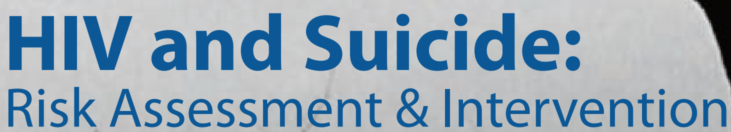

HIV and Suicide:
Risk Assessment & Intervention

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HIV and Suicide: Risk Assessment and Intervention

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Introduction

Suicide, attempted suicide, and suicidal ideation are complex clinical issues that may arise during the course of care for HIV-infected patients.[1, 2] Suicide is among the leading causes of death around the world, and is the 8th leading cause of death in the U.S., with 31,000 *reported* suicides per year, or 11.3 per 100,000 Americans.[3]

- An estimated 4.6% of people in the U.S. have made at least one suicide attempt.
- A prior suicide attempt is one of the best predictors of eventual death by suicide.[4,5]
- Even more Americans - about 16.8 million each year - have suicidal ideation, which includes thoughts about killing themselves or a wish to be dead.[6]
- Chronic diseases, including HIV, put people at increased risk for suicidal ideation, suicide attempts, and completed suicide.[7,8] Compared to people at high risk for suicide who do not have HIV, people living with HIV (PLWH) have significantly increased frequency and severity of both suicidal ideation and death thoughts.[9]
- Suicidal behaviors in PLWH may be associated with an initial HIV or AIDS diagnosis, advancing disease, symptoms of illness, psychiatric disorders, and substance use.[10] Stigma, quality of life concerns, and issues regarding disclosure may also be contributing factors. Among PLWH, estimates indicate that:
    - As many as 2 of every 5 meet DSM-IV criteria for a mood or anxiety diagnosis.[11]
    - 30% have clinically relevant depression.[12]
    - 1 of 5 meet the criteria for a diagnosis of substance abuse or dependence, with some estimates as high as 40 – 60% specifically for alcohol abuse/dependence.[13,14]
    - 1 of 12 have diagnoses for both mental health and substance related disorders.[11]

- Substance use and sexual abuse are both risk factors for contracting HIV, and both increase the risk for suicide.
    - Autopsies reveal that alcohol was a factor in 25%-50% of those who died by suicide.[6]
    - A history of physical and/or sexual assault may also affect the risk of suicide; multiple assaults significantly increase suicide attempts.[12]
- "Suicide contagion" is the exposure to suicide or suicidal behaviors within a family or peer group (direct exposure) or through media reports (indirect exposure). Suicide exposures have been shown to increase suicidal activity in at-risk individuals, and can extend to the clinic setting. There is evidence that one patient's suicide can increase suicidal thoughts and actions among other patients.[15]
- Approximately 50% of people who completed suicide saw a primary care provider during the month before their deaths, and over 30% saw a mental health provider in the year preceding the suicide.[16]

Differential Diagnosis for Suicide

Mental status changes can increase the risk of suicidality and must be carefully assessed. It is important to assess for the following, which may affect mental status:[17]

- Systemic conditions such as endocrine abnormalities: hypogonadism and hypothyroidism
- Opportunistic illnesses such as CNS toxoplasmosis, cryptococcal meningitis, progressive multifocal leukoencephalopathy (PML), cytomegalovirus (CMV), TB, meningitis, or opportunistic neoplasms including primary Kaposi's sarcoma (KS) and CNS lymphoma
- Alcohol or drug intoxication or withdrawal symptoms
- Neuropsychiatric side effects of HIV medications, other medications, or drug-drug interactions
- Direct effect of HIV infection (e.g., HIV-associated dementia, HIV-induced mania, HIV-associated minor cognitive-motor disorder)
- Primary psychiatric illness (e.g., depression, mania, posttraumatic stress disorder)

Suicidality may be the direct physiological result of HIV (e.g., minor cognitive-motor disorder, which mimics symptoms of depression and may be an early stage of HIV-associated dementia), or a reaction to chronic pain, or an emotional reaction to having a chronic and life-threatening illness.

Treatment should include the risk assessment and intervention steps described below. If cognitive and mood changes are determined to be caused by HIV infection, treatment should also include antiretroviral (ARV) therapy that crosses the blood-brain barrier.[17] Antiretroviral medication recommendations change frequently as new findings emerge. Be sure to consult with HIV-care specialists and current federal guidelines to determine the best combinations of ARV therapies for each patient.

Don't be afraid to ask!

- Ask about suicidal thoughts in a nonjudgmental way.
  - Use normalizing questions such as: **"It is common for people with a chronic illness to have thoughts about suicide. Have you ever thought about harming yourself or killing yourself?"** Be sure to ask about both past and current ideation.
  - Use open-ended questions/statements to persuade the patient to talk honestly about suicidal thoughts. For instance, if a patient answers "yes" to the question above, you might follow-up with: **"Tell me about those thoughts."**
  - Ask about past responses to suicidal ideation, including any previous suicide attempts. You might say, **"Tell me what you've done in the past when you've had these thoughts."** Other follow up questions might include, **"Have you ever made a plan to kill yourself?"** or **"Have you ever tried to kill yourself?"**
- Asking about suicide does ***not*** make a patient more likely to commit suicide nor does it "put ideas into the patient's head."
- Failure to ask about suicidal ideation is often related to the care provider's discomfort with the topic, lack of time, or lack of skills in this area. Providers need to overcome those obstacles to provide comprehensive care to their HIV-infected patients.
- Thoroughly document all discussions about suicide or suicidal ideation.

Increased **risk for suicide has been associated with:**[18,19,20, 21]

- Past suicide attempts
- Family history
- An organized plan for suicide
- Suicidal ideation

- Substance use, including alcohol
- Impaired rational thinking
- Hopelessness about the future
- Limited social support
- Mood changes such as anxiety, anger, or feeling trapped
- Illness and uncomfortable disease symptoms
- Social withdrawal
- Being male (females make more attempts, but males are more likely to complete suicide)
- Age > 45 for men, > 55 for women

If a patient has suicidal ideation, assess the following:[6,19]

- Does the patient have a **plan**?
  - If the patient has thoughts about death or suicide, find out if there is a plan – or even ideas – about how to commit suicide.
  - Encourage the patient to discuss details of the plan.
- Does the patient have the **means** to carry out the plan, and how lethal are those means?
  - **All methods should be taken seriously,** but some methods (jumping from heights, guns) are more lethal than others (cutting, pills).
  - Find out if the patient has access to the method (e.g., a gun or pills).
- Does the patient **intend** to carry out the plan?
  - Find out if there is a timeline for the plan.
  - Ask when or under what conditions the plan might be used.
- **What holds the patient back?**
  - Ask what the patient has to live for.
  - Ask about plans for the future, or if anything needs to be finished before the patient dies.
  - Ask and listen. Don’t tell the patient why you think s/he should live. Give the patient time to think and respond.

Don't Rely on "No-Suicide" Contracts Alone

- These contracts are not effective if used as the provider's only intervention.[6,22,23]
- These contracts may increase, rather than decrease, legal risk if the provider fails to take appropriate and sufficient action.[22,24]

Don't Rely on Antidepressants Alone

- Antidepressants can alleviate depression, but their effectiveness in reducing suicidal risk has not been conclusively demonstrated.[6]
- Antidepressants may increase suicide risk.[25] Patients who experience an increase in energy but still feel hopeless may be more likely to attempt suicide. Changes such as a decrease in depression, a sudden sense of relief, a newly calm demeanor, or giving possessions away may indicate that the patient has decided to commit suicide.
- Tricyclic antidepressants can be fatal when combined with alcohol, so avoid prescribing tricyclic antidepressants with suicidal patients.
- Consider prescribing smaller amounts of medications with suicidal patients.

Always Refer to a Mental Health Professional if a Patient Seems Suicidal[26]

- Be aware that arranging mental health care can take time. Develop a referral network of mental health providers knowledgeable about HIV.
- Psychiatric hospitalization may be necessary.
- Counseling (a licensed professional counselor, social worker, psychologist or psychiatrist) can reduce suicidality,[6] especially as an adjunct to other treatment methods.
- Lithium (prescribed by a psychiatric care provider) may reduce suicidality.[6] However, the potential toxicity of lithium

overdose needs to be taken into consideration. Lithium has a narrow dose range, and can be lethal in overdose.
- For patients with psychotic symptoms, an antipsychotic medication (prescribed by a psychiatric care provider) may reduce suicidality.[6]
- Substance use (including alcohol) should be addressed.

Prepare the Patient for Referral
- Find out as much as possible about the actual procedures for a mental health referral in advance, in order to orient the patient and arrange the referral.
- Explain your level of concern, and explain that you want the patient to have additional help.
- Emphasize that working with a mental health professional will help you to assess the problem, in order to implement appropriate treatment.
- State that you will continue to be the patient's primary care provider for HIV, and that you will work closely with the mental health professional to coordinate care. Make it clear to the patient that you are not "handing them off."
- If necessary (e.g., severe, active suicidal thoughts with a plan or a recent attempt), call 911.

Maintain Frequent Contact and a Strong Relationship
- Let the patient know that you are willing to talk about a broad spectrum of feelings, including suicidal thoughts.
- Help the patient develop a coping plan in case suicidal thoughts occur.
- Coping plans could include calling a friend, a care provider, 911, or the local suicide hot line.
- Ask the patient to write the coping plan on a card to keep for future reference, especially during a severe bout of depression when details such as telephone numbers can be forgotten.

Summary

Given increased suicidality in people with HIV, assess HIV-infected patients routinely, know local mental health resources, and do not hesitate to refer for mental health care.

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