SUICIDAL BEHAVIOR AND COMMUNITY SUPPORT OF ADULTS WITH INTELLECTUAL DISABILITY: TWO CASE ILLUSTRATIONS

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Some adults with intellectual disability perform self-harming behaviors of potential lethality and in some cases, these appear to be intentional acts of suicide. Suicidal behavior, non-suicidal self-injury, and parasuicide among people who have intellectual disability are complex clinical concerns confronting mental health professionals. We present two case illustrations of adults with mild to moderate intellectual disability, psychiatric disorders, and multiple suicide attempts. Each adult was treated at a community-based residential setting with therapeutic support focused on their life-threatening behavior. The case illustrations detail treatment formulation, report outcome data, and describe long-term results.

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Suicide among adults with intellectual disability has not been studied extensively.12 Yet, 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 intellectual disability.9,11 Although completed suicides have been reported,3,4,13 most of the extant literature describes adults who made suicide gestures and unsuccessful suicide attempts by medication overdose,2,3 self-immolation,1 ingesting toxic substances,2,8,10 jumping from high places,15 hanging,6 running in front of a motor vehicle,7 and cutting or stabbing.8,16

Not much is known about the risk factors for attempted suicide by adults with intellectual disability. The strongest association appears to be persons with mild to moderate cognitive impairment who have a diagnosed mood disorder such as major depressive episode.9,11 Hurley8 noted the potential for suicide in an adult with mild to moderate intellectual disability if the person has “feelings of social rejection and hopelessness” and lives in a community setting with reduced caregiver supervision. Psychiatric comorbidity and crisis events (e.g., death of a parent, loss of a friend) also have been identified as precipitating influences.11

In addition to the clinical profiles of adults who have intellectual disability and attempted suicide, mental health professionals need more information about community-based treatment options. Some adults are able to access available services successfully through outpatient counseling and pharmacotherapy while living semi-independently or with family members.8 However, some high-risk individuals require services in more specialized settings in order to protect their safety and provide habilitation programming.

The present paper describes two adults with intellectual disability who received intensive residential treatment due to repeated self-harming behavior of potential lethality. Our presentation addresses each person’s suicide history, diagnostic formulation, the various interventions tried with them, and the long-term sequelae of community support. We conclude by discussing the unique features of each case and suggesting therapeutic recommendations.

Case 1

Mr. A was a 42-year-old man diagnosed as having mild intellectual disability, major depression (recurrent with psychotic features), and borderline personality disorder. He had been adopted as a young child and lived at home with
his family for many years. While at home, he received special education services, culminating in his first hospitalization at 18 years of age. Subsequently, and as the result of persistent problem behavior, he had two state hospital admissions and one private psychiatric hospital admission during an approximately 3-year period.

Sixteen years ago, Mr. A enrolled in a residential school. At that time, he displayed serious aggression, pica, and sexualized behavior towards peers and staff. He also had incidents of jumping from windows and elopement from the school. Less than a year later he was transferred to a secure unit at a private psychiatric hospital. This placement was precipitated by multiple suicide attempts and continued sexualized “acting out.” He remained in and out of the hospital for three years until he eventually became a residential client at a community-based habilitation services setting where he currently remains.

During the preceding 12 years, Mr. A demonstrated periodic self-injury by striking his body, jumping from the second floor of his community home, and cutting his wrists, on one occasion requiring 14 sutures to close a large wound. Periodically, he reported “feeling unsafe” and hearing voices to hurt himself, usually accompanied by a depressed mood, heightened anxiety, and sleep disturbance. When these behaviors were not evident, Mr. A was able to participate meaningfully in a variety of habilitation services, visit with his family, and he remained out of the hospital for a span of seven years (1995 through 2001). In 2002 (Figure 1), he transitioned to a new community home that provided him increased independence with reduced staff supervision. However, he eventually experienced multiple psychiatric hospitalizations that continued when he was returned to his former residence. Mr. A was hospitalized when he made repeated threats to injure himself, stated “I don’t want to live anymore,” or tried to commit a self-injurious act. Within the habilitation services setting, staff implemented a comprehensive behavior support plan with Mr. A that was focused on maintaining his safety, reducing serious problem behavior (aggression, verbal outbursts, elopement), and avoiding hospitalization. The plan provided him with preferred activities and increased social attention from staff when he did not demonstrate the problem behavior (differential reinforcement of other behavior). Staff also used physical redirection, response blocking, and therapeutic restraint when Mr. A became so highly agitated that he placed himself and others at risk.

Immediately following his last hospitalization in 2003, clinicians designed a revised behavior support plan for Mr. A. Whereas previously he received “1:1” staffing when it was possible, a staff person now was assigned to him continuously during waking hours. Two overnight awake staff also were present in the community home each day. Several environmental restrictions were put in place consisting of moving Mr. A’s bedroom to the first floor, securing upstairs windows, and eliminating access to sharp objects. Additional positive reinforcement for the absence of problem behavior and being hospitalized was programmed with Mr. A. Another behavior support plan component was the addition of a PRN medication regimen: a 0.5 mg. dose of lorazepam (Ativan) was given to Mr. A when he alerted staff that he heard voices telling him to hurt himself or other people in conjunction with aggression, self-injury, and attempted elopement. Figure 1 shows that the revised behavior support plan was associated with fewer psychiatric hospitalizations and relatively low incidence reliance on self-requested medication. It is important to note that the two hospitalizations in 2005 and the one hospitalization in 2006 occurred each time there was an attempt to withdraw (“fade”) the continuous “1:1” staffing arrangement.

Mr. A was seen by a psychotherapist and psychiatrist during the 12-year period he attended the habilitation services setting. He did not respond favorably to psychotherapy, so psychiatric consultation focused primarily on medication management. Before receiving PRN lorazepam described previously, he had been treated with olanzapine (Zyprexa, 10 mg.), bupropion hydrochloride (Wellbutrin, 150 mg.), lithium carbonate (Eskalith, 900 mg.), perphenazine (Trilafon, 32 mg.), and trazodone (Desyrel, 100 mg.) but none of these medications appeared efficacious.

Case 2

Ms. B was a 43-year-old female diagnosed as having mild intellectual disability, bipolar disorder, and borderline personality disorder. She also had hypothyroidism, seizure disorder, and non-insulin dependent diabetes. Ms. B had lived with her biological parents until she was 22 years old. In that time, she received special education and supported employment services. On at least one occasion, she was admitted to a private psychiatric hospital when she ingested a large amount of over-the-counter medication (Tylenol®). Ms. B had poor community adjustment while at
home including behavior outbursts and several incidents of consuming toxic substances.

Seven years ago, Ms. B entered a residential community-based habilitation services setting. She demonstrated many problem behaviors such as property destruction, aggression, and elopement. Ms. B frequently feigned illness by complaining of stomach distress and pain. She also ingested cleaning fluid, detergent, and similar toxic substances. On such occasions, she was admitted to a hospital emergency room for medical care and subsequently returned to the habilitation services setting. (Figure 2) Over the years she was treated with fluvoxamine (Luvox, 100 mg.), sodium valproate (Depakote, 1000 mg.), propranolol (Inderal, 50 mg.), and risperidone (Risperdal, 4 mg.) without significant improvement. Because of her limited insight and poor communication ability, she was considered a poor candidate for psychotherapy.

The behavior support plan for Ms. B featured differential positive reinforcement and noncontingent social attention from staff. In effect, Ms. B received access to preferred activities when she refrained from problem behaviors during specified periods each day. Noncontingent reinforcement (NCR) was implemented by having staff interact socially with her according to a fixed-time schedule. The purpose of NCR was to reduce Ms. B’s motivation to perform problem behaviors that appeared to be maintained by staff attention. In addition to these procedures, the physical environment was safeguarded by keeping toxic materials in secure locations within the community home.

Despite implementation of a comprehensive behavior support plan, Figure 2 shows that Ms. B successfully obtained toxic substances and ingested them. There was a lengthy period (19 months) from 2001 through 2002 without a hospital admission but then there were two suicide attempts in early 2003 around the time her father died. Following a July 2006 hospitalization, she returned to her community home with “1:1” staff support provided continuously. All potentially harmful materials in the home were locked in a central location and additionally, at each of three daily shift changes staff completed an “environmental checklist” by scanning all areas inside and outside the home to detect the presence of items Ms. B could ingest. The previously described positive reinforcement procedures remained in effect.

Ms. B did not respond favorably to the intensified behavior support and continued to seek out and ingest toxic substances. Due to her
high-risk condition, she was discharged to a secure psychiatric facility, with no community exposure and limited access to previously preferred activities. Reports from that setting verified that Ms. B had attempted to swallow several objects (coins, broken light bulbs) and required continuous supervision to prevent self-harm. She remains within a locked unit at the facility without a plan for community reintegration.

**DISCUSSION**

Suicide among people with intellectual disability is a complex and understudied clinical problem. The two adults presented in this report had protracted histories of self-harming behavior, multiple hospitalizations, and failed attempts to eliminate potentially fatal acts. With comprehensive behavior support, each person was able to benefit from community living. However, it was not possible to lessen the intensity of therapeutic intervention with them and ultimately, one adult could not be maintained safely at a community level of care.

Mr. A and Ms. B shared common features that have been identified as risk factors for suicide in adults who have intellectual disability: (1) a mood or personality disorder, (2) impulsivity, and (3) prior suicide attempts. A sudden change in personal relationships, employment or environment also can be stressful events that trigger suicide. Mr. A, it appears, reacted negatively when he transitioned from his long-time residence but unfortunately, reinstating that living arrangement did not immediately improve his community adjustment. Ms. B experienced the loss of her father but her suicidal behavior also predated and persisted long after this significant event. Certainly, Mr. A and Ms. B had other life changes with the periodic departure and arrival of staff and peers at their homes. Unfortunately, it is not possible to judge unequivocally whether these or other situations were instrumental in provoking suicide threats and actions.

Another difference between the two adults we described concerns their thoughts and language about suicide. As noted, Mr. A sometimes said he “felt unsafe” and wanted to “kill myself.” Ms. B did not make reflective comments nor did she speak negatively about her life or living condition. Furthermore, neither adult prepared a note about suicide or death. Acknowledging these factors, it is important to consider Hurley’s admonition that, “Although impaired intellectual ability and poor planning skills may limit success of plans for suicide, many suicidal acts are impulsive and do not require extensive planning ability.” (p.1619)

Like Mr. A and Ms. B, we have previously reported a case in which poor impulse control was closely
linked to life-threatening behavior in a person with intellectual disability.\(^{14}\)

Did Mr. A and Ms. B truly intend to take their lives or were their actions motivated by other factors? We mentioned earlier that they both enjoyed social attention from staff and frequently behaved inappropriately to elicit reactions. Similarly, the consequence of being sent to a hospital emergency room and psychiatric facility following a self-harming incident appeared to be strongly reinforcing, perhaps because of the attention given to them by medical staff, the transition to a novel environment, the relative absence of demands, or the effects of medications administered during hospitalization. For these reasons a primary objective of each person’s behavior support plan was to prevent hospital admission. It was encouraging that during their tenure in the community, Mr. A and Ms. B were able to avoid hospitalization for extended periods although not permanently.

The life-threatening behavior demonstrated by Mr. A and Ms. B also might be interpreted as parasuicide (deliberate self-harm), the defining characteristic being a person who mimics the act of suicide without intending to die. Rarely discussed among adults with intellectual disability, parasuicide is estimated to occur in 4-5% of the general population, may represent a genuine attempt to end one’s life, and could be the “cry for help” commonly seen in people with depression and other mental health problems.\(^{5,17}\) Self-harm that leads to accidental death certainly is consistent with parasuicide and the case histories presented in this report.

How to provide safe and therapeutically sophisticated care of adults who have intellectual disability and life-threatening behavior remains a challenge for mental health professionals. Essential in such cases would be properly diagnosing mental illness, controlling events that precipitate self-harming behavior, and eliminating the consequences that maintain it. We suggest further that community-based residential treatment for at-risk adults may require specialized staffing arrangements, environmental prevention, “contracting for safety” procedures, alliance with crisis intervention specialists, and pharmacotherapy.

**References**


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