INTRODUCTION

The psychiatric assessment of people living with HIV invariably includes an inquiry about suicidal thinking and behaviours. According to the literature, there is a higher incidence of suicidal ideation, suicide attempts, and completed suicide among people living with HIV than in the noninfected population. Assessing this aspect of a complex disease process has many inherent difficulties, however, and obtaining reliable data remains a challenge.

Existing data indicate that many people living with HIV think and talk about their death at great length with people in their social network, and some ultimately carry out their long-thought-out plans. Suicidal thoughts and intent are more prominent at some stages of HIV disease than others.

Monitoring thoughts and feelings about quality of life, death, and suicide is an ongoing process that should take place in the context of an honest, open relationship between the person living with HIV and his or her caregiver. Many people living with HIV talk about the value of having a safe and confidential place to discuss their fears about their illness, the uncertainty and unpredictability they live with day to day, and their desire to avoid the protracted pain, dependence, and financial decline that can be associated with advanced HIV disease.

When caring for someone living with HIV, psychiatrists should anticipate affirmative responses to questions about suicidal ideas more often than not. The task for the treating psychiatrist is to
understand the meaning of this suicidal ideation and its motivation in the context of the person’s life, the stage of the disease, and the other difficulties that a person living with HIV encounters each day. Psychiatrists should also identify any underlying treatable psychiatric illness that may be contributing to suicidal thinking.

This chapter will focus on clinical work with people living with HIV. It is worth noting, however, that some HIV-seronegative people knowingly expose themselves to HIV, either through sexual behaviour or needle sharing. The dynamics underlying this self-destructive act (often related to issues of self-esteem) should be actively pursued and resolved.

CASE STUDY

SUICIDAL IDEATION AFTER INITIAL HIV DIAGNOSIS

A family physician, working in a large downtown general practice, requests a psychiatric assessment for one of her patients. Gloria is a 32-year-old woman of aboriginal heritage. She has known of her HIV-seropositive status for about six months and was probably infected about two years ago. Her present CD4 count is approximately 700. She was probably infected about two years ago by a former boyfriend who, unbeknownst to her, was an intravenous drug user uncertain of his HIV status at that time. Because she was using oral contraceptives for birth control, they had unprotected sexual intercourse over the time they dated. Her three children from a previous marriage are HIV-seronegative.

Her family physician describes Gloria as a usually happy and busy woman who is involved in her community and works for a community support service for First Nations families. Since learning of her HIV status, however, she has become increasingly sad and now has a marked disturbance in her sleep, appetite, energy, concentration, and libido. During her most recent appointment, she expressed to her physician pervasive feelings of guilt and shame about her HIV status and ongoing worries about her ability to care for her children when she becomes ill. She admitted to her doctor that she was beginning to have frequent thoughts of suicide, which she had not experienced in the past. She was formulating a plan of stockpiling a cache of medications including barbiturates, benzodiazepines, and alcohol. She thought that once she was out of the picture her children would face a much brighter future with their aunt and uncle, who are a young, healthy couple.

What are some general principles in assessing someone living with HIV who has thoughts of suicide?

The psychiatrist must be comfortable dealing with death and dying issues. Someone’s honest and soulful account of his or her suicidal ideation should be met with compassion and empathy rather than fear, minimalization, and medicalization. While it is the psychiatrist’s task to identify treatable psychiatric illness, thereby improving quality of life, it is also the psychiatrist’s duty to listen to and understand what patients are saying.

A thorough suicide assessment of someone living with HIV includes:

- a complete history and mental status examination.
- a review of past psychiatric illness, previous suicidal thinking and behaviours, and substance use or abuse. Patients with a history of anxiety or mood disorder, characterological disturbance, or substance use may be at greater risk of acquiring HIV (because of increased risk-taking behaviours, decreased impulse control, impaired judgement, needle sharing). This history may also contribute to suicidal ideation. Several authors identify previous psychiatric illness and suicide attempts as the greatest predictor of those behaviours in people now living with HIV.
- a current psychosocial assessment, examining the person’s support network, leisure and recreational activities, activities of daily living, and connection to community support services. The more positive social connections a person has, the less likely that person is to attempt suicide.
- discussion about current medical status and medications. The number of symptoms someone has is more predictive of suicide than the actual CD4 cell count.
- an understanding of the person’s general philosophy about suicide, including cultural, religious, and ethnic factors. It is quite common for a patient to decide to commit suicide at some
time in the future, when the illness progresses to a point the person considers intolerable (for example, first opportunistic infection, decline in immune function). These thoughts are not necessarily associated with increased risk for suicide and even seem to help patients regain some sense of control over their lives. The threshold for what one can tolerate changes over time, particularly if illness progression is slow.

Are there predictable times when people living with HIV are more at risk for suicide?

Yes. When they are first diagnosed with HIV, many people react with disbelief, anxiety, and fear of what may lie ahead. They may become depressed and develop suicidal thinking. Effective pre- and posttest counselling can help reduce the risk of depression and suicide at this stage of the disease.

People living with HIV may become increasingly suicidal when their medical condition deteriorates. A drop in CD4 counts, an opportunistic infection, a hospitalization, or onset of treatment with antiretrovirals can trigger suicidal thinking. Suicidal ideation also increases in times of pain. In a survey of 103 HIV-seropositive outpatients, 39% of those with pain had suicidal ideas compared with 19% of those without pain.

Losses, especially when cumulative, are significant. The course of HIV disease is marked by a series of losses and crisis situations (for example, death of friends, loss of employment, rejection).

The death of a partner is particularly painful because it deprives the individual of his or her most intimate relationship at a point when there may not be sufficient time left to develop that level of intimacy again.

If a person living with HIV meets the criteria for major depression, the psychiatrist should treat the condition. Depression should not be assumed to be a normal reaction to a difficult life situation. If the diagnosis is unclear, the psychiatrist can consider a therapeutic trial given the decreased potential for suicide with newer antidepressants and their improved side effect profile. (See Chapter 4 on mood disorders.)

EPILOGUE

Gloria was diagnosed with a major depressive episode. Her social support was good, she was in no pain, and she did not abuse substances. She was, however, grappling with her recent diagnosis. She was started on a serotonin reuptake inhibitor and was seen for weekly supportive psychotherapy. Her psychiatrist recommended a group therapy program that was specifically for persons recently infected or recently informed of their HIV status.

Over the next few months, Gloria improved and her depressive symptoms decreased. She was able to discuss her fears and misinformation about HIV infection with her psychiatrist and in the group setting. The group members also provided significant support with their
common experiences and sharing of information.

CASE STUDY

SUICIDAL IDEATION IN THE LATER STAGES OF HIV DISEASE

Peter is a 42-year-old man who has been HIV-seropositive for approximately 12 years. He enjoyed a successful and challenging career as a corporate lawyer but, because of his declining health, has not worked for the past several years. He lives at home with Marc, his partner of eight years who is HIV-seronegative.

Peter has had a stable but low CD4 count for many years; in the past few months, however, his cell counts have continued to drop and he has developed several AIDS-defining illnesses, including an episode of Pneumocystis carinii pneumonia and the appearance of several Kaposi's sarcoma lesions on his back and legs.

As part of his ongoing effort to keep disease progression under control, Peter spends much of his time visiting various doctors’ offices and hospital clinics. He confides to an outpatient social worker that he is growing increasingly tired of his diminishing quality of life, the medicalization of his day-to-day routine, and the inevitable dying process that is approaching. He has begun to notice minor changes in his motor functioning (namely handwriting and walking), and he is concerned that these are the early signs of brain involvement. He states that if he were to develop more central nervous system symptoms or dementia, he would want to end his life so that he would not burden his partner, who would have to nurse him until his death.

Worried about Peter’s suicidal thinking, the social worker calls a psychiatrist. She is concerned that Peter may require hospitalization, psychiatric treatment, and possibly involuntary admission under provincial mental health legislation.

Should Peter be seen immediately and detained under provincial mental health legislation?

Suicidal ideas can be a symptom of major depression and may resolve with treatment, but most suicidal thoughts in people living with HIV are not a symptom of depression. These thoughts are a way for people to regain a sense of control when they are suffering from a condition that is extremely unpredictable. In this sense, they can serve an adaptive function.

In a crisis situation, it might be helpful to ask the person to postpone any final decision until a time when the emotions are not so intense, rather than trying to remove suicide as an option completely. Involuntary admission should be used with caution.

More collateral information from the social worker and Peter’s partner confirmed that Peter still feels able to press on and is not imminently planning to kill himself. Peter did tell the social worker, however, that at the point at which he can no longer tolerate the day-to-day difficulties he faces, he has a plan to end his life with the assistance of his partner.

In view of this extra information, the psychiatrist determined that Peter did not need immediate assessment in the emergency department. He made arrangements to see Peter and his partner within the next few days in his outpatient clinic.

During that interview, Peter’s partner, Marc, confirmed that they both agreed that suicide was an acceptable option. Marc would prefer to care for Peter until his natural death, however, because he finds every minute with him precious. He is quite concerned that Peter does not readily ask for or accept help, even in the face of obvious need. Peter defends his attitude by saying that he sees no value in caring for a debilitated partner and that things will be much easier for Marc after his death.

What are the different aspects of social support that should be explored as part of an assessment for suicidal ideas?

In assessing social support, the psychiatrist should consider the following points:

- The person’s perception of social support is more important than the actual number of people available. Even though the person may have stable social support, his or her perception of that support may change as the disease progresses.
- People living with HIV fear being abandoned, but they also
fear losing their autonomy. Anxious caregivers may get overinvolved, depriving the person of a sense of autonomy. Referral to community resources for friends and families might alleviate their anxiety and help restore better boundaries.

The person living with HIV may not be comfortable asking for help or may hope that the caregiver will guess what his or her needs are. The psychiatrist can explore the reasons for this reluctance and encourage more open communication.

An HIV-seropositive individual may be angry when not receiving all the help he or she feels is needed. This anger can be translated into suicidal ideas.

Some people living with HIV may want to spare their loved ones the painful experience of caring for them until death. This may indicate that the sources of support are becoming exhausted and that some additional resources are needed. This thought might also stem from a discomfort in being cared for. It is important for people living with HIV to have open discussions with their caregivers: can the caregivers deal better with suicide or with natural death?

Some people living with HIV (particularly gay men) have lost several friends to the illness and may wonder who will be left to care for them.

Suicidal ideas are common in people living with HIV. They usually present as a desire to end life at a certain point in the future. Most of the time, however, when these individuals reach the point when they once thought life would no longer be worth living, they find that their outlook has changed.

Can a physician assist a patient who wants to commit suicide?

The Canadian Medical Association has recently reiterated its position against physician-assisted suicide. In Canada, physician-assisted suicide is illegal.

What clinical approach should the psychiatrist take?

The psychiatrist can:

- explore the patient’s satisfaction with quality of life and its determinants.
- assess for the presence of reversible factors that negatively affect quality of life: pain and other treatable physical symptoms, lack of social support, clinical depression, recent crisis, difficulty with role transition.
- explore specific fears related to death. Does the patient fear pain or isolation? The psychiatrist should reinforce the role of palliative care as it relates to the patient’s fear and review the services available in the community.
- examine his or her own countertransference. Death anxiety may lead to a cold or an overcontrolling attitude in the health care professional. Psychiatrists should be aware of their values about what constitutes meaning in life. Would they accept living with muscular weakness? with chronic diarrhea and fever? with blindness? with disfigurement? Would he or she at some point feel that life is not worth living?

Some months later, Peter visited the psychiatrist again. He was terminally ill, and he asked for a prescription of barbiturates, vaguely saying that he planned to go to Florida for some time. The psychiatrist shared with him his impression that Peter wanted to commit suicide, which Peter did not deny.
these limitations. Do not overlook reversible sources of suffering that contribute to the patient’s wish to die.

- remain supportive even if he or she disagrees with the patient’s decision. The therapeutic alliance need not suffer if open communication is maintained. Psychiatrists should explore the meaning of their refusal to prescribe for the patient.

- seek support. The psychiatrist is encouraged to seek support and supervision when dealing with this complex emotional and ethical issue.

CASE STUDY

SUICIDAL IDEATION IN A CRISIS SITUATION

The psychiatrist-on-call attends the emergency department for a referral from the emergency room physician. Mary is a 28-year-old woman brought to the hospital by a friend who found her after she took an overdose of heroin. Mary has been successfully resuscitated and appears to have had no significant sequelae from her overdose. She insists on leaving the hospital.

She tearfully recounts a series of very sad and tragic events. Apparently, Mary’s two-year-old son died two weeks earlier at the children’s hospital from vertically transmitted HIV. Three months before that, her husband had died from a heroin overdose. He had suffered from advanced HIV disease with mild to moderate dementia and was in a wheelchair because of motor coordination difficulties. In his suicide note, he said that their son’s advancing disease and his own terminal illness were no longer tolerable and that he wished to end his pain and suffering.

The psychiatrist’s assessment reveals moderate to severe neurovegetative symptoms of depression with marked hopelessness, helplessness, and suicidal ideation. Having focused her attention on her son’s and husband’s illnesses, Mary has been neglecting her own health care, and she remains quite isolated in the community. Preliminary laboratory tests indicate her CD4 count is 350 and that her general state of health is not grossly impaired.

How should the psychiatrist manage Mary’s care?

In this case, there is a crisis situation and a clear focus for clinical intervention. Mary was admitted involuntarily under provincial mental health legislation. Further history revealed her lack of connection with community support services for HIV-seropositive women and her distrust of “the system.”

After several days of supportive care in the hospital environment, including detoxification and rest, Mary began to feel much better. Her mood improved, her suicidal ideation diminished, and she felt more hopeful about her future.

The psychiatrist helped Mary make many contacts in the community for women’s resources, including an HIV primary care physician and drug and alcohol counselling.

HIV disease is associated with loss. At all stages of the disease, caregivers should strive to optimize the person’s quality of life. Any intervention that increases longevity but has a significant negative effect on quality of life should be assessed carefully.

CONCLUSION

Suicidal ideas are common in people living with HIV. They usually present as a desire to end life at a certain point in the future. Most of the time, however, when these individuals reach the point when they once thought life would no longer be worth living, they find that their outlook has changed.

When people have more immediate thoughts of suicide, the psychiatrist should meticulously review the factors that contribute to the patient’s dissatisfaction with life, putting particular emphasis on areas where intervention is possible.

When someone who is terminally ill talks about suicide, this can elicit anxiety in the therapist. In this situation, psychiatrists should try to understand their counter-transference reactions. It may be useful to seek the support of a colleague in these difficult moments in order to remain emotionally available to the patient for as long as possible.

RESOURCES

MULTIPLE-CHOICE QUESTIONS

1. During an initial psychiatric assessment for a person living with HIV, the therapist should:
   a) ask questions about suicide gingerly to maintain a supportive relationship with the patient.
   b) not ask about suicidal thinking because the patient will raise the topic if it is an issue.
   c) tell the patient he or she may need to be admitted under provincial mental health legislation if suicidal thoughts are revealed.
   d) empathically inquire about the patient’s thoughts about suicide, previous suicidal behaviours, and current concerns.
   e) focus on the evaluation of major depression.

2. When a person living with HIV has thoughts of suicide, which one of the following statements is true? Involuntary admission is:
   a) always the safest thing to do.
   b) never indicated.
   c) occasionally needed for someone in a situation of crisis.
   d) rarely helpful; the patient will commit suicide at a better time.
   e) illegal.

3. Which of the following statements is true? The risk of suicide in someone living with HIV:
   a) is always high.
   b) increases as the person nears the end of life.
   c) varies over the course of the illness at certain predictable times.
   d) increases only when the patient decides he wants to die.
   e) is not increased.

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