Mental disorders can impede access to HIV-related medical care and antiviral treatment, complicate the doctor-physician relationship, and decrease adherence to complicated drug combinations and to safer sex and needle-sharing practices. Among those people with mental disorders who face the greatest challenges, both in terms of HIV prevention and care, are people with personality disorders.\(^1\,\^2\)

Using the borderline personality disorder as a lens, this article offers a view of what it is like to interact with seropositive clients with serious mental disorders.

**Defining Borderline Personality Disorder**

Personality disorders are inflexible, maladaptive ways of perceiving or relating to the interpersonal environment that cause functional impairment or subjective distress in an individual. These disorders—including, for example, narcissistic, antisocial, and histrionic personality disorders—are longstanding, characteristic ways of relating to the world, typically emerging in childhood or adolescence and continuing throughout adult life. This makes a longitudinal history essential to the diagnosis of personality disorders.\(^3\)

All of these disorders represent exaggerated styles of interacting with others and significantly interfere with a person’s ability to have positive, lasting relationships and to have accurate self-concepts.

The DSM-IV categorizes borderline personality disorder under Cluster B Personality Disorders, which includes clients who are often dramatic, erratic, or emotional.\(^3\) The diagnostic criteria include a pervasive and longstanding pattern of instability of mood, identity, and relationships. Identity disturbance leads to feelings of emptiness and boredom, while mood instability manifests with rapid swings in demeanor. Impulsive, self-destructive behaviors can also be part of this constellation. Although all personality disorders involve chronic maladaptive behavior patterns, borderline personality disorder is characterized in particular by disturbed interpersonal relationships, poor impulse control, a heightened potential for repeated self-injury, and an increased fear of being alone. People with borderline personality range from low-functioning to relatively high-functioning.

Psychodynamic and object relations theories postulate that borderline personality disorder is rooted in the child’s unsuccessful struggle to separate and differentiate during the first 18 months of life. Another theory suggests that borderline is a subtype of the affective disorders.

Epidemiological studies estimate the prevalence of borderline personality disorder as 0.2 percent to 10 percent in the general population and 15 percent among psychiatric clients.\(^4\,\^5\) Approximately 76 percent of borderline clients are female.\(^4\,\^5\) There is little data on personality disorder in people with HIV disease, but a 1993 study did find a 33 percent incidence of personality disorder (mostly borderline) among HIV-positive gay men versus 15 percent among seronegative gay male controls.\(^2\) Other studies indicate the prevalence of personality disorders among people at highest risk for HIV infection. A 1995 study of a genitourinary clinic in London found that 38 percent of homosexually active men and 28 percent of heterosexually active men had a personality disorder.\(^6\) A 1998 study of cocaine users found that 34 percent of participants had antisocial personality disorder.\(^7\) Borderline personality disorder is often coupled with substance abuse or uncertain-
Editorial: Borderline Prevention
Robert Marks, Editor

Mental illness is not widely acknowledged as a factor in the HIV epidemic and almost willfully underrecognized as an element of other social problems such as homelessness and substance abuse. There is a strange denial about mental illness: in a culture awash with antidepressant medications and television commercials about social anxiety, serious mental illness, albeit much more difficult to treat than garden-variety depression, seems absent from social consciousness.

Depression was once as invisible as other mental illnesses. It materialized with the development of the selective serotonin re-uptake inhibitors like Prozac, that is, when it became more easily treatable and when the media portrayed its cause as related to brain chemistry and not to the less socially acceptable topics such as childhood trauma. Many mental illnesses, including personality disorders, are not so well-recognized or treatable, so they are marginalized.

In the world of AIDS, HIV prevention efforts have only begrudgingly acknowledged mental health as a consideration; serious mental illness is rarely discussed as an influence on HIV risk. While research in the last few years has focused more attention on the psychological components of risk, most of this research looks at the psychological processes of people who are without serious or chronic mental illness. People with secondary diagnoses such as personality disorders are particularly absent as targets of specific interventions.

Ironically, while the need for HIV prevention for people with mental illness has not inspired much action, underlying prevention concerns have stimulated a great deal of research on the effects of mental illness and mental health on HIV treatment. These concerns have centered on the fear that inadequate adherence to complex HIV antiviral regimens would lead to drug resistance and potentially to the transmission of drug-resistant strains of HIV. The fact is that mental illness not only serves to increase HIV transmission risk, but also can undermine treatment efficacy, thereby threatening the physical as well as the mental health of people with HIV.

As Michele Killough Nelson and Rochelle Klinger point out in this issue of FOCUS, rates of personality disorder are much higher among people with HIV than within the general population. Other studies show that rates of serious mental illnesses such as personality disorders are also higher among homeless people and people with substance use problems. Unfortunately, such data usually gets interpreted in counterproductive ways: people with mental illness are flawed, therefore it is not worth expending resources to help them; and people with mental illness are too difficult to treat, so let’s focus on those without mental illness.

There is a certain logic to such conclusions. Working with these clients is challenging and success must be measured in small steps. But it would be foolish and self-defeating to avoid the effort just because it is difficult.

References

Robert Marks, Editor
Psychotherapy on their own and unless they are in crisis. Once the crisis has passed, they often flee therapy. It is more likely that seropositive borderline clients will be pushed into psychotherapy by their health care providers who feel frustrated with them.

Most psychotherapists feel challenged and frustrated when working with clients diagnosed with borderline personality disorder. These clients are difficult and time-consuming to manage, and the literature is unclear about whether anything other than limited improvement can be expected even with the best treatment. Clients with both borderline personality disorder and HIV disease often experience a magnification of borderline symptoms because they have difficulty coping with the added emotional, financial, and interpersonal stressors that a serious medical illness imposes.

There are four key clinical tasks for therapists treating borderline clients with HIV disease: helping clients secure resources—medical, financial, or social—that will minimize stressors; helping them improve interpersonal skills; teaching clients ways to reduce self-injurious behaviors and maximize adaptive ones; and addressing clients’ feelings in ways that promote open discussion of issues.

Interpersonal relationships are difficult for all borderline clients to sustain. Volatile mood, tendencies towards splitting (pitting one provider against another), poor impulse control, and a demanding nature preclude healthy, lasting relationships and instead result in alienation from others. HIV-positive borderline clients have more trouble maintaining positive relationships than other borderline clients because of HIV-related stigma and rejection. Their problems with impulse control and desires for immediate gratification may cause others to fear that these clients will act irresponsibly and spread the virus, and instead result in alienation from others. HIV-positive borderline clients have more trouble maintaining positive relationships than other borderline clients because of HIV-related stigma and rejection. Their problems with impulse control and desires for immediate gratification may cause others to fear that these clients will act irresponsibly and spread the virus, and instead result in alienation from others.

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In addition, health concerns and legitimate needs for attention are often camouflaged by the chaos of the client’s life and his or her anger about having become infected.

This profile is especially trying for men-}

Therapy does not alter a client’s basic personality structure; instead, it seeks to strengthen adaptive behaviors and coping mechanisms.


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improve quality of life. The therapist accomplishes this by providing constant feedback to help clients identify and generalize acceptable behaviors. During this process, the therapist labels maladaptive behaviors and coping mechanisms, encourages clients to avoid these behaviors, and helps clients learn to anticipate the consequences of their behaviors. It is important to remember that although most clients desire to live more positive, productive lives, this desire is insufficient to effect true change. Good intentions without good coping skills usually lead to feelings of frustration and disappointment.

The therapeutic relationship is perhaps the most significant tool in the treatment of clients with personality disorders. Borderline clients usually do not understand the role they, themselves, play in their difficult personal interactions. Therapists can use the safety of the therapeutic alliance to help clients explore feelings about relationships.

Therapists need to give clients constant and carefully phrased feedback and to remain open to feedback from clients. Being mindful that clients will relate to therapists in the same way they relate to others can enable therapists to respond appropriately when clients express ambivalent, conflicted, and angry feelings towards their therapists. This knowledge can also help therapists provide immediate feedback to clients when they begin to inject chaos into the therapeutic relationship, allowing clients to examine the emotional origins of their behaviors.

This helps clients understand the angry, rejecting responses of others and allows them to alter the situation and move forward. It is most easily undertaken by commenting on the therapeutic process rather than by directly addressing the content of what clients are saying or doing.

It is particularly important to stay calm and distant from the chaos borderline clients create. To minimize the effects of the chaos, therapists must set firm and consistent limits with clients and carefully outline the client’s and therapist’s responsibilities. This is often done by using contingency contracts, which outline specific client requirements and spell out the consequences of compliance or noncompliance. If clients bring chaos into the therapeutic relationship, they may succeed in baiting the therapist into conflict, thereby gaining inappropriate control. Arguing with clients, even borderline clients at their most contentious, is inadvisable, since it shifts the focus of therapy from the client’s well-being to the dynamics of a power struggle.

Interpersonal group psychotherapy is useful in treating some HIV-positive borderline clients. These groups focus on helping clients learn how to interact with others in appropriate ways by providing feedback about interpersonal style and encouraging participants to modify these styles within the group. Borderline clients may find these groups difficult, because they must “share” the therapist with others and do not receive the therapist’s undivided attention.

Conclusion

Working with seropositive borderline clients is a difficult task even for the most experienced clinicians. Providers must help clients process interpersonal problems, disease stigma, feelings of emptiness, and practical challenges. Reasonable but firm boundaries are crucial to avoid the chaos that borderline clients inject into therapy. Given these difficulties, it is important to realize that managing borderline clients can be frustrating, and it may be useful for therapists to explore negative countertransference in supervision both to better understand clients’ effects on others and to monitor these feelings in themselves. Nonetheless, the therapeutic relationship can help borderline clients improve the quality of their lives.


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This article was adapted from a chapter in The UCSF AIDS Health Project Guide to Counseling: Perspectives on Psychotherapy, Prevention, and Therapeutic Practice (Jossey-Bass Publishers, 1998).

References


Borderline personality disorder is characterized by volatile emotional states and emotional emptiness, poor impulse control, difficult and often stormy interpersonal relationships, and problems with anger management. Borderline clients typically require more planning, structure, emotional energy, and time, and may drain a disproportionate amount of resources away from a therapist’s psychologically healthier clients. But these challenges do not preclude the possibility of significant progress.

The hypothetical case of “Maurice” and his therapist “Anne Graham” exemplifies a common presentation. By using a combination of limit-setting and concrete problem-solving strategies, Dr. Graham was able to form a fragile alliance that allowed her client to make some progress.

Maurice: Abandoned, Disappointed, Scared

Maurice is a 34-year-old, gay, African American man who was referred to Anne Graham, PhD, a White psychologist, by the staff at the local infectious disease clinic because of problems with missed appointments, demanding behavior, volatile mood, difficulties getting along with the staff, and vague, but recurrent, suicidal threats. Maurice began his first meeting with Dr. Graham by telling her that he had heard many good things about her. He went on to say that his life had been difficult because, “Everyone’s gone out of their way to do me wrong.” Maurice was upset about his recent AIDS diagnosis and felt that everyone was abandoning him. He said that no one came to visit him in the hospital, and he complained that he felt misunderstood by his friends and family, who had rejected him when he disclosed his homosexuality. The only positive relationships he described were with his grandmother, who had died, and a new lover, who he had been dating for two weeks and who was “wonderful.” Maurice also told Dr. Graham that he had had many lovers in the past and described a series of intense relationships cut short as each boyfriend disappointed him. He said that it was no wonder that he had been driven to drink and use drugs—everything from speed to heroin.

Maurice acknowledged difficulties getting along with the staff at the infectious disease clinic. But he believed they “deserved it” because they saw him as “just another number.” Maurice said he sometimes felt suicidal—and he had been hospitalized for non-lethal gestures a number of times—primarily out of loneliness and frustration regarding various circumstances during the course of his life. He said he told the staff at the clinic about this, but he did not believe they cared.

Shaping the Therapeutic Relationship

Maurice’s goal was to confront people who had wronged him—including his parents—and he thought that therapy might help accomplish this. He was also concerned that he might become depressed and hoped therapy might stop this from happening. Finally, Maurice wanted to talk about dying, which sometimes “terrified” him, particularly when he was trying to sleep.

Dr. Graham encouraged Maurice to discuss these feelings further. She listened supportively and asked questions to clarify his statements and learn more about his previous relationships, his substance use, and his family. The last 15 minutes of the first session were spent...
planning treatment goals, including considering ways to improve Maurice's medical compliance, discussing how to get his needs met by others in more appropriate ways, and talking about improving his relationship with his family. Maurice agreed to compile a list of his concerns and questions about his medical condition for the next session. Dr. Graham said she wanted to coordinate and share information with Maurice's treatment team; Maurice signed a release that allowed her to talk with his health care providers. Maurice asked if they could set up a meeting with his team, and Dr. Graham encouraged him to wait until he had discussed his list of concerns with her. Dr. Graham and Maurice also discussed options to improve his social support, and Dr. Graham agreed to get information about local support groups for him and bring it to the next session. The two agreed to meet weekly.

Dr. Graham recognized that working with Maurice would require a slow and careful approach. She knew her task would be to try to sustain his good feeling towards her, while acknowledging to herself that she would inevitably disappoint him whenever she did not comply with his wishes. Dr. Graham hoped, however, that by anticipating problems, by explaining to Maurice what she could and could not be relied on to do, and by being explicit and consistent in her approach, she would be able to help him manage his feelings. When Maurice failed to keep his next appointment, Dr. Graham set up another, politely but firmly clarifying that he needed to keep this one. She reminded Maurice to bring his list of concerns. Maurice was agitated when he came to the rescheduled appointment. He had just broken up with his boyfriend and felt "devastated." He initially focused on his anger towards this man, but Dr. Graham refocused the session on the concrete goals they had discussed previously. She gave him information on local support groups and asked him to discuss his list of concerns. Maurice had forgotten to bring the list, but was able to compile it during the session.

Dr. Graham said that she was likely to anger Maurice at some point, but reminded him that they were working together to improve the way he felt. They carefully discussed the boundaries and dynamics of their relationship—for example, the therapist-client relationship, and the gender, racial, and ethnic differences—and the need to remain sensitive to and respectful of the differences between them.

Over the next sessions therapy focused on improving Maurice's relationship with his medical team and his compliance. Maurice actively participated in this and seemed to enjoy his role. Having met with success, Maurice was eager to pursue another goal, namely finding a long-term dating relationship. He and Dr. Graham examined his history of impulsive dating relationships, his tendency to initially idealize his partners and become overly involved with them too soon, and his inevitable sense of disappointment when the relationship flagged. Maurice was intrigued by his pattern, and he and Dr. Graham were able to notice it as he started dating again. The therapy continued over time—including many missed sessions and focusing on Maurice's anger—but was moderately successful at addressing one general goal at a time.

Conclusion

As mentioned earlier, therapy with borderline clients or individuals with other personality disorders is unlikely to alter a client's basic personality. Instead, by offering a constant and non-rejecting presence, a therapist like Dr. Graham may strengthen the adaptive behaviors and coping mechanisms of a client like Maurice, or, at least, help to contain a client's negative emotional states.

By using a combination of limit-setting and concrete problem-solving strategies, the therapist was able to form a fragile alliance that allowed her client to make some progress.

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**Recent Reports**

**Change in Psychopathology in Seropositives**


A two-year study of 118 gay men found that changes in personality disorder symptom levels were associated with changing levels of psychological distress, but not with progression of HIV infection. Thirty-eight of the study participants were HIV-negative and 80 were HIV-positive, but were asymptomatic or with only moderate physical symptoms, and none had AIDS. The mean age of participants was 38 years. Eighty-seven percent were White, and 90 percent had at least one year of college education. There was no significant difference in age, education, or ethnicity between the seronegative and seropositive subsamples. Researchers recruited participants through newspaper and newsletter announcements and by word of mouth, and gathered data through structured clinical interviews and participant questionnaires completed at the beginning of the study and at the two-year follow-up.

Personality disorder symptom levels remained moderately stable over the course of the study. Changes in personality disorder symptom levels that did occur were not associated with HIV status or with change in either CD4+ levels or HIV symptom levels. Increases and decreases in personality disorder symptom levels were, however, associated with corresponding increases and decreases in psychological distress.

**HIV Risk among Gay and Heterosexual Men**


In a study of 118 men attending a genito-urinary medicine clinic in London, antisocial personality disorder was the main predictor of sexual risk taking among homosexually active participants. The main predictors for sexual risk taking among heterosexually active men were cocaine or ecstasy use and, to a lesser extent, antisocial personality disorder.

The study group consisted of 61 homosexually active men and 57 heterosexually active men between the ages of 18 years and 50 years. Participants were either HIV-negative or did not know their serostatus. Thirty-eight percent of the homosexually active men and 28 percent of the heterosexually active men had a personality disorder; 15 percent of the homosexually active men and 17 percent of the heterosexually active men had antisocial personality disorder.

Based on responses to self-report questionnaires, homosexually active men were more likely to engage in some sexual risk behaviors than heterosexually active men. For example, 43 percent of homosexually active men had more than five partners in the previous year, compared to 4 percent of heterosexually active men. There was no significant difference in the use of condoms between the two groups, but 31 percent of homosexually active men and 40 percent of heterosexually active men reported occasional unprotected penetrative sexual intercourse with casual partners. Homosexually active men were more likely to use amyl nitrate as a sexual stimulant, have sexual intercourse in public places, and consume alcohol before sex.

**Risk, Cocaine, and Antisocial Personality**


In a study examining the effectiveness of HIV risk reduction interventions on cocaine users, participants with antisocial personality disorder engaged in HIV-related risk behaviors at higher rates than people without antisocial personality disorder, but were as likely as this second group to decrease their HIV risk behaviors over time. Researchers interviewed 333 cocaine users who were part of a drug abuse treat-
Injection program. The study sample was 72 percent male and 92 percent African American; the average age of participants was 33 years. Thirty-four percent of participants were diagnosed with antisocial personality disorder. All participants received standard HIV testing and counseling at baseline and one year later.

At baseline, 83 percent of participants with antisocial personality disorder reported cocaine dependence compared to 71 percent of participants without antisocial personality disorder. Antisocial personality disorder was also significantly associated with a number of sexual behaviors, including having more than one sexual partner, being intoxicated during sex, paying money for sex, and trading drugs for sex or for drugs. However, at the 18-month follow-up, trading drugs for sex was the only risk behavior significantly associated with antisocial personality disorder: while only 7 percent of participants without antisocial personality disorder reported trading drugs for sex at follow-up, 17 percent of participants with antisocial personality disorder reported this behavior. Although antisocial personality disorder was not significantly associated with specific behaviors, the overall trend at baseline and follow-up was toward higher rates of HIV risk behaviors among participants with antisocial personality disorder compared to those without antisocial personality disorder.

At the 18-month follow-up, all participants—whether or not they had antisocial personality disorder—improved across a wide range of HIV risk behaviors: cocaine use decreased from 100 percent to 38 percent; injection equipment sharing decreased from 39 percent to 14 percent; failure to clean syringes decreased from 62 percent to 28 percent; being intoxicated during sex declined from 74 percent to 35 percent; trading drugs for sex decreased from 22 percent to 11 percent; receiving money for sex decreased from 10 percent to 5 percent; and trading sex for drugs decreased from 11 percent to 4 percent.

**Injection Drugs, Risk, and Psychopathology**


Injection drug users are more likely than non-injection drug users to be diagnosed with antisocial personality disorder, but not other psychiatric disorders, and to report dependence on multiple substances, according to a large St. Louis study. Injection drug users also report more HIV risk behaviors, but do not differ from non-injection drug users in their perceptions of HIV risk.

Researchers recruited 158 injection drug users, including some who declined and some who accepted treatment, and 320 non-injection drug users through a street outreach program. Eighty-nine percent of participants were African American, 72 percent were male, and 36 percent were employed. Although members of both groups reported high rates of prior substance use treatment, injection drug users were more likely than non-injection drug users to have had such treatment.

In a test of HIV knowledge, 50 percent of injection drug users scored 20 or better on a 22-point scale, compared to 37 percent of non-injection drug users. But injection drug users were more likely than non-injection drug users to engage in risky behaviors.

Injection drug users did not differ from non-injection drug users in sexually transmitted disease (STD) history, but were more likely to report having engaged in risky sex practices during the prior six months, including anal intercourse, failure to use condoms, and sex with an injection drug user. Although injection drug users were more likely than non-injection drug users to report exchanging sex for money, they were no more likely to report giving or receiving drugs for sex.
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