Journal of Health Science & Education
An open access journal
eSciRes
JHSE-1-176

Commentary

Suicide is a Concern for the Chronic Invisible Illness Community

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Rates of suicidal ideation, attempts, and completion are alarmingly high in chronic invisible illness communities. Suicide is the second leading cause of death for people with myalgic encephalomyelitis/chronic fatigue syndrome [1], with 20% of patients dying by suicide [2]. In postural orthostatic tachycardia syndrome, approximately 50% are at high risk for suicide, with 15-18% reporting past suicide attempts, and 13% stating that they will likely make a future suicide attempt [3,4]. In the fibromyalgia community, 33% report suicidal ideation [5], while 4% of people with hypermobile Ehlers-Danlos syndrome attempt suicide [6]. Finally, 1,200 chronic Lyme disease patients die by suicide in the United States annually [7]. Clearly, the chronic invisible illness community is highly affected by suicidal ideation.

There are several reasons that people with chronic invisible illness are at particularly high risk of suicide. Nearly half of the risk factors for suicide - major physical illness, sense of isolation, hopelessness, job or financial loss, loss of relationships, and lack of good health care - are prevalent in this population. Common symptoms for many with chronic illnesses have also been linked with increased suicide risk, including functional disability [8], chronic pain [9], and sleep disturbance [10]. However, most people with chronic illnesses do not have a mental health diagnosis [11].

If the lifetime prevalence of depression is the same in the chronic invisible illness community as the general population [12], then why is the rate of suicidal ideation so high? In chronic illness communities, perceived burdensomeness has been demonstrated as a more important suicide risk factor than depression, loneliness, thwarted belongingness [4], or physical factors [13]. Feeling like a burden is common for adults with chronic invisible illnesses who cannot work or participate in many facets of family life. Perceived burdensomeness may be more important than depression for suicide risk in this chronically ill population, making the etiology of their suicidal ideation different from other populations. For them, suicide provides a mechanism to permanently alleviate both physical and emotional distress [14].

The healthcare community has an opportunity to intervene and decrease overall suicide risk for their chronically ill patients. Over 60% of people who attempt suicide visited a healthcare practitioner the previous month, and almost 40% visited the previous week [11], indicating a final effort to obtain assistance from the healthcare system. Healthcare practitioners have a chance to screen for suicidal ideation and make improvements for their patients. While these illnesses severely diminish quality of life [3], they are also notoriously difficult to diagnose and treat effectively. Genuinely listening to patients who have nondescript symptoms while aggressively treating the physical risk factors for suicide (chronic pain and sleep disturbance) may decrease suicide risk. Screening also provides an opportunity to refer patients to a mental health professional who can work to decrease feelings of burdensomeness while also building coping strategies to better deal with both the physical and psychological aspects of their illness.

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Received date: January 19, 2020; **Accepted date:** January 26, 2020; **Published date:** January 28, 2020

Citation: Pederson CL (2020) Suicide is a Concern for the Chronic Invisible Illness Community. *J Health Sci Educ* 4(1): 176.