MORGELLONS SURVEY

Tracing the 800-Fold Suicide Mortality Claim in Morgellons

A narrative evidence review and claim trace

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Version 1.0 · November 27, 2026

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Abstract

Objective. Trace the claim of an approximately 800-fold increase in deaths by suicide among people with Morgellons and review related clinical and mortality evidence.

Methods. This single-reviewer narrative review examined Savely's book and 2018 talk, the documentary and its director's Q&A, the later podcast, and Bransfield's conference material and published model. It also examined Savely's email and Ware's audio reply, alongside selected clinical, registry, and guidance sources. It compared case definitions, outcomes, denominators, follow-up, and comparison groups.

Results. Ginger Savely stated the claim in *Skin Deep*. In her reply, she described it as an informal estimate and advised against relying on it. Pi Ware recalled comparing figures from her practice with a national suicide rate. The original inputs and calculation remain unavailable. Bransfield's Lyme and associated diseases model yields about 54 deaths per 100,000 person-years, roughly one two-hundredth of the rate implied by applying the 800-fold multiplier to the 2024 U.S. rate. For hospital-recorded Lyme borreliosis, Fallon reported a suicide mortality incidence rate ratio of 1.75 (95% CI 1.18–2.58). The review found no comparative Morgellons mortality study supporting the claim. Morgellons and delusional infestation studies document impairment and distress.

Conclusion. The magnitude of any difference in suicide mortality among people with Morgellons remains undetermined. Clinical assessment of distress, skin-directed care, and access to support are warranted.

Introduction

In *Skin Deep: The Battle Over Morgellons*, Ginger Savely said people with Morgellons were over 800 times as likely to die by suicide as people in the general population. Director Pi Ware discussed how they arrived at the figure in a 2020 Q&A. A November 2026 *What the Morgs?* interview attributed the same multiplier to psychiatrist Robert Bransfield. The guest, Cindy Casey-Holman, is executive director of the Charles E. Holman Morgellons Disease Foundation. [1, 29, 31, 32]

This review traces the claim and examines what the available studies measured, so patients and clinicians can judge whether the statistic is reliable enough to repeat.

How the evidence was selected

Targeted web searches through November 27, 2026 combined *Morgellons* or *unexplained dermopathy*, *delusional infestation*, *delusional parasitosis*, or *Ekbom syndrome*, and *Lyme borreliosis* or *Lyme neuroborreliosis* with terms including *suicide*, *suicidal ideation*, *attempt*, *self-harm*, and *mortality*. Claim searches also included *800*, *800%*, *800 times*, Savely's and Bransfield's names, and documentary terms. I used publisher pages, PubMed records, and full text where accessible. For the claim trace, I checked the relevant quotations against the audio of the documentary, the director's Q&A, and the later podcast. I also examined conference materials, Savely's website and book, Savely's email reply, Ware's audio reply, and Bransfield's published calculation.

Sources were selected to trace the claim, compare case definitions, or examine relevant outcomes. I considered recruitment, outcomes, follow-up, numerators, and denominators. Depression, quality of life, and diagnosis incidence provide context. The review used targeted searches without exhaustive database screening, a registered protocol, a second reviewer, formal risk-of-bias assessment, or pooling. Abstract-only checks and unresolved items are identified below.

Positionality. I am a patient advocate and publish MorgellonsSurvey.org. I conducted this narrative review as a single reviewer. That affiliation and design are relevant when assessing how I selected and interpreted sources.

Funding. This review received no funding.

Competing interests. I publish MorgellonsSurvey.org and host *Morgellons Discussion*. In a 2021 video [37], I repeated a claim that people with Morgellons were about 800% more likely to consider suicide. I attributed it to an informal calculation by Ginger Savely and a colleague. I have found no published calculation or comparative study supporting that estimate, and I withdraw it.

Results

The claim in *Skin Deep* and the later podcast

At 57:48 in *Skin Deep: The Battle Over Morgellons*, Savely says people with Morgellons are "over 800 times more likely" to die by suicide than people in the general population. She then says she lost four patients the previous year. The documentary premiered in 2019 and was released digitally in March 2020. [31]

In the March 31, 2020 Q&A at 45:58–47:04, Pi Ware says he and Savely worked through the numbers together. He repeats the 800-fold comparison and describes it as a "guesstimate." At 47:04, Savely says undiagnosed cases make a total hard to determine and that she was unsure whether some deaths among her patients were intentional. Neither the documentary scene nor the Q&A supplies the cohort size, person-time, comparison rate, or arithmetic steps needed to reproduce the 800-fold figure. [31, 32]

Technical box · Working backward from four deaths

Illustration only. The original denominator, follow-up period, and comparison rate remain unknown. If the four losses mentioned in the film were deaths by suicide in one year, an 800-fold rate relative to the 2018 U.S. age-adjusted rate of 14.2 per 100,000 would require $4 \div (800 \times 0.000142) = 35.2$ person-years, or about 35 patients followed for a full year each. [31, 32, 35]

Under a Poisson model, four observed events give an exact 95% confidence interval of about 1.1–10.2 for the expected count over the same follow-up. The interval illustrates the imprecision of a four-event count. [36]

In her 2016 book, Savely reports 10 deaths from multiple causes, with suicide suspected in a couple of cases. At 46:10–46:42 in her April 2018 conference talk, she recalls three deaths by suicide in the preceding year and 10 over her years treating Morgellons. In the documentary, Savely recalls losing four patients the previous year. In the 2020 Q&A, she gives no new total and describes uncertainty about the intent behind some deaths. In her November 2026 reply, she recalled eight deaths by suicide and could not recall how many patients she had treated during the period covered (see Right of reply). Whether these accounts include any of the same patients remains unknown. Estimating a rate requires verified deaths and a defined group with a known period of follow-up. [31–34]

At 23:27–23:43, Girvan says, "supposedly we are about 800 times more likely" when discussing death by suicide. At 23:43, Casey-Holman replies, "That's that's a calculation Dr. Bransfield made." At 23:59 she says, "It is 800 times more likely." The exchange does not specify a comparison group or follow-up interval. [1]

An 800% increase would make a measure nine times its baseline. An 800-fold figure is 800 times the baseline. The documentary, Q&A, and podcast refer to the 800-fold version and concern deaths by suicide. Searches located no published study backing that claim with a defined Morgellons cohort, person-time denominator, and comparison group. [1–5, 31, 32]

Timeline · Public statements and follow-up replies

Date	Source	What was reported
2016	Savely's book, chapter 28 [33]	Savely reports 10 deaths from multiple causes and suspects suicide in a couple of cases.
April 2018	Charles E. Holman Morgellons Disease Foundation conference [2, 3, 34]	Savely reports three deaths by suicide in the previous year and 10 across her years treating Morgellons. Bransfield says Morgellons mortality had yet to be studied systematically.
2019	*Skin Deep: The Battle Over Morgellons* [31]	Savely says the likelihood of dying by suicide is over 800 times that of the general population and recalls losing four patients the previous year. The film premiered in 2019 and was released digitally in March 2020.
March 2020	*Skin Deep* Q&A [32]	Ware says he and Savely worked through the numbers. Savely says she was unsure whether some deaths among her patients were intentional.
August 2021	Author's own *Morgellons Discussion* video [37]	Murphree repeats a claim of an 800% increase in the likelihood of considering suicide and attributes it to an informal calculation by Savely and a colleague.
November 2026	*What the Morgs?* podcast [1]	Girvan cites an approximately 800-fold figure. Casey-Holman attributes it to Bransfield.
November 2026	Savely's email and Ware's audio reply [38, 39] (see Right of reply)	Savely recalls eight deaths, calls the estimate informal, and advises against relying on it. Ware recalls comparing practice figures with a national rate.

Right of reply. On November 27, 2026, I emailed Ginger Savely and Pi Ware separately to ask for the original calculation, including what was counted, how many people were followed and for how long, and which comparison rate they used. I asked for replies by December 4, 2026. Both replied on November 27, Savely by email and Ware in an audio recording attached to his email.

Savely recalled that her estimate drew on eight deaths by suicide among patients she had treated for Morgellons. She could not recall how many patients she had treated during that period, and her reply gave neither the dates covered nor a comparison rate. She described the figure as an informal estimate and advised against relying on it [38]. Whether any of the eight patients were included in the counts she discussed in the book, the conference talk, or the film remains unknown.

Ware recalled obtaining Savely's total patient count and the number of her patients who died by suicide, then comparing the result with a published national suicide rate for that year. In a November 28 follow-up email, Ware recalled the year as either 2018 or 2019. The replies left the patient count, death count, follow-up interval, and exact national rate unspecified [39].

The missing follow-up period matters. Treating deaths counted over several years as if they all occurred in one year would overstate the annual rate ratio. For illustration, suppose a practice recorded eight deaths by suicide and averaged 70 patients under follow-up. Against the 2018 U.S. rate of 14.2 per 100,000 person-years, eight deaths in one year would yield about 800 times the national rate. The same count over five years would yield about 160 times the national rate, or about 80 times over ten years. The period and comparison rate actually used remain unknown. [35]

Same count, different follow-up

Hypothetical example: eight deaths with an average of 70 people under follow-up. Values are multiples of the 2018 U.S. suicide rate.

1 year · 70 person-years		≈800×
5 years · 350 person-years		≈160×
10 years · 700 person-years		≈80×

These are illustrative calculations. The original patient count and follow-up period remain unknown. [35]

What Bransfield calculated

To check the podcast's attribution, this section compares the quoted Morgellons figure with Bransfield's published calculation and his conference remarks. [1–4]

Bransfield's 2017 paper reviewed 253 inactive charts of patients with Lyme and associated diseases from his own specialty psychiatric practice. The paper reports documented suicidal tendencies in about 43% of this selected clinical sample. [4, pp. 1579–1583]

Bransfield separately estimated a national annual death count for Lyme and associated diseases. In his conference talk at 28:25, he discusses that calculation. [3, 4]

At 38:23, he says Morgellons mortality had never been systematically studied. [3] His conference abstract makes the same point and acknowledges deaths known to the community. [2] He also co-authored Harvey's Morgellons case series. [8]

Technical box · Reconstructing the published model [4, pp. 1582–1583]

Step	Calculation	What the result represents
New cases with persistent symptoms	329,000 × 28% = 92,120	Estimated new cases with persistent symptoms per year
People living with persistent symptoms	92,120 × 25 years = 2,303,000	Modeled number living with persistent symptoms
People with suicidal thoughts	2,303,000 × 18% = 414,540	Modeled number with suicidal thoughts
Annual deaths by suicide	414,540 × 0.3% = 1,243.62	About 1,244 projected U.S. deaths per year involving Lyme and associated diseases

The 28% input drew in part on research into residual symptoms after treated Lyme neuroborreliosis. The 25-year average duration was assumed. If the duration were ten years, the same inputs would yield about 497 projected deaths per year. At five years, the result would be about 249. Neither alternative is an estimate of actual deaths. Bransfield attributes the 18% input to an unpublished Fallon conference presentation and uses 0.3% as an annual probability among people with suicidal thoughts. The paper cites a CDC statistics page for the 0.3% input. It leaves unstated the intermediate steps needed to derive an annual probability among people with suicidal thoughts.[1]

Doshi and colleagues later reported suicidal thoughts in 19.8% of the post-treatment Lyme symptoms group (81 patients), 27.1% of the HIV-positive fatigue group (70 patients), and 4.5% of the non-patient comparison group (44 participants). Per abstract, the Lyme–HIV difference was statistically inconclusive. Within the Lyme group, 6.5% with mild or no depression reported suicidal thoughts, compared with 63.2% with moderate-to-severe depression. These questionnaire findings concern ideation. They do not validate the earlier conference input or estimate suicide mortality. [15]

What the multiplier would imply

The 2024 U.S. age-adjusted suicide death rate was 13.7 per 100,000 person-years. For women aged 45–64, the age-specific rate was 8.1 per 100,000 person-years. That second baseline offers some context because published Morgellons clinic samples have included many middle-aged women. Neither baseline is a matched comparison group for Morgellons. [19, Figs. 1–2; 26, 28]

Technical box · Arithmetic consistency check

Starting point	Calculation	What it implies
Age-adjusted U.S. rate	800 × 13.7 = 10,960 per 100,000 person-years	About 11 deaths per 100 person-years
U.S. women aged 45–64	800 × 8.1 = 6,480 per 100,000 person-years	About 6.5 deaths per 100 person-years
Bransfield's modeled count and population	1,244 ÷ 2,303,000 × 100,000 ≈ 54	About 54 per 100,000 person-years, roughly four times 13.7

This is an arithmetic consistency check. The table reports rates per 100 person-years. In hypothetical cohorts starting with 1,000 people each, one year at the implied rates would yield about 104 deaths using the national baseline or 63 using the baseline for women aged 45–64, assuming constant rates and no competing causes of death. In this illustration, people who die contribute less than a full year of follow-up. Deaths on that scale would be hard for any patient community to miss, even with incomplete reporting. Casey-Holman recalls people she knew and notes that the Foundation may never hear about everyone affected. [1]

Over a decade with the same assumptions, roughly two-thirds and just under half, respectively, would die by suicide. Competing causes of death would lower those cumulative proportions at the same suicide hazard. The constant-hazard calculation uses $1 - \exp(-t \times \text{annual rate})$, where t is the number of years. [4, 19]

Bransfield's modeled rate of about 54 per 100,000 person-years is roughly two and a half times the approximately 21 per 100,000 person-years reconstructed from Fallon's observed deaths after hospital-recorded Lyme. The baselines were also different: 11 in Fallon's Danish comparison group and 13.7 in the age-adjusted U.S. population, per 100,000 person-years. The studies cover different countries and populations, so the comparison shows scale and cannot establish a risk ratio. [4, 5, 19]

Who counted as a patient?

Harvey and colleagues described 25 patients from one clinic. Entry required at least two chronic, unhealed lesions recorded by a clinician, among other criteria. Pearson and colleagues identified 115 patients under a broader definition requiring self-reported material emerging from skin with lesions or disturbing skin sensations. Of those, 41 underwent clinical evaluation. DI studies and guidance can treat patient-reported fibers as part of the content of a fixed belief of infestation. Some Morgellons-focused studies use clinician-observed fibers as a defining physical finding. A patient can have skin lesions and meet DI criteria. Recording reported material, observed findings, and DI criteria separately lets researchers measure overlap. [7–9, 13, 14, 26, 28]

What the studies measured

Evidence	Finding	Relevance to suicide mortality
Morgellons clinical descriptions [7, 8, 26, 28, 30]	Fesler classified 60 of 1,000 Lyme-seropositive patients in one practice as having Morgellons under a fiber criterion. Harvey reported clinical observations. Pearson assessed clinical and psychological findings. Savely and Stricker reported treatment for depression in 35 of 122 patients. The Middelveen historical review describes the literature.	Fesler's and Harvey's full reports and the historical review supplied no suicide data. Savely and Stricker's figure describes depression treatment. Pearson supplied no comparative mortality estimate.
DI case reports [9, 10]	Freudenmann and Lepping reviewed reports of suicidal thoughts, attempts, and death. Nasir and colleagues reported two cases, per indexed record.	Individual reports can identify serious outcomes. They provide no population denominator or comparative rate.
Specialty clinics [11, 13, 17]	Lockwood reported active ideation in 16 of 69 patients across diagnoses. Seven of the 16 were grouped under skin presentations of primary psychiatric conditions, including DI and dermatitis artefacta. Hauptman reported depression in 75 of 155 DI patients. Rew reported depression in 58% of 81 patients.	The Michigan samples in Rew and Hauptman share the same clinic, count, and January 2021–May 2024 dates. Rew's figures are per abstract. Patient-level overlap is unverified, so the samples were not combined. The studies measured ideation or comorbidity.
DI epidemiology and comorbidity [12, 22, 23]	Bailey found 64 incident diagnoses in Olmsted County in 1976–2010, or 1.9 per 100,000 person-years after age and sex adjustment. Foster described 147 Mayo patients, per abstract. Norberg reviewed 146 Swedish patients. Depression was recorded in 27 of the 62 with psychiatric comorbidity.	These reports describe the frequency of diagnoses or characteristics of patients. Norberg's full text and Foster's abstract supply no suicide mortality comparison.
DI clinical follow-up [24, 25]	Romanov's multicentre series assessed clinical severity in 211 patients. Lepping's later series reviewed 465 patients, with 193 lost to follow-up, per abstract.	Both studies reported changes in clinical severity. Loss to follow-up leaves mortality unknown.
Skin-disease mortality review [20]	In pooled analyses, hidradenitis suppurativa had an odds ratio of 2.86 for suicide death (95% CI 1.56–5.24). Melanoma had a standardized mortality ratio of 2.89 (95% CI 1.97–3.81). The included-study list covers neither DI nor a mixed psychodermatology cohort.	These pooled associations provide scale for other conditions. The measures differ from one another and supply no upper bound or estimate for Morgellons.

Bailey's study shows why a wider catchment matters. If 64 patients were each followed for ten years at the 2024 U.S. age-adjusted baseline, the expected count would be about 0.09 suicide deaths. That is an illustration using 640 person-years at 13.7 per 100,000. A cohort of this size would provide little precision for a mortality comparison. [12, 19]

What the Danish registries counted

Fallon and colleagues linked Danish records from 1994 through 2016. Among people with a hospital-recorded Lyme diagnosis, 25 died by suicide. The authors concluded that the absolute population risk was low. Their study did not identify a Morgellons group. [5]

Observed rates in the Danish Lyme study

Deaths by suicide per 100,000 person-years, rounded as reported in the study.

No hospital-recorded Lyme diagnosis		11
One hospital-recorded Lyme episode		20
More than one episode		33

The last group had three deaths, so its rate is imprecise. The study did not identify a Morgellons group. [5, Table 3]

Technical box · Absolute rates, adjustments, and follow-up [5, pp. 922–924, 926–927, Table 3]

- **Absolute mortality rates.** Table 3 reports 11 deaths per 100,000 person-years in the no-Lyme comparison group. It reports 20 after one Lyme episode (22 deaths) and 33 after more than one episode (three deaths). Across both Lyme categories, the rate is about 21 per 100,000 person-years. This review reconstructed that approximation from the rounded rates in Table 3. Fallon and colleagues reported the rates for each category separately.
- **Incidence rate ratios (IRRs).** The death-by-suicide IRR was 1.75 (95% CI 1.18–2.58), adjusted for age, sex, and calendar period. The recorded attempt IRR was 2.01 (95% CI 1.58–2.55). The suicide IRR was highest during the first three years after diagnosis at 2.41 (95% CI 1.25–4.62). More than one episode was associated with attempts. The estimate for death after more than one episode was imprecise and did not establish an increase. The neuroborreliosis subgroup likewise did not show a statistically clear increase in suicide mortality.
- **Eligibility.** The primary analysis excluded people with a recorded mental disorder or suicide attempt before 1994 and describes additional Lyme-group exclusions for those events before the first Lyme diagnosis after cohort entry (the stated criteria refer to attempts). The attempt models incorporated psychiatric history as specified in Table 3, while the mortality model used basic adjustment because only 25 deaths occurred in the Lyme group.
- **Headcount.** The abstract gives 12,156 people with Lyme. The Results give 12,616, matching the Results subgroup counts of 11,256 + 360 + 1,000. The source gives no explanation for the discrepancy. The published mortality IRR uses person-time. Dividing 25 by either headcount would give a crude proportion across unequal follow-up periods.

Obel and colleagues examined a narrower, laboratory-supported neuroborreliosis cohort of 2,067 people with 20,670 matched comparators. The all-cause mortality rate ratio was 0.90 (95% CI 0.79–1.03). All-cause mortality combines multiple causes of death and answers a different question from Fallon's suicide-specific comparison. [18]

Discussion

Distress deserves clinical attention

Gipple and colleagues reported poorer skin-related quality of life in their Morgellons clinic sample than in the psoriasis, atopic dermatitis, and prurigo nodularis comparison groups, per the publisher's extract. Hauptman and colleagues found recorded depression in 75 of 155 patients with delusional infestation (DI), or 48.4%, in two specialty clinics. Lockwood and colleagues identified active suicidal thoughts in 16 of 69 patients in a mixed psychodermatology clinic. The percentage from that clinic applies to the whole sample. The authors grouped DI with other diagnoses and did not give a DI-specific estimate. [6, 11, 13]

The British Association of Dermatologists advises clinicians to assess risk of harm, especially suicidal behaviour, in adults with suspected DI and consider referral where appropriate. Recommendation R8 is a good practice point. Ahmed co-authored the Lockwood study and led the guideline. The ESDaP Delphi consensus, per abstract, supports early care for both skin symptoms and psychiatric needs. The abstract leaves specific suicide-screening recommendations unconfirmed. Documented quality-of-life impairment, depression, and suicidal thoughts in clinic samples are clinically relevant regardless of what later mortality studies find. [11, 14, 21]

Where the figure first appears

The earliest public source identified in this review is Savely's statement in *Skin Deep*. Ware's Q&A and the two replies point to an estimate based on one clinical practice and a national comparison rate. The original calculation remains unavailable. The later interview credits Bransfield. His published model and conference materials provide no Morgellons comparison that could yield the multiplier. The sources reviewed do not establish how the figure reached the later interview. [1–4, 31, 32, 38, 39]

The claimed multiplier does not follow from Bransfield's calculation

His model yields a rate of about 54 per 100,000 person-years. Applying the 800-fold multiplier to the national U.S. baseline yields a rate about 200 times larger. The claimed multiplier cannot be reproduced from the published model. Morgellons mortality would need to be measured directly. [4, 19]

Limits of this review

The search was targeted and conducted by one reviewer. Some sources were available only as extracts or abstracts. The full texts of [21] and [27] were unavailable, so statements about them rest on the abstract or the Foundation announcement. The reviewed clinic studies drew from selected patients and measured different outcomes. A mortality comparison would require defined cohorts, complete and comparable follow-up, and consistent ascertainment of deaths.

How to measure suicide mortality in Morgellons

A registry study could apply explicit case criteria across several health systems and link patients to cause-of-death records. It would need enough follow-up to make any mortality comparison interpretable.

Technical box · Registry protocol checklist

1. **Case definitions.** Prespecify rules for clinician-observed fibers, patient-reported material, lesions, and DI. Record overlap.
2. **Recruitment and comparators.** Use multiple systems. Define comparison groups from the same source population and, separately, from patients with another chronic skin condition.
3. **Follow-up.** Start both groups at comparable index dates. Follow to death, emigration, or the end of registry coverage. Record earlier mental disorders and suicide attempts separately from distress documented after skin symptoms began.
4. **Outcomes and analysis.** Use consistent cause-of-death rules. Report deaths, total person-years, absolute rates, adjusted IRRs, and confidence intervals. Record ideation, attempts, non-suicidal self-injury, and deaths of undetermined intent separately.
5. **Sensitivity analyses.** Vary the case definition, comparator, and treatment of deaths of undetermined intent. State how incomplete linkage or small counts affect uncertainty.
6. **Privacy.** Obtain applicable ethics and data-governance approvals. Restrict access to identifiable records and suppress small cells in public tables.

Conclusion

Savely described the figure stated in the documentary as an informal estimate and advised against relying on it. [38] No comparative study identified in this review establishes the increase stated in the documentary and repeated in the later interview. The magnitude of any difference in suicide mortality among people with Morgellons remains undetermined. Clinical assessment of distress is warranted. Patients need care for their skin symptoms and support while better data are collected.

If you need support. In the U.S. and its territories, call or text 988 to reach the 988 Suicide & Crisis Lifeline. Outside the U.S., contact your local crisis service or emergency number.

Notes

1 **Bransfield model sources.** Bransfield [4], pp. 1576 and 1582–1583 and bibliography references 5, 110–111, and 117. Dersch et al. [16] provides context for residual symptoms after treated Lyme neuroborreliosis.

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