CARING FOR COLLEGE STUDENTS WITH EATING DISORDERS: MEDICAL, PSYCHOLOGICAL, & ETHICAL ISSUES
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If you will/will not be discussing any unapproved uses of pharmaceuticals or devices, add a sentence here to explain.*** Jen (or others) – any disclosures to make?
Recognize the legal, systemic, and developmental barriers to identifying and treating eating disorders in college setting

Recognize that the transition to college can exacerbate eating disorder symptoms

Identify the medical complications of eating disorders and over-exercise and discuss appropriate monitoring and treatment

Identify the potential and limitations of online programs to screen college students and athletes for body image issues and eating disorders, and peer-based interventions to improve body image and decrease disordered eating behaviors on college campuses
Eating Disorders are common
- Onset often in teenage years
- Tend to arise or worsen in times of stress or transition (puberty, adulthood)
- Found in all ages, genders, ethnic backgrounds, SES

Co-morbid conditions seen with Eating Disorders
- Anxiety Disorders
- Substance Use Disorders
- Personality Disorders

Eating disorders have the highest mortality rate of any mental illness
- Medical sequelae include:
  - Cardiac dysrhythmia due to bradycardia, prolonged QTc
  - Electrolyte abnormalities
- Suicide
Prevalence increasing in college:
- At one college over a 13 year period, eating disorders increased from:
  - 23 → 32% among females
  - 7.9 → 25% among males
- Percentage students following a special weight loss diet increased from:
  - 4.2% in 1995 → 22% in 2008
- Only 6% of college students with disordered eating were asked about it by a health provider

ETIOLOGY - A BIOPSYCHOSOCIAL MIX OF FACTORS

- Biological vulnerabilities - genetics
- Temperament
  - Risk avoidant, perfectionistic, self-doubting (Anorexia nervosa - AN)
  - Impulsive, risk-taking (Bulimia nervosa - BN)
- Family dynamics and peer relationships
  - Families do not cause eating disorders per se but stresses may make it difficult to recover
- Cultural factors/media exposure
- Normative behavior
- Life stresses and transitions - COLLEGE!
Increased autonomy
Separation and individuation
Decreased structure/family involvement
Homesickness
Relationships/breakups

Increased academic workload
Decreased physical activity
Poorly regulated diet and sleep
SPECIAL RISK FACTORS IN COLLEGE POPULATION

- Study abroad
- Consumption of stimulants, caffeine to augment studying
- Binge drinking

- Buffet Style cafeterias
- Late night snacking
- Limited access to grocery stores, kitchen
- Fear of “Freshman Fifteen”
- Thin ideal
Widespread belief that college students gain an average of 15 lb during first year of college

May influence college freshman to engage in preventive activities:
- Food restriction
- Overexercise
- Purging
MYTH OR REALITY: THE “FRESHMAN FIFTEEN”?  

- A nationally representative random survey found that freshmen gained an average of 2.5 - 3.5 pounds.
  - Only ½ pound more than same-age peers not attending college.
- Another study found most of the weight gain occurred during 1st semester.
  - Some continued gaining second semester, some lost weight.
  - Men more likely to continue gaining during sophomore year as well.

Study of 204 female college athletes from 17 sports at 3 universities:
- 2% classified as having an eating disorder
- Another 25.5% exhibited symptoms at a subclinical level

May have h/o rigorous training in high school, energy imbalance, amenorrhea prior to entering college

Athletic scholarships - pressure to continue competing

FEMALE ATHLETIC TRIAD

• Continuum of severity:
  • Low energy availability/disordered eating
  • Abnormal menses/amenorrhea
  • Bone loss/osteoporosis

• Imbalance between energy intake and output
• Increased risk of musculoskeletal injuries and strains, fractures
• More common in sports emphasizing weight or lean appearance (e.g. dancers, gymnasts, models, wrestlers, runners)
• Loss of menstrual cycles in athletes is never normal
• Important not to treat amenorrhea with oral contraceptives, (unless needed for contraception)
Anorexia Nervosa  
Bulimia Nervosa  
Binge Eating Disorder  
Avoidant Restrictive Food Intake Disorder
Co-morbid Conditions

- Mood Disorders, particularly depression
  - Monitor suicidality closely
- Anxiety Disorders, including OCD
- Substance Use Disorders
  - AN- Stimulants
  - BN- Alcohol and narcotics
- Personality Disorders
  - Borderline, Avoidant, Dependent, Obsessive Compulsive Personality, Narcissistic
 Levels of internal motivation and student’s engagement in treatment may:

- Vary at baseline
- Change in response to current medical or psychological condition
- Fluctuate over time in response to:
  - Academic and personal stressors
  - Real or perceived consequences on academic achievement, enrollment
Denial
Stigma
Financial concerns
Limited access to specialty care
Lack of insurance coverage (not all colleges have Student Health Insurance Plan (SHIP) or require health insurance)
Normalization of behaviors (“I’m just being healthy!”)
Not wanting to “fall behind” peers by taking a medical leave or decreasing course load
TREATMENT APPROACH

- Nutritional rehabilitation and renourishment - FOOD IS MEDICINE
- Safe, monitored re-feeding
- Medical stabilization of abnormal vital signs and electrolytes
- Therapy: individual, group, family - important to work with clinicians who are familiar with and understand eating disorders
- Medications: treat co-occurring mood and anxiety problems that persist after nutrition is restored
- Early detection, rapid (but safe) weight restoration, and regulation of eating patterns are associated with better outcomes
Team approach is standard of care
- Medical Provider (MD, PA, NP)
- Mental Health Professional(s)- may need therapist and prescriber
- Dietitian or nutritionist

Psychotropic medications should be reserved for use in co-morbid conditions. FOOD IS THE BEST MEDICINE!

Teams work best when collaborating closely with family and school

Most universities have an Eating Disorders Treatment Team that meets regularly to coordinate care. Teams may involve Student Health Center, Counseling Center, community providers

Often University models provide short term services, so student may need to be referred to the community
Evidence-based Psychotherapy in Eating Disorders

- Level 1: Well established treatments
- Level 2: Probably efficacious treatments
- Level 3: Possibly efficacious treatments
- Level 4: Experimental treatments
- Level 5: Treatments of questionable efficacy

* Using methodological review criteria from Journal of Clinical Child and Adolescent Psychology
Family Based Treatment “Maudsley”- Level 1 “well-established” for adolescents with AN, Level 3 “possibly efficacious” for BN

Systemic Family Therapy- Level 2 “probably efficacious” for AN

Adolescent Focused Therapy- Level 2 “probably efficacious” for AN

Cognitive Behavioral Therapy- Level 4 “experimental” for adolescents with AN, Level 3 “possibly efficacious” for BN, not studied in BED

Dialectical Behavioral Therapy- Level 4 “experimental” for adolescents with BED

Interpersonal Psychotherapy- level 4 “experimental” for adolescents with BED
Phase I: parents are tasked with renourishing their child
- Weekly sessions include all family members, weight is measured and reported at each meal, parents must be aligned
- Parents plan/prepare/plate all meals and snacks
- Close monitoring by medical provider
- RD consults to parents if needed

Phase 2: child begins to slowly and gradually regain independence under observation and supervision. Sessions are now biweekly

Phase 3: child is eating independently, focus shifts to normal adolescent concerns. Sessions are now monthly

Has been adapted for use with young adults and has shown a lot of promise in families where the student relies heavily on the family for emotional and financial support
Acceptance and Commitment Therapy- Asks patients to practice accepting their situation rather than focusing on trying to change or challenge thinking

Cognitive Remediation Therapy- may be particularly helpful for those who resist therapy interventions. Theory is that AN is associated with rigid and inflexible cognitive style, and that puzzles and games can help patient practice solving problems in ways that can be generalized to solving life stresses and anxiety
No psychotropic medications are approved for the treatment of eating disorders in children and adolescents.

Despite no compelling evidence to support their use, a high percentage of patients being treated for eating disorders are prescribed psychotropic medications (Golden 2011).

Studies have looked at a number of psychotropic interventions, including atypical antipsychotics, SSRI/SNRIs, atypical antidepressants- recruitment limited by:
- ego-syntonic nature of EDs
- unwillingness to try medications that may cause weight gain
- fear of increased side effects in medically compromised patients

Possible that we have not yet found specific target, or that polypharmacy may be necessary.

FDA indications for fluoxetine 60mg in adults with BN, lisdexamfetamine in adults with BED.

Bupropion is contraindicated in this population due to seizure risk.
Inpatient medical- severely ill; individual requires medical stabilization
Inpatient psychiatric- requires intensive behavioral monitoring, but medically stable
Acute residential- monitored weight restoration, groups, therapy. No acute psychiatric risk. Often able to have therapeutic passes.
Partial Hospital-day treatment. Allows individual to be home overnight to practice skills with intensive support in place.
Intensive outpatient- evening meal and groups. Allows individual to return to more normalized life, including work or school- typically allow gradual “step-down”
Outpatient- typically 1-2 hour long visits per week
National Eating Disorder Association collected data from 165 colleges and universities in U.S. in 2010

Survey measured the frequency and perceived importance of a variety of programs and services

Eating disorder services cited as most important:
- On staff counselor/psychologist/psychiatrist with specialty in eating disorders and body image issues
- Individual psychotherapy to address eating disorders and body image issues
- On staff nutritionist with eating disorders specialty
- Therapy groups for students with eating disorder

Supports Particularly Useful on College Campuses

- Intensive outpatient Programs - particularly useful if close to campus
- Meal support with dietitian or peer to increase accountability
- Peer support groups - may be triggering if not moderated
- FaceTime or Skype with parents or other supports during meals
- Contracts with family and/or treatment team that lay out clear parameters for voluntary medical leave and higher level of care
Initial medical assessment for medical complications, other organic illness, vital sign instability

Medical follow-up:
- Frequency varies by weight and severity of ED behaviors
- Weight and orthostatic vital sign checks
- Lab monitoring if purging
  - Potassium, phosphorus, magnesium

Engaging students in ongoing treatment can be challenging

Few external controls to enforce follow-up and participation in care
Hospitalization may be indicated for any of the following:

- **Physiological instability**
  - Severe bradycardia (pulse <50 beats/min in day; <45 beats/min @ night)
  - Hypotension (<90/45 mm Hg)
  - Hypothermia (body temperature <96°F, 35.6°C)
- **Orthostasis:**
  - Increase in pulse (>20 beats/min)
  - Decrease in blood pressure (>20 mm Hg systolic or >10 mm Hg diastolic)
- **Low weight:** ≤ 75% Median body mass index for age and sex
- **EKG abnormalities** (e.g., prolonged QTc)
- **Dehydration**
- **Electrolyte disturbance** (e.g. low potassium, sodium, phosphorus)
- **Acute medical complications** (syncope, seizures, cardiac failure, etc.)

Arrested growth and development
Failure of outpatient treatment
Acute food refusal
Uncontrollable bingeing and purging
Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (e.g., severe depression, suicidal ideation, obsessive compulsive disorder, type 1 diabetes mellitus)
ETHICAL/LEGAL CONSIDERATIONS

ETHICS
- Autonomy
- Beneficence
- Justice

PRIVACY
- Federal Education Rights and Privacy Act (FERPA)
- Health Insurance Portability and Accountability Act (HIPAA)

DISCRIMINATION & ACCOMMODATION
- Americans with Disabilities Act (ADA)
- Individuals with Disabilities Education Act (IDEA)
- Section 504, Rehabilitation Act
COMMON AREAS FOR PRESENTATION AND IDENTIFICATION

- Parents/family/student
- Student Health Service (abdominal pain, fatigue, amenorrhea)
- Counseling Center (“stress”, anxiety, low mood, poor concentration)
- Dietitians
- Athletics- MDs, coaches, trainers
- Residence Life- Hall Directors, Resident Advisors
- Peers/student staff
- Recreation Center
- Cafeteria, Environmental Services Staff
- Faculty and Staff
College Planning, School Related Issues

- **Location**
  - Urban, suburban or remote
  - Transportation options
  - Ability to purchase food off campus
  - Do family or close friends live nearby?

- **Housing options: Dorm or apartment? Roommates?**

- **Eating options: Dining hall, coop, chef, cooking, special needs, Flexible plan?**

- **Insurance coverage: make sure their insurance covers needed services**

- **Does the college have resources for eating disorders? Treatment team, support groups, inpatient unit**
Students in residential or intensive outpatient treatment
  - Never end treatment prematurely because school is starting!

Students still struggling, but close to their target
  - Consider deferring admission until they are well into recovery
  - Should achieve goal weight - 3 months prior to matriculation
  - Purging should be stable
  - Eating independence (dining halls are triggering)
  - How much information should the school have about the student’s history?
  - Are there more realistic options?
    - Gap year
    - Community college closer to home, then transition to 4 year college

Students doing well with an outpatient treatment team
  - Contact the university health center ahead of time and arrange a new team
  - Consider a contract so they will be accountable
Students well into recovery
- Plug into campus resources early to help with transition, prevent relapse
- Plan check-ins with health service
- Consider a contract

Students who develop disordered eating the summer before or shortly after arriving
- Treat aggressively and don’t let them progress to full eating disorders

For healthy students at risk
- Prevention programs
Consider specifying:

- Expected frequency of medical and therapy appointments, consequences if missing appointments
- Acceptable weight range
- When parent would be notified (e.g. drop below weight, unstable vital signs, misses more than one visit in a row)

Balance of privacy and notification - e.g. may have 1 week to return to acceptable weight range, before parent notified

Parents notified if contract is retracted by student
Eating and Health Outpatient Contract for XX

Objectives
1. To prevent inpatient hospitalization, PHP/IOP, or residential care treatment, unless XX decides she/he wants to pursue this level of care.
2. To remain enrolled at XX, and to live on campus.
3. To enjoy a full and joyful life, free from disordered eating.

Treatment Team
1. I will attend, be on time, and participate fully in all appointments with medical, psychiatry/psychology, and nutrition providers. I will sign release of information for all providers to communicate.
2. I agree to follow their recommendations.
3. I understand that my ability to see my therapist is contingent upon being medically stable and following medical treatment recommendations.
   a. Therapist: XX
   b. Medical Provider: XX
   c. Dietitian: XX

Meals and Snacks
1. X is in charge of planning and preparing all meals and snacks.
2. X and her/his team will adjust her/his meal plan based on medical progress.

Health and Weight
1. X will attend all medical appointments and follow recommendations.
2. Medical team will work with XX and her family to put a plan together to help patient regain health.

Activity
1. I will only do the amount of exercise that the doctor says is safe and healthy.
2. Additional exercise or activities are to be approved by the treatment team.

Enrollment at X University
1. My goal is to remain enrolled full time at X and to continue to live on campus. I understand that I must be healthy in order to be able to do this.
2. X University wants to support me and allow me to be successful.
3. If I do not adhere to this treatment plan (leaving AMA, refusing hospitalization, not attending appointments), my treatment team will notify my parents, XX (Residence Dean) XX (Student Health Care Manager), and XX (other pertinent people).
4. X University administration may require that I take a medical leave if I am not able to adhere to the treatment contract and there is concern about my medical stability.

X and the team may modify this contract based on progress and continued stability.

Patient Signature: ___________________________ Date: ____________
Parent Signature: ___________________________ Date: ____________
WITNESSED BY: ___________________________ Date: ____________

A copy will be given to all members of the treatment team as follows:
Multidisciplinary team

Meets regularly (usually weekly) to review list of students felt to be “at risk” and put plans in place to support safe ongoing enrollment

SOC leadership can meet with student if significant concern exists, to mandate assessment and (if necessary) ongoing treatment

Parents are almost always involved (less likely for older undergraduate or graduate students)

University has right to proceed with involuntary medical withdrawal if behavior is disruptive to community or places individual at risk
University administration should be involved in determining whether return is appropriate

Student provides evidence of stability and ongoing treatment (SOC communicates with providers)

Detailed relapse prevention plans are important

SOC generally provides support with return to school; monitoring becomes less intensive as student demonstrates return to health

Student discharged from monitoring when appropriate
“Love your Body Week”
- Coincides with National Eating Disorders Awareness (Feb)
- Events focused on balance, healthy eating and exercise
- Speakers
- Screening of documentaries
- Panel discussions

Fat Talk Free Week

Eating Disorder Screening Events

Small group presentations to sororities, nutrition classes, residence halls
2007 STICE AND PRESNELL: “THE BODY PROJECT”
Confidential online eating and body image screening

*StayingFit* - Online program for healthy weight management

*StudentBodies* - Online, moderated program for improving body image

*The Whole Image* - 1-unit online class about helping support body image culture change

*Reflections* peer-lead body image program

“*I am my potential*” poster campaign

bodyimage.stanford.edu
Evidence-based peer-led body image education and eating disorder prevention program

Targets campus sororities, with goal of changing social context to prevent eating disorders

Two, two-hour in-person sessions

• Evidence-based, 8-week online cognitive-behavioral intervention program with a moderated discussion group
• Designed to reduce body dissatisfaction and excessive weight concerns
• Among college-age women with high weight and shape concerns, intervention associated with significantly reduction in weight and shape concerns for up to 2 years and decreased risk for onset of EDs, at least in some high-risk groups.

I AM MY POTENTIAL

INSTEAD OF DROPPING POUNDS...
I AM DROPPING IT LIKE IT'S HOT!

//BODY IMAGE. STANFORD
I AM MY POTENTIAL
Instead of skipping out on cake, I'm enjoying it with my date!
http://bodyimage.stanford.edu
Pros & Cons of Peer-Led Interventions

Pros:
- Accessible, approachable, safe space for students
- Passionate leaders and participants
- Encourage leadership and advocacy for changes in personal attitudes and cultural norms related to body image

Cons:
- Need good mentoring and direction
- Privacy concerns
- Students with active eating disorder issues may trigger others
- May be inappropriate substitute for seeking professional help
VIGNETTES: SUSIE

- 18 yo female, about to become a freshmen at Ivy League College >1000 miles from home
- Pre-med major, valedictorian of high school
- History of separation anxiety and social phobia, successfully treated with therapy and a brief course of an SSRI
- Mother notices that she is losing weight in the months prior to high school graduation
  - Noted to be increasingly thin, at gym multiple hours each day, eats very limited number of foods
  - She is very quiet, isolates, spends most of time at library if not working out
- Susie does not feel that there is an issue, tells her mother to “leave her alone“
- Mom brings Susie to see you- What do you recommend?
21 yo male, senior at Midwestern Big 10 campus close to family
Communications major, active in club sports and fraternity
No previous psychiatric history other than visit to ED for alcohol poisoning during freshmen rush
Mother called Student Health Center due to concerns that he was throwing up after meals while home over Thanksgiving break
Environmental services staff have reported repeated calls to university-owned apartment for plumbing issues
Cafeteria staff have reported concerns about unusual patterns of eating (doesn’t have time to cook so still has a meal plan)- noted orders multiple omelets for breakfast, returns for multiple helpings
You are consulting to the SOC team at the University. How would you recommend they proceed?
CONCLUSIONS

- Eating disorders are common in college populations
  - New eating disorders can arise with the transition to college
  - Individuals with previous history may be vulnerable to relapse
- Eating disorders can be difficult to detect and difficult to treat, but individuals can improve with appropriate intervention
- Universities can form systems of care to detect, refer, and monitor students at risk due to eating disorders
- Exciting avenues for increasing advocacy and awareness, and promoting prevention of eating disorders on campus
- Health care providers should work with families launching high school students to college, to anticipate transition issues for teens with a history of eating issues
- Health care providers need to be aware of resources available for students managing recovery while enrolled in higher education
QUESTIONS?
REFERENCES

- Derenne JL. Successfully launching adolescents with eating disorders to college: The child and adolescent psychiatrist’s perspective. J Am Acad Child and Adol Psychiatry 52(6):559-561