INTO THE LIGHT: WORKING WITH DYING AIDS PATIENTS FROM A CONTEMPLATIVE PERSPECTIVE[1,2]

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Development is evolution; evolution is transcendence; and transcendence has as its final goal Atman, or ultimate Unity Consciousness in only God. All drives are a subset of that Drive, all wants a subset of that Want, all pushes a subset of that Pull—and that whole movement is what we call the Atman-project: the drive of God towards God, Buddha towards Buddha, Brahman towards Brahman, but carried out initially through the intermediary of the human psyche, with results that range from ecstatic to catastrophic.

—Wilber, 1980, p. ix

Through the course of compelling events in my life that provide friction or "grist" for my own evolution, I've come to feel that this so-called "Atman-project" is the underlying context and process of all life while my personal experiences provide the content.

By confronting some extreme conditions in myself and others I have moved through the despair of family traumas, the birth of my spiritual awareness, subsequent trainings in Buddhist meditation practice and Karma Yoga, a master's program in counseling psychology with a transpersonal emphasis, receiving a diagnosis of HIV+, and the challenges of working as a counselor through Shanti Project on the AIDS unit at San Francisco General Hospital.

These life events, plus years of personal psychotherapy and supervision and working in psychiatric wards, have expanded my awareness in ways that would not have been possible if even one single condition had been different. My aim in writing this paper is to relate how personal background, spiritual practice, and training in counseling psychology have prepared me for using a contemplative approach in working with dying patients that, hopefully,

furthers each of us on our paths toward unity consciousness or shared awareness.

PERSONAL BACKGROUND

As a young child I enjoyed peak experiences (Maslow, 1971) through nature and music which soothed me in the midst of family turmoil. At times I spontaneously felt a sense of joy and perfection of such depth that it seemed some force was being invoked beyond my limited, individual self.

When I was 15, my parents divorced. It was a very painful period during which my mother made numerous suicide attempts. I was driven through suffering to search for a deeper meaning in events that sometimes felt unjust and meaningless to me. Consequently, during a three year period of intensive individual psychotherapy I "awakened" to the psychological realm. I realized at 16 that this was the profession I was meant for but had never known existed. If healing my acute dissatisfaction with life was possible, then the potential for continuing growth seemed limitless.

At age 17 I began working as a counselor in a chemical dependency rehabilitation center and discovered biofeedback, which exposed me to increasingly subtle planes of consciousness. Later I was drawn to Buddhist meditation practices for their simplicity (I could leave the biofeedback equipment behind), though I intensely avoided getting involved in "religion" because of the way I had seen my mother and others use it to avoid dealing with their psychological problems.

That changed radically during my freshman year of college when I read a short story entitled, "The Transformation: Dr. Richard Alpert, Ph.D., into Baba Ram Dass" (Ram Dass, 1971). I felt I had "come home;" I had encountered a being who truly understood. His story validated the place in me that dared to imagine it was possible to transcend the limits of personal boundaries—that there was something more. As a result, my study of conventional Western psychology became entwined with a parallel pursuit of Eastern spirituality.

At the end of my junior year, my mother committed suicide, and

three months later, her father died. Nothing had prepared me for the despair and sense of meaninglessness that followed that summer. I became disillusioned with life and its apparent injustices, but I was also dealing with the issue of my own mortality. It was clear that if my grandfather and mother could die—the physical "source" and lineage of my own body—I would also.

Then at a week-long retreat, "Dying into Life," with Ram Dass, Stephen Levine, and Dale Borglum, I understood for the first time that that which dies is ultimately our sense of separateness. I saw that life consists of a continuous series of "mini-deaths," all of which are a natural unfolding and when not resisted make way for the birth of something more whole and evolved.

I met with Ram Dass in a one-room school in the woods, heard myself tell him my deepest secrets and fears, and felt myself being seen through unconditionally loving eyes. I told him of things that had hurt me, and he told me of similar things that had hurt him. I no longer felt alone. I saw how "my" pain was actually part of "the" pain (Levine, 1987) of being human. Suddenly my whole life made sense. I knew there was a meaningful order to things and that my life, including the manner of my mother's death, was entirely without error. Everything I had experienced was a necessary condition for that moment to occur.

Since that time my life itself has increasingly become the vehicle through which I pursue spiritual awakening or "the healing for which we took birth" (Levine, 1989). I am aware that by helping my patients I'm helping myself as well. The work forces me to confront my own attachments and gives me an opportunity to practice compassion through Karma Yoga, the spiritual discipline that emphasizes an attitude of devotional service in *all* of daily life. And working with AIDS patients while being HIV+ myself reminds me that time is short.

TRANSPERSONAL COUNSELING THEORY

Through the graduate program in counseling at John F. Kennedy University I developed a heightened appreciation of what Wilber (1986) terms a full spectrum model of human development.

In this model, which draws on object-relations theory of personality development and Buddhist perspectives on consciousness, the false split between "self" versus "no-self" is healed. Psychological and spiritual development become complementary aspects of an ever-expanding and inclusive hierarchy of wholes appropriate at different phases of development. This underscores the value and initial necessity of the personal self and the ways in which its development is required for successful functioning in the world. According to Engler (1986), both Buddhist psychology and psychoanalytic object relations theory define the essence of the ego in a similar way:

> . . . as a process of synthesis and adaption between the inner life and outer reality which produces a sense of personal continuity and sameness in the felt experience of being a 'self,' a feeling of being and ongoingness in existence. (p. 21)

Object relations refers to:

> . . . the sequence and quality of one's experiences with interpersonal objects, especially with primary caretakers, and the internalization of these interactions in a representation of 'self' and a representation of the 'object' which are linked by an affect. (p. 26)

Blanck & Blank propose that attaining stable emotional objects (i.e., object constancy) occurs at "the point of . . . differentiation between self and object representations, and the capacity to retain the representation of the object independent of the state of need" (cited in Wilber, 1986, p. 89). This process of structuralization in the infant is so critical that they consider it to be "the fulcrum of development."

The self-system becomes an independent organizing principle motivated to maintain itself. Rooted in the view that it is inherently separate, the personality tries to remain so out of fear of death. As structures of consciousness emerge, the self identifies with them. The emerging experience of self then becomes physical, emotional, and mental (Wilber, 1986). Thus, the self's nature is to preserve and solidify its believed existence in order to function in the world. From a psychoanalytic perspective psychological health is seen as the completion of intrapsychic organization of object-relations into

functional constellations or structures; psychopathology is the lack of structuralization, and each level of personal development has its associated dysfunction.

At the most basic level, the child who does not form a sense of physical boundaries remains "fused" with his or her surroundings, and this becomes a precipitant for psychoses. Once children are able to differentiate their bodies from their environment, an emotional self can be developed. With the capacity to differentiate their feelings from those of others, narcissistic disturbances are minimized at later stages of the life cycle. As the child learns to think, a sense of psychological separateness is created. This level of structuralization allows for regulation of self-esteem, identification, and effective styles of relating to the world. When adequate differentiation of self does not occur, weak emotional boundaries make the child vulnerable to "flooding" by the surrounding environment, resulting in borderline conditions. If successful, however, the prerequisite object relations allow for employment of repression and other "higher" defense mechanisms. Thus, the normal individual is functional, albeit neurotic.

In the Buddhist view, consciousness infers its existence via the basic ignorance that some identifiable "thing" is inherently separate from the whole. Attachment to this basic misperception is the root of all suffering. Transcendent consciousness is beyond the duality of subject and object and dependence upon sense organs. In the unboundless, no separateness or permanent self exists, so there is no suffering caused by the attachment of an inherent identity to what is impermanent.

Believing that one's embodied personality is an ultimate identity rather than a transient image that is only relatively real is referred to as "inverted view" (Engler, 1986). When our bodies inevitably change, the very fabric of who we believe ourselves to be is threatened, and fear ensues.

A transpersonal view of consciousness paradoxically includes all aspects of the personal and transcendent. *Dhyanic* or meditative consciousness "represents the union of the two aspects of conscious-

ness, in which individual consciousness is not lost, but is transcended in the union with universal consciousness" (Humphreys, 1984, p. 58). What was self or no-self is integrated, becoming self *and* no-self (Engler, 1986).

At a spiritual level, the personality is "pathological" to the degree that it functions under the illusion of separateness. Almaas (1986) proposes that "the personality and the ego identity develop to fill the void resulting from the loss of essence in childhood" (p. 45). Ego-based identification is, by nature, the very antithesis of unitive awareness or essence out of which it arises.

The optimum level of being is a state of wholeness or nonduality, which includes both the personal and transpersonal dimensions. It is ultimately *shunyata,* the all-inclusive ground of emptiness out of which ego structures arise as subsystems. According to Vaughan (1986):

> From a transpersonal perspective, one might say that to heal the self is to transcend the self. Wholeness lies in recognizing the illusory nature of all self-concepts. . . . Improving self-concept, then, may be considered an expedient teaching in which one illusion is exchanged for another. . . . However, since all separate self-concepts are misperceptions of reality and hence some form of delusion, they all tend to perpetuate suffering. . . . Only in complete disidentification and transcendence can the psyche be whole or fully healed. (p. 69)

The ultimate goal is the enhancement of a unitive or shared awareness. The process of cultivating this has been referred to as "retrieval of essence" (Almaas, 1986), and the "alignment of the personality with the total self" (Fadiman, 1980, p. 177). It is an integrated state of being which does not require complete dissolution of the personality but only a change in its relationship from master to servant of spirit.

In sum, while transpersonal psychology clearly appreciates the everyday value of ego structures, merely fortifying the ego is not considered the "summit" of well-being (Walsh & Vaughan, 1980). After developing a self, we later use it as a method or platform from which to return to its source. It is a process of continual expansion

of identities outward to include everything, eventually returning to no-thing: *shunyata*.

CONTEMPLATIVE PSYCHOTHERAPY

> Whether our methods involve words or touch, meditations or medicines, our techniques and interventions are vehicles of transmission. What they transmit is an environment in which healing can occur. Just as in a garden, we do not "grow" flowers; rather, we create the conditions in which flowers can grow.
>
> —Ram Dass (1989, p. 171)

Whatever the technique, the underlying principle of this approach is that of any contemplative orientation: the environment or context for healing arises out of the emptiness and awareness of the therapist. This requires that he or she have an experiential foundation in contemplative practice, a deeper center from which to act, rather than react, during the process of working in psychotherapy. My responsibility as a psychotherapist is to be mindful and accepting of my own fears and pain as they arise, in order to cultivate equanimity and perceptual clarity.

The nature of consciousness, which Vaughan (1986) says is "itself both the object and instrument of change" (p. 186), is a central focus in both therapist and client. The therapist's awareness creates an "optimally spacious environment" (Ram Dass, 1988, p. 9) in which psychological and spiritual realms can be bridged when clients are ready.

A therapist who is aware, compassionate, and comfortable with expanded dimensions of being will engender this in his or her clients; however, a therapist who is fearful and judgmental of clients limits their range of movement and is more likely to pathologize transcendent experiences. Ideally, because of the work we have done on ourselves, we can work within a place behind roles, beyond the limiting and entrapping relationship of "helper" and "helpee."

For me, all of the material that arises is worked with from the therapeutic *asana* (posture) of Karma Yoga. As a therapist, and in life in general, this requires that I intuitively feel the work to be *dharmic* (right conduct for my own evolutionary development, in

harmony with the lawful unfolding of things) and practice non-attachment to the outcome of my actions together with non-identification as the "doer." To the degree these principles are applied, a healing environment is created. One simply bears witness as if "acting by proxy" (Eliade, 1973, p. 158) for another to whom the fruits of our labor are offered. As Ram Dass (1975) describes it, "You are really nothing, and the more nothing you are, the more light comes through" (p. 88).

In relationships, therapeutic or otherwise, human beings are viewed as inherently capable of healing a personal self and of transcending this at a more sophisticated level of awareness than infantile "oceanic oneness" (Freud, 1966) as they access unitive dimensions. The ideal client-therapist relationship is one in which two beings—as I and Thou (Buber, 1958)—form a contract of reaching for truth *together*. There is a sense of camaraderie, a partnership of two travelers on a journey of unknown destination (Bugental, 1978). The therapist provides the context, the client brings the content, and together the process unfolds.

Defenses are seen as metaphors and coping strategies of the psyche and are worked with if and when they occur. The way that transference, countertransference, and resistance play out during therapy are viewed as examples of the ways in which they unfold outside the therapy hour.

Transference as Corsini (1979) describes it is "a form of memory in which repetition in action replaces recollection of events" (p. 21). If the situation is appropriate and the client is receptive, when such unconscious projections occur unhealed fragments can be brought to awareness and explored within the safety and boundaries of the therapeutic container.

Because the therapist is responsible for maintaining the therapeutic context or container, he or she needs to be especially aware of and process material from his or her own unhealed personality that clouds accurate perceptions of the client. Countertransference, of course, does not include appropriate reality-based emotional reactions to the client, which occur in the present and can actually

be very useful sources of information. Processing inappropriate reactions can occur through such methods as recentering, personal psychotherapy, or clinical supervision. If none of these helps resolve the therapist's issues, the client should then be referred elsewhere.

Due to my own history, I sometimes find countertransference issues arise with clients who threaten suicide. To maintain a therapeutic perspective, I remind myself that this client is not my mother and refocus on present conditions. When I'm aware of sadness, grief, anger, or other mental states which are not directly connected to the current interaction, I use such methods as mindfulness of breathing (Goldstein & Kornfield, 1987) and redirecting awareness away from my personal content.

Finally, the wisdom of resistance is honored as a positive function of the personality since it points to constrictions in the free flow of awareness. Michelle was a patient who had resistance to working on intimacy issues. She became angry with me whenever our level of contact began to deepen. With repeated explorations we found that while anger was an appropriate defense during childhood against her alcoholic, abusive parents, it now limited what she wanted most. In the safety of the therapeutic relationship, she was eventually able to relate to her anger as a barometer indicating her success in becoming more intimate. By noting her anger as it occurred and observing it rather than getting swept up in it she accessed a deeper level of relating that her personality had originally attempted to protect.

CONTEMPLATIVE THERAPY WITH DYING PATIENTS

> The acknowledgment of impermanence holds within it the key to life itself. The confrontation with death tunes us deeply to the life we imagine we will lose with the extinction of the body. . . . We imagine we will die only because we believe we were born.
>
> —Stephen Levine (1982, p. 3)

Philosophy

In my work as an AIDS counselor I'm concerned with issues of death and dying and their interface with issues of life and living.

It is my experience that individuals have extraordinary potential for awakening when death is approached consciously as a point of transition rather than with the common Western view of death as the enemy. Our personal experiences while dying provide the gateway to the underlying ground of being, upon which the *lila* (divine play) of God returning to God unfolds. When one is not consumed in fear, it becomes possible to die into the very life force that binds us all.

Dying is not special, contrary to what the melodrama surrounding it might suggest. According to the Tibetan Book of the Dead (Fremantle & Trungpa, 1975), the dissolution of the personality that occurs around the time of death is only one of several evolutionary passageways. Dying, like pain or suffering, merely prods us to awaken. As Levine (1990) reminds us, "It isn't pain that awakens us. Pain is pain and it's a drag! Pain gets our attention. And attention awakens us" (p. 4).

Existentially, a sense of well being arises out of directly confronting pain and fearful realities such as aloneness and mortality (Bugental, 1978). Working directly with such conditions is a powerful gateway to the transcendent. Avoiding this confrontation results in alienation, a sense of meaninglessness, and despair. By directly exploring our own death and fears surrounding it, I find that we inevitably ask ourselves such illuminating questions as "Who dies?" (Levine, 1982) and "Who am I?" (Maharshi, 1968). This, in turn, provides a portal for the shared awareness that is untouched by death.

It is an axiom of hospice training that people die the way they live. Clients who live their lives in denial tend to die in denial, and those who have been growth-oriented usually find that dying is enlivening. The way we relate to our fear of death—regardless of whether it is of an ego identity or the body—informs us about how we meet life itself, the depth of our surrender to what is.

In my job, I am an invited guest of the patient. It is not my place to impose additional burdens, particularly if they predominantly reflect my needs rather than the patient's. Sometimes those who are

dying are extremely fearful and ask me if I think they are dying. Regardless of how I respond (if they don't ask, I don't volunteer), it is necessary to assess the possible consequences to the patient. When the question seems genuine, and I intuit that the truth would be healing, I am willing to answer as honestly as possible. When my sense is that telling someone they are dying would merely intensify their denial, paranoia, or panic, I prefer to ask the person to talk about what they're experiencing and then empathize with their concerns. Most of all, my desire is to do no harm. As Stephen Levine put it at a meditation retreat, "We don't always have to *tell* the truth, we just have to be *able* to."

Fear can be either an impediment or a vehicle—that is, it can maintain an impenetrable wall or become, as Ram Dass puts it, "grist for the mill" (Ram Dass, 1975) of accelerated growth. On a physical level, fear consumes energy that could be used for healing and may inhibit the effectiveness of medical treatments (Borglum, 1990; Levine, 1987) or reduce receptivity to interventions. Psychologically, fear of death constricts personality functioning, reducing it to a more primitive level of defensiveness. Spiritually, clinging to fear blocks access to our essential being. By working with our fears of dying we can create the possibility of healing on many levels. None of us can be forced, however, into moving through and transforming those fears until we are ready.

Techniques

Generally, the content and level of work when dealing with AIDS patients are determined by the patient. Some want to learn to manage physical pain, some are concerned with psychological issues, and others (very few in my experience, probably less than 5%) sense the possibility of "dying into life" or healing into an experience of more profound unity while still alive. First we meet people where they are and then work with what is presented. As the head of my spiritual lineage, Neem Karoli Baba, is often quoted at his temples in India as saying, "God comes to the hungry in the form of food."

My approach to working with those who are concerned with spiritual issues follows the classic formula of Jack Engler (1986): "You have to be somebody before you can be nobody" (p. 17). In other words, when time and circumstance allow, we first have to work with basic personality issues and support the sense of self before using it as the foundation for spiritual expansion. Ultimately, the process becomes one of emotionally detaching from personal issues until "my" pain simply becomes "the" pain and the patient no longer feels isolated in suffering.

Methods that I find particularly interesting and effective emphasize enhancing a healing awareness. As with any therapy, the first requirement is *presence,* which allows for the contact that is the fulcrum of this work. Working with hospitalized patients, how I feel is often directly correlated with what happens. When I am feeling centered and open, we often have long in-depth sessions. When I am tired or shut down, suddenly they all seem to be taking naps. As Ram Dass (personal communication, Nov. 30, 1989) put it, "The key thing is that the person feels heard . . . that they're not isolated in the process, and that somebody is in there with them wherever they are," especially in those moments of confronting the unknown as death approaches.

Sometimes the patient becomes totally contracted in fear. Charles, for example, was gasping for air due to an AIDS-related pneumonia. I found him frozen with fear with his eyes rigidly focused on the wall of his room. Leaning over to meet his eyes, I simply placed my hand on his heart and began to breathe with him in an attempt to connect. Since I had just begun doing this work, I felt very helpless. I became aware that my need to appear infallible—to hide behind a role—prevented contact from occurring, and I began to share my experience with him while breathing in synchrony.

I told Charles it was hard for me to watch him suffer. Although I have often seen people out of their own fear inappropriately reassure someone who is dying, it felt intuitively right to tell him that while I had never experienced it personally, many people who have

been pronounced clinically dead and revived have reported non-frightening, even peaceful experiences. He seemed to relax as his respiration rate slowly decreased, and I left him, feeling he wanted to be alone. Fifteen minutes later he stopped breathing and died when his nurse momentarily stepped out of the room.

Once presence/contact is accomplished, other techniques are guided by what Levine (1987) calls the "Braille method." The therapist "reads" the situation for information and then tries to select optimum interventions. He or she draws on basic wisdom and compassion and on training in the use of techniques at the appropriate level within the spectrum of the patient's current identification. For example, with those who have unfinished business with their parents—a content area often emotionally loaded as death approaches—Gestalt techniques or education in basic communication skills may be indicated. If the parents are not available (or willing), a forgiveness meditation such as Levine (1987) describes can be very helpful. The use of medication for physical and emotional discomfort can be supplemented with instruction in self-management techniques such as self-hypnosis, coping imagery, the challenging of unproductive beliefs, or repetition of a favorite prayer or mantra. These can help the patient feel more of a participant in his/her treatment, thus providing a much needed self-esteem boost.

Listening inward also develops a conscious resonance with inner sources of guidance. I experience this heart/mind *(boddhi-citta)* somatically, as a tingling warmth in my chest region and other bodily shifts of the sort mentioned by Gendlin (1981). This was useful with David, one of my first AIDS patients at San Francisco General Hospital. We developed an alliance quickly despite coming from very disparate worlds. Then his condition deteriorated rapidly and exploratory brain surgery was performed, completely obliterating the person I had known. He lost his speech, became virtually unresponsive, and lay in bed with saliva dribbling down his front.

The nurses and I nearly gave up on ever making contact with him again, until I began to notice that he was, in fact, paying attention. There was awareness, even if the conventional indica-

tions were all but absent. I felt very awkward going to see him because I didn't know what to do. One day I sat down at his bedside and said, "David, just because you don't have your old personality anymore doesn't mean we can't hang out together." Suddenly his eyes brightened, he sat up, and our eyes connected, moistening with tears in a timeless moment. Had I not listened to my intuition, we would have never really met at a time and in a way that was so crucial for him.

Many times, nonverbal methods are necessary. For example, use of calming visualizations, breath work, focusing, and one-pointed concentration can often be used with pain or heavy emotional states. For people sleeping or in deep comas, "talking through the heart" (Levine, 1982) or sending loving kindness (*metta*) is one possible way of touching deeply. An attitude of love and support can also be transmitted by simply sitting with another, or imaging them if one is unable to be present.

Fortunately, humor and laughter do occur even on an AIDS unit and can be healing for all of us. Sometimes in the middle of the most profound suffering a simple joke dissolves barriers and broadens our perspective, even if only for a moment. When Rick was readmitted to the hospital he was reciting his litany of physical complaints: "My lung collapsed, I can't eat spicy food any more, I haven't been laid in a year, my head looks like a billiard ball, and I've lost sixty pounds." I said, "You're a train wreck!" We broke up into laughter, and for days afterward he told everyone he could corner that he was a train wreck. He saw the absurdity of his predicament and softened his attachment to his suffering, even if the effects were transitory. Later, "I'm a train wreck!" helped him when he needed it most.

Methods such as confronting transference which are commonly used with clients who have the luxury of time may not be appropriate to use when a client is dying. Lisa, for example, tended to project either all good or all bad transferences (splitting) upon the hospital staff. Because she was in the last few days of her life, my approach was to develop my own neutrality as deeply as possible

in order to create an environment in which she could complete her life's business rather than address her severe perceptual distortions directly. Although this was difficult at times because she had developed a positive transference towards me, my ability to remain a nonreactive mirror allowed her to ventilate her feelings and eventually access a state of deep inner peace.

Ultimately, it is not the application of methods alone that heals. As Ram Dass (1988) reminds us, "Anything can be the condition for liberation. Techniques don't liberate. Techniques provide sets and settings in which individuals, when they are ready, become liberated" (p. 8).

CONCLUSION

Because we all must face the existential fact of physical mortality, counseling the dying can be extremely helpful to therapists or counselors drawn to work on personal and spiritual issues of their own. It is extraordinarily beautiful when someone opens to a higher awareness at the time of death. There is a power and magnetism that I feel graced to experience, helping me as well to soften into truth. Cultivating this quality of surrender (not to be confused with defeat) is to me the ultimate strategy for dying *and* living.

Ken Wilber's position that "the key is to put practice first and let scholarship follow" (Ingram, 1987, p. 41) has been an invaluable guideline for me. I agree with the slogan used by Shanti Project during their volunteer trainings: "Your heart is your credential." When contemplative practice is informed by wisdom and grounded in available scientific knowledge, the healing environment needed for the relinquishment of suffering can be created.

These experiences have provided an enlarged context or capacity which enables me to relate to and empathize with a wide range of people. Ultimately, the extent to which I've transmuted the experience of *my* pain into *the* pain is the extent to which I have become a conduit through which healing can occur.

NOTES

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