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### Putting Developmental Disability on the Suicide Prevention Agenda

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Developmental disability encompasses a diverse range of conditions. This population is vulnerable to physiological, psychological, social, economic, and environmental correlates associated with suicide risk (Lunsky, 2004), and individuals with developmental disabilities die by suicide and manifest suicidal behaviors (Lunsky, 2004; Merrick et al., 2005). However, given their proximity to families, caregivers, and providers, suicide should be a “never event” (National Action Alliance for

Suicide Prevention, 2011) among persons with developmental disability.

Developmental disability is not even mentioned in major documents promoting suicide prevention in the US. The National Strategy for Suicide Prevention: Goals and Objectives for Action (US Department of Health and Human Services, 2001) and Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead (Litts, 2010) do not address suicide risk in those with developmental disabilities. “Special populations at risk”—American Indians, Alaskan Natives, individuals with severe and chronic mental illness, individuals who abuse alcohol and other substances, individuals with co-occurring psychiatric and addiction disorders, individuals in the criminal justice system, and others (US Department of Health and Human Services, 2001)—certainly include persons with developmental disabilities. However they remain invisible in the suicide prevention agenda.

Most references on suicidality and developmental disability focus on intellectual disability. A study by Sternlicht et al. (1970) of state school residents with mild and moderate intellectual disability found that 1% had made at least one attempt in the course of their institutionalization.

Walters (1990) found definite suicidal intent in individuals with IQs below 50 who made suicide

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serious attempts by

individuals with intellectual disabilities who had major depressive episodes and recent significant social losses. Pary (1996) commented that the prevalence of suicidal behavior in persons with Down syndrome may be greater than has been documented, and Lunsky (2004) found that one-third of respondents with mental retardation reported that they felt “life is not worth living.”

The interpersonal theory of suicide (Joiner, 2005) gives insight into why an individual with developmental disability might attempt suicide. This theory posits that a potentially fatal suicide attempt requires an extremely strong desire to die and the capability for lethal self-harm. An intense desire for death may come from the belief that one is a burden to others and/or the belief that one does not belong.

Burdensomeness arises from a sense that one is a liability and not fulfilling expectations or obligations. This may lead to thinking that one's death is more valued than one's life. Developmental disabilities can cause problems with communication, mobility, learning, self-help, and independent living. Research indicates that individuals with developmental disability have an objective perception of their impact on family caregivers (Chio et al., 2005). Psychosocial factors characteristic of some developmental disabilities may directly contribute to the emergence of a sense of burdensomeness and failed belongingness. An individual's sense of being a burden may begin at a very young age with early attachment experiences and vary with how accepting and supportive parents and/or siblings are of the disability (Kiddle and Dagnan, 2011).

Adolescents with intellectual disability tend to focus on being accepted by their peers and not being seen as "different" (Davis et al., 1991), yet social rejection and stigma may be encountered in school and the community. People with mild intellectual disability recognize the negative social aspects of their disability (Nezu et al., 1995), and those with intellectual disability tend to interact in small social networks made up of peers, family members, and provider staff (Clement and Bigby, 2009). This may make them vulnerable to failed belongingness brought on by misunderstanding social norms and the consequences of personal behavior.

How does an individual with developmental disability acquire the capability for lethal self-harm? This ability is acquired through experiences such as abuse, bullying, victimization, trauma, and a history of violence (Joiner, 2005). It is also facilitated through self-harm. A longitudinal study of self-injurious behavior in adults with intellectual disabilities found a prevalence rate of almost 5% (Cooper et al., 2009). Children and adults with intellectual disabilities are at increased risk of being bullied and possibly more likely than those without disabilities to also engage in bullying (McGrath, Jones, and Hastings, 2010). In a review of case studies of sexual abuse in people with learning disability, Sequeira and Hollins (2003) identified clinical effects of the experience, including depression, PTSD, loss of self-esteem, alcohol abuse, self-harm, and self-destructive tendencies. Acquired capability for lethal self-harm may also be a byproduct of past attempts (Smith and Cukrowicz, 2010), and suicide attempts preceding completed suicides in persons with severe intellectual disability have been documented (Menolascino et al., 1989).

The concurrence of perceived burdensomeness and failed belongingness is sufficient to produce an intense desire to die. Persons with developmental disability may have a significant exposure to these beliefs. Self-injury and victimization may habituate some persons with developmental disability to pain and foster an ability for lethal self-harm.

"Chronic suicidality" also occurs with developmental disability. This is "suicide attempts and deliberate self-harm inflicted with no intent to die" (Welch, 2001). Walters et al. (1995) report on a study of adolescents with mild to moderate intellectual disability with behaviors that suggest chronic suicidality: verbal statements about killing oneself without expressed intent to do so, voicing intent to harm oneself with no effort to do so, and potentially harmful actions with or without expressions of intent. Chronic suicidality may raise the risk of acute suicidality. Through such "mental practice" over time, the individual may acquire the ability for lethal self-harm (Smith and Cukrowicz, 2010; Van Orden et al., 2010).

Psychiatric hospitalization is the standard disposition for people with developmental disabilities at risk for suicide. A Canadian study of inpatient psychiatric care for individuals with developmental disabilities reported that suicidal ideation was the most common reason for admission and accounted for almost one-half of the intakes (Burge et al., 2002). A study of admissions to an inpatient program for children and adolescents with developmental disability found that 94% had suicidal ideation or had made suicide threats or attempts (Hardan and Sahl, 1999). Though inpatient psychiatric care assures short-term safety and stabilization, it appears to compound subsequent risk (Dennehey et al., 1996; Meehan et al., 2006). There is a high level of danger in the post-hospital period, as risk is highest immediately after discharge (Crawford, 2004).

A final consideration is that assessing suicide risk in individuals with some developmental disabilities may be problematic. An assessment should elicit risk and protective factors, warning signs, intent, and planning, and integrate these inputs into a clinical formulation of risk (Shea, 2009). However, intellectual disability may impair language skills and the ability to accurately describe feelings and experiences (Silka and Hauser, 1997). A tendency to acquiesce, to please those in authority, and to give the “desired” response may also bear on an evaluative interview. In some cases, out of necessity, the assessment may rest heavily on third party reports.

In sum, individuals with developmental disabilities are at risk along the continuum of suicidal behavior from ideation to completion. More effort must be invested in preventing suicide and raising awareness of risk in people with developmental disabilities. We must increase participation of family members, consumers, advocates, and providers on bodies tasked with setting national, state, and community suicide prevention agendas. Suicide prevention must also be part of the developmental disabilities agenda. Families, consumers, and providers alike must become more knowledgeable of the nature of suicidality. These steps are long overdue, and may prevent unnecessary deaths by suicide among those with developmental disabilities.

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