Suicide among people with AIDS thrusts upon everyone involved serious philosophical, legal, and ethical dilemmas. Health professionals often find that these profound questions of life, death, and choice disrupt their sense of professional obligations and force a review of moral responsibilities and legal restrictions.

Suicide is an especially pertinent issue in AIDS because of the profound and progressive nature of the disease, the seeming unchangeability of the condition, and the often painful and disfiguring deterioration that occurs. These factors may place thousands of people—from those with evidence of HIV infection to those with AIDS clinical disease—at particularly high risk for despair and hopelessness and thus at eventual risk for suicide. As the incidence of AIDS has risen, health care professionals have found themselves becoming involved with increasing numbers of clients with suicide-related concerns.

The Extent of the Problem
The scope of the suicidal ideation, attempts, and completed suicides among people with AIDS is unknown due to the lack of epidemiological data. However, the numerous anecdotal reports from across the United States and the limited record-keeping by San Francisco agencies indicate that suicide is, indeed, a salient issue in AIDS. Hospice of San Francisco has documented thirteen suicide attempts and six completed suicides in persons with AIDS from October 1984 to April 1986. In a recent six-week period (February-March 1986), the Shanti Project identified eleven persons with serious suicidal ideation, seven suicide attempts, and one completed suicide. The San Francisco Medical Examiner estimated that six to twelve persons with AIDS committed suicide in 1985. Since suicides are difficult to detect, this number may be low. The Tenderloin Outpatient Mental Health Clinic also reported that of the eight persons with AIDS and fourteen persons with ARC seen there, three had attempted suicide. In addition, the San Francisco Suicide Prevention Center reported that it receives 60 to 100 AIDS-related telephone calls per month.

While these numbers in no way reveal the extent of suicide in persons with AIDS-related health problems, they do indicate that it is likely that practitioners will be confronted by the many issues related to suicide in working with these individuals. Although the large urban centers with high numbers of AIDS cases may also have larger numbers of suicide-related problems, it is likely that similar problems exist in smaller communities. The possibly greater isolation and limited support services for people with AIDS in smaller cities may contribute to suicide behavior.

Definitions and Distinctions
AIDS-related suicide behavior is a specifically defined term which delimits the problem. Suicide behavior includes suicidal thoughts, suicide attempts, and completed suicides. Suicide attempts range from efforts by those with a high intention to kill themselves to those whose aim is other than self-destruction, for example, a cry for help. The term AIDS-Related refers to the whole range of AIDS concerns for those who are diagnosed with AIDS or ARC, those who are experiencing grief related to AIDS, people who have concerns related to their antibody status, and generally anyone who has concerns related to contracting the disease.

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The Euthanasia Society has defined Rational Suicide as a suicide in which the mental processes leading to the decision to commit suicide are unimpaired by psychological illness or severe emotional distress. Also, the motivational basis of the decision would be understandable to the majority of the person's peer group. For example, an individual may seek consultation about how to complete a suicide when the pain and deterioration have increased beyond the point of endurance. Thus, rational suicides can be compared with suicides in which the mental processes of the individual are clouded.

Responsibility of the Clinician
The basic premise of this discussion is that a clinician must understand and balance a person's right to competent professional psychological care with the right to die with dignity. With this in mind, the first responsibility for clinicians who counsel people considering suicide is to understand clearly what has led to their clients' suicidal thinking. The clinician must identify whether reasons exist for the person's thinking to be clouded. By helping clients clarify their thoughts and feelings, more satisfactory options may be developed. For people who continue to seriously consider suicide after carefully examining the issues, the clinician must consider taking more active measures, such as psychotropic medication or involuntary hospitalization.
AIDS-related suicide... continued from cover

The law in the United States clearly disallows clinicians from aiding and abetting a person to commit suicide. Individual states address this issue differently. For example, in California the Welfare and Institutions Code provides specific conditions under which the health provider is required to intervene to prevent suicide, i.e., if a person is judged to be a danger to self due to “mentally disordered or defect.” Under these circumstances the clinician must admit the person for psychiatric hospitalization — even if this is against the person’s wishes.

Difficult questions arise throughout the counseling process of suicidal clients. Some of the difficulty lies in the realm of clinical judgment: “Are the individuals truly a danger to themselves?” Vagueness in psychological theory and practice may also make decisions difficult: “What is meant by mental disorder or defect? Is suicidal thinking by itself an indication of psychological illness?” Other questions are more philosophical and ethical in nature: “Are there ever situations in which clinicians can agree with their clients that they are better off dead?”

In other words, are there rational suicides? If so, what is the clinician’s responsibility — a passive stance of noninterference or a more active stance of assisting? What are the limits of this assistance?

Legal Issues
Health professionals should consider three legal concerns to help determine their clinical responsibilities toward clients who are considering taking their own lives: (1) malpractice, (2) aiding and abetting, and (3) the need to hospitalize or detain people on an involuntary basis.

Malpractice. In terms of malpractice, the courts have taken a realistic view of the uncertainties inherent in clinical science. To avoid liability, the practitioner does not have to be proven “right” by the outcome. But clinicians have been found liable for defective clinical reasoning; for example, for the failure to recognize the risk of suicide and for underestimating the seriousness of the risk and for not taking the precautions needed to counter it. Burszatjn, Grutheil, Hamm, and Brodsky have outlined three standards by which possible negligence can be evaluated: (1) community standard, (2) maximization of benefits relative to costs, and (3) reasonable and prudent practitioner.

Community standard means that clinicians have exercised due care if they have done what others in the relevant professional community would do in a similar circumstance. Maximization of benefits to costs is a way to understand the complexity of decisions on the part of the clinician in order to prevent a client from committing suicide. The decision to hospitalize a client (voluntarily or involuntarily), to place a patient under closer observation and restraint in the hospital, or to discharge a patient is a complex one requiring the clinician to balance a host of possible costs and benefits. What is known as the “Learned Hand Rule” holds that negligent behavior represents the failure to invest resources up to a level that is equal to the anticipated savings in damages. The courts do recognize, however, that no amount of precautions can give absolute assurance that the patient will not commit suicide. The question here is “Could the clinician ‘reasonably’ have been expected to foresee the likelihood of a completed suicide or suicide attempt or taken greater precautions to prevent it?”

Aiding and abetting. Although it is not illegal to commit suicide, some state laws (such as those in California) clearly forbid aiding and abetting. This applies to everyone, not only health professionals. Such forbidden activities might include providing the actual means for committing suicide or actively encouraging a client to undertake a suicide. Aiding and abetting is considered a felony. Furthermore, health care providers cannot tell patients how to commit suicide. Informing someone about the Hemlock Society, by itself, would probably not constitute aiding and abetting. The courts would probably look on this in light of other actions taken by the practitioner.

Decision to hospitalize. When deciding whether to hospitalize or detain people on an involuntary basis, the clinician must balance overreacting (taking unnecessary restrictive actions to protect the client from himself) and underreacting (not taking appropriate measures to protect the individual). Paramount issues related to balancing legal responsibility involve protecting the client from self-harm and the rights of clients not to be unjustifiably incarcerated.

A legal requirement for the clinician working with a suicidal client is that of informed consent. Informed consent is the discussion of treatment options with the client, such as antidepressant medication and hospitalization, including the possible negative side-effects of each.

Clinicians must be especially careful to maintain confidence when dealing with people who have AIDS-related concerns. The possible damage to a person is considerable given the hysteria and possible reprisals connected with AIDS. This issue is made more difficult at times when people are assessed to be imminently a danger to themselves. At such a point their safety supersedes their rights of confidentiality.

The conclusions of Bursztajn, Grutheil, Hamm, et al. are relevant to these AIDS and suicide issues: (1) clinicians should feel reassured by recent court decisions which demonstrate a congruence between clinical and legal standards; (2) clinicians need to understand legal standards of negligence and informed consent; (3) clinicians are best safeguarded from malpractice suits by careful documentation of both objective information and subjective information; (4) clinicians need to review treatment options with clients and document the process of informed consent for treatment; (5) clinicians should request and document consultation in cases where action on the part of the clinician can be misconstrued.

Summary. Suicide issues are always difficult for the health care worker; the controversial social and political nature of AIDS only compounds the difficulties. Yet this complex issue is one that is likely to confront practitioners in increasing frequency as the number of people affected by AIDS continues to increase dramatically. An understanding of the ethical and legal concerns involved can help alleviate some of the uncertainty and distress for health care providers who cope with this emotionally-charged issue.

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REFERENCES

Diagnosis/Treatment
Suicide: Clinical Aspects

Peter Goldblum, PhD

To provide competent clinical services to people with AIDS-related suicide behaviors, the clinician must be aware of basic suicide interventions and be adept in applying them to the more specific AIDS issues involved. The following discussion highlights clinical insights derived from working with people who experience the full range of AIDS concerns.

Countertransference
Emotional issues surrounding AIDS may cloud clinicians’ judgment. Clinicians unfamiliar with working with medically ill
clients may feel overwhelmed by the pertinent medical information and terminology. Clinicians may also be affected by several countertransference responses. These include the following:

1. Clinicians should recognize their own reactions and biases when working with people who have suicidal thoughts related to AIDS.
2. Clinicians must face their own death anxiety. The uncertainty regarding the course of the illness may be unsettling to clinicians as well as to clients.
3. Clinicians must balance overreacting (taking unnecessarily restrictive actions to protect clients from themselves) and underreacting (not taking appropriate measures to protect clients).
4. Clients with long histories of unsuccessful involvement in the mental health system (especially those with severe personality disorders) may prompt clinician reactions that can cloud their judgment in assessing these clients' suicide risk.

General Suicide Assessment. In assessing the suicide potential of a person with AIDS-related concerns, the first step is to consider standard risk factors for suicide: depression, recent loss, substance abuse, age, sex, current stressors, prior suicidal behavior, current plan, resources, and support system.

Risk Factors for Suicide in Other Life-Threatening Diseases. Risk factors for suicide that have been identified in patients with life-threatening diseases may be helpful in alerting health providers to suicide risk among people with AIDS.

Faberow found distinctive psychosocial differences between terminally ill cancer patients who committed suicide and a control group of terminally ill cancer patients who did not commit suicide but who died from their disease. Characteristics of those who committed suicide are summarized below:

1. emotional stress over and above the physiological aspects of the disease;
2. exhaustion of physical and emotional resources (including a feeling of lack of family and hospital support);
3. prior suicide attempts;
4. significantly more complaints of pain and discomfort;
5. near-death physical condition;
6. alcoholism and drug abuse involvement.

Specific Risk Factors for People with AIDS-Related Concerns. There have been no formal studies to determine if there are factors which specifically place a person with AIDS-related concerns at risk for suicide. However, the following represent possible risk factors gleaned from clinical insight (These observations pertain mostly to working with gay men):

1. multiple losses related to AIDS — either deaths or illnesses of friends or lovers; or other losses, such as employment or housing;
2. intimate involvement with another person who has died of AIDS (This past experience often has a decided impact on people as they enter the final stages of their own illness);
3. different stages of the disease may pose different risks of suicide and personal needs may change as the illness progresses;
   (a). The Recently-Diagnosed Stage — The person may have a lack of information related to the course and nature of the disease and may not understand the resources that are available.
   (b). The Midstage — At this stage a person's defenses may begin to break down and thoughts of death and suffering may intrude the consciousness.
   (c). The Final Stage — At this stage clients confront increased issues of dependency, pain, and loss of control of bodily functions.
4. great anxiety for people with ARC who are uncertain of their health status and their future, find their life planning disrupted, experience a loss of physical stamina, and enjoy little of the special "status" given to those with AIDS;
5. recent notification of a positive result from the AIDS antibody test;
6. discrimination, insults, or injury due to fear of AIDS or homophobia;
7. personal histories of losses related to homophobia (family history of rejection, history of employment or legal problems related to being gay);
8. a prevailing attitude that "the world is a dangerous place to be gay" and subsequent suspiciousness and anger toward non-gays;
9. remaining in "the closet," that is, taking part in homosexual behavior but avoiding identification with the gay community and thus often experiencing guilt and personal conflict;
10. an unsettled sexual identity, especially experienced by adolescents who feel that they may be gay;
11. lack of a social and financial support system that is adequate for coping with the AIDS epidemic.

Personality Factors
Personality factors play an important role in how people cope with the full range of AIDS concerns. Segal and Tuckel suggest that a person's psychological make-up is more important than any particular disease in affecting the suicidal or non-suicidal outcome for a person coping with terminal illness.

People with severe personality problems may be blocked in their access to services due to their manipulative behavior and management problems.

Jerome Motto proposed a classification scheme of two distinct categories of people at risk for committing suicide. The two models are (1) those who are "stable and experience a forced change" and (2) those who are chronically "alienated.

The first group commit suicide after a significant loss or threatened loss. These individuals have a "high" rating for overall stability or prior life patterns. The "alienated" group, on the other hand, experiences suicidal ideas extending over years or a lifetime. These people have chronically low self-esteem. They may commit suicide without an apparent significant loss.

Clinical Interventions
The following clinical issues are important in working with people with AIDS-related suicide concerns.

1. Develop a good working alliance. Blocks to the alliance must be understood and worked through. If blocks cannot be overcome, the client should be referred to another mental health provider.
2. Clients with AIDS-related concerns come from a broad spectrum of racial, cultural, and sexual backgrounds.
3. Discussion of suicidal thoughts should be initiated early. Given the progressive, deteriorating nature of the disease, suicidal clients may plan their suicide many weeks in advance for when "the time comes." The final act may follow a change in health status, which may "trigger" the suicide.
4. Wherever possible, patients should be allowed choices and be given an active role in their treatment. People with AIDS and ARC may think of suicide as a means of having a measure of control over their lives.
5. Cognitive approaches to depression and hopelessness have been found to be useful tools. Beck has emphasized the importance of perceived hopelessness in suicidal potential. Efforts to help clients derive a measure of hope in the crisis is important.
6. Clinical assistance to support networks (lovers, friends, family) should be made available. People with AIDS moving into the final stage of the illness may commit suicide as an altruistic act to protect loved ones from protracted suffering.

continued on page 4
7. Suicidal thoughts may be an expression of anger directed at people in the immediate support system or the larger system. Encouragement of expression of feelings is an important starting point.

8. Suicidal thoughts may accompany the loss of physical attractiveness and changes in body image. These concerns must be taken seriously and the mourning of these losses validated.

9. Issues of blame and guilt are very complicated for people with AIDS-related concerns. Issues of internalized homophobia are particularly important in determining how gay people cope with AIDS concerns. It is important to allow people to express negative thoughts and feelings and then discuss how they want to relate to them.

Summary. Clinical services offered to people with AIDS and AIDS-related complaints may well ease the distress associated with concerns about suicide. Most people with AIDS and related health problems do not attempt to commit suicide. However, thoughts about taking one's own life are likely to accompany any life-threatening illness.

REFERENCES
1. Working group of mental health specialists convened by the UCSF AIDS Health Project to discuss the dual problems of AIDS and suicide behavior, April 1986.


BRIEFS

IN REVIEW


Although the author can be complimented for introducing AIDS to the teen audience, this novel is not great literature. It cannot compare with the grace and style of the novels of, say, J. D. Salinger or Rosa Guy. The teen characters, all from a privileged white suburb of New York City, seem overly interested in the latest designer jeans, and the constant reference to current rock music groups is an irritating intrusion into the plot.

Even with these limitations, "Night Kites" is still an important contribution to juvenile literature. The characters cope with realistic problems and, like real teenagers (and adults), they are often clumsy in their solutions. They have faults. They have feelings. They have sex.

When protagonist Erick's older brother Pete returns home diagnosed with AIDS, members of the family deal with their own fears and prejudices as well as the judgments of others, with varying levels of success. There are no miracle cures in this novel and no Hollywood ending. Readers do get a real sense of Erick's growth and grief — and his own type of personal triumph — by the novel's end.

AIDS educators, social workers, and other health professionals can appreciate the lack of popular literature that addresses AIDS in a realistic manner. This recent entry into the teen reading market helps demystify the health crisis, and may lessen the fear and isolation felt by young people who encounter AIDS in their circles of friends and family.

— Reviewed by Marcia Quackenbush, MS, MFCC, Coordinator of Youth and AIDS Prevention Program, UCSF AIDS Health Project.

RECENT REPORTS

Women with AIDS: A Comparison of Sex Differences. Women from the non-I.V. drug user ('other') category were diagnosed with AIDS later and entered hospitals for initial treatment at a higher level of illness severity than patients from all other comparison groups, according to a study conducted in New York City. Joanne E. Mantell and her colleagues at St. Luke's/ Roosevelt Hospital Center and New York Medical College also found that female patients had the longest average length of hospital stay. The study looked at sex differences in diagnosis, illness severity, treatment, hospitalization needs, and socio-demographic data.

These women also had the least amount of body system involvement in their illness and expressed the fewest number of suicidal threats. In sharp contrast to four-fifths of the male subjects, only one-half of female patients exhibited at least one form of neuropsychiatric behavioral problems that interfered with treatment. The researchers commented that "this finding might suggest that CNS [central nervous system] involvement manifests differently in women as compared to men, or that women exhibit more compliant behaviors during hospitalization." Researcher Mantell and her colleagues advised that caregivers should consider the reasons for women's apparent delay in seeking medical care. They also suggested that the problems of women with AIDS, such as care of dependent children after their mothers' deaths, merited special attention. The New York researchers presented their findings during the International Conference on AIDS in Paris.

The amount of research information now appearing in the medical and lay press staggers most AIDS health care and service providers. This newsletter represents an attempt to place much of the data and press reports in a context that will prove meaningful and useful to its readers. Suggestions and comments are welcome and encouraged. Please address correspondence to Editor, AIDS Health Project, 333 Valencia Street, 4th Floor; San Francisco, CA 94103. For information about the other AIDS Health Project programs, call (415) 626-6637.

NEXT MONTH

Health care professionals are well aware that the public perception of AIDS affects every aspect of their work — from patient care and hospital policies to education and service delivery. Public attitudes about contagion, new therapies, levels of research funding, homosexuality, and I.V. drug use are frequently gauged and monitored by national polls. In the December issue of FOCUS, Stephen Mills, doctoral candidate in communication at the University of Michigan and research analyst at SRI International in Menlo Park, California will look at the trends and changes in the public perception of AIDS during the last five years.

In addition, medical specialists from San Francisco General Hospital will discuss the management of psychiatric patients with AIDS on an inpatient psychiatric ward. Jay Baer, MD; Susan Lewitter Koehler, RN, MS; and Kris Holm, RN will consider the difficulties with patient disposition, symptom management, the kinds of patients being seen, and the rate of increase of psychiatric patients on Ward 7B, the hospital's inpatient unit for psychiatric AIDS patients. Baer is the attending physician on Ward 7B; Holm is the acting head nurse, and Lewitter Koehler is a clinical nurse specialist.