

# Suicide and Suicidal Behaviour in Learning Disability

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# What is a Learning Disability?

- WHO - 'a state of arrested or incomplete development of mind'.
- Somebody with a learning disability is said also to have 'significant impairment of intellectual functioning' and 'significant impairment of adaptive/social functioning'
- Individuals with a learning disability have:
  - Major difficulties with adaptive skills (cooking, handling money etc)
  - An IQ of less than 70 (average is 100)
  - Both of which should have been present before the age of 18 and not solely attributed to a head injury, infection or neurological problem
  - Only small no.of people have specific syndrome, most cases aetiology is unknown
  - You would walk past many people with a learning disability and never observe their difficulties – also many individuals are never detected or within services

# Individuals with a Learning Disability are....

- In the bottom 1% of the population in terms of intellectual functioning
- Vulnerable to abuse & exploitation (physical, emotional, sexual & financial)
- Less likely to be accepted in society
- Viewed as useless or a burden on the state by non-learning disabled people
- Less likely to be accepted into work
- Often have poor social and coping skills
- Less likely to have friends or be in a relationship (v small no.of individuals get wed)
- Increased risk of mental health problems
- Increased risk of isolation
- Increased risk of drug & alcohol abuse
- Increased risk of epilepsy & poor health
- Living in poverty
- Living alone

How good would you  
feel about yourself ?

Might there be times when you  
feel like ending it all ?

# Societal assumptions about suicidal thoughts in people with a learning disability

- “She is mentally retarded – how can she kill herself?”
- There is nothing we can do to help them
- “She has been saying she’s going to top herself for years, and she’s still here!”
- They’re just doing it for attention....
- She only took 20 paracetamol, if she was really serious.....
- “He hasn’t got the intellectual ability to be able to kill himself”
- “We don’t need to worry about him, the suicide risk is next to nothing – he’s retarded”
- “People with learning disability don’t feel anything”
- “People with a learning disability are not capable of committing suicide, so there is no point in putting resources into it”

## What does this mean for our clients?

- Thoughts and feelings get ignored
- Poor recognition of how people's lives really are
- No-one bothers to check out feelings – clients continue to feel low and bad
- Episodes of self harm are minimised
- Suicide attempts are minimised/ignored (doesn't seem possible)
- Clients don't get the help they need
- People with a learning disability do not appear in the literature or in the suicide data
- The National Confidential Enquiry do not record whether an individual has a learning disability
- Clients with a dual diagnosis will get lost in the data HENCE it seems that PWLD do not have suicidal thoughts

## Do people with a learning disability experience suicidal thoughts?

- Clinical experience tells me that this is a real problem for a significant minority of clients – 10% of referrals to psychology in my team
- Vastly under researched and under reported area
- Literature suggests that PWLD do experience suicidal thoughts, just like anyone else
- Clients often have poor problem solving skills and are less resilient to difficulties

# What the literature says about completed suicide

- Suicide is a relatively rare event in any population (5/100,000 female, 16.2/100,000 males – 2007 ONS figures)
  - 1300/year 'patient' suicides – representing 27% of all suicides in UK (NCI – Preventable Deaths, 2006)
  - 84 suicides/week in UK + 150,000 attempts/year (Eldrid, 1993)
  - 1 million suicides each year worldwide (WHO)
- LD prevalence rates reported to be @ 1/3 general population rates – but likely to be an underestimate

## What the LD literature says

### Patja 2004 follow up study

- 10/2677 individuals committed suicide. Notes available on 5/10.
- Case 1 – IQ – 52. Early traumatic life. Hx of psychosis and EP. Two previous attempts – death by ingesting cigarettes.
- Case 2 – IQ = 61. Childhood neglect. SZ. Sister committed suicide. Death by drowning.
- Case 3 – IQ = 62. SZ and EP. Attention-seeking behaviour. Numerous attempts. Death by OD of rifampicin (anti TB drug).
- Case 4 – IQ = 52. No psychiatric problems. Enjoyed cycling – almost hit by a car, was told off by driver. Death by hanging that day.
- Case 5 – IQ = 54. Depression and delusions. ECT failed. Death by drowning.

## What the LD literature says Patja 2004 study continued

- Common features of clients include:
  - 8/10 cases in contact with mental health services at time of death.
  - Long history of psychiatric problems
  - Lack of ability to handle socially difficult situations or abuse

## Suicide cases – 35 year follow up study (Patja, 2004) – predictors of suicide

- Severe psychiatric problems – of early onset and resistant to treatment
- Family history of suicide
- Untreated or under treated depression. Dual diagnosis hampers clinical diagnosis of depression.
- History of abuse
- Low levels of social support
- Communication problems

## Clinical and community study (Lunsky, 2004) 1

- Canadian study reported that half of admissions to psych. units (in those with LD) due to suicidality
- Tend to be more common in those with mild LD
- Suggest that thoughts and gestures are similar, but methods are different (linked to availability) – anecdotal evidence suggests this this is not the case locally
- Vastly under-researched and under reported

## Lunsky, 2004 study 2

- Recruited clients with borderline – moderate LD in a project investigating psychosocial risk factors for depression.
- 99 heterogeneous participants
- Investigated:
  - Mood, anxiety, suicidal ideation, loneliness, social support, stress levels
  - 98 completed information on suicidal ideation
  - 26/98 thought life was not worth living some of the time
  - 7/98 thought life was not worth living all of the time
  - Of the above 33/98 – 11 had a plan in place and had made previous attempts

## Lunsky, 2004 study 3

- Lack of social support, unemployment, loneliness, stress, anxiety and depression all associated with suicidal ideation – similar to general pop again
- Bereavement and abuse strongly linked to completed and attempted suicide
- Clinical implications – staff and families should be made aware that suicide can happen in this client group, learn what to look for and how to deal with it
- Ask the question ....if you don't ask you won't necessarily know !

# Management of depression and suicidal behaviour – Menolascino *et al.* (1989) 1

- Professional literature does not report on affective disorders in those with LD
- Psychiatric Aspects of MR Newsletter (1982) recommended:-
  - Differentiate between suicidality and SIB
  - Describe suicide attempts in terms of lethality and intent
  - Analysis and treatment of underlying psychiatric diagnosis
  - Determine future clinical risk for suicide to be based on past personal and clinical history of individual (as in any case).

# Management of depression and suicidal behaviour – Menolascino *et al.* (1989) 2

- Suicidal gestures in those with LD often overlooked or confused with SIB. Lethality of attempts is often low – gravity of intent sometimes minimised. If the person themselves considers it to be life threatening – deemed a suicidal gesture, regardless of the outcome.
- Present eight cases + describe their management:
  - 8/305 to show suicidal behaviour
  - 7/8 female
  - 7/8 mild LD, 1 = moderate LD
  - 5/8 – depressed and had severe adjustment reactions
  - 2/8 schizophrenia
  - 1/8 – bipolar disorder
  - Suicidal ideation secondary to psychiatric disorder

- Significant challenges in each case:-
  - Identifying underlying psychiatric disorder
  - Providing active intervention
  - Attempting to reintegrate person into community life with support to maintain emotional stability.

Most cases had psychotherapeutic input on some level.

Psychiatric assessment needed in all cases

# Mood disorders in LD (Hurley, 2006)

- Mood disorders frequently identified in individuals with LD, completed suicide rare
- Can be atypical presentation
  - Aberrant eating patterns
  - Challenging behaviour
  - Change in general behaviour
  - Suicidality
- Epilepsy is a strong predictor of suicide (Hurley, 2002)

## Suicide, mental health and autism – what the National Autistic Society have to say

- People with ASD especially vulnerable to secondary mental health problems (adolescence and early adulthood)
- Communication probs. - problems may be well developed before recognised – we may see total withdrawal, obsessive behaviours, aggression and threats, suicidal behaviour and attempts on life
- Suicide prevention strategy – in those with ASD - should focus on promotion of mental well-being

# Suicide, mental health and ASD

- NAS (2001) study
  - 32% experienced mental ill health, of whom 56% depression, 8% had felt suicidal or had made attempts.
  - Practitioners estimate a higher pattern of suicidal impulses in those with ASD (14/27)
  - Early diagnosis and intervention essential to good mental health
  - Clients with ASD extremely unlikely to be rated as a suicide risk
  - 65% Asperger's have co-morbid mental health problem
  - Link between Asperger's and 'schizoid personality' – more likely to manifest suicidal behaviour
  - Paucity of data on the management of such clients

# Key issues in ASD

- Learning disability
- Depression
- Bullying
- Unemployment
- Social isolation
- Single status
- 8% in sexual relationship (NAS, 2008)
- Prejudice – within peers and professionals
- General social exclusion due to having a communication problem
- Lack of confidence

# What NAS say about suicide management in those with ASD – mainly preventative

- Recognition of specific risk factors (probs. with communication and interaction)
  - Unemployment, living alone, alcohol/drug misuse
- Increased recognition of ASD by professionals – early diagnosis favourable
- Specific knowledge of co-morbid mental health problems in psychologists and psychiatrists – early treatment and prevention
- Do not ignore the risks

# A look at the risks for suicide in general population – no different in LD

- Male
- Living alone/unsupported
- History of psychiatric problems
- Unemployed/retired
- Previous episodes of DSH
- Poor physical health (epilepsy?)
- History of previous admissions to hospital
- ASD
- Alcohol & drug misuse
- Single, widowed or divorced
- High degree of hopelessness
- Open expressions of desire to commit suicide
- Lethal methods readily available
- Associated with conduct disorder in adolescents
- ?personality disorders
- Poor social support

# Management of acute suicidality in clients with LD

- Be aware that it does happen
- Consider how client may communicate suicidal feelings .....is it really any different?
- Think about risks:
  - Imminent
  - Long term

# Case examples

The right approach (or not)??

# Self harming behaviour

# Self harming behaviour what is self harm?

- Things that people do to themselves in a deliberate, and usually, hidden way. Anecdotal evidence indicates that people with LD are less able to conceal this activity (or have less opportunity?)
- It can involve
  - cutting and scratching
  - burning
  - scalding
  - ingesting toxic substances or objects
  - picking and poking at skin

## Self harming behaviour

- Average age of onset = 12 years
- highest incidence = 11-25 years
- In UK 142,000 young people attend A&E due to DSH each year (massive underestimation)
- Many more don't go to hospital
- incidence decreases with increasing age

# Self harm in the general population

- Viewed as a symptom of underlying emotional distress and dysregulation
- can be a means of coping with problems and is an effective way to regulate the emotions and make you feel better
- hard to give up, as it is very effective coping mechanism
- vastly under-reported, even in those in therapy (Arnold & Babiker, 2002)
- associated with shame, anger, guilt and hopelessness

# Self harm and people with learning disabilities

- Little is known about it
- LD literature covers SIB and pica
- some people with mild/moderate LD and being referred to treatment services for DSH
- seems to be a bigger problem in secure services (up to 58% in-patient pop)

# Self harm in the LD population

- Associated with physical, emotional and sexual abuse
- being treated 'like a nobody'
- self harm is commonly seen in those with BPD
- CSA is strongly associated with BPD
- reported protective function of DSH
  - not hurting others
  - doesn't affect anyone else

# Techniques to manage DSH

- Evidence from DBT literature (Linehan, 1996)
  - distress tolerance skills
  - emotional regulation skills
- Can be applied to those with LD, small amount of evidence - although may need to be more directive with clients
- DSH is strongly associated with suicidality
- Maladaptive coping strategy
- Is always at top of my therapy action plan – give client tangible/transferable skills, increases self efficacy, not 'doing things to client'

# Case Examples

Clients who self harm

Questions?