A Bio-Psycho-Social-Spiritual Approach to HIV and Homelessness
Barry Zevin, MD

The ache for home lives in all of us, the safe place where we can go as we are and not be questioned. —Maya Angelou

Over the past 25 years, homelessness and AIDS have formed intersecting epidemics, sharing roots in poverty and discrimination, and physical health, mental health, and substance use disorders. Approximately one-third to one-half of people living with HIV in the United States are homeless or at imminent risk of homelessness. HIV is more than three times as prevalent among homeless people than it is among those who are housed.

Suffering is prominent among homeless people. Physical health, mental health, and substance abuse problems are common, and death rates are high. This article explores the experience of working with homeless clients with HIV-related issues and proposes a bio-psycho-social-spiritual model to address multiple barriers to prevention and care.

Medical Concerns

HIV is only one among many conditions that affect homeless people differently than housed people. Homeless patients often present for care with advanced disease and acute conditions, including nutritional and dental problems, dehydration, hypothermia, and the physical consequences of traumatic assault.

Infectious diseases such as lice, scabies, and viral hepatitis are common. Sexually transmitted diseases, skin infections, and respiratory infections, especially tuberculosis, are also common, and are facilitated by the overcrowded conditions many homeless people live in, such as shelters, as well as the exposure to the elements experienced by those living on the streets. Substance abuse, widespread in this population, can itself lead to a host of physical consequences. Among these are permanent cognitive impairment, and liver, lung, and heart disease.

Psychological Issues

Psychological disorders, which are commonly undiagnosed and untreated in homeless people, are both a common cause of homelessness and are greatly exacerbated by it. Homeless people are five to six times more likely than the general U.S. population to have a serious mental illness such as schizophrenia, bipolar disorder, major depression, schizoaffective disorders, and severe personality disorders. These psychological disorders, particularly personality disorders, are also a cause of poor outcomes in the care of homeless people. They can interfere with the provider-client relationship and create difficulties maintaining housing, which can undermine medication adherence and treatment planning.

Research has documented the disproportionate risk of HIV infection among homeless people with mental health disorders and has implicated several factors. Among these factors are injection drug use with needle sharing, sex work, survival sex, and rape. Lack of privacy, as well as psychological issues, contribute to more unstable sexual relationships, and inability to afford condoms and to negotiate their use add further barriers to HIV prevention.

Cognitive impairment is a significant obstacle to both housing and prevention and care for many homeless people. Evidence suggests that homeless people are at greater risk than the general population for traumatic head injury. It is also common for these clients to experience cognitive impairment as a result of mental illness, chronic substance abuse, developmental delay, and HIV itself.

Substance abuse further complicates this mental health picture. While one in five Americans has a substance use problem, an estimated two out of three homeless people do, and up to 50 percent of people who are homeless have co-occurring mental health and substance use disorders.
As Barry Zevin pointed out when we first discussed his article in this issue of FOCUS, the public response to homelessness has paralleled the public response to HIV. An initial response of concern, even a sense of emergency, has given way to a tolerance of suffering, a sense of hopelessness, and “compassion fatigue.”

One reason for this is the feeling that we are powerless to help. The epidemics of homelessness and HIV have at times seemed remarkably resistant to change. Another reason is that for those standing outside the epidemics, it is easy to draw false distinctions between “us” and “them.” We know that many individuals and families are just a paycheck away from homelessness, but prefer to believe that the dividing line between “us” and “them” will protect us from a similar fate. The truth is that much of the time, it does. Health and housing do mirror patterns of class, race, and other demographics. While anyone can become homeless, just as anyone can contract HIV, some groups are much more vulnerable to these conditions than others.

Twenty-five years after fighting for the public to recognize that AIDS is not just a “gay” disease, the truth is that nearly half of all AIDS cases in this country still occur among men who have sex with men. Many, like Michael Cooley, the author of the second article in this issue, are young men at the time of their infection. People of color are also disproportionately represented among those with HIV and those who are homeless, with African American people representing almost half of both homeless Americans and people with AIDS in the United States.

In the middle class communities of the richer countries of the world, HIV incidence is stable—not diminishing and still large, but stable. A generation of activism was successful in “putting a face” on HIV. The success led to a shift from moral condemnation to social support, from assigning outsider status to gay people and people with HIV to accepting our common humanity. It led to more money for research, medical treatment, and psychological care, and, ultimately, to the antiviral regimen breakthroughs of the mid-1990s. Yet, separations based on economic class seem more resistant than ever to change, and HIV and homelessness continue to thrive in our poorest communities.

Both Zevin’s and Cooley’s articles give us a chance to connect with the concerns homeless people with HIV face. Zevin reminds us of the challenges homeless people face, and the small ways we can experience our homeless clients’—and our own—humanity. Cooley describes his transformative journey from homelessness and desperation to community and family reconnection. Each reminds us that lacking a roof over our heads should not mean losing our place in the world.

Post-traumatic stress disorder is another common, yet often unrecognized, problem. In one study of homeless women, almost 90 percent reported having been violently victimized at some point in their lives. Homeless men, especially those with mental health disorders, have similarly high rates of victimization. Despite being stereotyped as dangerous or violent, homeless people are, in fact, among the most frequent victims of violence.

Experiences of trauma, loss, fear, and shame shape the behavior and quality of life of many homeless people, narrowing the scope of living to mere survival. Yet providers often underestimate the role that shame plays in the behavior of homeless clients, especially shame related to HIV or HIV risk-related substance use or sexual behaviors. Further, providers may mistake a client’s shame-based avoidance of care as personal rejection or a lack of concern for health.

Social Influences

Stereotypes about homeless people are pervasive and may interfere with providing appropriate services. Among the most common of these stereotypes are judgments that homeless people are isolated, violent, unapproachable, lazy, and asexual. Support systems and social structures for homeless people may be unconventional, but few homeless people are entirely isolated, and most prioritize personal relationships as highly as housed people do. Interventions for homeless people that discount these relationships are frequently ineffective.

These stereotypes also contribute to the assumption that homeless people are unable to adhere to antiviral regimens. However, research and experience at the Tom Waddell Health Center in San Francisco has found that adherence rates and other outcomes are comparable to housed populations.

Homeless people are often unable to work due to discrimination or disability. Because these disabilities are often hidden, multiple, and difficult to classify, claims for benefits are often initially rejected, reinforcing the
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judgment that homelessness and inability to work represent a moral failure. Benefits and resource advocacy offers a strong incentive for homeless people to seek care despite these barriers. Obtaining benefits not only stabilizes a client's financial situation, it helps the client overcome shame, builds trust with providers, and promotes better health.10

Spiritual Aspects

In the course of assisting homeless people obtain basic resources for survival, it is easy to overlook spiritual concerns—those aspects of life that offer meaning and purpose and enable a person to transcend day-to-day existence. Homeless people face many of the same conflicts around identity and meaning as housed people, but with added challenges because homeless people are so seldom treated by others as valuable. These conflicts include finding a sense of personal power versus giving up in despair, living in silence and invisibility versus making connection and sharing one's story, and seeing oneself as dependent versus recognizing one's contribution to the community. Receiving an HIV diagnosis often raises the stakes of these conflicts, changing a person's perception of life and further stimulating a search for meaning.

Some providers may be surprised that some of their clients experience crises in the spiritual realm “just when things were going so well,” for example, clients move from homelessness to housing or from addiction to recovery. These transitions involve losses as well as benefits, and they demand that homeless people renegotiate identity and meaning as they relegate old social networks and ways of being to the past. Again, uncomfortable emotions may surface for clients just when providers assume they are having their greatest successes. For example, a client may experience loneliness after leaving his or her street family for housing, boredom when withdrawing from the drama of “life on the edge,” or anxiety in response to memories of trauma that return as clients achieve sobriety.

When providers fail to address these issues, clients may manifest increasing isolation, drug relapse, inability to adhere to medical treatment, exacerbation of psychiatric symptoms, hopelessness, and suicidality. Attention to these issues, on the other hand can foster engagement in the community, greater self-care, self-expression, and self-worth.

Comprehensive Care

Effective engagement begins with client-centered attention, in an atmosphere of dignity and respect. Simply addressing a client respectfully and shaking his or her hand may make the difference between engagement and alienation. Since many people hide their homelessness due to shame or fear, the simple question, “What is your living situation?” may be less stigmatizing than the question, “Are you homeless?” Attending to a client’s most urgent needs, including emergency housing, food, and medical care, creates an immediate bond and the foundation for a working relationship. Supportive listening and frequent appointments build a bridge between provider and client—even when it feels as if nothing concrete is “accomplished.”

Early in the course of care, provider and client should collaboratively define the client’s health and life goals, and later review and revise these goals as necessary. These goals will usually address medical and mental health care, housing, and choices about drug use, work, and possibly spiritual practices. Asking a client to describe his or her goals and reasons for them can naturally lead to discussions on a variety of issues, ranging from what support the client can reasonably expect from the agency to information about spiritual values.

Talking with clients about how they spend each day—and asking who they hang out with, who they might ask for help, and how they cannot ask for help—fleshes out the profile of the individual and his or her social system. Providers frequently avoid opportunities to develop a fuller picture because of inaccurate assumptions or the fear of “opening a can of worms.” For example, providers may overlook sexual history, because they assume homeless people are not sexually active or sexually attractive. This is particularly problematic when providers miss opportunities for understanding a client’s sex work, survival sex, or sexual disempowerment.

In homeless shelters and other programs for homeless people there is often significant discrimination against members of sexual and gender identity minorities. Homeless people often conceal their sexual orientation, sexual practices, or transgender identity for fear of being harassed or assaulted. Many services for homeless people are
organized or supported by religious groups with explicit prejudice against gays, lesbians, and transgender people. As these may be the only services in a particular area, individuals may need to suppress identity and needs in order to receive services.

Trauma histories are often buried as well, and some providers may avoid exploring these areas, concerned that even talking about violence may bring out violent behavior in a client or reveal problems that the provider does not feel qualified to handle. Providers can benefit from discussing with supervisors or consultants their concerns about the process, timing, and extent of sexual and trauma history taking.

Inevitably, some problems will arise for which providers have no ready solutions. When this occurs, providers strengthen their credibility with clients and reduce their own risk of burnout by admitting their own limitations. This honesty also gives clients permission to generate their own suggestions and move toward collaborative problem solving.

Multidisciplinary Care

Multidisciplinary care—the coordination of medical, psychological, and social service providers—is critical to effective treatment of homeless people and can be achieved by coordinating with like-minded providers within an agency or a community. The inclusion of peer staff, consisting of currently or formerly homeless people, can also be very effective. It is important to note that peer workers, in particular, need extensive support and training to deal with issues of boundaries, trauma, their own potential triggers, and harm reduction.

Agency policies and procedures help determine whether homeless people perceive services as accessible or exclusionary. For example, flexibility in scheduling and drop-in availability greatly reduces barriers to care for homeless people. Limiting the number of personnel who interact with an individual—for example, by assigning each client to a case manager and a primary point person in each area of care—can help create a supportive family or community-like milieu that increases a client’s comfort and trust and reduces confusion and service duplication. Clients with some mental illnesses and cognitive impairment may especially benefit from an intensive, long-lasting supportive case management relationship in which discussions and instructions are kept simple and are repeated.

It is critical to match a homeless client’s potential housing situation to his or her needs and capacities and plan for possible setbacks. Substance recovery program options and money management and eviction prevention services can help clients maintain housing, although some clients perceive these services as intrusive. In response, careful redirection back to collaboratively developed goals can be helpful, since the ultimate goal is not only housing, but the creation of a stable home. This may require services that support learning life skills, and provide structure, creative work, and an opportunity to “give back” to the community.

Conclusion

A comprehensive, integrated approach addresses the multiple physical, logistical, and psychological barriers to HIV-related health care, mental health care, and prevention for homeless people. While the divisions between these aspects of a whole human being are ultimately artificial, examining each aspect separately creates a framework for an integrated approach, one that can help providers prioritize the often overwhelming problems in their homeless clients’ lives.

References


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I went to a hospitality house in the heart of the Tenderloin. The smell can only be described as “homeless”: a combination of sweat, feet, dog, cigarettes, and alcohol.

Waiting for a Place

I found a phone booth and called the national runaway hotline. They told me to go to a social service program for youth in the Tenderloin, but when I got there, the program staff said I had to be under 18 to get a place, and I had just turned 18. The Tenderloin is in the heart of San Francisco’s red light district—a neighborhood where you had to have “street smarts” in order to make it. If I had had street smarts I would have lied and said I was 17, because it would have meant I would have had a place to stay for a few days. Instead, I told the truth and was given two food vouchers and sent on my way. This was a critical moment when an intervention—like getting into a youth shelter even though I was 18—would have kept me off the streets.

I was devastated and hungry, so I walked to a taqueria on Polk Street. I was fascinated by the street life passing by, I wasn’t used to electric-blue Mohawks, the punks, the skaters, the crack-heads, the queer hustler boys, two or three of them on every corner.

I went to a drop-in space in the heart of the Tenderloin. A now-defunct youth program existed in their basement. The smell can only be described as “homeless”: a combination of sweat, feet, dog, cigarettes, and alcohol.

As long as I can remember, my relationship with my dad was strained. People always ask if it is because I’m gay, but it goes back further. In 1973, when I was conceived, my father was 17 and in the army, and my half brothers were three and four. My dad left my mom soon after I was born. When I was seven, rampant alcoholism finally caught up with my mother. She became very ill and could no longer take care of me, so she sent me to live with my father and his new wife.

In 1991 when I was almost 17, I was kicked out of my father’s home in Prunedale, a rural town in central California. I stayed with various friends for a year, but kept thinking about San Francisco. It was the gay Mecca; I had seen the Pride Parade on television. I had dropped out of high school after my junior year, so I came to the city without a high school education and with no place to stay.

I had never lived in a city before. I was used to roosters crowing, horses, the slower pace of a quiet community. No one ever spoke to me about how to find work, how to find food, how to live. I was on my own without a home.

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and alcohol. Anne, a case manager, said it would be a month or so before I could get a bed at a halfway house for youth. Since I had already stayed the maximum number of nights at the Salvation Army, I was going to have to stay on the streets.

I immediately began to integrate into street-life. The friends I made quickly showed me how to make the best of it. I slept in “squats,” usually in a burned-out building or construction site, but I was always on the move. The police would chase us out, and we would wait a few days and come back. We had nowhere else to go. One night I came down with the flu and was too weak to get out of the “squat” to get food. My new friends brought me a bagged lunch from a missionary doing outreach on Polk Street that night. They took care of me.

After two months, I got a place in the halfway house. While I was there, the staff encouraged me to take my high school equivalency test. About two months later, I went to school for practice tests and did so well that the instructor asked me to take the official test right then. I passed that, too.

Really Homeless

Then I met the man of my dreams. Randy was a new guy at the house, and we began dating. When the house case managers found out, they said we have to stop seeing each other—it was a house rule—or we’d have to leave. If I had to do it all over again, I would have stayed in the house. But right then, it felt as if this relationship was the most important thing in the world. I didn’t know what the reality of being with Randy would mean once we were back on the streets again. Randy was a veteran hustler and speed addict. He had a case manager at a homeless youth agency that served HIV-positive clients. He managed to talk the case manager into letting me pay the extra $5.00 a day to stay in a rat-infested, run-down hotel on Sixth Street.

I learned from Randy how to hustle, what to say when negotiating payment to keep from incriminating myself in case I was talking to a cop, and, oh, also how to shoot up crystal meth. This was the beginning of my truly homeless days, scratching to survive and dreading the thought of giving my body up to lonely, needy men who were so desperate for attention that I couldn’t even try to respect them. I hated them.

I began using speed to get me to the corner and it was speed that kept me there. Randy was gone after a few months, and I was still looking for ways to pay my rent and get high. I found support in a network of other drug addicts; we were all outcasts. Every time I got tested for HIV, I knew that if the test came back positive, I would have a place to live. I didn’t want to be HIV-positive, but everyone around me already had it. It seemed like it was only a matter of time.

My visits to the test sites were unremarkable. I don’t remember really working on a way to reduce my risk. It wouldn’t have mattered anyway, since I let the “Johns” dictate what we were going to do. If I swallowed I could get more money; if I got fucked, it was a lot more money. We never discussed condoms, and I was in no position to make demands.

Living with HIV

I met Bobby sometime after I turned 19. He was 36 and a speed dealer. Bobby paid for a hotel room for me for two months, and I wanted for nothing. I eventually moved in with him in a small home in the East Bay. We spent the next two years “playing house.”

When I was 21, Bobby replaced me with his next boy-toy. I was back on the streets. I tested again, and this time I was HIV-positive. Because I had HIV, new resources were available, and I got into a hotel room that very night, happy to have a roof over my head.

I spent the next few years seeing Ron, a case manager. Ron always told it like it was: I would need to stop the drugs if I wanted to do anything but hustle tricks or sell dope. Looking back, I realize that although it was helpful to have a place to stay, I was still in the drug environment. Using the clinic for medical care and food services saved my life, but it also allowed me to spend all my own money on drugs.

A Moment of Clarity

Ron was right. This was no life for me.

Two things happened that drove me into treatment. The first thing has scarred me for life. I was robbed and severely beaten by a local drug dealer who knew I was an easy target. After that, I couldn’t sleep or

Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rob.marks@ucsf.edu or to Editor, FOCUS, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
I wanted them to understand the consequences of kicking me out, and I wanted them to hurt too. I hoped they would be upset and feel guilty. Instead, they drove up and told me that they loved me very much.
Recent Reports

Homelessness and Antiretroviral Adherence

In his overview article, Barry Zevin identifies obstacles to HIV antiviral drug adherence among people who are homeless. But he also notes that there is evidence that appropriate medical care can lead to good medical outcomes, including high levels of adherence, within this population. This University of Miami study, which focuses on a variety of factors that may affect injection drug users’ adherence levels, did not find a connection between homelessness and nonadherence.

Depression may be a more potent indicator than homelessness of HIV antiviral medication nonadherence among injection drug users.

High levels of adherence to antiretroviral medications are required to maximize therapeutic benefits and viral suppression. Injection drug use is associated with decreased adherence levels, unstable living conditions, and mental health problems.

Despite the prevalence of these nonadherence risks among HIV-positive injection drug users, there has been little study assessing the impact of homelessness and psychological distress on adherence in this population. This study evaluated the effects of housing status (homeless and marginally housed versus nonhomeless) and psychological distress, measured via depression, anxiety, and perceived stress, on self-reported adherence in 58 HIV-positive injection drug users.

Homeless and marginally housed HIV-positive injection drug users reported higher levels of anxiety and perceived stress than their nonhomeless counterparts. The groups reported similar levels of depression. However, only depression was significantly related to adherence.

Housing status, drug or alcohol use, and other demographic variables including gender, race and ethnicity, and years of education, were not associated with adherence. The study also found a relatively high rate of adherence in homeless and marginally housed injection drug users, with 63 percent of these subjects reporting perfect (100 percent) adherence levels.

Homeless Youth and HIV Risk

Homeless youth may have an especially high risk of contracting HIV. This Seattle-based study complements Michael Cooley’s memoir by reporting on the experiences and beliefs regarding the HIV risk of homeless youth.

Knowledge of HIV protective strategies differed by sexual orientation, according to this large Seattle study of young people. Heterosexual youth had the weakest knowledge of HIV protection strategies, especially compared with young men who have sex with men.

Researchers interviewed 272 homeless youth in order to determine how initial HIV prevention efforts were received and to assess ways that the youth’s beliefs and behaviors continued to put them at risk for HIV infection. The mean age for the 169 male youth was 18; the mean age for the 103 female youth was 16. Most identified as heterosexual, but 20 percent identified as gay or lesbian and 17 percent identified as bisexual.

Youth reported using condoms with casual partners during vaginal and anal sex and, among those engaged in sex work, with clients during oral, anal, and vaginal sex. Condoms were often not used during vaginal sex with main partners or during oral sex with casual or main partners.

Next Issue
Research has identified trauma, the result of either or both sexual and physical abuse, as a key factor influencing the behaviors most likely to result in HIV transmission. Studies have also identified high rates of trauma and post-traumatic stress disorder—the specific constellation of psychological symptoms that can result from traumatic experiences—among people with HIV. In the April issue, Deborah J. Brief, PhD, Assistant Professor of Psychiatry at Boston University, reviews the literature on the prevalence and manifestations of trauma and PTSD among people with HIV.

Also in the April issue, Nathan B. Hansen, PhD, Assistant Clinical Professor of Psychiatry, and Kathleen J. Sikkema, PhD, Associate Professor of Epidemiology, both at Yale University, describe the range of approaches available to treat PTSD and the application of these strategies to people living with HIV.
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