Inducing Wisdom: Philosophical Counseling for HIV-Positive Clients
Lou Marinoff, PhD

Most people sooner or later experience dilemmas or uncertainties involving questions of meaning, purpose, value, and fulfillment. Such questions emerge in the context of relationships, career, momentous change, personal responsibility, aspiration or disappointment, and decision-making under risk or potential conflict of interest. Normal problems of living are not regarded as "diseases"; rather, they are seen as opportunities for self-improvement, enhancement of self-understanding, or acquiescence to circumstances beyond one's control. People with medical problems need medical attention; people with emotional or affective disorders need psychological attention; but people with burning questions about meaning, purpose, value, goodness, and justice need philosophical attention.

Philosophical counseling, as defined by the American Philosophical Practitioners Association (APPA), is an educational approach, rather than a medical one, to resolving or managing some of life's problems. It is that branch of philosophical practice that engages the client, through dialogue with the counselor, in constructive explorations and reinterpretations of his or her belief system in order to find or modify a philosophical disposition that works for the client's interests.

There are many ways of implementing philosophical counseling, but no universal method exists. (It is like asking, "How does one bake a cake?") The counselor can conduct an open-ended philosophical inquiry with his or her client in the Socratic style of seeking truth and exposing falsehood.

The counselor can offer a particular philosophical position that suits his or her client's needs, relying on sources ranging from Aristotle to Ayn Rand. Or the counselor can employ a specific philosophical counseling method, examples of which have been published in Plato Not Prozac.

Philosophical counseling is both an art form and a dialogue, and each counselor—and each client-counselor relationship—is different. What they all hold in common is the philosophical basis of their exploration: rational understanding of oneself, the world, and one's place in it.

Philosophical counseling can also be helpful in tandem with medical treatment. Coping with illness, living with restrictions imposed by demanding regimens, balancing quality versus quantity of life, reconciling faith with doubt, confronting a person's own mortality, or grieving the passing of a loved one are scenarios deeply grounded in philosophical considerations. Developing a useful philosophical perspective in such cases may be the most important endeavor after actual medical care. In dire cases, where death is imminent or foreseen, it may be the only thing worth doing with the remainder of one's life.

Unlike stereotypical philosophy professors, who sometimes cultivate profound thoughts at the expense of interpersonal skills and more directly useful approaches, philosophical counselors have developed new applications for their disciplinary tools. Combining philosophical insights with professional counseling techniques, they seek to induce from their clients what Aristotle called "phronesis," or practical wisdom. The purpose of this article is to introduce philosophical counseling to the broad spectrum of counselors who work with HIV-infected clients and who may apply or adapt philosophical perspectives to their own modalities.
Socrates said that the unexamined life is not worth living, words that could easily be attributed to a modern mental health provider. Philosophical thought is an exploration of the ways human beings think about themselves and the world and the relationship among the self, others, and the universe. To some extent or another, psychotherapists have always harnessed philosophical tenets to help clients clarify values and philosophical tenets to help therapists have always harnessed some extent or another, psychotherapy of the client's belief system, and the identification of an appropriate "philosophical disposition." This issue of FOCUS introduces this approach and offers some ideas about when it might be a useful strategy.

There is something attractive about exposing clients to the practical wisdom of philosophers ranging from Socrates to John Stuart Mill. Marinoff, the author of a new book called Plato Not Prozac!, told me that that there are some times when philosophical counseling may be more appropriate than psychotherapy and other times when the situation is the reverse, and no doubt this is true. But, I expect that some therapists will find the introduction of formalized philosophical counseling to be one more assault on the psychotherapeutic tradition. It is, after all, a time when psychotherapy is under the increasing scrutiny of managed care cost-cutters, who are displacing long-term treatment with psychotropic medications and brief therapy.

I suspect that Marinoff is right, that philosophical counseling makes a unique contribution separate from other mental health approaches. Marinoff's article also offers insights for therapists into how philosophy might be more explicitly applied in psychotherapeutic settings. Rational suicide is certainly one such area, and James Werth's article touches on this relationship. Other areas emerge in the context of HIV, including everything from making treatment decisions to negotiating safer sex.

Philosophical counseling, as any cognitive approach, risks minimizing the emotional content beneath the surface, and as Marinoff acknowledges, it is not appropriate for many types of client. But, to the extent intellectual insight has an effect on behavior, thought, and emotion, the thousands of years of recorded human philosophical thought is a vast library of positive influence waiting to be harnessed.
have some concrete chance—even if it is only 5 percent—of walking away. Statistics should be used for comfort or hope, not for retrospective irony. In the context of HIV, this moral might be applied in the following way. Increasing numbers of people with HIV have extended their lives significantly by following medication regimens diligently and remaining vigilant about their health. These numbers can be used constructively, offering not false hopes but real odds to other people facing HIV. Even long odds are preferable to no odds and can catalyze an individual’s will to sustain treatment or fight for life.

The second moral is that life does end sooner or later, by one cause or another. Thus, in this gross respect, people with HIV do not differ from anyone else; they merely have surer knowledge of the probable duration of their lives and the possible causes of their deaths.

This raises interesting questions about values and one’s theory of values (which philosophers call “axiology”): is it preferable to know (or choose), or not to know (or choose), the hour and manner of one’s demise? There are good arguments on both sides. Not knowing that one is about to die may be good, in that such ignorance spares a person potential preoccupation, anxiety, or terror. But it may also be bad, in that such ignorance denies an individual the occasion to finalize personal affairs and to bid farewell to loved ones. This is also true for loved ones: while an unexpected death preempts the opportunity to say good-bye and attain closure, a lingering death can leave a train of unpleasant memories among the living, whose last images are not of a robust body and sound mind, but rather of an ephemeral shadow of a former being. Which would you rather be? Which would you rather see? To what extent does HIV disease obviate such choices? To what extent can or should such choices be available?

**Quality versus Quantity of Life**

Quantity, by its very nature, is susceptible to objective measurement; quality is not. The theoretical distinction between fact and value has long troubled philosophers, and it perennially reemerges in biomedical ethics. The fact that a person is alive, in an essential if narrow biological sense, does not necessarily entail that that person’s life has value, either to him or herself or to others. The human fetus has no civil rights until it is born; it is biologically a living entity, but its civic personhood has no guaranteed value *in utero*. Human bodies in irreversible comas or persistent vegetative states are similarly deemed to have lost their personhood, and along with it the value, though not the fact, of their lives. People with terminal illnesses—whether AIDS, Lou Gehrig’s disease, or malignant cancers—may face a deterioration in the perceived value of their lives, even though the legal fact of their being alive will not change until a physician pronounces them dead.

Like all people with life-threatening illnesses, people with HIV are capable of displaying a tenacious will to live, but they also have the right to refuse treatment if or when the costs of maintaining a factual existence outweigh the quality of life they experience from living. Most people will put up a fight for life if they have any reason to live or any hope of living reasonably. Most people with HIV do not rush out and commit suicide. Then again, many people in the end-stages of AIDS refuse heroic interventions, preferring a month or two of time spent entirely on their own terms rather than a few months of time spent entirely on someone else’s. If the unpleasant side effects of HIV antiviral therapy or the apparent non-efficacy of treatment lead the subject to abandon medical intervention, most biomedical ethicists and philosophical counselors alike would defend this decision as lying within the bounds of the client’s rationality and autonomy of choice. In this case, a provider would have a responsibility to confirm that the client’s ability to make this decision is not impeded by profound depression, psychosis, or cognitive impairment.

Asymptomatic seropositive people who accept treatment and people at the end-stages of HIV disease who refuse it are both good candidate groups for philosophical counseling. The former can apply numerous philosophical precepts on leading the best life possible in situations of threatened or diminished capacity; the latter, on dying the best death possible. Specific philosophical insights, from both Eastern and Western traditions, prove helpful in responding to this challenge.

**References**


For instance, the Roman stoics—Epictetus, Aurelius, and Seneca—taught that one should not overly value anything that can be taken away by external forces, because this would diminish one's self-empowerment. This stoic precept applies to life itself: what can never be taken away (only relinquished) is one's virtue. Socrates showed that an honorable death is preferable to a dishonorable life. John Stuart Mill asserted that he would rather be a Socrates dissatisfied than a fool satisfied, or a human being dissatisfied than a pig satisfied. Mill says, in other words, that most people would rather experience the heights and depths of their humanity, rather than become animals incapable of great thoughts or profound emotions.

The insights of David Hume, like the practices of Mahamudra or Zen Buddhism, illustrate that personal ego is a kind of fiction. If there is no one "in there," no one actually dies. John McTaggart's relational philosophy of time (his "B-series") implies that events that have happened can never "unhappen." All events, including one's life, are forever preserved in their entirety, even when the sequence that is a person's life reaches its end point. This panoply of philosophical tenets only begins to suggest the variety of perspectives that philosophical counseling can offer the ill and dying; and it is beyond the scope of this article to describe how they might be applied in philosophical counseling.1,2

Philosophical practitioners who counsel HIV-infected clients naturally run certain risks themselves. For example, supporting a decision to acquire and use marijuana for medical purposes could possibly be construed by some overzealous district attorney as being an accomplice in one or more crimes. In more drastic circumstances, so-called "rational suicide" counseling could be an indictable—even though morally defensible—offense. The APPA's Standards of Professional Ethical Practice, by which APPA-Certified philosophical counselors are bound, contains nothing that explicitly forbids such counseling and contains much that implicitly condones it. A philosophical practitioner's first duty as a counselor is to do no harm to his or her clients. Counseling against a measure that would alleviate pointless suffering could be interpreted as abetting the perpetuation of a state of harm. A physician who withheld an appropriate medical remedy could be guilty of malpractice through negligence; similarly, a philosophical counselor who withheld an appropriate moral justification for seeking a remedy could be guilty of ethical neglect.

While matters of innocence and guilt are determined by law, matters of appropriateness or inappropriateness of remedies are determined by morality. Laws are reflections of morals, and laws change as prevailing moralities change. Laws on medical marijuana and physician-assisted suicide will likely change to reflect new perspectives (as they have already in eight States and Oregon, respectively). Philosophical practitioners may be called upon to demonstrate as much courage as their clients in matters of civil, or even criminal, disobedience—after all, this too is part of the Socratic tradition of principled action, which comprises a visible manifestation of practical wisdom.

Conclusion

This short essay introduces philosophical counseling in the context of HIV disease, but it has by necessity neglected some important themes.* The issue of disclosure of HIV disease, in both professional and personal contexts, has ethical dimensions as does the problem of workplace discrimination. However, it should be clear from this article that sustaining a viable philosophy of life is usually helpful, and may become essential when life itself is threatened or when the end of life comes into view.

Authors


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Clearinghouse: Philosophical Counseling


O’Hara M. Emancipatory therapeutic practice in a turbulent transmodern era: A work of retrieval. Journal of

* Counselors who wish to familiarize themselves with philosophical counseling or make referrals of seropositive clients to certified philosophical counselors should contact the APPA (see Clearinghouse).
Rational Suicide and the Role of Values

James L. Werth, Jr., PhD

It is inevitable that a counselor’s values will play a part in virtually all therapeutic situations, but, because of the learned emotional response to suicide, the potential conflict between therapist and client is brought into high relief when a client raises the issue of rational suicide. On one hand, there is the counselor who, by the very nature of his or her work, attempts to affirm that change can occur, that hope is possible. On the other hand, there is the client who, for some possibly rational reason, rejects the belief that life is worth living. In the context of HIV disease, where rates of suicide have been especially high and discussions about rational suicide are not uncommon, providers are likely to confront this issue.

The notion of a mental health professional forcing his or her values onto a client is unsettling to most practitioners. Although it is widely recognized that counselors cannot be completely value-free in sessions, it is also commonly accepted that clients have the right to take actions that appear foolish. But this is not the case with suicide.

Balancing the Therapist’s and Client’s Values

Many authors have discussed how the therapist’s values affect the counseling process with clients who are suicidal. One of the most common points made is that a counselor’s belief in the sanctity of life at all costs can lead to lack of consideration of the client’s potentially rational belief that there is a limit to this philosophy. Commentators have noted that suicidal clients in general, and clients who may be rational in their suicidality in particular, confront counselors with existential questions about life’s value and meaning. Naturally, the easiest way to avoid such an existential crisis is to discard the idea that suicide can be rational or to relentlessly pursue the prevention of all suicides.

Such reactions demonstrate the counselor’s needs more than the client’s, and there is the danger that the therapist will believe that his or her values are paramount. Although some might argue that this stance is appropriate, it may fail to consider the best interests of the client. As a result, the counselor runs the risk of preventing suicide for the sake of prevention instead of for the sake of the client. Because counselors who impose their values on their clients may discount or misunderstand a client’s beliefs, or fail to express empathy, commentators usually suggest that clients “are the best judges of the proper balance of values in their

References


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See also references cited in articles in this issue.
lives.” Therefore, the appropriate role of the therapist is to help the client to evaluate the decision to end his or her life while also assessing whether the client’s ability to make decisions is impaired. Several assessment protocols have appeared in the literature recently.\(^1\)

The Impact of Spirituality on Values

Spiritual beliefs are one important component of values. As a result, the spiritual beliefs of both clients and counselors are vital components of the rational suicide assessment process. Many religious denominations are forcefully against both rational suicide and active euthanasia, and studies support the assertion that strength of religious belief is an important variable among members of the general public in determining their attitudes toward rational suicide. Furthermore, it is important to note that such views exist and are particularly strong in some cultures.

Some people are dissuaded from suicide by their spiritual beliefs, and such beliefs provide a basis for the interventionist stance of some mental health professionals. The concern here is not for the former but for the latter—the instances when these spiritually based values are forced upon the lives of clients. It is appropriate for a counselor to attempt to discuss a client’s spiritual beliefs and values, but it is unacceptable for a professional to disregard a client’s well-reasoned decision to end his or her life because it conflicts with the therapist’s spiritual beliefs.

Conclusion

Clearly, the personal beliefs and values of mental health professionals will affect their attitudes about the acceptability of rational suicide. Just as clearly, client-centered counseling requires therapists to consider their clients’ personal and spiritual values, and not impose their own. The standard approach in mental health work is to refer a client to another provider if a therapist has professional or personal reasons for not working with a specific person or on a given concern. This should also be the case with rational suicide. If a therapist cannot, because of his or her strongly held spiritual beliefs or other values, assess for rationality with a suicidal client who is requesting this, then the therapist should refer the client to another provider. Such an approach is analogous to referring a client to a therapist who specializes in work with a special issue or population. This is particularly important in the context of the HIV epidemic, which has consistently been the inappropriate object of broad projections of societal values.

Unfortunately, instead of utilizing an evaluative approach that would consider the client’s best interests and take his or here circumstances into account, mental health professionals have traditionally believed that standards of care require preventing any action that might harm the client. This seems to be changing: assessing whether a client has made a well-reasoned decision about dying appears to be widely acceptable to therapists.\(^1\) This suggests that counselors may no longer feel obligated to force values, which they may not even hold, upon clients. The beneficial result of these changes, hopefully, will be that clients will be able to define and potentially act upon their own beliefs about the sanctity of life, the role of suffering, and the proper way to live and die.

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Recent Reports

A Moral Vision

Moral visions are constellations of cultural values and assumptions that help people determine their sense of how they are doing and what it is they need to be doing, of what is good and desirable. According to a commentary on the relationship between moral visions and counseling, counseling theory embodies cultural conceptions of what a person is and should be.

Counseling relies on a number of theoretical concepts that reveal individualistic moral visions, including self-actualization, self-esteem, autonomy, and assertiveness. An alternative moral perspective—and one to which 70 percent of the world’s population subscribe—is collectivism. Collectivism emphasizes the virtue of harmonizing one’s relationships with one’s group. Individual worth derives from a person’s ability to excel at specific roles and functions within the social order. Codependency is an example of a psychological concept that addresses some real issues, but is culturally specific at best. It assumes that the self should be autonomous, bounded, and contained. For most non-Euro-American people and for many women, the self-other boundary cannot be so sharply defined. The self is interdependent, extending to include family and even nation.

Moral visions affect the practice as well as the conceptualization of counseling. For example, a young man may be diagnosed with an antisocial personality disorder because of his extensive history of fighting. But fighting may also confer on him celebrity, honor, dignity, and family reputation. Although many people would find this outlook troubling, it does not reveal the total absence of moral and ethical consideration that is stereotypically associated with antisocial personalities. This man’s problem is not the fact that he values honor or dignity, but the way in which he achieves them.

In large part, counseling can be viewed as an encounter between moral visions. But counselors can be caught between wanting to respect a client’s moral vision and needing to make some normative evaluations about what is proper and improper or what is psychologically healthy and pathological. Given the inescapability of moral visions, it seems promising to give up the pretension to objectivity and instead adopt an approach to counseling consistent with what has been called “social science as public philosophy,” which acknowledges counseling as “a tradition or set of traditions, deeply rooted in the philosophical and humanistic . . . history of the West.”

Moving beyond objectivism and relativism encourages not only the seeking of truth but also the realization that individual truths will never have certainty. Counselors must take a stance, and the stance will be a moral one, presupposing a moral vision. Ultimately, counseling is part of a cultural discussion about ethics and world view, about the good life and the good person.

Values Among Young People

College students who participate in higher risk activities are more likely than those who participate in lower risk activities to value leading “an exciting life” and less likely to value being “self-controlled,” “helpful,” “honest,” or “loving,” according to a study of the relationship between young people’s values and their HIV risk behavior. Moreover, there may be an association between participating in higher risk behavior and valuing risk taking, impulsivity, and sensation-seeking.

Study participants consisted of 761 predominantly late-adolescent and young adult undergraduates from the University of Southern California in Los Angeles. Fifty-four percent of the participants were men, and 95 percent of those who were sexually active reported having sex only with partners of the opposite sex. Each participant completed a Rokeach Value Survey—an instrument for qualifying behaviors and values—and a questionnaire on sexual behavior. Drug use information was obtained only as it related to sexual activity.

The value “an exciting life” was rated highest in importance among participants with three or more sexual partners in the previous year, those who reported inconsistent condom use with multiple partners, and those who frequently combined sex with alcohol and other substance use. Participants reporting these risk behaviors valued caution, restraint, and self-discipline less than did their lower-risk peers. Higher-risk participants also rated values reflecting personal concern and respect for others as less important.

The researchers surmised that higher-risk people consistently gave low ratings
to values such as “honest,” “loving,” “equality,” and “a world at peace,” because these individuals might tend to favor needs-oriented reasoning as opposed to other-oriented reasoning. Whereas other-oriented reasoning prioritizes other people’s perspectives and feelings, needs-oriented reasoning places precedence of egoistic needs and motives.

Discussing Life and Death
Goldblum PB, Martin DJ. Principles for the discussion of life and death options with terminally ill clients with HIV. Professional Psychology: Research and Practice. 1999; 30(2): 187-197. (Pacific Graduate School of Psychology, San Francisco; and University of California, Los Angeles.)

In the face of excruciating pain or suffering from terminal illness, a frank and empathetic discussion of the possibility of ending one’s life may actually reduce the risk of suicide, according to a commentary that proposes a model for evaluating and responding to the risk of suicide.

Useful guidelines to undertake this assessment and decision process include a set of seven questions, the answers to which determine the necessity of more discussion between client and counselor or more active suicide prevention intervention. For example, asking a client if he or she perceives his or her condition to be unbearable allows a therapist to gauge the client’s intent to commit suicide. Once a client’s intent is understood, questions may cover the adequacy of the client’s medical care and whether the client fully understands the conditions, prognoses, and treatment options available. Most terminally ill clients considering ending their lives cite severe pain as a reason to do so; thoroughly discussing pain reduction options may eliminate a person’s desire to end his or her life.

If, after thorough discussion and multiple therapy sessions, a client clearly and repeatedly expresses the desire to die and is mentally competent, supporting this wish may be the only client-centered option available.

Spiritual Beliefs and Dying
Kaldjian LC, Jekel JF, Friedland G. End-of-life decisions in HIV-positive patients: The role of spiritual beliefs. AIDS. 1998; 12(1): 103-107. (Yale University School of Medicine, New Haven.)

Discussions about end-of-life decisions may be facilitated by the belief in a forgiving God and impeded by the view of HIV infection as punishment, according to a qualitative study of hospitalized people with HIV. Understanding the role of spiritual beliefs may help health care providers meet unrecognized or unaddressed needs of their patients.

Of 104 eligible participants—patients at the Yale-New Haven Hospital—90 agreed to be interviewed for the study. Of this sample, 62 percent were African American, 24 percent were White, 13 percent were Hispanic, and 1 percent were American Indian. Sixty percent of participants were male. The mean time since HIV diagnosis for all participants was five years.

Of the sample, 71 percent stated that they had a purpose in life, and for 18 percent of these people that purpose was God. Twenty-six percent felt HIV disease was a punishment, and 44 percent felt guilty about having HIV. Twenty-four percent discussed end-of-life issues with a doctor and those who did were less likely to perceive HIV as punishment. Fear of death was more likely among participants who viewed HIV as punishment and those who felt guilty about having HIV; it was less likely among those who read the Bible or attended church.

Living wills were more common among people who prayed daily and whose belief in God helped them think about death. Approximately half of all participants believed it would be important to discuss death and dying and spiritual needs with their physicians, and slightly less than half felt the opportunity to pray with their physician would be helpful. Belief in a God who forgives and comforts may help some seropositive people accept HIV or the possibility of premature death; it may also signal to providers those individuals who would more readily discuss advance directives.

Next Month
Over the past year, the debate over whether HIV is the cause of AIDS has escalated. “AIDS revisionism,” based on the ideas of Peter Duesberg and others, asserts that AIDS is caused by recreational drugs and HIV antiviral regimens. These ideas influence not only the treatment and behavioral decisions of people living in the United States, but most recently the actions of the president of South Africa, who will host the July 2000 World AIDS Conference. In the May issue of FOCUS, Martin Delaney, the founder of Project Inform in San Francisco and a pioneer in facilitating AIDS treatment development and access, rebuts the main arguments of AIDS revisionism.
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