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Suicidal Behaviour in Severely Mentally Handicapped Patients

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Four patients with IQs below 50 displayed suicidal behaviour. This refutes the notion that the severely mentally handicapped are unable to form such an intention.

Suicides of in-patients of psychiatric hospitals are comparatively rare. Goh *et al* (1989) reported estimated figures of 1.3–2.5 per 1000 discharges, suggesting that for any individual psychiatrist experience may be limited.

A national postal inquiry in 1986 by the author to consultant psychiatrists working in mental handicap, into their experience of suicidal behaviour in severely mentally handicapped patients (IQ below 50) elicited 111 replies. Only five psychiatrists recalled patients who had committed suicide, all of whom were described as being mildly mentally handicapped or of borderline ability. All had IQs over 60 and clear diagnoses of psychiatric illness superimposed on their mental handicap. Thirteen recalled patients who had made suicidal attempts or gestures or who had threatened suicide: some were adolescents, one had an IQ of 53, and three may have been of more limited ability. A few respondents thought that severely mentally handicapped people with IQs below 50 would be unable to conceptualise and form an intention to commit suicide, but some considered that the severely self-injurious behaviour of some profoundly handicapped patients with autism could be suicidal. In these cases the behaviour was so forcible and unpredictable that serious injuries resulted. Examples were given of patients with IQs below 25 who repeatedly banged their heads against brick walls and of a young man who threw himself head first through reinforced glass windows.

During nearly 20 years as a consultant at Hanham Hall Hospital (approximately 200 in-patients, mostly male) four male mentally handicapped patients whose IQs were below 50 have exhibited behaviour judged to indicate an intention to endanger their lives.

Case reports

Case 1

WB was admitted to hospital at the age of 16. The cause of his mental handicap is unknown, but he does suffer from epilepsy.

At age 34 his IQ was 46; by 53 years his IQ was 34 and he was judged to have a mental age of five years and ten months.

He was subject to detention under Section 26 of the Mental Health Act 1959, suffering from manic–depressive psychosis between the ages of 46 and 50 years. There were episodes of mild hypomania in the early years of his illness and his episodes of severe depression were accompanied by hypochondriacal and nihilistic delusions with aggression. On several occasions when depressed he absconded from the ward in very inclement weather dressed in pyjamas in order to hide and die. Each time he talked of wanting to be "put in his coffin box". He received five courses of electroconvulsive therapy between the ages of 44 and 54 years but continued to be depressed and delusional with little response to treatment until his death in 1986 at the age of 64.

Case 2

PD suffers from familial mental handicap and epilepsy. He was admitted to hospital under Section 26 of the Mental

Health Act 1959 at the age of 28 in 1973 because of behavioural difficulties and alcohol abuse.

At the age of 24 his IQ was 46; at the age of 28 his IQ was 38 and his mental age six and a half. Three weeks after his admission he was found by nursing staff with a belt tightly fastened around his neck. On questioning he said he had done it "to kill meself, 'cos I can't go home with me mam". On inquiry it was found that he had previously been prevented by other patients from jumping over the stair bannisters. He was uncooperative and was noted to be disruptive, teasing and provoking other patients. His mood was depressed and a diagnosis of acute emotional distress was made.

His mother discharged him, giving 72 hours' notice. He has remained under out-patient care and his behaviour continues to be disturbed. He has been before the court on charges of indecent exposure on three occasions, and twice for causing wilful damage. He is at odds with his neighbours and has himself been assaulted. He has been frequently drunk and wanders around the countryside at night. He is socially untrained and has an inadequate personality. He responds to the occupational and social training available at his adult-training centre but his attendance is erratic.

Case 3

LC has Down's syndrome and epilepsy, and was admitted to hospital aged 21.

At the age of 30 his IQ was 30 and his mental age five years. His speech is limited to phrases and simple sentences, with very poor articulation and a severe stammer, so that no clear history of psychiatric symptoms can be obtained.

His mental state became disturbed at age 18, with screaming outbursts and violent behaviour. At age 21 he had daily episodes when he would scream, become agitated and hyperactive, breaking windows and throwing crockery and furniture. He was often unpredictably violent to staff and patients, causing injuries. Although his mental state improved with treatment in hospital, there were relapses at age 28 and at age 30 lasting several months, necessitating seclusion and cessation of activities. During each episode suicidal behaviour was recorded. In 1975, at age 28, he was found with a knife in his hand and he threatened to take his own life; at the age of 30 he was observed to put his leather belt around his neck and tighten it.

Observed behaviour thought to indicate delusional and hallucinatory experiences includes episodes of hysterical giggling and of talking incoherently to himself, urinating in inappropriate places, tearing clothing, head banging, smelling objects, and hostility to others. It is felt that he probably suffers from a psychotic illness. At age 33 he developed syncopal attacks as a result of heart block and was fitted with a cardiac pacemaker. He remains in hospital and is able to attend occupational therapy classes daily and participate in social activities, his mental state having improved.

Case 4

AH had a mental handicap of unknown aetiology. He was admitted to hospital at ten years of age. His IQ is 38, and he has a mental age of 5 years 11 months.

At age 74 years he was found in the bath with his head tilted backwards trying to submerge. When questioned he said "I'm trying to drown myself". It was noted that he had a urinary-tract infection and had suffered severe recurrent abdominal symptoms from an incisional hernia and distension of the small bowel, long-standing complications of operations for sigmoid volvulus (at age 58) and total colectomy (at age 73). The previous year he had had an operation for cataract extraction and lens implant, and had retired from his work in the hospital sewing room. Staff commented that he seemed to have lost interest in his friends and television in the preceding two or three weeks and was not eating well. He persistently complained about his hernia, his teeth or his spectacles.

At examination he was tearful, withdrawn and monosyllabic, saying he was unhappy and had no friends. A diagnosis of acute depression was made and he responded to treatment with tricyclic antidepressant medication. He died 15 months later of intestinal obstruction and infarction of the ileum.

Discussion

Each of these patients took independent deliberate action when staff were not present. Whether the acts which they committed would have resulted in suicide had they been better able to plan and execute them cannot be known. Their spoken comments at the time seemed to indicate an intention to end their lives. WB and LC were already receiving treatment for their mental illnesses, and AH was diagnosed as suffering from a depressive illness after the event, although his physical illnesses were well recognised and under treatment. These cases demonstrate the risk that even patients with IQs below 50 who are mentally ill can attempt suicide, and are able to appreciate that the outcome of the behaviour could cause death.

All the cases reported fall within categories well recognised and defined as at risk of suicidal behaviour among the general population. Serious self-injurious behaviour in patients who are severely or profoundly retarded or autistic may be potentially self-destructive, but Lovaas (1982) considers that such patients would probably be incapable of an intention to end their lives.

Suicidal behaviour has seldom been studied in the mentally handicapped population, and mental handicap is rarely mentioned in surveys of suicide in hospital populations. Sletten *et al* (1972) recorded three with a final diagnosis of mental retardation in a study of 97 patients who committed suicide in Missouri State hospitals. Carter & Jancar (1984) recorded one patient with affective psychosis for whom a verdict of suicide was returned in their study of sudden deaths. Kaminer *et al* (1987) reported three mentally retarded male adolescents who exhibited

suicidal behaviour. There was superimposed psychiatric disorder in all three and two had IQs below 50.

Mentally handicapped people are much more likely to suffer mental illness than the general population, and the more severe the mental handicap the more difficult diagnosis becomes. Many patients cannot complain of psychological symptoms and the illness often presents with a change in behaviour, but sometimes biological symptoms predominate, such as loss of appetite or disturbed sleep. The psychopathology of mental illness in the mentally handicapped may not differ from that in the normal population but will be very difficult to study in patients whose ability to communicate verbally may be severely restricted, even when well. The behaviour of a disinhibited excitable brain-damaged patient resembles that of early hypomania and the psychomotor retardation of a depressive illness may be unrecognised in a patient whose habitual mental processes are slow and undifferentiated. Such patients often do not recognise symptoms of illness in themselves and may not complain spontaneously of symptoms which accompany even common intercurrent physical illnesses, and so diagnosis may be delayed. Behavioural disturbances are also a common presentation of physical illness in this group of patients and this may lead to a misdiagnosis of psychological symptoms. The recognition of symptoms of mental illness in severely mentally handicapped patients depends upon the understanding, the knowledge, and the skill of their carers, nurses and doctors.

More specific attention should be given to the recognition and treatment of psychiatric and physical illness in severely mentally handicapped people in any training courses for nurses and other residential care workers. The risk of suicidal behaviour is small but may present serious management problems, and adequate facilities for appropriate hospital treatment with suitably trained nursing staff for these severely mentally handicapped patients with mental illness or severely self-destructive behaviour will be needed in the future.

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