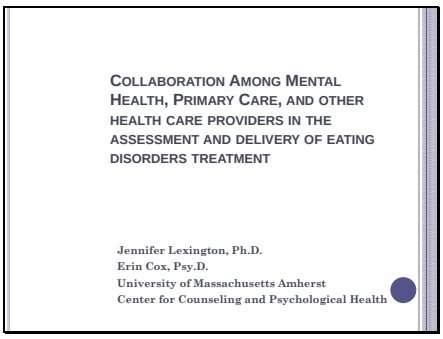
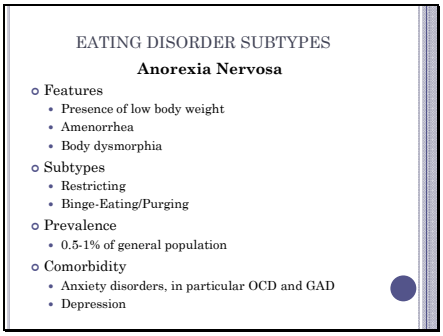
Slide 1



Twenty to thirty percent of college-aged women exhibit eating disordered pathology. When pathology becomes severe, a host of medical and psychiatric treatments can become necessary. One of the primary obstacles to successful treatment is the failure of mental health and primary care providers to effectively collaborate. Many, if not all, health care providers will encounter such issues in their practice.

Slide 2

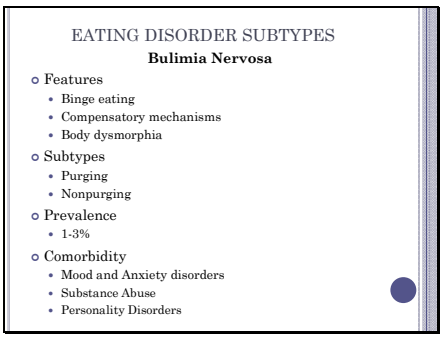


FEATURES:
-Low body weight = 85% of ideal body weight
-Amenorrhea = loss of at least 3 consecutive menstrual cycles
-Body dysmorphia = disruption in self evaluation

"Binge-eating" is a rather subjective term, as many of our anorexic clients perceive any eating as bingeing. We also commonly see overexercise in the context of anorexia.

COMORBIDITY:
-Rates of OCD are estimated at 40% in anorexics and GAD is an understandably frequent comorbid condition, when considering the need for control and the intolerance of uncertainty often seen in anorexics.
-In addition to the listed disorders, individuals with anorexia frequently display the following traits:
--need to control their environment, perfectionism
--inflexible thinking
--restrained emotional expression (alexithymia)

Slide 3



FEATURES:

-Compensatory mechanisms include purging (80-90% according to the DSM), excessive exercise, dieting, and laxatives (33%).

COMORBIDITY:

-Comorbidity rates of depression and anxiety are at about 66% (2/3) (Craig Johnson, Laureat). There is evidence that individuals with purging type suffer from more severe symptoms of depression (DSM IV-TR, p.592).

-Substance abuse is a commonly encountered problem with bulimia, particularly in younger women with a recent article in Health magazine (Jan/Feb 2002) indicating that 70% of alcoholic women under age 30 also have an eating disorder. It is predicted that approximately 30% of individuals with bulimia also suffer from substance abuse. Alcohol and stimulant use are the most common, with stimulants often used as a means to control appetite (DSM IV-TR, p.591). Further, the highest rates of suicide attempts in eating disorders are reported among bulimic individuals who have comorbid alcohol abuse.

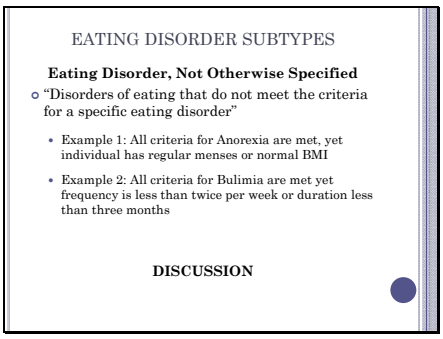
-The most common personality disorder associated with Bulimia is Borderline Personality Disorder (DSM IV-TR, p. 592).

-In addition to the DSM disorders, there are a number of other features associated with Bulimia: (DSM IV-TR, p. 590)

--Shame (binges often occur in secret)

--Feeling out of control

Slide 4

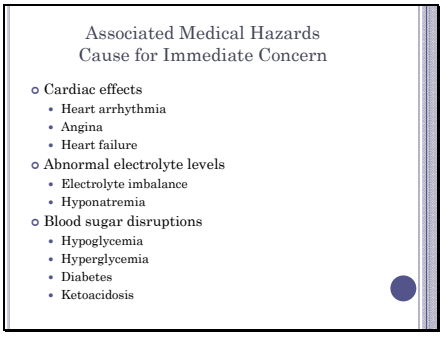


Discussion: Eating disorders can be difficult to diagnose, particularly anorexia, as the required criteria (e.g. 85% of ideal body weight) are difficult to meet. Despite the estimated rates of these disorders as presented earlier (.5-1% for anorexia and 1-3% for bulimia), it seems that we are seeing many college students that engage in eating disordered behaviors, whether or not they meet criteria for anorexia or bulimia.

What are you typically diagnosing in your college students? What behaviors, thoughts, etc do you see? Do they typically meet the specified criteria?

So when we are and aren't diagnosing Anorexia or Bulimia in our students, how so we decide the level of care that they need? Given that medical complications present independent of diagnosis, what signs should we be looking for as we assess our student's needs and our ability to meet them?

Slide 5



Heart arrhythmias can include bradycardia and tachycardia. Cardiac effects can in rare cases produce sudden heart attacks.

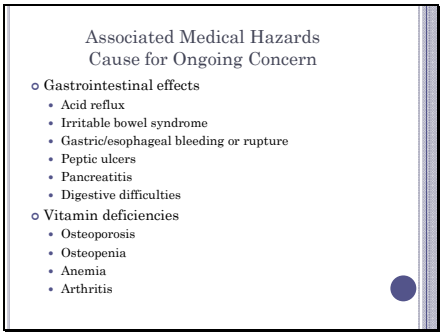
Electrolyte imbalance is particularly insidious as it can lead to unexpected seizures and long-term negative impact on the heart. We especially worry about potassium, sodium, and calcium deficiencies. Hyponatremia (excessive water:salt ratio in the body) can lead to fluid buildup in the lungs, swelling in the brain, confusion, and even death.

Blood sugar disruptions can be seen in ways that affect the body long term (e.g. diabetes) or can become an acute medical emergency (e.g. ketoacidosis – a consequence of diabetes in which the body produces very high levels of blood acids called ketones when there is too little insulin in the body). This occurred with a client of mine who had juvenile diabetes and was bulimic – she would misuse her medications to induce weight loss and presented to our emergency clinic in ketoacidosis.

In many of these cases, individuals are at high

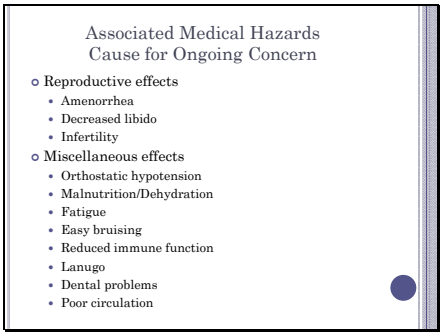
risk for serious and acute medical complications that can come without warning (e.g. sudden heart attack).

Slide 6



Though GI effects and vitamin deficiencies are common issues associated with eating disorders, they do not necessarily warrant immediate concern. In many cases, they can be used as leverage in helping a client obtain medical screening to assess more serious medical complications and/or as a therapeutic tool in working with the client toward motivation for change.

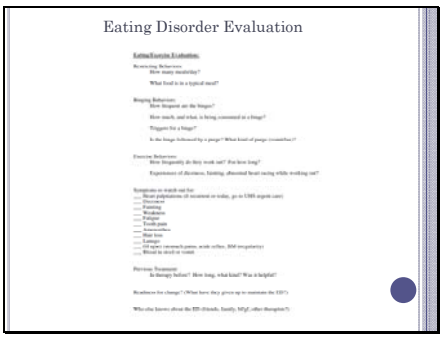
Slide 7



Similar to GI issues and the medical complications associated with vitamin deficiencies, though not cause for immediate concern, many of the effects presented here can be used as leverage with our clients in increasing their motivation for change. In particular, infertility can be a viable concern for many of the young women we work with and a potential deterrent to the eating disorder.

Malnutrition and dehydration in a long term sense are very dangerous, as health risks can include respiratory infections, kidney failure, blindness, seizures, brain damage, heart attack and death.

Slide 8



Concepts to explore:
1) This form versus another assessment tool (standardized)?
2) Reasons to use this one:
- makes more sense in our context
- helps us make decisions about level of care

3) Maybe this one for intake, whereas another standardized form for ongoing treatment?

Slide 9

In the conversation, make sure to assess participants' collaborative care models on their campuses

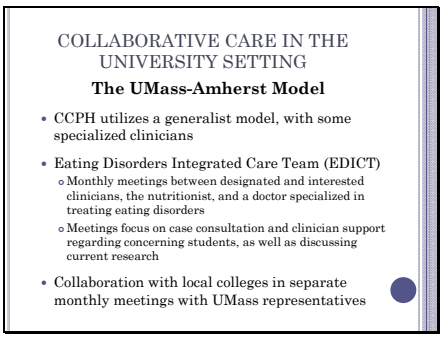
Who else do they work with (what types of providers), on campus/off campus, and how do they collaborate/communicate?

When can you/do you outreach a student when others have expressed concern? When do they involve family? What precipitates an involuntary medical withdrawal?

All this, in addition to what resources are available for people that have significant medical needs?

What about groups – how are they run, how are referrals made, content, etc?

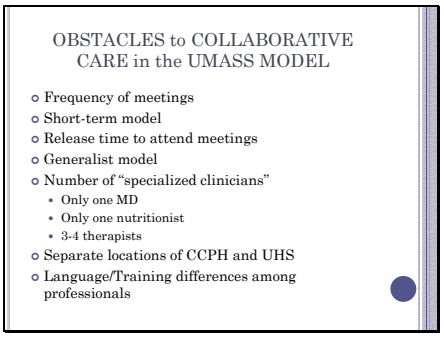
Slide 10



The history of the model should be discussed here:
-Pros and Cons to the generalist model.
-How teams have been organized in the past and then fallen apart. Highlight the difficulty of organizing meetings given scheduling demands from both the counseling center and UHS.
-Students falling through the cracks because of lack of communication between the ED Clinic and counselors
-**Jen**: Describe case of Melissa (pre EDICT)
-Point out that the EDICT model is new, but based on similar systems at both larger and smaller universities
-**Erin** – Describe recent intake case (Catherine).

OTHER UNIVERSITY MODELS
In discussing UVA and UT, it should be noted that UVAs model is rather similar to the EDICT model, while UT's is quite different and relies upon highly specialized clinicians and weekly meetings to discuss patients.

Slide 11



With such a large number of trainees (11) and separation of buildings

- hard to train up new staff with respect to ED treatment
- hard to ensure continuity of care
- hard to have consistent connections with medical providers (in another location).

And what obstacles do you face?

Slide 12