The Current Status of Suicide and Eating Disorders: What clinicians need to know

Overview

1. Statistics about suicide
2. Youth Suicides
3. Eating Disorders and Suicide Risk
4. Assessment
In 2015, 17 year-old Justin, who had been struggling with an eating disorder for more than a year, committed suicide.

Justin had been “pudgy” in 6th grade, his mother, April, felt he used food a coping mechanism for stress. As he gained weight, he struggled with self-esteem issues.

At age 14, he got taller and started running and going to gym. He began to restrict his food intake, as his eating disorder progressed, he was hospitalized for bradycardia and kidney distress. He was sent to Primary’s and UNI.
Justin’s story

- In April of 2015 he went to ERC in Denver. He stayed until June and then insurance would no longer cover his care. April, felt he did well for a few months and then she noticed large quantities of food missing. He has significant mood swings and began cutting on himself. But in November, Justin took his life with a gun.

How often does suicide occur in our practice?

- Trimble, Jackson & Harvey (2000)
- 437 psychologists
- 39% had a client suicide
- 76% had a client attempt
- 90% reported seeing clients with suicidal ideation
Coping with a client’s suicide

1. Talk to someone who can help: supervisor, mentor
   - Clinician Survivor Task Force of American Association of Suicidology (AAS)

Coping with a client’s suicide

3. Take time to grieve: vacation days, 6 months to process.
4. Know the research: data can help put things into perspective.
5. Learn from experience.
There were approx. 45,000 reported suicide deaths in 2016, 1 death every 12 minutes.
- 33.4% Tested positive for alcohol
- 23.8% for antidepressants
- 20% for opiates
- The strongest risk factor for suicide is depression.
- Suicide is a leading cause of death in the US.

Suicide rate has increased 28% in the last 17 years.
- 54% of people who die by suicide “are not known to have a diagnosed mental-health condition at the time of death.”
- Among males, suicide rate highest for those aged 65 and older.
Among females, suicide rate is the highest for those aged 45-54 years old.

There are 4 male suicides for every female suicide, but twice as many females attempt.

Suicide rates rose across the US from 1999 to 2016.

SOURCE: CDC’s National Vital Statistics System;
CDC Vital Signs, June 2018.
7.4% of adults have seriously thought about suicide.
2.7 million people have made a plan on how to kill themselves in the past year.
The spring months of March, April & May have highest suicide rates.
6% of suicides take place in psychiatric hospitals.

Suicides in psychiatric hospitals

- #1 sentinel event reported to JCAHO 1995-2007
- 2966 inpatient suicides
- 75% occurred in a bathroom, bedroom or closet
- 100% were hanging
- Most occur within 48 hours of admission or 24 hours prior to discharge
In a study of 76 patients who committed suicide while in the hospital or immediately after discharge:
- 78% denied suicidal ideation when asked
- 51% were on q-15 min checks.
- 57 were on the inpatient unit
- 4 patients were on 1 to 1

This is the deterioration in the therapeutic alliance “between patient, staff, and others due to negative perceptions of behavior (where the patient had been perceived as provocative, unreasonable, or over-dependent). This is commonly found in patients with recurrent relapses and resistance to treatment, and perceived by staff as a manipulative patient.
Facts and Figures

- Between 10% and 35% of people leave a note behind.
- Monday appears the day most suicides occur.
- 25% of driving death estimated as “autocides.”

Facts and Figures

- There are 4 male suicides for every female suicide, but twice as many females attempt.
- 90% of all suicides have a diagnosable psychiatric disorder.
### Suicide Means

<table>
<thead>
<tr>
<th></th>
<th>Males (77%)</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearms</td>
<td>57 %</td>
<td>32 %</td>
</tr>
<tr>
<td>Hanging</td>
<td>26 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Poisoning</td>
<td>9.5 %</td>
<td>33 %</td>
</tr>
<tr>
<td>Jumping off a bridge (only 2%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Need to be addressing access to firearms, this doesn’t have to be a debate about the Second Amendment.*

### Profile of Completer/ Attempters

- Male
- Caucasian
- Age 15-55 & 65 up 72 y.o. is highest rate
- Living alone
- Unemployed
- Depressive Disorder
- Substance Use Disorder
- Not in Therapy
- Extreme issues of despair, fatalism, self-devaluation
- Visited PCP within 6 months (70%); 20% in past week
- No intent communicated
Behavioral Warning Signs

1. Giving away prized possessions i.e. jewelry, personal collections
2. Writing/reading about death obsessively
3. Making a will/final arrangements
4. Writing suicide notes
5. Engaging in high risk activities
6. Sudden changes in behavior, feeling more settled (6 day warning sign)

Adolescent Suicides
Jamel wanted to tell his classmates at Joe Shoemaker Elementary School that he was gay.

“He was going to tell people he’s gay because he’s proud of himself,” the mother said.

She said when her son came out, he also opened up about wanting to dress more femininely.

He was teased and bullied by his peers.

He hung himself last month.

More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease, COMBINED.

4,600 Suicides every year and 5,400 attempts by kids from 7th to 12th grade

45% use firearms

40% hanging

8% poisoning
Youth Suicides (9-12th grade)

- 17% of students have seriously considered attempting suicide in the past year
- 13.6% made a plan
- 8% of students attempted suicide one or more times in the past year

Youth Suicides

- Among Hispanic students, 18.9% seriously considered suicide and 15.7% had a plan.
- American Indian/Alaska Native adolescents have 1.5 times high rate for suicide.
- Suicide is the 2nd leading cause of death for ages 10-24
- 4 out of 5 teens who attempt suicide have given clear warning signs.
Situational Risk Factors for Adolescents

1. Substance use to treat undiagnosed mental disorders
2. Isolation/aloneness
3. Victim of bullying
4. Acculturation challenges
5. Academic performance anxiety
6. Family Discord
7. Impulsivity/firearms (30%)
8. Legal status/ Conduct
9. Close friend suicides “contagion suicides”

Being bullied hurts....

- Project EAT- girls that reported being teased were 2 to 3 times as likely to binge eat, 2 x likely to report unhealthy eating
- 36% of girls that were teased by peers thought of suicide.
- 51% of girls that reported being teased by peers and parents, reported thoughts of suicide
Last fall, Brandy Vela died by suicide in front of her family after she was severely bullied over her weight. Brandy's family walked into her room as she was holding a gun to her chest, but they couldn't stop her.

Bullied about her weight her whole life, but a period of intense cyber bullying had started in April.

David’s Law for 2017

“David’s Law” focuses on bullying caused suicides by putting punishments behind the laws, including punishments for parents of bullies.

David Molak would have turned 17. He loved playing video games and keeping track of sports statistics. But he was bullied by his peers after school using social media website, texts, and mobile apps. His parents say, that bullying led him to take his life last January.
Contagion spreads either directly, by knowing a suicide victim, or indirectly, by learning of a suicide through word-of-mouth or the media.

- 15 to 19 year olds are 2 to 4 times more vulnerable to suicide contagion
- Clusters tend to happen where people socialize: schools, psychiatric hospitals or military units.

Contagion suicides

- In 2015, researchers found that people who know a suicide victim are almost twice as likely to develop suicidal thoughts as the general population.
- The closer the relationship, the greater the risk; the younger the person exposed, the greater the risk.
Death by Instagram

- Research from the 1970’s: suicide typically has a profound impact on six people and is limited to close family members.
- Suicide may now touch around 236 people, and about 33% of them experience a severe life disruption because of that suicide.

Risks of Social Media

“Facebook Depression”-defined as depression that develops when preteen and teens spend a great deal of time on social media sites and then begin to exhibit classic symptoms of depression.

Acceptance by and contact with peers is an important element of adolescent life.
CDC examined Utah’s high suicide rates, it appears that removing young people’s access to devices altogether may also be a hazard.

2011 to 2015 examined 150 Utah youth that died by suicide.

18 of the youth had recently had conflict with family due to restrictions by parents taking away cellphones, tablets and gaming systems.

Lack of social support, distress for losing technology, anger over being punished?

The state Board of Education has introduced and has encouraged schools to promote a smartphone application called SafeUT, which connects students to professional mental health help.
Adolescents- Survey of 450

4 Greatest Reasons
1. Quality of home life
2. Parental relationship/behavior
3. Lack of friends
4. Depression

- We need to assess:
  1. Friends
  2. Family
  3. Access to firearms

Why the higher risk?
Eating disorders and Suicide
Anorexia and Suicide

- Anorexia has the highest mortality rate of any psychiatric disorder, with death rates estimated as high as 17% (Keel et al., 2003).
- The risk of suicide is thought to be 57 times greater at every age for people with anorexia compared to the norm.

Eating Disorders and Suicide

- It was previously thought that the majority of anorexia-related deaths were a result of physical complications secondary to the disorder. Recent research reveals that most anorexia-related deaths are due to suicide.
Prevalence Rates

- Anorexia sufferers are 31 times more likely to make a suicide attempt than the general population.
- Individuals with BN are 7 times more likely to die by suicide.

Prevalence Rates

- 16% of patients with anorexia have attempted as an outpatient.
- 23% for bulimics treated as outpatients and have attempted.
- 39% of bulimics treated as inpatients have attempted.
- The highest rates of suicide attempts are reported among bulimic individuals who have co-morbid alcohol abuse (54%).
Who is at risk?

- Individuals with anorexia have the highest rate of completed suicide
- Individuals with bulimia have the greatest number of attempts
- Attempts by individuals with anorexia tend to be planned, while attempts by individuals with bulimia tend to be more impulsive.

Anorexia and lethal means

- Individuals with anorexia tend to decide to end their life
- Use highly lethal methods
- Jumping in front of moving trains, ingesting household chemicals, etc.
67% of patients with an eating disorder and a history of suicide attempts suffered from depression before the onset of the eating disorder (Caruso, 2016).

Adolescents demonstrate a strong relationship between suicidal behavior and completed suicides. 25% of adolescents with bulimia have attempted. Almost 15% of adolescents with binge eating disorder have attempted suicide. (Forest et al. 2016 examined 10,213 adolescents)
Females vs Males

- Dancyger & Fornari (2005) literature review:
- Males with eating disorders exhibited more than **double** the attempted suicides than females
- Males that attempted were more frequently homosexual in their orientation
- For **completed** suicides, males were considerably higher than females

Profile: Anorexia risk factors

- There is an increased risk of suicide attempts in anorexics who are (Steiner et al. 2004):
  - Older
  - Lower in weight
  - Struggle with substance abuse
  - Younger age of onset
  - Significantly longer duration of illness
  - More fixated on appearance and fearful of weight gain
  - AN-BP are the most pathological subgroup
There is an increased risk of suicide attempts in bulimics who have:
- Co-morbid psychiatric diagnoses
- History of physical or sexual abuse
- Abuse of laxatives and diuretics
- Multiple compensatory purging behaviors
- Lifetime history of impulse control problems (shoplifting, sexual promiscuity)
- Pregnancy (BED highest)

There is a significant difference between self-injury and suicide and they are also connected.
While an individual can self-harm without being suicidal, the risk of suicide increases 50% within the first year after an episode of self-injury in patients with ED’s.
Self injury vs Suicide

- The prevalence of self-injury among eating disorder patients is approximately 25% regardless of type of eating disorder (Eating Disorders 2002; 10;205)

Suicide and Self harm

- Koutek, Kocourkova and Dodova (2016)
- Examined **47 girls admitted into inpatient psychiatric** hospital with eating disorder diagnosis.
- 72% had depressive symptoms
- 11% had obsessive-compulsive symptoms
- 9% anxiety disorder
- 23% had substance abuse
- 60% had suicidal behavioral
- 49% had self-harm
- Association was found between self-harm and suicidality.
- Researchers state self-harm may be an important risk/predictive indicator.
Risk factors for ED’s and suicide

- Sweden Study- Sweden national registers from 1/1/1979 to 12/31/2001
- Risk factors for suicide include:
  - Purging behaviors
  - Depression
  - Substance abuse
  - History of childhood physical and/or sexual abuse
  - Bulimics attempt more often than anorexics
  - Anorexics have more deaths by suicides
- Cluster in families- Individuals who had a full siblings with any eating disorders had an increased risk of suicide attempts. Increased risk with half siblings, cousins and half cousins. “Family liability”

Family liability?

- 202 (10.8%) of the sample reported a suicide attempt by a family member
- Individuals with bulimia had a higher prevalence of any familial suicide attempt and mother suicide attempt than individuals with EDNOS.
Assessment
Assessments to Use: “Never worry alone...”
Robert Simon

- Columbia Suicide Severity Rating Scale
- Beck Scale for Suicide Ideation
- Beck Hopelessness Scale
- Reasons for Living Inventory
- Safety Plan Treatment Manual to Reduce Suicide Risk

When to Assess

- When are we assessing?
  - Intake
  - Each session
  - Contact between sessions
  - Discharge
What information are we gathering?

- Are you asking specific questions?
  - Have you wished you were dead or wished you could go to sleep and not wake up?
  - Do your thoughts scare you?
  - Do your thoughts give you relief?
  - Do you have Present/past self-harm?
  - Do you have means to harm self?
  - Practiced these plans? Aborted attempts?

What Protective Factors/Strengths does the patient have?

- Intact reality testing
- Fear of suicide or death
- Fear of social disapproval
- Restricted access to lethal means of suicide
- Easy access to variety of clinical interventions
- Effective clinical care for mental, physical and substance abuse dxs
- (Bryan & Judd; Suicide Prevention Resource Center et al)
Behaviors that may signal risk, especially if related to a painful event, loss or change:
- Increased use of alcohol or drugs
- Looking for a way to end their lives, such as searching online for methods
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression
- Fatigue
Research also shows that “method substitution” or choosing an alternate method when the original method is restricted, frequently does not happen. The myth “If someone really wants to kill themselves, they’ll find a way to do it” often does not hold true if appropriate safety measures are put into place.