

# Suicidal behavior in adolescents and adults with bulimia nervosa

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## Abstract

**Background:** Recent evidence suggests increased risk for mortality in bulimia nervosa (BN). However, little is yet known about suicidal behavior in BN.

**Aims:** To examine frequency and correlates of suicidal ideation and attempts in adolescents and adults with BN in two population-based samples.

**Method:** A total of 10,123 adolescents and 2980 adults in two nationally representative surveys of mental disorder were queried regarding eating disorder symptoms and suicidal ideation and attempts.

**Results:** Less than 1 percent (0.9%) of adolescents and 1.0% of adults met the criteria for BN. Suicidal ideation was more common among adolescents with BN (53.0%) compared with those with binge eating disorder (BED) (34.4%), other psychopathology (21.3%) or no psychopathology (3.8%). Similar trends emerged for the association between BN and self-reported suicidal plans or attempts. Among adults, suicidality was more common in BN than in the no psychopathology group, but not significantly different from the anorexia nervosa (AN), BED, or other psychopathology subgroups.

**Conclusion:** There is a high risk of suicidal ideation and behavior among those with BN. These results underscore the importance of addressing suicide risk in adolescents and adults with eating disorder symptoms.

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## 1. Introduction

Although the risk of suicide and increased mortality has been well-documented among those with anorexia nervosa (AN), the occurrence of suicidal ideation and attempts, as well as completed suicide among people with bulimia nervosa (BN) has been less well recognized [1–8]. As in AN, suicidal behavior is more prevalent in BN among those with purging behavior [9–11], and with co-occurring psychopathology such as obsessive–compulsive disorder [12], borderline personality disorder [13], bipolar disorder [14–17] and major depression [18,19]. Other factors that may increase the risk for suicidal behavior in BN are

impulsivity and body dissatisfaction, both of which have been strongly associated with BN [20–22].

Most previous studies of suicidal behavior in BN have been based on small clinical samples that may be biased because of differential representation of those with suicidal behavior in treatment settings. The high magnitude of comorbidity with mood, anxiety and substance use disorders in BN has also been demonstrated in community samples which may therefore provide a valuable resource to investigate potential links between comorbid conditions and suicidal behavior in BN. In addition, few studies have jointly evaluated the risk of suicidal behavior and its correlates in those with eating disorders across the life span. Identification of the specificity of the association between suicidal behavior with particular subtypes of eating disorders in both youth and adults could provide valuable information for potential preventive interventions. Therefore, the goal of this investigation was to examine suicidal behavior and its correlates in adolescents and adults with BN in two large population-based samples.

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## 2. Methods

The data for these analyses were drawn from the National Comorbidity Survey-Adolescent supplement (NCS-A) [23,24] as well as the National Comorbidity Survey Replication (NCS-R) [25].

The NCS-A was a nationally representative face-to-face survey conducted with 10,123 adolescents living in the continental United States. The survey included a nationally representative household sample ( $n = 879$ ) and a school-based sample ( $n = 9244$ ), with an overall response rate of 89.2%. One parent or surrogate of each participating adolescent was requested to complete a Self-Administered Questionnaire (SAQ) to collect information on their adolescent offspring's medical and mental health and other family- and community-factors. The SAQ was completed by 6483 parents, yielding an overall conditional response rate of 83.3%.

The NCS-R was a nationally representative survey of 9282 English-speaking participants aged 18 and older; the response rate was 70.9%. A two-part survey was used, with Part I including the core diagnostic assessment. Part II examined additional disorders and disorder correlates among 5692 participants (all participants who met lifetime criteria for a Part I plus a probability sample drawn from other participants); a probability subsample of Part II participants were asked to provide data on eating disorders ( $n = 2980$ ). Analyses for this paper are based on this subsample.

For each sample, DSM-IV disorders were established using the World Health Organization Composite International Diagnostic Interview (CIDI version 3.0) in the NCS-R and a modified version for age appropriateness experience in the NCS-A [25]. This fully structured interview was administered by trained lay interviewers to the participants. For adolescents, parent report from the SAQ was utilized to assess attention deficit/hyperactivity disorder. For conduct disorder and oppositional defiant disorder, diagnostic information was combined at the symptom level using 'or' rule, (i.e., the symptom was considered to be present if either informant (adolescent or parent/surrogate) reported). Both lifetime and 12-month diagnosis were available as well as age of onset. A more complete description of the diagnostic measures has been reported previously [23].

In addition to diagnostic assessment for eating disorders, the following were also assessed: mood disorder (major depressive disorder, dysthymia, or bipolar disorder), anxiety disorders (agoraphobia, generalized anxiety disorder, social phobia, specific phobia, panic disorder, post traumatic stress disorder, or separation anxiety disorder), substance use disorders (alcohol or drug abuse/dependence), and behavior disorders (attention deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder).

For these analyses, three primary ED subtypes were examined: AN and BN as defined by the DSM-IV, and binge eating disorder (BED) in keeping with the criteria proposed for further study in the DSM-5. The diagnostic algorithms adhered to the hierarchical distinction between AN

with purging such that those with the purging subtype of AN were not also classified as BN. These disorders were employed in accordance with the published diagnostic algorithms used by Hudson and colleagues [19]. Because the CIDI does not directly assess loss of control or distress associated with binge eating, for both BN and BED those two items were based on questions about eating disorder cognitions.

Participants were queried about lifetime suicidal ideation, plans, and attempts. The specific questions were: Did experience A [You seriously thought about killing yourself] ever happen to you? Did experience B [You made a plan for killing yourself] ever happen to you? Did experience C [You tried to kill yourself] ever happen to you? Participants were only asked about suicide plan and suicide attempts if they endorsed suicidal ideation. The method of attempt was queried for participants who reported an attempt in the preceding 12 months. Due to the sensitive nature of the questions, participants who were able to read were not asked those questions directly but rather read the questions and responded to them independently. Participants who could not read were asked the questions orally and answers were recorded.

## 3. Statistical analyses

All analyses were completed using the SUDAAN software system version 10 (RTI, Research Triangle Park, NC). In the NCS-A sample, the data were weighted to adjust for differential probabilities of selection of respondents within school and household samples, differential non-response, and residual differences between the sample and the United States population on the cross-classification of socio-demographic variables. In the NCS-R, the data were weighted to adjust for the differential probabilities of selection of respondents due to the multi-stage sampling design, differential non-response, and residual differences between the sample and the United States population on the cross-classification of socio-demographic variables. Taylor series linearization method implemented in SUDAAN was used to adjust for the effects of weighting and clustering of the NCS-A and NCS-R data on variance estimates of rates and statistical significance tests. Logistic regression models were used to obtain estimates of odds ratios, adjusting for age, sex, and race/ethnicity. Kaplan–Meier methods were used to obtain estimates for order of onset. Statistical significance was consistently evaluated using 0.05-level, two-sided test.

## 4. Results

The lifetime prevalence of BN among adolescents in NCS-A was 0.9%; lifetime prevalence for AN was 0.3%, and for BED, 1.6% [24]. The corresponding lifetime prevalence figures for adults in the NCS-R were: BN 1.0%, AN 0.6%, and BED 2.8% [19]. Demographic characteristics of the sample are also shown in Table 1.

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