



pro-
gressively so
with advanced immuno-
suppression. Therefore, when HIV-related
immuno-compromised persons become subject to
CNS-associated disorders, it can complicate the clinical picture, also regarding suicidal behaviour. Symptom presentation can occur along a constellation of cognitive, motor and behaviour changes characteristic of sub-cortical dementia, variously referred to as AIDS dementia complex (ADC), HIV-encephalopathy or HIV-associated dementia (HAD), and (during the early HIV-infection stage) minor cognitive-motor disorder (MCMD). Initial neuropsychological performance decrement can include psychomotor slowing (retardation), deficits in fine motor speed and dexterity, problems with cognitive flexibility, difficulty with concentration/attention, problematic memory/ retrieval, deficits in visuo-spatial skills/visual scanning, lability of mood/social disinhibition, and unexplained seizures. It is not clear how such neurocognitive complications affect decision-making processes and act as risk factors in suicidal behaviour and these aspects require further research⁵. Studies^{5,6} have described enhanced neurocognitive performance in some HIV/AIDS-positive persons after highly active ARV therapy, and the question of potentially reducing suicidal behaviour following such improved cognitive function also needs further research.

Management

Prevention of suicidal behaviour should be part of HIV/AIDS public education programmes within an appropriate socio-cultural context. The well-known suicide prevention and management interventions³ can be integrated into HIV/AIDS counselling

programmes.

An initial evaluation

should include assessing possible psychiatric and neurocognitive complications, a history of pre-morbid psychiatric disorders, and the onset of new psychiatric/psychological disorders. Suicidal ideation might be high during the risk periods, but in many instances these tend to reduce if the person comes to terms with living with the disease and has access to effective treatment, which should also include psychosocial support and stress management.

Finally, negative perceptions in both HIV/AIDS-positive persons and in the general public should be changed. Research³ in this regard has clearly shown that in any potentially-life threatening disease, it is not always the fear of the disease itself that presents as a suicide risk factor, but rather how it is perceived and managed.

Acknowledgement

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Selected References on Request