



WISSENSRAUM NO. 20

THREE BODIES, FIVE SHEATHS

A Map for the Invisible in Palliative Care

“The map trains perceiving more than interpreting.”

AKADEMIE DER WEISHEIT — WISSENSRÄUME

◆ 1. What Becomes Visible — and What Is Nevertheless There

What becomes visible in a sick person demands attention. But it is not everything that is there.

Palliative care usually begins where something becomes visible. A pain can be described and placed on a scale, breathlessness can be observed, and nausea, weakness, weight loss, a wound or a changed appearance call for attention and demand action. This is no failing of the gaze, but its responsibility. Whoever suffers should first of all experience relief, and relief needs a precision that orients itself by what shows itself.

Yet a person does not suffer only where something can be measured, positioned, treated or influenced by medication. Beside the pain there is sometimes a fear no one has asked about, beside the breathlessness the worry of suffocating, beside the physical weakness the shame over a body one no longer recognises. Behind the withdrawal there may be the question of guilt, behind the silence the longing for reconciliation. And in the midst of a serious illness a moment of calm can arise that medicine can hardly explain: a song, the hand of a familiar person, a look from the window into a garden, a prayer, or a stillness that for a moment asks nothing.

These hidden burdens and moments of peace belong just as much to this person's experience; they are only quieter. They fit no measuring procedure, they do not announce themselves, and they easily get lost in a working day timed by shift plans, ward rounds and documentation. This Wissensraum therefore asks for a care in perceiving: What do we overlook when we see a dying person only where something is visible, treatable or nameable?

| *“What does not announce itself is not for that reason absent.”*

◆ 2. A Map Smaller Than the Territory

Whoever wants to explore terrain that cannot be surveyed needs a map — and the knowledge that it is only a map.

Palliative care found a language early on for the many layers of suffering. The concept of total pain describes how suffering has physical, psychological, social and spiritual parts at once, and how these parts cannot be separated from one another in lived experience. It has lastingly changed perception at the end of life, and Wissensraum No. 19 — Palliative Care – Illness, Suffering, Death and Spirituality unfolds it in detail. The model this Wissensraum follows looks at the same person from another direction. It arranges the dimensions of experience not side by

side but from the outside to the inside, like the layers of an onion, leading from the visible through the subtler to what can hardly be put into words.

It is no alternative to the medical or nursing view and no substitute for it. It is an additional map that helps where the customary gaze reaches its limit. And like every map it is smaller than the territory it wants to represent. Whoever trusts it too much finally sees only what is marked on it, and whoever discards it altogether walks without orientation through a country he does not know. Its value lies in sharpening the gaze: it recalls which regions of the human being we have not yet entered, and it invites us to listen gently there instead of establishing something there.

“A map is there to sharpen the gaze, not to replace the terrain.”

◆ 3. An Ancient Map of the Human Being

The idea that the human being is surrounded by layers growing ever finer toward the inside is older than any modern nursing theory.

The teaching of the five sheaths comes from Indian philosophy. It is found as early as the Upanishads, philosophical texts more than two thousand years old, and was later connected in Vedanta with the idea of three bodies. The image behind it is simple: the human being is as if surrounded by layers, like an onion or a matryoshka doll. On the outside lies the visible body. Toward the inside the layers grow finer, down to the innermost core, the Self. Each layer describes a dimension of human experience and is meaningful for accompaniment, but none describes the whole person.

The word “body” here means more than the organic. It denotes a level of being human. The gross body is the visible, tangible physical body that we touch, wash, position and treat. The subtle body comprises everything alive that cannot be grasped and yet takes effect in the body: vital energy, feelings, thoughts, the power of discernment. The so-called causal body denotes, within this teaching, a subtle causal level that is associated with ignorance, imprints and the state of deep dreamless sleep. To the three bodies the teaching assigns five sheaths: the physical, the energetic, the mental, the sheath of wisdom and the sheath of bliss.

For palliative care this need not become a metaphysical creed. Its value begins with a very simple question: What do I perceive when I regard the person not only where his body is ill? The five sheaths can in this sense be understood as five directions of view, not as a hierarchy, not as stages of development and not as proof of a particular worldview. Each of them asks about a different section of the same person.

“Each layer describes a dimension of experience, and none describes the whole person.”

◆ 4. The Body and the Breath

In the two outer sheaths there shows what a person bears even before he speaks of it: his body and his strength.

The physical sheath is the body that lives on food, with its organs, its skin, its muscles and senses. Here pain, nausea, weakness, loss of appetite, wounds and the changes of appearance that a serious illness brings show themselves. Palliative nursing begins here with consistent symptom control according to medical prescription, with careful mouth care, comfortable positioning, attentive touch and the protection of intimacy. And yet bodily care is never merely bodily care. Whoever washes a weakened person touches at the same time his boundaries of shame, his self-image, his dependence and his dignity. The question is therefore not only what this body needs, but equally how this person experiences his body now.

One layer further in lies the energetic sheath, the vital force that animates the body. It becomes perceptible in the breath, in vitality and in the alternation of waking and resting. Breathlessness, exhaustion, restlessness and disturbed sleep are often closely interwoven in everyday palliative practice. Nursing here can mean spreading burdens across the day and planning pauses, relieving breathlessness through suitable positioning and a cool stream of air directed at the face, for instance with a handheld fan, and preserving the available strength for what matters to the person himself. Further nursing measures can be used individually as a supplement.

With this layer the guiding question changes, and with it the view. It no longer asks what someone can still manage, but what he wishes to spend his strength on today. The attention thus shifts from performance to meaning.

“Whoever has little strength should be allowed to spend it on what matters to him.”

◆ 5. Where Feeling and Thinking Dwell

In the mental sheath it shows most clearly how closely the layers of the human being are interwoven.

The mental sheath includes thinking, feeling, perceiving and remembering, the inner experience from moment to moment. Here dwell fear, worry, sadness and anger, nocturnal brooding and sometimes confusion, but equally hope, tenderness and the humour that does not vanish even at the sickbed. This layer in particular makes visible that the sheaths are not separate rooms.

Breathlessness can trigger fear, and fear intensifies the breathlessness. Restlessness can prevent sleep, and lack of sleep can intensify fear. The model does not separate these phenomena from one another; it rather makes their interaction visible.

Accompaniment in this layer often means less solving something than helping to carry something. It consists in listening, allowing the person to put feelings into words, informing honestly to the extent desired, and giving security through presence. A fear of suffocating is taken more seriously when it may be spoken, and when someone explains what is done in the event of breathlessness, which as-needed medication is ready, and what the emergency plan looks like.

At the same time this layer calls for professional care. Not every restlessness is to be understood psychologically, and not every confusion is an expression of inner struggle. It can be a sign of delirium, of depression, of untreated fear or of insufficiently relieved symptoms, and this must first be clarified medically and by nursing.

“Not everything a person bears can be taken from him. Some of it can be carried along.”

◆ 6. Where Life Receives Meaning

In the sheath of wisdom a person asks the questions that no finding answers.

The fourth sheath denotes the inner instance that distinguishes, evaluates, believes, doubts and interprets one's own life. Here lie values and convictions, faith and life review. Here questions can break open that for decades needed no room: Why me? Was my life right? Have I neglected something? Do I still need to say something to someone? Is there something that would have to be forgiven? What remains of me? And what sustains me when so much begins to waver?

Here lies a particular responsibility of the companions. A sentence such as “God is punishing me” is no invitation to theological correction. It is first of all a communication. Perhaps there is fear in it, perhaps guilt, perhaps a religious interpretation or a theme the person has carried all his life. The task of nursing is to perceive what the person himself says, and neither to confirm his words hastily nor to refute them or translate them into an interpretation of one's own. Whoever takes up the other's language instead of imposing one's own leaves him the space in which he can carry his question further. A sentence such as “It sounds as if you have been carrying something for a long time” opens this space without claiming what lies within it. And where a person wishes it, pastoral care can be offered later. How people interpret their suffering and what conceptions of death they bring is unfolded in Wissensraum No. 19 — Palliative Care – Illness, Suffering, Death and Spirituality.

“A sentence about God is first of all a sentence about the person who says it.”

◆ 7. When Nothing More Needs to Be Done

The innermost sheath is easily misunderstood. It describes nothing that would have to be achieved.

The word “bliss” sounds like a state one can strive for or miss. In the palliative context it means something much simpler: those moments of deep calm and connection beyond thinking and willing that sometimes arise in the midst of the gravest illness. They show themselves in listening to a familiar song, in prayer, in a look into a garden, in the nearness of a loved one or in a silence that asks nothing more.

Accompaniment here means making such moments possible and protecting them. That can mean placing the bed by the window, opening visiting times where a child sings, keeping familiar music ready, leaving a rosary within reach or offering a prayer if it is wanted. It can equally mean enduring silence together and letting go of the impulse always to have to do something. Perhaps one of the most difficult competences of palliative accompaniment lies here: to recognise when action helps and when presence is enough.

Restraint remains called for. These moments cannot be produced or expected, and not every person experiences them. Yet the sheath recalls that the experience of a seriously ill person need not consist exclusively of burden, and that moments of peace are possible too. How an accompaniment takes shape that does not fill such spaces with method is unfolded in Wissensraum No. 17 — Radical Presence.

“There are moments in which the best that can be done is to disturb nothing.”

◆ 8. The Self — A Limit of the Model

At the innermost point of the map, what can be described ends, and what can only be respected begins.

Beyond the five sheaths the tradition knows the core they surround: the Self. There it is not equated with the body, not with feeling and not with thought, and according to this teaching it remains untouched by illness. For the palliative translation, this idea can recall the inalienable dignity of the person, the thought that the human being is more than his illness. At this very point the model demands the greatest gentleness, and for palliative care the idea is therefore deliberately limited.

No one has to believe the model. And the concept of the Self need be neither explained nor conveyed to a dying person. For the companions it can mark a simple reminder: this person is never only what I am treating in him right now. He is not “the ovarian carcinoma in room four”, not “the restless patient”, not “the demented resident” and not “the dying woman”. A person remains a person, even where he no longer experiences himself as one. His dignity depends neither on clarity and independence nor on capacity for achievement, and it does not depend on whether he agrees with a particular image of the human being.

With this the boundary between the philosophical teaching and its use in nursing is marked. The question of what the Self is in an ultimate sense belongs in another conversation, which Wissensraum No. 12 — The Reality of Non-Duality conducts. At the sickbed another thought is enough: that someone is addressed, by his name, his story and his preferences, and that his dignity is preserved in every action. A sentence such as “Your true Self remains untouched, after all” does not belong at the sickbed if the person does not bring this view himself. It would be no accompaniment but an explanation, and a person who suffers first needs someone who lets his suffering stand.

“A person remains a person, even where he no longer experiences himself as one.”

◆ 9. Mrs M. — From Side by Side to Connection

How the map works in everyday life shows itself not in the model but in a person.

Let us imagine Mrs M. She is 67 years old, lives with an advanced ovarian carcinoma and has been on the palliative care ward for three weeks. She was a primary school teacher and sang for many years in the church choir. Her husband, 72 years old, visits her daily and seems exhausted and unsure what he should do “right”. The daughter lives three hundred kilometres away and comes at weekends with the grandchildren.

Her body is burdened. The ascites is increasing, she suffers from nausea and dull abdominal pain, she eats hardly anything and loses weight, and when getting up she has no strength at all. During personal care she holds the blanket firmly over her abdomen and says: “I no longer recognise my body.” Even while being washed she becomes breathless, after a few minutes of conversation she is exhausted, at night she lies restless and awake. “I have no strength left for anything.” She fears suffocating — “What if I can’t get any air?” —, broods at night and carries the worry of being a burden to her husband: “I’m only a burden now.” And one day she says, quietly, while she is being washed: “You know, Nurse, God is probably punishing me now. Back then I did something that was never forgiven me.”

At the same time there are moments that do not fit the burdens. When her nine-year-old granddaughter sings with her, Mrs M. becomes calm and relaxed. She prays the rosary, she looks into the garden for a long time and says: “In moments like that, everything is good.” And in the midst of all loss she remains recognisably herself, friendly, humorous, attentive: “I’m still me, after all.”

Without a map all this might seem like a side-by-side, like a list of problems and resources to be worked through one after another. With the map a connection becomes visible. The ascites belongs to the physical sheath, the breathlessness touches the energetic one, the fear the mental one. The question of punishment and guilt touches values, meaning and life review, and the singing with the granddaughter opens a space of calm and connection. None of this exists on its own. The breathlessness causes fear, the fear robs sleep, the lack of sleep wears down strength, the old theme of guilt intensifies the burden as a whole, and music and relationship give a moment of peace that does not heal the body and yet changes something in it.

From this follows an accompaniment that keeps several layers in view at once. The symptoms are treated according to medical orders, with increasing ascites a drainage procedure can be considered, food of her choice is offered in small portions instead of exerting pressure to eat, and during care the body stays covered and every step is announced beforehand. Care is given in stages with pauses, the upper body is raised, and a stream of air directed at the face, for example from a handheld fan, can relieve the breathlessness. Her fear of suffocating may be spoken, she learns what is done in the event of breathlessness, and at night someone is there. Her sentence about God is answered neither with agreement nor with contradiction, but with attention: “It sounds as if you have been carrying something for a long time.” Pastoral care is offered if she wishes it. The good moments are provided for: the bed stands by the window, the rosary stays within reach, the grandchildren may come, and her husband is included and relieved by the outpatient hospice service. Above all, though, she is addressed by her name, as the teacher and singer she is, and not as “the ovarian ca. in room four”.

The decisive insight thus lies less in the question of which sheath is affected. It lies in the question of what is acting upon what here.

“Not: *Which sheath is affected? But: What is acting upon what here?*”

◆ 10. Fine Listening

The five sheaths are not five drawers. They can become five ways of listening.

One can listen to the body: to posture, facial expression, the blanket held tight. One can listen to breath and strength, to the pace of a sentence and the pause after it. One can listen to feelings and thoughts, to what lies between the words. One can listen to meaning and life story, to the questions that surface only in subordinate clauses. And one can listen to those moments in which a person finds calm, and take this calm as seriously as any symptom. The model thus trains perceiving more than interpreting.

In practice this requires a stance that differs from the customary logic of taking a clinical history. It creates room instead of instructing, and asks instead of presupposing. It proceeds slowly, allows pauses and notices its own reaction, the stirring a sentence sets off in the listener which, unexamined, could become an interpretation. A spiritual question need not be answered, a story of guilt need not be solved at once, and a silence need not be filled. A person who no longer wishes to say anything need not be led into conversation.

Whoever wishes to practise this can enter a person he accompanies, anonymised, into the layers: with what he sees, with the literal statements, the burdens and, in a second colour, the resources. Then one can look for what reinforces one another, and note what can help and who in the team is best suited for it, for not everyone hears every layer equally well. The map replaces neither the clinical history nor the assessment. It supplements them with an attentiveness that cannot be translated into scales. A related stance of listening is described by Wissensraum No. 7 — Beyond Listening.

“Not every question that is heard wants to be answered.”

◆ 11. When Relatives Need the Map

Dying rarely happens alone. Whoever stands beside it lives through it too.

Relatives observe changes that often frighten them. The person hardly eats any more, he sleeps more, he speaks less, strength declines, and the breath changes. The decline of eating and drinking in particular can trigger great fear, because it feels as if one were letting someone starve or die of thirst. The model describes here a possible withdrawal from the outside to the inside: hunger and thirst decrease, strength fades, the breath changes its rhythm, interest in the outside world and in conversation recedes, the dying sleep a great deal or seem turned inward. Often clarification, farewell and last wishes follow, and in some people a perceptible calm shows itself.

This image can help relatives to put changes in context and, for example, to understand that diminishing eating and drinking can be part of the dying process. Where dry mouth is distressing, careful mouth and lip care can bring relief, and this is precisely something relatives can do themselves: moisten the lips, hold a hand, play familiar music, simply be there. The relatives too have their own sheaths, with their own exhaustion, worry and guilt.

At the same time what holds for every map holds here: it is an interpretation, not a rule. Courses of dying differ, not every dying takes this course, and not every dying is experienced as peaceful. This limitation belongs essentially to the image, for a map must never become a prescribed path.

“An interpretation can relieve relatives, as long as it does not become an expectation.”

◆ 12. What This Model Is Not

A map gains in value through the clarity with which it names its limits.

The model is no diagnosis. It replaces neither the clinical history nor the assessment. Nor is it a creed: it comes from a particular tradition, and those concerned need neither know it nor share it. For the companions it is an instrument of perception and not of worldview.

It is no hierarchy. The inner sheaths are not “more important” than the outer ones, and whoever is in pain needs relief first. A person who cannot get air cannot be asked about the meaning of his life, and inviting him to it would be no act of care. The model explains no suffering and justifies none, it promises no peaceful dying and calls on no one to interpret a dying person philosophically. And it does not release us from the question whether behind what appears as inner distress there lies a cause that can be treated.

Finally, the decision about what is spoken of always lies with the person himself. He determines which layer he wishes to show, and that is to be respected. It is precisely this limitation that makes the model viable. It is not about explaining a reality to a person. It is about perceiving more precisely which reality he himself is experiencing right now.

“A map that knows its limits does not tempt one to know better.”

◆ 13. The Companions Have Sheaths Too

Whoever accompanies brings himself along: with body, breath, feelings and convictions.

Not only the dying person experiences bodily, emotional, mental and existential movements. Whoever accompanies also brings a body, with its tiredness, its tension and the time pressure of

a shift that seldom allows rest. He brings feelings, compassion, fear, helplessness and sometimes anger. And he brings interpretations, his own idea of a good death, of what relatives should do, of what “letting go” means and of what he himself would want in this person’s place.

The map is therefore at the same time an invitation to self-perception. On which level am I answering right now, the person in front of me or my own fear? When do I want to reassure because I can scarcely bear the uncertainty myself? Two dangers are particularly near: transferring one’s own fears to the other, and passing off one’s own worldview as universally valid. Both are rarely meant badly, and both abandon the person at the very moment they want to come close to him. Wissensraum No. 19 — Palliative Care – Illness, Suffering, Death and Spirituality describes them more fully.

Against this stands a stance that holds closeness and boundary together: serving accompaniment without claim, which does not need the other in order to confirm oneself. To this belong self-care and a team in which not everyone has to be able to do everything, because one accompanies breathlessness particularly well, another the listening in questions of guilt, and a third the silence.

“Whoever wants to hear what another says must first notice what is loud within himself.”

◆ 14. Conclusion — A Map May Disappear

In the end the map should be put down again.

For no one dies in five sheaths. No one suffers in tables, and no one loves in categories. Models help in learning, in perceiving and sometimes in ordering, but in the moment of real encounter no model stands between two people. Someone sits at the bed. There is a breath, a hand, a question. Perhaps a sentence about God, perhaps silence, perhaps a song with a granddaughter.

Palliative care needs knowledge. But it needs just as much the ability not to explain a person to his end too hastily. The three bodies and five sheaths can be a map for this, not because they say what the human being is, but because they recall how much of him can be overlooked.

And what remains is what no map answers: why this suffering, why this person, and what happens where there is nothing more to be done. Wissensraum No. 21 — The Right to Suffer is devoted to what may remain unresolved. Perhaps accompaniment begins precisely where we become attentive enough to perceive also what escapes our first glance.

“Perhaps accompaniment begins where the first glance ends.”

∞ Further Exploration

Those who wish to pursue the questions touched on here will find adjacent explorations in the WISSENSRÄUME series:

- Wissensraum No. 2 — The Ethical Compass in Palliative Care
- Wissensraum No. 7 — Beyond Listening
- Wissensraum No. 12 — The Reality of Non-Duality
- Wissensraum No. 17 — Radical Presence
- Wissensraum No. 19 — Palliative Care – Illness, Suffering, Death and Spirituality
- Wissensraum No. 21 — The Right to Suffer

◇ Sources & Lines of Thought

This Wissensraum does not make a scientific argument. The following works show what its professional and scientific statements connect to — above all those of chapters 2, 3, 4, 5 and 8.

- Taittirīya Upaniṣad, Brahmanandavallī (second section). One of the early, classical presentations of the teaching of the five sheaths.
- Tattvabodha (attributed to Śaṅkara). Introductory Vedānta text that brings the three bodies and the five sheaths together.
- Cicely Saunders: The Management of Terminal Illness. London 1967. Early central presentation of the multidimensional understanding of suffering from which the concept of total pain emerged.
- D. Clark: 'Total pain', disciplinary power and the body in the work of Cicely Saunders, 1958–1967. *Social Science & Medicine* 49 (1999), 727–736. On the development of the concept.
- World Health Organization (WHO): Palliative care. Fact sheet. Definition of palliative care including physical, psychosocial and spiritual problems.
- C. M. Puchalski et al.: Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *Journal of Palliative Medicine* 12 (2009), 885–904. Consensus-based description of spirituality and spiritual care.
- H. M. Chochinov et al.: Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life. *Journal of Clinical Oncology* 23 (2005), 5520–5525. On the dignity of the person at the end of life.
- S3 Guideline Palliative Care for Patients with Incurable Cancer (Germany). Version 3.0, July 2026, AWMF register no. 128-001OL. On breathlessness, anxiety and delirium, dry mouth, and accompaniment in the dying phase.

○ WISSENSRÄUME — Appreciation

The WISSENSRÄUME series is a labour of love — free of charge, but not to be taken for granted. If these impulses have meant something to you and you would like to give something back, I welcome a voluntary donation: [PayPal.me/VossKati](https://paypal.me/VossKati)

Thank you for your appreciation. It helps such content continue to come into being — quietly, lovingly, and in the service of wholeness.

△ WISSENSRÄUME — Notes

The WISSENSRÄUME serve professional orientation, deepening and personal engagement with themes from health, nursing, palliative care, spiritual care, psychology and philosophy. They do not replace individual medical, therapeutic, nursing or legal advice — for acute or serious concerns, please turn to appropriately qualified professionals.