HIV Mental Health for the 21st Century

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I | Understanding HIV/AIDS
Using the Biopsychosocial/Spiritual Model

Mark G. Winiarski

- A woman, divorced after seven years of marriage and now in her thirties, says she refuses to date because she is afraid of AIDS.
- A fourteen-year-old high school student drinks a “40” (beer in a forty-ounce bottle) and then fails to use barriers during sexual intercourse.
- A Long Island executive, with a wife, a lively four-year-old son and a $300,000 house, dies of HIV-related illness, and the widow keeps the cause of death a secret.
- A man, proud to have stopped his habit of intravenous drug twelve years ago and having worked continuously since, is hospitalized for pneumocystis carinii pneumonia.

Our everyday lives are complicated enough and, too often, painful and hard to understand. Imagine, then, being faced with a condition that in the early 1980s manifested itself through a quick and unexplained illness and death. Then, within a decade and with medical progress, the condition became a long-term chronic condition, rather than a death sentence rendered quickly. Now we know this condition as Acquired Immune Deficiency Syndrome (AIDS), which is also called human immunodeficiency virus-related disease, named for the virus (HIV) that causes the disorder.
Imagine, also, as HIV/AIDS comes to public consciousness, mental health providers having to learn to respond with skill and compassion to a life-threatening situation that involves a complex constellation of personal and community considerations. As with heart disease, cancer, or a disabling injury, great emotional trauma is involved. But with HIV/AIDS, the emotional trauma is compounded by a societal reaction that judges the HIV-infected person very harshly, unlike current public reactions to those with heart disease or cancer. Often that severe reaction is internalized, creating a loathing of self.

If someone were asked to create a condition that would test our society where it was most vulnerable — on issues such as mortality and morality, compassion and judgmentalism — it is unlikely one could create anything more challenging than HIV/AIDS. Consider these issues:

- Because the human immunodeficiency virus is spread through exchange of bodily fluids — during sex, in artificial insemination, when sharing contaminated syringes during injection drug use, in transfusions and infusions of blood and blood products, and from mother to baby in utero and during breastfeeding — HIV and AIDS is a taboo topic for many.
- Because HIV is most often spread during sex and drug use, large portions of American society judgmentally regard persons with HIV/AIDS as moral degenerates who are to blame for their illness. The judgment is evident in the allowance made for infected children and for persons who were infected by contaminated blood products, who are viewed as “innocent” victims.
- Irrational fears of contamination have deprived many of adequate medical and other care, and even from basic human contact. As late as 1995, White House guards donned rubber gloves during a visit by a gay contingent.

Many people still believe that their communities, their family members, and they themselves are immune to HIV. The strength of this belief indicates the effects of the virus on our society. Too many claim immunity because they cannot acknowledge their fears or confront the implicit judgment, which is, “I am immune because I am not like those others.”

But now, and especially for the next century, no individual and no community can afford to dismiss HIV as a condition that happens to others. HIV threatens all our communities and all our clients, in ways overt and in ways subtle, hidden, and complex.

Mental health practitioners, especially, cannot be so dismissive or un-
aware. Each of the clinical anecdotes that began this chapter is HIV-related, and each person described is a mental health practitioner’s client. The woman who refuses to date because she fears AIDS may not be HIV-positive, but she is HIV-fear-positive, and that phobia can significantly affect her life. Or, perhaps, she may be using HIV fear as a plausible excuse that covers fears of intimacy. The secrecy that surrounded the death of the Long Island executive is fairly typical in suburban areas and is one reason that people in these communities are not aware of their incidence of HIV infection.

If a mental health practitioner believes HIV infection doesn’t occur in his or her community and therefore fails to learn how to address it appropriately with clients, he or she does clients a grave disservice. In fact, many would argue that discussion of HIV issues should be a part of every mental health practice. The practitioner must be able to respond empathically and skillfully:

- Whether a client is infected with HIV or is a family member or neighbor of someone with HIV/AIDS
- When a client says a fear of HIV is preventing a desired relationship
- When a client is sexually active and doesn’t fear HIV sufficiently to have safer sexual attitudes

These clients include us all.

The HIV-related tasks for mental health practitioners, then, are many and complicated. They involve constant self-scrutiny of our feelings and reactions (see chapter 3). They also involve constant learning.

Too often, however, practitioners confuse the collecting of facts with development of understanding. Certainly, the realm of HIV/AIDS knowledge is broad and can be confusing. But understanding HIV entails much more than assembling a headful of facts, be they medical or psychological, to be pronounced to oneself or to a client. Skillful practice requires, foremost, a conceptualization of HIV in which many interlocking and complicated pieces of knowledge may come together and be unified.

Think of this process as similar to assembling a jigsaw puzzle. Most of us look at the puzzle’s boxtop, which depicts the finished product, before we tackle the assembly of individual pieces. This chapter is the boxtop for the HIV/AIDS puzzle. It provides a conceptual framework that will help the reader piece together the many complicated aspects of HIV. Using this template, the practitioner can skillfully integrate the many facts that he or she will gather from reading this book and from other sources.
This conceptualization enables the practitioner to make a comprehensive assessment of the HIV-affected client. The assessment findings and the model then guide the practitioner in planning care that is far-reaching. Finally, the model informs interdisciplinary practice, which will be a hallmark of the next decade of care.

The Biopsychosocial/Spiritual Model

Fortunately, this author does not have to create this comprehensive view. A metamodel, which means a more comprehensive model or one that enfolds several other models, already exists that will illuminate the way. It is called the biopsychosocial model, developed by Engel and modified by this author to include spiritual aspects.

The biopsychosocial/spiritual model acknowledges that all persons have many aspects and that these aspects all interact. Figure 1.1 may help explain the model. In this figure, each circle represents an aspect of our lives. These broad, interlocking aspects have the following general definitions:

- **Biological or biomedical** — pertaining to flesh, blood and bone, organisms, and such entities as viruses.
- **Psychological** — having to do with the inner life of the individual, including emotions, self-judgments, motivations for relatedness with others, and internal reasons for behaviors, generally.
- **Social** — the person's participation or lack of participation in family, community and society (including the therapist), and the effects of family, community, and society on the person. One's culture resides in this realm, although one's reactions to the culture may be psychological.
- **Spiritual** — not necessarily an attachment to organized beliefs or religious institutions, although that certainly may be present. Spiritual aspects often include an internal belief or sense that acknowledges an "other," a reality beyond normal experience, which may be a presence or meaning that surpasses current reality. In this realm we include belief in God, "higher power," "the seed," and particular cultural expressions of spirituality.

Generally, our Western society views each of these aspects separately. When "health care" is mentioned, for example, most people think "medical care," an indication of our overemphasis on biomedical responses, to
the exclusion or neglect of care of other aspects of ourselves. In the biopsychosocial/spiritual model, the different realms may be separated out for purposes of distinguishing major components and for planning our assessment and interventions. Yet, the sophisticated provider realizes that all these aspects interplay; they all affect one another.

Consider application of the model to the situation of a person who, after testing, is told that she is HIV-positive.

Since the recognition of AIDS and HIV, and in many institutions still, the person who receives a test result that indicates HIV infection is immediately drawn into a whitewater torrent of months of laboratory tests, visits with medical providers, prescriptions for prophylactic (preventative) medicines, and discussions about the newest medical interventions.
While the body may generally be well cared for, other aspects require attention, such as:

- The person’s psychological reaction. Many patients, still unfamiliar with HIV, react with the belief they have been given a death sentence. (An unknowledgeable mental health provider may collude by joining in the client’s hopelessness.) Even those who cognitively “know” that HIV/AIDS is chronic are likely to have a strong psychological response that may include despair, fear, dread, guilt, shame, or even relief that comes with knowledge.

- The reactions of those who love that person, who make love with the person, go to church with the person, or are estranged from the person.

- The spiritual reaction of the person, who may or may not have a system of beliefs or feelings about God, “higher power,” or meanings of life. When Kubler-Ross (1969) suggested that one step in dealing with terminal illness is bargaining, she also suggested that most persons in that situation bargain with a God-type figure.

Two exercises may help you understand the interplay of our many aspects.

First, if your community has anonymous HIV testing — that is, a place where you do not have to give your name and where you will not be recognized — go and be tested. Regardless of your sexual history and your risk of having HIV, you are likely to have many emotional reactions to the experience, which will include a wait of up to two weeks for the results. Very few individuals, even those with no risks of transmission, escape the anxiety that ensues. In addition, consider telling others that you took the test. Take time to ponder your feelings and to consider what others’ reactions may be. Record your thoughts and feelings in a journal. If you are anxious and have no potential for infection, then imagine the anxiety of a person who has a high risk of being infected with HIV, and imagine the courage it takes for that person to be tested. If you fear telling someone, such as a parent or sibling, about your HIV test, imagine the fear of someone with actual risk of being infected.

To this exercise I must add several important cautionary notes. If you cannot be tested anonymously or at a place where you will not be recognized, it may be better to bypass this exercise. Too often a stigma is attached even to those who are tested, regardless of the results. Further-
more, some readers may be at risk for HIV infection, and testing may yield a positive result. A counselor competent in HIV/AIDS can help you assess your risk before testing. If you believe the risk may be significant, you should be confident that you understand all the consequences of a positive result and know about the availability of competent medical and psychological care, whether anonymity or confidentiality will be preserved, and the psychological consequences for yourself. Do not conduct this exercise if you do not understand its possible consequences.

To do the second exercise, sit with a friend in a quiet place, at a time during which you won’t be interrupted, and let the friend play the role of a physician or nurse who tells you something like this: “Two weeks ago, we took blood from you and sent it to a laboratory to be tested for HIV. I know you were concerned about the results because you had sex about six months ago with someone you didn’t know. The results have come back, and they show that you are HIV infected.” Take careful note of your emotional reactions, and imagine what the reactions of your friends, family members, and acquaintances will be. Discuss them with your friend.

Your reactions may include feeling that you should see a medical specialist, that you should pray, that you should be retested, that you should tell family members and friends or hide the fact. Your family and friends might respond with love and consolation, or they could respond with anger and shame. Personal reactions are varied — but all spring from people who are not just biological specimens but who have psychological aspects (emotions), who live in a community that has a culture (social environment), and who likely have considered the spiritual aspects of existence. Clearly, the knowledge that one is infected has significant psychological, social, and spiritual consequences.

Similarly, much that is psychological, social, and spiritual has led to behavior that carries with it the risk of introducing HIV into the body.

Take the case of the fourteen-year-old female high school student, who drank a “40,” became intoxicated, and failed to negotiate the use of a condom prior to intercourse. What factors may have led up to this unfortunate situation? A biological factor may be that she had too much alcohol in her bloodstream, which may have impaired her judgment. A psychological factor, such as low self-esteem, may have contributed to her decision to drink or to have sex. Many social factors may be implicated, including her peer group’s norms. A spiritual factor may also be involved: Perhaps she grew up in a traditional church and is oppositional and
defiant to the church's attitudes regarding sex. Many more issues may be involved here, and a skillful mental health practitioner is likely to pursue many hypotheses regarding what is involved in the young woman's risky behaviors.

And what about the man who stopped intravenous drug use twelve years ago and has worked steadily since? His bout with *Pneumocystis carinii* pneumonia, an opportunistic infection that takes advantage of a declining immune system, has serious psychological, social, and spiritual consequences. Psychological consequences may include depression and a feeling of being cheated. Social consequences may include loss of salary and of the ability to support his family, which may also affect his emotional well-being. Being sick, the man may seek a closeness to his God, or he may curse God for his situation. And what of the effects of the illness on his family, and its response? The interplay of all these aspects is what the HIV-infected person presents to the mental health practitioner, and what must be understood as such.

The biopsychosocial/spiritual model is useful because it allows us to think through what we know intuitively. Every aspect of HIV affects and is affected by others. (If we think it through, in fact, it seems that every aspect of life has biomedical, psychological, social, and spiritual components that affect one another.) But how does this awareness affect our mental health practice? It allows a sophisticated response to a client who learns that he or she is HIV-positive. The practitioner who views a client as a dynamic interaction of many different aspects assumes a professional stance that responds to each component. This response is a more comprehensive assessment that takes into account the various aspects and a treatment plan that derives from that comprehensive assessment.

**Background Reading**

Arguments for viewing the person as a biopsychosocial system are decades old, although authors have differed in their interpretation of the concept. The addition of the spiritual element as an important part of the model is newer, and somewhat controversial.

In the medical field, Engel in 1960 articulated a "unified concept of health and disease" (459) that, he said, derived from work as early as 1951. He calls "a concept of antiquity" the view that "disease is a thing in itself, unrelated to the patient, the patient's personality, bodily constitution, and mode of life" (460). Rather, he suggests that object relations, among other factors, affect health.
In 1977 Engel used the term “biopsychosocial” and listed arguments for its adoption in medicine and psychiatry. A year later Engel (1978) alluded to an integrated model of care. He noted that the posture that science and humanism are in opposition “promotes rivalry, if not antagonism, between and among health professionals. But the care of the sick calls for collaboration and smooth interaction between professionals, with complementary roles to fulfill and tasks to perform” (173–174). This article and a later one (1980) details a biopsychosocial model based on general systems theory, taking into account culture, subculture, community, family, and intrapsychic factors, among other factors.

In the field of HIV, several persons make reference to the model, albeit from a medical vantage point. Cohen and Weisman (1986) described a biopsychosocial approach to HIV care at an urban hospital, calling it “an approach that views these individuals as deserving coordinated care and treatment with dignity” (243). In 1990 Cohen called AIDS “a paradigm of a medical illness that requires a biopsychosocial approach” (98). This viewpoint differs from what we espouse: We view HIV-related illness as a chronic, life-threatening condition with many aspects besides the medical.

The multiple-aspects model is not just theoretical and a nice way to think about humankind. It is the basis of new ways of regarding health care, as well as of studies of mind-body connections.

One example of new approaches to health care is the field of health psychology, and an example of clinical applications of research in this area is Managing Chronic Illness: A Biopsychosocial Perspective, edited by Nicassio and Smith (1995). In its first chapter, Smith and Nicassio (1995) outline the biopsychosocial model and provide a very helpful outline for applying the model in assessment and intervention. In subsequent chapters, the authors describe health psychology research and its applications in the interplay of the biomedical, psychological and social aspects of chronic illness.

Another example of the acknowledgement of the biopsychosocial model is the American Psychiatric Association’s inclusion of a diagnosis called “psychological factors affecting physical condition” in its revised third edition of the Diagnostic and Statistical Manual of Mental Disorders and its revision of the diagnostic criteria in the fourth edition (American Psychiatric Association, 1987, 1994). Moreover, in the 1994 edition, known as DSM-IV, the American Psychiatric Association included information on culturally unique conditions.

Studies that acknowledge mind-body connections have emanated from
scientific areas such as psychoneuroimmunology (Ader, 1981), behavioral medicine, and psychosocial oncology. The results are described or applied in books such as *Minding the Body, Mending the Mind* (Borysenko, 1987) and in journals such as *Health Psychology, Psychosomatic Medicine, Journal of Health and Social Behavior* and *Journal of Clinical Oncology*. More and more scientific data describe the mind-body connection. A statistical analysis of the results of many studies in psychosocial oncology, for example, led the authors to conclude that “psychosocial interventions have positive effects on emotional adjustment, functional adjustment, and treatment- and disease-related symptoms in adult cancer patients” (Meyer & Mark, 1995, 104).

Engel idealistically advised physicians to employ the biopsychosocial model in their practice. But research and experience has taught us that primary-care practitioners and, perhaps even more so, medical specialists have difficulties recognizing or finding the time to address complex psychosocial problems such as those found in HIV-positive persons. When they recognize a problem, most physicians with biopsychosocial awareness believe that the time-saving and, therefore, cost-effective move is to refer the client to a mental health specialist.

*Addition of Spirituality to the Model*

While Engel and his successors deserve credit for uniting the biomedical, psychological, and social, those who work with HIV-affected persons soon learn that many infected clients, in the course of their illness, reveal a desire to investigate their spiritual feelings. Moreover, many professional caregivers have rediscovered their spirituality through HIV-related work.

What is it about the condition that encourages persons to look inward? In grief counseling a client often voices regret that more meaningful interactions were not experienced with the person now deceased. Similarly, a person diagnosed with a life-threatening chronic illness may come to realize that life is too short for trivialities. With crisis often comes a search for an anchoring, a deeper meaning. And many find the anchoring in a part of themselves that looks beyond this life and senses that more exists.

Fortunato (1993) notes that even those therapists who are atheistic or agnostic can respond to religious or spiritual belief by responding to “to a client’s need for eschatological hope. The word *eschatological* derives from the Greek word *eschaton*, meaning end times. It alludes to what happens to us after death” (1). Fortunato (1993) suggests that counselors
form no opinion about clients' belief systems. Atheistic caregivers, he says, can be helpful to clients who believe in life after death. "Perceiving a client's eschatological beliefs as illusory is fine, as long as the caregiver understands that they are useful, functional illusions (and as long as the caregiver can respect the client's perception of atheism as equally illusory)" (3).

For a more detailed inquiry into the spiritual aspects of HIV mental health care, see chapter 4.

**Tools for Clinical Practice**

The biopsychosocial/spiritual model offers these advantages to practitioners:

- The biopsychosocial/spiritual model provides a framework for a comprehensive assessment, which leads to sophisticated treatment and case management.

As the reader already has learned, the HIV-affected person's situation—both before and after infection—is complex, and the entire landscape needs to be seen and understood. To respond in a sophisticated manner, the mental health practitioner needs to survey the entire landscape by way of a complete assessment.

The outline presented in this section groups issues in a handy way. The reader, however, now knows that each aspect is interactive with others. Although we placed sexual functioning in the psychological realm, for example, the other realms are also involved in sex. The sophisticated provider will not neglect the biomedical, psychological, social, and spiritual aspects of every issue.

**Comprehensive Assessment Guidelines**

I. Biomedical issues

A. Medical Information

- Current T-helper (also known as CD4) cell counts and other markers of immune function such as viral load assays. (See appendix A for medical information.)
- Medical history, both HIV and non-HIV. An HIV-positive person may have other significant conditions, e.g., hypertension, diabetes, history of headaches.
- Medications being taken and those prescribed or recommended but declined. Ask about side effects experienced.
Include drugs obtained on the street, herbal remedies given by nonmedical practitioners, and other complementary remedies.

- Other treatments, including chiropractic care, acupuncture, spiritually based healing practices.
- Self-care practices, including nutrition and exercise.
- Names of all caregivers, medical and nonmedical, including dentist, ophthalmologist, occupational therapist, physical therapist, visiting nurse, nutritionist, Christian Scientist practitioner, and clergy. Understand their roles and the client’s choices. Are these persons well chosen, do they know about each other, do they work well together?
- Response to treatment, generally.
- Understanding of HIV-related conditions and his or her own condition. If the client is not knowledgeable or forthcoming about these issues, what might be the barriers?

B. Neurological condition

1. Because HIV, like certain medications, has a neurotoxic effect that affects the client’s quality of life, please consider:
   - Client’s baseline cognitive functioning
   - Symptoms of central nervous system involvement, such as cognitive slowing, memory loss
   - Client use of compensatory strategies, such as note taking or a reminder system
   - Peripheral nervous system involvement, indicated by pain, numbness or other symptoms in arms, hands, legs, or feet

II. Psychological issues

A. Mental state

   - How has client’s pre-HIV psychological functioning changed with knowledge of infection and progression of illness?
   - Client’s emotional response to HIV issues.
   - Acute psychological symptoms that the client attributes to HIV status or to other stressors, e.g., anxiety, unhappiness, depression, despair.
   - Longstanding psychological presentation. Neglect of personality disorders severely undermines any mental health intervention and can lead practitioners to feelings of inade-
quacy. The personality disorders of clients must be taken into account.

- History of, and attitudes regarding, current or past experiences with mental health professionals, who may include substance abuse program counselors; past or current participation in twelve-step programs, such as Narcotics Anonymous, Positives Anonymous.

- Use of psychiatric medications and psychoactive substances, either prescribed or obtained from street dealers. Do not overlook abuse of prescriptions and the possibilities of substance abuse in persons who do not meet your stereotype of drug abusers. The very respectable-appearing actor River Phoenix died in 1993 with cocaine, heroin, diazepam, marijuana, and an over-the-counter cold remedy in his bloodstream. When inquiring about substance use, use both street names and brand names. I usually ask, “Have you ever taken Librium . . . Valium . . . (etc.)? Have you ever done speedball . . . (etc.)?”

B. Sexual Functioning

- Assess history and current sexual functioning.
- Does the client practice safer sex?
- Type of sex preferred — anal, oral, receptive?
- What has changed since diagnosis or appearance of symptoms?
- Unwanted sexual occurrences?
- If gay, lesbian, or bisexual, the client’s comfort with his or her sexual preference.

III. Social issues

- For sophisticated and deeper understanding of the HIV-affected individual, strive to understand his or her culture. The client’s cultural affiliations may be multiple. How does the client identify himself or herself culturally? Ask the client to explain his or her cultural identification(s). (For more cultural issues, see chapter 6.)

- Consider the individual’s socioeconomic place in society; his or her vulnerability to racism, classism, heterosexism, and sexism; and the educational and economic opportunities denied or afforded this individual.

- Do not overlook one very important social aspect — the cli-
ent’s relationship with you, who becomes part of his or her social network. Note the client’s ability to have a relationship with you, to accept your empathy, and to open up to you. The person’s style of interaction with you is likely to mirror his or her style with similar figures outside the therapeutic relationship.

- Who are the caregivers? Does the client have two families—one of blood relatives and another of affiliation, such as friends and a partner? A genogram, or a visual display of the family, is always helpful (see McGoldrick & Gerson, 1985).
- What has been the response of “family”? Consider long-time family patterns of care and current support. Are any family members likely to flee during a crisis?
- Are others in the support system HIV-positive?
- Whom does the client designate to make treatment decisions if incapacitation occurs? Are the proper documents signed and filed with physicians and others? Whom should you contact in an emergency?
- Are children involved? What is their biopsychosocial status?
- What does the client want you to do if he or she misses an appointment and has no telephone or doesn’t answer?

IV. Spiritual Issues

- History of religious observance and current attitudes.
- Client’s definition, explanation, and practice of spirituality.
- Are these beliefs comforting or a source of discomfort? Do the beliefs facilitate patient’s dealing with his or her HIV status or hinder it?
- With whom does the client discuss spirituality?
- What are the client’s spiritual concerns?

This is by no means a comprehensive list of information that should be obtained. (For a broader list, see Winiarski, 1991). The information gathered should be expanded to encompass the client’s specific circumstances. On the basis of the information obtained through this process and your knowledge of HIV/AIDS, enter into a realistic therapeutic contract that anticipates, as well as reacts to, biopsychosocial and spiritual issues.

- The mental health practitioner who uses the biopsychosocial/spiritual model acknowledges and responds to a client’s many aspects.

Many years of experience providing mental health services to
HIV-affected persons have convinced providers that rigid frames of practice do not adequately serve clients. The inadequacy has several causes, including these:

— Much current practice is based on Western European models, that is, white majority-culture models, of providing psychotherapy. These models are foreign to and perhaps inappropriate for minority-culture clients and fail to meet their needs.

— Current psychotherapeutic models fail to account for the diverse and complex needs of medically involved patients.

This author emphasizes the need to be therapeutically flexible (Winiarski, 1991, 1993) and to use a style of practice called “bending the frame” (explained further in chapter 2).

While much is said about culturally sensitive or culturally competent practice, in fact it is so complicated that mental health practitioners largely ignore its implementation. Practitioners must realize that acceptance of, or sensitivity to, a client’s culture is insufficient; they need to be well versed in the culture, to understand it, and to accept its role in the client’s life. The therapist must create a therapeutic relationship and make interventions that are culturally consonant for the client. Obviously, cultural competence requires a great deal of study and experience.

- The model provides a metamodel under which many disciplines can interact.

Many contributors to this book practice as part of interdisciplin ary teams. They realize that just being around the same table doesn’t make for a team. Full teamwork—what many of us call integrated care—comes when people talk with each other and regard each other with respect. But, often, teamwork is hindered by a lack of a common way of thinking.

Because practitioners in this country all speak English, we fail to recognize that disciplines have different professional cultures and that these differences create some of the greatest barriers to integrated patient care. Physicians, nurses, psychologists, and social workers generally emerge from training with different worldviews, including etiological presumptions, treatment strategies, and decision-making styles. Even within specific disciplines, persons have different assumptions. A person who provides cognitive-behavioral psychotherapy, for example, likely has different
assumptions about behaviors than a psychodynamically trained psychotherapist.

The biopsychosocial/spiritual model does not require practitioners to change their worldviews. Rather, it facilitates a consensual treatment plan based on a common understanding that a person has biomedical, psychological, social, and spiritual aspects. On the basis of that common acceptance of the model, practitioners of diverse views can sit together, view the patient in many different ways, and blend their different views into a biopsychosocial/spiritual treatment plan. Thus, the entire patient is acknowledged, and different team members competencies to deal with the different aspects are validated.

One clinical example involves an anxious patient who sought benzodiazepines (a family of drugs that includes Valium and Xanax) to quell his symptoms. A physician wanted to write a prescription for what he viewed as a biomedical phenomenon. Psychosocial providers suggested that underlying psychological causes of the anxiety would not be addressed if the symptoms were medicated. The treatment plan that evolved from a multidisciplinary discussion included a prescription of medication that would be contingent upon significant participation in psychotherapy.

• *The biopsychosocial/spiritual model assists us in incorporating knowledge from other disciplines.*

The blending of knowledge within a system as just described also has to occur within each practitioner.

What occurs when the client tells his social worker that his T-helper cell count has dropped below 200? Will the worker understand the implications and respond appropriately? Similarly, if the patient tells his physician that he takes pleasure in nothing, will the practitioner recognize a symptom of depression?

Too often, we become prisoners of our training. A social worker may limit himself or herself to the social work aspects of care. But with the many aspects of HIV, this limitation is now insufficient for practice. To respond fully to the HIV-affected person, providers have to learn some of other disciplines' knowledge (see figure 1.2).
The darkened area in figure 1.2 represents the realm of knowledge owned by a well-rounded psychologist doing effective HIV work. This psychologist not only knows the knowledge of his discipline but has incorporated knowledge from the biomedical, social, and spiritual realms as well.

This incorporation of new knowledge allows the practitioner to understand the implications of information of different aspects, such as T-helper cell counts and case management issues, and to respond in a sophisticated manner. The psychologist will never have the training of a physician, a social worker, or a member of the clergy. But he or she must be able to understand the HIV-affected client’s concerns, no matter the aspect from which they come. Having a sense of other providers’ knowledge allows the psychologist to work better with colleagues and extends his or her professional reach.
Barriers

Barriers to the implementation of a biopsychosocial/spiritual model include the following:

- Being entrapped in one own's discipline and unwilling to extend one's breadth of knowledge. The greatest asset of a mental health provider is an open mind. If one's mind is made up, one ceases to grow professionally and personally.
- Adaptation of a simplistic, cartoonish view of what is meant by biopsychosocial/spiritual factors. While many practitioners use the term, few allow the concept to guide their practices. The term implies sophisticated, multifactorial conceptualization that should lead to multifactorial assessment and treatment.
- Current reimbursement systems for health care, both medical and mental health. These now pressure providers to be more productive, that is, to see more clients, and therefore allow less time for interdisciplinary meetings and discussions.
- Skepticism among patients. People who seek assistance in medical facilities generally believe that assistance comes in the form of medication. This belief requires mental health professionals in multidisciplinary programs to persuade clients of the worth of psychosocial, nonmedical services.

Conclusion

HIV/AIDS has been presented as a biopsychosocial/spiritual condition that requires a sophisticated, knowledgeable response that incorporates all its aspects. The biopsychosocial/spiritual model has been presented as a guide not only to understanding the condition but to assisting health care providers in structuring assessment and guiding intervention. The metamodel also informs multidisciplinary practice and encourages providers of HIV-related services to extend their knowledge beyond their disciplines. Understanding the model leads to a mental health practice that addresses all aspects of the person. This type of practice is often one in which we "bend the frame" of our theories. That is the topic of chapter 2.
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