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CHAPTER 3: PERSONALITY DISORDERS IN PATIENTS WITH HIV/AIDS

I. INTRODUCTION

Patients with personality disorders often present challenging therapeutic situations. Because patients with mental health disorders are at high risk for HIV infection, clinicians may encounter a number of patients with mental health disorders that complicate HIV treatment. Although a significant body of research has demonstrated a high prevalence of major Axis I psychiatric disorders among HIV-infected persons, there have been relatively few studies examining the prevalence of Axis II personality disorders.[1] One study indicates that people with personality disorders are at significant risk for onset of future Axis I disorders, as well as serious functional impairment, regardless of a past history of Axis I disorders.[2] Personality disorders among patients infected with HIV are associated with a higher rate of depression, maladaptive coping, and other psychiatric symptoms.[3,4]

In comparison with the general population, patients belonging to an HIV-risk-behavior group such as injection drug users (IDUs) may also be more likely to have a personality disorder, particularly borderline personality disorder or antisocial personality.[5] Antisocial and borderline personality disorders are the two most prevalent personality disorders among substance-using patients, with reported estimates of 22% for antisocial personality disorder and 18% for borderline personality disorder.[1] In addition to these findings, research has shown that patients with borderline and antisocial personality disorders are more likely to participate in sexual and needle-sharing risk behaviors.[6]

This chapter focuses on the fixed patterns of behavior and interpersonal relationships that characterize personality disorders, particularly the ways in which these behaviors impact medical care. Because interaction with others can be challenging for patients with personality disorders, they may be averse to medical treatment.[7] Patients with personality disorders may want care but may not know how to accept it. It may be difficult for them to feel comfortable within a medical setting, a context that may be confusing or stigmatizing for them. Clinicians can interact with these patients effectively with a plan that focuses on support between the patient and the care team.

II. DEFINITION OF PERSONALITY DISORDERS

Personality is the sum of an individual's behavioral and emotional characteristics. Facets of personality that are particularly relevant to patient care include perception of self and others, attitudes, styles of interaction, and behaviors related to coping, moods, and temperament. A personality disorder may be present when these features persistently and significantly limit a person's ability to adapt to his/her environment.

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*) defines personality disorders as persistent, pervasive, and inflexible patterns of inner experience, behavior, and interpersonal relationships that have been continuously present since adolescence or early adulthood and have resulted in significant distress and/or impairment in function. Areas of function affected may include social life, occupation, and self-care. The *DSM-IV-TR* uses a categorical perspective to describe 10 different personality disorders (see Table 1). Each personality disorder is delineated by a defined set of specific behaviors and personality traits. By *DSM-IV-TR* convention, personality disorders are grouped into three "clusters" based on shared descriptive features:

Cluster A—odd, eccentric
Cluster B—dramatic, emotional, or erratic
Cluster C—anxious, fearful

Descriptions of typical personality traits and behaviors that characterize each personality disorder are found in Section IV. B: *Approach to Specific Patient Types.* (Also see *DSM-IV-TR* for a complete discussion of personality disorders and their diagnostic criteria.)

TABLE 1
***DSM-IV-TR* AXIS II DISORDERS**

Cluster A Odd Eccentric	Cluster B Dramatic, Emotional, Erratic	Cluster C Anxious, Fearful
Paranoid Schizoid Schizotypal	Antisocial* Borderline* Histrionic Narcissistic	Avoidant Dependent Obsessive-Compulsive

* Although not conclusive, research suggests that borderline personality disorder and antisocial personality disorder, both Cluster B disorders, may be the most commonly occurring personality disorders among HIV-infected substance-using patients. In addition, among non-infected patients with personality disorders, those with borderline personality disorder and antisocial personality disorder are at higher risk for becoming infected with HIV.

III. DIFFERENTIAL DIAGNOSIS FOR PERSONALITY DISORDERS

RECOMMENDATION:

Clinicians should assess patients with maladaptive behaviors for any treatable underlying medical, mental health, or social disorders that may cause or exacerbate these behaviors.

Unlike other mental health disorders for which the clinician relies on the patient's description of symptoms to assist diagnosis, the clinical diagnosis of personality disorders may be primarily derived from observation of the patient's behavior and style of interacting with others. Maladaptive personality traits and behaviors may be caused or exacerbated by treatable underlying medical, mental health, and/or social disorders (see Table 2). For example:

- Disruptive behaviors may be symptoms of HIV dementia and may also mimic symptoms of personality disorders.
- Cognitive impairment may lead to exaggeration of underlying or prior personality disorders.
- Victims of domestic violence may appear inhibited, avoidant, excessively emotional, or submissive; however, once their safety needs are addressed, these behaviors may disappear.
- Some patients may try to mask their inability to process information due to low or borderline intelligence. Clinicians who are unaware of the patient's cognitive deficits may interpret these behaviors to be symptoms of a personality disorder.

If the maladaptive personality traits and behaviors persist after other treatable disorders have been excluded or adequately addressed, they may be attributes of an underlying personality disorder.

TABLE 2
MEDICAL, PSYCHIATRIC, AND SOCIAL DISORDERS THAT MAY PRESENT WITH MALADAPTIVE BEHAVIOR

• Delirium	• Post-traumatic stress disorder
• Dementia	• Psychotic disorders
• Other medical disorders of the CNS	• Substance use or withdrawal
• Mood disorders	• Domestic violence*
• Anxiety disorders	• Low or borderline intelligence*
• Metabolic disorders	
• Malingering	

CNS, central nervous system.
* See below for additional information.

A. Patients Who Are Victims of Domestic Violence

RECOMMENDATION:

Clinicians should screen patients for domestic violence annually and when patients display inhibited, avoidant, excessively emotional, or submissive behavior.

Patients who are victims of domestic violence are often reluctant to discuss this problem with anyone and may actively attempt to hide any physical injuries from medical staff. The only sign that they are victims of violence at home may be indirect, through their behavior with medical clinicians. Their behavior may mimic personality traits seen in patients with personality disorders; for example, they may appear inhibited, avoidant, excessively emotional, or submissive. Once patients' safety needs are addressed, these behaviors may disappear. When a patient with a preexisting personality disorder is also a victim of domestic violence, it is important to separate the consequences of the violence from those of the personality disorder, so that an important avenue of intervention is not overlooked. In addition, post-traumatic stress disorder and histories of childhood neglect and abuse can co-occur with domestic violence and/or personality disorders and require separate attention.

For more information on domestic violence, see Chapter IV: *Impact of HIV/AIDS on Families*, as well as the Prevention Guidelines *Domestic Violence: Prevention and Intervention*. For more information on post-traumatic stress disorder, see Chapter IX: *Trauma and Post-Traumatic Stress Disorders in Patients With HIV/AIDS.*

B. Patients With Low or Borderline Intelligence

RECOMMENDATION:

Clinicians should perform a mental status evaluation that includes cognitive function of patients who are suspected of having cognitive deficiencies.

Patients with low or borderline intelligence may mask their inability to process information. These patients often confuse and frustrate clinicians who are unaware of the patients' cognitive deficits. Their behavior could resemble any of the patient types described in Section IV. Therefore, it is important for clinicians to make a differential assessment of intelligence status. Clinicians should assess how patients process information that is given to them, such as by asking them to explain in their own words what the clinician has told them.

A mental status examination that includes cognitive function, along with an evaluation for history of underlying learning and developmental disorders, will also help identify these patients. Of note, mental retardation also falls under *DSM-IV-TR* Axis II disorders.

IV. MANAGEMENT OF PATIENTS WITH PERSONALITY DISORDERS

RECOMMENDATIONS:

Primary care clinicians should consult a mental health professional when the medical staff is unsuccessful in persuading the patient to replace old, maladaptive patterns of behavior with alternative, more adaptive behaviors.

Clinicians should clearly instruct the medical support staff about how to manage crises caused by patients with personality disorders, such as isolating the patient from other patients or contacting emergency services, when a crisis arises in the waiting area, laboratory, or other patient care areas.

In a clinical setting, patients may exhibit a range of personality traits and behaviors that seriously interfere with their ability to interact effectively with medical clinicians and staff. As a consequence, these patients may not only jeopardize their own medical care but may also disrupt overall patient care in a busy ambulatory care environment. Furthermore, individuals often present with features from more than one type of personality disorder. For example, patients may present with anger and hostility that seem unwarranted, they may present unrealistic demands for the clinician's time and attention, and/or they may have multiple complaints yet reject the clinician's offers of help or treatment recommendations. Section B: *Approach to Specific Patient Types* describes the different personality traits that a clinician is likely to encounter. A clinician's approach and interventions flow from an understanding of the patient's behavior.

Systems in primary care settings that ensure consistency in care, continuity of care, ease of access to care, and shorter periods of waiting will help diminish waiting room anxieties and displays of disruptive behaviors. If waiting room times cannot be shortened, it is important that patients have activities that will help prevent anxiety and disruptive behavior.

Educational videos, discussions with patient educators, printed materials, refreshments, and games help to create an environment that addresses the difficulty that some patients with anxiety disorders experience during wait times.

Clinicians should instruct their staff to speak to patients in a firm but nonjudgmental manner that makes it clear what a patient needs to do in order to avoid disruptive behavior that might prevent provision of care. Furthermore, a particular staff member may be better-suited for handling a certain personality disorder, trait, or behavior; therefore, clinicians should determine who among his/her staff should be the primary person to interact with a particular patient.

A. General Approach to Patients With Personality Disorders

The following are practical steps that clinicians can take to develop a trusting patient-provider relationship:

- Effective communication (see Table 3)
- Using an interdisciplinary team
- Developing a treatment plan with goals focused on health and behavior
- Educating support staff about engaging with patients with personality disorders

1. Effective Communication

RECOMMENDATIONS:

- **Clinicians should help all members of the staff develop and enhance their skills for working with patients with personality disorders.**

- **All staff members who interact with patients who present disruptive behavior should convey the message that the staff's intent is to assist the patient in obtaining necessary medical care and to improve the patient's function.**

- **Clinicians should clarify for the patient the role and responsibility of each staff member, as well as the patient's own responsibility for his/her treatment.**

Effective communication is the cornerstone of good patient care. For patients with personality disorders and associated maladaptive personality traits and behaviors, establishing adequate communication is not only necessary but may also be sufficient to prevent or alleviate disruptive behavior. Everyone who interacts with patients with disruptive behavior should convey the message that the staff's intent is to assist the patient to obtain the best medical care possible. Use of nonverbal communication skills often conveys this message as powerfully as direct verbal communication (see Table 3).

TABLE 3
GENERAL GUIDELINES FOR EFFECTIVE COMMUNICATION AND ESTABLISHING A THERAPEUTIC PROVIDER-PATIENT RELATIONSHIP

- Listen carefully to identify the patient's agenda
- Maintain eye contact
- Use body language that conveys support and respect; avoid abrupt movements
- Communicate in an unhurried manner
- Avoid the use of humor that may signify disrespect or lack of professionalism
- Offer choices and options whenever possible; this will involve the patient and help share responsibilities of care

Staff members can prevent the potential chaos that these patients may create by maintaining appropriate boundaries and providing structure. For example, when a patient first arrives for his/her office visit, a staff member may explain the schedule and the role of each staff member involved. Example:

> *Your doctor will see you first, although you may have to wait 15 to 30 minutes because he/she is a bit backed up today. After your office visit with your doctor, he/she may then want you to speak to the nurse to review your medications, or go to the lab for blood work.*

Patients are often unaware of the impact of their behavior on others and may react defensively with anger or withdrawal when confronted about the negative effect of their behavior. Clinicians should be supportive and offer patients alternative, more adaptive ways of interacting and behaving to lessen patients' sense of feeling criticized.

2. Interdisciplinary Team

RECOMMENDATION:

Because management of patients with personality disorders can be stressful for all staff members, a team approach that focuses on supportive, effective communication among everyone involved in the patient's treatment should be used when developing a treatment plan.

The importance of using a team approach with patients with personality disorders cannot be overemphasized. The care of patients with complex medical, mental health, and social needs may not be possible without collaboration among all members of the treatment team. By definition, patients with personality disorders often evoke intense feelings that are difficult for the people around them to process.

In addition, the feelings evoked in one staff member may contradict the experience of a different staff member. Consequently, staff may feel frustrated and isolated from each other and be particularly vulnerable to "burn out."

For these reasons, it is especially important that staff members who are "on the front line," such as registration clerks and nursing aides, be involved in treatment planning. Development of a procedure that allows staff to call on a colleague for substitution or supervision can enable team members to regroup and avoid feeling overwhelmed when stress is high. The team often functions as an important source of support for staff and can significantly enhance staff morale.

3. Developing a Treatment Plan

The development of a written treatment plan that is documented in an easily accessible place for staff may be useful to members of the treatment team. Treatment planning may occur in a team meeting and may require a comprehensive conversation among all members of the treatment team. The treatment plan should clearly delineate the goals of treatment and expected behaviors for staff and patients alike. It may take the form of a treatment contract between staff and patient. Patients should participate, whenever possible, in the treatment planning process and be encouraged to describe their treatment goals. The focus of goals should be on health and behavior, such as adhering to medications, keeping appointments, and arriving to appointments on time, rather than on general demands and feelings of the patient, which may be counterproductive.

If there is disagreement, the issues should be clarified and consensus reached. Behaviors that are unacceptable should be clearly delineated, along with corresponding consequences for the behavior. Staff members should be consistent in their response to unacceptable behavior and should avoid specifying consequences with which the staff is unwilling or unable to follow through. Staff should suggest alternatives to behaviors that are damaging to the patient or clinic. For example, if a patient becomes verbally aggressive or threatening and is unable to modify his/her behavior, he/she will be asked to leave the office.

This treatment plan will help both staff and patients feel more secure and in control, because the limits of safe behavior are known and agreed upon by everyone.

The healthcare network of a patient may need to be broadened to alleviate excessive demands on one individual care team. Collaboration with staff from the mental healthcare team may help formulate and implement treatment plans for patients with personality disorders. Patients who refuse psychiatric referral may accept consultation with a "treatment planning consultant," who is a mental healthcare professional, such as a psychiatrist, social worker, or nurse practitioner.

The consultation can be explained to the patient as an opportunity to express his/her particular treatment needs, so that those needs can be integrated into the patient's overall

treatment plan. This interdisciplinary collaboration is particularly important for patients at risk for harming themselves or others. The mental healthcare team may also help facilitate patient referrals to specialized treatment programs for patients with personality disorders.

4. Educating Support Staff

Support staff can diffuse some of the potential chaos by spending a little extra time to help the patient sort out what it is he/she feels is important. *There is no substitute for the extra time and attention required by some patients.* It is important and useful for members of the healthcare team to recognize that engaging with unfamiliar people, particularly people who are responsible for one's health, may be one of the most stressful situations that a patient with a personality disorder may experience. However, once patients get to know and are comfortable with their clinicians and the other medical staff, much of their problematic behavior may subside.

Staff should be educated about how to identify signs of problematic behavior and emotional discomfort, and steps should be taken to intervene early. They should be prepared for what to do in the following situations:

- When a crisis arises in the waiting area
- When patients present with suicidal threats or para-suicidal behavior, such as self-mutilation
- When patients are visibly intoxicated and disruptive

Crowded waiting rooms, long waits, and unscheduled acute visits can create anxiety and frustration, particularly among patients with personality disorders. Therefore, ongoing staff education is important for managing disruptions that can occur as a result of these stressful conditions. A plan that is based on available resources and expertise and that provides strategies for staff members to overcome discomfort in managing patients with personality disorders will facilitate effective responses to patients' needs.

For more information on treating patients with suicidal or violent behavior, see Chapter 7: *Suicidality and Violence in Patients With HIV/AIDS*.

B. Approach to Specific Patient Types

Although no patient will fit exactly into any one paradigm of personality type or style presented here, clinicians will likely encounter such personality traits in the care of HIV-infected patients. The patient types described below approximate patients who present with problematic styles of behavior and personality traits commonly encountered in real-life clinical practice.

Table 4 presents approaches to problematic personality traits that characterize patients who fall within each of the three personality disorder clusters.

1. Odd or Eccentric Patients

Guarded, suspicious, and argumentative patients are doubtful of others' intentions and motives. They may be openly or covertly suspicious of interventions. To the extent that they are convinced that others intend to harm them, they may also be hostile or menacing. Clinicians should maintain a respectful, professional distance from patients. Example:

> *I understand your reasons for not wanting to take medications. If you change your mind, please let me know. I would like to continue to work with you and help you do the things that will keep you as healthy as possible for as long as possible.*

Some patients who are mistrustful, or even paranoid, about medications may eventually accept treatment once they recognize trustworthiness of their clinician in other areas of concern. For this reason, it is especially important to clarify and respond to the patient's agenda. For example, a patient may refuse ARV medication yet request help with eating a healthier diet. Once the clinician has respectfully demonstrated competence addressing this problem, the patient may trust his/her advice about other matters. Furthermore, some patients may make clinicians particularly uncomfortable because, although guarded and unwilling to reveal much about themselves, they may be aggressively intrusive and overfamiliar with their clinicians. This behavior may represent a patient's attempt to protect him/herself from his/her own fear of being dominated and controlled.

Aloof or uninvolved patients are remote or uninterested in the details of their illness, and they have little sense of interpersonal relatedness. They may appear cold, detached, or bland and have a very restricted range of emotional responsivity. Uncomfortable with the involvement of professionals in their lives, they may miss appointments.

Idiosyncratic or eccentric patients tend to dress differently, have peculiar beliefs that can be characterized as not culturally sanctioned, and speak in constricted, loose, digressive, and/or vague ways. These patients may act guarded or may present with unusual complaints that do not have clear physiological patterns.

When complaints overlap with symptoms of co-existent somatic disorders, the situation becomes even more complicated. They may use logic that is idiosyncratic and may believe that they have special or magical powers. For example, they may reason that because HIV can be a terminal illness, they are entitled to the same benefits as a dying person, even though they may be asymptomatic and healthy. Usually, idiosyncratic patients respond best to a consistent approach to their complaints and beliefs that neither challenges their truthfulness nor reinforces their perspective. Example:

Your home remedies have kept you healthy so far. These medications won't mix with one of the home remedies. Can we find a replacement for only that specific remedy to make sure that it does not take away the treatment action of your medications? What other remedy might work for you with these medications? Let's talk about them, so we make sure they can be of help to you.

2. Dramatic, Emotional, or Erratic Patients

Dramatic, dependent, and over-demanding patients have increased dependency and poor tolerance for frustration. They may demand or require more time during office visits and/or may call frequently between scheduled appointments. Also, they may not view broken appointments and their demand for added attention as contradictory.

Dramatic, emotionally involved, seductive, and captivating patients develop intense, over- idealized relationships with primary care professionals. They may treat the clinician as if he/she were a close personal friend. In addition, the clinician may become *the only person who understands them, the only doctor who ever really cared about them, the only doctor they ever trusted*. Over-idealization may take the form of unquestioning compliance with all treatment recommendations. They may become jealous quickly when their clinician's attention turns to other matters. They may also treat the clinician with contempt and hatred if he/she disappoints or frustrates them. Often these patients are anxious about medical interventions. They can be particularly adept at provoking clinicians to retaliate with inappropriate and unhelpful responses.

A subgroup of over-demanding and/or emotionally involved patients may attempt to manipulate or control clinicians through para-suicidal or suicidal threats or behavior. They may respond to setting limits or confrontation by acting destructively toward their treatment or becoming more labile. They may behave similarly if they perceive or fear that their clinicians are going to abandon them.

Superior patients have exaggerated self-confidence. They may be smug, vain, or arrogant. Often their mood fluctuates between demanding brilliance from clinicians and needing to devalue, degrade, or demean these same clinicians. These patients may get "pushed away" by providers who feel they are being challenged. However, clinicians should realize that these patients are easily humiliated and usually have a very fragile sense of self. Without challenging the patient's need to feel superior, clinicians should carefully demonstrate their own competence. Example:

May I see that article you have on HIV treatment? [Clinician reviews the article, following with] *This is helpful. Can I keep a copy in the file? Now, for the next month, can you try* [clinician offers treatment recommendation]*?*

Sociopathic patients ignore the usual social rules through lying, theft, reckless behavior, and disregard for others. They usually lack empathy and may alternate between being demanding and abusive or flattering and ingratiating. Clinicians should

never tolerate behavior from these patients that is aggressive or that creates an unsafe environment. A mental health consultation may help with the development of an appropriate treatment plan.

3. Anxious or Fearful Patients

Orderly, controlled, and controlling patients use knowledge and routine to push away fear and uncertainty. They may be stubborn, rigid, and preoccupied with right and wrong. They have difficulty tolerating the "gray areas" in which so much of medical decision-making takes place. They may view a clinician's inability to guarantee the success of a treatment as a professional shortcoming. Illness and treatment are threats to their need for control. Their obsessions, compulsions, or need for control interfere with their function and may suggest obsessive compulsive disorder (OCD).

Anxiously avoidant patients may appear shy, easily embarrassed, and hypersensitive to criticism. The shame they experience associated with HIV usually pervades many other areas of their lives. The treatment of these patients may suffer because they are fearful of disclosing their HIV diagnosis and details about treatment to others. Criticism or rejection from someone on whom they feel dependent is the worst thing that could happen to them. They may avoid anything associated with HIV, including clinicians. Many of these patients will also meet criteria for social anxiety disorder, an Axis I disorder that significantly overlaps with their avoidant behavior.

Anxiously dependent and clinging patients are submissive and indecisive and allow the clinician and others to take responsibility for making all treatment decisions for them. Similar to dramatic and emotional patients described earlier, they fear separation and abandonment. They frequently need constant reassurance about their health and their clinician's availability. Their needs can feel unlimited and may overwhelm the medical staff. Generally, these patients respond best when their dependency is tolerated, which may, however, require that the healthcare network be broadened to alleviate excessive demands on one individual provider.

Controlling, avoidant, and dependent patients may also use passive-aggressive means to express their anger indirectly. Because they fear criticism or rejection, they may displace anger at clinicians onto other staff or "act it out." Their behavior may alienate other members of the medical staff, who may in turn resent the clinician because he/she sees only the adherent side of the patient. Patients may also act out their anger by missing appointments, not adhering to medications without informing the clinician, or not taking responsibility for other aspects of their care.

Approaches to problematic personality traits are presented in Table 4. In all cases, when complex mental status evaluations become necessary or a patient's behavior leads to instability or jeopardizes effective treatment, clinicians should refer patients to mental healthcare professionals.

TABLE 4 RECOMMENDED APPROACHES TO PERSONALITY TYPES	
Cluster and Patient Subtype	**Recommended Approaches**
Cluster A—Odd or Eccentric	
• Guarded, suspicious, argumentative patients	Acknowledge the patient's perception of the world, without debate or agreement, and try to focus his/her attention on healthcare treatment. Maintain a respectful, professional distance; the patient may appreciate a clinician who is more formal and "business-like."
• Aloof or uninvolved patients	Show that the patient's style is understood and his/her privacy is respected. Explain the need for personal questions but do not push the patient to increase social involvement.
• Idiosyncratic or eccentric patients	Provide a consistent approach that addresses the patient's complaints and beliefs; neither challenge the patient's beliefs nor reinforce his/her perspective.
Cluster B—Dramatic, Emotional, or Erratic	
• Dramatic, dependent, and over demanding patients	Set limits on interactions with the patient to prevent excessive and unrealistic demands from him/her. Refer the patient, if needed, to programs that extend his/her social and healthcare support networks.
• Dramatic, emotionally involved, seductive, and captivating patients	Demonstrate a supportive attitude toward the patient. Maintain professional boundaries to prevent the patient from provoking unhelpful responses.
• Superior patients	Recognize and support the patient's strengths and achievements, and show interest in the patient's opinions. Demonstrate competence without challenging the patient's need to feel superior.
• Sociopathic patients	Set realistic limits on patient visits; never tolerate aggressive behavior or any other behavior that creates an unsafe environment. Consider a mental health consultation, which may help with development of an appropriate treatment plan.
Cluster C—Anxious, Fearful	
• Orderly, controlled, and controlling patients	Clearly state the treatment approach and give the fullest details possible, with a discussion about treatment rationale and other treatment options. Always avoid a struggle over who is in charge.

• Anxiously avoidant patients	Show patience and availability and express empathy toward the patient's fears.
• Anxiously dependent and clinging patients	Consider providing more frequent but briefer appointments; scheduling interactions with the patient may help minimize his/her excessive demands at inconvenient times. Forewarn him/her of change, such as vacations and other absences.
• Controlling, avoidant, and dependent patients	Directly address concerns about the patient's behavior, suggesting that it may indicate underlying feelings about his/her illness and treatment. Encourage medical staff to avoid feeling resentful toward a patient who "acts out" his/her frustration.

C. Treatment of Personality Disorders

RECOMMENDATIONS:

Clinicians should refer patients to mental healthcare professionals when complex mental status evaluations become necessary or when the patient's behavior leads to instability or jeopardizes effective treatment.

Clinicians should develop treatment plans that focus on helping patients with personality disorders change their behavior and style of interacting with others in the healthcare setting and, if possible, in other settings as well.

Clinicians should be aware of symptoms in these patients that suggest a comorbid psychotic disorder.

The primary psychiatric treatment of personality disorders and maladaptive traits consists of psychotherapeutic and social interventions, sometimes used in combination with adjunctive pharmacotherapy. Psychotropic medications alone are rarely useful for the treatment of patients with personality disorders, but it is important to treat comorbid Axis I disorders, such as mood and anxiety disorders. Clinicians should also be aware of symptoms in these patients that suggest a comorbid psychotic disorder. In addition, evidence suggests that selective serotonin reuptake inhibitor (SSRI) antidepressants can be effective in relieving some of the depressed, anxious, and impulsive presentations in patients with personality disorders.

Specialized psychiatric treatment is necessary for patients to achieve fundamental, lasting change in their personalities. However, patients with personality disorders can often be effectively managed in the HIV clinic. Staff interventions should focus on helping patients change their behavior, style of interacting with others, and understanding of themselves and others rather than on changing their feelings. They must learn to tolerate uncomfortable feelings over time and focus on successful behavioral styles.

There are several different types of individual and group psychotherapies that may be effective in the treatment of patients with personality disorders. The choice of therapy depends on factors such as patient characteristics and availability of resources. A psychiatric consultation can assist referral to specialized treatment services.

The clinician should also consider referral to HIV-specific programs. For example, patients who need more support and structure may benefit from programs such as AIDS day-treatment programs or support groups and activities offered by community-based AIDS organizations.

Consultation with a mental health provider or social worker may assist referral to an appropriate HIV/AIDS-related program (see Appendices A and B, respectively, for listings of New York City Ryan White Title I and New York State Department of Health AIDS Institute grant-funded mental health providers).

Individual and group psychotherapies used in treatment of patients with borderline personality disorders include[8-12]:

- *Cognitive-behavioral therapy*: incorporates the theories of behaviorism, social learning theory, and cognitive theories to understand and address a patient's behavior. Short-term treatment is intended to help people redirect destructive thoughts and habits and learn healthier ways of addressing problems. Specific skills include identification of cognitive errors and core beliefs, setting and following an agenda, exploration of underlying assumptions, and seeking alternative explanations.

- *Dialectical behavior therapy*: structured in stages, and at each stage a clear hierarchy of targets is defined. Dialectical behavior therapy teaches patients the skills of mindfulness, interpersonal effectiveness, distress tolerance, and emotional regulation.

- *Transference-based therapy*: a form of psychodynamic psychotherapy that draws from three major theoretical perspectives: ego psychology, object relations, and self-psychology. The therapist explores the patient's early childhood and develops a healthy relationship with the patient in an attempt to resolve interpersonal problems. The goals of treatment include increased self-awareness, with greater impulse control and increased stability of relationships. Specific skills include clarification, confrontation, and interpretation; management of acting out; exploration of conflict; and relating past experience to present conflict.

- *Supportive therapy*: less intensive than psychotherapy and may be effective for engaging many people with borderline personality disorder in treatment, developing a therapeutic alliance, and working to attain treatment goals. Unlike psychodynamic therapy, supportive therapy minimizes the exploration of transferential feelings whereby transference is addressed only in situations where the therapy is threatened. The goals of supportive therapy involve reducing anxiety, strengthening defenses, building self- esteem, and enhancing coping mechanisms.

Other psychosocial treatment modalities may be helpful, and referral to a mental health professional is recommended. A psychiatrist can assist with referral to specialized treatment services for patients with personality disorders.

NOTE FROM CEUBYNET: PLEASE MOVE FORWARD TO THE ADDENDUM TO THIS COURSE WHICH SPECIFICALLY ADDRESSES SOME SPECIFIC CLINICAL APPROACHES TO SUICIDALITY AND VIOLENCE IN HIV-AIDS PATIENTS WITH PERSONALITY DISORDER AND OTHER MENTAL HEALTH ISSUES

THERE ARE ALSO SOME EXCELLENT RESOURCES IN APPENDICES "A" AND "B" AT THE END OF THIS COURSE, ALTHOUGH THOSE ARE NOT PART OF THE COURSE MATERIALS.

REFERENCES

1. Verheul R, van den Bosch LMC, Ball SA. Substance use. In: Oldham JM, Skodol AE, Bender DS, eds. *The American Psychiatric Publishing Textbook of Personality Disorders*. Washington DC: The American Psychiatric Publishing Inc.; 2005:463-475.

2. Johnson JG, Williams JB, Goetz RR, et al. Personality disorders predict onset of Axis I disorders and impaired functioning among homosexual men with and at risk of HIV infection. *Arch Gen Psychiatry* 1996;53:350-357.

3. Perkins DO, Davidson EJ, Leserman J, et al. Personality disorder in patients infected with HIV: a controlled study with implications for clinical care. *Am J Psychiatry* 1993;150:309-315.

4. Johnson JG, Williams JB, Rabkin JG, et al. Axis I psychiatric symptoms associated with HIV infection and personality disorder. *Am J Psychiatry* 1995;152:551-554.

5. Verheul R, Ball SA, van der Brink W. Substance abuse and personality disorders. In: Kranzler HR, Rounsavill BJ, eds. *Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders*. New York: Marcel Dekker; 1998.

6. Kelley JL, Petry NM. HIV risk behaviors in male substance abusers with and without antisocial personality disorder. *J Subst Abuse Treat* 2000;19:59-66.

7. Angelino AF, Treisman GJ. Management of psychiatric disorders in patients infected with human immunodeficiency virus. *Clin Infect Dis* 2001;33:847-856.

8. Hellerstein DJ, Aviram R, Kotov K. Beyond 'handholding': Supportive therapy for patients with BPD and self- injurious behavior. *Psychiatric Times* 2004;Vol. XXI: Issue 8. Available at: http://www.psychiatrictimes.com/p040758.html.

9. Koerner K, Linehan MM. Research on dialectical behavior therapy for patients with borderline personality disorder. *Psychiatr Clin North Am* 2000;23:151-167.

10. Linehan MM. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: The Guilford Press; 1993.

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

12. Linehan MM, Armstrong H, Suarez A, et al. Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Arch Gen Psychiatry* 1991;48:1060-1064.

FURTHER READING

Feinstein RE. Personality disorders in the primary care setting. *Resid Staff Physician* 2000;46:47-56.

Groves JE. Taking care of the hateful patient. *N Engl J Med* 1978;298:883-887.

ADDITIONAL RESOURCES:

- www.apa.org
- www.psych.org/psych_pract/treatg/pg/Practice%20Guidelines8904/BorderlinePersonalityDisorder.pdf
- www.nimh.nih.gov/publicat/bpd.cfm
- www.behavioraltech.com
- www.borderlinepersonality.ca
- www.bpdcentral.com
- www.brtc.psych.washington.edu
- www.psychiatrysource.de/psychsource/News
- www.tara4bpd.org

Addendum to Course 2H

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This Material Is Extracted Relevant Text From CEI's
'SUICIDALITY AND VIOLENCE IN
PATIENTS WITH HIV-AIDS'

HIV-infected patients may be at higher risk for suicidal behavior, particularly after a diagnosis of HIV disease or during progression to AIDS, as patients' health and quality of life decline.[1-4] ***Other patients, such as those with certain personality disorders, may be at increased risk for violent behavior.***[5]

Although only a small number of HIV-infected patients attempt or commit suicide or violence, routine mental health assessment and procedures in the clinic setting for responding to mental health emergencies can ensure that the potential for such behavior is identified and appropriately addressed.

VIOLENCE

Violence is defined as the threatened or actual use of physical force against another person with the intent to cause harm. No documented studies have established increased rates of violence among HIV-infected individuals compared with non-infected individuals or those of unknown HIV status.

However, studies indicate that certain personality disorders that are defined by impulsive or aggressive features, such as borderline and antisocial personality disorders, are more prevalent in certain groups of HIV-infected individuals, specifically intravenous drug users, compared with the general population.[5] Symptoms such as perceptual disturbances and mood instability may account for an increased risk of violence. In this extracted material, the following clinical approaches are briefly addressed:

I. ASSESSMENT OF SUICIDAL AND VIOLENT BEHAVIOR

- Detection
- Estimation of Risk

II. MANAGEMENT AND REFERRAL OF SUICIDAL AND VIOLENT PATIENTS

I. ASSESSMENT OF SUICIDAL AND VIOLENT BEHAVIOR

A comprehensive mental health assessment is essential for any patient who directly expresses suicidal or violent behavior or whose behavior and risk factors suggest potential for suicide or violence. Figure 1 provides an algorithm for assessing and managing suicidal or violent patients.

A. DETECTION OF SUICIDAL AND VIOLENT BEHAVIOR

RECOMMENDATION:

Clinicians should assess for suicidal and violent behavior at baseline and at least annually as part of the mental health assessment.

For many clinicians, questions about suicide and violence are difficult to ask. Some clinicians may be unsure of how to respond to a patient who expresses potential for suicide or violence. For example, a clinician in a busy clinic setting may think, *I have 10 people in my waiting room. What do I do now?*

The clinician may also feel that asking about suicide or violence might provoke suicidal or violent thoughts in patients or disrupt the clinician-patient relationship. However, when a patient recognizes concern and empathy in the clinician's lead-in questions, assessing risk of suicide or violence may actually strengthen the clinician-patient relationship. For example, *It sounds as if you are in great pain. Have you ever thought life was not worth living?* or *You sound as if you feel very angry and frustrated at home. Do you ever have the impulse to physically harm your partner or has the conflict between the two of you ever become violent?*

B. ESTIMATION OF RISK FOR SUICIDE OR VIOLENCE

RECOMMENDATION:

Clinicians should assess patients who have expressed thoughts of suicide or violence for specific risk factors that indicate suicidal or violent intent and for impaired impulse control (see Tables 1 and 2)**.**

Once a patient acknowledges that he/she has considered harming himself/herself or others, clinicians should ask about planned intent and risk factors. Risk factors for suicide and violence are illustrated in Table 1. The more risk factors a patient has, the greater the likelihood of suicide and violence. Although no study has indicated that one risk factor or set of risk factors is more predictive of suicidal behavior than others, most studies suggest that the best predictor of future violence is a history of past violence.

SEE TABLE 1 FOR RISK FACTORS FOR SUICIDE AND VIOLENCE

TABLE 1
RISK FACTORS FOR SUICIDE AND VIOLENCE

Category	Risk Factors	
	Suicide	**Violence**
Demographic	• White • Male (males more often complete; females more often attempt*) • Older age (>45 years) • Divorced, never married, or widowed • Unemployed	• Young • Male • Limited education • Unemployed
Historical	• Previous suicide attempts, especially with serious intent, lethal means, or disappointment about survival • Family history of suicide • Victim of physical or sexual abuse	• **Previous history of violence to self or others, especially with high degree of lethality** • **History of animal torture** • **t antisocial or criminal behavior** • **Violence within family of origin** • **Victim of physical or sexual abuse**
Psychiatric	• Diagnosis: Affective disorder, alcoholism, panic disorder, psychotic disorders, severe personality disorder (especially antisocial and borderline) • Symptoms: Suicidal or homicidal ideation; depression, especially with hopelessness, helplessness, anhedonia, delusions, agitation; mixed mania and depression; psychotic symptoms, including command hallucinations and persecutory delusions • Current use of alcohol or other drugs • Recent hospitalization for mental health disorder	• **Diagnosis: Substance-related disorders, especially alcoholism; antisocial personality disorder, conduct disorder; intermittent explosive disorder, pathological alcohol intoxication, psychoses (e.g., paranoid)** • **Symptoms: Physical agitation; intent to kill or take revenge; identification of specific victim(s); psychotic symptoms, especially persecutory delusions and command hallucinations to commit violence** • **Current use of alcohol or other drugs**
Environmental	• Recent loss such as that of a spouse or job • Access to guns or other lethal weapons • Social acceptance of suicide • Patient's perception of a lack of social support,† or actual lack of social support	• Access to guns or other lethal weapons • Living under circumstances of violence • Membership in violent group • Patient's perception of a lack of social support,† or actual lack of social support

Medical	• Severe medical illness: Presence of HIV-related physical symptoms; poor adjustment to HIV disease; failed medical treatment or first hospitalization for medical illness; loss of function or intractable or chronic pain from medical illness • Delirium or confusion caused by central nervous system dysfunction	• Severe medical illness: Presence of HIV-related physical symptoms; poor adjustment to HIV disease; failed medical treatment or first hospitalization for medical illness; loss of function or intractable or chronic pain from medical illness • Delirium or confusion caused by central nervous system dysfunction • Disinhibition caused by traumatic brain injuries and other central nervous system dysfunctions • Toxic states related to metabolic disorders, such as hyperthyroidism
Behavioral	• Antisocial acts • Poor impulse control, risk taking, and aggressiveness • Preparing for death (e.g., making a will, giving away possessions, stockpiling lethal medication)	• **Antisocial acts** • **Agitation, anger** • **Poor impulse control; risk-taking or reckless behavior** • **Statements of intent to inflict harm**
	• Well-developed, detailed suicide plan • Statements of intent to inflict harm on self or others	

Adapted, with permission, from Cournos F, Cabaniss D. Clinical evaluation and treatment planning: A Multimodal Approach. In: *Psychiatry, Second Edition.* (Tasman A, Kay J, Lieberman J, eds). Chichester, England: John Wiley and Sons Ltd.; 2003.

* NOTE: Distinction between male and female suicidal behavior may not apply to gay and lesbian youth, who may be at increased risk for suicide attempts associated with experience of harassment, homophobia, gender nonconformity, and disclosure of sexual identity. † In some cases, patients who are depressed may have family or friends who are supportive, but the patients do not perceive them as being supportive.

WHAT KIND OF QUESTIONS TO ASK?

Questions that ask directly about suicidal or violent thoughts are essential during assessment of the patient's level of potential danger. For example, questions such as, *Do you often think about hurting yourself or someone else?...How might you do that?...You know, there is a big difference between having those thoughts and acting on them. Is this something you might actually do?* may help determine the degree of harm.

Patients may describe thoughts of harming themselves or others, yet deny intent to act on these thoughts. Therefore, an assessment of impulsivity is an important aspect of estimating risk for suicide and/or violence. How to assess? During interactions with patients, clinicians may notice behaviors that suggest impaired impulse control. For example, patients may suddenly and unexpectedly become verbally aggressive and threatening while discussing a recent life change, such as a job loss.

Other patients may initiate a discussion about a significant event, such as a recent break-up with a partner, and then abruptly and prematurely decide to end the conversation or leave because of feelings of hopelessness. Neither of these situations alone would indicate serious risk of suicide. However, either situation in combination with other risk factors (see Table 2) should heighten concern about a patient's potential for suicide.

TABLE 2
FACTORS THAT MAY INCREASE IMPULSIVITY

- Patients do not feel able to control their feelings, impulses, behaviors
- Patients are currently using or withdrawing from alcohol or other substances
- Patients are acutely psychotic and experiencing command auditory hallucinations and persecutory delusions
- Patients have had a decline in cognitive function (gradual or accelerated)
- Patients are agitated or manic

II. MANAGEMENT AND REFERRAL OF SUICIDAL AND VIOLENT PATIENTS

RECOMMENDATIONS:

Clinicians should maintain an up-to-date list of easily accessible mental health referral resources for patients who require either immediate mental health assessment or for whom assessment is less urgent.

Clinicians should attempt to involve people whom the patient perceives as supportive, such as friends and family, in treatment planning and management.

The management and referral strategies for suicidal and potentially violent patients depend on multiple factors, including the presence of risk factors, whether the risk factors indicate imminent danger, and acute versus chronic nature of suicidal or violent thoughts. Patients who present an imminent risk of harm to self or others represent a psychiatric emergency. Patients who are not imminently dangerous, but present with multiple risk factors and fail to respond to mental health treatment by the primary care clinician, require a complete evaluation by a mental health provider. Social support and referral to outpatient mental health services may also be necessary.

- Involvement of people whom the patient perceives as supportive, such as friends and family, is essential for effective management of suicidal and potentially violent patients. For example, a patient who is not at immediate risk for suicide or violence might feel safer staying with a friend until he/she can see a psychiatrist for evaluation.

A. MANAGEMENT AND REFERRAL OF IMMINENT SUICIDAL OR VIOLENT POTENTIAL

RECOMMENDATION:

The clinician, or a member of the health care team, should escort a patient to the emergency department or call 911 when the patient expresses suicidal or violent thoughts accompanied by risk factors that indicate imminent danger.

A patient who expresses actual intent to commit suicide or harm others needs urgent intervention and

should receive immediate emergency department mental health assessment. A clinician's assessment that a patient is in imminent risk of harm to self or others overrules the patient's right to refuse treatment. In these cases, the clinician may need to call emergency services or the police.

New York State mental health laws provide legal procedures for the management of patients who are imminently suicidal and/or violent. Patients may be held against their will, for up to 72 hours, while a mental health assessment is performed to determine a patient's risk of harming self or others. If a mental health assessment, usually involving two psychiatrists, determines that a patient is at risk for suicide or violence, that person may be confined involuntarily beyond 72 hours for the purposes of mental health treatment. The clinician may also deem it necessary to warn any intended victim(s) of the violence. In this case, the clinician is permitted to overrule the patient's privacy privilege.

B. MANAGEMENT AND REFERRAL OF NON-IMMINENT SUICIDAL OR VIOLENT POTENTIAL WITH ACCOMPANYING RISK FACTORS

RECOMMENDATIONS:

Clinicians should refer patients who express suicidal or violent thoughts, *but who are not at imminent risk*, for a complete mental health evaluation when the mental health treatment by the primary care clinician is unsuccessful.

Clinicians should discuss with patients the reasons why they think about suicide or violence and should develop a plan to modify risk factors.

Patients with serious suicidal and/or violent thoughts who are not imminently dangerous, but who possess risk factors, may be helped through modification of the risk factors listed in Table 1. The following are examples for addressing risk factors:

- Treatment of underlying mental health disorder, particularly depression
- Reduction of social isolation
- Alleviation of physical pain, physical impairments, sleep disturbance
- Removal of access to means of suicide or violence, such as medications and guns

Suicidal thoughts can be amplified by HIV infection, particularly when suicide is consciously or unconsciously suggested to the patient by loved ones who cannot cope with the consequences of HIV/AIDS. Family, friends, and even healthcare workers who identify with a patient's hopelessness may further exacerbate suicidal thoughts by expressing ideas such as, *Well, I might try to kill myself under these circumstances too*. Rather than accept or reinforce such ideas, clinicians should explore with patients the reasons why they think about suicide or violence and explore means to modify risk factors For example, a patient may fear physical pain and suffering so a discussion of the treatment of the pain may markedly diminish the suicide potential.

C. MANAGEMENT AND REFERRAL OF CHRONIC SUICIDAL OR VIOLENT IDEATION

RECOMMENDATION:

Clinicians should refer patients who express chronic wishes to harm self or others for a comprehensive outpatient mental health evaluation and then maintain ongoing communication with the mental health provider(s) involved in the patients' mental health care.

Some patients present with longstanding suicidal and/or violent thoughts that remain constant, although the thoughts may fluctuate in intensity over time. The level of risk may be less easily modified in the short term than among patients with more acute symptoms. Patients with chronic suicidal or violent ideation often require long-term psychiatric management. Treatment is usually designed to address underlying factors associated with their suicidal and/or violent thoughts (see Table 3).

It is also important to recognize that patients with chronic suicidal and/or violent ideation may experience periods of acute worsening of symptoms that require a more aggressive treatment approach. For example, a patient with chronic suicidal and/or violent ideation who relapses to using alcohol or other drugs may require emergency evaluation. Similarly, increased suicidal ideation in a chronically suicidal patient may reflect new-onset depression that can be alleviated by treatment.

SEE TABLE 3 FOR MANAGEMENT STRATEGIES FOR CHRONIC SUICIDAL OR VIOLENT IDEATION.

TABLE 3
MANAGEMENT STRATEGIES FOR CHRONIC SUICIDAL AND/OR VIOLENT IDEATION

Type of Chronic Ideation	Description	Management Strategy
Chronic suicidal and/or violent ideation resulting from mental health disorders	May be a feature of personality disorders, such as borderline or antisocial personality disorder, or a feature of chronic mental health disorder, such as schizophrenia.	These patients usually require close coordination of treatment and communication between the primary care clinician and the mental health provider. Inpatient psychiatric hospitalization may be necessary during periods of acute crises.
Chronic suicidal ideation as a coping strategy	May be a coping strategy for patients with chronic medical illness. For these patients, thinking about suicide may be an unconscious attempt to regain a sense of control over their lives. Patients may say or think, *Well, if things get too overwhelming, I can always kill myself.* Such thoughts may lend some sense of control to patients by providing a future option that never has to be acted on. When no other risk factors are present, most patients who express this type of suicidal thinking do not act on it.	During acute crises or when other risk factors are present, these patients may be at more significant risk for suicide and require mental health assessment or inpatient hospitalization.
Chronic suicidal ideation among patients with desire for hastened death	Some patients, usually those with more advanced disease, may request that their clinicians assist them in either suicide or hastened death. Additionally, some patients may wish to hasten their own deaths by refusing treatment. These patients may be suffering from a reversible mental health disorder, most notably depression, which could contribute to their wish to die.	A mental health assessment should be performed to address any correctable problems, such as depression and poorly controlled anxiety, pain, or delirium.
Chronic suicidal ideation among self-injurious patients	Patients may also present with chronic and repetitive self-injurious behaviors, such as cutting, that may or may not be associated with suicidal intent. These behaviors are more likely to occur in patients with borderline and antisocial personality disorders. In these patients, self-inflicted injury may be an expression of anger or frustration and serves to relieve internal tension. They may feel better after injuring themselves.	These patients may benefit from ongoing specialized outpatient mental health treatment. They may also require brief mental health inpatient hospitalizations during crisis periods, when suicidal potential is heightened. See *Personality Disorders in Patients With HIV/AIDS*.

REFERENCES

1. Bellini M, Bruschi C. HIV infection and suicidality. *Affect Disord* 1996;38:153-164.

2. Siegel K, Meyer IH. Hope and resilience in suicide ideation and behavior of gay and bisexual men following notification of HIV infection. *AIDS Educ Prev* 1999;11:53-64.

3. Kalichman SC, Heckman T, Kochman A, et al. Depression and thoughts of suicide among middle-aged and older persons living with HIV-AIDS. *Psychiatr Serv* 2000;51:903-907.

4. Kelly B, Raphael B, Judd F, et al. Suicidal ideation, suicide attempts, and HIV infection. *Psychosomatics* 1998; 39:405-415.

5. Verheul R, Ball SA, van der Brink W. Substance abuse and personality disorders. In: Kranzler HR, Rounsavill BJ, eds. *Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders*. New York: Marcel Dekker; 1998.

6. Cooperman NA, Simoni JM. Suicidal ideation and attempted suicide among women living with HIV/AIDS. *J Behav Med* 2005;28:149-156.

7. Komiti A, Judd F, Grech P, et al. Suicidal behaviour in people with HIV/AIDS: A review. *Aust N Z J Psychiatry* 2001;35:747-757.

8. Roy A. Characteristics of HIV patients who attempt suicide. *Acta Psychiatr Scand* 2003;107:41-44.

9. Marzuk PM, Tierney H, Tardiff K, et al. Increased risk of suicide in persons with AIDS. *JAMA* 1988;259:1333- 1337.

10. Coté TR, Biggar RJ, Dannenberg AL. Risk of suicide among persons with AIDS: A national assessment. *JAMA* 1992;268:2066-2068.

11. Dannenberg AL, McNeil JG, Brundage JF, et al. Suicide and HIV infection. Mortality follow-up of 4147 HIV-seropositive military service applicants. *JAMA* 1996;276:1743-1746.

12. Nestor P. Mental disorder and violence: Personality dimensions and clinical features. *Am JPsychiatry* 2002;159:1973-1978.

Appendix A
New York City Ryan White Title I Mental Health Providers

AIDS Center of Queens County, Inc.
97-45 Queens Boulevard, 12th Floor
Rego Park, NY 11374
Phone: 718-896-2500
Fax: 718-275-2094

Alianza Dominicana, Inc.
715 W. 179th Street
New York, NY 10033
Phone: 212-927-6810
Fax: 212-795-9645

HHC Bellevue Hospital Center
First Avenue & 27th Street
New York, NY 10003
Phone: 212-562-4197
Fax: 212-562-3916

Beth Israel Medical Center
317 East 17th Street, 15th Floor
New York, NY 10025
Phone: 212-420-4352
Fax: 212-420-4332

The Bridge, Inc.
238 West 108th Street
New York, NY 11207
Phone: 212-663-3000
Fax: 212-280-7211

East New York Diagnostic & Treatment Center
2094 Pitkin Avenue
Brooklyn, NY 10573
Phone: 718-240-0600
Fax: 718-240-0601

Family Services of Westchester
One Gateway Plaza
Portchester, NY 10011
Phone: 914-937-2320
Fax: 914-937-4902

Gouverneur Healthcare Services
41-51 E. 11th Street
New York, NY 10037
Phone: 212-645-0875
Fax: 212-939-4050

Harlem Hospital Center
506 Lenox Avenue, Room 17-125
New York, NY 10037
Phone: 212-939-4252
Fax: 212-939-3399

Henry Street Settlement
40 Montgomery Street
New York, NY 10002
Phone: 212-233-5032
Fax: 212240-9515

Hudson River Community Health Center
1037 Main Street
Peekskill, NY 11233
Phone: 914-734-8762
Fax: 914-734-8758

Institute for Community Living, Inc.
2384 Atlantic Avenue, 4th Floor
Brooklyn, NY 11233
Phone: 718-495-0920
Fax: 718-345-2471

Jacobi Medical Center
1400 Pelham Parkway South & Eastchester Road
Bronx, NY 10461
Phone: 718-918-7805
Fax: 718-918-7185

Mount Sinai Medical Center
320 East 94th Street
New York, NY 10128
Phone: 212-423-2940
Fax: 212-731-7960

New York Presbyterian Hospital
622 West 168th Street
New York, NY 10033
Phone: 212-305-9099
Fax: 212-576-4196

North Central Bronx Hospital
3424 Kossuth Avenue
Bronx, NY 10463
Phone: 718-519-5038
Fax: 718-458-4481

Queens Child Guidance Center, Inc.
67-14 41st Avenue
Woodside, NY 11377
Phone: 718-458-4243
Fax: 718-458-4481

Salvation Army
601 Crescent Avenue
Bronx, NY 10458
Phone: 718-329-5410
Fax: 718-329-5409

Staten Island University Hospital
392 Seguine Avenue
Staten Island, NY 10025
Phone: 718-226-3801
Fax: 718-226-2652

William F. Ryan Community Health Center, Inc.
160 West 100th Street, 2nd Floor
New York, NY 10025
Phone: 212-769-7238
Fax: 212-932-8323

Woodhull Medical & Mental Health Center, Inc.
760 Broadway
Brooklyn, NY 11206
Phone: 718-963-7498
Fax: 718-630-3250

Appendix B
New York State Department of Health
AIDS Institute Grant-Funded Mental Health Providers

AIDS Center of Queens County
97-45 Queens Boulevard, 12th floor
Rego Park, NY 11374
Phone: 718-896-2500
Fax: 718-275-2094

AIDS Community Resources
627 West Genesee Street
Syracuse, NY 13204
Phone: 315-475-2430
Fax: 315-427-8184

AIDS Council of Northeastern NY
927 Broadway
Albany, NY 12207-1306
Phone: 518-434-4686 x2114
Fax: 518-427-8184

AIDS Related Community Services
40 Saw Mill River Road
Hawthorne, NY 10532
Phone: 914-785-8265
Fax: 914-785-8227

Rockland Office:
218 North Main Street
Spring Valley, NY 10977

Albany Medical Center Hospital
66 Hackett Boulevard
Albany, NY 12209
Phone: 518-262-2171
Fax: 518-262-2169

Alianza Dominicana, Inc.
715 West 179th Street
New York, NY 10033
Phone: 212-795-4226
Fax: 212-795-4285

Bedford-Stuyvesant Family Health Center
1407 Fulton Street
Brooklyn, NY 11216
Phone: 718-857-1006
Fax: 718-857-1042

Bronx-Lebanon Hospital Center
1650 Selwyn Avenue, Suite 2D
Bronx, NY 10457
Phone: 718-960-1069
Fax: 718-960-1354

Brownsville Community Development Corp.
592 Rockaway Avenue
Brooklyn, NY 11212
Phone: 718-345-6366
Fax: 718-345-3610

Harlem United Community AIDS Center
123-125 West 124th Street
New York, NY 10027
Phone: 212-531-1300 x403
Fax: 212-531-0141

Housing Works
57 Willoughby Street, 2nd Floor
Brooklyn, NY 11201
Phone: 347-473-7440

The Institute for Urban Family Health
16 East 16th Street
New York, NY 10003
Phone: 212-633-0800 x263

Interfaith Medical Center
1360 Fulton Street, Suite 502
Brooklyn, NY 11216
Phone: 718-399-3156
Fax: 718-636-5517

Montefiore Medical Center
AIDS Center
111 East 210th Street
Bronx, NY 10467-2490
Phone: 718-920-4430
Fax: 718-405-0610

Mount Vernon Neighborhood Health Center
107 West 4th Street
Mount Vernon, NY 10550
Phone: 919-699-7200
Fax: 919-668-0579

Mount Sinai Project Impact's Perinatally Infected Adolescent Program
320 East 94th Street, 2nd Floor
New York, NY 10028
Phone: 212-423-2907
Fax: 212-423-2920

New York Presbyterian Hospital
622 West 168th Street, VC4
New York, NY 10032
Phone: 212-305-7257
Fax: 212-305-7400

Project Hospitality
100 Park Avenue
Staten Island, NY 10301
Phone: 718-448-1544
Fax: 718-720-5476

Strong Memorial Hospital
300 Crittenden Boulevard
Rochester, NY 14642
Phone: 585-275-7418
Fax: 585-273-1093

SUNY Downstate Medical Center, STAR/MH
450 Clarkson Avenue, Box 1240
Brooklyn, New York 11203
Phone: 718-270-2758
Fax: 718-270-4244

Union Settlement Association, Inc. James Weldon Counseling Center
2089 Third Avenue
New York, NY 10029
Phone: 212-828-6151
Fax: 212-828-6145

United Bronx Parents, Inc.
773 Prospect Avenue
Bronx, NY 10455
Phone: 718-893-6555
Fax: 718-893-2850

United Health Services Hospital
HIV Mental Health Services
33 Mitchell Avenue
Binghamton, NY 13903
Phone: 607-762-2538
Fax: 607-762-329