FOOD FOR THOUGHT:
CHALLENGES AND TRAINING RECOMMENDATIONS FOR PSYCHIATRIC RESIDENTS CARING FOR COLLEGE-AGE PATIENTS WITH EATING DISORDERS

Fauzia Mahr, MD, Maxwell J. Berlyant, BS, Paul J. Sullivan, MA, Simone Behar, BS, Jenna Paternostro, BS, Robert D. Friedberg, PhD, Tania Nadeem, MD

Eating disorders (EDs) are on the rise in college students, who are particularly at risk due to biological and lifestyle changes.[1,2] However, a conspicuous lack of training curricula for psychiatric residents to manage EDs in a college-age population accompanies these trends. Therefore, practicing psychiatrists enter the field often ill-equipped to deal with these clinical challenges. This manuscript discusses the impact of EDs, identifies training challenges, and provides pedagogical recommendations for psychiatric residency training programs.

The Problem: Impact of Eating Disorders on College–Age Youth

The transition to college predisposes vulnerable individuals to develop EDs. Changing diets, less adult supervision, and more alcohol and energy drinks, along with new behaviors (including, for example, less sleep and "surfing" Facebook) mean that the average college student gains about 5 kg during their time at university.[3,4] Further, emotional eating (eating for comfort when stressed, angry, or sad), which Bennett *et al.* report as common in college students, predisposes individuals to dysfunctional eating behaviors during later adulthood.[1] When prevalence rates for EDs among college-age students are studied, they range from 8% to 17%.[5]

College-age women are more likely to recount a history of binge eating as well as endorse symptoms of anorexia nervosa (AN) or bulimia nervosa (BN), whereas men tend to report greater rates of binge eating and excessive exercise to control their weight.[5] Additionally, EDs in college-age populations are associated with a higher likelihood for major depression, panic disorder, generalized anxiety disorder, compulsive exercising, and suicidal thoughts.[5] A link between eating pathology and other high-risk behaviors, such as binge drinking, self-injurious behaviors, cigarette smoking, and marijuana use, is reported.[5] Moreover, correlation between dieting, binging severity, and alcohol abuse is documented.[5] Untreated EDs carry up to 18% risk of mortality.[2] Unfortunately, despite these serious issues, Banas *et al.* report that there is an over 7-month delay in treatment for EDs.[2] Multiple factors, such as availability of and access to services, lack of early identification/recognition, and stigma regarding receiving treatment, likely contribute to hold-up in service delivery.

The Challenge: Training Gaps in Treating College-Age Eating Disorders

The extant literature on training practices related to EDs in psychiatry residency programs is relatively silent.[6] The Accreditation Council on Graduate Medical Education (ACGME) does not provide any specific guidelines, and currently there are no standardized training curricula for EDs.[7] Jones *et al.*[8] remark on the wide variability among psychiatrists' knowledge of current biologic and psychosocial treatment options for EDs. The variability may have to do with experience: specific knowledge of EDs was reported higher in psychiatrists experienced in caring for patients with EDs.[2] The lack of uniformity in knowledge likely reflects inconsistent training practices and may adversely affect patient care.[2,7] A structured curriculum to improve ED management expertise may help remedy this problem.[2]

A survey of training directors revealed that only 34% of the programs offered curricula in EDs, and fewer than 29% of programs required trainees to take courses in EDs.[6] Given the prevalence, comorbidity, and mortality related to EDs, these statistics are alarming. In general, psychiatrists feel more confident identifying than treating EDs. In one study, 60.5% of psychiatrists expressed confidence in their diagnostic skills regarding EDs, and only 14.9% felt confident to effectively manage the various disorders.[8] In this same study, 34.7% of psychiatrists considered the use of selective serotonin reuptake inhibitors (SSRIs) for AN a recommended strategy, which is contrary to current guidelines.

The Way Forward: Improving Knowledge and Skills Through an Evidence-Based Curriculum

Curricula in psychiatric residency programs are jammed, and finding time for new training can be challenging. However, training in EDs can be easily integrated into existing curricula. Residency training directors typically shape their pedagogical decisions around their training goals. Case conferences, assigned readings, bedside teaching, and problem-based learning modules are effective teaching tools. Although general consensus emphasizes that pharmacotherapy should not be the primary treatment for EDs,[8] training in psychopharmacological management of EDs can be rolled into curriculum on pharmacology and current evidence-based practices.

A basic curriculum should include at least 3-4 seminars devoted to screening, diagnosis, management, and referral guidelines. Review of standardized clinical guidelines such as Academy of Eating Disorders recommendations, the AACAP Practice Parameter,[9] and seminal readings are appropriate educational platforms. Residents should develop strong interdisciplinary consultation skills and be exposed to various evidence-based options for psychosocial intervention to prepare them for coordinating care. In the new era of health care reform, psychiatric physicians are expected to fully partner with other health care providers to deliver a continuum of care.

Didactic instruction may be coupled with rotations characterized by supervised clinical practice conducting psychotherapy with ED patients. For problems emphasizing integrated biological and psychosocial treatments, specialized courses in the Maudsley model of family therapy for patients diagnosed with AN and cognitive-behavioral therapy (CBT) for BN are essential.[10] Finding additional time for ED-focused psychotherapy training is challenging, but learning cursory skills can be helpful.

Experiential learning is achieved through both carefully crafted classroom exercises and competent clinical supervision. Clinical instruction should include role plays based on ED patient encounters. Simulated role plays (SRP) are historically commonplace in medical education and are low-risk, practice-friendly, and flexible.[11] Training programs could easily contact nearby college and high school drama departments for volunteers to play simulated patients. This option is not necessarily costly since many drama students are more than willing to volunteer their services to augment their portfolio. While educational video libraries could be considered as places where old footage goes to collect dust, residents' SRPs could be nonetheless videotaped and stored to later illustrate crucial learning points. Digital storage is not costly, does not tax physical space limitations, and potentially provides resources for interested young clinicians.

Financially strapped training programs and those in isolated geographic locations face additional challenges. Many departments may not have a faculty member skilled in EDs. Therefore, considerable flexibility and creativity is required of residency directors to acquire the essential resources. Faculty development is crucial. Consequently, investment in faculty training in evidence-based methods such as the Maudsley model and/or CBT approaches is a helpful strategy. In the absence of an interested faculty member, the department may contract with national/international experts or link with other more developed training programs to provide ongoing didactic instruction, as well as clinical consultation via electronic platforms such as Skype or WebEx. The department may also want to invest in a training library filled with educational videos.

Conclusion

Box 1 summarizes four basic points psychiatrists should appreciate when treating college-age persons diagnosed with EDs. Development of ACGME directed guidelines for competence in EDs could possibly incentivize psychiatry training programs to develop distinct curricula to train psychiatry residents in the management of EDs. Effective ED curricula targeting all the ACGME-required core competencies, including medical knowledge, practice-based learning and improvement, interpersonal communication skills, professionalism, and systems-based practice, are necessary for promoting literacy about EDs in the college-age population. Basic proficiencies to screen, diagnose, manage, and refer EDs should be addressed accurately with a well-defined and modular curriculum based on the geographic and personnel needs of psychiatry training programs.

Take Home Summary

Eating disorders in college-age youth are both prevalent and pernicious. Child and adolescent psychiatrists are often called upon to care for these vulnerable individuals. However, too few child psychiatrists enter the profession equipped to treat these complex patients. Strong fellowship curricula emphasizing instruction in evidence-based assessment and treatment as well as clinical rotations should be developed.

Box 1. Four Takeaway Messages on Caring for College-Age Patients Diagnosed With Eating Disorders (EDs)

- Contextual factors during the college years including but not limited to emotional eating, consuming alcohol and energy drinks, dysregulated sleeping patterns, and performance/social pressures contribute to increased risk for EDs.
- Access and availability to well-trained clinicians who are equipped to diagnose and treat EDs are limited.
- Child psychiatrists may be more comfortable with diagnosis than with treatment of EDs.
- Residency training programs are well-advised to increase their educational offerings in treating EDS with evidence-based instruction using a variety of in-person, digital, and distance learning platforms.

About the Authors

Fauzia Mahr, MD, is the vice-chief of the division of child and adolescent psychiatry, director of Child and Adolescent Psychiatry fellowship training, associate professor of psychiatry and pediatrics, medical director of the Eating Disorder program and practice site medical director for Briarcrest Clinics at the Penn State Milton S. Hershey Medical Center/Penn State College of Medicine, Hershey, PA.

Maxwell J. Berlyant, MS, is a fourth-year doctoral student in the PhD Clinical Psychology program at Palo Alto University and a psychological trainee at El Camino Hospital, Palo Alto, CA.

Paul Sullivan, MA, is a fourth-year doctoral student in the PhD Clinical Psychology program at Palo Alto University and a psychological trainee at Kaiser Permanente Medical Center.

Simone Behar, MS, is a fourth-year doctoral student in the PhD Clinical Psychology program at Palo Alto University and a psychological trainee at St. Helena Center for Behavioral health.

Jenna Paternostro, MS, is a fourth-year doctoral student in the PhD Clinical Psychology program at Palo Alto University and a psychological trainee at Kaiser Permanente Medical Center.

Robert D. Friedberg, PhD, ABPP, is professor and director of the Center for the Study and Treatment of Anxious Youth at Palo Alto University.

Tania Nadeem, MD, is a psychiatrist on the faculty of Aga Khan University, Karachi, Pakistan.

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