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The Implementation of Disordered Eating Interventions in Institutions of Higher Education

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THE IMPLENTATION OF DISORDERED EATING INTERVENTIONS IN INSTITUTIONS OF HIGHER EDUCATION

by

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Abstract

Eating disorders are incredibly debilitating, dehumanizing, and detrimental mental illnesses that affect diverse populations around the world. Disturbing over 28.8 million Americans alone per year, eating disorders remain the *deadliest* mental illness. Yet, there exists a gap between the academic and medical literature around eating disorders, and the societally crafted perspective towards eating disorders. While medically, eating disorders are crippling and life-threatening, eating disorders are socially praised and accepted as a norm. Not only are eating disorders vastly regularized in society, but they are also *glamorized* from the broad media saturation of Eurocentric thin idealization. These ideals are encapsulated by the ideology of diet culture, which promotes habits of disordered eating and associates worth with aestheticism, specifically around one's body shape or size. Diet culture and the eating disorders that result from it are incredibly pervasive on college campuses, affecting almost a quarter of female students. Yet, there is sparse literature around proven interventions that are in place on college campuses. Therefore, it is crucial that colleges work to introduce successful and cost-efficient interventions on campuses to reduce the widespread illness of eating disorders. Though eating disorders are thought of to only affect thin, white women, they are widely intersectional. Socioeconomic and political barriers are inexorably intertwined with eating disorders, further hindering those from marginalized groups, racially, sexually, and socioeconomically. This has only been heightened from the COVID-19 pandemic. Henceforth, through the coalition between students and their institutions, colleges must work to apply intersectional interventions that are proven, innovative, and cost-effective. While there is not one intervention that stands supreme above all, I suggest multiple proven interventions and document my experience trying to implement a technologically innovative intervention, Wellory, at my institution.

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Introduction:
The Societal Impact of Eating Disorders

Eating disorders are "serious conditions related to persistent eating behaviors that negatively impact your health, your emotions and your ability to function in important areas of life," (Mayo Clinic). Though they are commonly thought to effect only a niche population of thin white females, eating disorders are a severe mental illness that have adverse mental and physical effects, and create significant barriers to living a fulfilled and thriving life. Eating disorders affect at least 9% of the US population, or 28.8 million Americans *per year* with an estimated economic cost of $64.7 billion every year (ANAD, 2021). Western society specifically is incredibly entrenched in diet culture and the internalization of the thin ideal, which promote the belief that a thinner body, specifically a woman's body, is emblematic of higher social and economic value. Given the extreme social pressure to inhabit a smaller body, it is logical that so many struggle with disordered eating or eating disorders.

The ideals that diet culture places on society are incredibly detrimental, both mentally and physically, and come at a dark cost. Due to the intense saturation of diet culture ideals in the media, in our social lives, and in our familial relationships, disordered eating commonly occurs relatively early, with 81% of ten-year-old children afraid of being fat, and 35-57% of adolescent girls participating in crash dieting, fasting, self-induced vomiting, diet pills, or laxatives (ANAD, 2021). Eating disorders are the deadliest mental illness, resulting in 10,200 deaths each year directly caused by eating disorders (ANAD, 2021). This amounts to *one death every 52 minutes.* Included in this high toll are the 26% of those with eating disorders that attempt suicide every year (ANAD, 2021). Eating disorders can also be extremely isolating, causing damage to

relationships and damaging one's occupational performance. This amasses to an estimated $326.5 *billion* in reduced well-being and $48.6 billion in lost productivity (Deloitte, 2020).

The issue is compounded by the high barriers to accessing treatment and even higher costs for receiving treatment. This is the focus on my thesis project. Here, I not only concur that there are intersectional systemic gaps in accessible eating disorder treatment, but I also engage with scholarly literature to provide the most viable, proven, accessible and cost-efficient proposed interventions to for future organizational use to reduce the severe prevalence of college eating disorders. Given that "the median age of eating disorder onset was 21 years old for binge eating disorder (BED) and 18 years old for anorexia (AN) and bulimia nervosa (BN)," I argue that it is crucial that interventions *target high school and college populations* (SingleCare, 2020). I offer specific interventions for these age groups, based on the peer-reviewed literature, my conversations with students, and my work with an anti-diet culture company. I selected these over the alternatives based on effectiveness, cost-efficiency, and pragmatism.

To best formulate my stance on institutional implementations, I situate my study and build up to my argument in a series of chapters. Chapter 1 provides a review of the literature on eating disorders, describing how these develop and the troubling consequences that incur when they are left untreated. In the second part of chapter 1, I delve into the literature to discuss treatment options. As a reminder, my focus is on college-age populations, and thus the literature I cite concentrates on this age group, as well. Chapter 2 serves as a segue to my experience at Scripps College, a private liberal arts women's college located in the greater Los Angeles area (see Appendix A for a description of the college/data on the college). In chapter 2, I delve into my eating disorder, how it festered, and my experience seeking help. Chapter 3 illuminates the heart of my thesis, my process attempting to implement an organizational eating disorder

intervention at The Claremont Colleges. Finally, my conclusion recaps the lessons I learned along the way in this process, as well as the future steps I plan to take.

Chapter 1:
Eating Disorders; Their past, their present, and their future

Eating disorders (also referred to as EDs) are especially widespread amongst college students. According a study conducted by the National Institute of Health, "In U.S. campuses, the prevalence of EDs is high – roughly 14% of female and 4% of male students screen positive for clinically significant EDs," which is "more than three time higher than rate of treatment" (Lipson et al., 2017). Their work highlights how eating disorders are not only ubiquitous on college campuses, but that they also go untreated. Lack of treatment can lead to heightened effects and severity, which is why it is crucial to nip eating disorder behaviors in the bud before they mature into a much more serious illness. Before digressing into the best ways to prevent and/or treat eating disorders among college campuses however, it is first important to grasp a better understanding of how eating disorders develop in the first place. By examining the factors that may lead to eating disorders, researchers can better identify ways to reduce their onset. Among the most significant factors are: exposure to a new environment, departure from familiar eating arrangement, and most recently, the COVID-19 pandemic. These are represented in the diagram below:

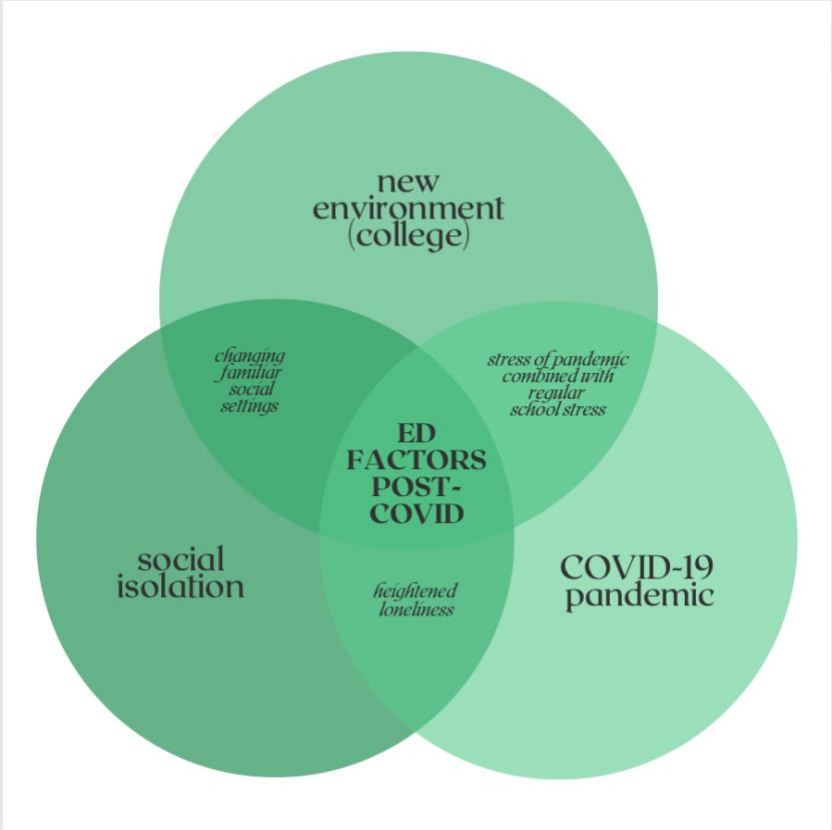

Figure 1: Contributing factors to eating disorders post-COVID-19

Factor 1: The College Context

Students starting at a new university are exposed to a plethora of new experiences and new liberties, which can be exciting, but also overwhelming. This can lead to habits that maximize their feeling of control so that they can calm their anxieties about feeling out of control. Given the intense introduction to living without family members, students "become responsible for their own eating habits, organizing their time, buying food, preparing their menus, and organizing meal schedules. All this can lead to skipping meals on a regular basis, preferring fast food, consuming alcohol, smoking, and *finally favoring the appearance of EDs*," (Hornberger et al., 2021). Because many college students are not previously educated on how to maintain healthy eating and lifestyle habits, they may opt for easy options, or develop a more

complex relationship with food than previously. While food was not up to their agency beforehand, the non-negotiability of the individual responsibility for food can be a large mental and physical deterrent for the development/continuation of a healthy relationship with food.

In addition to the overall anxieties of food choices, students are also met with high levels of academic stress that can contribute to the onset of disordered eating habits and thoughts. Due to increased class hours and hours studying, students often will have a harder time accessing food. As Interim Division Director of Adolescent Medicine at Children's Mercy, Laurie Hornberger and co-authors argue, "The lack of time caused by an increase in the hours of study is one of the main barriers to healthy eating by university students, as well as the lack of sufficiently healthy foods in university canteens" (Hornberger et al., 2021). When deciding if they have to leave the library to get a snack or continue studying, for example, many students will opt out of getting food, which can develop into a habit. Similarly, feelings of stress about grades and schoolwork can encourage food as a means of control, in which college students will find peace in being able to manipulate their caloric intake since they cannot change other stressful parts of their life. Because of this, studies have found that "academic stress can be associated with bulimic behaviors, as risk behaviors or thoughts can be generated as a factor in combating stress, increasing the possibility of developing eating disorders," (Hornberger et al., 2021).

Lastly, transitioning to college is a time that is filled with emotions, both positive and negative. This tumultuous time of emotions can alter one's perception of the necessity for food. Again, citing Hornberger and colleagues, "Negative emotions that have been studied and related to eating behavior include sadness, anger, frustration, anxiety, fear, and boredom. First-year college students experience negative emotions may be less motivated to make healthy food

choices and more likely to make poor food choices," which can lead to an overall complicated relationship with food (Hornberger et al., 2021). This inherently produces more stress, creating a toxic cycle of negative emotions towards food creating more negative emotions towards food.

Factor 2: The COVID Era

The COVID-19 pandemic has also played a significant role in the acceleration of eating disorder onset and prevalence. In fact, "[m]ultiple lockdowns, self-isolation, food insecurity, and e-learning implementation due to the COVID-19 pandemic have been associated with anxiety and depression symptoms among students leading to increased risk of developing or worsening ED" (Hornberger et al., 2021). There are multiple factors from the pandemic that have directly influenced the rise in eating disorder pervasiveness, which are still contemporaneous given the tumultuous pandemic. The main identified triggers for eating disorder acceleration are food insecurity, the media, stress, and social isolation.

Food insecurity is found to increase preoccupation with food and restrictive eating rituals, given the haphazardness of access to adequate nutrition. This is especially prevalent in low-income and marginalized populations who face comorbid barriers to healthy lifestyles in addition to food insecurity. Alongside food insecurity, the intense media saturation of the "Quarantine-15," and overall hazardous messaging about the pandemic instilled a deep fear of health in audiences, promoting disordered eating habits and high stress about the pandemic. Marita Cooper, PhD, and her colleagues at Children's Hospital of Philadelphia (CHOP) stress, "Even in non-pandemic times," … "behaviors associated with EDs (e.g., dieting and rigid exercise) are often glorified and praised, but during the COVID-19 pandemic, we have observed a substantial uptick in fatphobic media messaging surround dieting and exercise" (Cooper et al., 2021). The media contribution paired with general anxieties about the pandemic manifested high stress

levels in much of society, which have adverse mental and physical effects. Due to the increased social, financial, and work-based anxieties associated with the pandemic, eating disorder habits find a devious way of serving as a sense of control in a time of unknowns. As "research suggests [,] ED behaviors may function to reduce anxiety and distress associated with uncertain situations or outcomes;" consequentially, "stressful life events have been identified as predictive of ED onset, maintenance, and relapse," "with data suggesting individuals recovering from SARS experienced heightened psychological distress and eating dysregulation" (Cooper et al., 2021).

Factor 3: Social Isolation and Secrecy

Lastly, the social isolation necessitated by the pandemic has created significant barriers for those struggling with eating, who often rely on the help of others for recovery. Eating disorders thrive off of secrecy, which poses an eminent problem of the pandemic's enforcement of isolation. As loneliness is found to directly contribute to mental turmoil, these effects are especially prudent for those struggling with eating. With no one to hold a person in recovery accountable for their food choices, it is much easier for a person with an eating disorder to slip back into/get away with disordered habits. This is particularly true for minority populations, such as the LGBTQIA+ population in which "social support is a critical component of positive psychological functioning" (Cooper et al., 2021). As a result, "64% [of those *without* an ED] self-reported engaging in binge eating as a method to cope with stress due to the pandemic," "48% [of those *without* an ED] self-reported an increase in loss of controlled eating," and "60% [of the same group] reported that their concerns with weight, shape and eating had increased since the COVID-19 pandemic"(Linardon et al., 2022). Conversely, of those with already-diagnosed EDs, "87% reported that their symptoms had worsened, with 30% reporting that their symptoms were 'much worse because of the pandemic" (Linardon et al., 2022). In addition,

"42% of patients reported a reactivation of symptoms due to COVID-19," and "overall impatient admissions *doubled* in 2020 compared to 2019 for adults," and increased by 60% for child outpatient services (Linardon et al., 2022). These staggering insights show the severity of the pandemic's impact on youth and adult mental health and suggest that interventions must be enforced to reduce the rapid acceleration of eating disorders resulting from the ongoing pandemic.

Barriers to Treatment

The need for interventions has been made clear in numerous studies, as described above. Yet, knowing that treatment measures are sorely needed is insufficient. What is needed are thoughtful interventions that acknowledge and address the abiding obstacles to treatment. In the same way that we need to understand the common factors leading to EDs, we similarly must take stock of the significant social and financial barriers to seeking and receiving adequate treatment--which existed long before the pandemic and have only been deepened since. Here, I focus on: lack of perceived need, media-produced stereotypes, socioeconomic status, race, gender, and the discriminatory nature of the healthcare industry. These systems can all be shown in the diagram below.

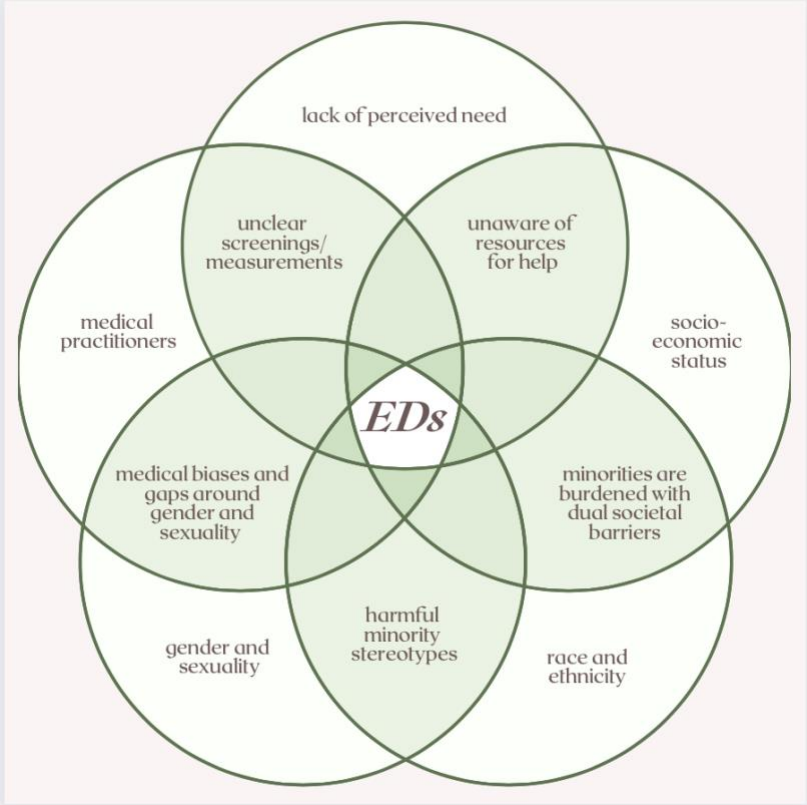

Figure 2: Intersectional Barriers of Eating Disorder Treatment

Barrier 1: Lack of Perceived Need

First, eating disorders are typically classified under the "SWAG stereotype" of Skinny, White, Affluent Girls (Sonneville, 2018). Although eating disorders are slanted towards women, this stereotype reveals the large disparities in eating disorder awareness and treatment for marginalized groups. Because of this, "higher-weight individuals, racial/ethnic minorities, those from socioeconomically disadvantaged backgrounds, and males may not recognize their need for treatment, may not be properly screened for EDs, and/or may not be referred to treatment" (Sonneville, 2018). This is evident in the results of a study conducted by Kendrin Sonneville, Sc.D, R.D., Associate Professor of Nutritional Sciences at the University of Michigan:

> *Females were more likely than males to perceive a need for treatment (OR = 1.97), to be diagnosed (OR = 4.66), and to be treated (OR = 1.64) for their ED symptoms.*

Socioeconomic background was associated with perceived need for treatment and past-year treatment, with students from affluent backgrounds having higher odds of perceiving need (OR = 1.52) and of receiving treatment (OR = 1.89) compared with their non-affluent peers.

The "SWAG stereotype" introduces a plethora of disparities associated with eating disorders that create significant barriers to accessing suitable care. Because of this, lack of perceived need is one of the largest obstacles to seeking and receiving treatment. In one study surveying barriers to treatment, "the most commonly reported reasons for not seeking treatment were: 'I prefer to deal with issues on my own' (28.1%), 'I have not had a need for counseling or therapy' (23.0%), and 'I'm not sure how serious my needs are' (19.7%)" (Sonneville, 2018). Another study conducted by Ali et.al found that 73% of those with ED symptomology did not believe they needed help (Sonneville, 2018).

This stems largely from overall poor mental health literacy, as mental health is rarely talked about in schools and is often misrepresented on social media. "Poor mental health literacy (especially a lack of knowledge about EDs) has been associated with individuals and their social networks overlooking or incorrectly identifying ED behaviour, thus preventing individuals from seeking appropriate treatment" (Hamilton, 2021). For college students who are no longer surrounded by family members that know their body type, they may not be able to recognize that they have a problem. This is especially prudent for those in marginalized bodies who are exposed to limited information about eating disorder manifestation in bodies that do not fit into the "SWAG stereotype."

Barrier 2: Socioeconomic Status

Socioeconomic status also represents a major obstacle to receiving treatment, as those coming from low-income background may not be aware of/able to afford adequate resources for help. Studies show that those from lower socioeconomic groups have a higher level of disordered eating but seek help less often than their affluent/middle income counterparts (Sonneville, 2018). Because individuals from higher-income backgrounds face fewer financial barriers overall, there will be less hindrance in asking for help, as these families will most likely not be forced to make significant tradeoffs in exchange for treatment. As a result, "Lipson and Sonneville (2017) found that students from affluent backgrounds had higher odds of perceiving need for treatment (OR = 1.52) and of receiving treatment (OR. = 1.89) compared with their nonaffluent peers" (Sonneville, 2018). In addition, a meta-analysis found that low SES was concomitant with poorer treatment results (Sonneville, 2018). One reason behind this is that "specialist services for individuals with eating disorders may be less accessible to people from lower socioeconomic groups as specialist services are typically concentrated in more affluent areas and many of the services are offered within the private healthcare sector," (Sonneville, 2018).

Most importantly, inpatient, outpatient, and residential care treatment facilities have exorbitantly high costs, and are coupled with the high prices of medication, hospital services, tests, and outpatient dietitian/therapist fees. "Inpatient stays for EDs were found by Owens et. al. (2019) to be the *costliest* at a hospitalization cost of $19,400 per admission and longest type of stays for mental and substance use disorders, with an average stay of 13.6 days" (Deloitte, 2020). This makes up at least 28% of the average household income in 2019, compared to costs for schizophrenia and alcohol-related disorders averaging below $9,000. For residential care – the highest level of treatment – the costs amounted to $796.3 million annually, of which anorexia

was the highest proportion of costs. Because of the high financial and social hurdles, "over *80% of afflicted individuals do not receive treatment,* existing treatments are effective for less than 50% of individuals, and relapse occurs in up to 32% of treated individuals" (Akers, 2021). This highlights the astronomically high financial barrier that adequate access to treatment poses, and proves the necessity of affordable, accessible, and effective alternative treatment interventions.

As lower SES groups face multiple barriers to receiving treatment, it is important that future solutions specifically target low SES populations.

Barrier 3: Racial and Ethnic Disparities

A third significant barrier in eating disorder and mental health care revolves around racial/ethnic disparities. "Compared with white students in [one] study, students of color were significantly less likely to receive an eating disorder diagnosis" (Sonneville, 2018). However, "black teenagers are 50% more likely than white teenagers to exhibit bulimic behavior, such as bingeing and purging" (CFD). There are various factors that contribute to racial/ethnic disparities in eating disorder treatment, most of which are the popularized "SWAG stereotype." "Given the portion of nonemaciated, nonwhite patients not seeking care, the conventional patient demographic profile as represented in popular culture has failed to resonate with a sizable portion of those with the illness, and this has considerable implications for treatment outcomes and illness burden" (CFD, 2021).

Another large barrier that racial/ethnic minorities face is one that is invisible but incredibly pervasive. "Public perception of Black communities has been created by the majority white media. This means that how the general population views Black people is, for the most part, how white people have wanted them to be seen" (Pono, 2021). Because of this, "two out of three Black Americans feel that they are not properly represented in the media," (Variety, 2020).

This contributes to an overall misunderstanding of the Black experience that is not only offensive in its ignorance, but also can be dangerous for the mistreatment of health issues for Black populations.

Black women, specifically, are often portrayed as "big," "thick," "curvy," and "strong," instituting the belief that Black women should not voice their concerns for help, nor should they struggle with emaciation. In regard to mental health specifically, there is a "strong Black woman identity" that posits "feeling an obligation to present an image of strength, feeling an obligation to suppress emotions, resistance to vulnerability, a drive to succeed despite limited resources, and feeling an obligation to help others" (Pono, 2020). These assumptions instill a sense of guilt or going against one's identity by asking for help, which can greatly discourage Black women from seeking the help they deserve. In short, the current media representation of Black women establishes the question, "If a Black woman is expected to be strong, how can she admit to having a problem with food, which is often associated with vanity or weakness?" (Pono, 2020).

Barrier 4: Gender and Sexuality

As the last example provided above suggests, gender and sexuality also represent a large barrier for receiving treatment. Firstly, "most studies of eating disorder-specific treatment-seeking among community samples do not include men," (Sonneville, 2018). While men are less likely to develop an eating disorder, they still make up a substantial amount of the eating disorder population – "approximately 13.5% of females and 3.6% of males enrolled at US universities screen positive for a clinical ED" (Lipson et al.); yet they are often overlooked in eating disorder research and treatment (see Figure 2). In accordance

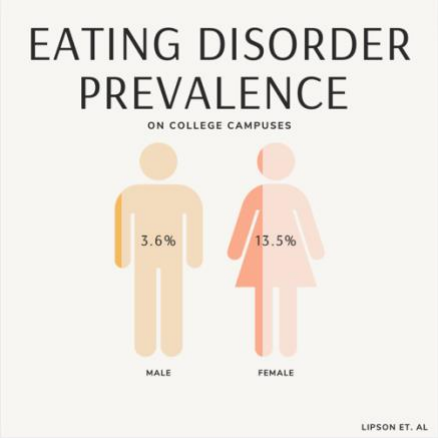

Figure 3: Prevalence of eating disorders on college campuses

with the “SWAG stereotype,” “males might be less likely to seek treatment because they are less likely to recognize their ED because they do not match the stereotype of EDs being a female problem,” (Sonneville, 2018).

In addition, similar to the identity stereotype Black women face, men also face a similar stereotype of being big and strong, which are characteristics counter to the typical conventions of eating disorders. “Males may be more susceptible than females to self-stigma of seeking psychological help because traditional male gender roles, including independence, resilience, and self-reliance, eschew the types of beliefs, attitudes and behaviors entailed in the act of seeking treatment for mental health problems,” (Sonneville, 2018). This can make it much more difficult for men to both recognize they have an issue and seek help. Especially with toxic “gym bro” culture that promotes disordered eating, it can be quite difficult for men to recognize the signs of an eating disorder. Consequentially, males are much less likely to ask and receive treatment. Aside from males, sexual minorities often face significant barriers to receiving help due to widespread stigma and stereotypes. “Recent reviews (Calzo et al., 2017; Grammer et al., 2019; Miller & Luk, 2019) suggest that young adults who identify as sexually diverse (SD) (i.e., those who do not identify as heterosexual) and/or gender diverse (GD) (i.e., those whose sex assigned at birth is discordant with their gender identity or who have diverse gender identities/gender expressions) are at increased risk for EDs and ED symptoms” (Lipson et al.).

These disparities may partially derive from Minority Stress Theory, which postulates that “poor health outcomes SGD populations result from the experience of discrimination, prejudice, and internalized stigma associated with one’s minority status” (Lipson et al.). As SGD populations face some of the harshest levels of discrimination due to their novelty in mainstream media, they will by product face heavy barriers to seeking mental health and specifically eating

disorder treatment. Because of these gruesome and pervasive stereotypes, SGD individuals may use disordered eating as a way to cope and find control, which creates a toxic relationship with food and identity. Therefore, it is crucial that there are interventions that specifically focus on eating disorders in SGD populations to directly address the impact of stereotypes and discrimination on eating disorder pathology.

Barrier 5: Medical Practitioners

Lastly, all the aforementioned stereotypes and barriers are especially perpetuated by medical practitioners. This is quite concerning to address, as medical professionals are the ones we trust most with our health; however, antiquated stereotypes about eating disorders and who they effect are still taught to clinicians, which creates severely harmful outcomes for marginalized groups. “Eating disorder researchers often rely on clinical, rather than community samples, thereby perpetuating the myth that there is an increased prevalence of eating disorders in high-resourced groups who are more likely to access care,” (Sonneville, 2018). This highlights not only the inaccuracies in beliefs of clinicians, but also failure for research to cover diverse populations.

Because of this, research and treatment solutions are specifically skewed to help those that fit into the “SWAG stereotype” and deter marginalized individuals. “From 41 studies, medical doctors, nurses, dietitians, psychologists, physiotherapists, occupational therapists, speech pathologists, podiatrists, and exercise physiologists demonstrate implicit and/or explicit weight bias toward people living with overweight or obesity” (Lawrence et al., 2021). These include the beliefs that obese people are lazy, lack control, or do not actively promote their own health. This is extremely unethical and harmful. “Longitudinal evidence shows that irrespective of baseline BMI, adults who experienced weight discrimination have 60% increased risk of

death" (Sonneville, 2018). This can be especially harmful from college students who are more prone to sensitivity and self-criticism. Moreover, 'weight bias is still widely prevalent among professionals who treat EDs (Puhl et al., 2014), and this is likely to play a considerable role in reduced treatment-seeking for individuals with BMIs in the healthy or higher ranges," (Hamilton, 2021).

Medical practitioners and their research significantly contribute to the overall disparities in eating disorder treatment seeking and receiving, and future medical studies must include diverse populations to better address the root issues that contribute to ED pathology. There are ample substantial barriers to receiving needed treatment that will take extensive time and resources to reduce, especially on college campuses. Therefore, it is imminently important to find sustainable interventions that directly target inequities in eating disorder care and are both scalable and cost-effective.

Interventions

There are a few concrete interventions that are gaining more traction for widespread use to reduce eating disorders in place of traditional treatment facilities. When deciding on which interventions to best aid the organization of the college institution, I focused on interventions that were cost-effective, accessible, future-oriented and directed to target diverse and/or underprivileged groups. While there are significant political interventions that could also be instituted to implement significant change, I focused on organizational interventions that have either already been executed or are gaining traction regarding current trend. I evaluate these interventions' cost-efficacy, their measured success, and their potential for future expansion.

Intervention Option 1: The Body Project

One intervention that has been studied extensively in college settings are cognitive dissonance-based interventions. "Cognitive dissonance is thought to occur when there is a discrepancy between one's beliefs or attitudes, and behaviour. The experience of dissonance is thought to create discomfort, and resultantly individuals change their beliefs to be in line with their behaviours" (clinicaltrials.gov). When used in an eating disorder setting, the goal would be for patients to realize the inaccuracy in their disordered thinking and remove themselves from these beliefs. The most studied cognitive dissonance intervention program is called The Body Project. The Body Project offers different modalities, ranging from peer-led to clinician-led to a virtual training format. "The Body Project consists of 4 weekly 1-h group sessions with 5-9 participants using a scripted manual. Participants voluntarily engage in verbal, written, and behavioral exercises critiquing the beauty ideal espoused by Western culture in and between sessions," (Akers, 2021).

The success of this intervention lies in its cost-effectiveness, its accessibility, and its proven success rate. Facilitator training makes up the majority costs, with the cost to train each clinician estimated at $330.52 and the cost to train each peer at $280.00, which is significantly less than the costs needed to afford on-call clinicians at schools. Not only is it cost-efficient, but it is also cost-effective: "For the money that would be spent to successfully treat one person with bulimia nervosa with CBT* ($20,317), enough peer-led Body Project groups could be delivered to prevent the onset of approximately *32 eating disorder cases*," and "for the cost of successful treatment for one individual with anorexia nervosa, one could prevent *186 eating disorder cases* (Akers). This represents a significant leap in success with a lesser cost. It was found that "on average, for every $640 a university invests in providing peer-facilitated Body Project groups

*CBT, short for Cognitive Behavioral Therapy, is a "form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders, and severe mental illness," (APA).

instead of referring women to an educational video, one additional at-risk person will avoid developing an eating disorder over the next 4 years" (Akers, 2021).

The emphasis on peer intervention is advantageous for widespread implementation, for the resources needed to institute a peer intervention program are much easier to secure than interventions that revolve around clinicians and other mental health professionals. The peer program, specifically, is demonstrated to have the highest success levels. A major reason behind its effectiveness may come from the fact that participants have more trust and commonalities with peer leaders than clinicians or web-based programs. Because peers can more closely identify with similar experiences, participants may be more open to embracing their ideas and sharing more honestly. "Peers have more credibility [than clinicians] because participants view them as similar, and as per social learning theory, people are more likely to change or modify attitudes and behaviors as a function of modeling when the source of that information is perceived as more credible" (Akers, 2021).

While this showcases both the effectiveness of a peer-led program, it also highlights the dangers of how easily social media influencers can manipulate the thoughts and behaviors of their followers. This is why it is crucial to implement programs that can remove the participant from the harmful information they may have garnered from the media. Instituting a peer program has proved to be quite successful, as "the peer-led Body Project produced greater reductions in risk factors and eating disorder symptoms than credible alternative interventions and that peer educators produced larger effects than adult teachers and clinicians who implemented substance abuse prevention programs." Moreover, The Body Project is the only prevention program that "has been found to reduce future eating disorder onset in multiple independent trials and produce effects relative to alternative credible interventions" (Akers, 2021). The Body Project should

most definitely be considered as an intervention to be used at a large scale, as it is cost-efficient, effective, and can be easily implemented at schools compared to other programs.

Intervention Option 2: School-based Eating Disorder Screening

Another effective intervention to reduce the onset and prevalence of eating disorders on college campuses is school-based eating disorder screening. "A screening test does not diagnose an eating disorder; rather, a screening test can identify individuals who may have a disorder but are not yet symptomatic or individuals who are at risk of developing an eating disorder," (Rindahl, 2017). Although studies have been conducted to measure its efficacy, school-based eating disorder prevention currently does not exist, as all screening efforts are directed towards childhood obesity. While youth obesity is a pressing issue for the country, the lack of school-based intervention programs for eating disorders complicates the process of seeking and receiving adequate care.

The implementation of a school screening program could help mitigate some of the barriers students face in getting help. The program operates using the SCOFF questionnaire, which prompts participants with five questions:

1) *Do you make yourself **S**ick because you feel uncomfortably full?*
2) *Do you worry that you have lost **C**ontrol over how much you eat?'3) Have you recently lost more than **O**ne stone (14 lb/6.4kg) in a three-month period?*
3) *Do you think you are too **F**at even though others say you are too thin?*
4) *Would you say that **F**ood dominates your life? (PCP Toolkit).*

If a student marks yes to more than 2 questions, they will receive a positive screening for an eating disorder. While it is quite difficult to identify an eating disorder from a small handful of questions, especially as eating disorders stem from a plethora of factors, the questionnaire can

help identify problematic thoughts and behaviors early on to better address eating disorder prevention in schools. This is especially helpful for those in households with absent/busy parents who may not be able to recognize the signs of an eating disorder developing, which can lead to the festering of an eating disorder until it becomes noticeable, in which the eating disorder is full blown.

From the data, school-based screening is a strong intervention. The screening program cost $2,260 per student and led to 0.25 fewer life-years with an ED, with a base cost-effectiveness of $9,041 per life-year with an ED avoided. Compared to students who were not screened, students who were screened reportedly spent significantly less time with anorexia (0.11 vs 0.46 years), spent more time getting treatment (0.95 vs 0.25 years), and consequentially spent significantly more time recovered from an ED (0.51 vs 0.26. years). Moreover, if schools were to invest $100,000 per quality adjusted life years (QALY) gained on school screening, the screening is 100% likely to be cost-effective (Wright et al., 2014). This suggests that school-based screening may be a viable option for school implementation that is effective through its costs and its results.

In addition, school-based screening is an optimal intervention for potentially reducing racial disparities in eating disorder care, as “low-income students have been found to benefit from ED screening more than high-income students,” (Wright et al., 2014). This is logical as those from higher-income households have access to more extensive and costly resources that may not be an option for those that are fiscally constrained. In addition, those that do not fit the “eating disorder stereotype” will often be overlooked by medical professionals or family members as people who could be struggling with an eating disorder, which is why screenings can help mitigate some of these barriers. As eating disorder screenings are gaining more traction,

there is a high potential for them to be implemented at schools. “A recent poll reports that 53% of US adults support school-based ED screening suggesting that, like body mass index screening, school-based ED screening will be accepted by stakeholders” (Wright et al., 2014). This is promising for the future of school-centered eating disorder interventions and can help reduce the stigma and disparities associated with eating disorders.

Intervention Option 3: Planet Health

Despite the benefits enumerated above, studies have found that school-based screening is not as cost-efficient as another intervention called *Planet Health*, “… an interdisciplinary curriculum focused on improving the health and well-being of sixth through eighth grade students while building and reinforcing skills in language arts, math, science, social studies, and physical education” (Planet Health, 2021). *Planet Health* works to directly combat both obesity and eating disorders among adolescents, which are both serious health issues that develop at an early age. The curriculum is purchasable through their website at a low cost, and resolvedly over 10,000 copies have been purchased since 2001. The practice is meant to be included as a part of public education and revolves around “sessions focused on decreasing television viewing, consumption of high-fat foods, increasing fruit and vegetable intake, and increasing moderate and vigorous physical activity,” (CDC, 1999). They involve teachers in trainings, conduct workshops, and teach pragmatic nutrition content to best prepare kids of all demographics and backgrounds to live healthy lifestyles. This is successful because it introduces healthy habits while discouraging unhealthy habits, creating a positive and rewarding environment for healthy behaviors. “Given the clear link between EDs and high BMI, there is emerging evidence that interventions can be effective in preventing both disordered eating behaviours and unhealthy weight gain” (Hornberger et al., 2021).

Plant Health is not only successful in its approach, but also in its cost-effectiveness. Total intervention costs were estimated at $33,677 per school, which is a cost of $14 per student per year -- less than both interventions above. From various trials conducted, it was found that an average of 4.1 QALYs would be saved from the intervention, resulting in $15,887 saved in health care costs and $25,104 in productivity costs (Wang, 2012). This converts roughly to $4306 per QALY saved with a net societal saving of $7,313 annually. Moreover, "the Planet Health Program prevented over half of expected new cases of disordered weight-control behavior among females" (Hornberger et al., 2021), proving that it is cost-effective and successful. In a Massachusetts school study, "cross-sectional data indicated that students in schools with greater exposure to the *Planet Health* program had lower odds of disordered weight control behaviors including vomiting, laxative use, and diet pill use after three years" (Ciao, 2014). It also contributed to reduce obesity specifically in female youths and reduce television consumption for both genders. Moreover, *Planet Health* seems to be a very viable option for educational organizations to embrace due to its efficacy and its cost-effectiveness. However, the bulk of its data is not current, and it is difficult to find if it is still an active program today. As it was introduced at the cusp of the millennial and revived in the early 2000s, it is unclear whether *Planet Health* is still functioning. However, there is a potential for organizations to reinvigorate this program due to its proven success and cost-efficiency, and its content that can be easily and accessibly disseminated.

Intervention Option 4: Technology-based Interventions

As we have seen above, there are various school-based interventions that are gaining traction, and which are shown to produce positive financial, social, and mental outcomes. These all prove to be relatively cost-effective, as well as successful and accessible, which are key

components in the construction of an efficacious school eating disorder intervention. Yet, as the pandemic has led all of society to embrace a more technologically focused lifestyle, there are budding developments in technology-based interventions for eating disorders that may have a strong prospect for future widespread implementation. One prominent example of how new technology can integrate to reduce eating disorders can be found in virtual and augmented reality, which fall under the umbrella term of extended reality. "Extended reality (XR) refers to all real and virtual environments combined together, where the interaction between human and machine occurs through interactions generated by computer technology and hardware. XR technologies consist of virtual reality (VR), mixed reality (MR) and augmented reality," (Hornberger et al., 2021). As the pandemic served as a breeding ground for innovation, XR has been used in various applications, ranging from medical usage to gaming.

A burgeoning literature around XR has surfaced around solicitation for mental health, as the many barriers of adequate mental health care have been more and more identified as a result of the pandemic. "With virtual reality (VR), computer-generated interactive environments, individuals can repeatedly experience their problematic situations and be taught, via evidence-based psychological treatments, how to overcome difficulties" (Freeman, 2017). Given its early stages in implementation, the research around XR and eating disorders specifically is sparse, with few established studies showing the clear efficacy of XR as a solution to eating disorders.

Studies that do show effectiveness, however, are promising. One study conducted by Cambridge University, for example, found that "suitable VR environments can bring on food cravings, with responses to VR food comparable to real food, and there has even been an initial test of high-calorie food presented using augmented reality" (Freeman, 2017). Another study by Keizer et al. "helped patients with anorexia nervosa to experience ownership of a healthy-body

mass index (BMI) body, which led to afterwards, for at least 2 h, to a reduction in body size overestimation," which is a central feature of body dysmorphia that can factor into an eating disorder (Freeman, 2017). These initial findings suggest that VR can simulate in-person experiences accurately, which can help solve the huge burden in-person treatment facilities face. As treatment centers have struggled in the pandemic to bring effective treatment to virtual patients, XR may pose a unique solution.

As a caveat, it is noted that "the two factors that are currently holding back the widespread use of VR technology in the clinical setting in general and in EWDs [eating and weight disorders] in particular are the high cost and complexity of its use and maintenance" (Gutierrez-Maldonado, 2016). However, the high costs of VR technology are quickly declining as they are being rapidly adopted and dispersed to consumers. As VR and XR technology grows in popularity, which top consulting and tech firms suggest they will, the barriers of cost and accessibility will decrease, meaning this could be a viable cost-effective solution for eating disorders coming out of the pandemic.

Intervention Option 5: Mobile App-based Solutions such as Wellory

Another prominent intervention that is gaining more traction is the introduction of mobile app- based solutions that are specifically targeted to combat eating disorders. Similar to the solution that XR poses, app interventions can help mitigate the high accessibility and financial barriers to seeking and receiving adequate treatment. One study conducted in 2014 introduced a cognitive behavioral therapy app with content that helped challenge common pre-existing thought patterns tied to disordered eating. It also utilized text messages and private calls in-app from coaches to provide in-depth support paired with the therapy from the app. Mobile applications can be a possible solution due to the widespread usage of apps every day, meaning

there may be fewer and lesser barriers to downloading and engaging with the technology compared to going to an in-person intervention or watching long web-based videos, specifically for college audiences. As Ellen E. Fitzsimmons-Craft, PhD, an assistant professor of psychiatry contributes, "College students are busy and often don't have spare time to seek the help they need, and many college counseling centers aren't equipped with clinicians who are trained in eating disorders, so we believe digital interventions like this one can dramatically increase access to care" (Dryden, 2020).

Based on the results from the Fitzsimmons-Craft study and feedback from scientists, researchers concluded that a cognitive behavioral therapy-focused app would be an effective and sustainable solution for future dissemination. A large part of its success was due to its ability to meritoriously engage participants and maintain this participation over time, compared to in-person care. The app was found to dramatically increase access to treatment, as well as produce significant reductions in ED pathology. "One striking finding was that so many women assigned to the digital intervention actually used the phone app, and it helped to reduce their symptoms, such as marked concern about their shape and weight, body esteem issues, and binge eating or purging," principal investigator Denise Wilfley, PhD, professor of psychiatry and Director of the Center for Healthy Weight and Wellness reported (Dryden, 2020). By utilizing short sessions in an accessible format, the app found its highest rate of success.

In addition, an unexpected result was the improvement in depression and anxiety that are often coupled with eating disorders. "Such interventions may be especially important on college campuses during the COVID-19 pandemic," Wilfley added. In a review of smartphone applications for the treatment of eating disorders, the National Institutes of Health proposed that the best apps should: make treatment interactive, utilize evidence-based principles (EBPs),

produce personalized random prompts for reflection, and synch information between other health-related apps and treatment facilities. While there is still ample work to be done regarding the implementation of a successful mobile app eating disorder solution, studies and current trends suggest that mobile apps may be the future of eating disorder prevention and treatment.

As obesity poses a significant, if not more, issue than eating disorders, it may be more difficult for colleges to invest in a program exclusively designed to help eating disorders. Because of this, it may be a more sustainable solution to introduce a technology that can combat both health crises on college campuses. This is also found in the *Planet Health* intervention which combats both obesity and disordered eating. In 2019, it was measured that over 37% of college students reported being overweight by BMI, and 16% were reported to be obese according to BMI (Manchester, 2020). While BMI is a dated and inaccurate measure of health that is flooded with racial disparities, this still reveals that obesity is a significant problem among college campuses, and the country.

One app, Wellory, may pose a unique solution to both these issues. Wellory is "a mobile service designed to challenge diet culture and reinvent personal nutrition to be accessible and affordable for all," hoping to "modernize the space by connecting clients with nutrition experts to create a custom plan tailored to their preferences, habits, and concerns," (Shacknai, 2020) –all key principles identified by the NIH to make a strong app intervention.

Compared to other diet apps such as Weight Watchers and Noom that prioritize weight loss and vigorous calorie tracking, Wellory is the first to take a holistic approach to health, serving all that want to develop a healthier relationship with food, whether this be disordered eating recovery or weight loss. While Wellory is not geared to directly aid full-blown eating disorders, the app can help students who are struggling with disordered eating, which makes up a

larger population than those specifically diagnosed with eating disorders. Because of this, Wellory may prove to be a more sustainable solution for widespread college distribution. "Through your Wellory App, you are empowered to optimize your daily nutrition routines and communicate with your certified coach for questions, support, and feedback. Ask & answer key questions about your eating habits like: 'What meals did I eat yesterday, last week… last month', and 'Should I eat fruits before, during, or after lunch?" (Wellory, 2022).

Access to in-depth personalized resources in not only a growing demand of modern-day consumers but is also a marker of a successful intervention. Because app users will access help that is specifically tailored to their individual needs, users may be more inclined to continue using the app, compared to a one-size-fits-all approach. In addition, the app focuses on implementing small behavioral and lifestyle changes that are sustainable and less daunting for a user that is scared to make any changes to their diet. The app focuses on experts instead of diets, meal-by-meal approaches versus drastic changes, photo tracking instead of calorie counting (a method commonly used by outpatient dietitians for eating disorder patients), and personal advice with zero judgements. The app also features unlimited messaging, video calls, personalized habit suggestions, and recipes to help promote a holistic healthy lifestyle. All of these pillars are conducive to a maintainable solution that focuses on encouragement instead of punishment, creating a more enjoyable and effective experience. As a result, "Most Wellory members begin experiencing lasting results within 10 weeks, with significant improvements by month 4" (Wellory, 2022).

Wellory currently does not have a college division but has demonstrated strong interest in opening a chapter specifically for The Claremont Colleges. Though the organization of The Claremont Colleges has been resistant to embrace an innovative disruption, Wellory has

proposed ample solutions for the dissemination of features of the app for a limited or absent school budget. As the company recognizes the necessity of having a successful solution on college campuses for disordered eating, the company is willing to work with The Claremont Colleges to create a sustainable, accessible, and effective solution to the prevention and reduction of eating disorders on college campuses. While the colleges have been rather unwilling to work with Wellory due to its originality and novelty, the efforts of the student body paired with senior partners at Wellory are making significant efforts to implement Wellory in some form at The Claremont Colleges. As the students themselves have demonstrated both a perceived lack of helpful resources for disordered eating and overall mental health at The Claremont Colleges, as well as a strong interest in a technological solution to help combat diet culture, Wellory should be considered for adoption at The Claremont Colleges.

It is encouraging to know that technology is rapidly improving accessible health care, and that eating disorders and diet culture are getting more traction in the media. By evaluating past, current, and future potential interventions for educational organizations such as The Claremont Colleges, I was able to advocate to my school the importance of working to improve healthy living and combat disordered thinking.

Chapter 2:
My eating disorder journey

I remember the first time I downloaded MyFitnessPal. I remember the first time I received my daily caloric limit on the app, my jaw dropping from the staggeringly low number my phone was displaying for its calorie recommendation. I thought to myself that surely this could not be the actual amount of food a human was supposed to eat in a day. I remember logging in the foods I ate that day and feeling depressingly amazed by how many calories were

in everything I consumed. I remember the first time I told my dad not to pack me that extra snack because "I wasn't hungry," when, in reality, MyFitnessPal was telling me I shouldn't be hungry. I remember sneaking into the bathroom of my first boyfriend's house to see if I had "room in my daily limit" to eat the ramen he had made for me. I remember coming up with a game with myself to see how much less than my recommended limit I could eat per day. The lower the number, the prouder I felt. I remember when I didn't even check MyFitnessPal anymore because I knew the amount I was eating was so dismally low that even MyFitnessPal would recognize a problem.

My eating disorder festered inside of me for several years, manifesting in different ways to serve different needs of mine. Yet, even without a clinical eating disorder, I, along with the rest of my generation, had been exposed to a superfluity of diet culture phenomenology. Diet culture can be described by "a set of beliefs that values thinness, appearance, and shape above health & well-being," (UCSD, 2021), and revolves around Eurocentric aesthetic ideals. Most importantly, diet culture feeds into the neoliberal mindset that a person's worth internally and societally is contingent on their body. Specifically, it dictates acceptance exclusively towards those that are in smaller, nonmarginalized bodies.

I grew up in the era of Weight Watchers and Atkins diets, with fat being society's modern day "F-word." When I watched television after school, I learned that I could "love my jeans in just 2 weeks" if I ate Special K every day. When I went to the supermarket, I saw shelves dotted with magazines promising instant abs with just a "little willpower." As I matured, I became infatuated by the metropolitan hustle culture of my home, New York City, and embraced media representations like Andy from *The Devil Wears Prada* as the person I wanted to be when I grew up. In the film, the main character ditches her frumpy look and for an elite job

and a new wardrobe to frame her thin model-esque figure. She rarely has time to eat, see her friends, or do anything pleasurable for herself, but she's successful and "beautiful." *That* was who I wanted to be. In the fast-paced, work-dominated lifestyle of New York City, taking time to care for oneself was far from praised. Instead, neglecting or even punishing one's body with long hours, undereating, and overexercising was the norm, and something that people bragged about competitively. I always imagined myself as this sharp-witted, thin, powerhouse that didn't need to eat or sleep. This was *sexy* to me, admirable to me. It was who I wanted to be when I was older. Little did I realize that what comes with being an under-fueled work boss is constant irritability, malnourishment, and the loss of enjoyment.

When I moved in the middle of high school across the country, I anxiously sought out ways to define and differentiate myself, feeling that I needed to prove my worth in some way external of my intuitive self. Additionally, I grew to adopt perfectionism and competitiveness as a result of an intense academic environment and felt the dire need to "be amazing" so that I could have a "good future." Similar to the corporate capitalist model that I was aspiring to enter, school facilitated the same level of competitiveness and perfectionism. Growing up in New York where it was even competitive to get into *preschool,* work ethic was crucial to surviving, let alone thriving. As the difference between getting into an Ivy League could be one percentage of a GPA point, academic and extra-curricular performance were key, meaning anything done for pleasure had to either be conducive to a positive college application, or was otherwise viewed as superfluous. Suffering became equated with achievement, and it became commonplace to compete for who had the most work. Talking about having a smaller workload or not being stressed was *not* something people wanted to hear about, and I learned that surrendering to school was the only way to win.

What these traits revolved around, though I did not know at the time, was control. In a system that felt tumultuous and irrepressible, it is logical that many of us turn to different methods of seeking control. Because I was gradually indoctrinated to believe that weight loss was both easily attainable and easily rewarding, food and exercise seemed like the logical facets to control. Now, I could have a fixation that would be my "something" in an environment that I felt I needed to be initiated into. Because of my "something," it would be okay if I felt socially anxious or insecure because I had control over something that I knew people would admire. In a melting pot of social and academic anxiety, I became an easy target for diet culture and its extremes.

I threw myself into the depths of the web for any information on how to look like the movie "it" girls I so desperately aspired to be. With the social media and online search engines that are only getting more precise with time, it was inevitable that I fell down the diet-promoting, body dysmorphic rabbit hole. This only intensified when I entered college and felt a forceful need for control in a new environment full of unknowns. Faced with myriad emotions, I fixated on learning as much as possible about nutrition, exercise, weight loss, and anything that was under the umbrella of "health." As the content I was consuming encouraged me to keep learning more, I became more and more intensely obsessed with "health." After a few months into college, I started compromising other things for my "health." I would spend 10 minutes less on homework because I needed to plan out my workout for tomorrow. I would skip meals with my friends because a website told me that eating slower would help me lose weight. I would stare at the clock every two minutes while studying for a test to see when I was finally "allowed" to eat a meal.

And yet, while these compromises were troubling, I only became more infatuated with them. It quickly propagated into my identity, and it was what I could champion myself by. If I had felt awkward at a party, I told myself it was okay because I was exercising more and eating less than "everyone else." And because of the world I grew up in and the information I absorbed, I believed that this made me acceptable. Not only acceptable, but *superior*.

Seeking help for my eating disorder

I had finally reached a certain point in my disordered thinking that I started to wonder if what I was doing was actually more *unhealthy* for my body than healthy. I was noticing that I couldn't focus on anything other than food and exercise, and that I had no energy throughout the day. I also was needing to wear more layers than usual, which was weird to me in a Southern California March and would dread walking to dinner needing to wear three sweatshirts. I didn't know why these changes were happening, and there was no information around my school or online for me to learn more. I went further down an Internet rabbit hole, now taking "Do I have an eating disorder" quizzes online and following Instagram accounts from people I thought were promoting recovery. I even called the NEDA hotline at one point, in which they told me I may have a problem and needed to seek help. Yet, with no resources around *how* to get help, nor any resources about *why* I should want to get help, I decided that these weird habits were serving me more than hurting me. After all, if I gave up this relationship with food and exercise, I wouldn't have anything "special" about myself, and that was not something I felt I could give up while still trying to figure out who I was.

Finally, my friends started to speak up about some of my concerning habits, but since they didn't tell me why they were bad or what I could do to stop them, I brushed off the

comments and used them to fuel my disordered thinking more. Mainly, I did not think I was "sick enough" to have a cause for concern. Looking at the rare media portrayals I saw of eating disorders, I envisioned malnourished 6"5' models picking on an apple for a day. I read stories of people's eating disorders and how they would only eat x meals a day, which taught me that I needed to eat less if I were to *really* have an eating disorder. I was on the cusp of feeling competitive about how disordered I could get while also in full denial that I could ever actually have a problem with food. From this, I entered a toxic relationship with my eating disorder – constantly wanting it to be exposed so I could not be the only one to think I had a problem and getting further disordered because it felt encapsulated all my darkest fears, anxieties, and aspirations.

My disordered eating and exercising had gotten so bad that I finally decided it might be time to talk to a doctor. I went to my college's Student Health Services and met with a physician who specialized in eating disorder care, even though I did not think I was "qualified enough" to have one. I remember the doctor told me that I most likely had an eating disorder and needed to seek help. I was told I needed to talk to my parents and go from there. And then I was on my way.

Left feeling overwhelmed and exposed, I decided I would *not* be telling my parents about this conversation and would just use this to get further disordered. Perhaps if I had been given resources for support with communicating or receiving help for my disorder, or reasons why I shouldn't engage in disordered eating/exercising, I would have chosen recovery then and there. Yet, my reality was that the next few months after that doctor's appointment would be my darkest and sickest months.

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I grew up fortunate enough to have an amazing family who supports me fully. I am grateful every day for the intimate relationships I have with my mother, father, and sister, and for the ample time I am privileged enough to spend with them. In college, it was much more difficult for them to check in with me, as I was busier and farther away. Conversations naturally became shorter, lighter, and sparser. It did not make sense for me to open up on a 5-minute call between classes about a potential eating disorder. Paradoxically, the more entrenched in my eating disorder I became, the less I wanted to talk with my family. The eating disorder was pulling me away from my friends, from my schoolwork, and now my family in its malicious ploy to stay hidden but fervent.

It was not until coming home for the summer and going on a family trip that my parents were easily able to recognize that there was something seriously wrong with me. I was constantly irritable, moody, freezing cold, and a ball of tension and difficulty when it came to meals. We could only sit down at a restaurant after exhaustively looking at every menu down the street to make sure there was something I wanted. We could only sit in heated dining areas because I would be immobilized in my coldness. We could only have a light-hearted conversation for a few minutes before my temper or mood would kick in. Reflecting with my mother the other day, she described it as always feeling like she was walking on eggshells around me. It took my parents confronting me and advocating for me to finally seek help. They were fortunately able to pay for my treatment which I entered, not knowing how it was going to save my life.

This is not a reality for many people. So many people like myself do not have two parents who have the time and relationship to realize that their daughter is struggling and needs help. I

am not sure if I myself would have ever sought out the help I needed. Because there were no resources that were telling me what I was doing was dangerous and life-threatening, I am not sure if I would have ever truly believed I needed help. Due to the intense stigma and glamorization of disordered eating, I, along with so many others, felt proud of my disordered eating and reveled in it being a part of my identity. Neoliberal capitalism works to association pleasure with laziness and discipline as productivity, feeding into a vicious mindset around how we treat our bodies. This instilled in me and surely so many others struggling that asking for help was a sign of weakness, and that I should just "toughen up" and not pity myself. Not only do eating disorders thrive off of secrecy, but they also feed off of guilt and insecurity. This culminates into a devastating mental illness that is isolating, exhausting, and dehumanizing. While I was fortunate enough to have my parents intervene for myself, this is not representative of all lifestyles. Therefore, it is crucial that there are concrete interventions put in place specifically in educational organizations to directly combat disordered eating and diet culture.

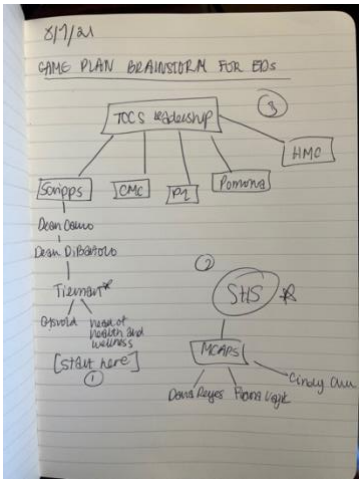
Chapter 3:
My experience trying to implement an ED intervention at the Claremont Colleges

In this section, I discuss the different tactics I tried, and the different organizational members I spoke to in attempt to raise the organization's consciousness around the issue. I reflect on my experience trying to bring awareness about the need for an intervention, its struggles, and the lessons I learned in trying to make a meaningful impact in this organization. Knowing that I did not want anyone to have to go through my experience, I set out to find the best strategy for the execution of resources at the school. In addition, I wanted to ensure that any future student could have the assets available to maintain or create change in the Claremont

community. Having lost students to eating disorders previously compounded with the impending mental health crisis brought upon by the pandemic, I did not think I would have much difficulty trying to get my point across.

Strategy 1: Understanding the organizational structure

Before reaching out to anyone, I wanted to get a better grasp of the organizational construction of my college. To make impactful organizational change, it is important to understand the innerworkings of the organization to best cater to its needs. An implementation that would be successful for one college could be the opposite for a differently organized educational institution. Therefore, the best course of action for myself and for any change-seeking agent was to examine the internal organization of each college and their relationship to each other. The Claremont Colleges is a consortium of 5 colleges that are connected by one Student Health Service center. Each college has its own internal government, and there is no president that oversees the consortium; therefore, each college is majorly run by itself and not in direct democracy with each other. Because of this, there were a few different tactics that I could potentially employ to create change. I laid out a game plan for myself (Figure 4) the summer before my senior year started of how I wanted to approach this process.



Looking at the different departments, I planned out who would be most strategic to talk to first. I based this on how high ranking they were in the organizational ladder, how accessible I believed they would be to reach, and how their role could best facilitate change. Because of this, I decided it would be best to reach out to The Claremont Colleges' Student Health Services.

Figure 4: First strategic map taken from journal entry

Strategy 2: Student Health Services

The Claremont Colleges Student Health Services department is in charge of all student health and wellness throughout the consortium. This includes both mental and physical health. There is a specific division dedicated to mental health services, which is known as Monsour Counseling and Psychological Services (MCAPS). The MCAPS staff "consists of psychologists, marriage and family therapists, psychiatrists, post-doctoral fellows, and administrative staff who are committed to providing excellent mental health and psychological wellness services to the students of The Claremont Colleges," (MCAPS).

Before COVID, I had conducted a student survey about Monsour to garner a better understanding of student sentiments towards the establishment. During this time period, mental health services were not talked about frequently on campus, and there was limited information on existing resources. I set out to determine why Monsour seemed so ambiguous, asking questions about students' experience. Those who did not go to Monsour shared that they had "heard bad things," "couldn't get an appointment," or "didn't know how to make an appointment." These represent significant barriers to mental health care access, which is already stigmatized enough on its own. When asked if they returned after their initial session, many again iterated that confusion with finding or scheduling an appointment made it either daunting or impossible to obtain care. Others contributed that they only went back because they had no other affordable option, "even though I don't feel like she listens to my concerns adequately." Yet the largest barrier by far was overall education about these resources existing. Almost all survey participants had only learned about Monsour from freshman year orientation and felt that the way they learned about Monsour was: "kind of like a side note," "kind of confusing," "generic," "4/10," and misleading about promising resources that do not actually exist.

When asked what an ideal mental health service would provide for its students, answers consisted of: “more experienced counselors,” “unlimited free therapy with little to not wait time [because] waiting weeks to see a therapist is ludicrous,” “trauma informed, intersectional therapy,” “more therapists so the waiting list is not as long,” “mental health appointments the minute that a student comes in seeking/asking for help,” and “very clear ways to get help if you don’t know how, especially if you don’t have a primary care doctor to talk to.” General themes from this prompt include accessibility, increased awareness, and intersectionally-informed care. In addition, many asked for both group therapy and other forms of therapy that allowed for easier and faster communication, such as an on-call therapist. Because of this, over half of the respondents concluded that the 5Cs do not support student mental health, and consequently, many feel that they have no one to talk to. Even if they do build the courage to seek help, the extensive waiting times and red tape the student must go through to get one appointment makes it incredibly discouraging. One student dishearteningly answered, “Monsour has actively made my mental health worse. And other support systems in place inevitably just tell you to go to monsour [sic] or dont [sic] give a damn about you.” When asked what they would propose to increase mental health on campus, many students voted to shut down, redo, or defund Monsour in place of better resources.

This was *before* COVID. Now, as mental health has exponentially deteriorated in the wake of the pandemic and social unrest, making resources accessible and effective is more imminent than ever. To start, I identified which members of MCAPS would have the closest areas of expertise for nutrition and disordered eating. I reached out to the doctor who had diagnosed me that first time I went to Student Health, as well as a few other psychologists and program managers. I also reached out to the head of Student Health Services directly. Some did

not respond, but I was able to afford a meeting with that doctor. Yet, as I did not yet have a concrete plan, the conversation did not amount to anything. After meeting with another member from MCAPS, I was able to better grasp the approach they take to eating disorders. Here is an excerpt from the email I received:

> *I can start by sharing a bit about what the work at MCAPS looks like for folks who display symptoms of disordered eating or have an existing eating disorder diagnosis. For students who have identified disordered eating as their primary goal for therapy and have goals that would be met within the short-term model at MCAPS we would work to challenge negative thoughts, create new patterns of eating, and work to understand their relationship with food and their body taking into account cultural and systemic factors. For students who have existing eating disorders or meet diagnostic criteria for an eating disorder we refer off-campus for treatment. As you may know, the treatment of eating disorders require a multidisciplinary team often times including nutritionists, family therapy, and open-ended treatment. The structure of university college counseling centers often times cannot support all of those needs. As of Fall 2020, MCAPS has adopted a new model for how we see students, utilizing a Brief Assessment Appointment to determine the needs and appropriate treatment options for clients. During these appointments if it is determined by the clinician that the most appropriate treatment for students with eating disorders or eating concerns is off campus we have several strong referrals in the Claremont area that we refer to.*

This was an extensive response that I was grateful for. After we connected, we decided we would revisit the subject at the beginning of the fall. Yet, upon trying to reconnect, I was told

they would no longer be willing to take on the project. I decided it was time to try a different strategy.

Strategy 3: Wellory

The summer before my senior year of college, I had thrown myself into the research that now makes up this thesis' literature review. Wellory, the proposed mobile-app intervention, had caught my eye for a new and innovative approach to combatting diet culture and disordered eating on campus. Unsure of where to start, I cold emailed the CEO. After a 5-minute call that I had not planned out strategically, I had not made any progress. Then, I decided if I wanted to have any potential of incorporating Wellory into my school, I would have to come in with a clear objective. One month later, I reached out to the Head of Partnerships at Wellory, Jackie, who was happy to connect with me. After an initial meeting, Jackie had come back with an extensive proposal, suggesting free workshops, discounted partnerships, and so many more interactive events that would be needed on campus. Though they were focused on a millennial consumer audience, they agreed that the college demographic could be a fresh segment. From our conversations, I was able to develop a relationship with the CEO and the Head of Partnerships who both pledged to help me involve Wellory with the Claremont Colleges.

Strategy 4: Scripps College and the proposal for Wellory

Before I had a concrete idea for an intervention, I had reached out to the head of Student Life to discuss eating disorder involvements on campus in May of 2021. Because this only involved Scripps, there was a greater potential for me to adequately get my point across and potentially institute real change. From here, I was referred to the head of the Scripps Tiernan Fieldhouse, which "provides a student-centered approach to promote a broad variety of fitness, health, and wellness educational programs, workshops, and services to foster learning and a lifetime

appreciation of being fit through a healthy lifestyle" (Tiernan, 2021). This exchange was the most promising yet. Though the head of Tiernan was unsure of how exactly we would work together, she was committed to continuing this conversation.

Around the same time that I connected with the head of Tiernan, I was forming my relationship with Wellory. With this newfound goal of introducing Wellory to The Claremont Colleges, I set out to make this a reality through Tiernan. Jackie, the head of partnerships at Wellory who had offered to help, had prepared an extensive proposal for The Claremont Colleges. In this proposal included sending "Wellorists" (Wellory nutritionists) to lead sessions and workshops at the schools, live events, and different price structures for the school's budget, which we were informed was minimal from the head of Tiernan. After finding time to walk through this proposal, we were told to wait for its presentation to the 7C Committee that oversaw all activity at The Claremont Colleges and their two grad schools. Similar to the last circumstance, the start of the semester complicated faculty members' capability to pay attention to new ideas. Everyone was just trying to keep the school running. Flooded with tasks to keep Scripps afloat, my Tiernan correspondent no longer had time to dedicate to a potential intervention that would additionally cost the school money. To aid this, she graciously connected me with Tiernan's head of Health and Wellness; yet, this member suddenly quit a few months later, leaving the position vacant. Overall, after much time and effort, Tiernan was unable to financially or organizationally support any program related to eating disorders.

From here, I was candidly discouraged. After half a year of trying to start a conversation about eating disorder prevention, all my strategies had fallen short. Yet, I was neglecting a resource that I was most invested in and most passionate about: my social media.

Strategy 5: @thefoodfreedomsociety

The first semester of school during COVID, my first semester graduated from treatment, I was feeling intense anxiety around the fact that so many people were struggling with disordered eating. There were plenty of options for adults who could pay for a dietitian, but there were no feasible options for college students. This set me on my initial journey to find my role in reducing eating disorders for students. As Instagram is ultimately what helped me recover in a terrible treatment center, I thought of how I could use social media to help others. Because of my body size, race, and socioeconomic status, I did not want to center the Instagram around myself. Instead, I took inspiration from the group sessions many Instagram dietitians I followed would run. These group programs cost around $600 and involved intimate support from the dietitian, education, and a support group. These were features that would be incredibly influential for students. Yet, they were inaccessible and not targeted for this age demographic. Though I wasn't a dietitian or a trained health professional, I decided to start the Instagram, @thefoodfreedomsociety to educate others on diet culture and recovery, and to facilitate group Zoom support sessions.

Figure 5: My first Instagram post.

This received a huge wave of positivity. The Instagram instantly gained traction, and I launched my first Food Freedom Society Session. With a turnout of about 15 people (way more than I had expected) we had an amazing talkback, with individuals voicing their struggles and wins. We had strict community guidelines to keep the space positive, encouraging, and not triggering so that we could educate

each other without threat of bringing someone down. These weekly sessions grew to cover different topics, such as how to intuitively exercise, that came directly from the best scholarly sources.

Figure 6: Food Freedom Meeting Instagram Post

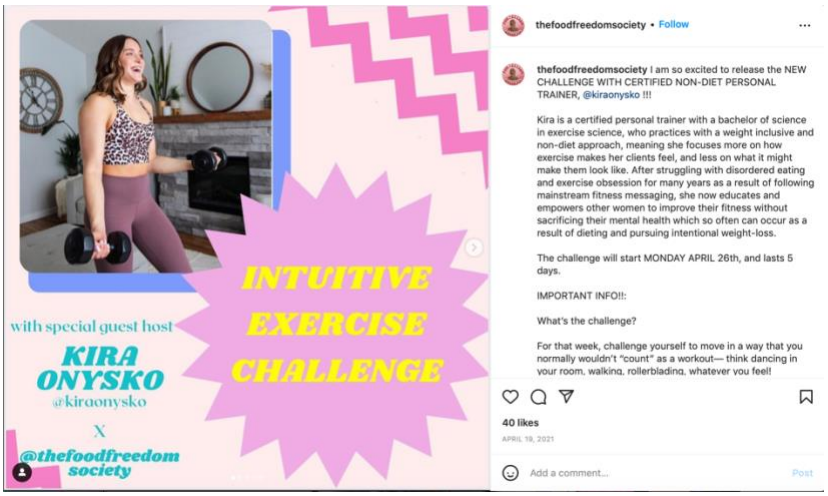
These sessions lasted for the semester and were discontinued after my pivot to focus on content. I learned that it was a lot to ask students to show up to another Zoom session on top of class Zoom fatigue, be vulnerable in front of strangers, and dedicate an hour out of their day. While taking an entrepreneurship class, I rethought how I could best help others. My goal was to make nutrition information and disordered eating care accessible, and I knew that I alone could not do this. I reflected on what I most enjoyed with my own dietitian and recognized a few themes: I liked having a cheerleader for when I ate something challenging, a credible person combatting the destructive thoughts in my head, and clear-cut challenges to help me slowly break down my disorder. Using these, I decided to launch my first Food Freedom Challenge.

Figure 7: Food Freedom 1st Challenge Instagram Post

Central to this challenge was the creation of a Food Freedom Support group. Because it was so helpful to be able to reach out for support whenever I needed, I wanted everyone to feel that they had someone to go to when they were struggling. I created the GroupMe (which now has over 40 members) and launched the challenge. I started with a challenge that targets a popularly demonized food group – carbs. Knowing that this would be something many people struggled with, I thought it would make for a good first challenge. For one week, participants messaged every time they included a carb in a meal, if any thoughts came up, and how they motivated through. It was so inspirational to see people supporting each other with these deeply difficult struggles. From this, I knew that the challenges were something I wanted to continue.

Yet, the one problem was that it felt wrong for me to be running these challenges. Therefore, I sought out the Instagram anti-diet community I had become well-versed in and, after spamming hundreds of dietitians and personal trainers online, finally found a Certified Personal Trainer (CPT) who was willing to monitor the challenge for free. We brainstormed an idea that would be applicable for lots of people and launched the second challenge with great success. Participants loved being able to get support from a real CPT while also getting encouragement from other members.

Figure 8: Food Freedom Exercise Challenge Instagram Post



I continued these challenges for a few months on, and slowly fizzled them out as I moved on to focus on eating disorders at my school. This Instagram account has shown me that it is never impossible to help other people, no matter where in the world they are. It also served as a bridge for connecting myself with others who wanted to help. From the Instagram account, I was connected to other students at The Claremont Colleges and at other colleges throughout the country who all wanted to make an impact in reducing the harm of disordered eating on college campuses. This, though I did not realize at the time, led to my last strategy: working with others to make change.

Strategy 6: Working with other students.

Through my Instagram account, I found a community of others going through the same or similar journeys. One of the greatest reported aspects of my created GroupMe was that it helped people feel less alone going through this terrifying process. Though the account was not making monumental change on any level, it was still helping others from all over with their journey to find a healthy relationship with food. What came from the account's inception was not only a tangible support system, but to my surprise, others asking to help. Because eating disorders are so isolating, I did not grasp just how many people in my life had struggled with food at some point, and I still am surprised each time a person I know privately messages me about their disorder. I have shared experiences and brainstormed resources with students from

NYU to Notre Dame about working together to promote heathy lifestyles at all college campuses. Though I have been able to connect with individuals from all over through this account, I also befriended two students at The Claremont Colleges who were similarly dedicated to improving disordered eating in college. From working together over the last month or two, we have pivoted to target other schools at The Claremont Colleges that may have more bandwidth for mental health funding.

These two peers have inspired me to reevaluate my process of implementing change. Instead of pushing for a substantial program such as Wellory, they have created a huge impact by instituting smaller-scale interventions. For example, one has managed to have her school pay for a registered dietitian to run an open office hour once a week for anyone. This significantly decreases barriers for students who are unable to access any type of nutrition education or support and shows the student body that the school actively cares about their well-being. The other student has created an Intuitive Eating Series funded by her school that features a new dietitian each week and covers a range of topics from nutrition information to social justice. While their colleges admittedly had larger budgets, their approaches were incredibly admirable, and most importantly, effective. The workshops and on-site dietitian have consistently witnessed strong turnouts, highlighting that there is a robust need for resources around healthy living.

We are still working together to continue to reduce disordered eating on campus and increase the promotion of healthy living. By remaining positive through each other's support, we are able to stay level-headed and strategic, allowing for the best ideas to come through. Though we are just 3 people, there are so many more, at our colleges and around the world, who are seeking adequate help for recovering from an eating disorder, unlearning diet culture, or generally trying to live a healthier lifestyle. By continuing to brainstorm, advocate, and seek

change, I know that our schools will be able to contribute to a flourishing and healthy life for their students.

Conclusion

From my experience thus far trying to implement organizational change at my institution, I am unsure if there is one best approach to the reduction of eating disorders and the production of healthy living. This is especially true given the COVID-19 pandemic. With a larger budget of both time and money, colleges are better able to support their students. Yet, with labor shortages, health threats, and more, it is logical for schools to be compromised with their ability to engage with new ideas for their improvement. Especially by advocating for a program that involves some budget, I put myself at a disadvantage for making Wellory come into fruition. There are still faculty members who have not responded to my emails, or scheduled meetings that have yet to happen; however, I am not discouraged.

From this experience, I have come away with 5 main lessons:

A. *Change takes time.*

   What I did not realize at the time was that the rate of change in an organization is not equivalent to the change agent's enthusiasm for this change. Though I felt an intense urge to improve my school's mental health and eating disorder resources, this did not mean that the school would be equally willing or able to dedicate time to my goals. Because I came from an emotional stance, watching every day as the people around me and online struggled more and more with their mental health, it was difficult to not feel upset or defeated by my school's lack of response or fervor. This caused me to not always think rationally of how to best work with my school's needs, instead only thinking of what I needed from the school.

B. *Next time, I wish I would have started smaller.*

Because of Lesson A, I now realize that a slighter approach may have been more viable for effectively creating change in this organization. Focusing on small steps to amount to larger steps is a process that I had not contemplated in my anxious passion, and I wonder if I would have been able to make real change if I had started with a smaller goal in mind. Instead of only considering a large, never-before-seen intervention compared to starting out with one of the above-introduced interventions that already exist, I hindered the potential implementation of an eating disorder resource on campus. Therefore, if I were to start this process over again, I would start with a small idea, such as creating a club or support group, going from there.

Now, I am conscious of this fact, and have been pivoting to focus on smaller-scale changes that have more viability for the school's capabilities at this point in time.

C. *Planning out a strategy is essential.*

Similar to the above, I realize that I failed to create a sturdy strategy for improving eating disorders and disordered eating on campus. Instead, I only had the goal of making the school better. Because of this, my experience working with Scripps felt unorganized, rushed, and unsatisfying. Though I had mapped out a brief chart of action for myself, I had failed to take ample time to truly evaluate the best people to talk to, how to talk to them, and what I wanted to talk to them about. Consequently, my meetings with school officials often lacked substance, and I failed to get my goals executed. Had I prepared a more extensive plan that included alternative individuals to work with, perhaps I would have been able to more efficiently and more successfully institute change in the organization.

D. *Always plan out alternatives.*

Because I was so focused on the integration of Wellory within The Claremont Colleges due to its ingenuity and potential, I had failed to discuss other substitutes with the faculty members I met with. Though I have found multiple proven interventions, I wanted the *best* option for my school, which clouded my judgment to advocate for other options alternatively. However, each proposed intervention involved financial commitment, meaning it still might have been quite difficult to bring these mediations into realization. Yet ultimately, the combination of the need for an education of the company, a financial investment, and a time commitment from the school, pushing a new startup technology as the top option for a school's adoption may have been too daunting for the current circumstance. Therefore, I am now actively advocating for the school's embrace of other alternatives in addition to Wellory to produce the most holistic and advantageous strategy.

E. Working with others goes a long way

In the theme of eating disorders, I felt very alone throughout this whole process. It felt that no one else at my school understood my passion and that no faculty members wanted to help their students. It felt as though whatever method I attempted failed. This drastically changed once I met those two other students. Hearing both their passion and their success reinvigorated me to keep trying, even though it seemed as though no one would be willing to help. Being able to bounce ideas off them, share our successes, and bond over our shared experiences has made this process not only more efficient, but also more enjoyable. Without feeling the weight of getting eating disorder resources on campus all on my shoulders, I felt more clarity to delegate tasks and derive a future strategy. Though my time at Scripps and The Claremont Colleges is coming to a close, I

plan on leaving a legacy of change through my work with these two peers, and with The Claremont Colleges.

Eating disorders are a vicious mental illness that affect extraordinary amounts of people daily. You *never* know what someone is struggling with, especially as a result of the pandemic. Mental health has gotten worse, but the resources for it are only improving. Overall telehealth use has increased by 38 times, and Deloitte Global predicts that global spending on mobile mental health applications will reach close to $500 million in 2022," (Landi, 2021) a growth rate of 20%. Mental health awareness is increasing every day, and I plan to dedicate my life to improving the mental health of others.

Though I would never wish an eating disorder onto my greatest enemy, I am thankful for what my eating disorder journey has given me: the understanding that I deserve to treat my body with respect, and a life of freedom. I am grateful for my school's willful attempts to promote the well-being of its student body despite the consistent burdens from the pandemic and from general organizational struggles. Their efforts do not go unnoticed by its students, and I am thankful for the intimate liberal arts environment that seeks to include all people and identities. Through my school's support, I have gleaned a better understanding of the ways to create the most sustainable and effective change. Through one conversation, meeting, or Instagram post at a time, I hope to continue to make change in my community and contribute to a world that promotes health for the sake of its people, and for nothing else.

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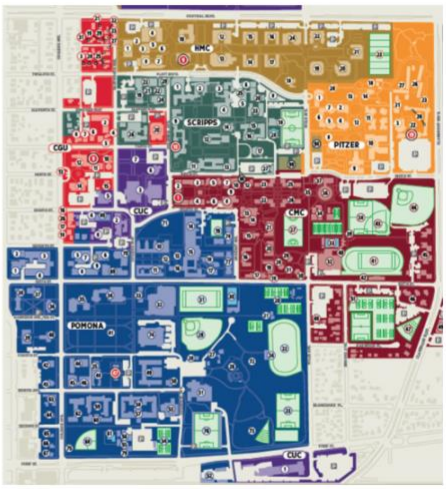
Appendix A: Scripps College

Scripps College is a prestigious women's liberal arts college located an hour east of Los Angeles in Claremont, California. Scripps is a part of an elite consortium of 5 colleges: Claremont McKenna College, Pomona College, Harvey Mudd College, Pitzer College, and Scripps College, and includes two graduate schools, Claremont Graduate University and Keck Graduate Institute. All located across the street from each other, The Claremont Colleges hold 9,000 students from around the world.

Taken from the Claremont Colleges website, https://colleges.claremont.edu/fivecadmissions/2019/06/10/hello-world/



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Figures 9 and 10: Photo and Map of The Claremont Colleges