SUICIDE IN EATING DISORDERS:
Who is at highest risk and how do we work more effectively with these clients?

Emily M. Pisetsky, PhD
Scott Crow, MD, FAED
Lucene Wisniewski, PhD, FAED
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

Silverman et al., 2007
Suicidality in People with Eating Disorders

Scott Crow, M.D.
University of Minnesota
The Emily Program
• Mortality in people with ED
• Suicide in people with ED
Excess Mortality of Mental Disorder

Harris & Barraclough, 1998

<table>
<thead>
<tr>
<th>Condition</th>
<th>SMR</th>
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<tbody>
<tr>
<td>Opiate</td>
<td>6.38</td>
</tr>
<tr>
<td>ED</td>
<td>5.38</td>
</tr>
<tr>
<td>Bipolar</td>
<td>2.02</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1.57</td>
</tr>
<tr>
<td>MDD</td>
<td>1.35</td>
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</tbody>
</table>
Suicide as a Risk in ED

- Bruch, 1974
- Blinder et al., 1970
Suicide as an Outcome for Mental Disorder

Harris & Barraclough, 1994
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
Suicide Ideation in NCS-R

Crow et al, Comprehensive Psychiatry, 2015, 55:1534-1539
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
<table>
<thead>
<tr>
<th></th>
<th>Suicide Ideation</th>
<th>Suicide Plan</th>
<th>Suicide Attempt</th>
<th>Multiple Suicide Attempts</th>
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<tbody>
<tr>
<td><strong>NCS-A</strong></td>
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<tr>
<td>BN, % (SE)</td>
<td>53 (5.9)</td>
<td>25.9 (6.5)</td>
<td>35.1 (6.6)</td>
<td>17.1 (5.6)</td>
</tr>
<tr>
<td>AN, % (SE)</td>
<td>31.4 (11.2)</td>
<td>2.3 (1.4)</td>
<td>8.1 (5.7)</td>
<td>1.2 (9)</td>
</tr>
<tr>
<td>BED, % (SE)</td>
<td>34.4 (6.2)</td>
<td>5.1 (1.9)</td>
<td>15.1 (7.2)</td>
<td>5.1 (1.4)</td>
</tr>
<tr>
<td>Non-ED Psychopathology, % (SE)</td>
<td>21.3 (1.4)</td>
<td>7.7 (0.8)</td>
<td>6.7 (0.5)</td>
<td>3.5 (0.4)</td>
</tr>
<tr>
<td>No Psychopathology, % (SE)</td>
<td>3.8 (0.4)</td>
<td>0.6 (0.1)</td>
<td>0.3 (0.1)</td>
<td>0.1 (0.0)</td>
</tr>
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</table>

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 & Sonneville, 2020; Pisetsky et al., under review)
  - Transgender women may be at particularly elevated risk (Simone et al., unpublished data)
- Lesbian, gay, or bisexual (Lipson & Sonneville, 2020; Pisetsky 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

- Thwarted Belongingness
- Perceived Burdensomeness
- Desire for Suicide
- Suicidal Intent
- (Near) Lethal Suicide Attempt

Factors:
- Fear of Death
- Pain Tolerance
- Acquired Capability

Arrows indicate the direction of influence or causation.
Interpersonal Theory of Suicide

- Thwarted Belongingness
- Perceived Burdensomeness

Desire for Suicide

Suicidal Intent

(Near) Lethal Suicide Attempt

- Fear of Death
- Pain Tolerance
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**Interpersonal Theory of Suicide**

- **Thwarted Belongingness**
- **Perceived Burdensomeness**

**Desire for Suicide**

**Suicidal Intent**

- **Fear of Death**
- **Acquired Capability**
- **Pain Tolerance**

**(Near) Lethal Suicide Attempt**
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

Thwarted Belongingness

Perceived Burdensomeness

Suicidal Ideation

Pisetsky et al., 2017

Smith et al., 2016
Pisetsky et al., 2017
Evidence for IPTS in Eating Disorders

Fearlessness About Death

↑ Pain Tolerance

(Near) Lethal Suicide Attempt

Smith et al., 2016

Pisetsky et al., 2017

Forrest et al., 2017
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

Lucene Wisniewski, PhD, FAED
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
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<tr>
<td><strong>Best practice: ask the suicide question</strong></td>
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- **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?
LINEHAN RISK ASSESSMENT AND MANAGEMENT PROTOCOL (LRAMP)

Client: ______
Person Completing: ______
Date Contacted: ______
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:
   ______________________________________
   ______________________________________
   ______________________________________
   ______________________________________
Pull out all the stops (while maintaining the relationship)
If chronically suicidal \textit{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

CEBTOhio
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

Stress in school
I can’t handle this: I am going to fail
It doesn’t matter: I’ll kill myself
Decrease anxiety-negative R*

CEBTOhio
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
Connect Present Commitments to Prior Ones

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@cebtohio.com