



July 2006

v21 n7

# FOCUS

## A Guide to AIDS Research and Counseling

## Dialectical Behavior Therapy for Clients with HIV

Christopher A. Kenedi, MD, MPH and Thomas R. Lynch, PhD

*Lisa was considered a “difficult client.” In her late thirties, she seemed unable to engage in her treatment or communicate effectively with Dr. M, her HIV physician for the past year. She had screamed at Dr. M during her most recent visit because the clinic was running 10 minutes late, stormed out, and then called Dr. M the next day to apologize. This was not the first time she had engaged in a disruptive outburst at the clinic. She tended to idolize her physicians when she first met them, then demonize them when they failed to live up to her expectations.*

*Lisa and Dr. M had initially gotten along quite well. At her second office visit with Dr. M, she had remarked that she felt much more comfortable with him than her previous physicians. She said she trusted him and that he was “the best doctor I have ever worked with.”*

*Over the six months before her outburst, however, her office visits and phone calls had become more frequent and crisis-oriented. Dr. M found himself unable to isolate any single complaint and had difficulty keeping her appointments focused on her HIV care.*

*At the end of Lisa’s first year in his care, Dr. M felt overwhelmed and frequently exhausted by his exchanges with Lisa. From his point of view, the most difficult issues were her complaints of intolerable side effects from her HIV antiviral medications. The somatic complaints that she associated with her regimen were often implausible (sometimes side effects occurred within seconds of her placing the pill in her mouth), and she frequently stopped taking medications without contacting him. Clinic staff felt that Lisa was demanding and over-*

*bearing, which led to confrontations with them. Over the year, her viral load climbed and her CD4+ cell count steadily declined.*

*After the episode when Lisa’s screaming disrupted the clinic and staff called hospital security, Dr. M told her he would only treat her if she saw an outpatient psychiatrist. She agreed to the referral and was evaluated. Although she had previous diagnoses of major depression and bipolar disorder, the psychiatrist, Dr. C, diagnosed her with borderline personality disorder.*

### Borderline Personality Disorder and HIV

The term borderline has historically been applied to patients considered to be on the border between psychosis and neurosis. Patients are caught in a pattern of waxing and waning self-destructive and dysfunctional behavior. They experience moments of crisis with fleeting psychosis and brief episodes of dissociation.

At the core of this disorder is an inability to regulate emotions. Individuals show a pattern—sometimes subtle—of instability in emotional regulation, impulse control, self-image, and interpersonal relationships. This distress creates difficulty in establishing and maintaining healthy relationships, and it causes functional impairment not only in social settings and work but also in health care settings.

Impulsive and self-destructive behaviors are characteristic of borderline personality disorder and may lead to exposure to HIV.<sup>1</sup> This is why the prevalence of borderline personality disorder is higher among people with HIV compared to the general population.<sup>2</sup> The strong component of impulsivity in borderline personality disorder leads patients to engage in unprotected intercourse or needle sharing even though a rational part of their mind might be screaming for them to stop.

In addition, a high percentage of clients with borderline personality disorder have been sexually abused—up to 75 percent according to several studies.<sup>3</sup> Because of

# Editorial: Hope on the Borderline

Michelle Cataldo, LCSW

As any clinician will tell you, much of the progress clients experience in therapy is a result of the “therapeutic alliance.” More than any specific technique, it is often the quality of the partnership between providers and clients that is the source of healing.

Few mental health disorders disrupt the potential for this partnership more than borderline personality disorder. Characterized by impulsivity, unstable personal relationships, and self-injurious behavior, the disorder not only cripples the ability to relate in general, but also fundamentally thwarts a client’s capacity to participate in the therapeutic relationship. Ironically, these clients, who most fear abandonment, are most likely to behave in ways that make their therapists want to run away.

Even a small proportion of such clients in a clinician’s practice can monopolize the bulk of that provider’s time, energy, and resources. HIV providers know

that many of the characteristics of borderline personality are also potentially related to HIV acquisition and transmission. Impulsive sexual and substance-using behaviors, as well as chronic feelings of emptiness and suicidality all threaten to increase HIV risk.

Add to this mix of therapeutic challenges the fact that until recently there was little hope for effective treatment of borderline personality disorder. Not surprisingly, for many years, clinicians have viewed these clients with a combination of frustration, annoyance, and dread. Some have avoided working with them altogether.

Enter dialectical behavior therapy. Since the 1990s, this approach has shown new promise in treating people with borderline personality disorder. In this month’s issue, Christopher Kenedi and Thomas Lynch describe the merging of cognitive-behavioral therapy and mindfulness

approaches that form the foundation of this new therapy. As Kenedi stated when we first conceived of doing this article, the sense of helplessness that providers often feel when they think about working with borderline clients parallels the feelings of early HIV providers, who had no effective remedies to offer. It makes a world of difference to know that an effective treatment is available.

New studies are testing the therapy’s effectiveness in populations of people with borderline personality disorder and HIV to boost medication adherence. It is also being tested in people with depression, substance abuse, and eating disorders. Despite the exploration of these new frontiers, dialectical behavior therapy is not a cure-all. It is a relatively new, time- and labor-intensive treatment. But it has offered fresh hope: for clients, who were once dismissed as virtually impossible to treat; for therapists, who now experience greater optimism regarding treatment and actual success with these clients; and for the health and success of the provider-client partnership.

this, borderline patients often see sexuality as a tool to achieve goals rather than as an act of intimacy or pleasure between willing partners.

*Lisa contracted HIV through injection drug use with her ex-husband, who was physically abusive to her and at one point kidnapped her at gunpoint. She had been sexually abused as an adolescent and had a history of several suicide attempts by overdose. She underwent two brief inpatient psychiatric hospitalizations but had never followed up with referrals for outpatient psychiatric treatment. During her recent psychiatric evaluation, Lisa described the incident where she had screamed at Dr. M. She said it was like “a slow motion car wreck, spinning out of control.” While she had intense remorse after she left the clinic, she could not explain exactly what had gone wrong. This lack of insight is not uncommon among people with borderline personality disorder and is one of the factors that makes treating clients with this disorder so challenging.*

## An Untreatable Disorder?

Before 1990, borderline personality disorder was considered an essentially untreatable illness. The best hope was that people with the disorder—who are mostly women—would outgrow its worst aspects over time.

The borderline diagnosis is associated with parasuicidal behaviors, including suicide threats, suicide attempts, and self-mutilation. Psychiatrists often “treat” these behaviors by hospitalizing patients. Inpatient treatment for one to five days, however, is more effective in protecting the therapist or emergency physician from liability than it is in treating the emotional dysregulation that drives the behavior.

Clients typically present with a variety of symptoms over time. If an individual with borderline personality disorder is not evaluated comprehensively, the symptoms are likely to be incorrectly diagnosed and treated as depression, mania, or psychosis. The resulting use of multiple psychiatric drugs is often referred to as the “borderline

sprinkle.” The client presents for treatment taking a mood stabilizer, an antidepressant, an antipsychotic, and a benzodiazepine. Unfortunately, these medications often contribute to pathology rather than ameliorating it: the drugs treat the symptoms of the moment but create additional side effects and ignore the pattern of dysfunction—the emotional dysregulation—that is at the core of their distress.

*Lisa initially idealized Dr. M and followed his instructions exactly, however, she did this for Dr. M and not for herself. This resulted in better adherence to her HIV regimen, and her viral load improved dramatically. Dr. M increased the length of time between follow-ups, and Lisa’s appointments became briefer. At some level, Lisa perceived this as abandonment by Dr. M. She expressed her dependence on emotional support from Dr. M through impulsive drug holidays, which intensified his concern for her. However his disappointment at Lisa’s poor adherence led her to express an intense sadness and irritability that he diagnosed as major depression. He treated Lisa with trials of Paxil, Wellbutrin, and Effexor. When her depressive symptoms failed to resolve, she responded with anger at what she perceived as the failure of Dr. M and the clinic to help her.*

Non-pharmacological therapies for people with borderline personality disorder also lead to inconsistent results. While a few individual therapists seem to be able to treat these kinds of clients successfully, their techniques are not translatable and these therapists describe the process as overwhelming. Therapies that focus exclusively on helping clients change their thoughts, feelings, and behaviors lead to clients’ feelings of invalidation and criticism, and, eventually, to high drop-out rates. Treatments that focus entirely on acceptance of the client “as-is” also fail, because they invalidate the seriousness of client suffering and the urgent need for clients to experience change in their lives.

### A Dialectical Approach

In 1991, psychologist Marsha Linehan published the results of a randomized controlled trial examining a new treatment for chronically parasuicidal borderline patients.<sup>4</sup> The study showed that her

structured treatment led to a significant reduction in days of psychiatric hospitalizations, fewer parasuicidal behaviors such as self-cutting, and an increased likelihood of remaining engaged with therapy.

These results have since been reproduced in at least eight randomized controlled trials. In addition, dialectical behavior therapy has demonstrated efficacy in

treatment of chronic depression, depression with a personality disorder, and eating disorders. It has consistently resulted in reductions in self-injurious behavior, suicide attempts, suicidal ideation, hopelessness, depression, and bulimia. The therapy has been “manualized” and outlined in a skills workbook for clients and therapists. The book guides

***Dialectical behavior therapy is anchored in a philosophy that encourages both acceptance and change.***

both parties through exercises designed to help clients develop the skills they need to manage their out-of-control emotions.<sup>5</sup>

Dialectical behavior therapy, now well established as the dominant treatment paradigm for borderline personality disorder, represents an evolution of cognitive-behavioral therapy. Linehan discovered an important deficit in standard cognitive-behavioral treatments, which treated change and acceptance as opposing, mutually exclusive forces. In contrast, Linehan anchored her therapy in a dialectical philosophy that encourages both acceptance and change. The “dialectic” of dialectical behavior therapy lies in the tension between clinicians’ expressed acceptance of clients as they are and clinicians’ simultaneous efforts to help them change.

This dialectic is achieved through a step-by-step format that is predictable and discrete—again reinforcing structure in the lives of clients who previously flitted from one emotion or crisis to the next. The approach requires therapists to engage in therapeutic judo, emphasizing a clinical interaction in a way that throws a client’s world-view off-balance and allows him or her to entertain a new perspective. This is done not through cleverness or trickery but through the dialectic of balancing acceptance and change. Its core strategies include: showing compassion for clients through validation and acceptance; enhancing clients’ ability to function through skills training; helping clients

### References

1. Brody S, Potterat JJ, Muth SQ, et al. *Psychiatric and characterological factors relevant to excess mortality in a long-term cohort of prostitute women.* *Journal of Sex and Marital Therapy.* 2005; 31(2): 97–112.

2. Golding M, Perkins DO. *Personality disorder in HIV infection.* *International Reviews in Psychiatry.* 1996; 8: 253–258.

## Dialectical Behavior Therapy Techniques

**Target Goals:** Focusing first on suicidality, then therapy-interfering behavior, then life-interfering behavior

**Dialectical Approach:** Balancing acceptance and change

**Core Mindfulness Skills:** Helping clients participate in the “here and now” of their lives

**Emotion Regulation Skills:** Learning to identify emotions and separate them from events; counteracting emotions

**Distress Tolerance Skills:** Developing discrete strategies to use to avoid crisis or the escalation of crisis

**Integral Therapist Self-Disclosure:** Modeling skills for clients

**Chain Analysis:** Collaborative examination of a problem behavior in order to understand the factors controlling the behavior, and develop solutions

**Commitment Strategies:** Fostering the client’s commitment to acquire new skills and behaviors

**Validation as an Explicit Therapist Skill Set:** Finding the grain of truth in every client’s perspective

**Telephone Consultation:** Maintaining contact outside the group in order to reinforce client skills

*This table was adapted by the authors from: Lynch TR, Chapman AL, Rosenthal MZ, et al. Mechanisms of change in dialectical behavior therapy: Theoretical and empirical observations. Journal of Clinical Psychology. 2006; 62(4): 459–480.*

generalize their experiences from therapy to their regular environments; and supporting the therapist through consultation with other practitioners.

### Staying on Target

Dialectical behavior therapy relies on a variety of standard therapeutic tools ranging from reinforcement and skills building to irreverence. At the same time, it uses interventions that are unique to its approach (see

*Dialectical Behavior Therapy Techniques*, this page). Among these key interventions are the focus on skills-building and target goals, the validation of difficult emotions, the application of mindfulness, and the balance of acceptance and change.

The skills incorporated into dialectical behavior therapy are designed to target behaviors that cause dysfunction in the client’s ability to operate in the world. To respond to the safety concerns that are central to borderline personality disorder, the first therapeutic target is to decrease the number and severity of suicidal behaviors. When clients present in crisis at every session or are chronically late for sessions, therapeutic progress becomes difficult. Because borderline traits so often interfere with the therapeutic process itself, the next therapeutic target is to reduce these therapy-interfering behaviors. Finally, behaviors that interfere with the client’s quality of life, called “life-interfering behaviors,” are targeted. Examples might include a client’s unwillingness to look for a job because of fears of not being respected, or a client’s decision not to take a certain medication because he or she is angry at the prescribing physician.

Next, therapists work with clients to increase skills such as core mindfulness skills, interpersonal effectiveness, emotion regulation, distress tolerance, and self-management. Other targets include decreasing the client’s experience of post-traumatic stress, helping to increase his or her self-respect, and helping clients achieve individual goals such as antiviral medication adherence or appointment adherence.

### Validating Difficult Emotions

One of the features that distinguishes dialectical behavior therapy from other approaches is that the therapist focuses

## Clearinghouse: Dialectical Behavior Therapy

### References

Binks CA, Fenton M, McCarthy L, et al. Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*. 2006; 25(1): 1–72.

Clarkin JF, Levy KN, Lenzenweger MF. The Personality Disorders Institute/Borderline Personality Disorder Research Foundation randomized control trial for borderline personality

disorder: Rationale, methods, and patient characteristics. *Journal of Personality Disorders*. 2004; 18(1): 52–72.

Comtois KA, Linehan MM. Psychosocial treatments of suicidal behaviors: A practice-friendly review. *Journal of Clinical Psychology*. 2006; 62(2): 161–170.

Evershed S, Tennant A, Boomer D, et al. Practice-based outcomes of dialectical behaviour therapy (DBT) targeting anger and violence, with male forensic

patients: A pragmatic and non-contemporaneous comparison. *Criminal Behaviour and Mental Health*. 2003; 13(3): 198–213.

Frederick JT, Comtois KA. Practice of dialectical behavior therapy after psychiatry residency. *Academic Psychiatry*. 2006; 30(1): 63–68.

Lanius RA, Tuhan I. Stage-oriented trauma treatment using dialectical behaviour therapy. *Canadian Journal of Psychiatry*. 2003; 48(2): 126–127.

Lescano CM, Brown LK, Puster PM, et al. Sexual abuse and adolescent HIV risk: A

on what is functional about a client's existing behavior. Rather than hammering away at what the client is doing wrong, the therapist seeks to validate—but not condone—this functionality.

*Dr. C initially focused Lisa's therapy on accepting her view of the world: he acknowledged that Lisa was responding to her world in ways that made sense to her in the moment, even if they did not help her in the long run.*

Validation helps clients realize that they are not alien creatures to whom no one else can relate. It is a powerful tool that can defuse an escalating confrontation or, in another context, help a client focus on the information a clinician is trying to convey. For instance, clients with borderline personality disorder are often "somatically hypersensitive," and they attribute clinically unlikely side effects to medication. This characteristic tends to frustrate HIV physicians, who seek to balance issues of effective viral suppression, adherence, tolerability, and side effects when making treatment decisions.

*Rather than argue that Lisa's symptoms were not due to the medication, Dr. C told Lisa: "I understand that you feel numbness and tingling in your lips when you take lamivudine. I am glad you asked me about it. While I can't explain why you are experiencing this symptom, I believe what you are feeling is real. However, I don't think it represents a danger to your health." Dr. C followed this validation by helping Lisa focus on the benefits of the medications—their capacities to suppress the virus and to prevent opportunistic infections.*

### Core Mindfulness Skills

Mindfulness skills, taught throughout the course of dialectical behavior therapy, are an essential component of the

process. Clients learn that there are three states of mind: the "reasonable mind," the "emotional mind," and the "wise mind." The "reasonable mind" is in action when a person is focused and plans his or her behavior based on experience. The "emotional mind" operates when a person's behavior and thoughts are controlled primarily by his or her emotional state. It is difficult during this state to think logically and anticipate consequences.

The "wise mind" is not only the balance of the "emotional mind" and the "reasonable mind," it is a synergy of these two states that also incorporates self-awareness. This allows a person to make intuitive decisions that are intellectually appropriate yet guided by heartfelt emotions.

*Dr. C first taught Lisa the ability to observe her emotions, actions, and behaviors. Later, they also practiced describing her feelings and the events in her life. This allowed Lisa to learn to separate emotions from the events that occurred around her. Learning mindfulness is like learning to hit a tennis ball: it requires repetition and correction until the focus is no longer on the mechanics of the stroke but on the action of hitting the ball. Lisa and Dr. C practiced mindfulness skills until she could participate with attention and awareness but without self-consciousness.*

Other core mindfulness skills focus on how a person sees and participates in the world. These skills orient the clients to notice when they are judging and labeling, when they are distracted from the task at hand, and when they are being ineffective because they are focusing on what is "right" rather than what is needed.

### Balancing Acceptance and Change

Dialectical behavioral therapy works by training people to cope with intense,

3. Bryer JB, Nelson BA, Miller JB, et al. Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry*. 1987; 144(11): 1426–1430.

4. Linehan MM, Armstrong HE, Suarez A, et al. Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*. 1991; (12): 1060–1064.

5. Linehan MM. *Skills Training Manual for Treating Borderline Personality Disorder*. New York: The Guilford Press, 1993.

6. Perkins DO, Davidson EJ, Leserman J, et al. Personality disorder in patients infected with HIV: A controlled study with implications for clinical care. *American Journal of Psychiatry*. 1993; 150(2): 309–315.

group intervention framework. *Journal of HIV/AIDS Prevention in Children and Youth*. 2004; 6(1): 43–57.

McMain S, Korman LM, Dimeff L. Dialectical behavior therapy and the treatment of emotional dysregulation. *Journal of Clinical Psychology*. 2001; 57(2): 183–196.

Nee C, Farman S. Female prisoners with borderline personality disorder: Some promising treatment developments. *Criminal Behaviour and Mental Health*. 2005; 15(1): 2–16.

Ross CA. A proposed trial of dialectical behavior therapy and trauma model

therapy. *Psychological Reports*. 2005; 96(3 Pt 2): 901–911.

Spoont MR, Sayer NA, Thuras P, et al. Practical psychotherapy: Adaptation of dialectical behavior therapy by a VA Medical Center. *Psychiatric Services*. 2003; 54(5): 627–629.

Wagner EE, Miller AL, Greene LI, et al. Dialectical behavior therapy for substance abusers adapted for persons living with HIV/AIDS with substance use diagnoses and borderline personality disorder. *Cognitive and Behavioral Practice*. 2004; 11: 202–212.

### Contact info

Christopher A. Kenedi MD, MPH  
Duke University Hospital  
Divisions of Medicine and Psychiatry  
DUMC Box 3837, Durham, NC 27720,  
919-684-8113, chris.kenedi@duke.edu  
(e-mail).

See also references cited in articles in this issue.

uncomfortable feelings of emptiness and anger. Therapists accomplish this by helping clients replace their old coping mechanisms, which sometimes “worked” but were also harmful or destructive, with new techniques such as mindfulness, problem solving, contingency management, and limit setting.

***In the HIV clinic, the therapy could be adapted to improve adherence among patients with severe impulsivity, emotional dysregulation, and poor coping skills.***

*During therapy, Lisa was able to describe how her past suicide attempts had alleviated her crises. Her first suicide attempt, a Tylenol overdose, occurred when she was 18, after her family kicked her out of the house. A later attempt gave her a brief respite in an inpatient psychiatric unit from her husband who was physically abusing her. Her actions were extreme, but her intent to seek help was genuine. After acknowledging Lisa’s pain and anguish in those situations, Dr. C worked to help her perceive alternate routes for change.*

*For instance, several months into their therapy, Lisa’s increased adherence to her HIV medications resulted*

*in the reconstitution of her immune system, as evidenced by a CD4+ cell count of 250. Dr. M and the clinic staff praised Lisa for her dedication and persistence. However, Lisa viewed her improved health with trepidation: now that she was no longer at risk for many opportunistic infections, she was afraid that she would no longer receive the level of staff scrutiny and support that had made her feel safe.*

*To help Lisa avoid feeling abandoned, Dr. C employed a contingency management technique. He praised (and thus reinforced) her adherence and at the same time, he directly acknowledged her fears as valid. Since Lisa’s dialectical behavior therapy group was working on emotional regulation at this particular time, Dr. C emphasized emotional regulation skills in his individual therapy sessions with Lisa. They discussed the response of Lisa’s “emotional mind” to her success and to Dr. M’s praise. In particular, Dr. C helped Lisa to practice describing what she was feeling after her adherence success: the fear of being alone and receiving less help from Dr. M. In later sessions, Dr. C built on Lisa’s descriptions and responses to those emo-*

*tions as the two explored techniques of distress tolerance. Lisa learned not only how to recognize an emotional response, but also how to avoid letting emotions take control of her interactions with Dr. M.*

## **Conclusion**

In the HIV clinic, dialectical behavior therapy could be adapted to improve medication adherence among patients with borderline traits such as severe impulsivity, emotional dysregulation, and poor coping skills. Duke University is planning a pilot program to study dialectical behavior therapy aimed at increasing adherence to HIV antiviral therapy. The pilot will place participants with poor adherence, impulsivity, and other borderline traits into either a standard support group or an HIV-dialectical behavior therapy group.

Borderline personality disorder not only increases the risk of HIV transmission and infection, it can also make HIV-related treatment difficult or impossible.<sup>6</sup> Because personality disorders are often difficult to recognize, many clients can remain undiagnosed for a significant portion of their lives. Further, some clinicians may be reluctant to label a client as suffering from borderline personality disorder because they incorrectly view it as an untreatable condition.

Many HIV providers have clients whose borderline personality disorder causes the clients varying levels of functional impairment. These clients’ ability to adhere to their HIV antiviral regimens often corresponds to the level of crisis in their lives. When an HIV provider has a suspicion that a patient is suffering from impulsivity and emotional dysregulation, the clinician should refer the patient to a licensed mental health professional trained in dialectical behavioral therapy for evaluation and treatment. In Lisa’s case, dialectical behavior therapy allowed her to gain enough control of her emotions to participate in her health care for her own sake.

## **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](mailto:rob.marks@ucsf.edu) or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

## **Authors**

*Chris Kenedi, MD, MPH is a fourth-year resident in the combined Internal Medicine and Psychiatry Program at Duke University Hospital.*

*Thomas R. Lynch, PhD, is an Associate Professor of Psychiatry and Behavioral Sciences and Director of the Cognitive Behavior Research and Treatment Program at Duke University.*

## Recent Reports

### Dialectical Behavior Therapy: New Directions

Robins CJ, Chapman AL. Dialectical behavior therapy: Current status, recent developments, and future directions. *Journal of Personality Disorders*. 2004; 18(1): 73–89. (Duke University.)

*Christopher Kenedi and Thomas Lynch discuss adaptations to dialectical behavior therapy that might benefit people living with HIV and borderline personality disorder by improving HIV antiviral adherence. This Duke University review article explores several other adaptations of dialectical behavior therapy across diagnoses, client populations, and settings. It suggests the potential of this therapy for clients with substance abuse issues, impulse control disorders, and depression. This summary was adapted from the article and its abstract:*

**A 2003 New York study of triply diagnosed subjects found that borderline personality disorder was both prevalent and associated with HIV antiviral nonadherence.**

Dialectical behavior therapy was developed as a treatment for parasuicidal women with borderline personality disorder and has been adapted for several other populations. This article describes standard dialectical behavioral therapy and several adaptations of it. It reviews outcome studies with borderline clients in outpatient, inpatient, and crisis intervention settings, borderline patients with substance use disorders, sui-

cidal adolescents, clients with eating disorders, inmates in correctional settings, depressed elders, and adults with attention-deficit hyperactivity disorder.

A 2001 randomized controlled trial by Telch and colleagues enrolled 44 women with binge-eating disorder. It compared group-based dialectical behavior therapy adaptations with a wait-list control condition. Subjects in the dialectical behavior therapy intervention showed greater improvements in outcomes related to bingeing, body image, eating concerns, and anger than did those in the control condition. Eighty-nine percent of treatment participants were abstinent from binges after the dialectical behavior therapy treatment compared to 13 percent of control participants.

A 2003 study by Lynch and colleagues adapted dialectical behavior therapy for

depression in 34 elderly subjects. The researchers randomized subjects to 28 weeks (two cycles of the skills group) of either antidepressant medication only or medication plus modified dialectical behavior therapy. While the treatment groups did not differ significantly on changes in interviewer-rated depression symptoms, 71 percent of medication-plus-therapy subjects were in remission after treatment compared to only 47 percent of medication-only subjects. Only the medication-plus-therapy group showed significant changes on a depression assessment questionnaire. At a six-month follow up, 75 percent of medication-plus-therapy subjects were in remission compared to 31 percent of medication-only subjects.

### Adherence and Borderline Personality Disorder

Palmer NB, Salcedo J, Miller AL, et al. Psychiatric and social barriers to HIV medication adherence in a triply diagnosed methadone population. *AIDS Patient Care and STDS*. 2003; 17(12): 635–644. (Montefiore Medical Center/Albert Einstein College of Medicine, Bronx, New York.)

*This study explores the intersection of HIV, substance dependence, and mental health diagnoses, and suggests that borderline personality disorder may be linked more strongly than other psychiatric diagnoses to HIV medication nonadherence. This finding raises the same question posed by Kenedi and Lynch: Can treating borderline personality disorder lead to improved HIV medication adherence? The following summary was adapted from the abstract of the study and the article itself:*

Borderline personality disorder was both prevalent and associated with HIV medication nonadherence in this New York study of triply diagnosed subjects. Researchers used a convenience sample of HIV-positive clients on methadone maintenance who had at least one psychiatric diagnosis in addition to opioid dependence. Interviewers utilized modified versions of the Structured Clinical Interview for DSM-IV Disorders (SCID-I), the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), and the Addiction Severity Index (ASI-Lite) to diagnose clients.

Thirty-seven percent of the sample met criteria for borderline personality disorder compared with 56 percent who had antisocial personality disorder, 35 percent who had major depressive disorder, and 15 percent who had dysthymia. Diagnostic categories in the study were not exclusive: some subjects had multiple psychiatric diagnoses.

Borderline personality disorder was the only psychiatric disorder significantly associated with nonadherence to HIV medications, including both a more general

**Executive Editor; Director,  
AIDS Health Project**  
James W. Dilley, MD

**Editor**  
Robert Marks

**Clinical Editor**  
Michelle Cataldo, LCSW

**Founding Editor**  
Michael Helquist

**Medical Advisor**  
Stephen Follansbee, MD

**Design**  
Saul Rosenfield

**Production**  
Suzy Brady  
Carrel Crawford  
Jennifer J. Regan  
Lisa Roth  
Jenny Sarmiento

**Circulation**  
Jennifer J. Regan

FOCUS, published 10 times a year, is a publication of the AIDS Health Project, affiliated with the University of California San Francisco.

Ten issues of FOCUS cost: **Individual:** Paper—\$48; Paper Outside U.S.—\$60; Electronic—\$36 (inside and outside U.S.); Both Formats—\$58; Both Formats Outside U.S.—\$70; Limited Income—\$24 for either format and \$30 for both formats. **Institutional:** Paper—\$105; Paper Outside U.S.—\$125; Electronic—\$90 (inside and outside U.S.); Both Formats—\$120; Both Formats Outside the U.S.—\$140. **Make checks** payable to “UC Regents.” Address subscription requests and correspondence to: FOCUS, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884. For a list of **back issues** and information about cost, write to the above address, call (415) 502-4930, or e-mail [jennifer.regan@ucsf.edu](mailto:jennifer.regan@ucsf.edu).

To ensure uninterrupted delivery, send new address four weeks before you move.

Printed on recycled paper.

©2006 UC Regents:  
All rights reserved.

ISSN 1047-0719



measure of adherence and the self-reports of subjects on their medication use over the prior weekend. Only 39 percent of borderline subjects were adherent compared to 65 percent of non-borderline subjects. Fifty-two percent of borderline subjects had skipped their medications over the past weekend compared to 30 percent of non-borderline subjects.

### Medication Treatment for Borderline Clients

Simpson EB, Yen S, Costello E, et al. Combined dialectical behavior therapy and fluoxetine in the treatment of borderline personality disorder. *Journal of Clinical Psychiatry*. 2004; 65(3): 379–385. (Harvard University; and Massachusetts Mental Health Center.)

*In their article, Kenedi and Lynch explain how physicians have used medications to treat the symptoms of borderline personality disorder, which has historically been resistant to psychotherapeutic treatment. The two summaries below describe mixed results regarding the efficacy of two medications: fluoxetine (Prozac), an antidepressant, and olanzapine (Zyprexa), an antipsychotic, in treating borderline personality disorder. The studies also underscore the potential of dialectical behavior therapy. The following summaries were adapted from the articles below and their abstracts:*

Researchers found that the addition of the antidepressant fluoxetine to a course of dialectical behavior therapy provided no additional psychological benefits to a small group of subjects with borderline personality disorder.

Between January 1998 and February 2000, researchers conducted a 12-week, randomized, double-blind, placebo-controlled study of subjects with borderline personality disorder (identified using the Structured Clinical Interview for DSM-IV Axis II Disorders). All subjects received individual and group dialectical behavior therapy. Of the 20 subjects that completed treatment, 9 were randomly assigned to receive up to 40 milligrams per day of fluoxetine and 11 were randomly assigned to receive a placebo. Subjects were evaluated at baseline and at either week 10 or week 11 using self-report measures of depression, anxiety, anger expression, dissociation, and global functioning.

There were no significant group differences in scores from pretreatment to post-treatment on any measure. However, within the dialectical behavior therapy/placebo group, there were significant pretreatment/posttreatment improvements on all measures. No significant pretreatment/posttreatment differences were found within the dialectical behavior therapy/fluoxetine condition.

The researchers conclude that adding fluoxetine to an effective psychosocial treatment does not provide any additional benefits, but that further studies with larger sample sizes are warranted.

Soler J, Pascual JC, Campins J, et al. Double-blind, placebo-controlled study of dialectical behavior therapy plus olanzapine for borderline personality disorder. *American Journal of Psychiatry*. 2005. 162(6):1221–4. (Sta. Creu and St. Pau Hospital, Barcelona, Spain.)

Sixty subjects with borderline personality disorder were included in a 12-week, double-blind, placebo-controlled study. Researchers sought to determine the efficacy and safety of dialectical behavior therapy plus the antipsychotic medication olanzapine compared with dialectical behavior therapy plus a placebo. All subjects received dialectical behavior therapy and were randomly assigned to receive either olanzapine or placebo following a one-month baseline period.

Seventy percent of the subjects completed the four-month trial. Combined treatment showed an overall improvement in most symptoms studied in both groups. Olanzapine was associated with a statistically significant improvement over placebo in depression, anxiety, and impulsivity/aggressive behavior. Researchers concluded that a combined psychotherapeutic plus pharmacological approach appears to lower dropout rates and constitutes an effective treatment for borderline personality disorder.

### Next Issue

Mindfulness-based therapeutic approaches apply the Buddhist practice of awareness and acceptance of the present moment to the challenges clients face and to the therapeutic interaction itself. In the August issue of FOCUS, **Kevin Barrows, MD**, Director of the Mindfulness-Based Stress Reduction Program at the UCSF Osher Center for Integrative Medicine describes the evidence for mindfulness-based approaches in the treatment of medical illnesses, including HIV.

Also in the August issue, **Kate Kitchen, MSW, RSW, LISW**, Advanced Practice Clinician at the Centre for Addiction and Mental Health in Toronto, and **Bill Gayner, MSW, RSW**, a psychotherapist at the Clinic for HIV-Related Concerns of Mount Sinai Hospital, also in Toronto, discuss the role of mindfulness in individual psychotherapy.



**FREE** searchable archive

# DID YOU KNOW?

You can access a FREE searchable archive of back issues of this publication online! Visit

<http://www.ucsf-ahp.org/HTML2/archivesearch.html>.

You can also receive this and other AHP journals FREE, at the moment of publication, by becoming an e-subscriber. Visit [http://ucsf-ahp.org/epubs\\_registration.php](http://ucsf-ahp.org/epubs_registration.php) for more information and to register!



## ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit [http://ucsf-ahp.org/HTML2/services\\_providers\\_publications.html](http://ucsf-ahp.org/HTML2/services_providers_publications.html).



## HIV COUNSELOR PERSPECTIVES

### HIV NAME-BASED REPORTING

California has long sought to protect HIV-related information, and recently has some of the strongest HIV-related confidentiality laws in the United States. Since April 17 of this year, the status of people who test HIV positive has been reported to the national HIV database. PERSPECTIVES discusses the history of AIDS and HIV case reporting in California, explains the new system, and addresses potential concerns regarding confidentiality and stigma.

#### Research Update

The Centers for Disease Control and Prevention (CDC) estimates that approximately 1 million new HIV infections occur every year in the United States. To better understand trends in the epidemic, the CDC recommended in 1999 that states begin reporting cases of HIV by name. Since then, California has reported HIV cases by name since 1999. However, California has shifted to a name-based reporting system, instead of a case-based system, in 2004. Tracking HIV cases, rather than reporting HIV cases, allows public health officials to better understand where and how HIV is occurring. This information will be used to help allocate federal and state funding for both prevention and treatment. Since 1985, California's physicians have reported AIDS cases by name to health departments at the local and state levels. Gathering information about AIDS helped public health officials respond to the spreading epidemic. However, as the epidemic advanced, it became clear that knowing the number of people with AIDS without also knowing the number of people with HIV who had not yet progressed to AIDS provided only a limited picture of the scope of the epidemic. Some states—including California—were concerned that reporting names might discourage people from getting tested for HIV infection. Others feared that reporting names would deter treatment, since reporting also occurs when clients access medical services. Some HIV-positive people had already lost employment or insurance coverage and experienced other losses. Both the federal government and the California state government have strengthened prohibitions against HIV-related discrimination. These

- Inside PERSPECTIVES**
- 1 Research Update
  - 5 Implications for Counseling
  - 7 Case Study
  - 8 For Yourself
  - 8 Using PERSPECTIVES