

## HIV: A Psychosomatic Disorder

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### Abstract

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Despite the ever-changing dynamic of families that have teens across generations, Marriage and Family Therapy (MFT), a specialty of psychotherapy, has maintained its broader influence on the lives of not only teens, but the family at large. Psychosomatic illnesses that largely affect teens have been one of the many causes of change within family systems. In this paper, Human Immuno-deficiency Virus (HIV) is defined as a psychosomatic illness and the scope of the disease is narrowed to its effect on at-risk youth and their families. Structural Family Therapy (SFT) is one of the many approaches to family therapy and this paper gives a detailed description of the model's context in treating at-risk teens and families affected by this disease under the constraints of a practicing clinician. This paper also takes an in-depth look at SFT as a preferred therapeutic approach and how it can be implemented in therapy to foster change, considering its limitations and strengths working with this diverse population.

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Human Immuno-deficiency Virus (HIV) has been well known to be a phenomenon that predominantly affects at-risk adults. Nonetheless, a growing population that this infectious disease has become a common place to is at-risk youth. Adolescents have always been a complex population due in part to their developmental stage and scores of researchers conduct studies on an annual basis to better understand this demographic group as well as formulate appropriate treatment measures that are most effective to them. The Centers for Disease Control and Prevention reported in April 2009 that more than one million people are living with HIV in the United States and that every 9.5 minutes someone is infected with HIV in the United States (Centers for Disease Control and Prevention, 2009). Most data indicates that the youth are mostly infected and affected by HIV.

The most recent estimates showcase that 10 million youth (ages 15-24) are living with HIV (UNAIDS, 2007) and 45% of all new HIV infections worldwide are within this age category (UNAIDS, 2008). In developed nations, youth prevalence rates vary widely but in the United States, 15% of newly diagnosed HIV/AIDS cases in 2006 were among youths aged 13-24 (Centers for Disease Control and Prevention, 2008). In developed countries such as the US, the concentration of HIV and Acquired ImmunoDeficiency Syndrome (AIDS) among youth in specific socio-economic and socio-behavioral categories has caused researchers to focus on the considerable challenges facing at-risk youth (Centers for Disease Control and Prevention, 2008b). Little research has examined the impact of developmental and psychosocial factors that affect this at-risk group of individuals. Such a focus could help practitioners and researchers better understand the general developmental tasks of adolescents who suffer from serious diseases such as psychosomatic disorders and HIV/AIDS.

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The term 'psychosomatic' has been typically defined as a series of illnesses in which somatic injury breaks out from psychic conflict not recognized as such (Carter, 2011). Some examples of psychosomatic illnesses are high blood pressure, diabetes, asthma, anorexia nervosa, etc. Such conditions are rounded towards symptomatic behavior. Symptomatic behavior is a reaction to an individual or a family under stress and unable to accommodate to changing circumstances, as in the case of a child with schizophrenia. In this view, all family members are equally symptomatic despite efforts by the family to locate the problem as residing in one family member (Carter, 2011). The condition (Schizophrenia) causes symptomatic behavior (reaction) from the family. To further explain, a father has high blood pressure due to the continuous stressors and negative emotions generated from troubling behaviors of his delinquent son and in reverse, the son is an asthmatic boy and has trouble breathing due to a heightened level of anxiety from getting in trouble with his father for his troubling act. This same case with a family system would apply to a troubled youth suffering from anorexia that deprives oneself of food and nutrients because of low self-esteem from a negative self-image, and it is only fair to state that the same would also apply to a HIV-positive adults or youths who are at risk of advancing to AIDS due to suffering from stress or other depressive symptoms.

Before proceeding further, it is imperative to understand that traditionally, HIV has not been seen as a psychosomatic illness. This paper places an emphasis that HIV is, in fact, psychosomatic.

HIV, as a medical condition should be considered as a psychosomatic illness due to its progressive nature upon impact with psychosocial factors such as depression. HIV challenges an individual physically, socially, and psychologically. Furthermore, it may threaten one's sense of meaning, purpose, and significance in life (Simoni, Martone, & Kerwin, 2002). This condition does not only affect an infected person medically but effects mental health and social life. The current literature in the medical, psychosomatic and psychiatric journals does not clearly indicate and define HIV as a psychosomatic illness but recent research and current trends amongst HIV-positive clients who present with depressive symptoms in social service agencies just as Foster & Williamson (2000) state that the impact of HIV/AIDS on children and families is compounded by the fact that many families live in communities already disadvantaged by poverty, poor infrastructure and limited access to basic services. This is the norm for the majority of clientele serviced by the many social service agencies all across the nation.

There have been a number of studies conducted that support the assumption of HIV being classified as psychosomatic. Researchers from the University of North Carolina conducted a longitudinal study and published the findings in the journal of psychosomatic medicine in 1999, and the study was based on the researchers examining effects of stress, depressive symptoms and social support on the progression of HIV infection on (n=82) men for a period of 5.5 years (Leserman, Jackson, Petitto, Golden, Silva, Perkins, & Evans). They found that more stress and less social support accelerate the course of HIV disease progression. Other researchers such as Ickovics and his colleagues examined the health effects of chronic depression in HIV-infected women (n=765) during a period of 7.0 years and found that women with chronic depressive symptoms were twicemore likely to die from AIDS than those who never experienced depression (Ickovics et al., 2001). Another 7.5 year study on (n=1716) women from five cities across the US showed that those with chronic depressive symptoms were more likely to die from HIV (13%) than those women that had less or no depressive symptoms (6%) (Cook et al., 2004). In relevance to the youth population, there have been limited studies to test the correlation between life stressors and the progression of this disease. There was a 1.0 year study conducted on (n=618) HIV-infected youth and the study found that two or more stressful life events was related to an almost three-time increase in risk of immune suppression therefore a decline in CD4 count (Howland et al., 2000).

These studies conducted clearly act as a basis for determination to support the notion that psychosocial factors indeed can affect the progression of HIV, therefore the disease can clearly be considered as a psychosomatic illness.

Individuals diagnosed with HIV typically seek mental health services that are often made available to them free of charge at the local community HIV/AIDS service agencies. These mental health services include substance abuse counseling, early intervention counseling for the newly diagnosed, group workshops for the infected and sometimes, individual counseling by licensed professional counselors. The therapeutic interventions that are currently being practiced by numerous clinicians are such as the integrative family-based model for drug-involved juvenile offenders called the Multidimensional Family Therapy HIV/STD Intervention (MDFT/HIV-STD) (Marvel, Rowe, Colon-Perez, Diclemente, & Liddle, 2009), or the Structural Ecosystems Therapy for HIV-Seropositive clients (SET) (Szapocznik, Feaster, Mitrani, Prado, Smith, Robinson-Batista, & Robbins, 2004) have been known to incorporate the whole family system but still place the emphasis on the identified patient rather than dissolving the problem within the family in order for them to work through their own problems related to psychosomatic illnesses.

Structural Family Therapy (SFT) is a therapeutic approach that was developed through working with delinquent teens and can be considered to be a useful model to be used in therapy with teens that are HIV-positive. SFT is a treatment model based on systems theory that was developed primarily at the Philadelphia Child Guidance Clinic, under the leadership of Salvador Minuchin. Minuchin shifted the focus from the world of the delinquent adolescent to the dynamic patterns of the family after he was appointed Director of the Philadelphia Child Guidance Clinic and this was a starting point for him to working with a wider cross-section of families. The client population presenting problems at Philadelphia were of a medical nature. The clients that gave this model a new twist were diabetic children with an unusually high number of hospitalizations for ketoacidosis. Their conditions could not be explained medically and psychotherapy to help the clients handle stress became ineffective (Colapinto, 1991).

Apart from working with diabetics, Minuchin also worked with asthmatics and clients diagnosed with anorexia nervosa that led him and his colleagues to the publication of *Psychosomatic Families* (Minuchin, Rosman & Baker, 1978).

Prior to this, strategies used in dealing with psychosomatic illness were medically based despite family therapists acknowledging that the family system played a role in specifically, eating disorders. This was mostly evident with Laségue, who might be regarded as the world's first family therapist recognizing the role that the family environment plays in anorexia, describing the relations between his anorexic adolescent patients and their families (Corraze, 1998). The publication of *Psychosomatic families* helped not just other clinicians, but also gave families that were struggling with these conditions seek therapeutic help. During this same period of time, the clinical experience supporting this model went far beyond the psychosomatic field.

SFT is primarily a way of thinking and operating in three related areas which are the family, the presenting problem, and the process of change. According to Colapinto (1991), structure refers to the internal organization that dictates how, when, and with whom individuals within a system can relate. SFT conceptualizes the family structure as a living open system despite it being affected by a HIV as a medical condition. In every system the parts are functionally interdependent and as an open system, the family is subject to the surrounding environment through its own culture. Mainly the families that are affected by the HIV pandemic have their own distinct culture besides the stigmatic culture already embedded in them due to the diagnosis.

This model's main goal emphasizes on structural change within the family system. Carter, (2011) emphasizes that the goal of therapy is the restructuring of the family's system of transactional rules, such that the interactional reality of the family becomes more flexible, with an expanded availability of alternative ways of dealing with each other. With other approaches that are implied to at-risk teens, there is a lack of emphasis on restructuring these transactional rules that have been the norm for the family even before the diagnosis. SFT approaches this differently through forming new rules and ways of interactions.

This therefore, helps the family form problem solving abilities within themselves and develops healthy boundaries and realigns unhealthy boundaries between subsystems within the family.

In an article streamlining the effectiveness of SFT on treatment of juvenile Anorexia Nervosa, Fishman, (2006) emphasizes that family therapists are distinct among mental health professionals. They are trained to address clients' problems by seeking to transform their context.

The problem is seen not as residing in the individual or as one of communication; rather it is viewed as stemming from the patient's social context, the family. This therefore, supports the main premise of SFT which is involvement of the whole family system. In Structural Family Therapy, the goal is to disrupt the negative cycle of the family, and to bring out healthy parts of the family members that are not currently being used (Pruitt, 2007). When a teen's depressive levels have increased due to the isolation that he/she faces from family members or due to the HIV diagnosis or stressors related to their delinquent behavior, there are negative cycles embedded within the family that fuel the dysfunctional relationships amongst the individual members of the family. It is the role of the therapist to help the family to bring up those healthy interactions within the family that they might not have explored yet in order to function to their fullest potential. This theory's basic principles of characterization of therapy as a transitional event go hand-in-hand with the therapist's functions which are to help the family reach a new stage, emphasize on present reality with the diagnosis and nature of the at-risk teen as opposed to the family's history, displace the symptom from the HIV-positive delinquent teen to the system of transactions, help the family understand the diagnosis as a constructed reality, and allow the system to maximize its potential for conflict resolution and individual growth. As a marriage and family therapist clinician, one has to be fully aware that clients who present to therapy with a HIV diagnosis typically suffer from depression (Gorv et al., 2010) and need to be further assessed and treated for it individually if the need arises.

The structural approach to family therapy envisions families with a set of systems and subsystems, roles and rules, boundaries, power, and hierarchy (Aponete & VanDeusen, 1981). The therapist may utilize these concepts or main tenets to facilitate change within the family structure. These tenets are utilized during the process of restructuring. Indeed, this restructuring leads to a control of the symptomatology and assists the recovery process (Fishman, 2006). Restructuring the family's current dysfunctional relationship to a healthier one fosters positive relational change. This thus is the theory of change that underlies the clinical work for this model in its application to at-risk teens diagnosed with HIV. This process of change is facilitated by the therapist's role which is to help the family reach a new stage and allow the system to maximize its potential for conflict resolution and individual growth.

During the initial sessions, therapists are to assess the client or family and do not begin the intervention process until all necessary information is gathered. The therapist formulates a working relationship with the family. According to Nichols & Tafuri, (2013), assessments are about information gathering; interventions are about problem solving. The therapist broadens the focus from the identified patient to more relational patterns of the family through respectful questioning. One of the purposes of using this technique is that it helps shift the symptom, or locus of pathology from a specific individual to a more interactional understanding within the family system, thus, Circular Causality. In fact, what family therapists call "circular causality" is a misnomer because the shift from linear to circular thinking not only expands the focus from individuals to patterns of interaction but also deliberately avoids cause-and-effect explanations (Nichols & Tafuri, 2013). It's designed to help the family come to a realization of what's keeping them stuck, who is capable in the family to resolve the issues presented in therapy and who is unwilling to do the same rather than shifting the blame solely towards the diagnosed teen. Therefore the family members become their own agents of change. During this process, Family members are taught to listen to one another with respect and empathy, and to communicate thoughts and feelings without blaming, judging, and/or criticizing (Lewandowski, 2007).

Now that the therapist is able to see the family interaction from his/her own lens, the therapist needs to organize all the information that is obtained through the observations. The question of which family member gets to talk about HIV/AIDS while in therapy is crucial as well. Instinctively, the individual that is diagnosed is responsible and has priority to communicate in therapy about HIV unless the individual is a teen that is highly unaware of the diagnosis. More than likely, individuals who are diagnosed are required to go through numerous HIV educational classes through the social service agencies coinciding with other services being rendered and these are classes that are geared towards educating the diagnosed individual about the disease. With this, family communication is structured since the diagnosed family member can act as an educator to the other non-informed members of the family and healthy and constructive discussions can be sparked within.

In SFT, families are differentiated into groups based on their generation, age, function within the family and gender. These are well known as subsystems. Subsystems (Minuchin, 1974) refer to components of a family system that exist to carry out various tasks necessary for the functioning of the family.

Such examples of subsystems are the parental, couple/marital, grandparental, and sibling/children subsystems. These differentiations are defined by invisible barriers that are known as boundaries. Types of boundaries between family members can range from enmeshed to disengaged; enmeshed boundaries are characterized by minimal autonomy between individuals and disengaged boundaries are evidenced by limited communication between family members as well as outside systems (Ramisch, McVicker & Sahin, 2009). Disengaged boundaries are also termed as rigid boundaries and are very restrictive and allows little to no contact between subsystems while enmeshed boundaries are diffuse. Diffused boundaries allow too much information to travel in and out of a system and can lead to family members who are overly involved, thus blurring the lines between subsystems. Clear boundaries are often viewed as being the most functional, families will shift and sway in their boundaries when necessary. Subsystems need to be protected by boundaries so that the development of relationship skills between subsystems is not limited.

Subsystems that have clear boundaries tend to possess a hierarchical structure. Fish and Priest, (2011) defined Hierarchy as individuals and subsystems that work in leadership roles to help families resolve tasks and make decisions. An example of a subsystem with a clear boundary is the parental subsystem where there is an aspect of leadership responsibility within the family. Hierarchical relations and coalitions are frequently in need to be redefined if there is evidence of unhealthy enmeshment of subsystems such as parent and child subsystems that are in battle for authority. In this case, the therapist can subsequently strengthen such boundaries through individual sessions with these two conflicting subsystems and make a boundary therapeutically that would elicit a more functional relationship. This can be made possible through realigning the two subsystems and balancing the parental and child subsystems in order to decrease and eliminate the battle for authority. In this case, the therapist can unbalance the two opposing subsystems and destabilize the subsystems by taking sides equally and forming coalitions during conflict in therapy in order to realign and eventually balance the boundaries between the two. The ultimate goal here for the therapist is to create stress and a crisis situation between the two subsystems and with this, it requires the therapist's full involvement. In treatment, the planned process of generating stress and providing support helps the family reach a new level of organization.

The therapist is required to generate enough intensity, through effective use of self, to activate the family (Lappin, 1988).

This therefore produces the process of change after it has been effectively implemented by the therapist. Moreover, while it is possible to generalize about overall strategies, specific interventions must be tailored to the specific requirements of the situation, and they are often a unique expression of the therapist's personal style (Nichols & Tafuri, 2013).

Applying this concept to families that are struggling with a teenage family member who is diagnosed with HIV might sound easier in theory than it is practically but with the strengthened relationship at the beginning of sessions where the therapist places emphasis on the joining process, the infected teen places a level of trust with the clinician to allow for the process to take its course. A great example of this is played out in the case of the Herbole family. This is a family that had been seen in therapy at the San Antonio AIDS Foundation (SAAF) for four months with a presenting problem of heroin addiction and its associated issues. The distressed mother called the agency wanting to bring in her only son for treatment of anger and low self-drive issues as well. At 17, R.H. had been HIV-positive for 19 months due to sharing needles with an infected individual. He was concurrently receiving addiction treatment while in therapy. He has been dependent on his mother and any time he needs money, M.H., his mother always gave it to him.

The precipitating event was that he was charged with aggravated assault for seriously beating a schoolmate after realizing that the schoolmate had spread rumors about his sexual orientation. At the time of our initial session, R.H. was still awaiting trial, he had extremely low esteem and was at a depressed state. His viral load was high and wasn't adhering to his HIV medication. He used cough medicine to get intoxicated since he was 14 years old as a coping mechanism for his father's death. His mother knew of this but countered it minimally out of the fear that her son would get involved with much harder drugs if she was to stop him. This was the same approach she used with money, never wanting him to go without. After the assessment, the therapist joined with the family until the level of acceptance as a member of the family system. During these initial phases of the therapy, the main issue of R.H.'s diagnosis was externalized. Made to be a different entity within the family. The issues of him being a dependent adolescent was highlighted. On subsequent sessions, crisis situations in the therapy room were created and coalitions formed with R.H., and then formed similar coalitions with the mother. The following interaction took place:

Therapist: So looking at these lists of roles, seems to me that you have more power at home compared to your mom. Basically, you're the man of the house here. (Looking at him)

R.H.: No I'm not.

Therapist: I think you are. Do you want to know why? (As he nods his head wanting to hear the reason). Mom, would you explain to him why you think he's more powerful than you?

M.H.: Actually, you're not powerful at all (looking at her son). You're just irresponsible and being the only male in the house and you always take out your anger and frustrations together with your problems to me and you expect me to handle it for you. It's about time you grew up. I'm always helping him out and he's just learnt to rely on me for everything and he doesn't care about anything but himself and never thinks about his family.

Therapist: (to M.H.) Is that so? Because I think that you're deflecting the blame to your son. He didn't make himself dependent on you; you helped him to reach this point.

M.H.: I don't know about that ...

Me (therapist): Seems to me that you are all the cause of his problems. Would you agree with that? (Looking at M. H. as she stared speechlessly at the therapist with her eyes wide open).

R.H.: I just don't know why she never understands me.

Therapist: Well I'm glad you said that. (As the therapist reaches his hand out to shake his hand as a sign of acknowledgement).

Mom, I think that through time you have enabled these problems to persist and it would only be appropriate if you acknowledged it in order for us to move on.

Such intensity, and the therapist incorporating the aspect of self in therapy, acts as an agent of change due to challenging the perception of reality that both the mother and son had developed through time. During subsequent sessions, and utilizing enactment and building coalitions between the two, it came to actualization amongst the family that the mother was not only grieving the loss of her late husband, but the loss of her son as well. R.H.'s anger issues and acting out at school and with his neighborhood friends was due to grieving for the loss of his father. He was the only one that stayed strong for everyone in the family during his death and he still didn't get a chance to grieve his father's loss. Psychoeducation was incorporated about HIV as well as healthy means to interact and function as a family.

One of the goals of therapy was for R.H. to become more independent in dealing with his probation, look for a job and to stop using his mother for money. M.H. lacked confidence in R.H., attempts were made for the family to allow R.H. to try and complete his recovery from addiction as well as look for a job without the mother providing too much financial support without considering the implications. The enmeshed boundary between the two was clarified. R.H. eventually found a job at a local car wash detailing cars. He became aware of himself and didn't let the diagnosis deter him from experiencing life in a healthy manner. He began to take his HIV medication, was sober throughout treatment and eventually had his viral load at a low level. The family had the task of maintaining these new rules and boundaries at home and they did it well through the four month period.

The next process after this is for the family and subsystems to maintain the positive change that they have achieved. Once satisfied with this, the therapist then needs to start the process of distancing himself/herself from the family in order to terminate sessions.

The family as a living system is in constant transformation and there are some transactional rules that evolve over time as each subsystem evolves or obtains a different role for any period in the family's life as a system. Structural family therapy is based on the concept that a dysfunctional family, specifically a family that is struggling with a psychosomatic illness just like HIV can be identified by an enmeshed or a rigid boundary that does not allow the family to solve her problems adequately.

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