

SUICIDE IN EATING DISORDERS:

Who is at highest risk and how do we work more effectively with these clients?

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Overview

- Mortality in EDs and prevalence of suicide attempts
- Factors associated with increased risk of suicide attempts
- Psychological models of suicide risk
- Motivation and commitment strategies with the suicidal ED client
- Q & A

Terminology: Suicide

- Suicidal ideation: thoughts about self-inflicted lethal harm
- Suicide attempt: self-inflicted harm with some intent to die without fatal outcome
- Suicide: self-inflicted harm with some intent to die with a fatal outcome

Suicidality in People with Eating Disorders

Scott Crow, M.D.
University of Minnesota
The Emily Program



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- Mortality in people with ED
- Suicide in people with ED

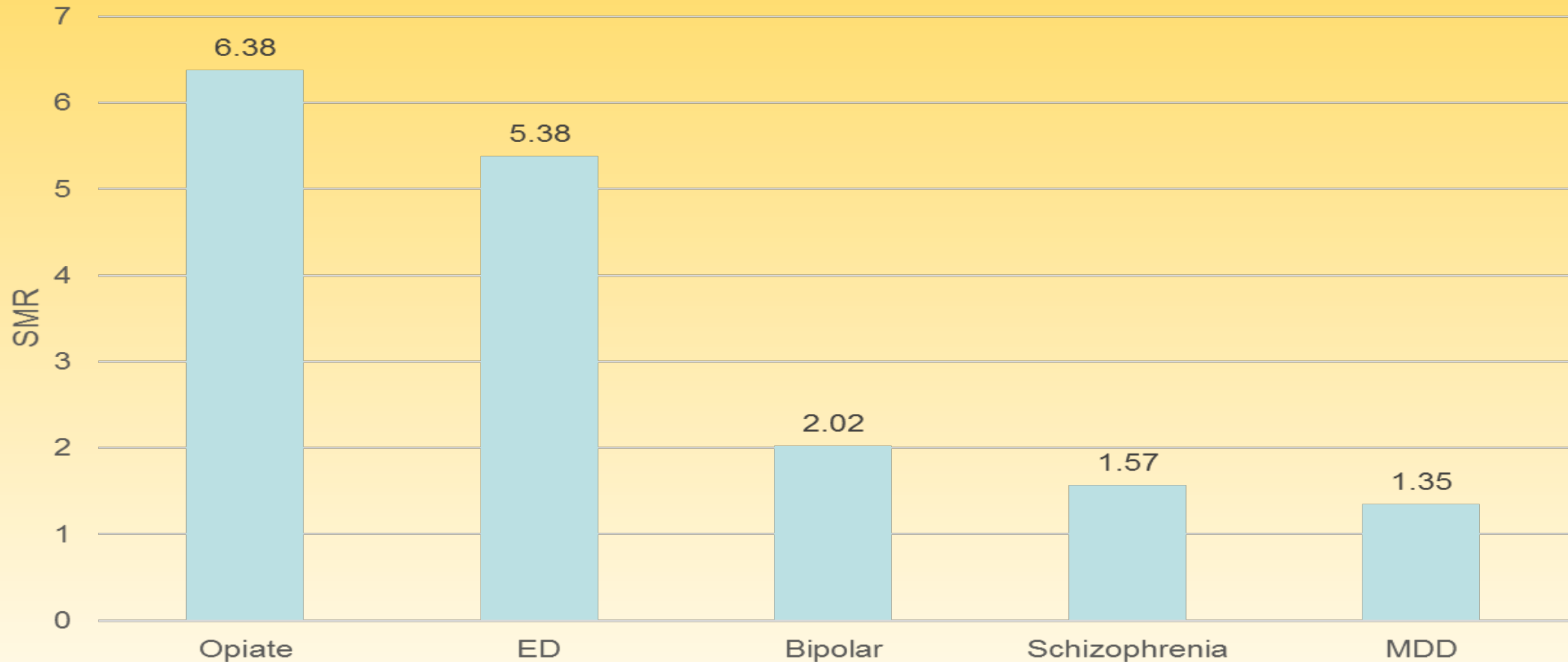




Richard Morton



Excess Mortality of Mental Disorder



Harris & Barraclough, 1998



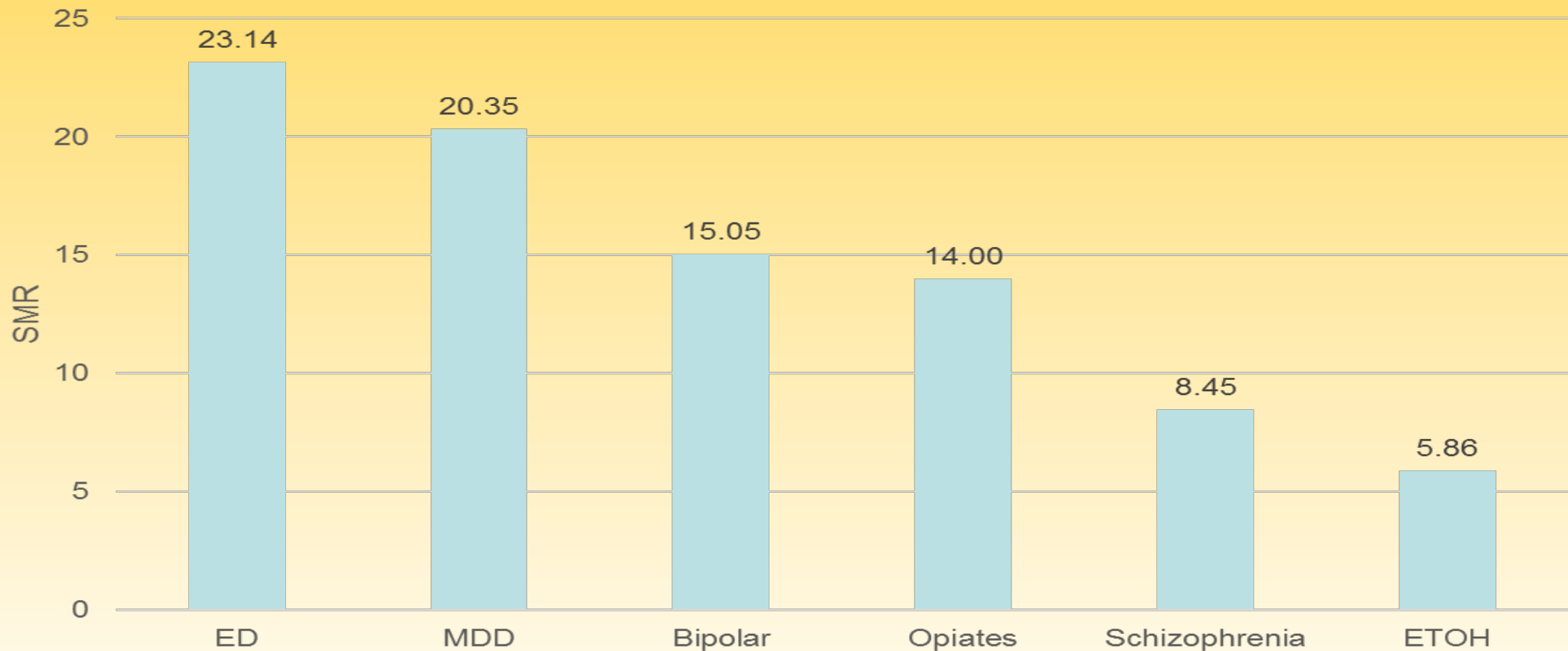
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Suicide as a Risk in ED

- Bruch, 1974
- Blinder et al., 1970



Suicide as an Outcome for Mental Disorder



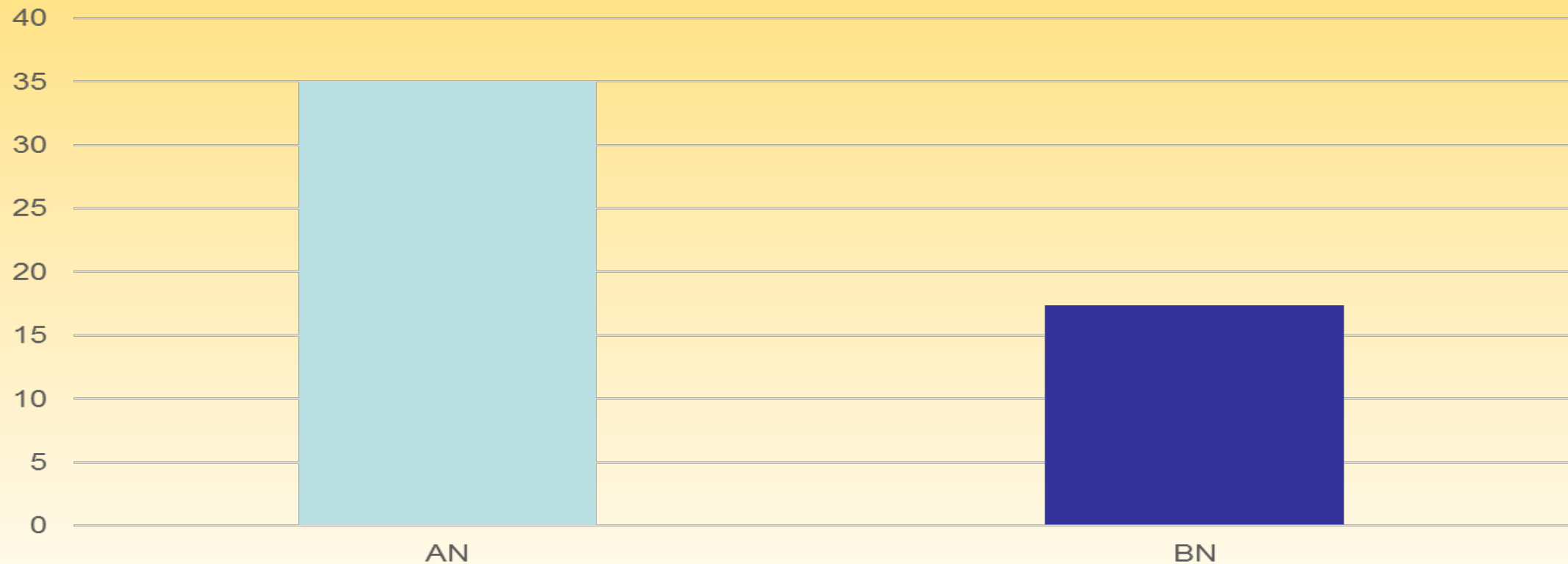
Harris & Barraclough, 1994



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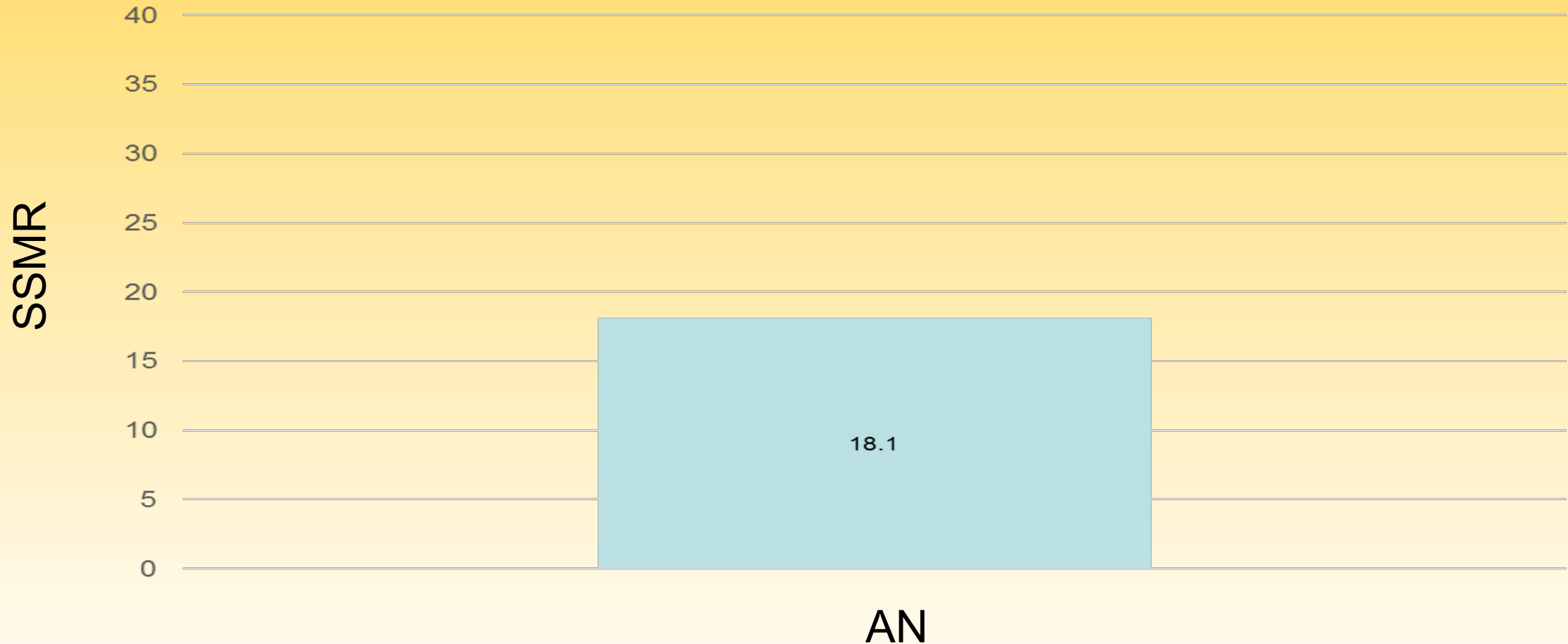
Meta-analysis of Suicide in ED

Preti, et al., 2011
Acta Psych Scandinavica 2011; 124: 6-17



Re-Meta-Analysis of Suicide in AN

Keshaviah, et al., *Comprehensive Psychiatry* (2014) 1773-1784



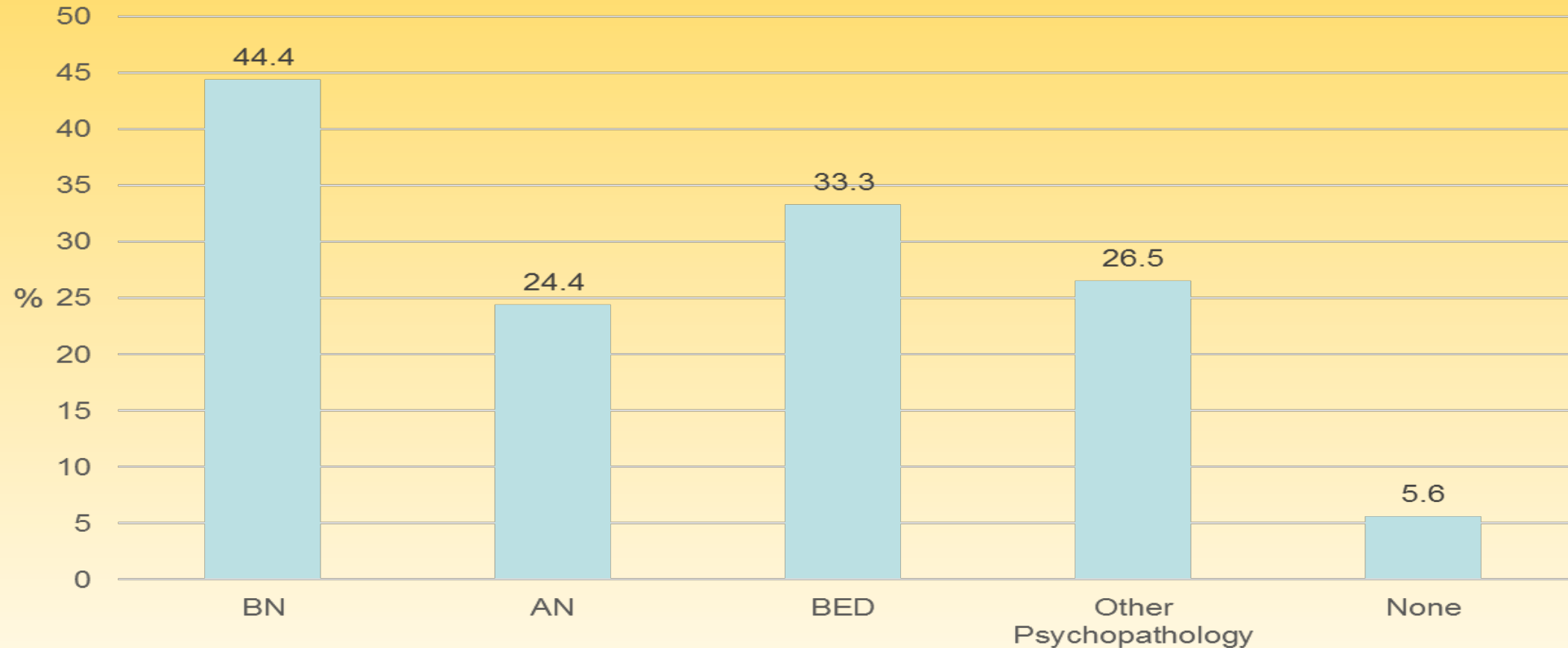
What are the rates of suicidality in adolescents with BN in a community sample?

Crow et al, Comprehensive Psychiatry, 2015, 55:1534-1539



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Suicide Ideation in NCS-R



Crow et al, Comprehensive Psychiatry, 2015, 55:1534-1539



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NCS-A: Design

- Nationally representative sample of US adolescents
- N=10,123
- Dual sampling method
 - Adolescents from households sampled for NCS-R
 - School sample
- Ages 13-18 years

Crow et al, Comprehensive Psychiatry, 2015, 55:1534-1539

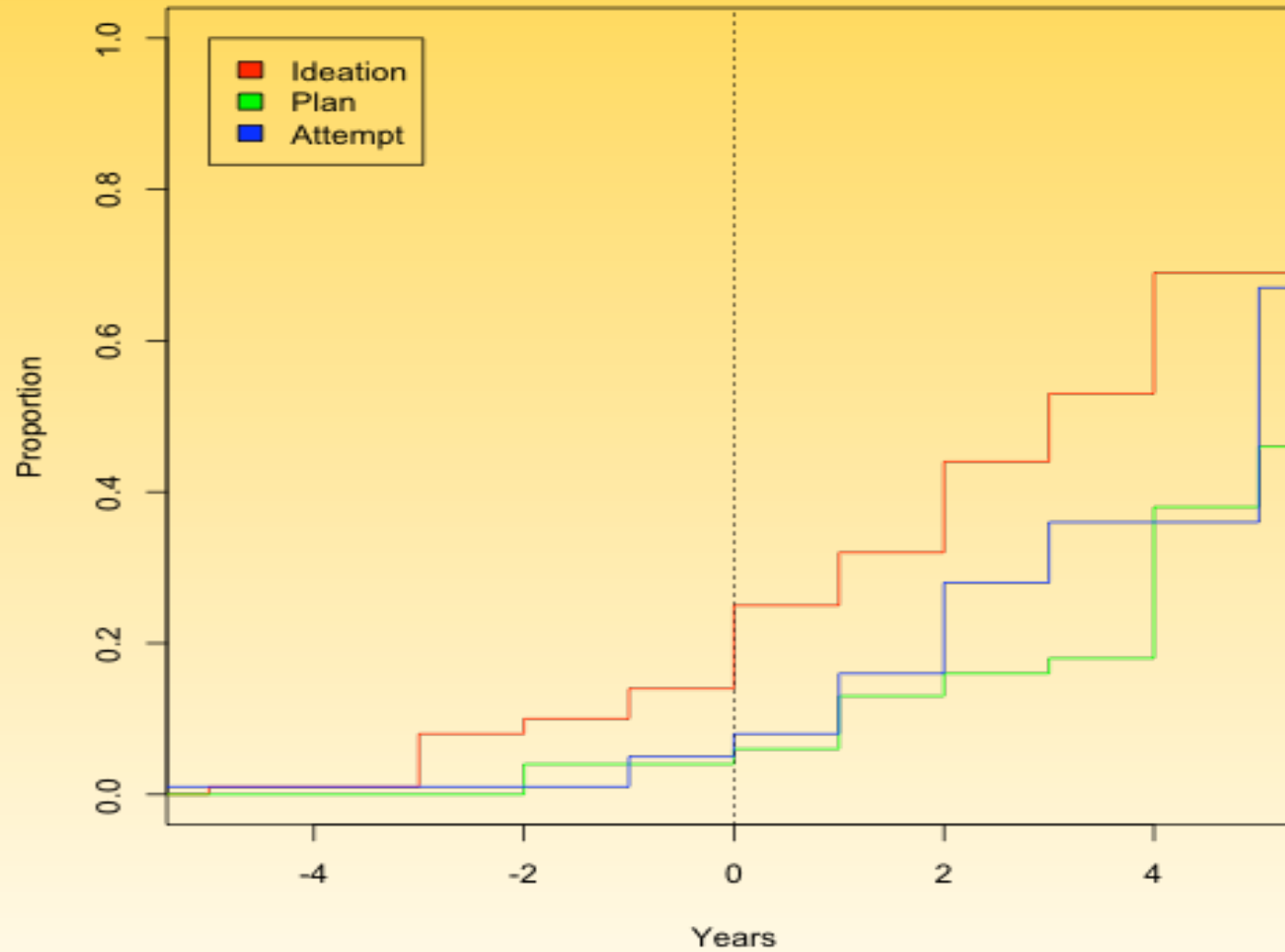


	Suicide Ideation	Suicide Plan	Suicide Attempt	Multiple Suicide Attempts
NCS-A				
BN, % (SE)	53 (5.9)	25.9 (6.5)	35.1 (6.6)	17.1 (5.6)
AN, % (SE)	31.4 (11.2)	2.3 (1.4)	8.1 (5.7)	1.2 (9)
BED, % (SE)	34.4 (6.2)	5.1 (1.9)	15.1 (7.2)	5.1 (1.4)
Non-ED Psychopathology, % (SE)	21.3 (1.4)	7.7 (0.8)	6.7 (0.5)	3.5 (0.4)
No Psychopathology, % (SE)	3.8 (0.4)	0.6 (0.1)	0.3 (0.1)	0.1 (0.0)

Crow et al, Comprehensive Psychiatry, 2015, 55:1534-1539



Order of Onset of Suicidality Relative to BN Onset (NCSA)



Crow et al, Comprehensive Psychiatry, 2015, 55:1534-1539



What/who is missing?

- Other psychopathology
- Most subgroups
- Information re: ED in other samples



Conclusions

1. Mortality is high in people with ED
2. Death by suicide is much more likely in people with AN than in the general population
3. Suicidal ideation is much more likely in people with ED than other groups, perhaps especially for those with BN



Who is at highest risk and why?

Emily M. Pisetsky, Ph.D.

Eating Disorder Symptoms

- **Purging** (Franko & Keel, 2006; Pisetsky et al., 2013)
- **Excessive exercise** (Smith et al., 2013)
- **Lifetime low body weight** (Favaro & Santonaso, 1997; Forcano et al., 2009)
- **Longer duration of illness** (Favaro & Santonaso, 1997)
- **Earlier age of onset of ED** (Forcano et al., 2009)
- **Greater number of treatments** (Forcano et al., 2009)



Psychiatric Comorbidity

- **Depression** (Ahn et al., 2019; Bulik et al., 2008; Pisetsky et al., 2015)
- **Anxiety disorder: panic disorder, “any anxiety disorder”** (Ahn et al., 2019; Bulik et al., 2008; Milos et al., 2004; Pisetsky et al., 2015)
- **PTSD and lifetime trauma** (Bulik et al., 2008; Smith et al., 2015)
- **Alcohol and other substance use disorders** (Anderson et al., 2002; Bulik et al., 2008; Corcos et al., 2002; Franko et al., 2004)
- **Non-suicidal self-injury** (Dodd et al., 2018; Perez et al., 2019)



Personality Traits

- High persistence (Bulik et al., 1999)
- Low self-directedness (Bulik et al., 1999; Forcano et al., 2009)
- High harm avoidance (Forcano et al., 2009)
- High identity problems (Pisetsky et al., 2015)
- High emotion dysregulation (Ahn et al., 2019; Gómez-Expósito et al., 2016; Pisetsky et al., 2015)



Marginalized/Stigmatized Identity

- Transgender or genderqueer (Lipson & Sonnevile, 2020; Pissetsky et al., under review)
 - Transgender women may be at particularly elevated risk (Simone et al., unpublished data)
- Lesbian, gay, or bisexual (Lipson & Sonnevile, 2020; Pissetsky et al., under review)
- Perceived weight status and experience of weight stigma (Douglas et al., 2019; Eaton et al., 2005)



Why are individuals with EDs at elevated risk?

Shared Genetic Liability

- 10% of individuals with EDs have a family member who have a lifetime suicide attempt (Pisetsky et al., 2017)
- Individuals with full sibling with AN or BN have increased risk of suicide attempts (Yao et al., 2016)
- Twin study has demonstrated common genetic pathway for suicidality and “any ED” (Wade et al., 2015)
- Separate twin study found shared genetic factors for AN and suicide attempts (Thornton et al., 2016)

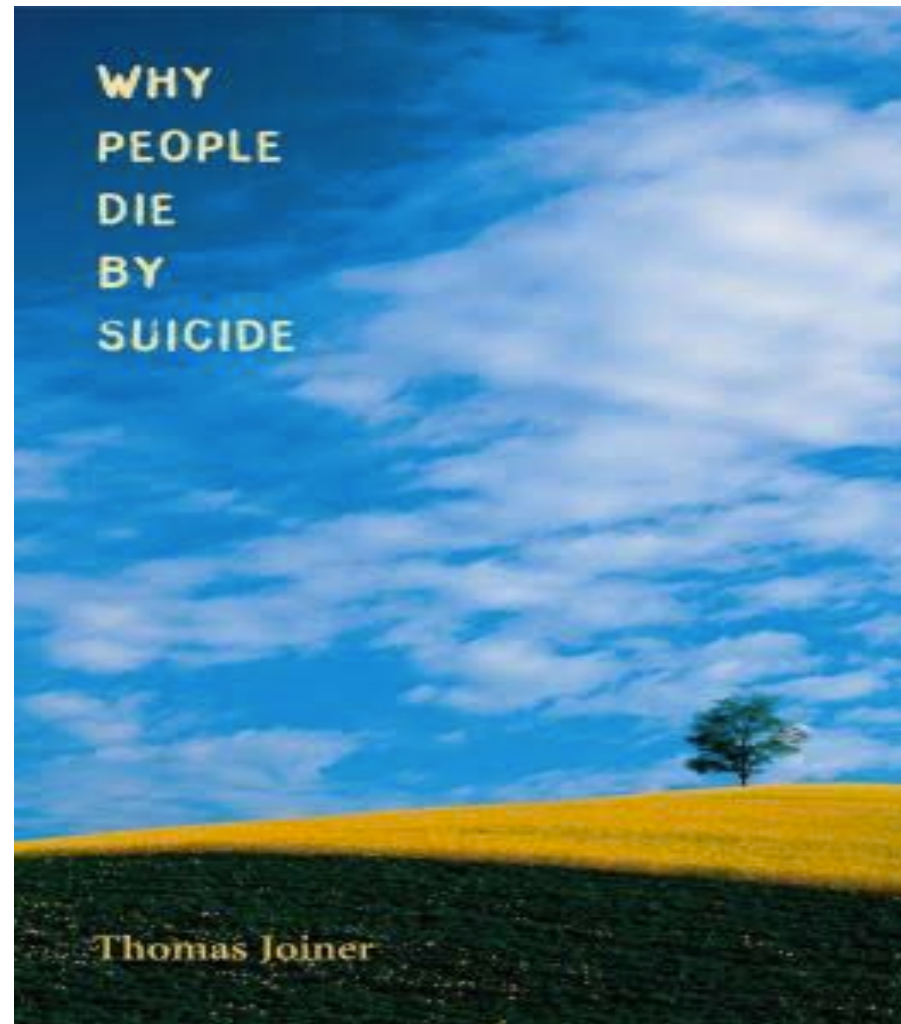


Psychological Theories of Suicide

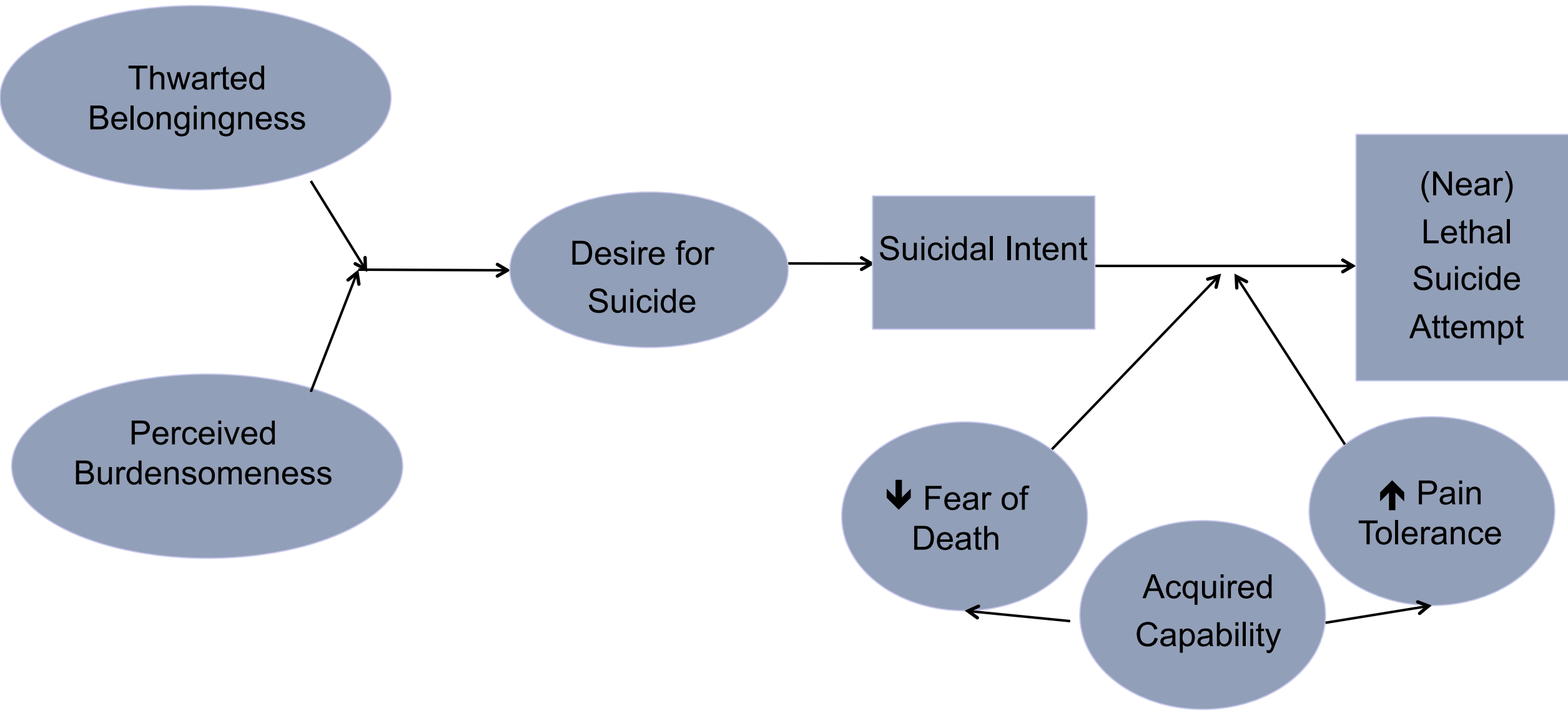
- Escape Theory (Baumeister, 1990)
- Hopelessness Theory (Beck, 1986; Abramson et al., 1989, 2000)
- Psychache Theory (Shneidman, 1993, 1999)
- Interpersonal Theory of Suicide (Joiner, 2005)



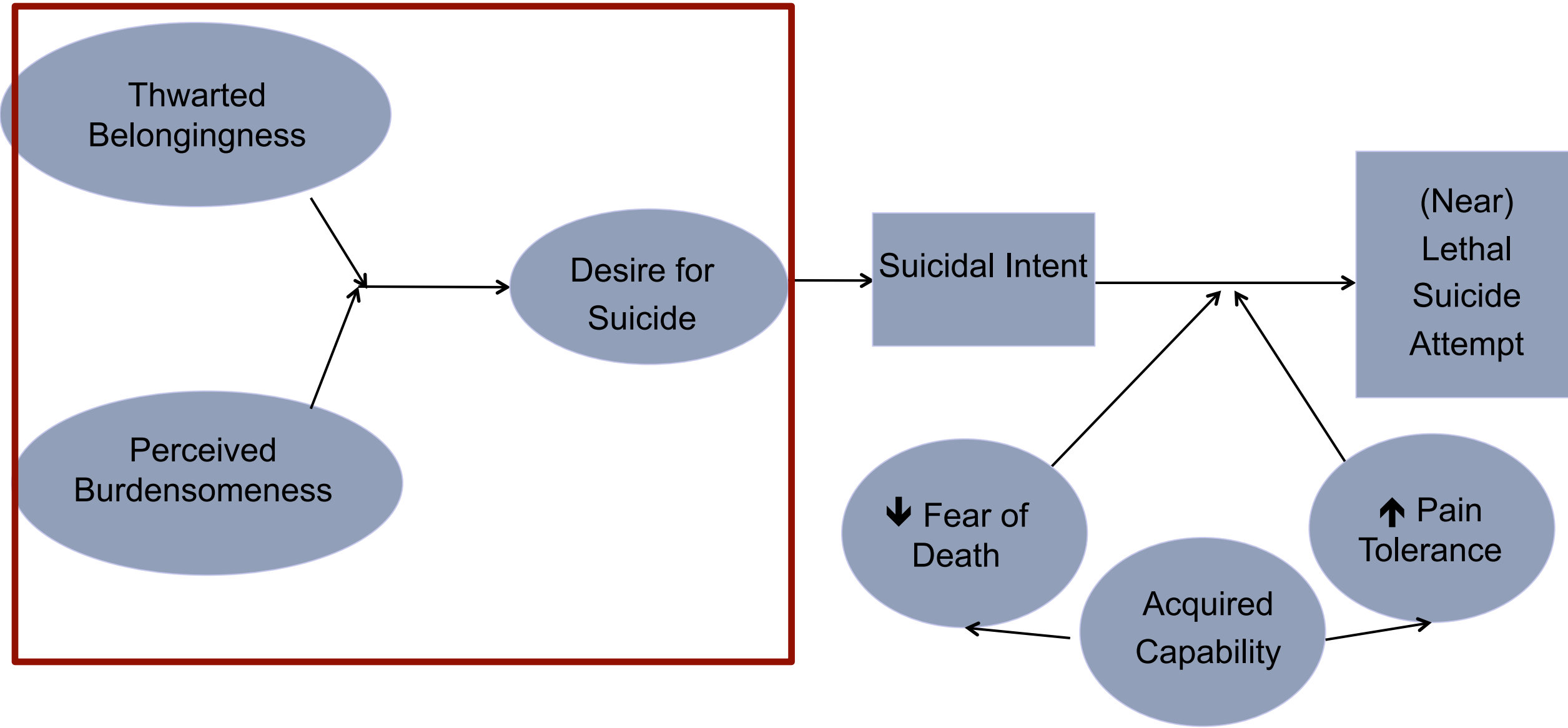
Interpersonal Theory of Suicide; Joiner, 2005



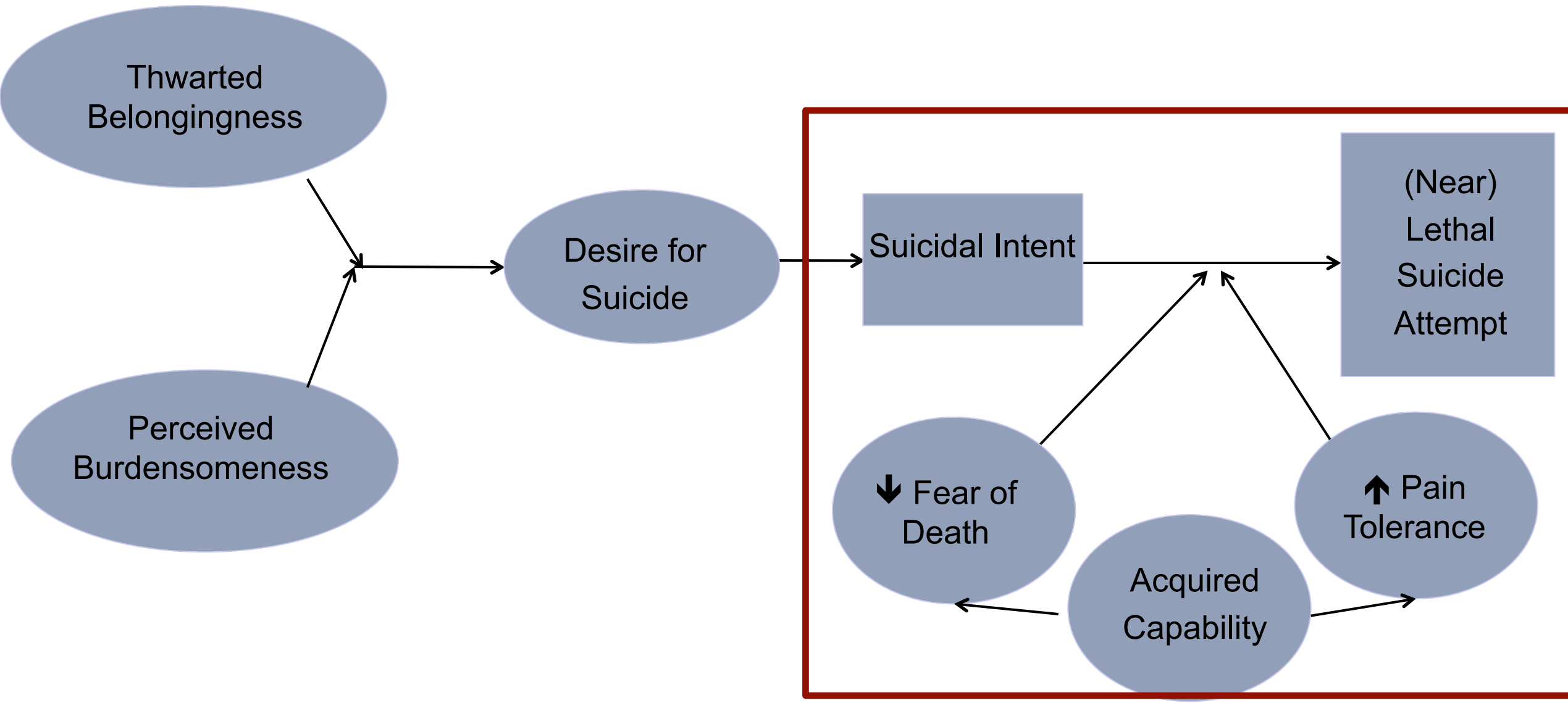
Interpersonal Theory of Suicide



Interpersonal Theory of Suicide



Interpersonal Theory of Suicide



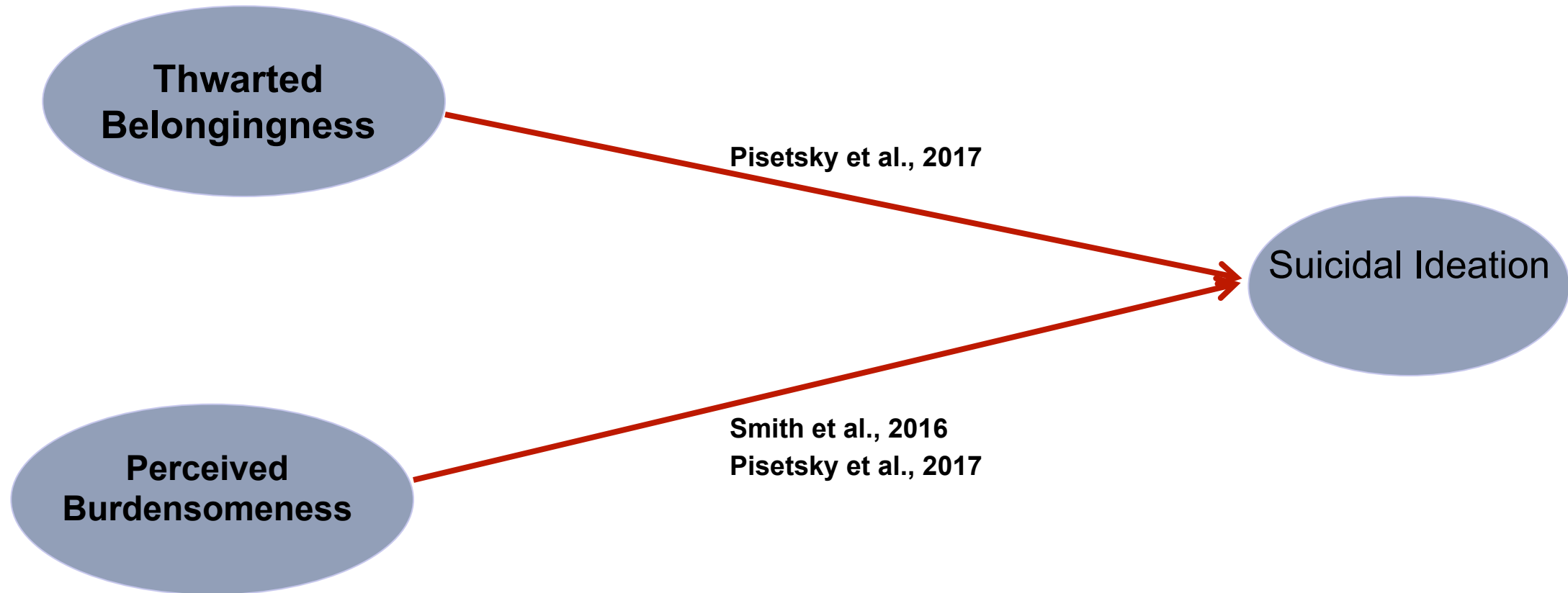
Is the IPTS a useful framework for understanding suicide risk in EDs?

Evidence for IPTS in Eating Disorders

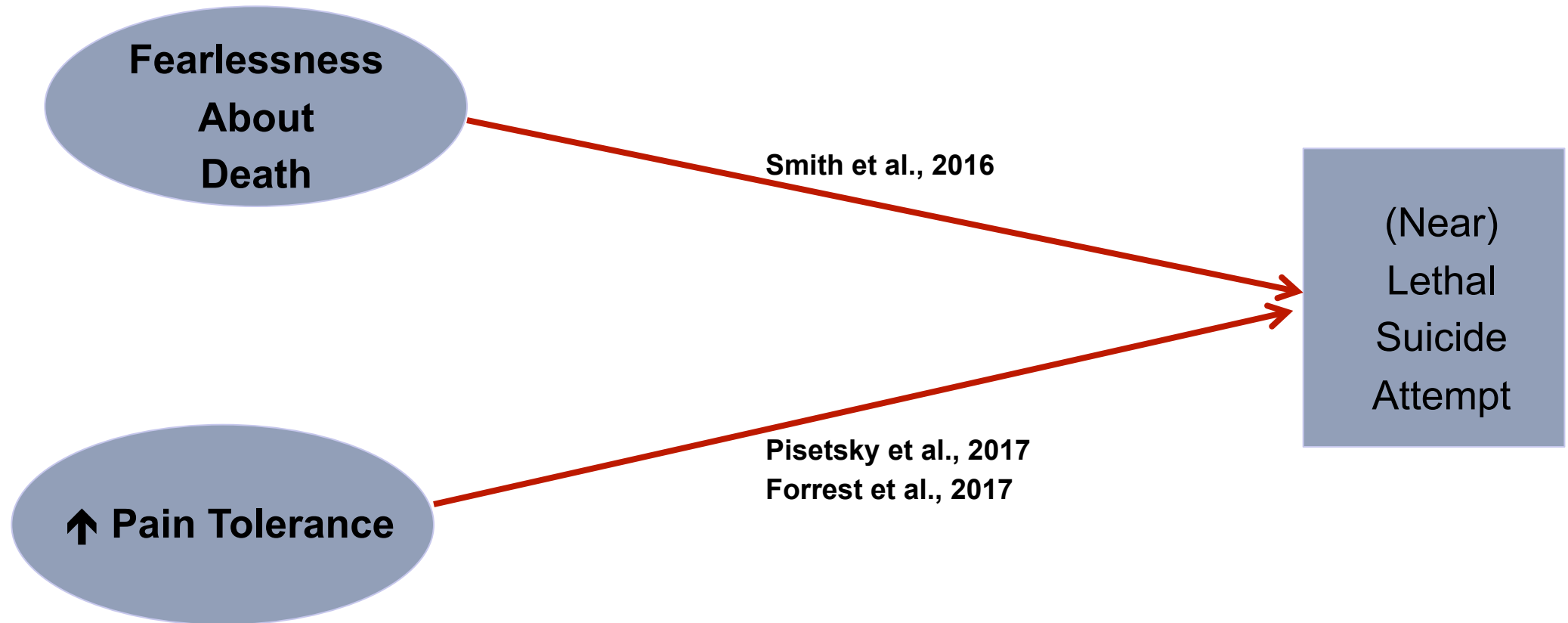
- Belongingness & Burdensomeness
 - Individuals with AN and BN have smaller social networks (Levine et al, 2012)
 - Dissatisfied with the support they do receive (Levine et al., 2012)
 - Often dependent on families, emotionally and financially (Whitney et al., 2007)
 - Caregivers endorse high levels of burden (Graap et al., 2008)
- Acquired Capability
 - Increased pain tolerance (Raymond et al., 1999)
 - Purging, starvation, excessive exercise physically painful (Smith et al., 2013)



Evidence for IPTS in Eating Disorders



Evidence for IPTS in Eating Disorders



NEXT DIRECTIONS...

Next Directions

- Longitudinal studies
 - Epidemiological studies
 - Does the ED precede suicidality (Smith et al., 2019)
 - Ecological momentary assessment → ecological momentary intervention
- Social cognition
 - Deficits in social processing may lead to difficulty maintaining social connections
- Interoceptive deficits
 - Out of touch with bodies, disconnected, view bodies as an object (Smith, Forrest, & Velkoff, 2018)



New technology and methodology

- Smart phones
 - Facial features
 - Tone
 - Cognitive variables
- Wearable devices
 - HRV, sleep, GPS
- Social media
- Network analysis (Smith et al., 2020)
- Machine learning and big data



Research challenges

- Logistic challenges
 - Low base rates
 - Time before an attempt time of significant distress
 - IRB and ethical considerations – when to intervene?
- Methodological challenges
 - How do you define a discrete episode?
 - Does the relationship between suicide risk factors and suicidal thoughts and behaviors change over time?



Motivation and Commitment Strategies with the Suicidal ED client

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Case Western Reserve University and Center for Evidence Based Treatment
Ohio



Addressing Chronic vs. Acute Suicidality



Patient A: BED and MDD, spike in depression leads to acute SI.

Patient B: BED and MDD, chronic depression and chronic SI.

When do you worry about safety?

Are you monitoring urges?

Do you have an agreement?

Do you have a safety plan?

If acute

Need resources

- Most of us have had training in acute management

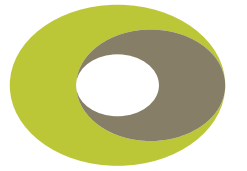


Best practice: *ask* the suicide question



Be	Be direct. Ask them.
Use	Use specific words like “commit suicide,” “kill yourself,” “take your life”
Listen	Listen for hesitation, reluctance to answer
Do	Don’t necessarily accept the first “No” response (put it in context)

Specific questions



Are you afraid you might do something rash? That you might regret?

Are you thinking about hurting yourself?

Are you thinking about killing yourself?

Should I be worried?

Do you have a specific plan?

file:///C:/dbtohoio/assessment%20measures/LSSN-LRAMP-v1.0.pdf

LRAMP

LINEHAN RISK ASSESSMENT AND MANAGEMENT PROTOCOL (LRAMP)

Client: _____ Date Contacted: _____

Person Completing: _____ Date Created: _____

SECTION 1: REASON FOR COMPLETION

1. Reason for completing:

- ☐ **History** of suicide ideation, suicide attempt, or non-suicidal self-injury at intake
- ☐ **New** (or first report of) suicide ideation and/or urges to self-injure
- ☐ **Increased** suicide ideation and/or urges to self-injure
- ☐ **Suicide communication** or other behavior indicating imminent suicide risk since last contact
- ☐ **Suicide attempt and/or self-injury** since last contact
- ☐ Suicide attempt and/or self-injury occurred or was **ongoing** during contact
- ☐ Other

Please explain: _____

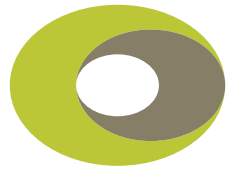
2. Describe the specific incident or behavior that occurred:

10:02 PM 5/21/2017

Pull out all the stops (while maintaining the relationship)

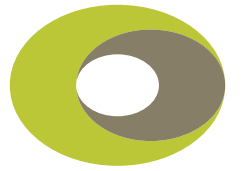


If chronically suicidal *and* have an ED



Things get a little complicated

Life-threatening behaviors?



Suicidal Behaviors/Intentions

Intentional Self-Harm Behaviors

Suicidal Ideation/Communications

Homicidal/Assaultive Behaviors

Eating Disorder Behaviors?

immanently life threatening

Bradycardia

Arrhythmia

Electrolyte Abnormalities

Chronic Ipecac Abuse

If chronically suicidal AND have an ED



Need consult your model/framework of treatment

- How does your treatment model impact your conceptualization?

Commitment to staying alive

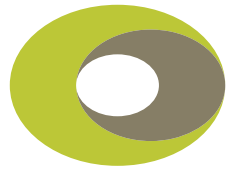
- Did you already discuss this?

Monitor life threatening behaviors

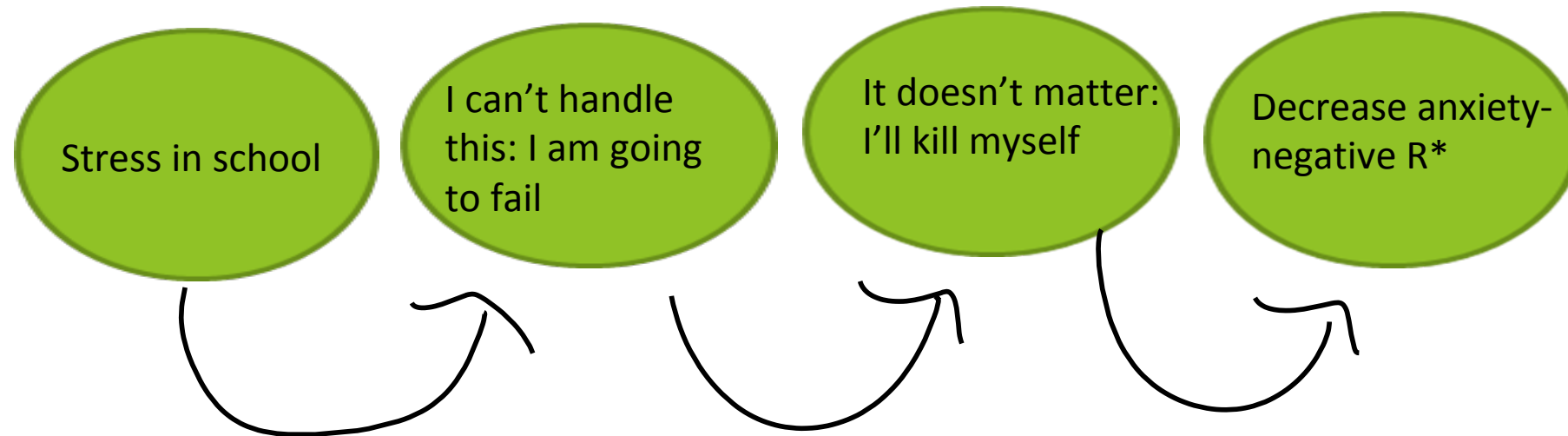
- DBT
- CBT
- What if not using a treatment that uses self-monitor?

Behavioral analysis on changes in SI

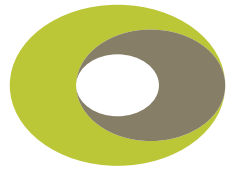
BCA: College Student with OSFED



VF: Learning
disability &
perfectionism



BCA: Adult female with AN:B/P



VF: Chronic
depression &
trauma
impulsivity

Stress at work or
home

"Too much
going on"

I get no help/
invalidation

Distress/extreme
hopelessness

My K+ is off.....

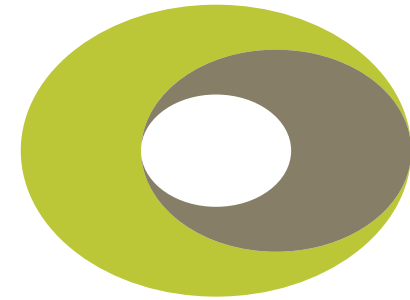
Then this wont
matter

Need to
kill myself

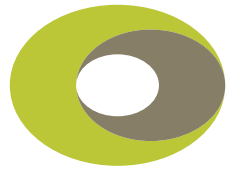
I cant handle this –
things will never
change

But you still need to know what to do about SI...

You are going to need a lot of skills....



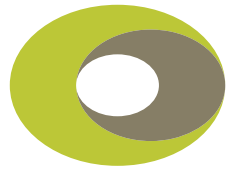
Strategies: how to help in the moment



Monitor:

- If increase or decrease – talk about it
- If increase
 - Remind of agreement/commitment use M&C strategies
 - Reference understanding of pattern
 - If don't have it yet – talk about how will understand
 - Validation of experience if can
 - Figure out with an eye toward understanding maintaining variables.
- In DBT
 - Call for coaching
 - More frequent contact for doing WELL not worse

Foot in the Door (from DBT)



Make an easier first request followed by a more difficult request.

- E.g.
 - 1. Will you agree to putting the knife down
 - 2. Will you agree to giving the knife to your spouse?



Door in the Face (from DBT)



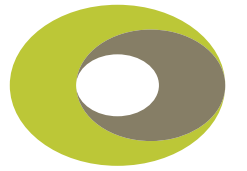
1. Request something much larger than you expect
 2. Request something easier
- E.g.
 - 1. request that patient throws away all of her pills
 - 2. request that she lock them in a safe in the house



Highlight Prior Commitments

- But I thought we had agreed to...
- Help clarify current commitment.
 - Are you willing to....
- Focus on re-commitment.
 - Can you agree right now that you will....

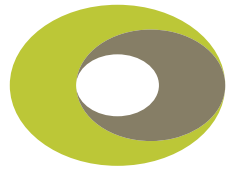
Cheerleading



- Patients need hope
 - Difficult to commit with out hope



We know this is not enough



Please let us know what else you need in order to feel more competent in working with ED clients who also might be suicidal.

We want to give you the skills to do so.

Questions?

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- Lucene Wisniewski: lwisniewski@cebt ohio.com