

Assessment of Eating Disorders and Suicide in University Populations

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Overview

- **Facts About Eating Disorders (EDs)**
- **EDs and Suicide**
- **Interpersonal Psychological Theory of Suicide (IPTTS) and EDs**
- **Current Research at Magnolia Creek Treatment Center for Eating Disorders (MCTCED) on EDs**
- **Assessments for EDs in University Populations**
- **Assessments for Suicide in University Populations**
- **Questions and Comments**

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Facts about Eating Disorders

- In the United States, as many as 10 million females and 1 million males have anorexia or bulimia. Millions more are struggling with binge eating disorder
- Anorexia has the highest mortality rate of any mental illness
- Research dollars spent on anorexia average \$.70 per affected individual, compared to over \$159.00 per affected individual for schizophrenia

(Crowther et al., 1992; Fairburn et al., 1993; Gordon, 1990; Hoek, 1995; Shisslak et al., 1995)

	Illness Prevalence	NIH Research Funds (2008)
Eating Disorders	10 million	\$7,000,000
Alzheimer's Disease	4.5 million	\$412,000,000
Schizophrenia	2.2 million	\$249,000,000

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Facts about EDs in University Populations

- **As many as 10% of college women suffer from a clinical or nearly clinical ED**
- **By first year of college, 4.5 to 18% of women, and 0.4% of men, have a history of Bulimia; as many as 1% of females between the ages of 12 and 18 have Anorexia**
- **Nearly 91 % of women surveyed on a college campus had attempted to control their weight through dieting; 22% dieted “often” or “always”**

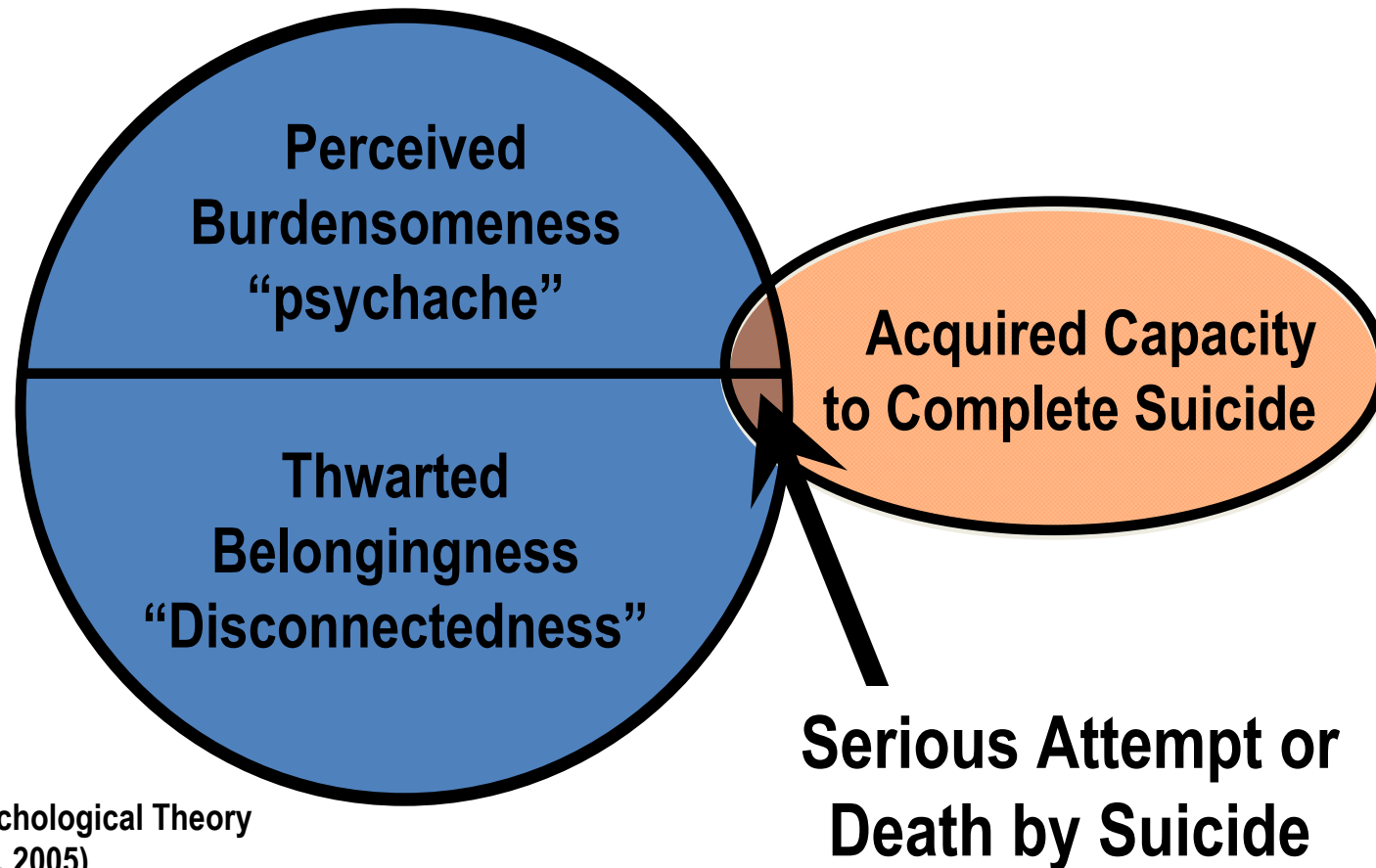
(Kurth et al., 1995; Association of Anorexia and Related Disorders, 2009)

EDs and Suicide

- **Suicide Rates 23% Higher Than in Other Disorders:**
 - **AN: Mortality about 10%; most AN deaths due to suicide, not from complications from the disorder**
 - **BN: Mortality rate about 3%; one-third will attempt suicide**
 - **ED-NOS: Mortality rate about 5%**
 - **Suicide risk in ED-NOS similar to that of AN**
 - **Individuals with BED are more likely to have a history of past suicide attempts than the rest of the population**

(Corcos, 2002; Crow et al., 2009; Grucza et al., 2007; Harris & Barraclough, 1997; Sullivan, 2002)

Suicide and EDs: What is the Connection?



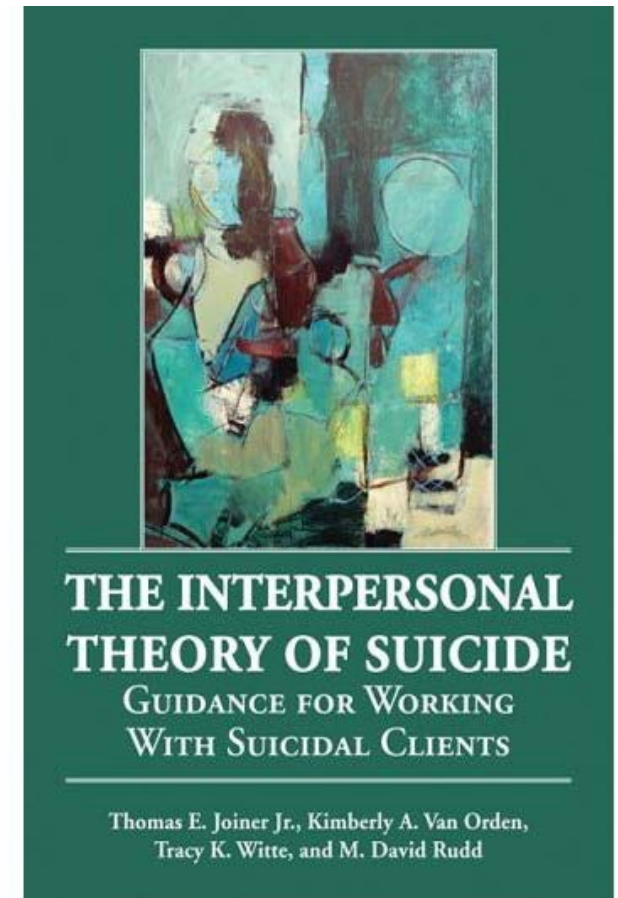
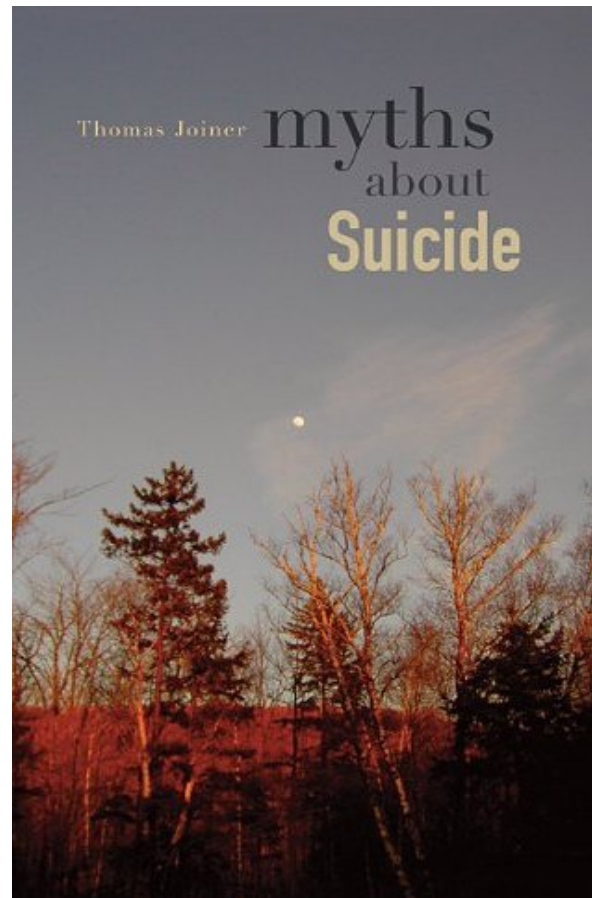
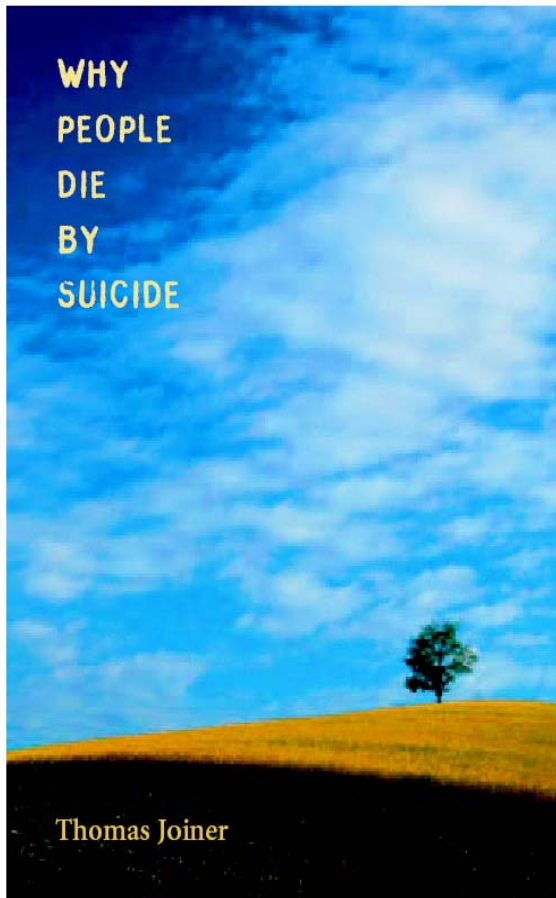
Interpersonal Psychological Theory
of Suicide (Joiner, 2005)

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Current Studies on EDs and Suicide at Magnolia Creek

- **Collaboration with Dr. Thomas Joiner's Lab at FSU**
 - Investigating Suicidality and Self-Harm in Patients with AN, BN, BED, and ED-NOS
- **Collaboration with Dr. Tracy Witte at Auburn University**
 - Investigating Pain Tolerance as Predictor of Suicidality in Eating Disorders
- **Pending Study at United States Air Force Academy**
 - Investigating Suicide, Resiliency, and Eating Disorders (awaiting IRB approval)

Works by Dr. Thomas Joiner Singly and in Collaboration



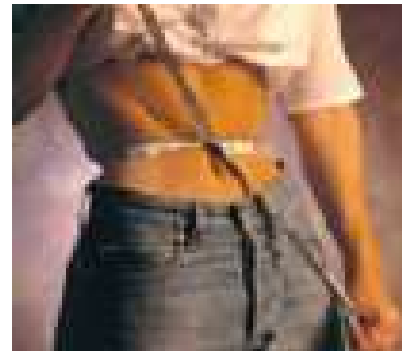
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TREATMENT CENTER FOR EATING DISORDERS

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Assessment of EDs: Diagnostic Changes in the DSM-5

- **Bulimia Nervosa**
 - Frequency criteria reduced to 1X/week for three months
- **Anorexia Nervosa**
 - Amenorrhea criteria removed
 - Specific weight criteria removed
- **Binge Eating Disorder**
 - Separate diagnosis
- **Eating Disorder Not Otherwise Specified (ED NOS)**



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Determining Appropriate Level of Care

Inpatient

- Medically Unstable
- Unstable or depressed vital signs
- Laboratory findings presenting acute risk
- Complications due to coexisting medical problems such as diabetes mellitus
- Psychiatrically Unstable
- Symptoms worsening at rapid rate
- Suicidal & unable to contract for safety

Residential

- Medically stable - no intensive medical interventions (e.g., NG feeds, IV fluids, daily labs)
- Unable to respond to PHP or outpatient treatment
- Possible plan for suicide, no intent
- Needs supervision with meals or will restrict
- Complete role impairment, requires structure to prevent compulsive exercising
- Lacks treatment structure/support system at home

Partial Hospitalization

- Medically Stable
- Eating disorder may impair functioning but not causing immediate acute risk
- Needs daily assessment of physiological and mental status
- Psychiatrically Stable
- Unable to function in normal social, educational, or vocational situations, but not suicidal
- Daily bingeing, purging, severely restricted intake, or other pathogenic weight control techniques

Intensive Outpatient/Outpatient

- Medically Stable
- No longer needs daily medical monitoring
- Psychiatrically Stable
- Symptoms in sufficient control to function in normal social, educational, or vocational situations and continue to make progress in recovery.

(APA, 2006)

Assessment of EDs: Relevant Issues in Universities

- When is Outpatient Treatment No Longer Appropriate?
 - When to Refer (handout)
- When is it Appropriate for a Student to Return to School after Treatment?
 - Sample Readmission Criteria (handout)

Treatment of Eating Disorders in an Outpatient University Counseling Center When to Refer

The severity of a student's eating disorder may require a more intensive level of care than can be provided at the university. Referral to a higher level of care than outpatient treatment is typically warranted based on at least one the following:

- **Chronic physiological signs (based on one or more of the following):**
 - heart rate <40 bpm
 - blood pressure <90/60mm Hg
 - glucose <60mg/dl
 - potassium <3 meq/liter
 - electrolyte imbalance
 - temperature <96.0 degrees F
 - dehydration
 - hepatic, renal or cardiovascular organ compromise requiring acute treatment
- **Inability to maintain a BMI of at least 18**
- **Inability to “break the cycle” of chronic eating disorder behavior**
- **Inability to engage in effective outpatient therapy**

Adapted from University of Notre Dame

Assessment Instruments for EDs

- **EDE-Q (Fairburn, 2008)**
- **EDI-3 (Garner et al., 2006)**
- **SCOFF (Morgan, Reid & Lacey, 2000)**
 - Do you make yourself sick because you feel uncomfortably full?
 - Do you worry that you have lost control over how much you eat?
 - Have you recently lost more than one stone (14 lb) in a 3-month period?
 - Do you believe yourself to be fat when others say you are too thin?
 - Would you say that food dominates your life?
- **EAT-26 (Garner et al., 1982) <http://eat-26.com/Form/index.php>**

Assessment of Suicide in University Populations

- **No Other Patient Behavior Generates More Stress and Fear among Mental Health Professionals**
- **Few Counselor Education, Psychology, and Psychiatry Programs Train Clinicians to Deal with Suicidal Clients**
 - **Most Mental Health Professionals Receive Only Two Hours of Formal Suicide Training**
- **50% of Practitioners Fail to Ask about and Adequately Assess Suicidal Ideation**

(Berman, 2007; Foster & McAdams, 1993; Peterson, Luoma, & Dunne, 2002; Rogers et al., 2001)

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Assessment Instruments for Suicide

- **Depression Screening Index—Suicide Scale (DSI-SS)** (Metalsky & Joiner, 1997)
- **Interpersonal Needs Questionnaire (INQ)**
(Van Orden et al., 2008)
- **Acquired Capability for Suicide Scale (ACSS)**
(Van Orden et al., 2008)
- **Agitation Index (AI)**
(Ribeiro, Bender, Selby, Hames, & Joiner, 2011)
- **Painful and Provocative Events Scale (PPES)**
(Bender, Gordon, Resin, & Joiner, 2011)

* *Link to Download Available Instruments: www.magnolia-creek.com/presentations*

Additional Assessments for Suicide

- **IS PATH WARM?**

- Ideation
- Withdrawal
- Anger
- Recklessness
- Mood Change
- Hopelessness
- Substance Abuse
- Purposelessness
- Anxiety
- Trapped

- **Risk and Protective Factors**

- By clinician and patient

- **Suicide Intent and Assessment Checklist**

(Bartlett, Siegfried, Witte, 2010)

12/3

Protective Factors that're keeping me Alive:

1. Faith
2. Fear of misunderstanding of my intention.
3. Fear of losing control of my freedom.
4. Family (my parents)
5. Pets
6. Friends
7. The desire for social interaction
8. Education
9. Treatment

How Do I Get to This?

My SELF LOVE/TOURNAIS

SH
SH
SH
S
S
S

RISK FACTORS

1. Depression
2. Attempts of suicide
3. History of self harm
4. trauma
5. Family
6. Alcohol
7. Poor coping skills
8. Deficit in px solving skills
9. Social Isolation
10. Self hatred SH ↓
11. Shame
12. Co-dependant Traits

SHORT TERM PAIN
FOR LONG TERM GAIN

Student Suicide Intent and Assessment Checklist

1. Does the student express current suicidal ideation (has the patient indicated thoughts about wanting to hurt or kill self?)
 - a. How strong is the student's desire to kill himself/herself (0 = not intense at all; 10 = very intense)?

If No, Assessment is complete. If yes, continue Assessment.

- | | | |
|---|-----|----|
| 2. Does the student have an identified plan to die by suicide? | Yes | No |
| 3. Does the student have an identified a means of executing his/her plan? | Yes | No |
| 4. Does the student have access to the means of executing his/her plan? | Yes | No |

If Yes to Questions 1 through 4, a definite referral for hospitalization is indicated; however, continuing this assessment will provide more information regarding the student's situation.

- | | | |
|--|-----|----|
| 5. Is the student visibly agitated? | Yes | No |
| 6. Does the student express feelings of hopelessness? | Yes | No |
| 7. Does the student have a history of mental illness? | Yes | No |
| 8. Does the student express no fear of dying? | Yes | No |
| 9. Does the student use alcohol or illicit drugs? | Yes | No |
| 10. Is there a family history of suicide? | Yes | No |
| 11. Has the student made prior attempts of suicide? | Yes | No |
| a. Has the student made multiple suicide attempts? | Yes | No |
| 12. Does the student feel connected to other people (i.e., are supportive relationships completely absent)? | Yes | No |
| 13. Does the student feel as though the people in his/her life would be better off if he/she were gone? | Yes | No |
| 14. Does the student omit references to the future? | Yes | No |
| 15. Is the student experiencing disorganized thoughts? | Yes | No |
| 16. Is the student experiencing hallucinations? | Yes | No |
| 17. Has the student experienced any recent personal losses (e.g., death of a loved one, major break-up, job loss)? | Yes | No |
| 18. Has the student recently been diagnosed with physical illness? | | |
| 19. Is the student experiencing guilt, blame, or shame for personal behaviors? | | |

Student Name: _____ Date of Assessment: _____

Signature & Title of Assessor: _____

This form was adapted from the Suicide Intent Checklist by Lee, J. B., & Bartlett, M. L. (2005). Suicide prevention: Critical elements for managing suicidal residents and counselor liability without the use of a no-suicide contract. *Death Studies*, 29, 1-19.

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Questions and Comments



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