

Case Report

The Convergence of HIV and Mental Health Issues: A Case Illustration

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Abstract

Mental health care is identified as an unmet healthcare need of persons living with HIV/AIDS. Psychiatric/Mental Health Nurse Practitioners, physician providers, and other health care team members may be part of an integrated care solution. Presented from the patient's point of view, the case of a 48-year-old African American male addresses the complexities of living with HIV disease and psychiatric/mental health issues. The case is used to illustrate the convergence of HIV with major depression, anxiety, substance abuse and borderline personality disorder with prominent narcissistic and antisocial features, as well as the complex demands that chronic, comorbid physical and other mental health conditions can have on quality of life and treatment outcomes. Observations and care offered too late in his complex life by a psychiatric nurse practitioner are discussed. Many patients in acute distress and crisis, particularly those living with borderline personality disorder and other mental health issues, need to feel understood. Borderline personality disorder causes intense mood swings, impulsive behaviors, and severe problems with self-worth¹. It can lead to troubled relationships in every area of a person's life. An understanding of these issues is key to the therapeutic process.

INTRODUCTION

This case narrative addresses the complexities of living with HIV disease and mental health issues from the patient's perspective. It illustrates the complex demands that chronic, comorbid health conditions—one physical health challenge—HIV, and multiple mental health conditions—borderline personality disorder with prominent narcissistic and antisocial features, anxiety, depression, complex trauma, and substance abuse present in this case. Many patients in distress and crisis, particularly those living with borderline personality disorder, are not as interested in understanding their problems as they are in being understood [1-2]. Borderline personality disorder causes intense mood swings, impulsive behaviors, and severe problems with self-worth [3]. It can lead to troubled relationships in every area of a person's life. An understanding of these issues is key to the therapeutic process. The narrative is told from the perspective of the patient who seeks to be understood and includes observations of a psychiatric/mental health nurse practitioner (PMHNP). This case illustration includes the expertise of the PMHNP over two-year period and includes data collection methods that are common for advanced practice nurses in mental health to utilize in professional practice. These include interviews, observational techniques, review of the medical history, and the interpretation and analysis of these data.

THE NARRATIVE: BUILDING TYRONE'S STORY

Tyrone was removed from his family at the age of 10. The incident that provoked this extreme action was that he stabbed his father while his father was beating his mother, as Tyrone's father often did. His father stopped beating his mother long enough to catch Tyrone. Punching and kicking him repeatedly, his father flung him out of the third-story window of his home. He landed on the roof of the porch below, breaking his neck. Tyrone was hospitalized for nearly a year after this incident. His mother visited him frequently in the hospital, often appearing with a black eye. Tyrone believed that his father often beat his mother because she was visiting Tyrone. He wanted his mother's approval and love so very much; but she was withholding of these feelings, and he often felt that she thought it was his fault that his father beat her. Usually, though, he stated that his mother was an angel, the strongest person he has ever known, and the most important woman in his life. She only beat him for good reason; he would say: "and the best mother anyone could have." He idealized her and compartmentalized the anger he held towards her. She had ten children, but his father killed the youngest by repeatedly hitting his head against a wall when he was an infant. His father would round all nine of them up and put them in the bathtub while he abused his mother for what seemed like hours. They all stood huddled together, immobilized by the terror of those long hours.

One night his father beat his brother “within an inch of his life,” and Tyrone said that beating should have been for him. He still hears his brother yelling, “Police,” before he fell unconscious. He doesn’t like the smell of alcohol on one’s breath because it reminds him of his father coming into his room at night—sometimes to beat him and sometimes to force him to clean the house. He doesn’t buy Spic and Span because it reminds him of kneeling on top of the refrigerator at 3AM while he scrubbed it as commanded. The consequences were severe if it wasn’t clean enough for his father. It usually wasn’t.

Tyrone was often in trouble at school and with the law. He wasn’t allowed in a lot of places. He smiles as he recalls a nice white guy who used to let him sit at the counter of a local fountain when he was young to drink his lime rickey. You see black kids weren’t allowed to sit at the counter. He had his first child when he was 14 and was married at 15. At eighteen years of age, he started his own business, managing the group of prostitutes who worked for him. At nineteen years of age, he went to prison for murdering the man who brutally beat and raped his four-year-old daughter. In between these times, he abused many different substances including marijuana, heroin, and LSD. In prison he used his management skills once again to organize and run a drug-import business. His wife visited him often bringing women with her who smuggled drugs inside their bodies to her husband. In his wife’s presence, he reports to have had sexual intercourse with these women in the walled yard in which they visited. He says he never had a problem getting girls and that he was five when he had his first sexual encounter. He watched his older brothers engage in sexual acts, and he tried to do what they did with a little girl who lived up the street. He was forced to leave the first foster home in which he was placed because he engaged in sex with one of his foster sisters and was caught. He always had a girlfriend, even when he was married. He begins to tell me about the time he was raped when he was 8 by a white guy almost five times his age, but he didn’t finish that story.

Life in prison presented many opportunities for relationships—intense, unstable, violent, abusive relationships that revolved around power, hate, and control. He was considered a discipline problem, and the guards used any means available to attempt to control him. He spent many months, which probably totaled years, in the “hole”. He was brutally beaten, tortured—physically and mentally—and urinated and defecated on. He treated the pain of these wounds with heroin. With rage submerged just below the surface by these drugs, he says, “I didn’t speak—I growled.” I understood he was not emphasizing how he was treated in this moment but how he felt—what he had become. He says he was exposed to HIV in a prison stabbing and did not know he was infected until he had “full-blown” AIDS. He won’t talk about sexual abuse or the choices he made to satisfy his sexual needs while in prison. Usually he reveals extreme homophobia, but then speaks of a gay man who did his laundry for him and in return Tyrone protected him. I think there is some tenderness reflected in this story. His arms and chest bear the scars of the many times he has mutilated himself repeatedly. He is chronically angry about the way black people are treated; he says he hates all Haitians, most white people, yet denies he is racist because white people own that domain. His hatred of Haitians derives from his distorted cognitions about HIV and its spread as well as a projection of his own self-hatred.

Twenty-five years later, his sentence is finally overturned, and he is released from the correctional facility where he spent most his life. He has a full-time job managing the problems he encounters living with AIDS, end-stage kidney disease, and mental health issues including borderline personality disorder, severe depression, intense anxiety, as well as other multiple medical conditions secondary to his HIV disease. He did work briefly after being released from prison; in fact, he started his own contracting firm. He went back to prison shortly thereafter for embezzling funds from his clients to support his cocaine addiction. A few years ago he and his wife split up for the last time, although they still have an intense and stormy relationship. He says he left her, but in a rare moment of conscious awareness and honest disclosure of his real intention says, “I really left her so she wouldn’t leave me.” He gives a girlfriend oxycodone, diazepam, and MS-contin to keep her coming back. He speaks only rarely with his six daughters. When some reason brings them together, they argue; he reports saying crude and hurtful things related to events over which his daughters had no control. Only later is his despair evident when the anger explodes with little provocation. He requires frequent hospitalization for his illnesses, but he usually signs out against medical advice (AMA) just before a scheduled surgery or because some “stupid idiot” made him really mad. He says, though, that he can’t talk about it because he is just too angry. He is also observed to be anxious, impatient, impulsive, manipulative, exploitive, demanding, and controlling. He complains of being lonely and hates being alone. He is often alone. He thinks the people who work at the hospital can’t get anything right and says that they are arrogant, stupid, and have nasty mouths.

He wants a private room because he hates his roommate, a man whom two days earlier he described as a really nice guy. The tension between them feels heavy. He is not allowed in several hospitals in the city for various aggressive acts he committed that he says were not his fault. He keeps pressing his call light without response. In response to his call, a passerby would hear his nurse cry out, “Oh no!” He yanks it out of the wall, screaming obscenities, as he throws it across the room. With a wild look in his eyes, his tall, thin frame teeters back and forth as he tries to support his weight on the crutches that bear his withered legs. He calls his doctor long after hours, demanding that he get right over here now to straighten out this mess these stupid idiots created. He has never seen such stupidity. He is raging out of control once again, saying, “That’s it; I am out of here!” His crises are unrelenting.

He signed out AMA, and was accompanied to a taxi by security. After a few days of angry acting out, he settles into another severe depression. No one can reach him by phone.

DISCUSSION OF CASE NARRATIVE

Tyrone’s story is familiar to many healthcare professionals and illustrates the complexity of the pain experienced by the patient, its manifestation in anger and self-destructive acts, and its impact on those involved in his care. This dramatic case of a 48-year-old African American man illustrates the psychiatric and psychosocial complications relevant to the treatment of HIV disease. It also illustrates the complex demands of its symptoms and complications and the detrimental effects of

untreated psychiatric illness. The case also addresses the need for interprofessional collaboration with all members of Tyrone's healthcare team—a need which was unmet due to lack of engagement because of violent behaviors; the role of the psychiatric mental health advanced practice nurse was the sole provider with whom he was cooperative. In this role, the psychiatric mental health advanced practice nurse served as the liaison to all others on the healthcare team since they were not able to establish and maintain rapport.

This patient was encountered by the psychiatric nurse practitioner and other care team members at a large acute care facility in the northeastern US. Due to multiple medical problems, he was being evaluated as an inpatient for hip replacement. Because of the risks posed at that time by multiple, chronic life-threatening infections, end-stage kidney failure, and his overall state of poor health related to advanced AIDS, doctors refused to perform the needed surgery caused by a motor vehicle accident that occurred six months earlier. This trauma caused multiple hip and pelvic fractures that progressed to osteonecrosis. The osteonecrosis was also likely worsened by his HIV status and antiretroviral medication therapy. We met when a psychiatric consultation was ordered because he presented as a behavioral problem on the unit. The patient admits he did not take his antiviral medication consistently; in fact, he took frequent drug and dialysis holidays. His infectious disease specialist validated this information, and his laboratory values were consistent with the patient's self report of poor adherence. His CD4 count was reported to be low, and his viral load was extremely high according to his infectious disease specialist.

In September of the same year, we met again on the same unit where I was a nurse when he was hospitalized for another infection, and at this time he expressed his wish to die. He had decided to stop dialysis. He told me that he thought he would be dead in three weeks. We met a few more times when he was a patient at the hospital. During one of our meetings, the conversation went like this:

"Ask me to live."

"You can't live because I want you to."

"Then you do want me to live."

"I think you have more living to do, and from what you say, I don't think you really want to die now."

"But do you want me to live?"

"Yes, I want you to live some more before you die. And I use the word "live" as an active process. We often die the way we live. And I think the way you are forced to live is causing you much suffering. From what you say, I think there are things you want to make peace with—to live in peace, to die in peace."

"I agree, but I am not sure I can do this."

"Well, until you are sure, you could make some choices to improve the way you feel, like dialyzing once again. That alone could improve the clarity of your thinking by removing toxins from your body".

My role at this time on the unit as a nurse and psychiatric nurse practitioner was to work with patients who were

considered "difficult." Later through funding provided by a grant, I became his nurse case manager at home. My role included giving nursing care for his physical health problems, assisting with peritoneal dialysis and medication management, as well as providing supportive psychotherapy. Two months later during one of our meetings, he said, "I don't want to die anymore. I feel like I am waking up from a very deep sleep." During the next several months, he made significant efforts to improve his health by consistently dialyzing, taking his prescribed medications (which totaled 117 pills per day), and performing self-care. After six months, blood tests revealed that the HIV virus was barely detectable, and his CD4 count had climbed to greater than 500 cells/mm³, according to his infectious disease specialist. Seven infection-free months later and in much-improved health, his hip was replaced successfully. During this period, he was hospitalized for more than two months. It was an intensely stressful time for him during which time he underwent several surgeries related to orthopedic and dialysis complications. His interactions with hospital staff were often hostile strained by transference and countertransference issues. During each of his hospitalizations, he made unsuccessful attempts to reconcile with his daughters, and these attempts would trigger increased hostile and aggressive interactions with his former wife. As case manager and in consultation with his team of care providers, visits were scheduled periodically while he was hospitalized. These visits did help during this period to contain his aggression so that he could obtain treatment. In the months following hip replacement, his health again began to deteriorate, complicated by behaviors related to his complex psychiatric comorbidities and the knowledge that the grant for case manager and homemaker services would not be renewed. Unfortunately, the grant was funded for one year, and all services expired, thus leaving this patient without resources to deal with his complex health issues at home. The patient was not considered homebound which was the reason nursing agencies refused his case, yet he only left his home to keep medical appointments.

On numerous occasions, Tyrone threatened and acted out suicidal dramas, as well as extremely self-destructive, and other violent and aggressive behaviors. Each episode resulted in setbacks in his recovery. His chaotic, angry, and confusing experience of relationships and self, paired with a lack of recognition and revision of his self-perpetuating harmful patterns and the accompanying raw emotional states associated with certain relationship roles made containment and management very problematic. His anger impaired his cognition in that it distorted his attention and information processing faculties. Immediate perceptions and actions were judged more relevant and weighted much more heavily than anything else. He dedicated all his attention to the immediate and ignored any potential future consequences of his actions. His depression and these personality-disordered strategies impaired his abilities to conceptualize, design effective strategies, and execute them. Each time he made the decision to live again, he started the journey back from a decreased baseline.

He would demand treatment on a privileged or preferential basis. Because of the interpersonal difficulties he presented, he often did not get the care he needed in the time he wanted it, and his frustration would mount. He was refused by a number

of homecare agencies. He would act out his frustration in self-destructive acts. Complaining of numerous symptoms, he tended regularly not to cooperate with recommendations. He regarded himself as very clever, more intelligent than most, even unique in that way, displayed a diminished capacity for empathy, regarded clinicians as inferior to him—all classic signs of the narcissistic aspects of his borderline personality disorder. He externalized his problems, blaming others for his numerous difficulties, and was always in search of someone willing to take responsibility for his life. His mood varied with degree of depression, anxiety, and despair. Anxiety was the frequent mode in which he experienced the war raging within. Depression seemed to relate to how he experienced perceived abandonment, rejection sensitivity, and his reservoir of aggression and violence. He often became severely depressed following an outflow of intense, angry, aggressive feelings, as if he exploded and then became buried under the weight of the rubble. He said more than once that he destroyed everything he touched. Through severe depression, he acknowledged that something was so fundamentally wrong and dangerous in him—that there is no way to gain the upper hand. His depression worsened each time following aggressive and rageful behavior or when he perceived abandonment or rejection. Three months following surgery, he stabilized at yet another decreased baseline and was discharged. Soon thereafter the issue of termination with his case manager was introduced. The grant had expired for case manager and homecare services, and he was unable to extend the grant. In his crowded, tiny, one-room home, surrounded by more than 30 large cartons of dialysis supplies, he was permitted a small pathway to move from bed to the door. He now had to begin a search for a new residence large enough to accommodate all his dialysis supplies without homecare services.

A period of nine months preceded termination with his nurse case manager. This period was chosen, as he was stable in that symptoms were not worsening. It was anticipated that it was going to take time to find the services he needed, to teach caregivers and the patient needed information and tasks, like performing peritoneal dialysis regularly, and to deal with the powerful and extremely difficult interpersonal issue of abandonment for this patient. Tasks to be delegated at this time included medication management; dietary planning; household tasks, such as cleaning, shopping for food and personal items; ordering and procuring medical supplies; laundry; and organizing his appointments. The increased involvement of willing family members, a friend, a neighbor, and services of the AIDS Action Committee were sought. He resisted these efforts as the termination exacerbated his abandonment issues. Efforts were increased to involve psychiatric services to no avail.

He suffered depressive symptoms in intense and self-fulfilling cycles. Underlying profound anguish was anger that came forth at the slightest provocation. His behavior would alienate those few remaining people who were close to him. His interpersonal relationships became distorted and disrupted, exacerbating his depression and his abandonment issues further, and interrupting the services he needed. He took aggressive, sometimes violent, actions to alienate further his few remaining friends and family members. Hostility, avoidance, and histrionic behaviors increased. His abandonment issues would motivate him to make

desperate and dramatic attempts to regain their attention. Some time after termination with his case manager, Tyrone moved to a new residence without case manager or homecare services and died nine months later.

The Theory: Understanding Tyrone's Story

Object relations theory [4-6] and attachment theory [7-10] emphasize the primacy of the basic need for closeness and relationship. The term "object" refers to another person who is the object of one's interest and impulses and, similarly, for the term "attachment." Kernberg's [4] and Gunderson's [11]. studies of borderline personality disorder describe typical characteristics of patients with severe attachment problems: intense feelings of abandonment, chronic anger, multiple physical and psychiatric symptoms, alternating good and bad representations of self and others, absence of healthy and engaging activities, frequent feelings of emptiness, impulsivity, use of defenses of splitting and projective identification, and a tendency to briefly lose touch with reality in intense interpersonal situations [4,11]. Object relations and attachment theory posit a wide spectrum of potential pathology in those without healthy attachment relationships ranging from reasonably functional with uncomfortable inner experiences to severely dysfunctional and extremely symptomatic. Patients fall generally within a certain range on the spectrum and alternately improve and regress. Tyrone would be on the far end of the spectrum, showing improvement with severe regression under stress. Fear of abandonment as a psychodynamic problem evidences itself in insecure attachment to others. The fundamental behavioral question in object relations and attachment theory is: what earlier relationship is being replayed and repeated and what object and attachment representations are stimulated or triggered? Because of Tyrone's history of trauma and abuse, he had no stable representations. Under the stress of powerful feelings evoked by fear and abandonment or anger and aggression in borderline personality disorder, there is a tendency to develop split representations of self and other and to project feelings onto others [12]. Tyrone was witnessed treating his caregivers as if they were those who had abused him. He re-enacted these patterns over and over. He needed a lot of reinforcement about how his behavior's created greater problems for himself, as Tyrone's self and other representations were formed long ago as a child and shaped within the experience of terror, and his current relationships triggered these old violent programs within him.

Even during more positive times, he considered his life, his experiences, his relationships, and past with a thick layer of grief and longing. In this sense, he was cognitively distorted. He perceived his experiences, self, and future in a totally negative way. This pattern helped to sustain the distorted perceptions. Support was often rejected for a variety of reasons and served as a kind of punishment at a psychological level. Neither accepted support nor success could completely break this cycle, probably because it was so conditioned and self-sustaining. Dysphoric affect supported distorted perceptions, which enhanced dysphoria, which encouraged self-defeating behaviors, which brought about failure, which justified depression. This circular pattern became protective because it was so predictable or familiar, never failing and available—the properties of the missing parent. In a sense, it

was both addictive and adaptive because it was a strong “object” or love substitute. Much like substances he used, it had its own rituals. It imposed schedules and behavior patterns on him. He slept all day, stayed awake at night, did not answer the phone, did not eat, did not perform peritoneal dialysis the necessary 4-6 times per day, nor take his antiviral or other medications. He did, however, awaken to smoke cigarettes and marijuana; take his diazepam and narcotics for pain often in amounts far greater than prescribed, leaving him without medication before month’s end. Issues related to substance withdrawal probably complicated his physical and psychological distress further. He avoided other situations even if they held the promise of improvement. In an effort to assert control over his life, he became further recalcitrant, often preceded by displays of borderline rage, not to comply with any treatments. He had been conditioned by repeated stimuli to freeze (immobilized in speechless terror huddled in the bathtub); he had no energy left to escape or rage against his cruel world. Later conversation revealed that he also relied on magical thinking. During these drug, dialysis, and self-care holidays, he thought that his health was not deteriorating because he had the distorted cognition that he was protected from or immune to the consequences of his own acts. Most of his self-destructive acts reflected this cognition. He thought everything stayed at the same level because he willed it that way. He was so filled with negative thinking about himself, his goals, his relationships, his emptiness, his loneliness, and uncertainty about so many things, that no cognitive or rational input seemed to affect the situation. It was immediately reinterpreted to fit his negative paradigm. Fear of death, some intervention, or some unknown factor he may have chosen not to disclose (withholding and punishing), eventually would prompt him to emerge by taking some action toward improvement. Only his fear of death was greater than his fear of life because he thought of himself as so flawed and evil. His religious beliefs, conditioned early in life, told him that the punishment of death would be greater than the punishment of life. Each time he emerged from severe depression, he had paid a heavy price in deteriorated health for accommodating his dysfunctional yet adaptive-for-survival inner narrative. He had never, prior to this period or during this period, been treated for depression or his personality disorder—except in a limited way within the prison and hospital systems to deal with the difficulties and challenges he presented to these systems—in part because of his own fear of psychiatry, but largely in part because of unavailability of psychiatric services to him.

Because issues of interpersonal control are prominent in borderline patients [11], psychotherapy and medication may take on meaning as agents of control and symbols of who is in control. Medication may be perceived as a chemical means by which the prescriber can control the patient. Taking medicine as prescribed may be seen as relinquishing control to the clinician. Gunther [13]. discussed countertransference reactions that may be unconscious and not helpful to patients among staff who work with patients who have had catastrophic injuries. Often Tyrone would leave the hospital for hours at a time. Inquiries into his whereabouts would reveal that the nursing staff did not know where he was or when he was expected to return. He was avoided because of the difficulties he presented to the staff. He was considered difficult, evoked strong negative feelings,

and countertransference reactions were often evident. Staff were relieved when he was off the unit. The nursing staff that has the most frequent and persistent interactions with patients who are considered difficult may be particularly stressed by the demands, psychiatric illness, or abusive behavior of these patients. Providing emotional support and education for nursing and other care providers to deal with these patients is vital. Countertransference reactions while interacting with these patients can be intense and difficult to contain. Instead of viewing these patients empathetically, care providers may instead view them as being ungrateful, unmotivated, provocative, and a threat to their competence resulting in avoidance or hostility. These responses may be conscious or unconscious [13-15]. It is stressful to work with patients who are angry, hostile, and potentially aggressive. Dubin [16] contends some patients’ angry explosions often are provoked at some level as responses to remarks and unrecognized punitive reactions that develop out of staff’s frustration, anxiety, or even unconscious rage which the patient living with borderline personality disorder will react with hostility or aggression. His symptoms of dementia seem to have worsened, but it was hard to separate out these symptoms from the effects of HIV disease; metabolic, electrolyte, and toxic derangements; depression; dissociation, acts intended to manipulate, anxiety; medication; and substance use.

Socio-health Context of Care for Mental Illness and HIV

Mental health and substance use disorders are considered to be major contributors and a problem of sizable magnitude to the burden of physical disease globally according to the World Health Organization (WHO) [17]. In its 2003 report, mental health disorders were described as “hidden behind a curtain of stigma and discrimination” which needs to be brought out in the open. It links mental health intrinsically to physical disorders, identify them as risk factors for poor and worsening physical health, and further interfere with adherence to treatments.

International organizations, funding agencies, business and governments were urged to seriously address the problems of the nearly 450 million people worldwide suffering from mental illness, calling for services that are more effective and humane[17].

Four of the six leading causes of disability were identified as psychiatric disorders, and a prevalence of 44% for major depression was found for persons living with HIV/AIDS [17]. Beyond the enormous health and social costs of mental illness, the report¹⁷ identified individuals living with mental illness as victims of human rights violations, stigma, and discrimination. It concluded that mental health and mental disorders are not given anywhere near the same importance as physical health but rather ignored and neglected [17].

On March 23, 2010 the Patient Protection and Affordable Care Act (ACA) [17] was signed. In purpose and intent, it addresses key issues of concern to all Americans and advances equality for persons living with HIV. At that time, nearly 30% of those living with HIV did not have any healthcare coverage¹⁹. In purpose and hope, it is one of the greatest acts of legislation in the fight against HIV/AIDS in our history. Insurance coverage, however, is not

the same thing as access to treatment. Shortages of psychiatric clinicians were at that time, and still are a serious problem and vary by region throughout the entire US [20,21]. These shortages represent a growing crisis and seriously impede access to care. The actual size of the problem in mental health is thought to be greater than reported but unknown because the data for mental health access is scarce or inconsistently collected. Part of the problem is that there is no consistent definition of mental health and the way data are collected or if collected at all. The same complexities were found when exploring insurance access to mental health.

The intent of the ACA [18] is to provide greater access to care and, as such, will increase the demand for mental health services within a scarce market of providers. It is estimated that 62.5 million Americans became eligible for mental health services in 2014 while the supply of mental providers was expected to decrease by 18-21% [22]. Available data indicate that psychiatric nurse practitioners continue to rise at a greater rate than psychiatrists and are more economically viable than psychiatrists [22] which potentially could serve as a realistic solution to the shortage of mental health services.

Mental health care is one of the most common unmet needs among persons living with HIV/AIDS and remains untreated for a variety of reasons [23]. As a nation, we cannot successfully reach the goals of the ACA unless we address at a systems level the mental-health needs resource availability and access challenges for persons living with HIV/AIDS.

CONSIDERATIONS FOR PRACTICE

The care needed by patients living with HIV and complex psychiatric issues is complicated. It is imperative that a strong therapeutic alliance with a mental health clinician who understands the psychological and existential issues of HIV be established as soon as possible in HIV care. With the trust and support of this therapeutic relationship as well as the potential understanding gained, it may enhance adherence and the much-needed continuity of care required by patients living with HIV disease or any potential chronic illness. It is important to underline the role of consultation-liaison psychiatry in the treatment and diagnosis of HIV disease. As this case illustrates, his medical needs and the management of his aggressive behaviors overwhelmed the patient and the system. Just as in prison, he was viewed as a discipline problem in the hospital. Security was often called to manage his behavior. On more than one occasion, he was encountered alone restrained to his bed. He was often found crying on these occasions and in a particularly regressed state. The collaboration between an infectious disease specialist and psychiatry was critical in addressing the many transitions and adjustments that this individual faced. Additionally, he needed someone to enable him to make the connections between his behaviors and the results of those behaviors.

In the beginning of the limited therapeutic work we did together, he worked very hard at making the connections with his past, present behaviors, and the problems they created for him now. Initially, he responded positively to the support and unconditional positive regard he was offered; however, as time progressed and the grant, which paid for his care, was

expiring, his abandonment issues threatened regularly to derail treatment. His needs were tremendous; no one person could possibly meet them all, illustrating how important the team is in working together. He did respond positively to the support and understanding he was shown. It was, however, of limited duration, offered too late, and insufficient for his needs. At one point, his infectious disease specialist requested that his case manager accompanied him to visits as he responded favorably to her guidance, and his cooperation was more easily gained with co-management of the plan. The patient was able to make the connections he needed to make with support, and with time could possibly internalize his own newly learned skills to manage and contain intense feelings.

For the borderline patient, crises may present as part of a defensive pattern related to earlier life experience. The first step in dealing with crises is to ensure safety, assess suicidal potential, and contain emotions and impulses. Under these circumstances, the patient's main concern is to obtain relief from his distress. A sense of being understood produces relief and helps to contain the behavioral disorganization and emotional turmoil. In this state, containment should be the clinician's goal. Failure to achieve containment usually leads to escalation of affect and possibly an increase in self-harming acts.

Even for the mental health clinician, the diagnosis of borderline personality disorder may be of limited value in treating the disorder. Ways of connecting its behavioral manifestations to the underlying internal and developmentally damaged processes would be of more use. This knowledge could then serve as a basis for appropriate interventions at an individual or group level, and the interventions can focus on the problems that lie at the core of these behaviors. Without an understanding of the distorted cognitions, faulty beliefs, and intense emotional states that drive these behaviors, the cycle perpetuates itself.

Given the amount and severity of the stressors that these patients have to face during their complex illness, depression needs to be promptly and aggressively treated. The approach should be an integrated approach that involves psychotherapeutic as well as psychopharmacological interventions and one that addresses the needs of the whole person. Individuals living with borderline personality disorder and depression are more likely to attempt suicide [24]. The comorbidity of borderline personality disorder and major depressive episode increase both the number and the seriousness of suicide attempts [25]. Death by suicide in borderline personality disorder may be the result of impulsivity, a core feature of the disorder, interacting with violent-aggressive tendencies²⁶. It may be difficult for patients and healthcare providers to determine if the struggle is just too hard to bear any longer or if social, psychological, or medical intervention would change the wish for death.

Also illustrated in this case is the role of the use and abuse of substances in the attempt to cope with psychiatric illness, devastating disease, sleep disturbances, and physical and emotional pain. The expertise of a psychiatric/mental health nurse clinician is needed to tease out aspects of these complex problems, as well as the nature of some of the neuropsychiatric complications. It is likely medication was worsening both his depression and anxiety. HIV dementia from years of untreated

HIV disease may also have been a contributing factor significantly affecting his memory.

Finally, psychosocial complications are very common in this population, and it is important for psychiatric/mental health nurse or advanced practice nurse to be aware and sensitive to these contexts in HIV care. From a psychotherapeutic point of view, treatment requires a commitment to full continuity of care considering both physical and mental health needs as well as psychosocial problems of living. Like the treatment of HIV, the treatment of mental health should not stop when an episode of depression has remitted, or anxiety is relieved. Continued treatment is part of the remission process. Regular mental health assessments are important and continue to be necessary so that appropriate intervention can be offered. Despite the pessimistic picture often presented by these patients, borderline personality disorder seems to lessen in severity within the first decade of treatment [11].

Given the critical importance of adherence to therapy for optimal patient outcomes, public health concerns, and quality of life for these patients, assessing and treating psychiatric comorbidity is a key consideration. Various forms of impulsivity are associated with borderline personality disorder [1]. The psychodynamic theme of impulsivity prominent in borderline personality disorder includes sexual impulsivity [11]. Individuals diagnosed with borderline personality disorder are more likely to engage in unsafe sex, exhibit greater sexual preoccupation, have earlier sexual exposure, engage in casual sexual relationships, have a greater number of sexual partners, engage in acts characterized by sexual victimization, and contract more sexually transmitted diseases [27,28]. Depression has been found to be associated with HIV treatment nonadherence²⁹ and is therefore a modifiable risk factor for poor adherence that needs to be actively targeted for treatment. The cost of HIV treatment is extremely high, and the risk of creating resistant strains of the virus increases by poor adherence [30,31]. Clearly, interventions to effectively diagnose and treat active psychiatric illness should be examined as a potential strategy to improve adherence and prevent the transmission of HIV infection to others.

Non-mental health professionals and those who provide HIV care may be understandably reluctant to treat depression because it is a specialty outside of their usual range or focus of practice. It is important for all clinicians to familiarize themselves with the recognition and the treatment of depression because many patients may not have the personal resources to seek appropriate psychiatric/mental health care or may be unwilling to be treated in a psychiatric/mental health setting. Assessing and addressing issues related to substance abuse is also critical to the comprehensive plan of care. The importance of the interprofessional team in developing a plan of care for complex patients is critical. In this case, Tyrone's care was more challenging since there was limited engagement of other mental health providers, physicians, social workers, and home health aides.

LIMITATIONS OF CASE NARRATIVE

This case narrative is an interpretation of the author's professional relationship over time with this patient. Some of

the case narrative contains data from the patient's perspective, collected through interviews and observation, and comes with innate bias. It is presented in as objective format as possible with rich description of the subjective experience of Tyrone. Specific details about the patient have been adjusted to preserve confidentiality.

CONCLUSION

Further study of the unique care needs of those with HIV and mental health issues is urgently needed. Patients living with borderline personality disorder and complex trauma may challenge our best personal resources for composure by the demands of their symptoms and behavior. This case highlights the importance of considering the phenomenological or prototypical aspects of depression in borderline personality disorder and complex trauma in individuals living with HIV disease. Analysis may reveal that depression in those who live with borderline personality disorder and complex trauma is only partially responsive to medication while more prototypical or character-related aspects of these depressions may persist and require regular ongoing psychotherapy in the various stages of the illness for which referral to a mental health specialist is recommended. Psychiatric nurse practitioners and clinical nurse specialists can provide psychotherapy, as well as prescribe medications, and some specialize in treating patients with medical co-morbidities. In addition, nurses have an understanding of the physical aspects of their healthcare needs as well. Mental illness compromised physical health, poor health-related quality of life, and poor support systems are complicated, synergistic, and intertwined. With the shortage of available psychiatrists, the professional expertise of a PMHNP could be part of a comprehensive treatment plan in HIV care. The PMHNP is well educated for the task.

This case emphasizes how both HIV disease and psychiatric comorbidity seriously affect health-related quality of life. Both conditions are clinically important and should be identified and treated early. Such treatment may reduce utilization of health services and improve health-related and overall quality of life. Further, issues of sexuality are prominent in individuals with borderline pathology and are associated with the increased risk of HIV transmission to others. Illustrated in this case was very early initiation of sexual activity and sexual abuse. In the context of mental health issues, many interactions and relationships become sexualized in patients diagnosed with borderline personality disorder. These factors combined with factors related to impulse control and the propensity of an "everything here and now" focus, places sexual safety at high risk. This case dramatically illustrates the need for research in the area of behavioral change in the care of those living with HIV and co-morbid psychiatric conditions. The literature in this area is limited, but there is evidence that HIV disease and its progression is, in part, driven by untreated psychiatric conditions, and that treatment improves outcomes and decreases risks. The individual with comorbid HIV disease and psychiatric illness, may be crying out for guidance, understanding, and acceptance. Compassionate, skillful integrated care is the only proper human response.

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