and meet the end. That holds with a full bedside or an empty one.

You can't do this for your person. You can make room for it. Start early. Life review and letters take energy your person will have less of every week.

Ritual: Life Review

If your person wants a life review, set aside the time they want ~ a few minutes or an hour, more than once if you can. Your person talks; you listen; a lay witness records, if your person agrees, by hand or by phone. Your person decides who may read or hear it. Some prompts:

- What are you proudest of?
- What do you want the people you love to remember?
- What did you learn that you want passed on?
- What do you wish had gone differently?

Don't steer. Don't correct. If your person goes somewhere painful, stay with them. If they want to stop, stop.

Exercise: Unfinished Business

Ask your person: Is there anything you need to finish? Write the list together. It may hold a call to make, a thing to give away, a wrong to name or set right. It may hold the practical things: the will, accounts and passwords, who gets the watch, funeral or memorial wishes, burial or cremation, organ donation. Help with what can be done, and let the rest be named. Naming it counts.

If your person names harm someone did to them, don't push for forgiveness or a reunion. The other person may not want contact either. An unsent letter can stay unsent.

Exercise: Legacy Letters

If your person wants to, help them write letters to be read later ~ to children, grandchildren, friends, people not yet born. You can take dictation and read it back. Short is fine. One true sentence is enough. Ask who may receive each letter, when, and where to keep it.

Module 7: The Goodbye

In the final days, the body withdraws on its own. Your person will likely sleep more, eat and drink less, and speak less. That is the landing. If your person wants to talk, don't postpone what matters. Saying goodbye doesn't require an answer. If speech is already gone, say what you came to say anyway.

Don't wait for the right moment. The right moment is any moment your person is inside the window.

What to Say

Hawaiian culture has long had a practice for this. Ho‘oponopono ~ "to make right" ~ brings a family together to repair what is broken between them, through prayer, discussion, making amends, and forgiveness. A later self-help adaptation uses four phrases: *I'm sorry; please forgive me; thank you; I love you.* Palliative care physician Ira Byock offers four phrases of his own: *please forgive me; I forgive you; thank you; I love you.* You don't need all four. You need the ones that are true. No one owes forgiveness.

Ritual: The Goodbye Circle

If your person wants a goodbye circle, gather the people they want there. A lay witness keeps time and keeps the room steady. Each person who wants to speak says what they came to say, briefly, directly to your person. Your person can answer, or not. Anyone can pass. Stop when your person wants to stop. End with whatever your family does ~ a song, a prayer, a meal, silence. Keep it simple. The point is that it gets said.

For the Ones Who Can't Be There

Someone will be too far away, too sick, or too estranged to come. If your person wants contact, phone or video works. A letter read aloud works. Even when your person can't answer, they may still hear it.

Children and Teens

Children in the family know something is happening. Silence frightens them more than the truth. Use plain words: "Grandpa is dying. His body is wearing out, and the doctors can't fix it." Avoid "going to sleep" and "going away"; young children take those literally.

Let children choose how much to be part of it: a visit, a drawing, a recorded message, a place in the goodbye circle, or staying away. Prepare them for what they will see ~ the bed, the breathing, the quiet. Tell their teachers. Name one adult whose job is the children, so they aren't left in the hallway.

Faith and Spiritual Care

If your person has a faith, a tradition, or a practice, bring it in: clergy, a prayer, a ritual, a song. Hospice teams include chaplains who work with people of any faith or none.

Module 8: Psilocybin and Ketamine

Some people never learned organized surrender before the fall. For them, there is psilocybin. It is not a guarantee. The research is strong enough that your person deserves to know about it. The decision is your person's, made with their medical team.

What the Research Shows

In 2016, trials at Johns Hopkins and New York University studied people with life-threatening cancer and clinically significant anxiety or depression. Each participant had preparation, a psilocybin session with trained support, and follow-up. Anxiety and depression dropped substantially and stayed down at six months. NYU's long-term follow-up found the reductions held in most surviving participants at about three and four and a half years. Many rated the experience among the most meaningful of their lives. These were small studies, and the long-term follow-up had no comparison group. Research continues at universities and medical centers across the country.

Roland Griffiths, who led the Hopkins trial, went in cautious about what the experience would do to someone facing their own death. The results were the reverse of what he feared.

What It Is and What It Is Not

A psilocybin session is not a shortcut around presence. Preparation, a trained guide during the session, and help making sense of it afterward are the mat. Fear, confusion, and distress can happen even with that mat. Without it, a person can collapse there too. This is not something to do at home.

Legal Routes for Psilocybin (as of November 2026)

Psilocybin remains a Schedule I substance under federal law. Legal access exists through specific routes, and the rules change quickly. Check with the regulator before you act. Local decriminalization is not a licensed program.

- *Oregon:* licensed psilocybin service centers with trained facilitators. Clients must be 21 or older. No diagnosis is required.
- *Colorado:* licensed healing centers under the Natural Medicine Health Act (Proposition 122). Clients must be 21 or older. No diagnosis is required.
- *New Mexico:* a medical psilocybin program created in 2025. End-of-life care is a qualifying condition. As of November 2026, the Department of Health reports that patient enrollment has not started; its goal is to enroll the first patients by the end of December 2026. The law requires the program to be running by December 31, 2027.
- *Clinical trials:* search ClinicalTrials.gov for psilocybin studies in cancer, palliative care, and end-of-life distress. Check recruitment status, eligibility, and location, then contact the study team.

- *Federal review:* on November 9, 2026, Compass Pathways completed its FDA application for COMP360, its psilocybin formulation, for treatment-resistant depression. It is not yet approved, and the application is not for end-of-life care.

Ketamine

Ketamine is the psychedelic-assisted option available now, legally, in every state. It is an FDA-approved anesthetic, and physicians can prescribe it off-label for depression. A related nasal spray, esketamine (Spravato), is FDA-approved for treatment-resistant depression. Ketamine also has a long history in palliative care for pain.

Intravenous ketamine can work faster than standard antidepressants ~ often within hours to days rather than weeks ~ and that matters when time is short. The evidence in hospice is small: in a 2013 open-label trial, 14 hospice patients started daily oral ketamine; the eight who completed the month showed improvement in depression and anxiety. In those eight, anxiety improved significantly by day 3 and depression by day 14. There was no comparison group. Ask your person's hospice or palliative team about it. If they don't offer it, ask who does.

Medical Screening

Neither medicine is right for everyone. Every legitimate program or prescriber screens medically and psychiatrically. A personal or family history of psychosis or bipolar disorder needs careful review. So do heart and blood pressure problems, delirium or significant cognitive impairment, and every medication and supplement. Being eligible for a legal program is not the same as being medically safe to take part. Your person's hospice or palliative team should be part of the decision. Don't stop or change medications to qualify without the prescribing clinician. Travel to another state is a real burden for someone who is seriously ill; factor that in.

How You Can Help

- Ask your person if they want you to gather information, and which question they want answered first. If they say no, close the folder.
- Help find and evaluate a program, study, or prescriber. Ask how facilitators are trained, how screening works, and what preparation and follow-up look like.
- Help with logistics: travel, scheduling, medications, the hospice team in the loop.
- On the day, follow the program's rules about who may be present.
- Afterward, listen. Your person may want to talk about what happened, or may need time. Don't interpret it for them. Ask what it meant to them.

Module 9: The Final Days

The final days usually bring more sleep, less eating and drinking, changes in breathing, and cooler skin. Ask the hospice or palliative team what to expect for your person, which changes mean you should call, and whom to call at night. This is the body withdrawing on its own. It is not a failure of anything you did or didn't do. Call the team promptly if a change is sudden, if your person seems distressed, or if you are unsure. Pain, struggling to breathe, and new agitation are not things your person has to endure.

Restlessness and Confusion

Some people become restless or confused near the end ~ picking at the sheets, trying to get up, calling out. It is common, and it can often be treated. Call the team.

Keep Talking

A small 2020 study found brain responses to sound in hospice patients who could no longer respond. It doesn't tell us how much a dying person understands. Talk to them anyway. Tell them who has come to visit. Tell them what you want them to know. It counts.

Touch

Go by what your person has wanted. Some people want a hand held; some don't. Ask, if they can answer. A hand on the shoulder, a cool cloth, lying beside them ~ follow their lead, not the picture in your head.

The Vigil

- Make a roster so people rest, with a backup. A vigil that exhausts everyone puts everyone out of the window.
- Use the window check from Module 2 every time you take your seat.
- Let your person have quiet if that seems to be what they want. Presence does not require talking.
- Keep family disagreements and travel plans out of the room.
- Some people die when everyone has stepped out of the room. If that happens, it is not because you left.

In the Hospital or ICU

Many people die in hospitals, and many in intensive care. The window is hardest to stay in there: the alarms, the machines, the rotating teams, the decisions made in hallways.

When I worked in the ICU, I often went with doctors to talk with families and insisted they give two answers: the best case and the likeliest case. Not to discourage anyone. To prepare them for what was coming. Ask for both.

- What is the best case? What is most likely?
- Does my person understand their condition? What have they said they want?
- If we don't do this, what will you do for comfort?
- Can palliative care join us? It can be added alongside treatment.

If your person understands their condition and still wants everything done, that is their choice, and it deserves support. Everyone in the room is entitled to an opinion ~ doctors, nurses, family. No one is entitled to pressure an uncertain family toward a decision based on beliefs your person doesn't share.

- Bring your person's documents from Module 5. The health care proxy speaks for your person's wishes, not the family's hopes.
- If the decision is to stop life support, ask what will happen, how comfort will be managed, and how long it may take. It can be minutes. It can be days. Decide if you want to be there.
- Ask about visiting hours, music, photographs, a familiar blanket. Rules often bend near the end. Ask.

The Moment of Death and the Hours After

For an expected death at home under hospice, call the hospice, not 911. Paramedics may be required to attempt resuscitation unless they can verify an applicable DNR order or a POLST that says not to attempt CPR. The hospice nurse comes to the home, confirms the death, and helps with what comes next.

There is usually time. Ask the hospice how much time local requirements allow. Unless your person's wishes or your faith say otherwise, you may be able to sit with your person for an hour or for several. You can hold them, talk to them, wash their hands and face, dress them, brush their hair, light a candle, open a window. Call the people who want to come. Children can say goodbye too, if they choose.

When you are ready, you or the hospice nurse will call the funeral home, and they will come for your person. Some families leave the room. Some walk beside their person to the door. In a hospital, ask the nurse how much time you can have before your person is moved.

Module 10: After

Grief takes people out of the window too. Expect to brace and expect to go numb, sometimes in the same hour. The window check still works.

Ask for Ordinary Help

In the first days, name small jobs: a dog walk, groceries left at the door, one person to answer the family's messages. Ask by text if a call is too much. You can turn down an offer without explaining.

Ritual: Return

If you want one, and when you want it, gather with a lay witness or a few people who knew your person. Read aloud something your person said, wrote, or loved ~ the life review, a legacy letter, a recipe. Say one thing you are grateful for and one thing you are still carrying. Anyone can pass. Then eat together. Choosing no ritual is also a choice.

When to Get Help

Grief has no fixed timetable. If it stays as heavy at six months as it was in the first weeks, talk with a grief counselor. Don't wait six months if grief is making daily life hard to manage. Medicare-certified hospices provide bereavement support to families for up to a year after the death; ask yours what it offers. For the people helping you through grief, share *Good Grief, Complicated Grief & Traumatic Grief*, the supporters' grief manual on this site. If you are thinking about ending your life, call or text 988. If there is immediate danger, call 911.

Supporting the Supporter

You will need someone before and after the death. Name them while you still have the energy to ask. Give them a job they can do: bring dinner Thursday, sit with me after the appointment, handle the messages to the wider family. You don't have to give everyone the same job.

The shared tools on this site are yours too: the Regulation Toolkit, Guided Imagery Studio, Alpha Wave Music, the Compassionate Inquiry Framework, the Self-Care Assessment, and the Crisis Safety Plan. Use them for yourself. Offer music or imagery to your person only if they want it. The Crisis Safety Plan is for suicide risk or a mental health crisis, not for expected dying.

Resources

- 988 Suicide & Crisis Lifeline: call or text 988 (United States). Call 911 for immediate danger.
- Your hospice or palliative care team: your first call for symptoms, medications, and what to expect.
- Oregon Health Authority, Oregon Psilocybin Services.
- Colorado Department of Revenue, Natural Medicine Division (healing centers), and Colorado Department of Regulatory Agencies (facilitators).
- New Mexico Department of Health, Medical Psilocybin Program.
- ClinicalTrials.gov: search "psilocybin" or "ketamine" with "cancer," "palliative," or "end of life."

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