

## The prevalence of self-harm behaviors among a sample of gastric surgery candidates

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### Abstract

**Objective:** The surgical treatment of obesity is becoming increasingly popular; yet, little is known about the self-harm characteristics and adjunctive self-regulation difficulties of those seeking such surgery. In the literature, one study has explored presurgery suicide attempts and several studies have explored the prevalence of postsurgical completed suicides. However, beyond suicide attempts and completions, little is known about the broader self-harm/self-regulation profiles of these patients. In this study, we examined the prevalence of 22 such behaviors among a sample of gastric surgery candidates. **Method:** Using a cross-sectional approach, we examined 121 surgical candidates for 22 self-reported self-harm and self-regulatory behaviors. **Results:** The

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studied behaviors with the highest prevalence rates in this cohort were sexual promiscuity (22.3%), torturing oneself with self-defeating thoughts (20.7%), alcohol abuse (19.0%), and engaging in emotionally abusive relationships (16.5%). With regard to suicide attempts, 9.1% of participants acknowledged a history and 9.1% reported past overdoses. **Conclusions:** These data suggest that (a) adjunctive self-regulatory difficulties may affect a substantial minority of individuals who are seeking gastric surgery for obesity (e.g., promiscuity and alcohol abuse), and (b) the anticipated prevalence rate for past suicide attempts in this population appears to be approximately 10%.

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Bariatric surgery is rapidly becoming the standard of care for the treatment of adults with severe obesity [1]. Surgical intervention has become increasingly advocated because of its efficacy, broader availability, coverage by insurance, and the recent use of laparoscopic entry [2]. Intervention is generally restricted to individuals with body mass indices (BMIs) greater than 40 or those with a BMI greater than 35 and concomitant medical comorbidities such as diabetes and

hypertension [3]. A recent increase in the surgical treatment of obesity is well documented [4–6].

With regard to the literature on the self-harm histories and adjunctive self-regulatory disturbances among obese individuals, there are a number of empirical studies on suicide attempts or completions. For example, in a general US population sample, Carpenter et al. [7] found that an increase in BMI was associated with an increase in suicidal ideation. In addition, in a large family sample of adults, Dong et al. [8] found that individuals with BMIs between 40 and 50 and those with BMIs greater than 50 reported suicide attempts at a rate 87% and 122%, respectively, higher than the general population. These findings suggest that, in the general US

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population, increasing weight status is associated with an increased risk of suicide. However, other studies in general population samples indicate an *inverse* relationship between BMI and suicide [9–11].

In addition to studies in general populations, there are a handful of other empirical studies that reflect very diverse population samples but provide some insight into the complex relationship between weight status and suicide. For example, Goldstein et al. [12] reviewed the findings of 11 double-blind controlled trials of fluoxetine in various samples of obese individuals; the incidence of suicidal ideation among both active drug and placebo groups was identical (0.24%), and there were no completed suicides. Lester [13] examined Native American samples and found that suicide rates were not significantly associated with non-insulin-dependent diabetes, which is frequently associated with obesity. Frank and Dingle [14] studied US women physicians and found associations between depression and obesity and between depression and nonstatistically significantly higher rates of suicide. These data continue to present an inconsistent relationship between obesity and suicide attempts/completions.

In addition to the preceding studies, several investigators have directly examined the prevalence of suicide attempts or completions in pre- or post-gastric-surgery populations. For example, compared with obese women who declined bypass surgery, Rosen and Aniskiewicz [15] found that women who underwent the procedure had a significantly higher frequency of past suicide attempts. Adams et al. [16] prospectively examined nearly 8000 postsurgical patients for a mean follow-up period of 7.1 years; compared with nonsurgical matched obese controls, the suicide rate was higher in those undergoing gastric bypass surgeries (i.e., 15 patient suicides in the surgical vs. 5 patient suicides in the nonsurgical group). Hsu et al. [17] summarized the outcomes of four bariatric surgery studies (total  $N=1197$  patients) and found that, at various points in follow-up, only eight patients completed suicide. Omalu et al. [18] described three cases of postsurgical suicide. Higa et al. [19] found that, among 1040 patients, only one individual completed suicide in the postsurgical follow-up period. Finally, Omalu et al. [20] examined the suicide outcome among post-gastric-surgery patients up to 9 years following intervention. The study sample exceeded 16,000, and during the 9-year period, 440 patients died. Of these 440, 4% (16) suicided and 3% (14) overdosed on drugs and died. The suicide rate in this sample was 0.009%. These data indicate that (a) the lifetime history of suicide attempts among the obese seeking surgical intervention is not well studied, and (b) completed suicide following the surgical treatment of obesity is a very infrequent event.

In summary, the literature is controversial regarding the risk of suicide attempts among obese adults both in clinical and nonclinical settings. Coupled with this observation, the majority of studies in gastric surgery populations have

examined the suicide risk in the *aftermath* of intervention, and rates have been minimal. In this study, we examined among a sample of gastric surgery candidates the lifetime prevalence of various self-harm behaviors including suicide attempts as well as several self-regulation disturbances. To our knowledge, such a thorough inventory of these behaviors has never been examined in this type of study sample.

## Method

### Participants

Participants were both males and females, aged 18 years or older, who were undergoing consultations for gastric surgery for obesity (i.e., either a laparoscopic banding or bypass procedure). Exclusion criteria were medical, cognitive, or psychiatric (i.e., specifically psychosis) impairment that would preclude the successful completion of a survey. Of the 124 individuals who were approached, 121 agreed to participate for a response rate of 97.6%.

The resulting sample consisted of 104 women and 17 men, ranging in age from 20 to 70 years (mean, 44.6 years; SD, 11.8 years). The majority of participants had attained a high school diploma as their highest level of completed education (77.5%); only 19.2% of the sample had attained a college degree. The majority (82.6%) was white, 14.0% were black, one participant was Native American, two participants were Asian, and one participant was Hispanic. Body mass indices in this sample ranged from 27.2 to 92.1 (mean, 47.2; SD, 9.7).

### Procedure

All participants were seeking consultation from one surgeon, and each was recruited by the program's social worker as time permitted (i.e., a sample of convenience). Following an introduction to the project and successful recruitment, participants were given a survey booklet to complete. The survey booklet explored demographic information as well as the participant's height and weight history and history of self-harm behaviors.

Self-harm behaviors and difficulties with self-regulation were assessed with the Self-Harm Inventory (SHI) [21], which is a 22-item, yes/no, self-report inventory that explores participants' lifetime histories of intentional or purposeful self-damaging behavior as well as several behaviors relating to self-regulation difficulties. Each item in the inventory is preceded by the statement, "Have you ever intentionally, or on purpose,..." and items include, "overdosed, cut yourself on purpose, burned yourself on purpose," and "hit yourself." Each endorsement is in the pathological direction. Self-Harm Inventory total scores of 5 or higher are predictive of borderline personality disorder [21]. Indeed, in comparison with the Diagnostic Interview for Borderlines [22], the SHI demonstrates a diagnostic

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