HIV Mental Health for the 21st Century

Winiarski, Mark G.

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In the early years of my practice with HIV-infected patients in an acute-care hospital, I met Edwin. Ed, who died several years ago, was an Hispanic man in his early forties, born a Roman Catholic in New York City. He had spent most of his adult life in and out of prison, and for most of the time I knew him, he remained an inmate in the New York State correctional system.

One day Ed was musing on his life. “You know,” he told me, “when I was growing up, I was sure that I wasn’t lovable, that I wasn’t good enough, that somehow I didn’t meet the mark or the standard. I kept trying to be macho, to earn my way, to be recognized in the crowd.” With a gentle smile, he continued: “What I’ve learned is that eventually you have to outgrow your ego. And what I finally discovered is that who you really are ain’t so bad after all.”

Edwin did not have a college education. He had not studied Jung’s theory of individuation or his theory of the emergence of the self and transformation, nor had he been connected beyond his childhood with any institutional religion, Roman Catholic or otherwise. Yet, he had one of the most thoughtful and developed spiritualities of anyone I have ever met. There was a peace about him—a kind of spaciousness of spirit—that remained with him even as his body weakened and his
mental faculties deteriorated. How might we describe that inner process that was so apparent in Ed’s case? And what might it tell us about the holistic care of persons who are living and dying with HIV-related illness?

It is undoubtedly a truism that it is persons who get sick, not just bodies. It follows, then, that care needs to be directed to the whole person, not simply to a set of physical symptoms. Occasionally, I have been asked as a chaplain/pastoral counselor how I deal with persons who are not religious or “spiritual.” I have long since ceased to offer any elaborate explanations about practice in this regard. I simply note that I have yet to meet anyone who regards himself or herself simply as the sum of his or her body parts.

More often, it seems to me, it is the physically healthy person—the counselor or therapist—who is uncomfortable or unfamiliar with the spiritual, both in him- or herself and in others. In professional practice, this discomfort can show itself in any number of ways. A therapist may think, “I’m not a believer, so I cannot help anyone when he or she starts talking about God.” An even more subtle barrier to effective work may be found in this statement: “He’s talking about God and how God will help him. But I’m not so sure of that. My God is a different God. I’m religious, but he’s not talking my kind of religion.”

In either case, the caregiver starts with predispositions or assumptions—about him- or herself and about the client—that are barriers to skillful care. The therapist’s task in this work is not to make judgments about the client’s expressions of spirituality. Rather, the therapist needs to appreciate the client’s revelation of something deeply personal. The client’s statement begins to communicate how the transcendent presents itself to that client. It is an opening to consideration of eternal questions. Now the task is to listen for and to work with the client’s images, views and expressions of spirituality. All that is required of the clinician is to remain open to these expressions.

With this in mind, this chapter deals with the area of spirituality as it is experienced in the world of HIV-related illness. Following some introductory comments on what we mean by spirituality and on the distinction between spirituality and formal religious practice as it is generally understood, the chapter is divided into three sections:

1. HIV-related illness as an opening into the deeper levels of human life and consciousness, that is, into the area of spirituality. What is it about
the illness and its surrounding circumstances that seem to evoke—one might even say require—the journey inward?

2. HIV-related illness as requiring us to look more fully and directly at death, not only as the inevitable outcome of the course of HIV-related illness but much more as a teaching about life. How can we be with the client whose life span is considerably foreshortened in a way that will be genuinely skillful, helpful, and, most of all, loving and compassionate?

3. HIV-related illness as inviting us as caregivers in the field to a consideration of our own lives and spirituality. Is there a gift for us in the work? Is there an opening for us, an invitation into the deeper levels of human life and consciousness? What are some of the intrapersonal and interpersonal dynamics involved in this process?

**Spirituality and Religion**

The term *spirituality* as I use it here is to be understood in its broadest and most basic sense. Spirituality encompasses the relationship between a person and the transcendent, however it is that the transcendent is imaged, experienced, or named by that person—God, life with a capital “L,” Jesus, one’s Higher Power, Enlightenment, Unconditional Love. It embraces one’s entire life as felt, imagined, and understood in relationship to the transcendent, the metarational, or the profoundly immanent—an imaging and an approach that might be more characteristic of persons who come out of an Eastern rather than a Western worldview.

Religious practice is an expression of this relationship, offering in its healthier forms a loving and consistent community of support and encouragement in the journey toward wholeness and communion that represents the best of the human spirit. Religious practice also includes a host of symbolic and ritual expressions of the relationship between the human person and the transcendent.

While formal religious practice is not synonymous with spirituality, it is important for the mental health practitioner or pastoral caregiver to be aware of the client’s religious and cultural background, even if the person has long since left behind any formal church or congregational affiliation. This is so simply because particular symbols will carry (or fail to carry) for particular persons the experience of the transcendent or unconditioned, depending primarily on the person’s background, personal history, and culture.

Just as the caregiver needs to be cognizant of the person’s religious and
cultural history, it is also essential that he or she remain open to how that person's religious or spiritual journey has unfolded over the years. We need to be wary of making unwarranted or rigid assumptions — for example, that Pentecostals always respond in a particular way, or that persons out of Jewish tradition would never respond to this or that practice. The skillful practitioner always takes his or her lead from the patient, open to the unexpected as it presents itself. In the area of spirituality, as with so many other dimensions of life, Stephen Levine's (1987) observation that the mind can be a wonderful servant though it makes a terrible master is especially appropriate.

**HIV/AIDS as an Opening into Deeper Life and Consciousness**

What is it about HIV-related illness that seems to evoke or even require a deeper exploration of life in all its dimensions? Is there something distinctive in this regard with respect to the world of HIV/AIDS care, something that distinguishes it from practice with persons suffering from other serious or life-threatening illnesses?

There is no doubt that HIV-related illness and its surrounding psychosocial context present a distinctive challenge and opportunity. The following realities shape and describe the world of HIV-infected person. They need to be kept in mind, since they provide the backdrop or context within which we do our work:

- The relative youth of persons who are HIV-infected. Somehow, our worldview, particularly in the West, suggests that people ought to become ill and die in some sort of chronological order. To put it another way, we assume that it is natural or normal for older persons to get sick and die, but not so for younger persons. There is an assumption, often unspoken but nevertheless communicated at a nonverbal level, that the value of a life is measured in terms of the number of years a person has passed on earth rather than in terms of the quality that has characterized these years. This is not so, for example, in an American Indian culture, where one is seen not in a linear way but rather as a circle that becomes complete at about puberty with the rites of passage. From that time on, one is seen as a wholeness that continues to expand outward. Once the circle has formed, anytime one dies, one dies in wholeness. And wholeness, in American Indian wisdom and
spirituality, is seen not as the duration one has lived but rather as the fullness with which one enters each complete moment (see Levine, 1982, 4–5).

- The enormous loss connected with HIV-related illness. A diagnosis of HIV-positivity and the course of the illness as one becomes sicker carry with them a series of losses that can be genuinely devastating. The person is dealing not only with the loss of good health and the loss of a sense of physical well-being but, more profoundly, with the loss of work, productivity, economic independence, normal social life, and, in some cases, family relationships. Given some of the enduring fears and prejudices in our society regarding HIV-related illness, there can also be a sense of loss of respectability, with a concomitant need for secrecy and a pervading sense of embarrassment and shame. This, of course, can impact the person spiritually or at the deeper levels of human consciousness by eroding his or her sense of self as worthy or lovable and of the diminished life as worthwhile or “useful” at all.

- The reality of death as coming sooner rather than later. Although there has been substantial progress in the treatment of the opportunistic infections related to HIV-positivity, and although patients generally live longer from the time of diagnosis than they did ten years ago, there is still no proven way that the virus can be removed from the body once it is there. In that sense, HIV-related illness remains incurable and ultimately uncontrollable by our present advanced medical technology and knowledge. It is a life-threatening condition, a fatal illness. It brings one face to face with the reality of impermanence and death. At one level, it is a terrible blow; at another level, it is a precious gift that can uncover aspects of the person and his or her most precious values, values that have been hitherto unacknowledged or unexplored.

Randy was a black man in his early thirties. When I first met him, he was hospitalized with a serious HIV-related pneumonia. Randy was gay, articulate, well educated, and successful. He came from a socioeconomically poor urban background, and his parents had worked hard to educate him and his six siblings. He grew up in a Baptist tradition, but when we met he was not connected with any church or congregation.

When he was well enough to chat, Randy spoke with simplicity and candor about his situation. He was clear that his physical condition was
terrible. "I certainly do not want to suggest that this illness is a good thing," he told me. "At the same time," he continued, "something has really happened to me since I was diagnosed and particularly as I have grown sicker. I was really on the fast track. I was ambitious, doing well in my career, making a lot of money, and enjoying a very active and not always wise social life. But this illness stopped me in my tracks. So many of the things that seemed important to me didn't matter that much any more. I got back in touch with my family in a way that was wonderful for me. I've slowed down, and I've discovered deeper levels of myself and of life, dimensions of love and relationship and values that I had somehow lost track of when I was well and active in the business world. In that sense, the illness has brought its own gift."

Randy's story, though it may not always be so well articulated, is repeated over and over again in the world of AIDS care. Randy came in touch with the distinction between healing and cure. His HIV illness was never cured, and he died a relatively young man. But Randy experienced healing in the sense that he felt more and more whole as his illness progressed. His spirit was intact, even as his body was assaulted by the illness.

I believe that it is our task as practitioners simply to provide a context or caring environment within which such stories can be told and within which that deeply instinctive exploration of both inner and outer space can take place.

To facilitate this process, I suggest three attitudes or stances on the part of the practitioner (therapist, case manager, chaplain, counselor) that are central to providing such an environment or context: attentiveness, acceptance, and compassion. These stances are undoubtedly essential to any therapeutic relationship. But in the area of spirituality they take on an added dimension, since they represent, communicate, or symbolize that which is, in all the classic religious or deeply humanistic traditions, most characteristic of the mystery we call God, Unconditional Love, or ultimate Union.

**Attentiveness**

Listening carefully is undoubtedly at the heart of our work. In the area of spirituality, it requires a centeredness on our part, an in-touchness with our own inner worlds. This is not so much a rational thing—a habit of mind, so to speak, that keeps us aware of what we think. Actually, what
we think often changes, so what is important is that while we remain aware of that changing mental scene, we stay rooted in the Mystery of Life which goes far beyond any verbalization of how things are or ought to be. In that sense, we need to be wary of any facile attempts to explain the meaning of life, the meaning of illness, a “theology of suffering,” or some other such approach. If that mental apparatus is churning away in us, we will be distracted and not really able to hear the openings into the transcendent, into the metarational, that are always there in the patient or client.

We do not need to work hard at this. The content that we deal with in this area is deep within the person. We do not have to “bring it up” or produce it. What we need to listen for are clues to the person’s larger sense of himself or herself, questions related to why this is happening, who the person is in the midst of all this physical limitation and illness, what will become of him or her as this process continues on what is apparently an inexorable course.

Acceptance

As mental health practitioners, we are present to our patients or clients at some level simply to receive them where they are in their journeys and to hear what they have to say. It is not necessary or helpful, particularly initially, to “do something.” We have neither to agree or disagree, approve or disapprove. I have from time to time seen brochures offering what is termed “nonjudgmental” pastoral care. Is there any other kind? And what does it say about the field, about churches and religious congregations, or about the society in general, that we feel compelled to assure our sick brothers and sisters that we offer them “nonjudgmental” care?

At the same time that we offer our clients an accepting and hospitable space in which to tell their stories, there are ways — through conversation, through our manner (particularly in what is communicated nonverbally), through the skillful use of ritual — in which we can assist the person to come more in touch with what is, in any sound religious or humanistic tradition, a more genuine and helpful spiritual belief and practice.

In the world of HIV-infection, we have more than our fair share of clients whose personal histories have been defined by physical and mental abuse, low self-esteem, and a kind of affective deprivation in their formative years that is astounding and deeply distressing. In many cases, they have experienced the world from their earliest years as a hostile and
unloving environment. And it is often out of this early experience that an equally hostile and unloving deity emerges. This may be either a deity who is busy punishing so-called wrongdoing by inflicting illness and general reversal of fortune, or one who stands by idly in some remote and distant way when he (or she) could be doing something useful to alleviate the situation. Either way, it is not a perspective that is in keeping with healthy religious and spiritual tradition, nor is it helpful in the process of healing and wholeness that is at the heart of the human journey.

Where we are dealing with clients whose religious or spiritual belief and practice torture and constrict them, or if the person is obsessed or consumed by religious images and concepts that are clearly not loving or peace-giving, it might be wise to refer the person, if he or she is open to it, to a more specialized practitioner such as a skillful clergyperson or pastoral counselor. That clergyperson or counselor might assist the client, through conversation, instruction in prayer and meditation, ritual (sacramental confession, the anointing of the sick, special blessings, affiliation with a congregation or spiritual support group), or a combination of these things. In any event, the assistance of a spacious, gentle, accepting mental health practitioner remains an important modality in filling out the spiritual dimension in HIV mental health care.

Compassion

No quality, affection, or feeling comes closer to the heart of spirituality — both belief and practice — than compassion. Compassion is an emotion or quality of connection, rather than separation. It recognizes that, at the deepest level, we are all one as participants in a common humanity. It is clearly distinguishable from pity, which arises primarily out of our fear and which is characterized always by a sense of distance.

Despite the differences that may exist between ourselves and our clients by reason of personal history, lifestyle, education, culture, and other factors, it becomes obvious with any kind of openness and attentiveness that all of us have the same essential needs and seek the same things in life: love, acceptance, and some help when we are in need. We share the same fundamental desire to be happy and to avoid suffering. We experience the same loneliness, the same fear of the unknown, the same secret areas of sadness, the same half-acknowledged feelings of helplessness (see Rinpoche, 1992, 175). In the long run, the transcendent is reflected in our lives most by the longing in our hearts for love — for a love that goes
beyond our so-called worthiness or unworthiness, for a love that in some mysterious and inexplicable manner lives on without limit. There is a sense in which a single lifetime, no matter its extent chronologically, does not seem capable of holding and completing the longings of the human heart. The very impermanence of everything we experience as human beings on this earth or on this plane of existence seems to point toward something else, toward something beyond what is immediately tangible.

Offering to our clients who are affected by HIV-related illness our compassionate, connected, loving presence is perhaps the greatest therapeutic gift we can give them, since it most nearly reflects the transcendent dimension of human existence and, as such, provides a context or environment for the healing of spirit that is always available to us in the human situation.

Looking More Fully and Directly at Death

HIV-related illness remains incurable at this point in history. As indicated earlier in this chapter, it is a life-threatening condition, a fatal illness, and, as such, it brings one face to face with the reality of impermanence and death. In one sense, it is the ultimate invitation to spiritual reflection. Difficult as facing this reality may seem at one level, it is also at another level a "window of opportunity," an invitation to deeper reflection on values and on what really matters in the course of a human lifetime.

In Tolstoy’s masterful short novel, The Death of Ivan Ilych (1886/1981), Ivan Ilych is close to death and struggling mightily with the meaning of his life. Ivan has lived a superficial, self-satisfied, proper, ordered, somewhat mean, externally successful life; yet, he finds himself deeply depressed, angry, tortured, and isolated as his illness proceeds on its relentless course. His life seems to him at this point to have had no meaning at all. Ivan muses: “Yes, all of it was simply not the real thing. But no matter. I can still make it the real thing — I can. But what is the real thing? Ivan Ilych asked himself and suddenly grew quiet” (132; italics are the author’s).

Perhaps that is the central question of everyone’s life. What is the real thing? What is really of enduring value? What or whom do I care about most? These are the questions for all of us, and we can offer no better service to our clients with HIV-related illness as they grow sicker and come closer to death than to be with them in a skillful, gentle, and compassionate way as these questions present themselves.

There was a short film produced several years ago in one of our state
correctional systems. It was a skillful piece of film making, and it was
designed, I am sure, with the good intention of raising inmates’ awareness
of risk behaviors that could lead to HIV infection. However, it had an
unfortunate title: *AIDS: A Bad Way to Die.* HIV infection is undoubtedly
a “bad thing” to get, but dying from the complications of AIDS is not
necessarily a “bad” way to die any more than is cancer, heart disease, or
kidney failure. When all is said and done, a good way to die is the same as
a good way to live: in love and connection.

In the day-to-day world of HIV mental health care, what are some of
the ways in which we can be of assistance as illness becomes more serious
and death becomes more imminent? I suggest the following as essential
in care and support of our clients at this stage of their illness:

• *Deal with the fear of death*

Underlying all spiritual care of the dying is our view of the
relationship between life and death, between living and dying.
Particularly in our Western mentality and worldview, we tend to
separate living and dying too sharply. Actually, death is not the
opposite of life, but rather an aspect of life. It is an event in that
process we call being or becoming. Joseph Campbell suggests
that one can experience an unconditional affirmation of life only
when one has accepted death not as contrary to life but as an
aspect of life. He goes on to suggest that dealing with the fear of
death can be the recovery of life’s joy (see Campbell, 1988, 152).
If this is so — and my experience of working with hundreds of
terminally ill AIDS patients over the past decade tells me that it is —
then, paradoxically, looking directly at the prospect of death
often allows for a better, fuller, happier life. One terminally ill
patient is said to have commented during the course of her illness
that she had never been so fully alive as since she was told that
she had a terminal illness. And another quipped: “I think that
survival has been vastly overrated.” One of my own patients,
Dan, told me on his thirty-seventh birthday, an occasion that he
celebrated in the hospital in the last stages of his illness, how
happy he was. “I don’t have to prove myself any more,” he said.
“All I have to do is love.”

• *Be truthful.*

It follows from the first point that we need to be truthful.
Truthfulness does not mean insensitivity, or a kind of awkward,
self-conscious bluntness that is ill attuned to the sick person’s timing and inner space. But it does mean that we recognize and acknowledge what the patient usually knows already: That there are limits to medical knowledge and technology, that he or she is not getting better, that the body is weakening, and that he or she will die sooner rather than later. Again, Tolstoy describes the sick person’s predicament:

Ivan Ilych suffered most of all from the lie, the lie which, for some reason, everyone accepted: that he was not dying but was simply ill, and that if he stayed calm and underwent treatment he could expect good results. . . . And he was tortured by this lie, tortured by the fact that they refused to acknowledge what he and everyone else knew, that they wanted to lie about his horrible condition and to force him to become a party to that lie. (Tolstoy, 1886/1981, 102–103)

In this context, too, I suggest that it is generally not helpful to suggest to persons, particularly at this stage of the illness, that they “fight.” “You can beat this thing,” some well-intentioned friend, relative, or caregiver might say. But the truth of the matter is that this is a battle that, ultimately, we cannot win and are not meant to win. Suggesting, therefore, that the patient put his or her already limited energy into fighting death can exhaust the patient and make him or her feel like a failure or disappointment in our eyes. Finally, there is often a direct correlation between fighting life and fighting death. It is time to put the battle to rest and to encourage our loved ones and clients to use the energy saved to live fully and attentively and to love deeply and extravagantly.

- **Counsel to live in the present.**

  The best preparation for death, the best “spiritual practice” for living and dying, is to live in the present moment and to embrace whatever is happening. It is resistance to the moment—in a sense, it is resistance to life—that can cause suffering as death approaches and that seems to evoke such tightness and fear in all of us when death is mentioned. Whatever we can do to assist the very ill person to live in the present, to be free of the endless cycle of guilt and regret over the past or fear and apprehension over what will happen in the future, is all to the good. Practical matters—such things as advance medical directives, guardianship of minor children, and financial concerns—are best taken care of
earlier rather than later when the person becomes very ill. The task at the end is primarily a task of the heart and of the spirit. As far as possible, we need to encourage our clients to leave themselves space for that task by taking care of the rest earlier along the way.

• *Provide an atmosphere of love.*

Finally, it is important in the care of the terminally ill and dying to provide an atmosphere of love and encouragement, rather than one of agitation, fear, regret, and excessive “busyness.” We need to remind the person verbally and nonverbally that we are more than bodies and that who we are is far greater than what is happening physically. I have sometimes said to patients along the entire course of their HIV illness: Remember—you have the illness. The illness doesn’t have you.

Ultimately, our true nature—our most essential identifying characteristic as human persons—is the ability and desire to love and to be loved. To remind a person at the end he or she is loved is perhaps the greatest service we can offer. Ivan Ilych discovered this in the midst of his anguished question, “But what is the real thing?” Tolstoy tells us:

This took place ... an hour before his death. Just then his son crept quietly into the room and went up to his bed. The dying man was still screaming desperately and flailing his arms. One hand fell on the boy’s head. The boy grasped it, pressed it to his lips and began to cry. At that moment Ivan Ilych fell through and saw a light, and it was revealed to him that his life had not been what it should have but that he could still rectify the situation. “But what is the real thing?” he asked himself and grew quiet, listening. Just then he felt someone kissing his hand. He opened his eyes and looked at this son. . . . (Tolstoy, 1886/1981, 132)

*An Invitation to Caregivers*

There is a wonderful vignette in the Franciscan tradition that recounts a conversion story of Francis, that great medieval romantic and founder from whom sprang a number of religious communities that survive even to the present. It is a story that is significant in the context of this chapter, since it is particularly germane, I believe, to how we go about our work in the field of HIV/AIDS mental health care and to the gift that the work might conceivably hold for us.

The historical sources tell us that Francis, the son of a wealthy Italian
merchant, gradually was drawn to leave his worldly position, of which he was quite fond, to follow Jesus and to explore more deeply his own religious and spiritual journey even as he served the poor of his day. One day, so the story goes, Francis was on the road between Assisi and Lazzaro, the location of the hospital that cared for those suffering from leprosy, an illness that in Francis’s time was viewed with fear and aversion. In the course of his journey, Francis met one of the patients from that hospital, and, in spite of the man’s appearance, he found himself deeply moved and drawn to him. Francis bent down and kissed the sick man, and, in so doing, he finally came in touch with himself—with himself as he was: limited, lovable and loved, capable of loving.

In the Franciscan tradition, this event is regarded as a key moment in Francis’s conversion, as a kind of turning point in his spiritual journey. It is noteworthy, too, that some of the hagiographers over the centuries attempted to “clean up” the story by changing the original account to read that Francis saw Jesus in the leper—and that’s what led him to embrace the man. But subsequent Franciscan scholarship has confirmed the original version: The story—and the teaching it reveals—remains as written.

Perhaps this vignette reflects the central reality of the connection between our professional work as practitioners in the world of HIV mental health and our own human and spiritual journey. There is a gift for us in the work that is real, mysterious, and at some level priceless. Essentially, we are in service to our brothers and sisters with HIV-related illness not as some sort of distant benefactors but as fellow human beings on the same human journey. There is only a single work, really: The work with ourselves and the work with our patients or clients are one and the same.

Working with HIV-related illness, particularly in its later stages, encourages us to learn, ourselves, to live fully in the present moment, to let go of our strong need and desire to control, and to embrace the reality of impermanence and death. The work invites us to an awareness that carries with it a simultaneous mindfulness of what is going on in the person who is ill as well as what is going on in the inner world of the clinician. We become aware of our own fears, yearnings, doubts, and hopes. In short, we become aware of our own search for “the real thing.” Joseph Campbell (1988), the teacher and scholar who did such important work in the exploration of myth, suggests that the only really inexcusable sin is inattention, and Stephen Levine (1987) regularly reminds us that anything that is not brought to awareness cannot be healed.
In the Christian spiritual tradition, there is a way of reading some of Jesus's stories, particularly the parables of the kingdom, on an intrapersonal level, and this is undoubtedly true of stories in other traditions. The familiar lost sheep and the lost coin, for example, represent those pieces of our experience and of ourselves that we have marginalized, denied, or exiled. Failure to come back in touch with them, failure to acknowledge them and to invite them back in can close us to healing and can block the further growth to which we are called all along the way. Working with those whom the society has frequently marginalized invites us not to perpetuate that mode either with ourselves or with others. As we encourage our clients to wholeness, we are reminded to seek such wholeness for ourselves. Conversely, continuing to marginalize or deny parts of ourselves and of our experience inevitably allows us, both individually and as a society, to continue to shut out from our embrace and our care those who are most in need and who often have the most to teach us.

Finally, attentive work with persons with AIDS teaches us compassion, a sense of profound connectedness and benevolence, what a Buddhist tradition might term "nonduality" and what is expressed in the Judaeo-Christian tradition as "loving one's neighbor as oneself." In a very real sense, our neighbor is ourself, and as we befriend him or her we befriend ourselves. As the work continues to invite us to reclaim or recall those parts of ourselves and of our experience that we reject or disallow, inevitably we come to realize, as Edwin did, that who we really are "ain't so bad after all."

REFERENCES


READINGS ON SPIRITUAL ISSUES

In my experience of nearly ten years of working exclusively with persons suffering from HIV-related diseases, many of them in the last stages of their illness, I am
particularly indebted to the work of Stephen Levine. Three of his books provide an excellent source of both theory and practice:

- *Meetings at the Edge* (New York: Doubleday, 1984)
- *Healing into Life and Death* (New York: Doubleday, 1987)

Levine has also written a more recent book that includes some excellent material that can be adapted to a wide spectrum of patients or clients at various stages of their illness: *Guided Meditation, Explorations, and Healings* (New York: Doubleday, 1991).

For those who would like to explore more deeply and thoroughly some of the connections between mental health practice and spirituality, there is a fine work by a psychiatrist, Gerald May, titled *Will and Spirit: A Contemplative Psychology* (San Francisco: Harper and Row, 1982). The chapter titled “On Being a Pilgrim and a Helper” is particularly pertinent to our work in the field of AIDS. Also, Jon Kabat-Zinn’s most recent book, *Wherever You Go There You Are* (New York: Hyperion, 1994), is a good practical guide in the area of spiritual practice.

Finally, there is a collection of excellent interviews in *Timeless Visions, Healing Voices* by Stephan Bodian (Freedom, CA: Crossing Press, 1991). The book comprises a series of conversations with persons Bodian describes as “men and women of the spirit.” The interviews with Arnold Mindell, Joan Borysenko, David Steindl-Rast, and Stephen Levine are especially relevant to the subject matter that we have been considering in this chapter on spirituality.