Identification and Management of Personality Disorders and how they can Affect HIV/AIDS Care

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Why is this Important?

- 20 – 40% with HIV Disease have Personality Disorder
- Risk factors for HIV disease associated with Personality Disorders – adverse childhood events (especially sexual traumas); impulsivity and addictions
- Management of HIV disease requires positive alliance with treatment team and compliance with treatment regimen – challenging tasks for many with Personality Disorders
Personality Defined

- Emotional and behavioral traits that constitute stable and predictable ways a person perceives, appraises and relates to their inner (self) and outer (others) world.

- Personality reflects ‘schemas’ – knowledge structures – that represent a person’s knowledge about themselves and their world.

Theories of Personality Formation

- Infant is biologically incapable of maintaining life separate from mother.
- Bowlby: parent – infant attachment (affectional tie) necessary for infant’s emotional survival.
- Winnicott: infant is extremely dependent at birth; needs ‘good-enough’ mother – affective attunement to soothe, contain, infant in times of distress.
- Kohut: infant needs holding, mirroring, facilitation to establish cohesive self image.
Theories of Personality Malformation

- Failures of attachment, attunement, relatedness can dominate infant’s interpretation of the outside world.
- Emotional experiences that are unresolved gets expressed through ‘acting out’.
- Infant needs indulgence and personal attention; needs to feel loved and pleasing; needs to feel a sense of personal security.

Personality Disorders

- Extremes of normal personality characteristics.
- Patterns are rooted in primitive defenses aimed at facilitating survival – denial, splitting, projection.
- Dysfunction in thinking, emotional regulation and behavior - personality manifests at levels that are socially excessive, rigid, and causes functional impairment.
DSM-V definition of PD

- An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture manifested in at least two areas (cognition, affect, interpersonal functioning, impulse control).
- This pattern is inflexible and pervasive.
- This pattern leads to significant distress.
- Is stable and of long duration.
- Not better explained by another mental disorder.
- Is not attributable to substance use or medical condition.

HIV Risk Among PDs

- People with antisocial and borderline PDs were reported to have significantly higher rates of high risk sexual behavior and needle sharing behavior.

PDs among People with HIV/AIDS

- The National Comorbidity Study (Kessler et al., 1996) showed that substance use disorders are highly co-morbid with other psychiatric disorders (e.g., bipolar disorder, depression, psychotic disorders, anxiety disorders, and antisocial and borderline personality disorders).

PD among IDUs

- Injection drug users are more likely than the general population to have PDs.
- Antisocial and borderline PDs most common
- 22% of IDUs reported to have antisocial PD.
- 18% of IDUs reported to have borderline PD.

HIV + Psych ER Visits

- 58,000 consecutive visits
- 2.0% known HIV +
- HIV + patients more likely to be:
  - Male
  - Homeless
  - African American
  - Demented
  - Substance abusing
  - Suicidal
  - Diagnosed with a borderline personality disorder

Murray Bennett, Joesch, Mazur & Roy-Byrne (2009)

DSM-IV-TR Axis II Clusters

- Cluster A: Odd, Eccentric
- Cluster B: Dramatic, Emotional, Erratic
- Cluster C: Anxious, Fearful
Cluster A – Odd, Eccentric

- Paranoid PD – distrustful and suspicious
- Schizoid PD – detached and restricted range
- Schizotypal PD – eccentric, weird

Cluster C – Anxious, Fearful

- Avoidant PD – inhibited and hypersensitive
- Dependent PD – submissive and clinging
- Obsessive-Compulsive PD – preoccupation with orderliness, perfectionism and control
Cluster B – Dramatic, Emotional, Erratic

- Antisocial PD – disregard/violate the rights of others
- Borderline PD – dysfunction in emotional regulation system
- Histrionic PD – excessively emotional and attention seeking
- Narcissistic PD – self absorbed: grandiose, lack empathy, need admiration

Antisocial Personality Disorder

- Disregard for right and wrong
- Persistent lying or deceit
- Using charm or wit to manipulate others
- Recurring difficulties with the law
- Repeatedly violating the rights of others
- Child abuse or neglect
- Intimidation of others
- Aggressive or violent behavior
- Lack of remorse about harming others
- Impulsive behavior
- Agitation
- Poor or abusive behaviors
- Irresponsible work behavior
Case study of Mr. J

Mr. J was a 19 year old African American man diagnosed as HIV+ in September of 1996. Over the course of the next year Mr. J. had unprotected sex with many young women in a small industrial town in a mostly rural community not known for high rates of HIV infection. The emergence of a cluster of new cases began an investigation. Epidemiological interviewing of the first six cases led public health officials to identify Mr. J as the source of infection. Investigators identified more than three dozen young women who admitted to having slept with Mr. J. Of this group, 16 of the women have confirmed cases of HIV infection. The youngest of this group was 13 years old at the time of infection.

- Relentless and charming
- Menacing form or glamour
- Sold crack and said he was a member of the Bloods
- Showered his girls with gifts
- Never used condoms
- Became physically abusive when threatened
Case of Mr. J

- Had a history of incarceration
- Claims to have slept with over 300 women

Borderline Personality Disorder

- “All is caprice, they love without measure those whom they will soon hate without reason”

Thomas Sydenham (1624-1689)
Borderline Personality Disorder

- Self Dysregulation:
  - Identity disturbance – unstable self image
  - Chronic feelings of emptiness

- Interpersonal Dysregulation:
  - Frantic efforts to avoid real/imagined abandonment (staff vacation; changes in plans)
  - Unstable and intense interpersonal relationships alternating/oscillating between idealization and devaluation (good/bad doctor)


Borderline Personality Disorder cont

- Behavioral Dysregulation
  - Destructive impulsivity – spending, sex, substance abuse, binge eating, reckless driving
  - Recurrent suicidal behavior, gestures, threats, or self-mutilating behaviors – (precipitated by fears of rejection, separation or expectations of self-responsibility)

- Cognitive Dysregulation
  - Transient stress related paranoid ideation or severe dissociative symptoms
Case Report

Ms. R was a 29 year old woman referred for HIV care to a hospital based outpatient clinic after testing positive. She was assigned to be seen by Dr. B an ID physician on the team at the clinic. After routine intake and a follow-up visit with Dr. B she stated that he was the “best doctor I have ever seen.” the relationship between Ms. R and Dr. B seemed to be working very well for the first few months. She reported taking her medication as prescribed and her labs showed a rise in CD4 cells and a drop in viral load.

Case Report

Encouraged by the good results Dr. B decided to decrease the frequency of Ms. R’s follow-up appointments. After scheduling less frequent appointments Ms R began making many phone calls to Dr. B complaining of odd symptoms and medication side effects. She stated that she would experience these side effects as soon as she put the pills in her mouth. Also at this time Ms R began missing scheduled appointments and showing up at the clinic at non-scheduled times demanding to be seen.
Case Report

- She began to act out in the clinic, throwing a tantrum when told that Dr. B was running behind and would be a half-hour late. The nursing staff and support staff did not want to interact with her because she seemed to volatile. During one unscheduled visit, when the receptionist told her that she could not be seen that day and to please schedule an appointment she threatened to hurt herself and raised the sleeve on her blouse to show that receptionist several dozen razor cuts up and down her forearm.

Case Report

- The receptionist became upset by this and reported it to the nursing staff who admonished Ms. R for her behavior. Feeling affronted and not supported by the clinic staff Ms. R wrote a letter of complaint to the hospital administrator, in her own blood.
Differential Diagnosis of PD

- Unlike other mental disorders where clinicians rely on the patient’s description of symptoms to assist in diagnosis, the clinical diagnosis of PD must often be derived by observation of the patient’s behavior and style of interacting with others.

- Dysfunctional patterns are ego-syntonic (“nothing wrong with me”)

Rule Outs for PD Diagnosis

- Delirium
- Dementia (HAD) Psychosis
- Other CNS disorder
- Substance abuse
- Mood disorder
- Domestic violence
- Anxiety disorder
- Borderline IQ
- Metabolic disorder
- Malingering
- PTSD
HIV-Associated Dementia

- HIV is neurotoxic (subcortical).
- Early symptoms: impaired concentration, memory loss, depressed mood, unsteady gait, motor weakness, ataxia.
- Late symptoms: global cognitive dysfunction, amnesia like features, mutism, organic hallucinations and Parkinson-like symptoms.

HIV-Associated Dementia

- 15% of HIV infected and 30% of AIDS cases will show symptoms of HAD
- Disruptive behaviors may be symptoms of HAD and may mimic symptoms of personality disorders or psychosis.
CNS Infections and HIV

- Maladaptive personality traits may be caused by underlying CNS infections.
- CNS infections common to AIDS are:
  - HIV encephalopathy
  - Lymphoma in brain
  - Progressive multi-focal leukoencephalopathy
  - Toxoplasmosis of brain

Domestic Violence Victims

- Clinicians should screen patients for domestic violence annually when patients display behaviors that may be suggestive of it, such as inhibited, avoidant, excessively emotional or submissive behavior.
Borderline Intelligence

- Patients with low or borderline intelligence may mask their inability to process information and may frustrate clinicians unaware of the patient’s cognitive deficits.

- Clinicians should perform a mental status evaluation that includes cognitive functioning.

Characteristics of Unstable Extroverted Persons

- Present time orientation vs. past and future orientation

- Feeling dominated vs. thought dominated

- Quick emotional threshold vs. gradual threshold

- Reward seeking vs. consequent avoidant
Approach to Patients with PD

- Effective communication
- Interdisciplinary integrated team approach
- Effective treatment plan
- Mental health Management

Effective Communication

- Listen carefully to identify the patient’s agenda
- Maintain eye contact
- Use body language that conveys support and respect
- Communicate in an unhurried manner
- Offer choices and options whenever possible to involve the patient in the responsibilities of care
- Establish clear, consistent and rational strategy about when to support and when to confront
Interdisciplinary Team

- Adopt team approach that focuses on clear communication among everyone involved in the patient’s care - frequent staff conferencing

- Minimize client’s attempts at staff-splitting and projection (e.g. staff group meetings vs. individual to set limits with patients)

Effective Treatment Plan

- Concentrate on setting limits
- Use a behavioral contract
- Make all staff (including support staff) aware of the contract
- Use a healthcare network to provide care – primary and mental health care must be INTEGRATED!!!!
- Focus on long term goals, not immediate rewards
Mental Health Treatment Approaches

- CBT
- DBT
- Pharmacotherapy – SSRI, Mood

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Davidson K. Cognitive behavioral therapy for personality disorders. Psychiatry 2008 7:3 117-120
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Cognitive Behavioral Therapy

- Therapist develop formulation on dysfunctional schemas – punitive parent; detached protector; the abandoned child; angry and impulsive mode
- And, the resultant maladaptive core beliefs and overdeveloped behaviors
- Therapist and patient agree on ways to strengthen, practice, support new, more adaptive, underdeveloped behaviors
Dialectical Behavioral Therapy

- Staged, psychological treatment based on principles of oneness, truth as a synthesis of thesis and anti-thesis; change is inevitable and constant
- Pre-commitment – patient commits to reducing self-harming behaviors
- Stage 1 - development of new behavioral skills
- Stage 2 – increase patient’s ability to experience a full range of emotions and to reduce PTDS symptoms
- Uses CBT strategies – behavioral analysis, exposure, contingency management, cognitive restructuring

Pharmacotherapy

- Mood stabilizers – e.g. Lithium, anti-convulsants e.g. Topiramate, Gabapentin
- SSRI – e.g. Fluoxetine, Sertraline, Paroxetine
- Anti-psychotics – Risperidone, Ziprasidone, Aripiprazole
- Be cautious with Benzodiazepines: PD co-morbidity with SUD
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