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Thai Women: Meditation as a Way to Cope with AIDS

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ABSTRACT: Mental-health professionals often ignore the spirituality and religious beliefs that can aid a person's ability to cope with a life-threatening illness such as HIV/AIDS. As the physical body succumbs to the disease, people with HIV/AIDS search for ways to lower their stress, regain control of their health, attain some peace of mind, and hope to prolong their survival. This sense of personal control is important when dealing with chronic or terminal illness. The purpose of this study was to explore the role of meditation in Thai Buddhist women who are infected with HIV/AIDS. Interviews were conducted with 26 Thai women living in the northern part of Thailand known as Chiang Mai, where the incidence of AIDS is the highest in Southeast Asia. Although the scope of this study is limited and not generalizable, it supports the idea that a spiritual approach to healing, in conjunction with conventional medical treatment, is a source of great comfort to persons living with HIV/AIDS and may influence immune functioning.

As we enter the twenty-first century, the intimate connection between body and mind is widely acknowledged (Kabat-Zinn, 1990; Smith, Stefanek, Joseph, Verdeck, Zabona and Felting, 1993). Prayer and meditation have been shown to have measurable influence on health and well-being (Perrira, 1995; Murphy and Donovan, 1988; Shapiro and Walsh, 1984). The value of sitting quietly, using various techniques to cultivate stillness or focused attention, has been well recognized. Once the domain of speculation by mystics and philosophers, this realm has recently been visited and revisited by scientists. Impressive inquiry and documentation is beginning to percolate through the scientific community (Cousins, 1989; Levine, 1987; Boryspenko, 1984; Ornish, 1983; Epstein, 1998; Menahem, 1997). Meditation is a tool that is beginning to be utilized in the fields of medicine and mental health. Meditation-based stress-reduction interventions have been undertaken by people suffering cancer and receiving oncology treatment (Brennan, 1998); psoriasis (Kabat-Zinn et al., 1998); a chronic illness as fibromyalgia (Kaplan et al., 1993); and long-term survivors with AIDS (Carson, 1993). It is a way of looking deeply into oneself within the spirit of self-inquiry, self-understanding, and healing (Kabat-Zinn, 1990). With this in mind, it can be practiced, and used for a variety

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of medical ailments, including HIV/AIDS, as a complement and support for medical treatment.

The multitude of losses and stressors which are associated with HIV/AIDS can be overwhelming. It often intrudes on people's lives, in manners which challenge their daily survival. Without a cure on the horizon there is a need to identify ways to sustain hope and spiritual well-being in persons with AIDS (Carson et al., 1990). Only recently has the AIDS pandemic spread to Asia. Since September of 1985, when the first case of AIDS was reported in Thailand, the number of reported cases of AIDS has increased progressively. In 1996, the UNAIDS branch of WHO (World Health Organization) reported an estimated 3/4 of a million people living with HIV/AIDS in Thailand. India and Thailand have been cited by WHO as the two countries showing the most alarming increases in infection. The incidence of HIV infection is expected to exceed the one-million mark within the next one to two years. Infection with the human immunodeficiency virus (HIV) has emerged as a serious public-health problem in Thailand, particularly in the north which has the country's highest HIV-incidence rates. As many as 800,000 persons may currently be infected with HIV; approximately two-thirds reside in the northern part of the country. Health experts and NGO (non-governmental organization) workers believe that people in northern Thailand are dying of AIDS at the rate of one a day. The HIV/AIDS Surveillance in the WHO South-East Asia Region AIDSWATCH which was published in February 1997, reported 44,471 cases of AIDS as of November 1996 (AIDSWATCH, 1997).

Although the rates of HIV infection in women who are commercial sex workers (CSWs), or former CSWs is high it has recently been noted that increases in rates of HIV infection are predominantly in women who have never been sex workers and are in stable relationships (Beyrer et al., 1997). The prevalence of HIV among pregnant women who attend prenatal clinics in Thailand varies geographically; but the rates in the upper north are between 4% and 8%. According to the World Health Organization (1996) a zealous nationwide anti-AIDS effort has dramatically increased AIDS awareness and condom use, particularly among commercial sex workers. Problems, however, remain with Thai men who don't like condoms, or don't believe they work, and with prostitutes who are often too intimidated to ask clients to wear them. Many Thai men view women as either sexual objects or obedient homemakers, and a visit to brothels while they are married is customary. This causes transmittal of the virus to their monogamous wives.

Despite significant advances in medical science over the last 20 years, people diagnosed with the virus continue to struggle with stress, pain, and illness. Human immunodeficiency virus (HIV) infection impacts on quality of life at a time when many of those infected are in their most productive years. Disease progression slowly strips away the human form and dignity. As the physical body succumbs to the disease, those with HIV/AIDS oftentimes search for meaning and stress reduction as they seek ways to prolong survival. When healing through traditional medicine is not possible, or physical

ministrations prove inadequate, persons with AIDS may shift their attention from treatment of the disease to developing a personal understanding of the process of life and connectedness. In countries where Buddhism is practiced, meditation is seen as essential to psychological health and well-being.

The theoretical foundation of this study is based on the work of Benson (1984, 1996), Kabat-Zinn (1990) and Venerable Phra Acharn Rattanayano (1997). According to these researchers, the mind or brain can influence the body's ability to fight disease. Herbert Benson's research at Harvard in the early 1970s showed promise in Western culture to support meditation in ameliorating stress. In *Beyond The Relaxation Response*, Benson (1984) concluded that meditation acted as an antidote to stress. Dr. Kabat-Zinn (1990) at the University of Massachusetts has undertaken research studies that demonstrated a decrease in levels of pain in people who had been unresponsive to standard medical treatment. The majority of the patients in Kabat-Zinn's studies who were taught to meditate improved by taking major steps toward transforming their relationships to their bodies and minds and to their problems, while control groups of similar patients showed no significant improvement. Various related studies have shown improvement in pain from muscle tension, headaches, dysmenorrhea, and other conditions (1990). The Venerable Rattanayano (1997), a Buddhist monk in northern Thailand in the village of Mai Hong Song, began to teach meditation on dhamna-osot for the treatment of AIDS in the hopes of improving the immune system. He is known for practicing meditation by rotating the upper part of the body. According to Rattanayano, "people rid themselves of stress and depression through different forms: by screaming; crying; or vomiting. After the meditation they feel light and fresh."

In northern Thailand, heterosexual women are the fastest growing population with HIV/AIDS. Although meditation is increasingly recognized as an essential component of health and well-being, little attention has been given to the meaning and use of meditation on the quality of life of Thai women living with HIV/AIDS. The purpose of this exploratory study was to examine the role of meditation in heterosexual women infected with HIV/AIDS and living in the northern province of Chiang Mai, Thailand, where the rate of disease is greatest.

Focus on the use and impact of meditation as ameliorating stress in their lives was explored. A promising framework to examine Thai women and their families would be a cultural approach. In the cultural approach, the assumption is that a woman's behavior and development can be understood within the context of cultural traditions, values, and norms of the family and extended family (Wilson, 1984). The researcher made the assumption that meditation is an essential component of Theravada Buddhism which is the religious belief system for 95% of the population in Thailand (Mensendick, 1997). Generation of such knowledge can provide an understanding of how meditation might influence health outcomes. It may be especially useful to describe how women use meditation in the experience of HIV/AIDS. Further, it can

provide insight in responding to women infected with the virus, and lead to the development of supportive interventions that may increase the quality of life and concerns of well-being.

The researchers' experience with Thai Buddhist women in the U.S. led to seeking participants from Thailand during a sabbatical year. Contact was made through a senior researcher at Johns Hopkins University Hospital in Baltimore, Maryland, who has done considerable research in northern Thailand in collaboration with the Thai Red Cross Society's Program on AIDS and Chiang Mai University.

Sample

The women were recruited from a home-care program, sponsored by the Thai Red Cross Society's Program on AIDS. Data was constructed from a convenience sample of twenty-six women aged 23 to 47 years. All came from the surrounding villages of Sampatong in the northern part of Chiang Mai, Thailand. All women were widows, and one was remarried to a man with HIV. Viral transmission for all of the participants was through sexual intercourse with their husbands. All husbands were dead from AIDS. The women were unaware of their husbands' HIV status until they became seriously ill and died. All husbands died over the past six years.

Procedure

A convenience sampling was secured by asking nurses for referrals. This was to ensure a study population of at least 25 women. Nurses from the Thai Red Cross were asked to distribute flyers to women with children when they came for their clinic check-up. This number was based on the availability of participants (mothers with children) and the time constraints of the study. Twenty-six women participated in January 1998 in a one-time study. Participation criteria entailed HIV sero-positivity and motherhood. The women were told that the purpose of the study was to explore how HIV-infected women cope with their illness in a Buddhist country such as Thailand, where family support is valued, and suffering, illness, and death are aspects of life that the culture prepares people to accept. The research examines the function of meditation and attempts to understand the effect it has on the lives of these women.

All the women contacted agreed to participate in the study and gave a verbal agreement to the nurses. The researcher met each woman formally one week prior to the interview at the Thai Red Cross where they attended an annual New Year's party. Through an interpreter, the researcher explained the rationale for the study. All the women gave informed consent. Five additional women wanted to participate in the study. Two were hospi-

talized and three did not meet the criteria, that is, they were widows but did not have children.

Method

The data-collection instrument consisted of a two-hour semi-structured interview. The role of meditation as a coping mechanism was examined to understand its effects on living with HIV/AIDS. Data was collected on sociodemographic characteristics, household income, health, formal and informal supports, personal concerns of living with HIV, and their coping with the disease. Since persons with AIDS (PWAs) are likely to experience direct, associative, and perceived stigma, questions regarding HIV-related discrimination and stigma were included and related to stress and coping. The study questions explored the stressors of the women infected with HIV, and sought to understand how they cope with their illness while raising their children in the face of a life-threatening disease. Examples of questions are: (1) What was their history and their husbands' with HIV/AIDS? (2) What difficulties do they experience living with the disease? (3) With whom can they talk about their illness? (4) When they feel sad or upset, how do they make themselves more relaxed? (5) What are the life situations that they describe as stressful? (6) Whom do they turn to for help? (7) Are family supports and informal and formal networks helpful? (8) How do they manage stigma? Questions about their meditation practice and its effect was explored. To answer these questions a qualitative methodology was employed based on Wyche and Lobato (1996) study of African American women. The questions were modified to attend to cultural differences. Interviews were transcribed and analyzed for consistent themes and patterns.

Content analysis was used to analyze and interpret the data (Mostyn, 1985). Data analysis was a multi-step procedure that included data reduction, coding, and connection, and major themes were identified (Krueger, 1994). Initial categories were independently developed by two members of the research team. These categories were compared. Discrepancies were identified. We then argued to consensus about the best assignment of themes and the categories were revised. This process led to the further clarification of the categories. Many thematic content units were identified in this manner (Stewart and Shamdasoni, 1990). A final review was made by a bilingual researcher for cultural sensitivity.

Interviewers

Six Thai bilingual interviewers were trained in the purpose and procedures of the study (Tom-Orme, 1991). They were R.N. nurses in Chiang Mai hospital and two of the nurses had a master's degree in nursing. All were women and

spoke the dialect of the north. Each interviewer had research experience interviewing the Thai villagers, and when possible, they were matched to respondents on the basis of dialect (Cardenas and Arce, 1982; Markides, Liang, and Jackson, 1990). Face-to-face interviews lasted about two hours and all were conducted at the Thai Red Cross. Mothers received $20 U.S. for participation, money for transportation, a lunch, and a small gift, which clearly served as an incentive, and an opportunity to get information on their worries, services, stigma, coping, the role of meditation, and their informal or formal supports. The commitment and skill of the interviewers in obtaining and completing interviews, and ensuring high-quality data were essential, particularly given the sensitive nature of many of the questions.

Translation. Noting that direct translations of measures may not be culturally or linguistically appropriate for ethnic-minority populations, Zambrana (1988) recommended that bilingual people of the same ethnic origin as the study population, who are experienced in the community, translate and review the instrument to ensure correct colloquial words, symbolic meaning, and word structure. This method offers a viable alternative to direct back translation, which, according to Zambrana (1988), makes unwarranted assumptions that threaten the validity of the data.

Thus, the data-collection instrument was first translated by an experienced Thai translator. An interviewer who had also worked as a translator and had extensive nursing experience with the local villagers then scrutinized each question closely. Several items were revised as a result, and further adjustments were made on the basis of two pretest interviews. Finally, each completed interview schedule was evaluated for possible problems in interpretation or understanding.

Results

Respondent characteristics. Ages of the women ranged from 23 to 47, with a mean age of 33.1 years. Study participants had very low levels of formal education and household income. Nineteen respondents (73%) had completed primary school and seven (27%) reported that they completed secondary school, which is represented in Table 1. They were caring on average for one child; five mothers cared for two children. Nineteen of the children were male and their ages ranged from 3 to 19 years. Twelve children were female and their ages ranged from 4 to 16. None of the children were HIV-infected. All women were employed at the time of the study. They generated income by producing handmade goods, working on a farm, sewing clothes and bags, or selling flowers at the market. Financial support for the basic needs was supplemented by the government, charitable organizations, and the Red Cross for 24 women. Two respondents stated that “no one” helps them.

TABLE 1

Socio-Demographic Characteristics
(*n*=26)

Variable	Number	Percent
Age		
30–39	15	57.69%
20–29	7	26.92%
40–49	4	15.38%
Education		
Primary School	19	73%
Secondary School	7	27%
Number of Children		
1	21	81%
2	5	19%
Ages of Children		
6–10	12	39%
0–5	8	26%
11–15	7	23%
16–20	4	13%

According to the women, their husbands were sick over a period of 3 months to 4 years before they died. All women stated that they cared for their husbands during their brief illness and accompanied them on hospital visits. The husbands' HIV virus was not discussed by 24 women during their illness. One woman said, "I was very angry and I scolded him. I now have similar symptoms." Another woman reported "feeling sad after finding out my husband infected me." All women reported their husbands became infected through a prostitute when they were working and living outside the village for several months. One woman said, "My husband went to a prostitute before our marriage." Little overt anger was described but about half of the women cried during the interview.

Participants' knowledge of their HIV status ranged from one year to eight years. Women were told about their HIV status after being tested in the hospital. Only one woman reported having symptoms of anxiety and feeling stressed before she was tested. Half of the women stated that at this time they were in good health. Many experienced symptoms similar to their husbands', such as fevers, colds, and headaches. Herpes-zoster was diagnosed in one woman. Five women occasionally felt weak and sometimes unable to work, especially in the hot sun. Prior to the illness they worked on the farms five to six days a week. Two women reported a weight gain and 15 women felt their health had not changed since being diagnosed.

Key themes

Despite the range in responses, four dominant themes emerged from the interviews about living with HIV/AIDS: worry and stress, informal or formal supports; stigma and discrimination, and concerns for the future.

Worry and stress. Stress plays a prominent role in illness. All mothers described their stress by giving striking accounts of their worries. Understandably, the most frequently identified worry reported were concerns about their children. In facing their own death, many of the women feared there would not be enough money for their children's education or survival. Families are under tremendous financial strain because of social and economic problems in Thailand and multiple health eruptions. One woman vividly expressed her worry: "I had to change schools twice because of discrimination and not having enough money for my son's schooling. It's hard to find steady work." Another woman said, "Nobody can help. My parents, relatives and friends can not give me money to pay for my child's uniform."

Seventeen women described worries about their health and the possibility of becoming sick. "If I get sick, I don't know what I will do. It is frustrating not knowing where I can go for help." Another woman stated, "I am scared to get a skin disease. I will feel discriminated against." Presently, none of the women had debilitating or overt HIV-related symptoms.

One woman felt her stress was related to her difficulty of accepting the fact that she was infected by her husband: "My future is now unpredictable, and I may not be with my daughter when she grows up." The commonalities among the women were striking as they related accounts of the stress they experienced in protecting their children from discrimination. This fear was realistic as women described discrimination in their villages when seeking employment and requesting government funding.

Subjective distress felt by some women were changes related to their financial situation. Four women worried about lack of employment, which was a source of stress since it related to another worry, insufficient income. Due to seasonal work on the farms and unpredictable health problems, many women found it difficult to secure steady work, thus adding an additional burden to their lives.

Social supports. Social supports are viewed as a buffer against environmental stress and are used for economic as well as emotional support. AIDS, like all illnesses, affects the entire family system. Social roles, economic functioning, and the relationships among family members are derailed. Support was found in different places, and with each woman it had a personal resonance. Some found it in family and friends; others felt alone and isolated, and others felt the monks and other formal support groups were helpful.

In response to questions of emotional support, a mother, sister or female

friends were frequently cited by the majority (21) of women. Despite the frustrations the women experienced, the majority felt they could depend on family members for instrumental and emotional support. Six women felt their fathers were available for support and eight women felt their brothers would help them when they feel sad and hopeless. This finding is important since the social-support literature has not indicated that males are part of this process and has not examined their role. Ten women felt that a monk from the local temple would be helpful and provide food, and give them an opportunity to earn money through sewing and handicraft. Some women who brought food to the monks did not disclose this fact because they felt ashamed, thus minimizing support and compounding their isolation.

HIV disclosure can result in loss of social support and result in stress and social isolation. Isolation occurs when family members do not include or accept a member with HIV. This type of isolation can be painful to the sick member and often result in miscommunication that leads to family conflicts. The women can feel deprived of family participation on their mourning and caring for them during their illness. There is a major fear of being rejected and not having their family care for their children when they die.

Four families were not encouraging and contributed to the women feeling marginalized and unsupported. There was a range of responses to the diagnosis. Two women stated, "My family cried, 'Don't tell anyone. They will dislike you and your family.'" Fear of contagion was a concern for families as they responded, "Don't cook for us or use our utensils." Another form of support that is essential to minimize isolation is to depend on a support network that can buffer the effects of living with AIDS. Secrecy complicates grief work and prevents opportunities to find some level of comfort. One woman reported that her family said, "Don't tell others about your disease. People who get AIDS will die soon. Our society doesn't like AIDS." Often families of HIV-infected families experience prejudice that is deeper than that experienced by individuals with other types of illness or social problems and build a web around themselves as protection. One women stated she had no family member to receive support since they had all died from AIDS.

Because the stigma from AIDS is so severe, it alienates the person with AIDS from community supports when they are particularly vulnerable. To receive support from the formal organizations, the women would have to reveal their diagnosis. The cultural values of respect for authority and politeness stimulate them to do the "right thing" to avoid losing face. Largely, the participants felt they were given support and compassion by several providers and did not approach these organizations with trepidation. Formal supports were viewed by twenty-four women as helpful and available for both emotional support and concrete services. The women cited the Thai Red Cross, hospital support groups, charitable organizations, and the government as giving needed assistance. They recalled encounters with nurses as respectful, helpful to their needs, and non-judgmental about their husbands' life-

styles. Two women said, "No one helps them," causing them to feel alone and isolated.

Stigma and discrimination. A diagnosis of HIV/AIDS carries both the stigma of being contagious and the expectation of death. Historically in Thailand, HIV has been primarily viewed as a disease of addicts, commercial sex workers, and men engaging with prostitutes (Beyer et al. 1997). Women who are mothers are needed and valued in the culture. HIV disclosure can be complex since secrecy regarding the disease is sometimes necessary to protect women from discrimination and to save face. Unfortunately this can smother the natural experience of grief. What to share and with whom was an issue that each woman faced, some more than others. Whether the mothers had experienced the effects of HIV discrimination, all were cognizant of its existence and how people were often rejected.

The majority of women in this study felt they could disclose their illness to their parents and siblings and receive support and encouragement. The experience of empathy enabled them to make adequate plans for the future of their children. They felt, however, that presently they wanted to protect their children. Thais believe that what is said is not as important as what is left unspoken. There was no immediate need for fifteen women to disclose their illness to the children. They felt they were too young and could postpone disclosure. The average age was 6.7 years. The nine women who disclosed their illness to their children had children who were predominantly adolescents. They told the children not to talk about their mothers' illness at school, in an effort to protect the children from feeling stigmatized. They feared discrimination and felt their "children would suffer." As cited earlier, one woman whose child knew of her illness had to change schools twice. Two women said their children, ages 7 and 13 years, knew indirectly about the mother's illness since their father had died and they had to go to the medical clinic with their mother.

Within the HIV-support-network community, all the women felt safe and did not experience discrimination: "We help each other, give cheer and support." There seemed to be a sense of love and community among the women who worked in the temple sewing and making flowers.

Work appears related to stress, stigma, and discrimination. In the outer non-HIV community, discrimination is experienced in the following statements:

> My life is different since I have HIV. My health is sometimes not good and they will not hire me to do work on the flower farm.

> In my village, they look at me in a strange way. It's hard to get additional money for rice. They don't want me around. I look diseased.

Future concerns. Thailand has the advantage of going into the HIV/AIDS epidemic with a complete monitoring system to anticipate problems to come. According to Altman (1997), Thailand has a good AIDS-prevention program for a developing country, and one can learn about the preventative measures that have attended to cultural norms. However, "AIDS is increasingly a threat to the global market economy." Families here have traditionally absorbed orphaned children into the family network. This may need renewal and new systems as day care is expanded and strengthened to provide for AIDS orphans. Respondents were asked about their future concerns. Many responses reflected the overall stressors the women reported during the study. Six women stated a wish for money for their children's education and day-to-day living. Four strongly stated they wanted to "make people understand what it's like to live with this illness and take steps to reduce discrimination against families living with HIV." Traditional leaders, such as teachers, monks, and village headmen can be enlisted as models of educating and providing social and psychological support to affected children and their infected parents. Further, the women expressed a strong desire to be accepted by the people in their community since they felt stigmatized and disenfranchised. Maintaining hope in the face of a terminal illness, with no apparent cure, was conveyed by two women. "We strongly hope for a cure," from the traditional medical community. It's a way to stay upbeat and essential when surrounded by multiple losses. There was a resounding echo of confidence in the medical community and in particular the treatment regimens received at the Thai Red Cross. They felt the doctors and nurses to be non-judgmental and respectful of incorporating cultural practices of healing with traditional health beliefs. Another two respondents wanted to convey a message to the world that was caring and protective, "If they are not HIV-positive, tell them to STAY THAT WAY."

Relaxation-meditation. The stressors of living with a fatal disease and struggling to meet the emotional, physical and financial needs of children can be daunting. HIV can create a disequilibrium in the lives of those diagnosed as they attempt not only to cope and survive but to find meaning in the experience. Often the virus leaves diagnosed people with a roller-coaster ride of emotions. The women describe both external and internal ways of coping with HIV/AIDS. Inner strength, a strong family, and social-support networks influence the physical and mental health of the women.

Positive thinking and maintaining a positive outlook were essential to good health for most of the women. Meditation was an inner resource that the women drew on to find meaning, hope, comfort, peace and connection as they coped with the virus. The women continued to seek medical treatment but felt that meditation could also heal them. All 26 participants were Buddhist and practiced meditation.

TABLE 2

Mediation Over Last Six Months
***n*=26**

• Own Health	19	33%
• Personal	10	17%
• Children	9	16%
• Financial Problems	7	12%
• Other's Health	5	9%
• Parents	3	5%
• Other Relatives	2	3%
• Friends	3	5%

Traditionally in Buddhism, one prepares oneself to die with moment-to-moment awareness or mindfulness. This work involves the complete "owning" of each moment of experience—good or bad. Death is not something to be afraid of; it is a part of life. This practice can be used to help people in the final stages of AIDS to die peacefully. Meditating on death also helps reduce anxiety, thus allowing people to live longer and be more accepting of their condition. It can also be an opportunity for enlightenment or enable the person to achieve a better rebirth (Sivaraksa, 1998). A number of women reported a change in their meditation practice and positive thinking since they were diagnosed with HIV. Meditation was central to their lives and they reported an increase in the range of time that they spent in meditation practice. (See Table 2.) Eight women meditate 2–3 times a week. Five women meditate every night. Five women meditate less than twice a week and eight women meditate from occasionally to 3-4-5 times a week, as reflected in Table 3.

Regardless of the time spent in meditation, all the women felt that meditation was helpful and gave them strength. Twenty women said that meditation helped them to maintain a positive outlook and reduce negative thoughts. Five women said "it does not help at all with the illness" and two women were unsure.

A sense of peace was identified as an important aspect of meditation, in response to the question "How does meditation help?" The twenty women who stated that meditation helps one attain a sense of peace reported the following: "I feel more calm," "I can breathe better," "I feel more relaxed," "I feel focused," "My mind is clearer," "Just feeling good." Almost all the women (18) felt "they were able to get a more restful sleep."

Meditation is a salient component of positive coping. Meditation appeared to be a strategy for resistance in the face of suffering. Twenty-four women said that meditation reduces their worries about their children and financial problems. Since being diagnosed with HIV five women felt meditation re-

TABLE 3

Average Time Spent Meditating
***n*=26**

• 2–3× per week	8	31%
• Every night	5	19%
• Less than 2× per week	5	19%
• 4–5× per week	3	12%
• Not often/occasionally	5	19%

duced their thinking about death, and helped them accept their illness. It made others calm and less apt to lose their temper. For some participants, meditation provided a source of strength to face the realities of daily life. One woman said, "Meditation helps me stay well and keep sober, due to life's complications." "My mind is more relaxed. I don't have to drink to be quiet," said another woman. This sense of peace builds upon the women's strengths and was achieved despite the formidable challenges they faced with the illness.

The particular meditation practice of these women was different from the behavioral component of going to the temple. Many of the women took their children to the temple and "making merit" was undertaken by the majority of the participants. They discussed early morning visits to the monastery where they would bring food and flowers to the monks. For them it was a way to heal and prepare for a better life. This was an outward symbol of the women's Buddhist cultural and spiritual beliefs.

Discussion and implications

The experience of meditation among Thai women infected with HIV/AIDS is similar in some aspects to that reported by Kabat-Zinn (1990), Benson (1984, 1996), and the Venerable Ratana Ratanyano (1997). The women viewed meditation as an essential part of their lives and of coping with their illness. Acceptance of meditation as a component of health and quality of life requires a shift in perspective in the health-care and mental-health communities. Despite the presence of a terminal and debilitating disease such as HIV, the development of alternative or complementary care strategies may be both meaningful and helpful to persons with AIDS when no medical cures are known. It is important for health-care clinicians to recognize the immense stress and discrimination that Thai mothers with HIV/AIDS face, and the internal resources they use to cope. Unlike the United States, where parents with HIV do not rely on their social-support network (Weiner and Septimis, 1991), the majority of women reported having the support and love of their

children, family, and friends. Meditation, however, was clearly identified as a source of peace of mind and a way of giving some meaning to living with their illness.

The sample on which the present study is based is small and not broadly representative. Generalizability is limited and any conclusions are made with caution. All the women elected to participate in the study and were not randomly chosen. Thus, the women who participated in this study may in fact compose a somewhat biased group as against women who are not affiliated with the Thai Red Cross. The study, however, supported the existence of AIDS-related stigma, and a deep level of discrimination was experienced by the women, exacerbating stress. The four themes raised in the interviews may serve to provide a framework for further research with a larger population, utilizing a comparison of cultures from East and West.

Mothers with the HIV virus require assistance in addressing the multiple needs and stressors they experience. Mourning the losses they confront as they remain connected to their children, family, and friends needs to be acknowledged and strengthened. This research also raised questions regarding what types of services are needed to address the stigma and discrimination that women face in their work and community. How does one develop communication skills using a group modality where participants with limited education can "save face" and reveal what is helpful to them while enhancing their dignity and self-esteem? "Disenfranchised grief" (Doka, 1989) is particularly felt by these women in communities where there is a lack of sensitivity to the stresses associated with the disease. This experience prevents Thai women from expressing their feelings and concerns and intensifies a sense of powerlessness. There is little suggested in the literature about this phenomenon. Research initiatives should begin to explore what kinds of community outreach and education might prove to be supportive and minimize the social stigma associated with HIV/AIDS. Stigma management can be offered to help families and enhance empathy while appropriately confronting those who persecute them (Levy, 1993). Mental-health professionals can call "network meetings" to answer questions, share information, participate in group problem solving (Lesar and Maldonado, 1997), and teach meditation.

The everyday stressors, such as money issues, health problems, discrimination, and lack of work, can be formidable. Services structured to address the financial needs of women have been undertaken by monks in a number of temples. Some private and public agencies have provided economic assistance and social support to offset the changes in the women's financial status and subjective distress resulting from the pressing demands of the illness. The monks have provided space and equipment for the women to make handicrafts and sew clothes and bags as sources of income.

Positive thinking, relaxation, and maintaining a positive outlook through meditation seemed essential to good health for most of the women. Since meditation has been reported as a positive link to healing and emotional and

psychological well-being, teaching meditation may give women an opportunity to work through their anticipatory mourning. For some it can provide peace of mind as they face a stigmatizing illness. Further it can enable them to feel more relaxed and centered and to find some fulfillment, even though their lives may be abbreviated. These findings support earlier work (Kabat-Zinn, 1990; Benson, 1984; Goldstein, 1976). Since many women in the rural areas routinely go to the Thai Red Cross, district health center, or the hospital for clinic visits, support groups can be established to teach meditation practice to reduce stress and complement medical treatment. Monks at local temples can provide a valuable opportunity not only to give advice and help with problem solving but in drawing from ancient traditions of self-inquiry and healing, as they teach meditation to enhance health and quality of life.

Although meditation is known to be used by professionals in coping with their lives, only occasionally is it used as an intervention with clients and their families. Medicine as a science has tended to ignore the spiritual dimension in favor of a secular naturalism and a rationalist approach, and continues on the whole to be skeptical of spiritual influence on healing even when it has been quantifiable (Menahem, 1997; Epstein, 1998). Research on the biological effects of meditation and spiritual healing has been growing, demonstrating that at times meditation goes beyond a sense of well-being to a measurable physiological effect (Kabat-Zinn, 1990). Dossey (1993) speaks of "not doing" and quotes the thirteenth-century mystic Meister Eckhart, "Nothing in all creation is so like God as stillness."

Facing this growing pandemic in Southeast Asia, meditation can be a useful intervention to support women with HIV/AIDS and to provide a measure of control, to enhance their immunological response to stress, to reduce the side effects of treatment, and to diminish anxiety and fear. The relaxation response achieved during meditation has multiple benefits, particularly on the immune system. As one begins to explore the use of meditation as a newly integrated tool in health care, one enters into uncharted territory. Because the literature has given only limited attention to the emerging needs of women with HIV in Southeast Asia, clearly more research endeavors are needed to explore the intervention of meditation as a complement or support for traditional medical treatment.

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