SUICIDALITY AND VIOLENCE IN PATIENTS WITH HIV/AIDS

I. INTRODUCTION

RECOMMENDATIONS:

Clinicians should clearly instruct medical support staff about how to manage emergencies involving patients with suicidal or violent behavior, such as contacting emergency services or isolating the patient from other patients.

Clinicians should obtain an emergency evaluation if they determine that a patient is at imminent risk of harm to self or others. Patients who are not at immediate risk should be referred to outpatient mental health services when the mental health treatment by the primary care clinician is unsuccessful.

Clinicians should assess HIV-infected patients for depression to ensure early detection and treatment of patients who may be at increased risk of suicide due to depressive symptoms.

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.

Key Point:
A significant percentage of patients who commit suicide will have seen their primary care clinician in the month before their suicide. This underscores the importance of routine mental health screening in the primary care setting, which can help identify patients who are at risk for suicide and enable them to receive treatment for the underlying cause of their suicidal behavior.

This chapter discusses suicidal and violent behavior, self-injurious behavior, and the desire for hastened death. Suicidal behavior is defined as suicidal ideation; suicide attempts; deliberate self-harm, with or without suicidal intent; or completed suicide. Violence is defined as the threatened or actual use of physical force against another person with the intent to cause harm.

II. PREVALENCE AND RISK OF SUICIDE AND VIOLENCE

A. Suicide

Rates of suicidal behavior have been more widely studied in gay men than in other populations,[6] although some studies have shown that HIV-infected women have higher rates of suicide attempts than HIV-infected men.[7,8] Studies conducted before the introduction of HAART indicated an increased risk of completed suicide in patients with HIV/AIDS that was 7 to 36

times greater than in the non-HIV-infected population.[9,10] Since the introduction of HAART, more recent evidence suggests that suicide among HIV-infected patients may be mediated more often by factors other than HIV, including depression, alcohol, or other substance-related disorders. Because patients with suicidal behavior often present with comorbid depression, screening for and timely treatment of depression may reduce a patient's risk for suicide. For information regarding depression among HIV-infected patients, see *Depression and Mania in Patients With HIV/AIDS*.

Suicide risk in HIV-infected patients may be higher than in populations with other chronic medical illnesses, such as cancer.[11] Evidence suggests that risk for suicidal behavior increases during the initial weeks following a diagnosis of HIV disease and then declines as patients adjust to their HIV status.[1,2] However, as patients' health and quality of life decline, risk of suicide may again increase,[3,4] particularly among middle-aged and older patients, who frequently experience poorer health-related quality of life when progressing to AIDS.[3]

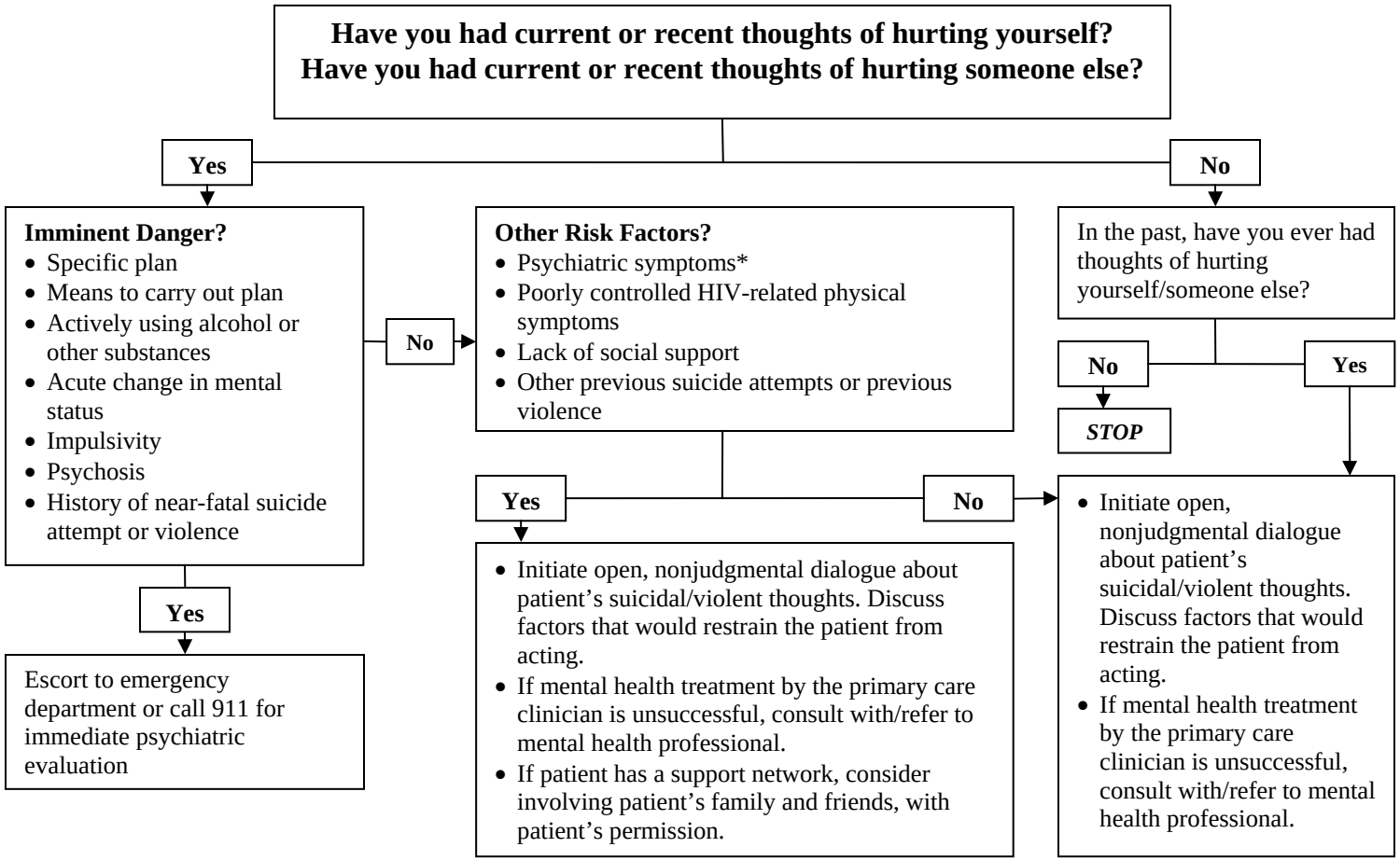
B. Violence

No documented studies have established increased rates of violence among HIV-infected individuals compared with noninfected 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.

Key Point:
The combination of mental health and substance use disorders places people at the greatest risk for violence.[12]

III. 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.



*Psychiatric symptoms such as depression, hopelessness, or agitation.

Figure 1. 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 (see Figure 1)**.**

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.

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 • Past 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.

* This 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.

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.

Key Point:
People who lack adequate impulse control may represent a serious risk despite stated wishes not to harm themselves or others.

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. 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

IV. 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.

Key Point:
Social support is fundamental to effective management of suicidal and potentially violent patients and can enable patients to accept help. Sources of support may include involvement of family, friends, or community-based services and the clinician's interest in understanding reasons for patients' wishes to harm themselves or others.

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. 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 (see Figure 1)**.**

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. 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 (see Figure 1).

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

Key Point:
Patients with chronic suicidal and/or violent ideation often require long-term psychiatric treatment.

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. 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.

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	A mental health assessment should be performed to address any correctable problems, such as depression and poorly controlled anxiety, pain, or delirium.

	reversible mental health disorder, most notably depression, which could contribute to their wish to die.	
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*.

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FURTHER READING

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