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Personality disorders lead to risky behavior, treatment obstacles

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Psychiatric disorders are frequently discussed in the HIV/AIDS literature as contributing to both the risk of acquiring HIV and interfering with HIV treatment efforts. Personality disorders make up a subset of these psychiatric problems, and are more prevalent among people living with and at risk of acquiring HIV than among those in the general population. The prevalence rate of personality disorders among people living with HIV ranges from 19% to 36%, and from 15% to 20% among those at risk for acquiring HIV (Jacobsberg, Frances, Perry, 1995; Johnson, Williams, Rabkin, & Goetz, 1995; Perkins, Davidson, Leserman, Liao, & Evans, 1993). In contrast, the prevalence rate of personality disorders in the general population is approximately 10% (Lezenweger, 2008). Although it is clear that most individuals with HIV do not have a personality disorder, the disproportionate prevalence rates among those living with HIV and at risk of acquiring HIV, compared to the general population, certainly warrant concern. Due to the complex nature of personality disorders and varying notions about what constitutes personality in general, researchers and theorists are far from drawing conclusions about the relationship between HIV and personality disorders. Nevertheless, literature in the area does shed light on how certain personality styles may lead to high risk behavior and treatment obstacles, as well as on how providers may better reach these patients. This article aims to highlight the literature that helps explain the relationship between HIV risk and personality disorders, as well as offer a brief discussion regarding how Axis II pathology can interfere with treatment and what steps can be taken to overcome these obstacles.

DSM-IV-defined personality disorders

In the face of an elusive and complex concept, *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR, American Psychiatric Association [APA], 2000) offers one of the most widely used conceptualizations for understanding personality disorders and includes them on Axis II of its multiaxial system.

For additional reading: <http://www.hivguidelines.org/wp-content/uploads/2009/06/m-personality.pdf>

The DSM-IV-TR broadly defines personality disorders as “an enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual’s culture,” and specifies that this pattern is demonstrated in at least two areas, including cognition, affectivity, interpersonal functioning, and impulse control (p. 287). The DSM-IV-TR also indicates that to be characterized as a personality disorder, the pattern must be inflexible, pervasive, leading to significant distress or impairment, and have an onset in adolescence or early adulthood.

The DSM-IV-TR (APA, 2000) categorizes the various types of personality disorders into three main “clusters.” Cluster A personality disorders are characterized by odd behavior and consist of paranoid, schizoid, and schizotypal personality disorders. Cluster B, or the “dramatic cluster” as it is sometimes called, includes antisocial, borderline, histrionic, and narcissistic personality disorders. Finally, Cluster C personality disorders are typified by anxiety and consist of avoidant, dependent, and obsessive-compulsive personality disorders. Research suggests that Cluster B personality disorders, especially borderline and antisocial personality disorders, are the most common class of DSM-IV-TR-defined personality disorders among people living with HIV (Golding & Perkins, 1996; Jacobsberg, Frances, & Perry, 1995).

The DSM-IV-TR requires that an individual exhibit three of seven symptoms to meet criteria for antisocial personality disorder, and five of nine criteria to be diagnosed with borderline personality disorder. A person labeled “antisocial” will fail to conform to social norms, lie, and disregard the safety of self and others, as well as exhibit impulsivity, irritability/aggressiveness, consistent irresponsibility, and lack of remorse. According to the DSM-IV-TR, an individual must be at least 18 years old and have a history of conduct disorder before age 15 to receive this diagnosis. The symptoms used to identify borderline personality disorder include: frantic efforts to avoid real or imagined abandonment, a pattern of unstable and intense interpersonal relationships, an unstable sense of self, potentially self-damaging impulsivity, recurrent suicidal or self-harming behaviors, emotional instability, chronic feelings of emptiness, inappropriate anger/difficulty controlling anger, and stress-related paranoia or dissociation.

Because the DSM-IV-TR provides an etiologically atheoretical method for classifying mental disorders, the relationship between HIV and Cluster B personality disorders is not inherently understood. Instead, this relationship may be best considered by examining the symptoms and personality styles associated with these disorders. For example, a common explanation is that poor impulse control (a symptom of both antisocial and borderline personality disorders) and substance abuse, which is often comorbid with these personality disorders, contributes to the practice of behaviors that put these individuals at risk of acquiring HIV (e.g., Golding & Perkins, 1996).

Dimensional model of personality

Personality researchers are increasingly moving away from the discrete categories of personality disorders offered by the DSM-IV-TR to a dimensional model for understanding personality and the associated difficulties. Treisman and Angelino (2004) outline how they

use a dimensional conceptualization of personality to understand the relationship between HIV and personality disorders, specifically borderline and antisocial. These authors (and clinicians) promote the use of two intersecting dimensions of personality (which are visually depicted in Eysenck's Personality Circle, from Treisman & Angelino, 2004, p. 86), for understanding what puts individuals at risk for HIV and how to best approach treatment. One dimension highlights the degree of emotional stability an individual tends to exhibit, ranging from stable on one end of the continuum to unstable on the other. The other dimension extends from introverted to extraverted, and refers to the way an individual tends to respond to stimuli (with inhibition versus excitation, respectively). The authors reported that at the Johns Hopkins AIDS Psychiatry Service Clinic, approximately 60% of patients present with a "blend of extraversion and emotional instability" (Treisman & Angelino, 2004, p. 84). They explain that these patients are preoccupied with often transitory feelings, which guide their actions and make their behavior unpredictable. In addition, the authors highlight that it is not lack of intelligence that leads to HIV risk behavior, but rather, a focus on the current emotional state and an intense drive to immediately gratify emotional needs, regardless of long-term negative consequences. In other words, unstable extraverts are present-oriented and reward-driven. They are unlikely to plan ahead for protected sex or to accept the decrease in pleasure associated with condom use and are more likely to use drugs or alcohol for the quick experience of pleasure or immediate relief of emotional and/or physical discomfort. The authors contend that it is more efficient and prognostic for providers to consider where an individual falls on these two dimensions, than to determine whether or not they meet a sufficient number of the nine or so criteria delineated in the DSM-IV-TR. In addition, the authors cite literature that indicates that individuals with antisocial or borderline personality disorder score higher on extraversion and emotional instability scales (in Treisman & Angelino, 2004). This is not to say that any individual with a tendency toward an unstable extraverted style has a personality disorder. Indeed, the authors point out that using a dimensional model to help understand patients and inform treatment approaches draws the focus away from potentially stigmatizing diagnoses of personality disorders, which have a reputation for being difficult, if not impossible, to treat.

Substance use and personality disorders

It has been hypothesized that substance use mediates the relationship between personality disorders and HIV risk behaviors, and is therefore worthy of special attention. Substance use is a well-known risk factor for the transmission of HIV/AIDS and rates of substance use among individuals living with HIV/AIDS are consistently found to be higher than the general population. For example, about half of the participants enrolled in the Health Care Services Utilization Study—a nationally representative sample of HIV-positive individuals currently in care—reported illicit drug use during the previous year (Bing *et al.*, 2001). As explained previously, rates of personality disorders are also significantly higher in individuals infected with HIV compared to non-infected individuals. Combined with evidence that suggests that up to two-thirds of drug users have a comorbid personality disorder (Seivewright & Daly, 1997) there is thus strong theoretical support for the hypothesis that Axis II pathology is a risk factor for HIV infection specifically among substance users.

Few studies to date have assessed the relationship between personality disorder pathology and substance-related HIV risk. Those studies that do take into account comorbid personality disorders have focused primarily on the role of antisocial personality disorder, which is the most common Axis II diagnosis among drug users, with studies finding 42-44% meeting diagnostic criteria (Brooner, Bigelow, Strain, & Schmidt, 1993; Kelley & Petry, 2000). It has been demonstrated that intravenous drug users with a comorbid diagnosis of antisocial personality disorder are significantly more likely to be HIV-positive than those without antisocial personality disorder, regardless of ethnicity, gender, and treatment status (i.e., currently in methadone treatment versus not in treatment) (Brooner *et al.*, 1993). The higher rates of HIV infection among drug users with antisocial personality disorder have been shown to be due to higher incidence of HIV-related risk behaviors, specifically more sexual contacts, needle use, and injection-equipment sharing, (Brooner *et al.*, 1990; Gill, Noliml & Crowley, 1992). Though sparse, the research offers theoretical support for the notion that substance abuse and personality pathology have an additive effect on the expression of HIV risk behaviors.

Personality disorders and obstacles to treatment

Unfortunately, many of the characteristics of personality disorders that are associated with increased risk of acquiring HIV also produce complications for HIV treatment. Indeed there are isolated examples observed in our own clinic where a single feature of a patient's personality disorder directly interferes with his/her treatment: the patient with antisocial personality whose disregard of normative behavior and disdain of authority leads to disruptive behavior in the clinic and eventual expulsion; the patient with borderline personality disorder who impulsively ingests an overdose of medication leading to an emergency room visit and brief hospitalization which disrupts the overall medication regimen; the patient with paranoid personality with a history of multiple grievances against agencies and institutions who is so distrustful of others that it takes months of weekly visits before he can be convinced to simply begin his medication regimen. The very terms used in the DSM IV-TR describing the diagnostic criteria for personality disorders glaringly suggest trouble ahead for the patient and the provider: suspicious, unforgiving, solitary, detached, eccentric, peculiar, deceitful, impulsive, reckless, irresponsible, unstable, angry, self-important, arrogant, rigid, and stubborn, among others.

There also exist less symptom specific and more global patterns that apply to those diagnosed with a personality disorder that have been consistently associated with treatment obstacles, of which we will discuss four. The most obvious of these is the presence of mental illness, which has been repeatedly demonstrated to interfere with adherence to treatment and to poorer treatment outcome (Fogarty, Roter, Larson, Burke, Gillespie, & Levy, 2002; Uldall, Palmer, Whetten, & Mellins, 2004; Griffin, 2010). Indeed, as defined by the DSM-IV-TR, personality disorders alone constitute a mental illness and recall that an individual with such a diagnosis "experiences significant distress or impairment" (APA, 2000, p. 287). However, personality disorder is also often accompanied by an Axis I diagnosis; depression, anxiety, traumatic stress, and of course, substance abuse, among others. Undoubtedly, these individuals are vulnerable to many levels of mental illness, further complicating the likelihood of treatment adherence and success.

Medical and health problems among people with personality disorders may also produce complications for HIV treatment. There is evidence that suggests that the physical health of those diagnosed with personality disorder (most notably borderline personality disorder) is generally poorer than a normal population. El-Gabalawy, Katz, & Sareen (2010) recently reported that a variety of medical conditions including hypertension, arteriosclerosis, hepatic disease, gastrointestinal disease, cardiovascular disease, arthritis, and others was “associated with a greater likelihood of having borderline personality disorder” (p. 643). In addition, neuropsychological and cognitive impairments may differentially impact people with HIV and a personality disorder. Bauer and Shanley (2006) examined HIV-seropositive males who met criteria for antisocial personality disorder compared to a seropositive control group who did not meet the personality disorder criteria. They found patients with antisocial personality disorder to show decrements in frontal brain structure and function with accompanying impairment on neuropsychological testing, which is consistent with earlier research by the same group (Bauer & Houston, 2004; Bauer, O’Connor, & Hesselbrock, 1994). These findings likely represent the effects of substance abuse. However, the fact remains that it is the person with antisocial personality disorder who is more likely than those not so afflicted to engage in that behavior. The findings point to not only another physical problem related to a psychiatric diagnosis but a problem that has the potential to directly affect one’s ability to deal with complexity or even day-to-day matters, including the consistent attention that HIV treatment requires.

Quite related to the patients’ physical functioning is their reported Health Related Quality of Life: HRQoL (Burgess, Carretero, Elkington, Pasquel-Marsettin, Lobaccaro, & Catalin, 2000). Hansen, Vaughn, Cavanaugh, Connell, & Sikkema (2009) found in an HIV-positive population that both antisocial personality disorder and borderline disorder were significantly related to low HRQoL. The authors reported that their study was the “first empirical evidence linking personality disorder indication with increased HIV symptoms and reduced HRQoL among HIV seropositive adults” (p. 254). Clearly, an increase in symptoms and a general reduction in quality of life have implications for treatment outcomes and potential treatment adherence.

Another significant area in which the individual with a personality disorder works against his/her own best interest, creating even more conflict and even more problems, is related to difficulty in maintaining a support network, including family support. Palmer, Salcedo, Miller, Winiarski, & Arno (2003) assessed HIV-seropositive patients who were triple diagnosed: HIV, substance abuse, and additional psychiatric diagnosis. With 37% meeting criteria for borderline personality disorder and 56% meeting criteria for antisocial personality disorder, the sample was significantly weighted in the direction of Axis II pathology. Palmer *et al.* used the ASI-Lite (McLellan, Kushner, & Metzger, 1992) to measure the stability of the subject’s support system. This study determined that poor family and social resources were significantly related to poor medication adherence. They concluded that “serious interpersonal problems were a greater barrier to adherence in this sample than drugs or alcohol, employment problems or legal problems” (p. 640).

These four areas of influence on the HIV patient with personality disorder— mental illness, compromised health, poor health-related quality of life, and poor support system—are not

independent but complexly intertwined. The multifaceted aspects associated with personality disorder and HIV treatment are highlighted here to stress the point that the problems related to those with personality disorder are much more far reaching than the behavior observed first hand in the clinic or office.

Treating HIV patients with personality disorders

Although most people with HIV do not have a personality disorder, based on the previously discussed complex obstacles associated with treating patients with Axis II pathology it is clear that they are likely to consume many of providers' physical, financial, and emotional resources. Sadly, but understandably, it is not uncommon for healthcare workers to become disillusioned when treating patients with personality disorders, and begin to believe that these individuals either do not want help or cannot be helped. It is therefore important to approach treatment with a conceptual framework that promotes appropriate boundaries and instills hope in both the patient and the provider. Treisman and Angelino (2004) contend that using the dimensional model described earlier not only helps minimize the stigma associated with personality disorders, but also provides a solid conceptualization for working with patients who exhibit personality styles that present problems for treatment. The authors specifically discuss individuals who fall on the extraverted and unstable ends of the continuum and stress the idea that "extraverts" are more likely to be motivated by rewards and are not likely to change behavior to avoid negative consequences. In addressing medication adherence, for example, they talk to extraverted patients about "how many viral particles are destroyed" if they take all of their medication (Treisman & Angelino, 2004, p. 89), and focus on the restoration of the immune system, rather than the increased possibility of death if they fail to care for themselves. Providers are encouraged to find ways to discuss behavioral change and medication adherence with these patients in terms of the benefits of a prolonged life, instead of dwelling on avoiding death. Similarly, finding ways to eroticize condom use, rather than reiterating the dangers of failing to use condoms, may promote condom utilization among more extraverted patients.

The authors also recommend directly discussing with extraverted patients that they tend to have an above-average amount of feelings, phrasing this as an "extra endowment" (Treisman & Angelino, 2004, p. 90) and using examples from the patients' lives to explore how strong emotions led to behaviors that ultimately caused trouble for the patients. Conversations such as this can help patients understand the strength of this "extra endowment," and ideally motivate change when this quality becomes a liability. Subsequently focusing on thoughts, rather than feelings, helps these patients become less emotionally driven and more thoughtful in his/her actions. Behavioral contracts can be effective to this end, as they offer an unwavering plan in the face of ever-changing, emotionally-charged priorities and demands. In order to be maximally effective, behavioral contracts should be agreed upon and uniformly implemented by all members of interdisciplinary teams. Consistency and collaboration among providers can ward off problems created by the tendency of individuals with extraverted personality features to impulsively pursue gratification of their needs from various providers unbeknownst to the individual providers. Finally, the authors suggest that the treatment of extraverts is further complicated by the fact that the health care field tends to attract introverts who are motivated

by consequences and who stress function, not feeling. It may be difficult for the “look before you leap” provider to appreciate the benefits of the extravert’s “he who hesitates is lost” approach (Treisman & Angelino, 2004, p. 89).

Conclusion

Personality is a broad construct that has been, and will continue to be, explored through the lens of an assortment of theoretical approaches. Personality disorders, although neatly outlined in the DSM-IV-TR, are similarly scrutinized and debated by researchers with an array of perspectives. This article has intended to draw from broad theoretical approaches and related literature to shed light on the way that problematic personality patterns contribute to vulnerability for acquiring HIV and create obstacles to successful HIV treatment. In the discussion, we hope to have communicated the complex nature of these relationships, offering an “amuse-bouche” for intellectual and clinical curiosity into the topic, rather than a comprehensive review of the field. In addition, we aimed to set a tone of acceptance and hope regarding the challenges faced when treating individuals with personality disorders, highlighting alternative ways to think about and approach these patients which may require a sharp departure from our natural style of solving our own dilemmas and life trials.

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