

Eating Disorders and Suicide

Eating Disorder Center of Excellence

August 28, 2025

1- 2 PM EST



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Welcome!

Thank you for joining



September is National Suicide Prevention Month



Suicide prevention is important every day of the year. September allows us to shine a special, encouraging light on this topic that affects us all and send a clear, hopeful, and powerful message that help is available and suicide can be prevented.



If you or someone you know is struggling or in crisis, help is available.
Call or **text** 988 or chat **[988lifeline.org](https://www.988lifeline.org)** to reach the 988 Suicide & Crisis Lifeline.

Housekeeping Notes

Warning



This webinar discusses themes of suicide, suicidal ideation, self-harm, and other topics that may be disturbing or upsetting to some.

Recording



This webinar is being recorded. By attending, you consent to being recorded.

Questions



During the webinar, feel free to submit questions and feedback in the Zoom Q&A feature. There will be dedicated Q&A time at the end of the presentation.

Sound/Video



Participants are muted upon entry and videos turned off. For technical assistance, please use the chat.

Presentation Materials



Participants will receive a link to the presentation slides and a recording via email after the webinar.



DISCLAIMER

The views expressed in this webinar do not necessarily represent the views, policies, and positions of the U.S. Department of Health and Human Services.



Our Speakers



Facilitator

Jeffrey Greenberg, PhD

Director, Eating Disorder Center of Excellence



Presenter

Dr. Jean Doak

Executive Subject Matter Expert

RELEVANT EXPERIENCE

- Clinical psychologist
- Specialized training in PTSD evaluation and treatment
- Experience leading behavioral health initiatives with federal entities such as United States Navy Bureau of Medicine and Surgery (BUMED), Defense Centers of Excellence for Psychological Health and TBI (DCoE), National Center for PTSD, Veterans Health Administration (VHA), and the United States Air Force Medicine
- Experience leading in-person and virtual TTA efforts to implement new behavioral health programs and treatments

RELEVANT EXPERIENCE

- Clinical Director of the UNC Center of Excellence for Eating Disorders
- Licensed psychologist
- Focused on education, training and clinical practice in adolescent medicine/mental health with a specialization in eating disorders
- Expertise in training, program development, research/practice integration and clinical operations
- Previous experience as the Assistant Professor at Baylor College of Medicine/Texas Children's Hospital and Regional Director at Cleveland Center for Eating Disorders/The Emily Program

Our Mission

Serve as the **preeminent federal resource in eating disorders** to advance education, public awareness, prevention, treatment, and recovery.

We will do this by **equipping** healthcare professionals, **educating** unique audiences, **advancing intervention** capabilities, and **accelerating** public health **solutions**.

- ✓ Educational webinars
- ✓ Engaging peer-to-peer communities
- ✓ Tailored resources

Poll



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Which of the following statements are true?

Note: More than one statement may be true

A

Talking about suicide can increase risk for individuals

B

Most people who consider suicide do not want to die

C

Once someone survives a suicide attempt, the danger is over

D

Suicide is preventable

E

Only people with diagnosed mental illnesses die by suicide

Which of the following objectives are you hoping to learn today?

A

The relationship between eating disorders and suicide

B

Suicide warning signs and risk factors

C

How suicide risk guides eating disorder treatment

D

Example patient case studies

E

Resources for support

Today's Topic and Goals

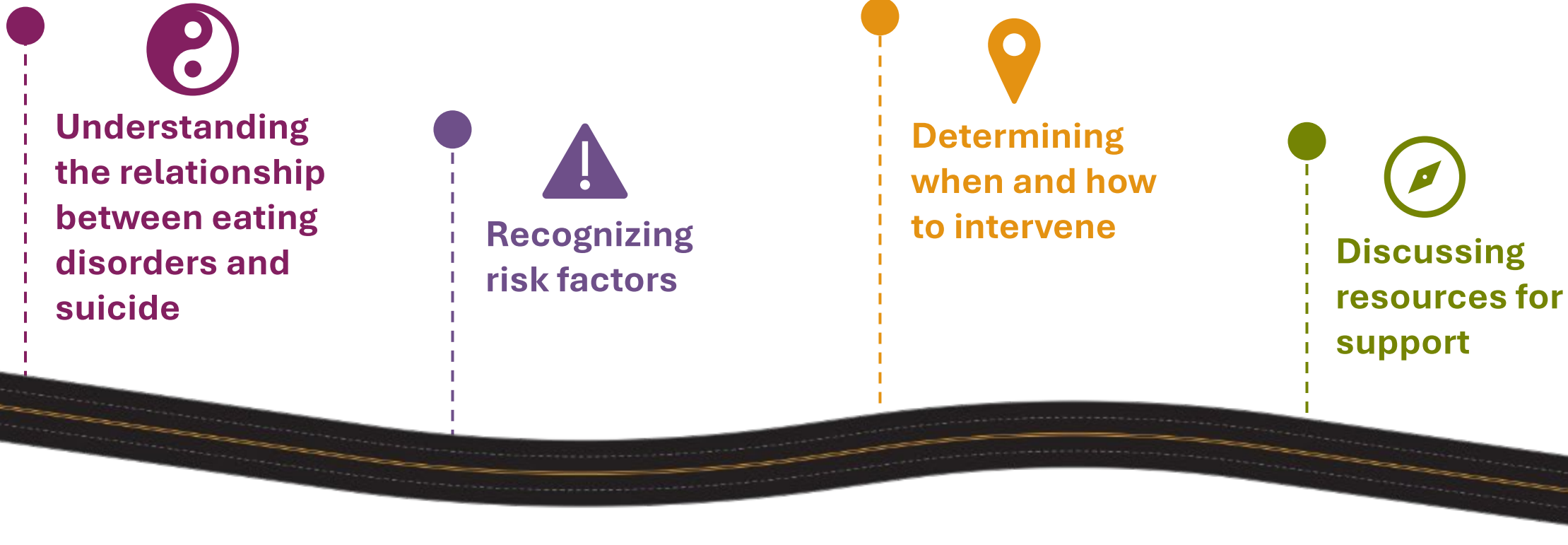


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Our Road Ahead

Today's discussion will be organized around four session goals.



Introduction to Suicide: Theory and Practice



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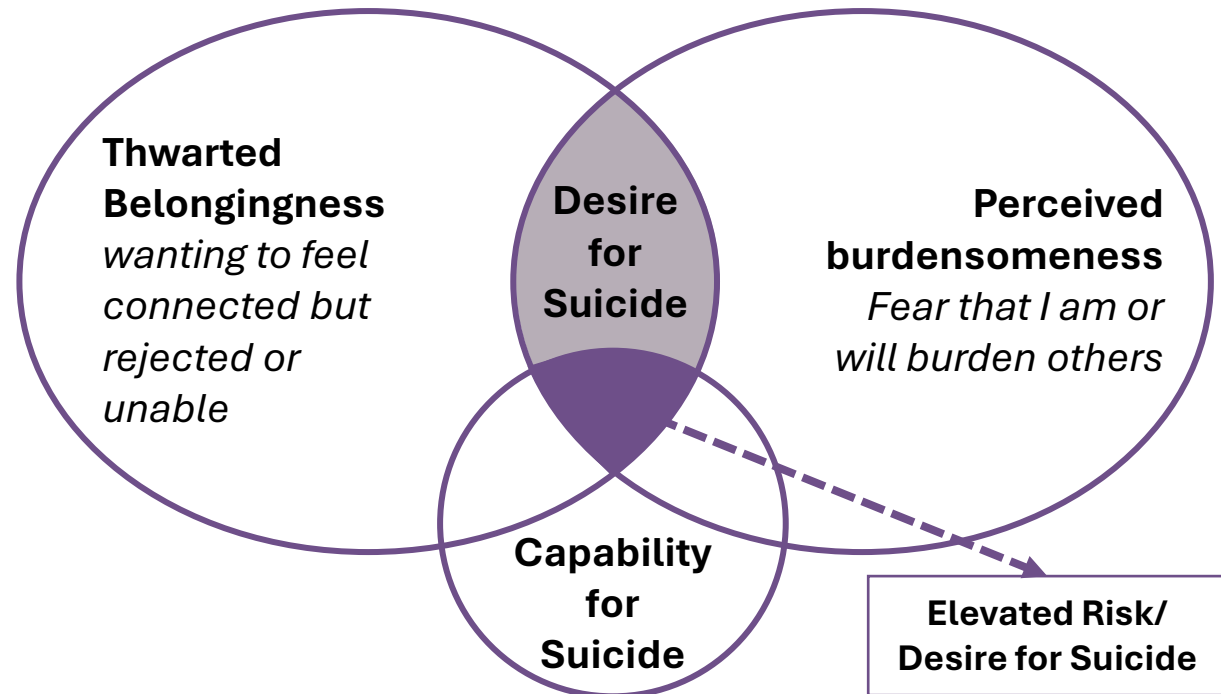
Joiner's Interpersonal Model of Suicidality

Joiner's model provides a framework for identifying individuals at risk for suicide and developing targeted interventions.

Model Description
<p>This theory is composed of two psychological constructs:</p> <ul style="list-style-type: none">• Feeling that attempts to connect to others are unsuccessful (thwarted belongingness)• A perception of being a burden to others (perceived burdensomeness)



Model Diagram



Note, neither of these states are enough to move a person to act on the desire for death, but together with a capability (or fearlessness) they result in a high-risk state for suicide.



Providers Can Take Actions to Prevent Suicide

Because suicide prediction can be difficult, there are specific best practices and actions that providers can take to minimize self-harm and suicide risk.

Best Practices

Suicide prevention is comprised of benevolence and non-malevolence:



First, do no harm



Discuss the limits of confidentiality



Respect autonomy, create a safe environment, create a safety plan, refer as needed;

C

Three C's – Connection, Collaboration, and Choice

R

Three R's – Recognize, Respond, and Refer



Suicide is not fixed; risk may rise and fall

Specific Action Steps

1

After identification of suicide risk, **discuss** the limits of confidentiality, danger to self, and others, or if subpoenaed

2

Conduct a first risk appraisal, identify if there is a history of self-harm or prior non-fatal self-injurious behavior

3

Continue risk assessments are continued from session to session because risks can shift based on numerous factors

4

Create a safety plan including:

- Warning signs
- Internal coping strategies
- Social and supportive contacts who can provide assistance
- Emergency resources (e.g., therapist contact number, hotlines, emergency room locations)
- Working toward a safer environment (e.g., remove access to means)

5

Refer to a high level of care, if necessary (e.g., increased sessions, more frequent check-ins, refer to inpatient care)

The Relationship Between Eating Disorders and Suicide








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Suicide in Individuals with Eating Disorders

Research shows there can be a correlation between eating disorders and risk of suicide. Below are key characteristics:

-  **Symptomology** Eating disorders are often associated with poor self-esteem, self-hate, and suicidal behavior
-  **Risk Factors** Those with **anorexia nervosa**, **bulimia nervosa**, and **binge eating disorder** tend to be at the highest risk of suicide
-  **Co-Morbidity** There is high co-morbidity between eating disorders and mood disorders
-  **Treatments** Individuals with eating disorders and elevated risk of suicidality can be difficult to treat and may require care in a secure environment
-  **Outcomes** Not everyone with an eating disorder will experience suicidal thoughts or behaviors



Mood Disorders and Eating Disorders Co-Morbidity

There is a high co-morbidity between eating disorders and mood disorders which can significantly complicate diagnosis, treatment, and recovery.

Co-Morbidity Facts

- Up to **54% of individuals** with eating disorders also experience mood disorders such as major depressive disorder (MDD)
- Eating disorders and mood disorders share **neurovegetative symptoms** like changes in appetite, sleep disturbances, and low energy
- Overlapping symptoms can make it difficult to determine which condition is primary

Co-Morbidity Causes

- **Serotonin dysregulation:** Implicated in both depression and EDs, affecting mood and appetite regulation
- **Hypothalamic-pituitary-adrenal (HPA) axis impairments:** Associated with stress responses
- **Gray matter volume reductions:** Found in brain regions related to reward and emotion processing
- **Genetic variants:** Some genes may predispose individuals to both conditions

Co-Morbidity Outcomes

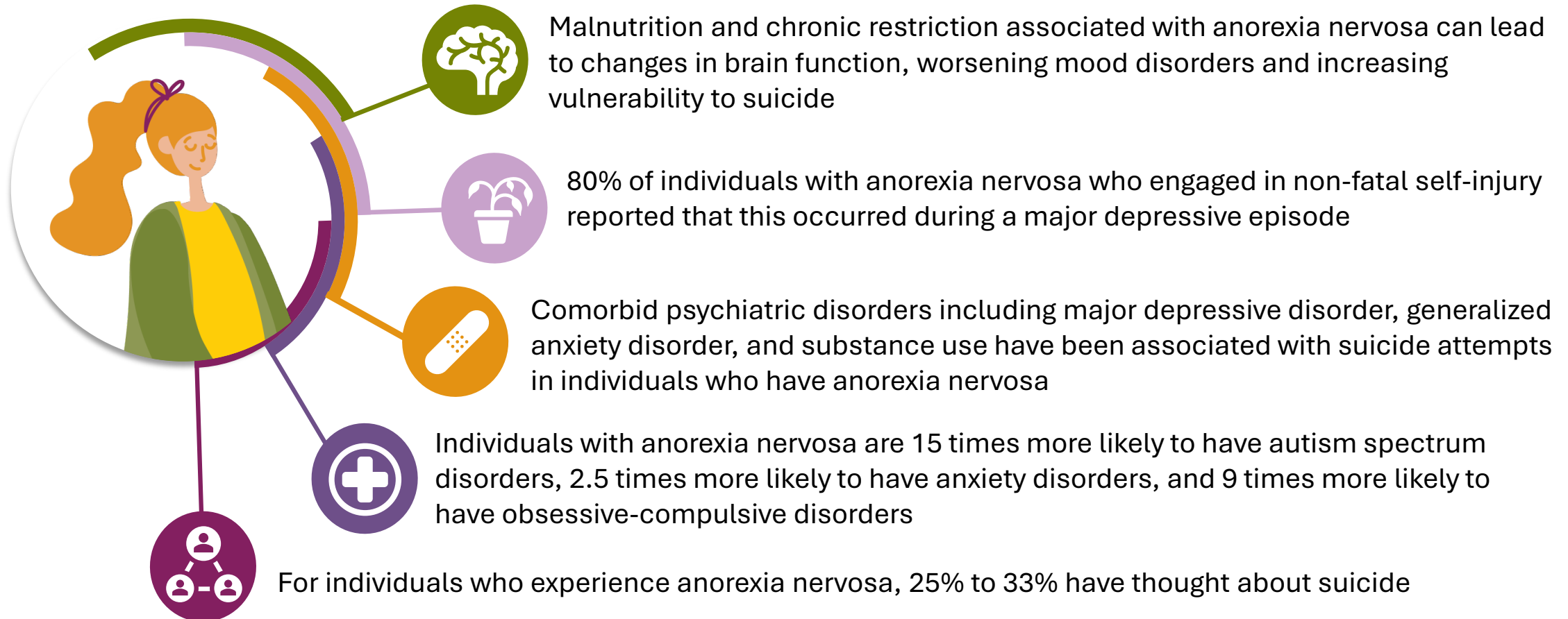
Co-morbidity often leads to

- Increased severity of symptoms
- Feelings of hopelessness
- Low self-worth
- Emotional dysregulation
- Impulsivity
- Greater functional impairment
- Higher risk of non-fatal self injury and suicide



Understanding Anorexia Nervosa and Suicide

Individuals with anorexia are **two to nine times** more likely to engage in non-fatal self-injurious behavior.





Malnutrition Damages Mood and the Brain

Malnutrition associated with eating disorders can have profound structural and functional impacts on the brain.

Structural Impacts



Reduced Brain Volume

Prolonged malnutrition leads to loss of gray and white matter, particularly in areas responsible for emotion regulation, decision-making, and self-perception



Shrinking of Brain Tissue

MRI studies show that individuals with anorexia may experience brain atrophy, which can reverse with nutritional rehabilitation but may leave lasting effects if untreated



Leptin and Cortisol Dysregulation

These hormones affect hunger and stress responses. Malnutrition alters their levels, which can impair emotional regulation and increase vulnerability to mood disorders

Functional Impacts



Brain Fog and Poor Concentration

Lack of essential nutrients like glucose, B vitamins, and omega-3 fatty acids impairs cognitive function, leading to memory issues, slowed thinking, and difficulty focusing



Emotional instability

Malnourished brains struggle to regulate emotions, increasing irritability, impulsivity, and mood swings



Low Insight and Distorted Self-Image

Brain regions involved in self-awareness and error detection may function abnormally, making it harder for individuals to recognize the severity of their condition



We Have a Collective Suicide Awareness Responsibility

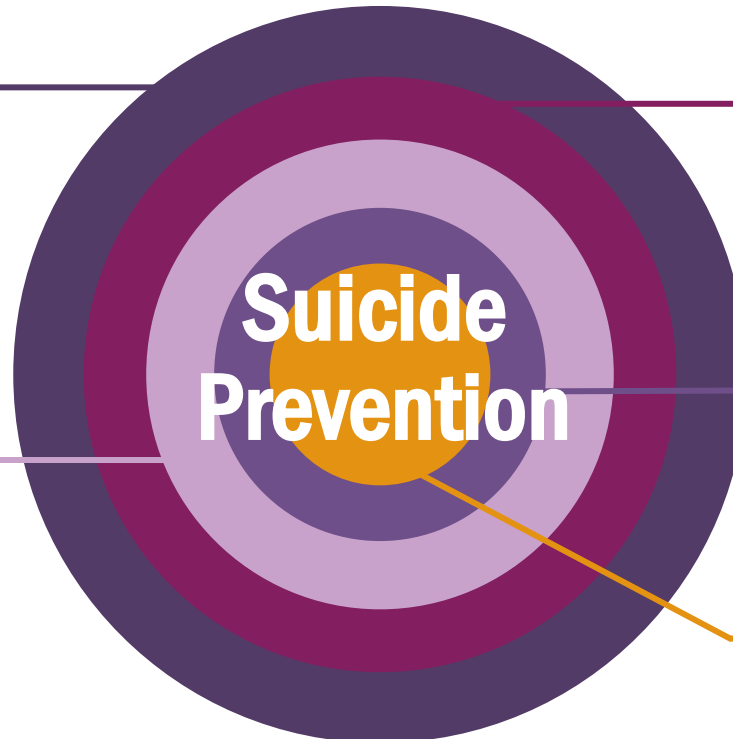
We each have a critical role in fostering early intervention by actively supporting those around us.

Behavioral Health Providers

Conduct routine screenings, monitor changes in mental health/safety status, develop personalized safety plans, and practice de-escalation techniques

Primary Care Clinicians

Implement clinic-wide protocols for suicide prevention, refer patients to behavioral health specialists when needed, determine necessity of involuntary hospitalization, and work within integrated care teams to ensure follow-up and continuity of care



Suicide Prevention Specialists

Lead the development and implementation of suicide prevention plans using public health and safety approaches

School-Based Personnel

Recognize warning signs, respond to at-risk students, establish student safety plans for at-risk students, and create a supportive environment

Greater Community

Check in on friends, family, colleagues, and community members without judgement

Your understanding and advocacy is vital to addressing suicide risk with eating disorders

Eating Disorders and Suicide Statistics



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Up to **33%** of individuals with eating disorders report engaging in nonfatal self-injury at some point

Anorexia nervosa has the 2nd highest mortality rate of any other mental illness of 5.1 (deaths per 1000 person-years)





Individuals with anorexia nervosa are **18 times** more likely to die by suicide, and those struggling with bulimia nervosa are **7 times** more likely to die by suicide

Approximately **1/4**
to **1/3** of people
with anorexia
nervosa and
bulimia nervosa
have engaged in
nonfatal self-
injurious behavior



Understanding Warning Signs and Risk Factors



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Be Aware of the Suicide Warning Signs & Risk Factors









People who are considering suicide often exhibit similar signs and risk factors.*

COMMON WARNING SIGNS

- Beginning to withdraw from social activities
- Isolating from others
- Talking about feeling trapped
- Displaying extreme mood swings
- Starting to give away possessions
- Expressing thoughts about death or dying, not being around in the future
- Saying goodbye to family and friends
- Taking dangerous risks such as driving extremely fast
- Eating or sleeping more or less
- Using drugs or alcohol more often
- Reduced eye blink rate may indicate imminent risk



INDIVIDUAL RISK FACTORS

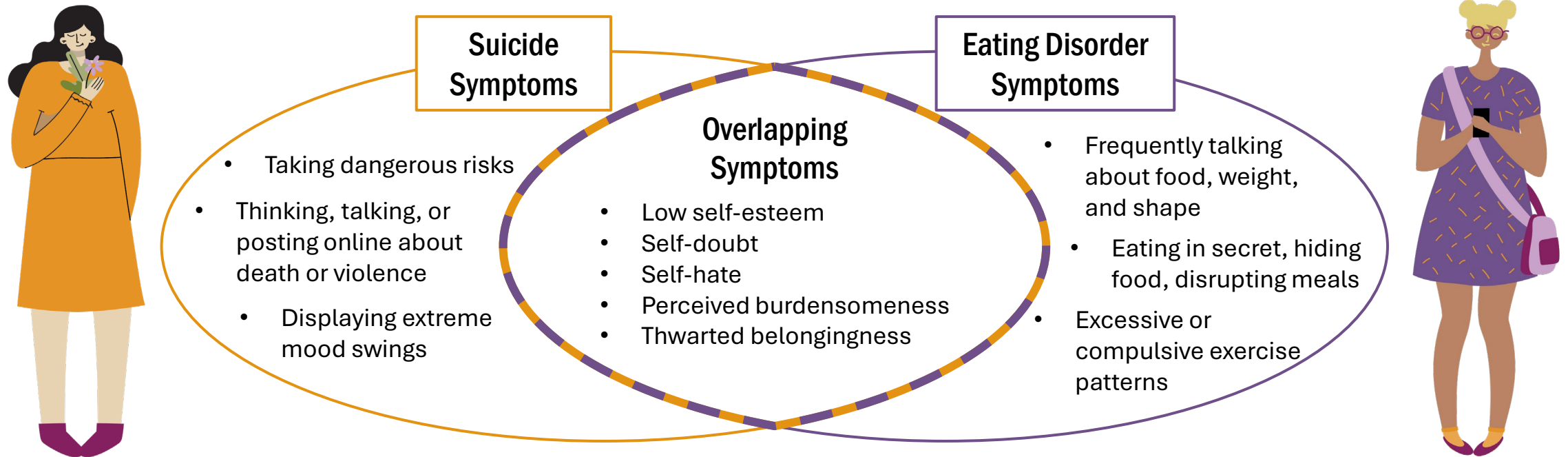
-  Substance misuse
-  Family history of suicide
-  Difficulty regulating emotions
-  Self-harm behaviors or access to lethal means
-  Hospitalization, treatment history, or chronic pain
-  Tolerance for high risk and impulsive behaviors
-  Co-occurring psychiatric disorders (e.g., mood and anxiety disorders)
-  Financial problems

*Note, this list is not exhaustive. Visit the [National Alliance for Eating Disorders](#) for more information.



Understanding Interconnected Symptomatology

Eating disorders and suicide often display overlapping symptoms which can be used to more easily detect suicide risk in individuals.



Suicidal ideation affects approximately 25–33% of individuals with anorexia, bulimia, or binge eating disorder



Risk Factors and Protective Factors That Can Make a Difference

Risk factors and protective factors affect the chances of outcomes like suicide and operate at individual, relationship, community, and societal levels.

Risk Factors



Individual-level

Mental health conditions and substance use



Relationship-level

Family conflict, experience with suicide loss (especially in family), social isolation



Community-level

Community violence, historical trauma, access to lethal means



Societal-level

Stigma, racism, discrimination

Protective Factors



Individual-level

Problem-solving and coping skills, positive self-esteem, sense of purpose



Relationship-level

Family connectedness, supportive friendships



Community-level

Access to behavioral health services, cultural norms discouraging suicide, ties to social/community groups



Societal-level

Cultural identification, anti-discrimination policies

Recognizing Suicide Risk to Guide Eating Disorder Treatment



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It's Important to Screen for Suicide Risk

Screening for suicide risk is critically important—especially in populations with mental health conditions like eating disorders—because it can **save lives**.

1	Screening Importance	2	Suicide Screener	3	Screener Results
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Early Identification

- Suicide risk often goes unnoticed until a crisis occurs
- Screening helps identify individuals of all risk levels who may be silently struggling, allowing for early intervention

Prevention

- Timely screening enables mental health professionals to provide support, therapy, and crisis intervention

Guiding Treatment Decisions

- Understanding suicide risk helps care providers tailor interventions such as referral to care and medication

*Visit the [National Institute of Mental Health](https://www.nimh.nih.gov) to access the ASQ tool and additional resources
 **Note: Clinical judgment can always override a negative screen

SUCIDAL IDEATION		Since Last Visit
<p>Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.</p>		
<p>1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you thought about being dead or what it would be like to be dead?</i> <i>Have you wished you were dead or wished you could go to sleep and never wake up?</i> <i>Do you wish you weren't alive anymore?</i> If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/unassisted methods, intent, or plan during the assessment period. <i>Have you thought about doing something to make yourself not alive anymore?</i> <i>Have you had any thoughts about killing yourself?</i> If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it." <i>Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?</i> If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them." <i>When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.</i> If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out/worked out the details of how you would do it?</i> <i>What was your plan?</i> <i>When you made this plan (or worked out these details), was any part of you thinking about actually doing it?</i> If yes, describe:</p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No <input type="checkbox"/> <input type="checkbox"/></p>
<p>INTENSITY OF IDEATION The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).</p>		
<p>Most Severe Ideation: _____ Type # (1-5) _____ Description of Ideation _____</p>		<p>Most Severe</p>
<p>Frequency <i>How many times have you had these thoughts?</i> _____ Write response _____ <small>(1) Only once (2) A few times (3) A lot (4) All the time (5) Don't know/Not applicable</small></p>		

The Columbia-Suicide Severity Rating Scale (C-SSRS) is an additional suicide risk screening tool



Questions to Screen for Suicide Risk

The first step in assessing suicide risk is conducting a screening. The Ask Suicide-Screening (ASQ) can be administered in 20 seconds or less.*



Screening Questions

- 1 In the past few weeks, have you wished you were dead?
- 2 In the past few weeks, have you felt that you or your family would be better off if you were dead?
- 3 In the past week, have you been having thoughts about killing yourself?
- 4 Have you ever tried to kill yourself? If yes, how?

If the patient answers “YES” to any of the above, ask the following acuity question:

- 5 Are you having thoughts of killing yourself right now? If yes, please describe.

Note on Screener Eligibility

The Ask Suicide-Screening Questions (ASQ) toolkit is designed to screen medical patients ages 8 years and above for risk of suicide. As there are no tools validated for use in kids under the age of 8 years, if suicide risk is suspected in younger children a full mental health evaluation is recommended instead of screening.



Suicide Screener Result Meanings

The Ask Suicide-Screening (ASQ) will provide feedback on next steps depending on suicide risk level.

1 Screening Importance

2 Suicide Screener

3 Screener Results

Screening Result Meanings

A **“YES”** to any questions 1-4 and **“NO”** to question 5 indicates a non-acute positive screen.** Alert physician or clinician responsible for patient’s care.

A **“YES”** to any questions 1-4 and **“YES”** to question 5 indicates an acute positive screen with imminent risk identified. Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.



Next Steps After Screening

Patients who screen positive for suicide risk on the ASQ should receive a brief suicide safety assessment (BSSA) conducted by a trained clinician (e.g., social worker, nurse practitioner, physician assistant, physician, or other mental health clinicians) to determine if a more comprehensive mental health evaluation is needed.



Suicide Risk Guiding Eating Disorder Treatment

An individual's risk for suicide informs the decision-making process and a recommended treatment plan.

<p>1</p> <h2>High Risk</h2> <p>If a patient is at an immediate risk of death suicide, a higher level of care may be necessary. Follow ethical guidelines on management of risk (e.g., respect for person, beneficence, non-malevolence, least restrictive environment). Maintaining safety of life is paramount.</p>	<p>2</p> <h2>Medium Risk</h2> <p>If a patient is at a moderate level of risk of suicide, then care and planning is warranted. With deference to the rules of respect and autonomy, safety plans should be discussed and agreed to with the patient. Clinical care for an eating disorder can be implemented, with the need to maintain risk awareness.</p>	<p>3</p> <h2>Low Risk</h2> <p>Any patient should be assessed for risk of self-harm. During initial session, the limits of confidentiality should be discussed and questions answered. With recognition that self-harm is a risk in the eating disorder population, safety planning should be discussed. Clinical care for an eating disorder can be implemented, with regular risk appraisal.</p>	<p>4</p> <h2>Monitoring Risk</h2> <p>Not all self-injury or suicidal ideation indicates a high suicide risk level or being actively suicidal. Screening should be performed regularly to determine the need for treatment. Follow best practices and consider tools such as the Columbia Suicide Severity Rating Scale, Ask Suicide Screening Questions Toolkit, and Patient Health Questionnaire-9.</p>
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These categories can be fluid for a patient. A patient could be low risk today, but that does not guarantee they'll be low risk tomorrow.



Preparing High, Medium, and Low Risk Patients for Care

Specific steps can be taken with individuals at high, medium, and low risks to prepare for specialized care.

1 High Risk

1. **Express** concern for individual's safety
2. **Discuss** the need for higher level care
3. **Identify** supportive individuals
4. **Develop** safety plans for check-in, tools to reduce distress, and a plan for higher level care
5. **Follow** safety plan agreement and implement inpatient care as agreed with involuntary hospitalization as the last resort

2 Medium Risk

1. **Discuss** current and recent risk level noting concern for safety
2. **Discuss** options for higher level care should the patient need this for safety
3. **Implement** a plan for inpatient care if needed
4. **Implement** a commitment to call plan including contacting specific individuals for proactive planning

3 Low Risk

1. **Discuss** the limitations of confidentiality and how safety is essential
2. **Develop** safety plans as a precaution with understanding that risk for self-harm in eating disorder patients can be high and can fluctuate
3. **Remind** individual of your intention to act in their best interest with safety paramount, even though limited planning is needed

*Example safety plan can be found in subsequent slide



Example Patient Scenario 1

Consider this individual's risk category and proper follow up steps to take as a provider.

Patient Background

- David is a 33-year-old man with a family history of mental health disorders
- David was diagnosed with anorexia nervosa 1 year ago and obsessive-compulsive disorder (OCD) five years ago

Changes in Behavior

- Over the past year, David began to run excessively, eliminate foods, and create food rules, leading to his anorexia nervosa diagnosis
- Over the past year, David has been admitted to inpatient care for his anorexia nervosa twice. Both times, he gained enough weight required for discharge but inevitably relapsed.

David



Presenting Concerns

David visits his therapist for his weekly appointment and mentions the following information

- Reports increasing feelings of hopelessness over the past month
- Mentions feeling “guilty” after eating certain foods and feeling a burden to family and friends

David's clinician finds that David is engaging in more risky behavior (e.g., drinking more alcohol)



Example Patient Scenario 1 Explanation



David could be placed in the medium-risk category

2

Medium Risk

Important Data Points:

- David has a diagnosed eating disorder and has been previously admitted to inpatient care
- David is showing signs of behavior which while concerning do not specifically constitute self-harm
- The combination of behavioral health conditions combined with increased alcohol consumption causes his therapist to be concerned about David's potential for self-harm

Recommended Next Steps:

- David's therapist should discuss these concerns and develop a safety plan which includes the potential for inpatient care
- David's therapist should address the risks of alcohol use, identify if anything has changed recently, and work with David to discontinue use of alcohol
- David's therapist should more regularly monitor for safety, and be prepared to initiate the agreed upon safety plan should David present at heightened risk



Example Patient Scenario 2

Consider this individual's risk category and proper follow up steps to take as a provider.

Patient Background

- Harper is a 25-year-old female
- Harper was diagnosed with anxiety and Polycystic Ovary Syndrome (PCOS) 4 years ago

Harper



Presenting Concerns

Harper visits her primary care doctor for her annual physical and mentions:

- A recent difficulty concentrating in work and general disinterest in activities
- Recent abdominal pain

Clinician Assessment

The clinician finds:

- Harper has lost 30 lbs. since her annual physical the year prior with no underlying health causes but is within normal BMI



Example Patient Scenario 2 Explanation



Harper could be placed in the low-risk category

3

Low Risk

Important Data Points:

- Harper has PCOS and depression/anxiety which are often co-occurring mental health conditions to an eating disorder
- Harper is showing signs of bulimia nervosa

Recommended Next Steps:

- Harper's doctor should ask why and how Harper believes she lost 30 pounds
- Harper should receive a comprehensive psychological evaluation including assessment for eating disorders
- Individuals like Harper benefit from a comprehensive evaluation to identify a full clinical picture (e.g., depression, anxiety, bulimia nervosa). A treatment plan which also considers safety planning (considering the higher risk of self-harm associated with ED's) should be developed and implemented.



Example Patient Scenario 3

Consider this individual's risk category and proper follow up steps to take as a provider.

Patient Background

- Alex was diagnosed with anorexia nervosa three years ago
- Alex has past a history of a significant non-fatal self-injury

Changes in Behavior

- Alex discloses current self harm behavior including recent notable self-administered cigarette burns

Alex



Presenting Concerns

- Alex visits her primary care doctor for her annual physical and discusses current thoughts of ending it all

Clinician Assessment

The clinician finds:

- Alex's BMI continues to drop
- Alex has new substance use including use of a GLP-1 from an online resource



Example Patient Scenario 3 Explanation



Alex could be placed in the high-risk category

1

High Risk

Important Data Points:

- Alex's disclosure of current thoughts to end her life requires immediate action by her healthcare provider
- Alex has a history of a significant non-fatal self-injury and an ongoing eating disorder diagnosis

Recommended Next Steps:

- Alex's doctor should discuss his/her concerns of Alex's reported thoughts and signs of self harm
- Alex's doctor should suggest Alex be immediately transferred to in-patient care
- If Alex is not willing to be transferred to in-patient care, discuss a safety plan and appropriate next steps for care

Resources for Support



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Removing Shame to Support Suicide Prevention

Removing shame from the conversation around eating disorders is crucial for suicide prevention. It is important to remember the following to increase acceptance:



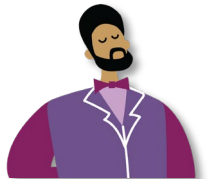
Encouraging Treatment is Key

Individuals experiencing eating disorders who are at risk of suicide can often face intense feelings of shame which negatively impact their willingness to seek treatment.



Longterm Survival is Common

90% of individuals who have engaged in non-fatal self-injury and survive will not go on to die by suicide at a later date.



Minimizing Risk is Important

Patients with chronic psychiatric illness in general are a highly vulnerable population, and feelings of helplessness and discouragement are inherent in the battle for recovery.



Open Communication Increases Connection

Talking about suicide does not increase an individual's risk factor to engage in a non-fatal self-harm activity.



The Path to Healing Takes Time

It is common for patients to repeatedly "fail" treatment before making progress towards recovery. The path is not linear.



Full Recovery is Possible

Many people go on to live healthy, fulfilling lives after struggling with eating disorders and risk of suicide.



Utilizing a Safety Plan for High and Medium Risk Patients

A safety plan outlines the steps an individual in crisis can take to protect themselves. This example safety plan is provided by the 988 Suicide & Crisis lifeline and can be found [here](#).

Example Prompts/Questions

- 1 Write 3 warning signs that a crisis may be developing.
- 2 Write 3 internal coping strategies that can take your mind off your problems.
- 3 Who/What are 3 people or places that provide distraction?
- 4 Who can you ask for help? Write name/place and phone numbers.
- 5 Professionals or agencies you can contact during a crisis (clinician, local urgent care or emergency department, 988, chat 988lifeline.org, etc.)
- 6 Write out a plan to make your environment safer (write 2 things).



988
SUICIDE & CRISIS
LIFELINE

988 is available through call and text as well as chat through 988lifeline.org



Incorporating 988 Services in Care

988 offers 24/7 judgement-free support for mental health/substance use crisis and those experiencing emotional distress.

The 988 Suicide & Crisis Lifeline provides free and confidential emotional distress counseling 24 hours/day and 7 days/week through a national network of over 200 local crisis centers

Visit the [988 Crisis Systems Response Training & Technical Assistance Center \(CSR-TTAC\)](#) for a library of resources on 988 and upcoming training opportunities, webinar, workshops, and more

You Are Not Alone.



988 | SUICIDE & CRISIS
LIFELINE

*The 988 Suicide & Crisis Lifeline also offers dedicated help for Veterans through a press 1 option that directs callers to the Veterans Crisis Line (VCL).

Recap and Closeout



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Recap of Lessons Learned



Eating Disorders and Suicide Are Deeply Interconnected

Individuals with eating disorders – especially anorexia nervosa, bulimia nervosa, and binge eating disorder – are at significantly high risk for suicidal ideation and behaviors.



Recognizing Warning Signs and Risk Factors is Important

Common suicide warning signs include social withdrawal, mood swings, and giving away possessions. Risk factors include co-occurring psychiatric disorders, substance misuse, and a history of self-harm. Early identification and routine screening are critical for prevention.



Suicide Risk Should Guide Eating Disorder Treatment

Patients can be categorized into high, medium, low, or monitoring risk levels, which inform treatment decisions. High-risk individuals require immediate in-patient care and safety planning.



Reducing Shame and Promoting Open Communication Saves Lives

Removing stigma around eating disorders and suicide encourages individuals to seek help. Full recovery is possible, and many individuals go on to live fulfilling lives with proper treatment and support.





References

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- [The Relationship Between Eating Disorders and Suicidality - National Alliance for Eating Disorders](#)
- [988 Lifeline - If you need emotional support, reach out to the national mental health hotline: 988.](#)

Q&A



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