Crisis and Suicide
Demographics and Risk Assessment Inclusive of the Learning Disability Population

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Crisis Theory
Precipitating event
Perception of the event
Failure of usual coping mechanisms
CRISIS

危機
The Chinese word for crisis shares a character with the word for opportunity.

機會
Crisis Theory

- Three Core Components
  - A precipitation event occurs: The experience of stressful events is not itself a crisis.
  - Perception of the event: Leads to subjective distress. These feelings or emotions can feel overwhelming to the person in crisis. Still not a crisis in and of itself.

Crisis Theory

- Usual coping methods fail: If normal coping is not effective and the person feels overwhelmed, a crisis has occurred.

Crisis Intervention

- Change in client perception
- Decrease in client distress
- Increase in client functioning
  (Kanel, 1999)
Number and Rates of Suicide by Age Group and Gender, Canada, 2000-2003

![Graph](image)

Methods of Suicide - Males
Canada, 2003

![Pie Chart](image)

### General Statistics

- About 60 – 70% of those who complete suicide are seen by a physician within the preceding 8 months.
- 20% of the people who kill themselves have visited their doctor in the week prior to killing themselves.
- Suicide is the fifth most common cause of premature death.
- Suicide is second only to accidents as the cause of death for people under the age of 35.
- up to 14% of the Canadian population considers killing themselves every year.
- in Canada, suicides claim from 10-40 victims per 100,000 per year depending on the age.

### Additional Information

- Suicide is one of the leading causes of death in both men and women from adolescence to middle age.
- 27-39% of people who completed suicide had experienced a stressful life event within the six weeks preceding their attempt (Rich, Richard, Fogarty and Young, 1988).
- Being physically attacked, was one indicator of increased risk for suicide among Montreal area students (Tousignant, Hanigan, 1993).
SI and Intellectual Disability

- Has not been extensively studied
- Published incidence data reveal that negative thoughts about living, intent to kill oneself and potentially lethal suicide attempts occur in 6-34% of community living adults who have an intellectual disability

SI and Intellectual Disability

- Not much known about risk factors for attempted suicide
- Strongest association seems to be persons with mild to moderate cognitive impairment;
- And have a diagnosed mood disorder, most commonly major depression
- (Luiselli, JK et al., 2008)

Intellectual Disability Statistics

- Finnish Study, 2001 examined suicide mortalities over a 35 year period. Results: Women with an intellectual disability had an equal suicide rate to Finnish women in general, while men had 1/3 of the population risk. Risk factors were similar to those in the general population.
- Most of the suicide victims has a mild I.D.
- (Patja K. et al, 2001)
Intellectual Disability Statistics

- Canadian study examined mental health of Canadians with self-reported learning disabilities aged 15-44yrs
- Results: Persons with a learning disability were more than twice as likely to report high levels of distress, depression, anxiety disorders, suicidal thoughts, visits to MH professionals, and poorer mental health than those without disabilities

- Males with L.D. were more likely to report depressive episodes, anxiety disorders and consultations with health professionals
- Females were likely to report high distress, suicidal thoughts and poor general mental health relative to people without learning disabilities
- On balance, LD were not found to more detrimental to mental health for one gender or the other
- (Wilson, A et al., 2009)

Dual Diagnosis and Suicide

- Women diagnosed with D D in the Provincial Psychiatric Hospitals (PPH) have higher rates of suicide attempts than men with a DD, prior to receiving PPH services (5.2% male vs 15.2% female)
Dual Diagnosis and Suicide

- Comparison of Younger and Older patients with a DD on Diagnosis: Suicide Attempt
  - Under age 65: 10.4%
  - Over age 65: 1.6%

Symptom Severity for Patients by Status: Suicide

Suicidality and anxiety were more commonly reported in those with mild disabilities vs those with severe disabilities.

Intellectual Disability and Suicide

Diagnosis and Clinical Issues for Patients With and Without a Dual Diagnosis: Suicide Attempt

- Dual Diagnosis: 15.3%
- Non Dual Diagnosis: 22%
Intellectual Disability and Suicide

Symptom Severity for Patients With and Without a Dual Diagnosis (mean scores): Suicide

Dual Diagnosis: 2.41
Non Dual Diagnosis: 2.06

*these scores are based on likert scale of 1 to 9 with 9 being most severe

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

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)
Vastly under-researched and under reported
(Lunsky, 2004)
Suicide behaviours in intellectually disabled patients (Bobinska, K et al, 2009)
- Hospitalized individuals in Lodz, in 2006 diagnosed with intellectual disabilities
- No statistical significance in attempting suicides depending upon sex
- Statistical significance depending on level of intellectual disability—more patients who were more mildly impaired attempted suicide
- Frequency of committed and attempted suicide was lower than in general population, however should not be ignored.

S.I. and Intellectual Disability
- State institution experienced 9 suicide attempts per 1000 patients (Sternicht, M., 1970)
- 90 consecutive admissions to inpatient ward for adolescents with ID, found 10 adolescents who made attempts.
- 6/10 of those acts were potentially lethal (Walter AS et al., 1995)

S.I. and Intellectual Disability
- Large clinic for individuals with SI reported 12 patients who made suicide attempts and 10 who had SI.
- Methods used in that study were: ingestion of medication, cutting self with sharp object, suffocation and ingestion of toxic liquids were the most common methods found (Benson BA, Laman DS, 1988)
S.I. and Intellectual Disability

- Study of 204 sudden deaths among patients with Intellectual Disability over 50yr period in institution found 1 suicide which resulted from the individual jumping off a bridge (Carter G, Jansen J., 1983)

Risk Assessment:
Predictors of Suicidal Behaviour

- Precipitating Factors: Acute factors that create a crisis, leading to suicidal ideation (Health Canada, 2002). These factors may be an event such as:
  1) Interpersonal conflict
  2) Perceived or actual losses eg love, esteem, wealth, health, innocence (after an assault)
  3) Anniversary reactions on the dates of major losses. *Note individual may not be aware of impact or significance of date.

Risk Factors for Intellectual Disability Which May Impact Suicide Risk

Social Factors:
- Conflicts with family members, residents, or staff members
- Difficulty developing fulfilling relationships
- Physical, sexual and psychological abuse
Possible Precipitating Risk Factors

These are areas that may be identified as potential stressors:

- Interpersonal loss or rejection,
  - Loss of parent, friend or caregiver
  - Breakup of romantic attachment
  - Being fired or suspended from school

- Environmental
  - Overcrowding, excessive noise, disorganization
  - Lack of satisfactory stimulation
  - School or work stress

- Transitional Phases
  - Changes of residence, school or work
  - Developmental landmarks (e.g., onset of puberty)

- Parenting and social support problems:
  - Lack of support from family, friends or partner
  - Destabilizing visits, phone calls, or letters
  - Family chaos
  - Neglect
  - Hostility
  - Physical or sexual abuse
Possible Precipitating Risk Factors

- Stigmatization:
  Taunts, teasing, exclusion, being bullied or exploited
- Frustration:
  Due to inability to communicate needs/wishes
  Due to lack of choices about residence, work situation, diet
  Because of realization of deficits
  (Expert Consensus Guidelines, 2004)

Risk Assessment:

Predictors of Suicidal Behaviour (cont)

- Predisposing Factors are enduring factors that make an individual vulnerable to suicidal behaviour (Health Canada, 2002)
- History of major mental illness
- Previous suicide attempts
- Level of lethality
- Gender
- Disturbance in interpersonal relationships
- Previous family history of attempted or completed suicides

Predisposing Factors

- Disturbed interpersonal Relationships: Major factor in suicidal behaviour. They are one of the major causes of visits to the ER. Often due to the threat of rejection or abandonment or the loss of approval, acceptance, affection or attachment.
- Lethality of method. Is it escalating from earlier attempts? Ie superficial cutting to overdosing on cardiac medications. The more lethal the means, the greater the risk of successful suicide. Men tend to use more lethal and violent methods, ie hanging, firearms.
Predisposing Factors

- Gender: Males commit suicide more frequently and are hospitalized less frequently.
- Repeated attempts: The greater the number of past attempts, the greater the likelihood of committing suicide successfully, especially if lethality level is increasing.
- Mental illness: Strongest risk factor associated with suicide. Over 90% of individuals who successfully commit suicide have a diagnosable mental condition at the time of death. The majority of people who commit suicide have seen a physician within six months of dying, and frequently within one month.

Intellectual Disability Possible Predisposing Risk Factors

- Illness or disability:
  - Chronic medical or psychiatric illness
  - Serious acute illness
  - Sensory deficits
  - Difficulty with ambulation
  - Seizures (higher risk of suicide if suffering from epilepsy)

Psychological factors:

- Impaired sense of judgement
- Lower thresholds for stress tolerance
- Poor self image
- Immature psychological defence mechanisms when under stress (e.g. regression)
Intellectual Disability Possible Predisposing Risk Factors

- Inability to solve problems using abstract thinking
- Learned dysfunctional or abnormal coping strategies
- Lack of emotional support


- Risk factors: history of prior hospitalization
- Co morbid physical disabilities
- Loneliness, sadness
- Depression or anxiety

Intellectual Disability Possible Predisposing Risk Factors

- Severe psychiatric problems of early onset and resistant to treatment
- Family history of suicide
- Untreated or under treated depression (DD hamper clinical diagnosis of depression)
- History of abuse
- Low levels of social support
- Communication problems (Paźa, 2004)
Vulnerability of Persons with ID to Psychiatric Disorders

- No inherent biological predisposition to psychiatric disorders though there are;
- Events and conditions that produce CNS damage or other biological alterations that can produce Intellectual Disability and an additional DSM-IV diagnosis in the same person (Simpson J., 2002)
- The psychiatric disorder is one that may be a cue for monitoring for possible risk factors

Vulnerability of Persons with ID to Psychiatric Disorders

- Down syndrome: depression
- Fragile X: Restless, hyperactive, social withdrawal, depression and anxiety
- Prader-Willi syndrome: obsessive/compulsive behaviours, obsessive eating

S.I. and Down Syndrome

- Depression is the most frequently diagnosed disorder for person’s with ID, especially Down Syndrome
- Study with 40 patients with Down Syndrome and depression (large sample size)
- No mention of dying or SI (McGuire, 1996)
S.I. and Down Syndrome

- In a study of Down, depression and dementia in seven individuals with clinical depression, (Burt & Loveland, 1992) SI was reported as a level of .1 for severity on a 1-3 scale (lowest ranked)
- Sadness ranked 2.4 and crying spells 2.7

Studies examined:
- Single case report of person with Down syndrome, severe ID and epilepsy (Walters, R.M., 1990) who did make two attempts two years apart; threatened self with a knife, use belt to tighten it around his neck
- Two cases of suicide attempt (Hurley, A., 1998) identified from a group of 19 individuals over a 10 year period.
  - Both individuals lived with their families and received vocational and case management services.
S.I. and Down Syndrome

- Each experienced a distressing experience:
  - One was continually rejected by nondisabled women he approached for a date which left him feeling hopeless, sad and frustrated
  - Second individual was prohibited from attending from social programs and occasionally vocational programs by her mother. She expressed hopelessness, sadness and discouragement

S.I. and Down Syndrome

- Each occurred during a major depressive episode
- Both had mild level of ID and were articulate
- Both used potentially means of attempting suicide; jumping from a 2nd story window/jumping in front of a car

S.I. and Down Syndrome

- Conclusion:
  - Although reports of death through suicide in those with Down Syndrome are infrequent, it does happen
  - Although impaired intellectual ability and poor planning skills may limit the success of plans for suicide, many suicidal acts are impulsive and do not require extensive planning ability
S.I. and Down Syndrome

- Pary (1996), also suggests three possible reasons for the low documentation numbers:
  - 1) Suicidal behaviour is clinically overlooked and occurs more often than reported
  - 2) The literature is an accurate reflection of the reduced prevalence of suicidal behaviour in persons with Down Syndrome who have major depression. Some type of protective factor when depressed
  - 3) Insufficient attention has been paid to suicidal behaviour in previously published studies

Contributing Factors

- Contributing factors are factors that either expose or increase exposure to precipitating or predisposing factors such as:
  - Social isolation
  - Drug or alcohol use or abuse
  - Age
Contributing Factors

- Antidepressant use
- Akathisia
- Organic illnesses ie chronic medical conditions
- Epilepsy

Contributing Factors

- Social Isolation: Suicide rates are higher for those who live alone which include widowed, divorced, separated. Also feeling isolated within a relationship would be included.
- Age: Adolescents and elderly (especially males) are the highest at risk groups. The elderly are the most likely to commit suicide.
- Drug or alcohol use: Can cause disinhibition and increase impulsivity. Can also interact with medication used for overdosing, ie amphetamines, barbiturates, cocaine and opioids.

Contributing Factors

- Existing medical conditions: Physical health may already be compromised or lack of health may decrease quality of life and increase urge to die.
- Antidepressants: Depressed individuals are most at risk after commencing antidepressant therapy. It may decrease vegetative symptoms ie give increased energy BEFORE any feelings of relief from the depressive symptoms are felt.
- Agitation/profound anxiety: Feelings of anxiety may also increase risk of impulsivity.
- Akathisia: Motor restlessness. In extreme cases can be very distressing for individuals and may prompt urge to kill self to end this sensation. (most associated with neuroleptic use)
Contributing Factor: Adolescence with LD

- Huntington, D & Bender, Wm (1993) notes that the emotional development of many adolescents with LD is not often positive, and these individuals appear to be at increased risk for severe depression and suicide.

- Bender, Wm et al (1999) discusses the increased risk for adolescents with LD may be due to the fact they (a) suffer from increased rates of depression, or (b) the other correlates of learning disabilities (e.g. impulsivity, deficits in social skills, etc) may predispose them to higher rates of suicide.

- Certain subgroups of adolescents with a LD such as non-verbal learning disability (Bender, 1999., Rourke, B et al, 1989) may have higher rates of depression and increased suicidal risk.

Protective Factors

- Those factors that reduce the risk of suicidal behavior (Health Canada, 2002).
- Family supports
- Children
- Occupation
- Healthy coping skills
- Future Oriented
**Intellectual Disability Protective Factors**

- Family support system
- Professional staff support system
- Increasing coping skills, where possible
- Decrease frustration levels where possible
- Remove/control possible methods, ie blister packs rather than open bottles for medications. This may thwart impulsive actions. Consider evidence of Britain and Coal Gas
- Use most optimal style of interaction to reduce stress

**Awareness of possible stress situations and controlling for that as much as possible**

- Having medical/psychiatric symptoms stabilized as much as possible
- Supportive living environment

**Awareness of transitional phases**

- Family education regarding potential stress situations
- Use strengths associated with each intellectual disability group: ie
  - Down syndrome: stronger in visual processing skills than in auditory. So use coping methods that capitalize on visual processing skills
**Intellectual Disability Protective Factors**

- Fragile X syndrome; 1:1 interaction more comforting, as may be more anxious in group situations (although working towards increasing comfort as much as possible in time, may become protective)
- Williams syndrome: sensitive and social, so group based therapies to develop crisis coping skills may be helpful

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**Risk Formula**

- Predisposing factors
- Contributing factors
- Precipitating factors
- Protective factors

= Suicide Potential

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**Warning Signs**

<table>
<thead>
<tr>
<th>Suicidal behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeated expressions of hopelessness, helplessness or desperation</td>
</tr>
<tr>
<td>Signs of depression (loss of interest in usual activities, changes in sleep pattern, loss of appetite, loss of energy, expressing negative comments about self)</td>
</tr>
<tr>
<td>Loss of interest in friends, hobbies or previously enjoyed activities</td>
</tr>
<tr>
<td>Giving away prized possessions or putting personal affairs in order</td>
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<tr>
<td>Telling final wishes to someone close</td>
</tr>
<tr>
<td>Expressing suicidal thoughts</td>
</tr>
<tr>
<td>Expressing intent to commit suicide and having a plan, such as taking pills or hanging oneself at a specific place and time</td>
</tr>
</tbody>
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(Health Canada, 2002)
Additional Warning Signs

- Presence of a suicide note, references to having made out a will
- No future orientation ie unable to see themselves in any future circumstances.
- Stockpiling medication or access to a weapon
- Child care arrangements made
- Alluding to a plan, but not openly discussing it with health care provider

Elements of a Risk Assessment

- All previous risk factors explored:
  - Evidence of isolation?
  - Age? Gender?
  - Disturbance in interpersonal relationships?
  - Drug/alcohol use?
  - Previous attempts and degree of lethality?
  - Few or no protective factors
  - Precipitant event?
  - Note written, will made?
  - Future orientation present?
  - Existing medical conditions?

Elements of a Risk Assessment

- Has a plan?
- Has the means to carry out the plan?
- Past family history of suicide attempts?
- Has a major mental illness? Evidence of depression! Any psychotic symptoms, command hallucinations?
- On antidepressants just started?
- Evidence of anxiety/agitation?
- Feelings of helplessness/hopelessness
Example of a Risk Assessment
Scale

- In the past month did you:
  - Think that you would be better off dead or wish you were dead? NO YES 1 point
  - Want to harm yourself? NO YES 2 points
  - Think about suicide? NO YES 6 points
  - Have a suicide plan? NO YES 10 points
  - Attempt suicide? NO YES 10 points
  - In your lifetime did you ever make a suicide attempt? NO YES 4 points

Current Suicide Risk: 1-5 points Low 6-9 points Moderate Greater than 10 points High


Safety Contracts

- Safety contracts; what are they? A verbal or written contract or agreement, made by the individual to not harm self, or to seek help before attempting self-harm.
- Are they legally valid? NO!!
- May instill a false sense of security in care provider.
- Individual may feel able to agree to contract when speaking with you, however may not be able to adhere to conditions or may not be truthful in intent to carry out conditions agreed to.
- NEVER use a contract in place of a risk assessment.
- Best practice is not to rely or use them at all.
Remember:

- If you feel the person is at imminent risk for self-harm, you may intercede even if they do not wish you reveal this to anyone.
- Rights of privacy do not take precedence over imminent safety issues.

A Final Word

- Trust your instincts. If you have that inner voice warning that harm is imminent, listen to it!!
- Get assistance for the individual such as:
  - Family Dr
  - ER
  - Crisis Service
  - Police
  - Family