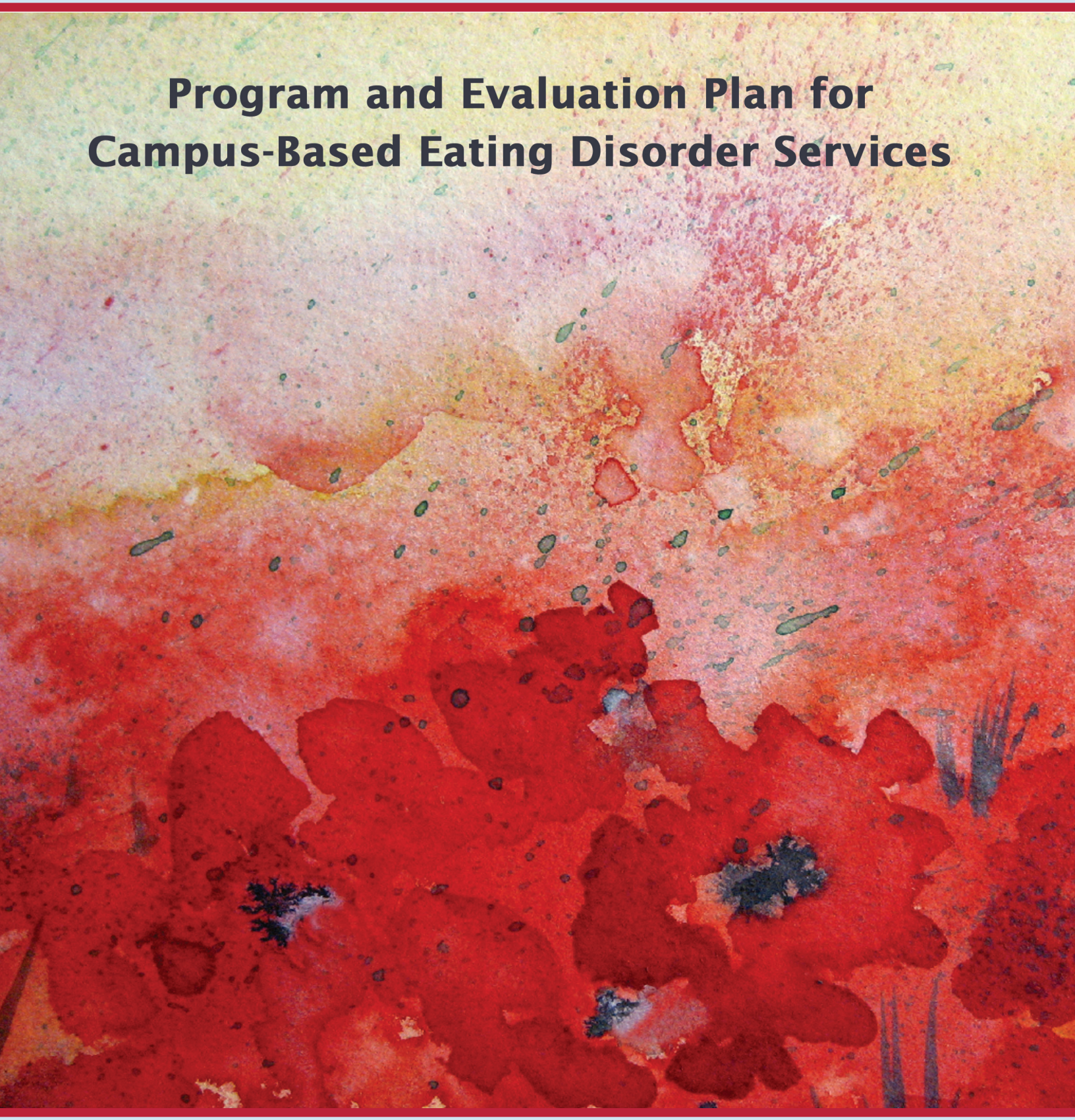
Counseling Center Guidelines

Program and Evaluation Plan for Campus-Based Eating Disorder Services



HynesRecoveryServices

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AED

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— **AED maintains almost 30 special interest groups** to help members with common interests interact.

– **The Student SIG** helps student members of the Academy to interact with one another, collaborate, and offer guidance in various areas.

– **The Universities Special Interest Group** (USIG) works to discover and develop expertise for university health professionals to help them support the recovery of students with eating disorders who are attending colleges and universities.

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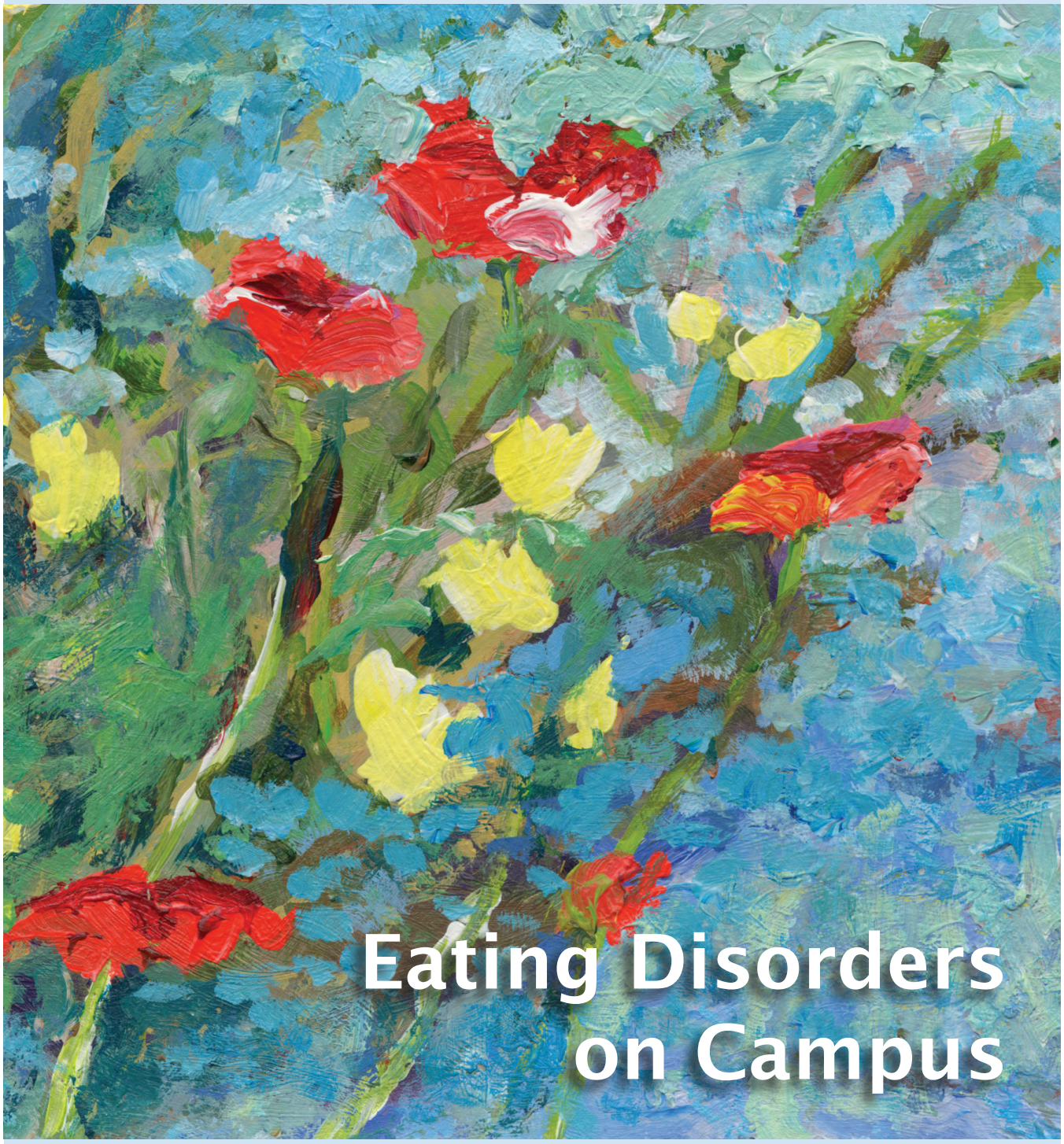
Dawn Hynes, Founder of Hynes Recovery Services, holds a Master's Degree in Social Work from Washington University in St. Louis. She is a passionate advocate dedicated to making eating disorder treatment accessible to more students and providing practitioners with state of the art training and resources. For the past 25 years, Dawn has been active in eating disorder recovery work as an advocate, clinician, and volunteer. She has trained staff, developed clinical manuals, and worked with groups and individuals at Boston Children's Hospital and Laurel Hill Inn's Residential Treatment Program.



Eating Disorders on Campus

My Recovery from Anorexia

I had an excuse ready at all times. Why are you removing the bread from your sandwich and eating the remnants as if it were a salad? *I find that the bread overpowers whatever is inside so it tastes much better this way*. Why are you asking if they also have cheese-less pizza? *I'm lactose intolerant*. Are you sure you don't want a piece of cake? *No thanks, I had a really big dinner*.

When excuses were not enough, I found other ways out. Take one small bite of the cookie then place the rest in the large pocket of my hoodie to throw away as soon as I could escape. Chew innumerable pieces of gum to satisfy my hunger for a day in preparation for the meal I would have no choice but to eat in front of friends later that evening. Have a diet coke on hand for the frequent times I was so tired I struggled to keep my eyes open in class.

It's funny to look back on – somehow, at the time, I managed to convince myself that I was acting rationally. There was nothing wrong with me. I really liked chewing gum – two packs a day was not excessive. A whole day without anything but apples – I really liked fruit. I was in denial. There were many times when friends and even acquaintances pulled me aside and expressed their concern. I told them they were wrong. I had digestive problems so I had to be careful what I ate. That was it, nothing more.

Eventually, I could not deny it anymore. As I lay in the hospital bed, hooked up to a heart monitor and my parents terrified by my side, I finally acknowledged my reality. I had an eating disorder. There it was, the truth was out. Finally admitting what I had worked so hard to hide and had repressed for so long was both terrifying and an overwhelming relief. This moment began my path to recovery – a path that was not linear. I was forced to postpone my return after winter break to my international high school in Wales for my final semester. I spent three weeks in a day treatment program in Ohio. My program involved a common treatment method for adolescent Anorexia Nervosa known as the Maudsley Approach in which, "parents play an active and positive role in order to help restore their child's weight to normal levels expected given their adolescent's age and height, and hand the control over eating back to the adolescent". Although it was necessary at the time, allowing my parents to make all decisions regarding what I ate, how much I ate, and when I ate was beyond difficult. The very essence of my eating disorder was the need to have absolute control over every aspect of my diet and exercise habits. Allowing, or rather, tolerating, someone else to make decisions for me felt as though my very identity was being stripped away.

During treatment, all patients gathered together in a room to eat. I can easily recall glancing around the room at the plates of those around me in envy of whoever had the least amount of fatty foods or carbohydrates in front of them. During meals and snacks, we weren't allowed to wear anything with pockets. Our hands had to be visible on the table at all times. Water was not allowed – we needed all the calories we could get. Every last crumb or drop of liquid had to be consumed before being excused. Yes, this meant that if you finished your chips before your hummus, you were left to eat spoonfuls of hummus. I am now a professional at getting that ratio right. Twice a week, before we entered the dining room for breakfast, we were asked to strip naked and put on a paper gown – but not before peeing in a cup. After being weighed, our vital signs were taken. While in treatment, I developed a hobby for knitting. It was the only thing I found comforting in the midst of my reality. Three weeks and five scarves later I managed to convince my parents and myself that I was ready to go back to school in Wales. My treatment team disagreed and I was discharged "against medical advice". But it was okay – I had decided I was no longer going to restrict what I ate. I had decided I was no longer going to wake up at the crack of dawn to fit in a workout.

But here's the thing – an eating disorder is not something you choose. No matter how much I wanted to continue to recover, the illness remained stronger than my desire for health. While I managed to maintain my recovery during my last few months of high school and throughout the summer post-graduation, during my next big transition, entering college at Brown University, I relapsed.

It didn't take long at Brown before I was faced with the familiar feeling that everything was out of my control. How could I possibly keep up with my peer in my beginner Portuguese class who was conjugating verbs in different tenses after week 1? And what about my roommate who was waking up before sunrise to train with her team? Or the girls I saw everywhere I looked with their zero-calorie Vitamin Waters and packs of gum? How could I study so hard for that exam and still get a B? Unconsciously, I resorted to the one thing that satisfied my need to feel accomplished – my eating disorder. As the end of my freshman year approached and summer was in sight, I received an email from a dean at the university. She wanted to see me. I was confused and worried I had somehow violated some academic code of conduct. As I talked with the dean, she clarified that I was not in any kind of academic trouble. Rather, she revealed that someone had anonymously expressed concern about my health. The dean demanded that I see a doctor at Brown Health Services immediately and perhaps it "would be in my best interest" to take a medical leave and re-consider that summer class I was already enrolled for. It's funny; it began to feel like I was facing the same consequences as someone who had been called in due to plagiarizing on a paper or collaborating on an independent assignment.

With the support of my parents and psychologist, I worked out a plan with Brown Health Services and the administration. I could remain at school and could take my summer class, but only if I visited the health center on a weekly basis and demonstrated that I was gaining weight. While I satisfied the university's requirements for regular visits to the health center and managed to gain the necessary weight, I do not attribute my successful recovery to the ultimatum I was given.

Recovery is a process that no one should tackle alone. My family played a huge role in my journey and I will forever be grateful for the endless support they continue to provide. While I was initially reluctant to share my experience with my friends at Brown, I realized what a helpful support network they could provide. I feared I would be judged for my eating disorder and worried about the potential for being labeled; it turns out, I had no reason for concern. My friends provided encouragement and helped me to feel less alone. Opening up about my journey also enabled me to become a part of a community of others who have experienced an eating disorder or related mental health issue. Together, these support networks helped alleviate my feelings of isolation and allowed me to feel a part of something greater than myself. I had finally ended the most destructive relationship of my life, my relationship with my eating disorder, and I felt so free.

I wish I could say that freedom was maintained throughout the duration of my time at Brown University, but doing so would mean I was lying to you and to myself – something my eating disorder would want me to do. As I previously expressed, recovery is rarely linear. I experienced some setbacks, but I do not fault myself for this. Fortunately, my extensive treatment, my continued work with my psychologist, and my strong support network helped me to recognize the onset of such "slips" and each time, I was able to get back on track. In my opinion, to be aware of your triggers and risk factors for relapse is essential to maintaining recovery from an eating disorder.

Reflecting back on my experiences over the past six years, I can't help but feel sad. I feel sad that my disordered thoughts prevented me from trying the traditional foods of the countries I traveled to while studying in Wales; I feel sad I opted for an early night's sleep so I could wake up to exercise in the morning, rather than going out in the evening with friends at Brown; I feel sad about the lies I told – to myself, to my friends and to my family in order to deny the reality of my illness; most of all, I feel sad that I caused my loved ones so much worry.

While it's important to allow myself to feel emotional and acknowledge the degree to which my eating disorder interfered with my happiness, it's critical that I celebrate how far I have come. I now go out for meals with friends and family and enjoy the company and the delicious foods. I now exercise because it's fun and provides an outlet to release my stress, not because I feel like I should. I now go out late for drinks with friends and am fine with the fact that I may need to sleep in more than usual in the morning. I now feel like my eating disorder no longer prevents me from being me.

I would like to say that I have fully recovered from my eating disorder, but quite frankly, I'm not quite sure what that means. I understand my feelings of anxiety and how they have the potential to negatively influence my behavior. I have developed effective strategies for managing those feelings in order to remain healthy. That being said, some days are harder than others. Some days, I feel so tempted to give in. But I haven't, and right now, as I sit here typing, I don't think I ever will.

Eliza Lanzillo
Program Director of Advocacy Initiatives, Hynes Recovery Services

Introduction

College is meant to be a time of growth and change, defined by wonderful new experiences a young student will remember for the rest of their life. Regrettably, too many college men and women today are getting caught up in eating disorders that not only threatens the present, but can vastly alter the course of their lives.

Although the average age of eating disorder onset is 14 years old, the next most "at risk" population is the young adult population. This is partly due to all that college represents and entails: stress, unique challenges, feelings of vulnerability or loneliness, high academic expectations, new environment and social structure, and the greatest change of all, freedom from parents. For most college freshmen, this is the first time they've lived away from home. Amidst such pressure, an eating disorder can easily take hold, especially if the student is already predisposed by virtue of genetics, perfectionism, high achievement in academics or sports, and/or peer pressure.

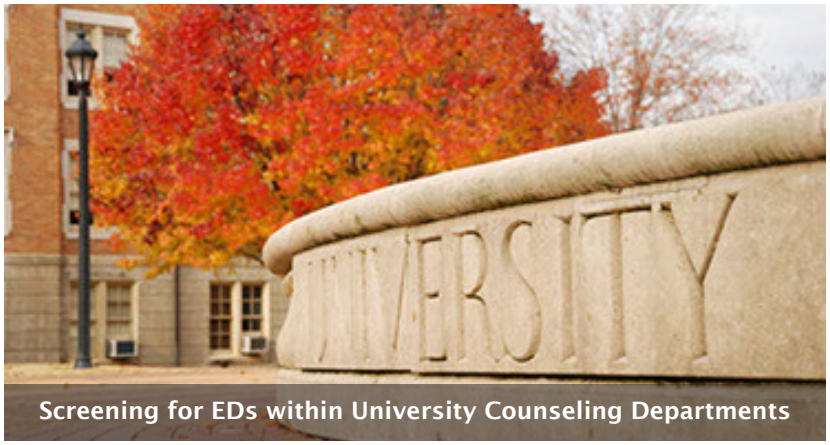
If the college environment is highly chaotic or confusing, a student may try to assert a modicum of control in their life by strictly monitoring what they are consuming. Bulimia may begin in a different fashion, since it is usually connected with the need to regulate emotion. Even when change is expected, it can still be highly stressful. Turning to food for comfort is not unusual when an individual is anxious, worried, lonely or depressed. This is especially common in a college setting, since no parent is nearby to question or comment on their compensatory behaviors.

In addition, research indicates that a significant number of students with eating disorders also struggle with alcoholism. Drinking alcohol to excess is certainly nothing new on college campuses. However, drunkorexia is fairly new. This is a condition that is alarmingly common with young women in college today. It refers to individuals who starve themselves throughout the day, then go out later that night and consume alcohol to excess. The term is somewhat misleading because it implies that the individual most likely suffers from anorexia. On the contrary, a student with drunkorexia is far more likely to be bulimic than anorexic; in fact, the alcohol may play a key role in one's binge/purge cycle. (Click **here** for the **Addiction Treatment Directory** Timberline Knolls created with Hynes Recovery Services).

Regardless of the type or extent of one's eating disorder, it is crucial that colleges and universities nationwide become more aware of the increasing numbers of both men and women who are dealing each and every day with these issues. Without support from the university community, these students will continue to suffer in silence. Fortunately, there are many treatment options available for the students in your care. (Click **here** for HRS' **National Eating Disorder Treatment Directory**).

Introduction (cont.)

In the university setting, on-campus providers who conduct intake assessments and/or provide ongoing treatment should be prepared to screen for this potentially life-threatening illness. Once a student is diagnosed with an eating disorder, the next step is to make a determination as to how campus providers can most effectively treat that particular student. This will involve creating an individualized treatment plan which may involve one or more of the following objectives: referring to an on-campus psychotherapist, setting up bi-weekly weigh-ins with a nurse practitioner, consultation and weekly appointments with a registered dietitian, contacting family members to assist with developing a treatment contract and/or facilitating admission to a higher level of care (if indicated). To help facilitate this process, Dr. Margaret Nagib has created the webinar below. (Please click **here** to access this presentation).



Screening for EDs within University Counseling Departments

During this webinar, Dr. Nagib will address the prevalence of eating disorders in the college environment. She will review signs and symptoms, examine common risk factors on college campuses, and talk about identifying eating disorders in students via screening and assessment tools. Screening measures including the SCOFF, EDI-3, EDQOL, EDE-Q and EAT-26 will be reviewed. How these tools may be used as part of the intake process will be discussed as well. (As research indicates that a significant number of these students often struggle with addiction, this co-occurring disorder will also be addressed). Dr. Nagib will also provide helpful suggestions on how best to broach this topic with students who either fail to report these symptoms or are struggling with denial or lack of insight into the severity of their problems. Lastly, Dr. Nagib will share off-campus treatment options available to students as well as common treatment practices within the university setting.

Margaret Nagib, PsyD, is a licensed clinical psychologist specializing in inner healing and treating eating disorders, trauma, addiction, self-injury and mood disorders. For more than 15 years, she has provided individual, family and group therapy. Dr. Nagib also provides clinical trainings and presentations to professionals at conferences nationwide.

Diagnostic Criteria for Eating Disorders - DSM-5

The new edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines and classifies mental disorders in order to improve diagnosis, treatment, and research. The criteria are concise and explicit, intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings. DSM consists of three major components: the diagnostic classification (includes a diagnostic code), the diagnostic criteria sets (indicates symptoms that must be present - and for how long - as well as a list of other symptoms, disorders, and conditions that must first be ruled out to qualify for a particular diagnosis) and the descriptive text (includes the following categories: Diagnostic Features, Associated Features Supporting Diagnosis, Subtypes and/or Specifiers, Prevalence, Development and Course, Risk and Prognostic Factors, Diagnostic Measures, Functional Consequences, Culture-Related Diagnostic Issues, Gender-Related Diagnostic Issues, Differential Diagnosis, and Recording Procedures).

Please see below for information related to the following eating disorder diagnoses: *Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder* and *Avoidant Restrictive Food Intake Disorder*. (Additional eating disorder diagnoses are also outlined in this clinical manual).

Anorexia Nervosa:

A. Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Bulimia Nervosa:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by BOTH of the following:
    1. Eating in a discrete amount of time (ex: within a 2 hour period) an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
    2. Sense of lack of control over eating during an episode.
B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Diagnostic Criteria for Eating Disorders - DSM-5 (cont.)

Binge Eating Disorder:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
    2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:
    1. Eating much more rapidly than normal.
    2. Eating until feeling uncomfortably full.
    3. Eating large amounts of food when not feeling physically hungry.
    4. Eating alone because of feeling embarrassed by how much one is eating.
    5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

ARFID:

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
    1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
    2. Significant nutritional deficiency.
    3. Dependence on enteral feeding or oral nutritional supplements.
    4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Source: *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th Ed. Arlington, VA, American Psychiatric Association, 2013.*

Eating Disorders in Type 1 Diabetes

Women with Type 1 Diabetes (T1DM) are close to 2.5 times as likely to develop an eating disorder than women without diabetes. This includes Anorexia Nervosa and Bulimia Nervosa but also something called "Diabulimia" by the media and lay public. This term refers to an eating disorder which includes the symptom of intentional insulin restriction as a powerful and dangerous calorie purge.

To better understand this phenomenon, one must first understand T1DM and its treatment. T1DM is an autoimmune disease in which the body's immune system selectively attacks the cells of the pancreas that produce insulin. Insulin is the hormone that allows our bodies to access energy from food by moving glucose out of the blood stream and into our cells for use or storage. Without insulin, blood sugar levels rise and the body attempts to regulate these levels by excreting glucose in the urine. Also, the body cannot use the glucose for fuel – resulting in rapid and unhealthy weight loss because the cells are starving. T1DM treatment involves multiple daily doses of different types of insulin with the goal of approximating the functioning of a healthy pancreas. Patients must regularly monitor blood sugar levels and calculate food amounts so that they can estimate insulin doses. A blood test called the A1C indicates the average blood glucose level over the past 3 months with a target as close to 7% as possible.

Warning signs of eating disorders in T1DM:

- Unexplained elevations in A1C values*
- Concerns about weight and body shape**
- Change in eating patterns, which may include dietary restriction and/or binge eating
- Intense exercise (sometimes associated with frequent hypoglycemia)
- Repeated problems with Diabetic Ketoacidosis (DKA)*
- Amenorrhea

*Some of these warning signs are specific to eating disorders involving insulin restriction, but eating disorders without this symptom can also occur in T1DM.
**There is not one particular body size that should elicit concern. People can have what appears to be a healthy body weight and still be experiencing medically significant eating disorder symptoms.

As many as 31% of women with T1DM report intentional insulin restriction for weight loss, and rates peak in late adolescence and early adulthood (40% of women ages 15 to 30 years). Eating disorder behaviors often persist, become more common, and increase in severity over the young adult years. Indeed, eating diagnoses occur around 23 years of age, meaning symptoms are likely worsening during the college years. Some speculate that this may be because college is the first time that young people with T1DM are managing their diabetes without hands-on support from family and their diabetes treaters.

The complications of T1DM, such as eye disease, kidney disease, and nerve damage may be prevented or delayed with adherence to current treatment recommendations. However, patients who restrict their insulin doses and run their glucose levels high develop diabetes complications at younger ages. Most significantly, they are at increased risk of early death from these long-term complications as well as an acute medical crisis known as Diabetic Ketoacidosis (DKA) that can be fatal.

Eating Disorders in Type 1 Diabetes (cont.)

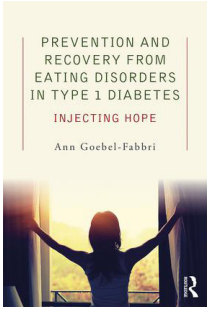
As stated above, Diabetic Ketoacidosis (DKA) is often a primary warning sign of eating disorders in T1DM. Some of the signs and symptoms of DKA include the following: profound thirst and frequent urination, fatigue, nausea and/or vomiting, muscle pain and weakness, labored breathing, chest pain, disorientation, and a "large" level of ketones - which can sometimes be recognized by a distinctly fruity smell on the breath.

Since eating disorders in T1DM typically develop in late adolescence and early adulthood, college health center staff and mental health professionals may be the first providers to help identify when a particular student is showing risk factors. **[Please refer to Warning Signs]**. Being familiar with signs and symptoms makes it possible to help vulnerable students access the care they need. Also be sure to educate patients about "insulin edema"- mild to severe fluid retention that happens just when patients are attempting to improve and reduce their glucose levels. It can leave patients feeling bloated, swollen, and "fat." Because this is a group of patients acutely sensitive to body weight and shape changes, they need increased support and reassurance that weight gain due to this condition reflects fluid retention not "fat" and that it will resolve over time. In the absence of this support and education, edema can present as a common reason for relapse and/or treatment dropout.

It is important to work closely with the student's diabetes treatment team to understand their diabetes regimen and health history and to collaborate with them to review blood glucose patterns and insulin protocols. It is helpful to review the signs of DKA with the student in order to help them know when to access treatment to reduce their medical risk. In conjunction with the diabetes treatment team, the student should be empowered to establish small, realistic goals to improve diabetes-management.

Reducing blood glucose levels too quickly is actually dangerous and can trigger "treatment induced complications" that include all the long-term diabetes complications listed above. Working slowly and steadily at improving overall glucose levels, reduces this risk of treatment-induced complications, the severity of edema, and may help the patient to feel less overwhelmed.

It is rare to find an eating disorder specialist who also understands T1DM and equally hard to find treatment programs with this specialty. The best approximation is to find eating disorder specialty care that is open to strong collaboration with the patient's diabetes team. Without this in place, symptoms can go unrecognized and/or misunderstood. Most importantly, work with this population requires a non-judgmental and steady stance – one that neither over- nor under-reacts. This can help solidify the treatment alliance and allow for open and honest communication about symptoms related to this complex dual diagnosis.



Ann Goebel-Fabbri, PhD
Licensed Psychologist in Private Practice
Assistant Professor of Psychiatry, Harvard Medical School
Author, *Prevention and Recovery from Eating Disorders in Type 1 Diabetes*

My Recovery from Diabulimia

By the time I went to college, my eating disorder had become the single most important thing in my entire life. It dictated who I was, my daily schedule, my relationships and every single choice I made - both for school and in my personal life. No longer living with my family (who were already concerned about my eating habits and poor diabetes management), made it easy to fall into the dangerous and all-consuming rituals associated with diabulimia.

None of the new friends I made at school ever questioned my choices or my behaviors because no one had the slightest clue about Type 1 Diabetes - they just figured I knew what I had to do to take care of myself. The obsession with weight, food, and exercise left no time for studying. I passed my classes with the bare minimum of requirements and in some cases failed them altogether. I rarely went out with my friends or did anything that used to bring me joy. I used all my energy to hide my eating disorder from both my friends and family members. I felt as if no one could understand what I was struggling with partly because of my Type 1 Diabetes. But I also felt like I wasn't allowed to have an eating disorder because of the fact that I had a dangerous chronic illness. I worried that if I admitted I was omitting my insulin for weight loss purposes and that I also struggled with over exercising and binge eating, I would feel even more judged and isolated than I already felt. I lived with this terrible secret throughout my entire time at college. A year before I made the courageous decision to seek help, I had seen many signs of the destruction that my eating disorder had created. In addition, my joy and enthusiasm for life had been replaced with anxiety, constant irritability and I could barely remember what I had ever been passionate about.

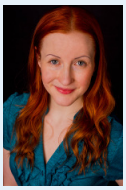
I realized that I didn't have any other dreams except to attain the unrealistic and unhealthy goals that my eating disorder had ingrained in my psyche. I was tired of merely existing - I wanted to LIVE again. So I bravely and tearfully told my father this dark secret. Without judgment, he hugged me and said that he would go with me to my first appointment.

Nothing about recovering from an eating disorder was easy, but I was determined to find a way out of the nightmare I had been living for ten years. I wanted to have a life worth living, and I knew that wouldn't be possible if I continued to live with an eating disorder.

During my first year of initial recovery, I faced new challenges every day. Thankfully, I had a team of providers that never stopped believing in me. Finding the right therapist made a huge difference in how I viewed myself, my chronic illness and why I was so afraid to let go of my eating disorder. Also, learning DBT skills offered concrete tools for staying aware and present when my eating disorder would try to reclaim the driver's seat.

Living in recovery means I don't scrutinize myself for hours in front of the mirror. It also allows space in my mind to think about what truly matters in my life. Most importantly, I finally feel comfortable in my own body – this alone was worth every challenge I had to face, in order to experience this very new and wonderful sense of freedom.

Asha Brown



Asha Brown is the Founder and Executive Director of ***We Are Diabetes***, a nonprofit organization. She works with college students, their families and health professionals nationwide. Asha uses her personal experiences with ED-DMT1 to offer hope and support to those still struggling.

"The **We Are Diabetes** ***Recovery Toolkit*** was created for any individual working towards recovery from ED-DMT1. We've taken note of the most frequently asked questions about recovering from ED-DMT1, and with the help of our contributors, have addressed those questions in our online toolkit". - Founder, Asha Brown

Effective Treatment

Approximately 90 percent of eating disorders develop in individuals between the ages of 12 and 25. The same high-achieving, perfectionistic temperament that predisposes these individuals to developing eating disorders often plays a role in their pursuit of higher education. In many cases, eating disorders develop, intensify or resurface during the college years. Add the stressors associated with heightened academic rigor, new social pressures or anxiety about living away from home for the first time, and many university students find themselves at the campus mental health center seeking treatment for eating and body image issues.

Effective treatment in the university setting will generally encompass four key best practices:

Engage medical providers in initial assessment and ongoing monitoring. A thorough history and physical exam, indicated laboratory tests, and ongoing medical monitoring are essential components of effective eating disorder care in an outpatient setting. Professionals in the health center—including primary care providers, mental health providers, dieticians and nursing staff—should provide a complete evaluation, identify current medications and allergies, and assess the student for signs of medical and psychiatric instability associated with eating disordered behaviors.

- **Medical findings may include:** Changes in vital signs like bradycardia or orthostasis; changes in weight (such as drastic weight loss or gain); syncope; chest pain; hair loss; lanugo; edema; abdominal pain or GER; blood in vomitus; GI issues (such as constipation or diarrhea); and loss of menstrual cycle. The recognition of malnutrition as a serious health concern is imperative.

- **Recommended medical tests include:** Height and blind weight; vital signs (including lying and standing heart rate and blood pressure); comprehensive metabolic panel; phosphorus and magnesium (for low weighted individuals); TSH; complete blood count; urinalysis; and ECG.

- **Other tests may include:** Pregnancy test; DEXA bone scan, and other tests as clinically indicated.

Leverage evidence-based treatment interventions. Students struggling with body image and eating issues on college campuses often begin treatment in short-term counseling sessions. Sometimes, these sessions represent the extent of eating disorder treatment options available in the university setting. To optimize progress in this situation, counselors can leverage several evidence-based treatment approaches, including: CBT (especially in Bulimia Nervosa), DBT (especially when characterological pathology is co-morbid), Acceptance and Commitment Therapy (ACT), and other therapeutic modalities, including the possibility of FBT with young college students.

In tandem with therapeutic sessions, patients should work with a nutrition specialist to receive dietary education and counseling to normalize patterns of eating and beliefs about food. Registered Dietitians with experience treating eating disorders will often deliver their care in alignment with the therapeutic principles above, recognizing the importance of highly coordinated care and consistency in treatment philosophy and messaging across the full multidisciplinary treatment team.

Effective Treatment (cont.)

Recommend academic leave and refer to a higher level of care when clinically indicated. Acute symptoms and medical complications may necessitate a higher level of specialized eating disorder care to interrupt symptoms, stabilize health, and effectively address the illness. General criteria for recommending a medical leave includes:

- Student is malnourished (below 80% of IBW) and unable to stop weight loss and restore weight with outpatient treatment.
- Student is using daily purging behaviors and unable to stop them with outpatient treatment.
- Medical issues, including significant abnormalities in vital signs, ECG, laboratory tests or symptoms like syncope, altered mental status, etc. that indicate significant medical risk.
- The eating disorder is causing or accompanied by significant mental health issues such as clinical depression, anxiety, panic attacks, self-injurious behaviors and suicidal or homicidal thoughts (some of these may constitute psychiatric emergencies).
- The student's inability to maintain personal safety, appropriate social interaction and academic performance. Absenteeism and a drop in grades should raise the concern that the student is not feeling well physically, mentally, or prioritizes engagement with the eating disorder rather than with school participation.

Mandate eating disorder-specific continuing education for student health center staff and, if possible, for all staff that interacts with students. Eating disorders are complex illnesses with biological, psychological and psychosocial underpinnings. Medical, mental health, nursing and nutrition professionals in the university health center should develop and maintain a deep understanding of these illnesses, including warning signs/symptoms, common medical complications, psychiatric co-morbidities and diagnostic criteria for eating disorders. Professionals should also be well versed in the latest evidence-based outpatient treatment modalities to help their students.

Ovidio Bermudez, MD, FAAP, FSAHM, FAED, F.IAEDP, CEDS
Chief Medical Officer and Medical Director of Child and Adolescent Services, Eating Recovery Center

Levels of Care

Eating disorders are complex illnesses that require professional treatment. An outpatient therapist or an eating disorder program can provide a thorough evaluation of the psychological and physical symptoms and make recommendations for the level of care warranted. Below are brief descriptions regarding levels of care:

Outpatient: Individual or group work that takes place in an office setting with a licensed professional who delivers therapeutic and/or nutritional counseling.

Intensive Outpatient Program (IOP): Intensive Outpatient Programming is designed for individuals who need additional support beyond outpatient treatment. It is often used in combination with outpatient treatment and typically meets 2 to 5 days or evenings per week for 2-3 hours each day. Treatment includes case management, nutrition guidance/counseling, group meal, individual and group therapy.

Partial Hospitalization Program (PHP): A Partial Hospitalization Program combines the highly structured environment of a daily hospital program with independent living. Depending on the setting, a PHP might meet 5 to 7 days per week from 5 to 12 hours each day. At the end of the day, individuals return home to practice the skills learned in the program within their home environment. Throughout treatment at this level, individuals receive medical management, psychopharmacology, and nutrition counseling, in addition to both individual and group therapy.

Residential: A residential facility is a medically monitored and therapeutic program that provides 24-hour care to individuals as they recover from their eating disorder. An individual in this level of care is medically stable but needs to be treated in an environment that provides structure allowing for physical and psychological healing to begin. Onsite physician and nursing care, nutrition management and counseling, individual, couples, family and group therapy are typically available as well as case management and coordination with an outpatient team.

Inpatient/Acute Hospitalization: This is the most intensive level of care offered to patients. The goal at this level of care is to provide medical stabilization to an individual who has become medically compromised due to his/her eating disorder. At this level, an individual's vital signs will be monitored regularly and nursing staff will be available 24/7 to ensure proper medical care is delivered. Individuals who require this level of care will receive 24-hour supervision throughout the duration of their stay as behaviors are interrupted. Treatment includes medical monitoring and management, nutrition counseling, individual, group and family therapy.

Treatment Guides

National Eating Disorder Treatment Directory

One of our most important roles at Hynes Recovery Services is to ensure that we are providing college students with the most useful information about treatment options throughout the country – based on the information shared with us during their initial assessment. With this in mind, our organization has created a very comprehensive treatment guide, which includes eating disorder and other support services specifically geared for college students in any stage of the recovery process.

Resource Guide for Collegiate Athletes with Eating Disorders

In this directory, HRS shares an overview of this at-risk student group, who may be exhibiting body image and/or eating issues. University athletic departments must establish campus-wide policies and protocols to ensure the best care of these vulnerable students. Therefore, we've included an outline for establishing such a policy, as well as guidelines for athletic staff on how they can effectively address these concerns with their student-athletes.

Addiction Treatment Directory

Hynes Recovery Services collaborated with Addiction Partner Timberline Knolls to create a directory with treatment options (both locally and nationally) for students struggling with a substance use disorder. In addition, there is educational content that will benefit those in recovery, their friends and family members, as well as addiction practitioners both within and outside of the university community. There are also training resources highlighted for campus staff seeking additional expertise in treating this clinical population.

Transitioning back to campus: A collaborative process

There are several important factors to consider as students transition back to campus following a leave of absence. For the student, they may feel eager to return, anxious to make up for lost time and worried about relapsing in behaviors. For the campus staff, providers and family members supporting the student, they may feel eager to see the student succeed, uncertain as to how they can best support them and concerned about the student's overall health and well-being. While the needs of each student are unique, it is important to work collaboratively and openly with each student as they transition from more intensive treatment back to college life.

Outlined below are suggestions for supporting a student in their transition back to campus. The process is broken down into phases that generally correspond with 1) the end of residential/partial treatment, 2) time at home before returning to school, and 3) restarting school. These phases may look different for each student and the recommendations are meant to be flexible.

Ending Residential or Partial Hospital Treatment

Proactively establishing expectations: It is important for the student and their support system to be on the same page concerning expectations for both treatment and recovery. If the school has certain expectations around returning from a leave of absence, this should be communicated clearly and directly with the student. For example, individuals involved in the student's care should agree upon frequency of therapy, weigh-ins, identifying lapses vs. relapses and how to determine if the student needs additional support. This is a useful time for the student to meet with supportive resources on campus (academic advisors, office of accommodations, counseling center and/or athletics).

Helping the student see treatment as a bridge instead of barrier: Many students with eating disorders have been asked to leave school in order to participate in treatment. This can then set up the belief that treatment is a barrier to school rather than a bridge. In turn, they may be reluctant to engage in treatment once they are out of a higher level of care. It may be useful to remind the student that the goal of continued treatment is to support them in a way that enables them to feel successful both academically and personally.

Time at Home Before School

Identify goals for college: Students may be eager to return to college for many reasons, but this does not necessarily mean they have thought about what they truly want out of their college experience. It is useful to support the student in identifying their own values around school such as academic goals, social experiences, personal growth, etc. When a student has more clearly defined goals around their college experience, it may be easier to remain motivated or notice if eating disorder behaviors are getting in the way of one's recovery.

Transitioning back to campus: A collaborative process (cont.)

***Transition to more independence*:** As a student prepares for a return to school, they will benefit from practicing more independence around eating and exercise related behaviors. Compared to being in treatment, eating in college may be a highly unstructured and overwhelming experience. It is beneficial for the student to assume more responsibility in planning and preparing their meals, as this will be the expectation once they are back in school. The student will also benefit from continued practice with eating in more unstructured environments, such as the on-campus dining hall.

***Implementing accommodations*:** Many students benefit from campus accommodations as they co-manage their mental health and college experience. It is important to have these accommodations in place before the student begins the semester so that they can enter an environment with the appropriate level of support for their specific needs. Some examples of helpful accommodations for students with eating disorders include changes in housing assignments (to live closer to dining hall options), taking a reduced course load and eliminating any weigh-in requirements if the student is an athlete.

Returning to School

***Validating their desire to be a "normal college student"*:** Although as treatment providers we understand students may take a variety of paths, taking a semester off or leaving campus for a therapy appointment can feel like an isolating or "abnormal" experience. Letting the student know that you also see maintaining a social life and catching up on school work as important can be a useful step in working collaboratively with these young adults. Assist students in scheduling their appointments in a way that doesn't intrude on classes. Also, remember to validate that it can often be challenging to balance treatment obligations with school obligations.

***Prepare for times of increased stress*:** Throughout the semester, it is beneficial to plan for times of increased stress when lapses in eating disorder behaviors are more likely to occur. For example, students may experience more stress during the initial return to school or around mid-terms and finals, where academic expectations are heightened. Allowing for more frequent check-ins, therapy sessions and/or external support can help the student prepare in a more proactive manner.

Conclusion

Balancing treatment, recovery and college life can be a complicated and constantly evolving process. By working collaboratively and openly with your students, they will have a better chance of succeeding in all of their academic, treatment and personal goals.

Caitlin Nevins, Ph.D.
College Mental Health Program, McLean Hospital

Relapse Prevention Strategies

Recovery from an eating disorder is rarely a linear process. Many individuals who have struggled during adolescence (or as a young adult) will experience setbacks during the recovery process. Developing coping strategies, building a support network on campus and creating a relapse prevention plan are three important tools that can help students manage minor setbacks and avoid a relapse into previous eating disordered thoughts and behaviors.

Developing coping strategies

Identify triggers: Planning and preparation are essential as students in recovery navigate the transition to campus life. Anticipating challenges and developing plans to cope with these challenges can facilitate the recovery process. Students can work with their treatment team to identify triggers and high-risk situations, understand the impact these situations may have on their thoughts and emotions and learn specific skills which can be used to overcome some of these challenges. Helpful strategies include positive self-talk, utilizing stress management techniques and planning for various "free time" periods (1-2 hours, half-day, evenings, week-ends and winter/summer breaks).

Manage cognitions: Students in recovery are often challenged with maladaptive thoughts, judgments and negative feeling states related to their eating behavior and physical appearance. These challenges may present themselves after exposure to a trigger or when confronted with academic stressors and sleep deprivation. Using Cognitive Behavior Therapy (CBT) skills to challenge and reframe self-critical thoughts (and judgments) and Dialectal Behavioral Therapy (DBT) skills to tolerate distress and regulate emotions can often lessen the impact of these cognitions, thereby reducing the risk of relapse.

Engage in therapeutic activities: Part of developing a coping strategy entails establishing a list of activities one finds enjoyable which have been effective during previous recovery periods. Encourage students to inquire about on-campus student groups that are personally meaningful. Or perhaps suggest volunteer opportunities in the community that do not have an academic focus. This can create a nice break in their weekly schedule to be with others who share a similar passion, with a new peer group. Activities such as mindfulness practices and journaling can help students manage their eating disorder cognitions, regulate emotions and decrease stress.

Building a support network

Campus resources can be extremely helpful in supporting students in their recovery journey by establishing multidisciplinary eating disorder treatment teams. Once in place, these practitioners need to collaborate closely with one another, in order to identify red flags that may indicate a lapse or relapse. Residential Life programs can help promote an inclusive and accepting environment by confronting a culture of stigma through body acceptance activities, as well as by avoiding judgmental language and diet and fat talk within the student community. Eating disorders often thrive in isolation – therefore, encourage your students to allow non-professional supports within the campus community to become an integral part of their support network as well. These relationships can help a student feel less alone during their recovery journey, especially when they are wanting to isolate after a recent slip and/or relapse.

Relapse Prevention Strategies (cont.)

Creating a relapse prevention plan

Maintain motivation: Recovery from an eating disorder can be a long and challenging process. Moreover, eating disorder behaviors once served a purpose for the student in their life. There may be times when they will struggle to maintain their motivation for recovery. Revisiting the progress and success a student has experienced while also discussing goals and values that have driven the recovery process can help to reignite motivation in a student wavering in this area.

Set expectations and build structure: Open communication among students and the members of the campus support network can be instrumental in preventing relapse. Students can work with this network to set expectations for maintaining recovery and to define the actions that will be taken if they should lapse or relapse. Expectations can be related to participation in therapy, attendance at meals, engagement with community activities and academic progress, among others. Setting these expectations can help students build structure around their daily activities while also holding them accountable, letting them know that they are not alone in their recovery.

Monitor progress: It is important to recognize when a lapse has occurred and to act upon it expeditiously to prevent a further and more prolonged relapse. Consistent monitoring can help students to re-engage in adaptive activities and get back on the recovery path as soon as possible. The most efficient plan for ongoing evaluation would be to create an on-campus Eating Concerns Team which meets on a bi-weekly basis. (See pages 32-33 for an overview of this collaborative effort).

Developing a treatment plan: During this process, collaborating with other providers is crucial and the recommendations for care can serve as a guide for monitoring progress and determining future goals. It also enables professional (and personal) supports to be on the same page regarding the role of each team member and family representative. For those in crisis, students are expected to make a commitment to ongoing therapeutic appointments (and/or attendance in support groups), medical monitoring and medication management (if the student is also diagnosed with a co-occurring disorder). Also, it is ideal to encourage students to sign a Release of Information form, so that parents and providers can communicate freely with one another if concerns arise. If the student appears to be struggling, perhaps they may need to return home for a short break, in order to explore additional levels of support. To ensure comprehensive care, treatment team members should also take into account ongoing reviews of the student's progress by considering other areas of their life. These factors include, but are not limited to: level of social interaction and relationships with roommates, teammates and close friends, participation in extra-curricular activities, eating, sleep and exercise patterns (including meal support options), communication with RA's and other university staff, level of communication with family members and non-weight measures of mental health.

Developing a plan that will optimize the chances that a student will stay in recovery can help to set the student up for success in both their recovery and their academic endeavors.

Wendy Foulds Mathes, MS, PhD, LPCA, NCC

Peer Guidelines: How to help a friend

Supporting a friend who appears to be struggling with an eating disorder: Eating disorders are not only about food. There is always a deeper issue that is causing an individual to focus so intently on their food intake. Eating disorder symptoms are often the outward manifestation of inner turmoil – such as low self-esteem, depression, anxiety, relationship concerns and/or family issues. (A friend's eating disorder can be seen as an attempted solution to these issues). In time, these symptoms will begin to fade away when this inner turmoil is addressed, and counseling can be incredibly helpful during this process.

- ***Make sure you approach the person one-on-one.*** If a group of you is concerned, it is very important that only one person be chosen to talk with the friend. Group confrontation can make a person feel "ganged up on" and can cause a friend to feel betrayed, as if everyone has been talking about them.
- ***Make a plan to approach your friend in a private place.*** Try to choose a non-stressful environment where you will have enough time to talk at length, if necessary.
- ***Present what you have observed and what your concerns are in a non-confrontational, caring way.*** Tell him or her that you are worried because of what you have noticed and that you would like to offer some help. Refrain from saying "we've been talking and are worried" – focus on what you yourself have seen, it is less threatening. (Friends who are too angry or hurt to talk supportively should not participate in this type of confrontation).
- ***Offer human company and empathy.*** You don't need to agree with your friend's feelings or stance. There is a place for advice, information about treatment options and/or confrontation. Generally, that place is after he or she feels their experience is understood and accepted for what it is.
- ***Listen carefully and non-judgmentally.*** Offer your friend time to hear what you have to say and for them to verbalize their feelings in return. Ask clarifying questions and then accept their response without judgment. Encourage him or her to talk about their feelings, asking how you can be most helpful to them in this particular situation.
- ***Do not argue about whether or not there is a problem.*** Power struggles are not helpful and in most cases, are very ineffective. You could say, "I hear what you are saying and I hope that you are right and that this is not a problem. However, I am still concerned about what I have seen and heard because I care about you." (Be sure to use "I" statements). It is best not to say what other people feel or what they have noticed.
- ***Do not lay guilt trips, such as "Look what you are doing to your family or roommates".*** We are each responsible for our own feelings. Bear in mind that individuals with eating disorders yearn to know that someone could both know the worst about them and still love them and care about them unconditionally.

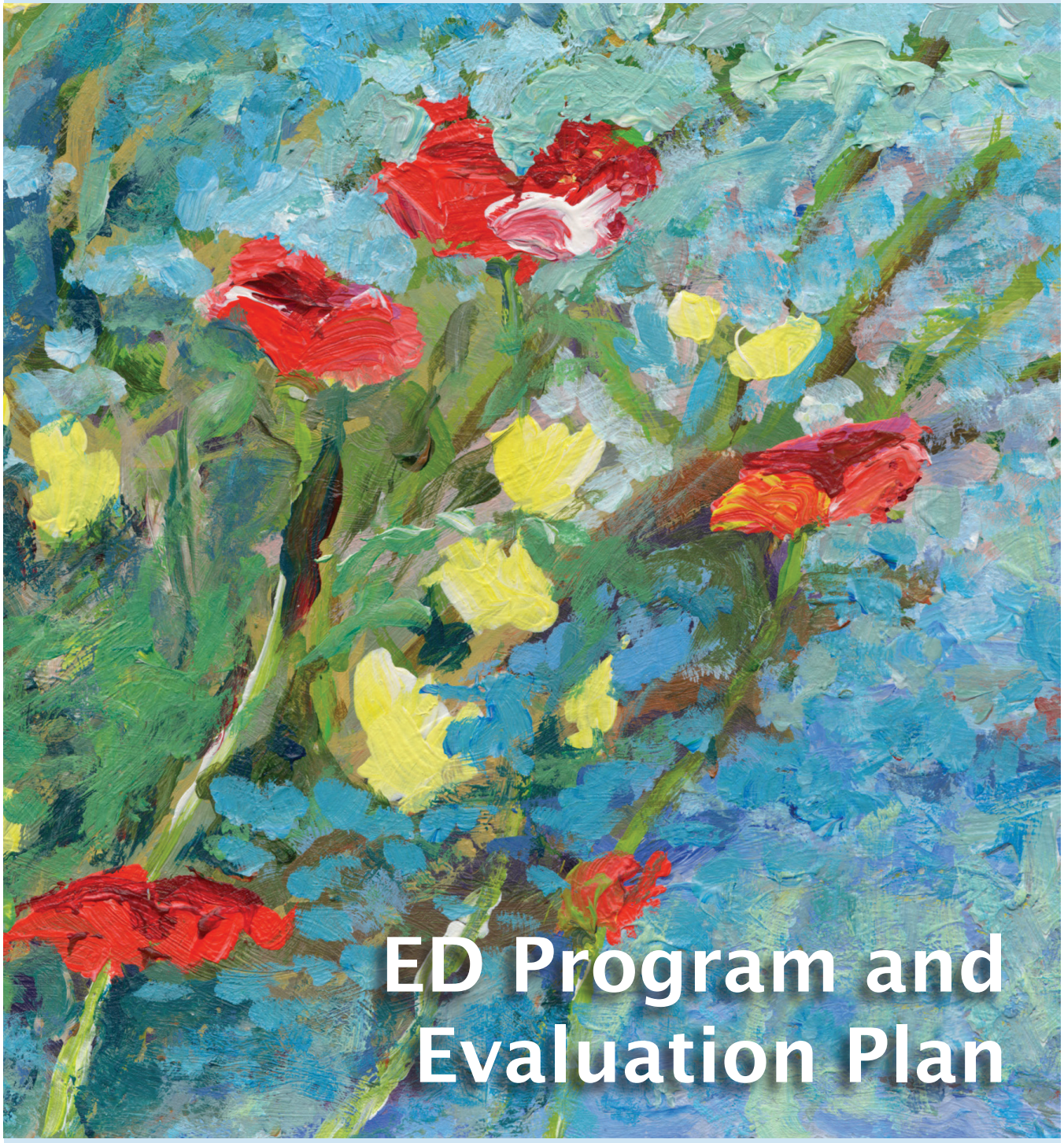
Peer Guidelines: How to help a friend (cont.)

- ***If the person denies the problem, becomes angry, or refuses treatment, understand that this is often a part of the illness.*** They have a right to refuse recommended treatment (UNLESS their life is in danger). You may feel helpless and angry. In this situation, perhaps respond by saying, "I know you can refuse to go for help, but that won't stop me from being concerned. I may bring this up again later – maybe we can talk about it then." Follow through on this plan, and other promises you might make. Your friend may need time to process what you have shared with them. Don't expect an immediate positive response - the important thing is to follow through with your offer to help and be consistent with your support.
- ***Provide information and resources for treatment.*** Before you talk to your friend, learn all you can about eating disorders, which includes becoming familiar with resources available both on-and off-campus. Encourage him or him to see a counselor, nutritionist and/or physician, with an offer to go with them to their first appointment.
- ***Do not try to be the hero or rescuer.*** If you do the best you can to help on several occasions and the person is still unwilling to enter treatment, take a break from sharing your concerns. Eating disorders are very complicated illnesses, and treatment is most effective when the person is emotionally ready to begin this process. By expressing your concerns, this friend will know that you're available as a support in the future.
- ***Make sure you get support for yourself.*** It can be difficult to be friends with someone struggling with an eating disorder. Reach out to your RA and/or counseling center if you're feeling stressed or overwhelmed while dealing with this difficult situation.

Remember that he or she is more than their eating disorder. Focus on their other characteristics which make them a great friend. The more you help him or her identify their positive attributes, the easier it will be for them to let go of their "eating disorder" identity.

- ***Don't be afraid of conflicts.*** Certain issues need to be brought out into the open, not hidden. Be sure to keep the lines of communication open.
- ***Do not focus on weight gained or lost.*** Instead, focus more on their mental state. If you say, "you look thin" you are focusing on appearance and feeding into their behavior. If you say, "you look healthy" he or she may think you are saying, "you look fat."
- ***Don't focus on achievements.*** Instead, talk about their inner qualities and strengths. Set an example – be good to yourself and they will see this as an attainable goal.
- ***Stay positive!*** Individuals can and do recover from having an eating disorder. Students who have sought help and fully recover often acknowledge the importance of their friends who believed in them and continued to be supportive during this challenging time in their life.

Boston College, Women's Resource Center



ED Program and Evaluation Plan

Strategic Guidelines for University Counseling Centers

University counseling centers have a unique role in supporting college students struggling with body image issues, disordered eating and/or an eating disorder. In addition to providing clinical services, staff also have the opportunity to provide information, support and consultation services to health centers, residential life programs, the Dean's Office, sororities, fraternities and/or athletic programs. The following outline created by **Hynes Recovery Services**, will provide guidance to both administrators and clinicians in the process of establishing (or improving upon) campus-based eating disorder support services within their university community. Review these guidelines with colleagues, enlisting their support in establishing a comprehensive system of care for this unique clinical population.

Develop a comprehensive strategy to support students on your campus presenting with body image and/or eating concerns.

Implementation steps:

- *Print out our **Recommended Reading** outline for both students and university staff.*
- *Establish and conduct baseline eating disorder training for all clinical staff.*
- *Provide information, support, and if necessary, referral services to students around body image and/or eating concerns. (Create outline of on-campus resources for counseling center webpage).*
- *Download our treatment directories: **National Eating Disorder Treatment Directory, Resource Guide for Collegiate Athletes with Eating Disorders, Addiction Treatment Directory***
- *Establish an **Eating Concerns Team** with participation from on-campus professionals across the university system. These members may include, but are not limited to, the following entities: Health Center, Counseling Department, Athletics, Dean's Office, Residential Life, Disability Services and the Greek System.*
- *Assist staff in delivering therapeutic eating disorder interventions to students through supervision and training opportunities within and outside of the university setting.*
- *Collect/adapt/create training materials on related mental health concerns, including anxiety and depression, obsessive-compulsive disorders, trauma, substance abuse, self-mutilation behaviors and suicidal ideation, providing staff with clear guidelines on how to most appropriately respond to these clinical issues.*
- *Design group therapy training for clinical staff, including an outline on group therapy models and research articles providing information on group therapy development.*
- *Provide monthly 1 hour staff meeting to offer clinical support, case consultation, group supervision and/or in-service training to all counseling staff treating students with eating disorders. (For additional training opportunities, click **here** for our "ED Screening" webinar series).*
- *Develop support structure for clinical interns, including plan for individual skill and knowledge development.*
- *Request conference call with HRS to learn more about resources available to the university community.*

Strategic Guidelines for University Counseling Centers (cont.)

Support clinical staff in providing effective treatment services for students through program development and quality improvement initiatives.

Implementation steps:

- *Coordinate needs assessment to inform technical development. Follow-up during team meetings to brainstorm ideas involving program development based on survey results.*
- *Draft protocols for screening, identifying and intervening with students who disclose sexual assault and/or incidents of domestic violence (as these situations are common with college students exhibiting body image concerns and/or eating disordered behaviors).*
- *Create list of educational brochures for students on various clinical issues. (Request affiliated organizations to send copies of their programming to your on-campus University Health Center and Counseling Department in order to establish student/professional resource library).*
- *Create list of community resources specializing in eating disorder treatment.*
- *Establish follow-up guidelines with referral protocol for outpatient providers, eating disorder treatment programs and/or in-patient facilities.*
- *Develop mechanisms to evaluate and measure the impact/efficacy of all recommendations, including outreach with students to determine effectiveness of recommended resources.*
- *Conduct bi-annual student record reviews and surveys with providers to inform improvement efforts.*

Provide On-Campus Support Group

Implementation steps:

- *Request our **Support Group Outline** specifically designed for the university community.*
- *Provide:"The Rights of Group Participants" outline to all group members.*
- *Create group orientation session introducing students to the purpose and benefits of group therapy.*
- *Create 6-week curriculum, which will include the following materials: group flyers, pre-assessment questionnaire, intake forms (administrative/clinical) and confidentiality agreement, along with individual and group outlines on topics relating to eating disorder recovery.*
- *For each designated topic, include an overview of the clinical issue being addressed (specifying goals to be achieved during each group session), as well as a list of books and research articles to be utilized as supplemental reading material for group leaders.*
- *Create group therapy evaluation form for students, allowing for feedback on structure and effectiveness of group sessions.*
- *Establish plan for monthly group therapy supervision to assess effectiveness of existing groups.*
- *Upon conclusion of the final group session, provide students with a list of both on and off-campus resources from group leaders, including other group options and suicide prevention hotlines.*

Strategic Guidelines for University Counseling Centers (cont.)

Identify and address issues that affect smooth communication and coordination of services among administrative and clinical staff.

Implementation steps:

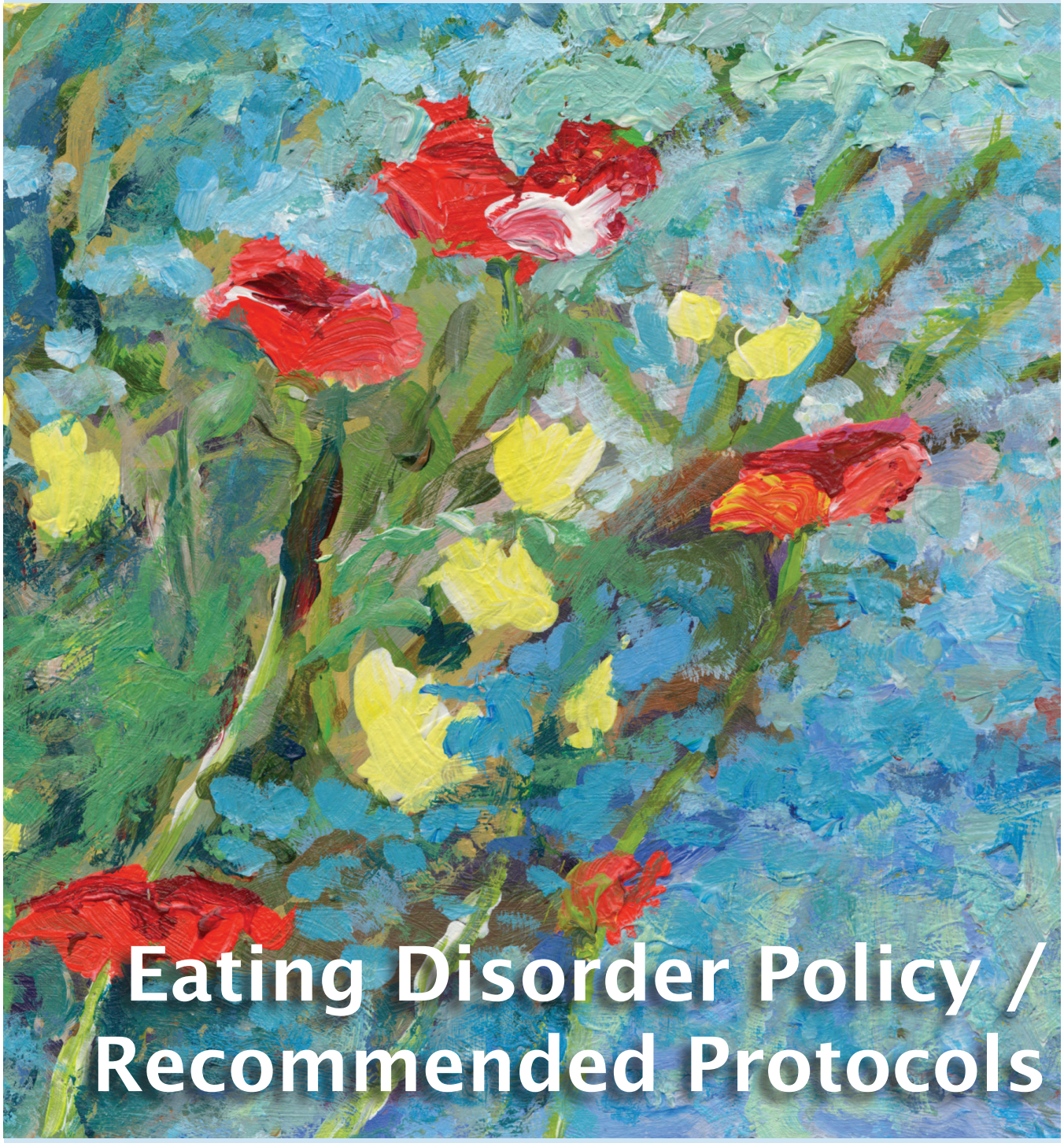
- *Develop staff survey regarding current practices and flow of communication.*
- *Coordinate an information sharing/support structure for your counseling department (and/or health center). This should include providing staff sufficient time to review referral and intake information prior to a student's initial clinical session.*
- *Organize system regarding follow-up of all critical incidents, since not all staff are available for on-going treatment team meetings.*
- *Create an ED Response Team binder, composed of: ED University Protocols, minutes from team meetings and educational materials presented during in-house trainings.*
- *Implement individual meetings between Clinical Director and other staff to provide support, case-sharing and in-service training.*

Collaborate with community programs to address gaps in services for students struggling with eating disorders.

Implementation steps:

- *Conduct surveys with students seeking eating disorder services to assess gaps in services and barriers to accessing treatment and other clinical resources.*
- *Increase collaboration and service coordination among all campus departments which support students with an eating disorder diagnosis.*
- *Develop comprehensive treatment directory, including guidelines for students to assist them in seeking either outpatient providers and/or a higher level of care. (For guidance with treatment options, click* **here***).*
- *Contact local and statewide eating disorder organizations to:*
  - *Inquire about being placed on their mailing lists. (This will provide information on current services, awareness events, upcoming conferences and/or other training opportunities). Also, express desire for collaboration, to increase ease in referring students for support outside of the university setting.*
- *Plan a community outreach and awareness strategy around the identification and treatment of students with eating disorders throughout the entire university community.*
- *Establish affiliations with research initiatives such as the* ***Healthy Minds Network****, a resource for higher education administrators.*
- *Become a University Affiliate. (To learn more about this exciting opportunity through Hynes Recovery Services, click* **here***).*
- *Request our* ***Advocacy Toolkit*** *(created by Eliza Lanzillo), which is an important resource for members of the university community interested in advocacy initiatives on both a state and national level.*

Dawn Hynes, MSW
Founder, Hynes Recovery Services



Eating Disorder Policy / Recommended Protocols

Introduction

There are over 20 million students attending college within the United States (National Centers for Education Statistics; 2015. Retrieved from: **nces.ed.gov**). Due to the fact that a significant number of these young adults (both male and female) are entering their Freshman year with an eating disorder history, educational institutions must play a crucial role in the identification, assessment and intervention of those struggling with body image and/or eating concerns. As each school is unique in regards to student population, campus size, availability of mental health resources and expertise in treating students with eating disorders, our team developed this resource as an informal guide, designed to highlight the most important recommendations to consider before drafting and/or implementing an "Eating Disorder Policy" on your respective campus.

Policy Recommendations:

1. To maintain effective university-wide ED Policies, adhere to the following objectives: Increase understanding and awareness of eating disorders within the university community, alert staff to warning signs and risk factors related to an eating disorder diagnosis, offer support to staff dealing with students exhibiting eating disordered behaviors and provide guidance to students currently suffering from (or recovering from) eating disorders.
2. Review the **ED Practice Guidelines** established by the American Psychiatric Association [Practice Guideline (May 2006); Guideline Watch (August, 2012); and Quick Reference Guide].
3. Review the following forms and guidelines annually - with special attention to how students with an eating disorder might need additional accommodations: *Intake Form, Refusal of Care Policy, Medical Leave of Absence Form and Guidelines, Involuntary Leave of Absence Form / Criteria for Re-admission, Sample Student Contract, Return to Sport Guidelines / Scholarship Considerations, Medical Clearance Form, ED Team Consultation Outline and a Family Contact Policy (in accordance with FERPA/HIPPA regulations)*.
4. Determine the referral process, intake protocol and evaluation tools for students with eating disorders, identifying a "team leader" who will oversee all new cases and ensure ongoing communication among providers for continuity of care. Request a follow-up meeting with each student, to review clinical recommendations and the creation of a treatment contract, including an outline of how often care should be reviewed and what the family involvement might be.
5. Consider how, or if, to proceed with a student's schooling while they are suffering from an eating disorder. In these situations, all of those within a student's personal network (including professional treaters) should be consulted and provided the opportunity to provide feedback on suggested treatment recommendations.
6. Join the **Academy of Eating Disorders** to receive up-to-date research findings on clinical issues and treatment protocols within the eating disorder field. Also, download their **"Eating Disorders: A Guide to Medical Care"**, a booklet written for physicians and other health care professionals highlighting critical diagnostic and medical management information.

For additional support, Hynes Recovery Services can assess your existing level of care for this clinical population and create eating disorder policy guidelines for your campus community.

Dawn Hynes, MSW
Founder of Hynes Recovery Services

Establishing an Eating Concerns Team

Eating disorders are among the most challenging diagnoses to treat in the university setting. Not only can they be medically and psychologically complex, but they can involve significant social and academic dysfunction. For these reasons, multiple partners across campus should be at the table when trying to help these young adults (doctors, nurses, nutritionists, mental health providers, coaches, deans, etc.). For universities who want to streamline (and improve) their management of support for students, a team approach is best. An "Eating Concerns Team" (ECT) can be used to facilitate care for students, coordinate referrals both on- and off-campus and transition students to and from care when it takes them away from full-time status.

Please review the template below, which can be adjusted accordingly depending upon the size of your educational institution, campus structure and availability of clinical services.

Discuss the needs and goals of your ECT: What can (and should) your ECT be doing on your campus? Will the team be involved in ongoing patient care? Will the ECT function purely as a referral source? If so, who is referring students to the ECT? Are there any existing ED-related policies at your institution - academic, medical or otherwise? Has there been any kind of needs assessment for ED services on campus? Does your school have any medical leave policies and if so, do they speak to eating disorders specifically? Who at your school currently approves students to return from medical leave? What kind of care coordination is lacking and how could an ECT address this issue? Don't try to reinvent the wheel. Reach out to other schools and ask questions, share ideas and trade documents. The same issues and challenges exist at all institutions; however, the solutions may vary and new ideas are always welcome.

Identify team members and campus partners: The team's basic structure should include medical providers, mental health practitioners, and nutritionists/dietitians (potentially including those from Athletics). This is the aptly named "therapeutic triangle" of care. These partners do not all have to be campus-based but they do need to commit to holding regularly scheduled meetings at a convenient (and private) location.

This triangle includes the most common entry points for students with eating concerns, therefore those providers must establish a collaborative relationship with one another to allow open communication. It is common for both medical and mental health facilities to have very strict patient confidentiality practices. Providers on the team will have to discuss how best to share clinical information while following these protocols. Discuss what kind of consent is needed from the students to discuss their care within the ECT. The team may decide these individuals are only identified by initials, or your ECT may decide to have a procedure for documenting what is discussed in their medical record.

The basic team structure can easily expand to include social workers, nurses, referral coordinators, athletic trainers and any others that are involved in facilitating direct care of these students. Given the sensitive and detailed information discussed, other partners on campus like professors, deans, student intervention services, disability services, academic advisors, athletic coaches or student conduct officers can potentially be pulled into a meeting if indicated, but should otherwise not participate in ECT meetings. Information regarding the team structure should be made available to these campus partners however, as they will sometimes be the point of entry for students and will need to know how best to refer a student for further evaluation.

Establishing an Eating Concerns Team (cont.)

Decide the timing and structure of meetings: Most teams meet at a minimum every week and at a maximum every month. Timing should be based upon volume of patients and how often it is feasible to coordinate the team member's schedules. Meetings usually consist of 1-2 hours of discussion. The ECT meeting detailed below could be scheduled monthly for 90 minutes. The first 30 minutes would consist of brief updates on individual patients, i.e. "check-ins". These might be students that the team has previously discussed in more detail, or those known to several members of the ECT. The bulk of the meetings consist of one of the following: case discussion, didactic portion, or Balint. A case discussion is a 30-45 minute presentation from all members involved in a student's care. Each provider presents their experience with a particular student - then the team has a larger discussion about medical and psychological issues, what further evaluations may be necessary, referrals to consider and/or a discussion about whether a higher level of care is indicated.

The didactic portion is purely educational though it may use a known student as a starting point. Given that team members may be coming from very different educational backgrounds, taking turns presenting topics helps staff get on the same page, so to speak. Medical providers can present on physiological changes or discuss recent journal articles. Mental health providers can discuss different therapeutic methods used in eating disorder treatment. Nutritionists can educate the team on how they determine nutritional needs of students in general (or student-athletes) as well as share insight on the most recent fad diet controversies. As our field is evolving and it's hard to stay current outside of your own area of expertise, having this didactic portion approximately 4-6 times per year can be quite helpful. Consider staggering case discussions and didactics in a roughly 2:1 ratio over the course of the year.

Balint is a structured session, led by a psychologist or psychiatrist (preferably not a current ECT member), where a provider presents a particularly challenging case. The aim of the discussion is to better understand the clinician-patient relationship and examine how they can better connect with and care for the student in crisis. Most eating disorder providers at some point feel emotionally drained by this population, or start to endorse feelings of burnout. Incorporating Balint sessions once a semester offers a structured and safe place to explore these feelings.

Additionally, if a student is recommended for a higher level of care (HLOC), it should be discussed at the ECT meeting. If this is something your school can mandate (i.e. non-voluntary leave) then your ECT should become a standard part of that protocol. If only voluntary leave exists, it can still be helpful for both the student and providers to go through an organized process before a final decision is made. All campuses should create written policy outlining the process for an eating disorder evaluation and ongoing clinical services. The ECT can start this conversation with the upper level administration, while also reaching out to other schools to request their policies for review (and ideas). Collaborating with peers who also utilize ECT's can provide new information on how campuses can most effectively support this unique population.

Amanda Finegold Swain, MD

ED Screening Tools

The continuum of eating disorders is separated by important differences and each is complex in its presentation. It is important to note that on college campuses, an eating disorder might look like other common psychiatric illnesses such as depression, anxiety or an adjustment disorder because there are similar symptoms of weight loss or gain. Additionally, other mental health challenges often co-occur with an eating disorder, thereby making it hard to differentiate between them.

Further complicating the clinical picture, students may share compelling stories about how they lost weight, and they may not be fully aware of or understand how precipitating events might have culminated in disordered eating. Some students may also not be aware of additional risk factors, such as poor body image, perfectionism and a drive to overachieve and how these situations may impact eating behavior. Other students may have an established history of an eating disorder and fear that being forthright and seeking help may put their academic pursuits on hold.

In all cases, these factors make an eating disorder more obscured and campus personnel may easily miss an opportunity to further question the possibility of an eating disorder diagnosis.

Fortunately, there are two excellent screening tools to help raise awareness that an eating disorder may exist, thereby prompting an appropriate referral. Two of these tools, the SCOFF and the EAT-26 will be discussed here.

SCOFF

The SCOFF was developed in London in 1999 and has since been studied internationally and found to be a reliable screening tool. It is a short paper and pencil form commonly used in healthcare settings but it is not limited to primary care. This helpful screener was developed to identify important aspects of anorexia and/or bulimia.

The SCOFF consists of five questions and is quick and easy to use. The results are not meant to diagnose an eating disorder; rather, the outcome can trigger a quick referral to a specialist for evaluation, diagnosis and treatment. There are two versions of the SCOFF and the questions outlined below are for the United States version:

1. *Do you make yourself sick because you feel uncomfortably full?*
2. *Do you worry that you have lost control over how much you eat?*
3. *Have you recently lost more than 15 lbs. in a 3-month period?*
4. *Do you believe yourself to be fat when others say you are too thin?*
5. *Would you say that food dominates your life?*

For every “yes” answer, there is a score of 1. A score of 2 indicates that anorexia or bulimia may be present and a referral to a specialist could lead to definitive diagnosis, treatment and ultimately a better prognosis.

ED Screening Tools (cont.)

EAT-26

The Eating Attitudes Test* (EAT) was first developed in the late 1970s with the intent to detect the possibility of anorexia nervosa in high risk populations. The updated version (EAT-26) is a self-report questionnaire commonly used in university settings that measures symptoms and concerns characteristics of eating disorders. Like other screening instruments, the purpose of this tool is to screen for disturbance and not diagnosis.

There are three distinct sections on the EAT-26. First, there are 26 statements rated on a 6 point scale which requests responses to how often one engages in specific behaviors. The second section has four "Yes or No" behavioral questions. The third section is completed based on a weight table (included) that specifies body weight for those considered to be significantly underweight according to height. Directly below are samples of several EAT-26 statements following an instruction to "Please choose one response by marking a check to the right for each of the following statements:"

- Am terrified about being overweight
- Feel extremely guilty after eating
- Like my stomach to be empty
- Avoid foods with sugar in them

One behavioral question is: "In the past 6 months, have you ever made yourself sick (vomited) to control your weight or shape?"

Upon completion of the EAT-26 screener, a referral box is completed by entering the total statement scores. A response of "Yes" on any one of the four behavioral questions is also noted. Finally, the student's weight is compared to the table and recorded as "Yes" if it is below the weight listed. Conditions for referral exist if there is a response score of 20 or more on the statement section, or one affirmative answer to the behavioral questions, or if the student is significantly underweight according to the table. If any one of these three sections meet this criterion, a referral to a health care professional or therapist is indicated for a more thorough diagnostic assessment.

The use of the SCOFF or the EAT-26 as screeners are important tools for college campus professionals. Early identification and appropriate referral is critical to help reduce the serious consequences of an eating disorder, which include high mortality rates, chronicity and comorbidity. Simply, early detection can lead to more positive outcomes for both students and their families.

* The EAT-26 has been reproduced with permission. Garner et al. (1982). Permission to use the EAT-26 can be obtained from David Garner through the ***EAT-26 website*** at no charge. Additionally, instructions and scoring information can also be obtained from the EAT-26 website.

References:

Morgan JF, Reid F, Lacey JH (2000). The SCOFF questionnaire: a new screening tool for eating disorders. West J Med. *172* (3): 164–5.
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Nutrition Guidelines

Campus nutritionists/dietitians play a vital role in the support of students with eating disorders and are recommended for inclusion on an Eating Concerns Team (ECT). In many cases, these health care practitioners may be the first point of contact for someone who is struggling with an unidentified eating disorder. However, some of these practitioners that work on a college campus do not identify as specialists with the eating disorder population. Equipping nutritionists/dietitians with basic information on screening for eating disorders and how to therapeutically approach students with a "do no harm" mindset can be a strong protective factor, as well as a tool for appropriate referral to the ECT for a full eating disorder assessment.

Nutrition Screening: Screening tools are available and highly recommended in practice (including the SCOFF and EAT-26 highlighted earlier in this guide). While beneficial, these may not be conducted routinely during initial nutrition appointments, particularly if the student has self-identified with another specific need for visiting the health center. For example, the student may be newly diagnosed with diabetes, express a desire to improve athletic performance and/or share concerns about their family history of high cholesterol. Despite the reason for the visit, disordered behaviors related to food and body may still be present. Diving into traditional meal planning or nutrition education at the outset may fuel the disordered behaviors. Instead, it is recommended that providers identify underlying relationships with food and body in order to best assist the student with their overall nutritional needs and long-term wellbeing.

"Do No Harm" Approach: This approach serves to prevent undesirable/unintentional effects of well-intended treatment for particular health concerns. A significant factor with this approach is to understand supportive treatment options for a wide range of nutritional concerns while also acknowledging ineffective ways to treat specific health issues (e.g. weight concerns).

Key points to remember:

- *Individuals whose weight falls in the normal, overweight, or obese range (or those who suffer from other specific medical conditions) are not exempt from having or developing an eating disorder.*
- *Dieting is a significant risk factor for the development of all types of eating disorders.*
    - Nutritionists/dietitians should focus on eating patterns to better fuel the body throughout the day, rather than on specific food constituents. Providers can bring in macro and micro nutrient balance suggestions as work continues and a better understanding develops of their relationship with food and body.
- *Weight is not always a proxy for health.*
    - Focusing solely on specific numbers can fuel an eating disorder. It is important that numbers (such as kcals, weight and grams) do not aid in developing a healthy relationship with food and body. These are internal changes that must also be personally explored rather than externally categorized.
    - Weight loss may be a side effect of balanced eating; however, focusing on weight loss as a goal removes emphasis from healthy behaviors and internal regulation.

Nutrition Guidelines (cont.)

Refocus Overall Nutrition Goals: To aid in the "Do No Harm" approach, nutritional interventions should focus on "Eating Competence". This is defined by nutrition expert Ellyn Satter as "being positive, comfortable and flexible with eating, as well as being matter-of-fact about getting enough to eat of enjoyable and nourishing food". It also includes the ability to "maintain stable body weight that is in keeping with the individual's genetic endowment and lifestyle."

More specifically, refocused nutritional goals may include:

- *Developing positive attitudes about food and body.*
- *Creating food acceptance skills which support eating an ever-increasing variety of foods.*
- *Reconnecting with internal regulation to promote intuitive eating in order to provide enough energy and stamina to support stable body weight.*
- *Increasing skills and resources to manage food within context (environment, food availability and emotions) as well as guidance with preparing meals.*

Appropriate Nutrition Language: Combining "do no harm" with "eating competence" involves modifying traditional nutrition language. Additional recommendations include:

- *Reduce use of dichotomizing language.* Examples include: good/bad, healthy/unhealthy, excessive/restrictive, better/worse, should/shouldn't.
- *Avoid use of terms such as "underweight," "overweight" and "obese".* This will result in placing an individual in categories that often have minimal association to health. Instead, use words such as "living in a larger/smaller body."
- *Conversation of weight may be triggering for some students.* Mindfulness of client preference of knowing a specific number or having a discussion about this number is important for all interactions in future sessions.
    - Additionally, focus on weight has shown to increase body dissatisfaction and dieting behaviors, lower self-esteem and increase weight bias, all of which may influence maladaptive weight and shape-related behaviors.
    - Emphasizing target weights or BMI are not supportive and/or helpful strategies.
- *Listening is key.* Do not praise or agree with comments made by students or make premature nutritional recommendations. "Okay" is an acceptable response when someone is providing weight loss/gains they have experienced, diets followed or comments about their body.
- *Once there is an understanding of the student's thought processes around food and body, nutritional assessments and recommendations can then be initiated while still practicing the above suggestions.*

Assessment Modifications: The information collected by nutritionists/dietitians during standard assessments is still necessary for full evaluation and referral to the ECT; however, the suggestions listed on the following page can collect similar information, but through "do no harm" and "eating competence" lenses. These questions can also provide additional insight for food and body relationships.

Nutrition Guidelines (cont.)

Consider modifying your nutrition assessment protocol with the information below:

- **Weight:**
  - What is your general relationship with your weight and weighing history? (State that you are not requesting specific numbers).
  - What are you looking for when you weigh yourself? If there are negative emotions after seeing your weight, does this have an impact on your day-to-day activities?

- **Food intake:**
  - What does your typical day with food look like? (Be aware of responses that provide great detail to measurements of food and/or nutrient content).
  - Are you comfortable with your food intake? Please share a few examples of certain foods that you like or dislike, including thoughts on why you've chosen these specific foods. (This provides additional insight on the student's unique relationship with food).
  - Are you able to enjoy the foods you eat? Please explain further.
  - How often are you thinking about food and/or planning your meals in advance?
  - What tools and cues do you utilize to determine when you should start, stop and/or continue eating? (This can help gauge use of internal versus external regulation).
  - What would you like to do differently/keep the same with regards to your current eating patterns?
  - Do you ever feel "out of control" while eating meals and/or snacks? (This can replace the often-asked question of: "Do you ever binge?").
  - Do you ever feel the need to get rid of the food you consume? If so, in what ways have you compensated for an intake of food that felt uncomfortable? (This can replace the often-asked question of: "Do you purge?").

- **Activity:**
  - What activities and movement do you do throughout the day/week? How do you choose these activities/movement? (Be aware of compensatory or reward driven activities tied to food, energy burn, punishment, etc.).
  - Do you feel comfortable with (and/or enjoy) these activities/movements? If not, please explain further.
  - If you are unable to engage in these activities/movement, how does that make you feel? Does this increase the likelihood of any compensatory behaviors?

Exploring the areas above will shed light on how an individual's thoughts and feelings around food impacts their behavior (in both healthy and unhealthy ways). In addition, it's important to become familiar with the most up-to-date nutritional interventions to help students learn more effective ways to manage any stress or anxiety they may experience around eating, especially in the campus environment - a very challenging setting for those with disordered eating behaviors.

Emmy Lu Trammell, PhD, RDN, LD

Ten Tips for Managing Your Eating on Campus

- **Eat regularly.** College students are notoriously erratic in their eating. Some may be able to do this without much consequence. However, if you struggle with disordered eating, not eating regularly can send you into a tailspin of over- or under-eating.
- **Breakfast isn't optional.** Waiting too long before you eat your first meal of the day can lead to an early-day blood sugar crash that can be almost impossible to recover from as the day goes on – and can potentially set you up for rebound overeating later in the day. Even if you have to keep some breakfast food in your room, or eat on the run, don't skip this important meal.
- **Watch out for dining hall pitfalls.** The all-you-can-eat buffet style meals can be overwhelming and hard for someone with disordered eating to navigate. Until you have the skills to be spontaneous and balanced with this type of eating, plan out your meals so that you know what you are going to eat before arriving at the dining hall. Being prepared can often prevent anxiety around your upcoming meal.
- **Be mindful of fast food.** It's common for college students to rely on fast food to fill gaps in their eating, especially if they are up late studying or socializing. Don't let this be an excuse to undue your recovery work. Balance and moderate eating is an important approach to eating in this campus environment.
- **Exercise moderately.** "Moderate exercise" varies for the individual, whether you are a casual mover or a collegiate athlete. When you find that you can't take a day off or you exercise even when your body says it's too tired, then there's a good chance that you aren't exercising at a healthful level.
- **Think carefully about whether to have food in your dorm room.** If you struggle with binge eating, having extra food around could be challenging. Ask yourself if you might find yourself binging more with lots of food nearby. Conversely, having food in your dorm room could also be helpful and keep you from feeling deprived. Perhaps having a snack before you dine out with friends could prevent the overeating that often occurs when you go out very hungry.
- **Choose your dining friends wisely.** If you struggle with eating, it may help to have an encouraging, non-judgmental friend with you at meals (carefully consider which friends and roommates make you feel most comfortable during mealtimes).
- **Beware of alcohol and other substances.** Not only can these possibly derail your progress around eating, but they can have dangerous and mood-altering effects that hamper your overall recovery and sense of well-being.
- **Listen to your body.** This requires extra effort when eating in communal spaces. If you find that it's a challenge to eat a balanced, healthy meal with friends, find a quiet space to eat on your own. Take good care of yourself first, and work toward being able to eat socially, if you need to. Practice the skills of listening to your hunger and fullness. If you need help, ask a registered dietitian who specializes in eating disorders to assist you with this important skill.
- **Request help to stay on track with eating.** Again, if you find yourself struggling with your relationship with food and your body, a registered dietitian/nutrition therapist can provide varying levels of support. It's particularly important to find a nutritionist who understands and works with eating disorders. In addition, having a treatment team of supportive professionals nearby (therapist, nutritionist, medical doctor, etc.) can help you navigate the challenging environment that is campus living.

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Registered Dietitian in Private Practice

Eating Disorders in Collegiate Sport: Unique Risks, Policies and Procedures

Athletes at Risk for Eating Disorders

While athletes have increased nutritional needs to support growth, development, training, competition, and post-work-out recovery nutrition, most athletes do not have ready access to nutrition professionals inside their athletics department. Nutrition knowledge is often low for the college-age population and misinformation abounds in the sport environment. As such, athletes are at increased risk for disordered eating and eating disorders (ED). Like in the general public, athletes are susceptible to a variety of predisposing factors: interpersonal characteristics that determine communication and coping skills, psycho-social stress, low self-esteem or poor body image, cultural factors, beliefs, attitudes, and societal pressures including the glorification of the thin ideal and potent pressures to diet. Pre-existing mental health conditions such as anxiety, depression and obsessive-compulsive disorder increase risk, as does trauma. Environmental influences in the home or on campus can contribute to ED risk, and the transition from life at home to life on campus can trigger an eating disorder in the college-aged population. Athletes have an additional environment and an extra "family" in sport that exposes them to unique risk factors. Performance pressures (often tied to scholarships), authoritative coaching styles, vulnerability to overtraining and under-fueling, injury, competitive drive for perfection, and revealing uniforms that accentuate body shape and size are known risk factors. Practices inside athletics that value weight, shape or size over performance, reinforced by frequent or public team weigh-ins, send direct or covert messages to athletes that promote dieting and other restrictive eating behaviors that are role modeled by teammates. In addition, athletes are targeted by a supplement and functional food industry that preys on their unrelenting pursuit of the competitive edge. Both the thin ideal and the muscular ideal are perpetuated in sport culture and are tied to athlete identity. Inside most collegiate sport settings, there is limited access to nutrition professionals to provide education, accurate information, and individualized nutrition recommendations to help athletes understand their distinct nutritional needs, further increasing an athlete's vulnerability to an eating disorder.

What makes EDs in athletes particularly challenging is the reality that athletes are more likely to underreport their symptoms, considering them benign or "not bad enough" that they would require intervention. Others view the symptoms as a sign of their commitment to sport or consider their burden a badge of honor as an elite athlete. Male athletes may be less likely to report eating concerns or even consider that what they are dealing with is an eating disorder because of stigma or the common misperception that only women get eating disorders. Similarly, those suffering from binge eating disorder are more likely to go undiagnosed because they may be at what appears to be a healthy weight or even in a larger body size, not visibly wasting away like someone suffering from anorexia. Once known as the Female Athlete Triad, the concern over low energy availability (as seen in athletes who diet or have disordered eating), amenorrhea, and compromised bone integrity has been expanded and rebranded as a Relative Energy Deficiency in Sport (RED-S). The RED-S model makes it clear that the physiologic and metabolic derangements associated with eating disorders in sport affect males as well as females, and also affect nearly all organ systems of the body, not just bone.

Eating Disorders in Collegiate Sport (cont.)

Goals of the Eating Disorder Program in Sport
The goal of an eating disorder program in athletics is to ensure that treatment is provided to all individuals in need and that treatment is not delayed so that recovery is maximized and the athlete experiences a full return to sport participation. Not only are we concerned about the physical well-being of the athlete and the threat to sport performance, but the emotional despair and suicide risk associated with eating disorders demand swift and appropriate intervention. Waiting to intervene when an eating disorder is deeply entrenched and the athlete demonstrates overt signs and symptoms including repeated stress fractures and other injuries is considered a missed opportunity with dangerous, possibly deadly, consequences.

The goal of early identification and treatment applies to males and females, to those in weight-sensitive or traditionally "lean" sports as well as in ball sports, and to those suffering from anorexia, bulimia, binge eating disorder, or other types of eating disorders or sub-clinical disordered eating. This goal requires the following components: (1) ongoing screening and assessment to allow early identification of athletes who are at risk or in crisis, (2) timely intervention that is comprehensive and endorsed by all members of the sport leadership team and (3) ongoing prevention activities that include nutrition education and promotion of athlete mental health.

The use of a treatment contract is recommended, particularly for cases that meet diagnostic criteria and for athletes who are determined to be medically ineligible to train and/or compete. The contract outlines the recommended action plan, specifies treatment providers and treatment frequency, and identifies a schedule for ongoing monitoring and reassessment to determine readiness to return to sport. Signed by the athlete and the sports medicine doctor (or athletic trainer), the contract holds the athlete accountable for engagement in treatment and specifies consequences of non-compliance.

Policies and Procedures in Collegiate Athletics: The Eating Concerns Team
A multidisciplinary team inside the Athletics department on campus is the ideal configuration for an Eating Concerns Team. This provides access to a visible, identifiable and consistent set of professionals who form a circle of trust for the athlete. If this is not possible, a tight network of expert providers in the community is needed to augment the work of the on-campus sports medicine team. Collaborative communication is essential.

The team works collectively to set policies and procedures and to track data on athlete outcomes and well-being. Policies and procedures should be reviewed annually and revised/updated as informed by outcomes achieved and emerging new guidelines that identify best practices. The team must act with authority to recognize and act on eating concerns. Experts are advocating for eating disorders to be treated as seriously and as swiftly as other sport injuries, like concussions, categorizing an eating disorder as a metabolic injury that can sideline an athlete if not taken seriously and treated appropriately.

Eating Disorders in Collegiate Sport (cont.)

Services delivered by the Eating Concerns Team need to be conveniently located, easily accessible, and in a setting that is private, confidential and trusted in order for athletes to access them. Members of the team include the sports medicine doctor, certified athletic trainer, sport psychologist, behavioral health expert or licensed mental health counselor, and a sport nutritionist. It is essential to clearly identify the point person who will serve as case manager for all athletes with an eating disorder concern or diagnosis. This assigns oversight responsibility so that athletes are appropriately followed. This is typically the sports medicine physician or a senior athletic trainer on campus. Within their respective scopes of professional practice, all members of the team should have training and expertise in eating disorder risk assessment and treatment, and all should be intimately aware of the unique demands of the sport environment and the unique needs of student-athletes. Supporting athletics staff to engage in professional development and/or annual in-service education with expert consultants is a wise allocation of administrative resources to support student-athlete mental health.

Prevention Strategies

Team culture goes a long way in supporting self-care habits and a healthy mindset. On the contrary, team culture can contribute to the spread of disordered eating beliefs and behaviors. Zero tolerance for body shaming, public commentary on athlete's weight, or judging personal food choices can be enforced by coaches, assistant coaches, captains and teammates by addressing locker-room talk, meal-time talk, and other sources of negative energy that chip away at an athlete's body image, self-worth or self-esteem. Use of punishment techniques to motivate selected athletes to lose weight or whip into shape by imposing extra work-outs such as timed cycling regimens added on top of a grueling practice schedule (sometimes referred to by coaches and/or athletes as Chub Club) contribute to public humiliation over body size and reinforce a value system centered on weight loss and dieting. Resources available from the NCAA in its detailed report on student-athlete mental health entitled, *Mind, Body and Sport*, can assist coaches and athletics administrators with programs and policies to enact on campus to promote positive psychology in sport and a healthy culture inside athletics.

Policies that identify how often athletes are weighed or undergo body composition analysis (by Bod Pod or skinfold caliper assessment), who performs those assessments, and who has access to those data can assist ED prevention efforts. It is recommended that only the sport nutritionist perform those assessments and have conversations with athletes about weight. In collegiate settings, weight (if required or justified for a weight-class sport like crew or wrestling) should be monitored by a nutrition professional, sports medicine doctor, athletic trainer, or perhaps a strength and conditioning coach. Since not all collegiate athletic departments employ registered dietitians, these practices are highly variable. However, most sports medicine professionals agree that to avoid contributing to weight bias, stigma, body image concerns, dieting or disordered eating or exercise behaviors, coaches should not be given information about athletes' weights.

Eating Disorders in Collegiate Sport (cont.)

Weight concerns should be managed by a qualified nutrition professional, not a coach. If a coach has a concern about an athlete's weight, he/she should express that concern to the nutrition professional (not to the athlete) and let the nutritionist assess the athlete, determine whether weight change is appropriate, and initiate a proper plan of nutrition intervention. The work between the nutritionist and the athlete should remain private and confidential, with the coach placing full trust that the nutritionist is managing the case and monitoring the athlete's progress towards goals. This allows the coach to focus interactions with the athlete on skill, technique and training, not on weight.

It is particularly dangerous for a coach to comment on an athlete's weight or tell an athlete to lose weight without providing access to an expert who can safely help the athlete achieve that goal. First and foremost, it is not in the coach's professional scope of practice to assess the appropriateness of weight loss for an athlete or to make well-informed, holistic recommendations for diet or for weight loss. Nor is the coach in the position to educate and guide the athlete on how to lose weight safely and effectively, while fueling adequately for sport. A coach cannot safely monitor an individual athletes' diet quality, nutritional adequacy, behavioral practices, trajectory of weight loss, or emotional mindset that ensues in response to their advice to lose weight. As such, a coach who tells an athlete to lose weight places the athlete at risk. A coach who gives weight loss advice without, at a minimum, connecting the athlete to a nutritional professional potentially does more harm than good. The authoritative power of the coach over the athlete naturally creates a dynamic that can undermine the athlete's emotional and physical well-being.

Annual training for coaches, strength and conditioning coaches, and athletic training staff is essential to ensure ongoing education, continuing professional development, and enforcement of policies and procedures. Coaches need to know more than just the signs and symptoms of eating disorders; they need annual refreshers on policies, procedures, action plans, and prevention strategies, and they need an opportunity to ask questions and have access to nutrition and mental health professionals for open discussions. Annual education for athletes provided by mental health experts, sports psychologists, and sports nutritionists is also recommended. Athletes need permission and guidance to develop the necessary life skills to practice and sustain self-care in the intensely demanding competitive sport environment. Availability of the multidisciplinary team of providers on campus ensures ongoing access for athletes to receive on-demand individualized services. This is a more effective model than simply bringing in experts to give talks from time to time without them being available to the athletes when they need them.

Screening

Annual screening for eating disorder risk is recommended as a part of the pre-participation physical, yet this is not necessarily done inside most athletics departments using anything more than an assessment of weight (using BMI criteria) and amenorrhea in female athletes. Sometimes, only freshmen are screened comprehensively – leaving athletes vulnerable beyond that freshman screen. Any time an athlete comes to attention for displaying disordered eating behaviors, visible signs or clinical symptoms of an eating disorder, a full assessment should be done.

Eating Disorders in Collegiate Sport (cont.)

The SCOFF and EAT-26 assessment tools mentioned earlier in this guide are useful, but are somewhat limited, for use with athletes. The only screening tool identified by the NCAA on its website is the SCOFF. This is likely in large part due to its simplicity and ease of use in the sport setting. The NCAA version recommends that any athlete who scores 1 point should be referred for further evaluation. Normally, the SCOFF recommends referral with a score of 2 or more, so the threshold triggering action is appropriately lowered for the collegiate athlete population. It should be noted, however, that the wording on the SCOFF is not necessarily appropriate or most relevant to athletes' experiences and, for this reason, risk could be under-appreciated perhaps even more so by male athletes. For instance, athletes may not consider themselves "fat" but simply may have low body esteem and not consider their body shape or size lean enough or muscular enough for their sport or their position in sport. As well, the SCOFF screening question on weight loss may fail to identify the risk in an athlete whose weight may be stable but has been either chronically too low or at weight that appears "desirable" but not acceptable to the athlete (or the coach) causing the athlete to chronically engage in a binge and purge cycle over many years of their sport career, possibly since early adolescence.

The importance of customizing screening tools and interview questions cannot be overstated when interacting with athletes. Few athlete-specific validated tools exist. Interview questions must reflect an awareness of sport-specific risk factors, an appreciation for the demands, pressures and expectations on competitive athletes, and a sensitivity to the stigma and fear associated with disclosing an ED in the collegiate sport setting.

The Female Athlete Screening tool provides a validated assessment of eating disorder risk factors unique to the sport environment, but currently there is no companion version for male athletes. While body image disorders are not routinely screened for in an athletics setting, the Female Athlete Screening Tool and the EAT-26 both include the thin ideal construct. There are other tools that specifically assess body dissatisfaction or body dysmorphia that may be used by an ED specialist upon referral. The EC-Satter tool identifies individuals with low eating competence and can identify ED risk in an athlete who has high nutritional needs but is not competent in feeding self-care. Finally, the Clinical Assessment Tool put forth by the RED-S model (REDS-CAT) is designed for use with athletes identified by other screening tools as being at increased risk for eating disorders.

Referral

A strong referral network of providers on campus (as in the Student Health Center if not in Athletics) and in the local community who have expertise in treating eating disorders and in working with athletes is essential for every college athletics department to establish. Behavioral health programs inside college health services may or may not employ a dietitian. Many are set up simply to conduct mental health assessments and triage care to outside providers. Campus counselors and dietitians may or may not have eating disorder expertise and most cannot provide the duration of treatment required to appropriately break the cycle of disordered eating or treat an entrenched eating disorder.

Eating Disorders in Collegiate Sport (cont.)

In the absence of a complete team of ED experts on campus or inside athletics, outpatient providers in the community will be providing treatment to any athlete identified at high risk or with an ED diagnosis. The outpatient treatment team includes, at a minimum, a licensed mental health professional and a registered dietitian/nutritionist (RDN). Additional collaborators in the referral network might include pediatricians or internal/family/sports medicine physicians with ED expertise, and certified strength and conditioning coaches or fitness professionals who are trained in working with ED clients. Some yoga instructors and personal fitness trainers work on mind-body connections with clients healing from eating disorders and body image issues. If an athlete needs a higher level of care than can safely be provided on campus or by an outpatient provider, an eating disorder treatment program that offers residential treatment, partial hospitalization programs (PHP) or intensive outpatient programs (IOP) is required. Level of care is determined by the degree of medical instability and is best determined by the team physician or a licensed mental health professional who evaluates vital signs (heart rate, pulse, blood pressure) along with physical, behavioral and emotional signs and symptoms of the disorder.

Treatment
Treatment frequency and duration are dictated by the level of care required to address the acuity of the athlete's physical and emotional state. These decisions are made by the physician overseeing the case, in cooperation with the mental health professional assisting with the diagnosis. Depending on the athlete's clinical health indicators, behavioral patterns, level of care required, and compliance with the treatment plan, the athlete may or may not be allowed to train or compete during ED treatment. It is absolutely essential that the treatment plan and recommendations be endorsed by all members of the treatment team to send a unified message to the athlete about expectations and return-to-play criteria. For this reason, effective communication between team members and outside providers is critical.

Collegiate athletes may or may not want their parents, or their coaches, involved or even aware of the diagnosis and treatment plan. As such, protecting privacy and confidentiality is essential unless the situation is life-threatening. There are many barriers to treatment for athletes, including stigma surrounding mental health conditions in general and eating disorders in particular. Working to break down stigma and make treatment providers accessible will increase the likelihood of an athlete complying with referrals and appointments. The treatment contract helps with this, along with on-campus providers who are inside the athlete's circle of trust.

The case manager on the athletics Eating Concerns Team coordinates communication with the various off-campus providers and follows the athlete's progress in treatment. The RED-S model provides a set of guidelines for Return-to-Play that are used in conjunction with treatment compliance to determine when the athlete can safely resume training and competition. An athlete on scholarship who needs to take a break from training and competition should be eligible for a medical red-shirt. Eating disorders are mental health conditions and, as such, student-athletes should be supported by the Office of Disability Services on campus to help them negotiate their needs and their rights with regards to athletics and academics. A reduced course load and/or an academic leave of absence may be necessary for the student to engage in a higher level of care or for a longer duration of care.

Eating Disorders in Collegiate Sport (cont.)

Approaching a Student-Athlete about an Eating Disorder Concern
Athletes are at increased risk for eating disorders. No sport, position or individual is immune to the risks. The transitional life stage of the collegiate athlete further increases risk. A comprehensive, ongoing, pro-active eating disorders response plan across the entire athletics department will need to address policies, protocols, coach education, documented action plans and accountability. This is necessary to help avoid stereotypes, stigma and bias in practices related to prevention, screening, identification and intervention efforts. A multidisciplinary team approach built on direct communication and proper evaluation of athletes displaying risk is required to achieve early intervention and the best possible outcomes in terms of physical health, emotional well-being, academic success and performance in sport.

- **Know the signs and symptoms of an eating disorder.** Have objective data and personal observations that align with those warning signs documented for your discussion. Do not act on hearsay or second-hand information that could be false or inaccurate.
- **Discuss your concerns with the Athletic Trainer** who can provide validation, ask insightful questions for clarification, share additional observations, provide clinical input, and help you decide who on the Eating Concerns Team should have this difficult conversation with the athlete. The power dynamic between the head coach and the athlete may necessitate that an assistant coach or an AT be the one to speak with the athlete.
- **Set up a private meeting** with the athlete to discuss your concerns. Do not have this conversation in public, during a heated moment (like when an athlete has a bad race or suffers an injury) or without some purposeful advance preparation.
- **Establish rapport** by asking the athlete how he/she is doing and how things are going. This opens the floor for the athlete to confide in you, but don't be surprised if they don't. You may get *"just fine!"* in response. It is unlikely that they will open up willingly, even if they are struggling and want help. Athletes fear the consequences of such disclosure.
- **Start by expressing your concern for the athlete.** Then tell them what you've observed. Stick to the facts; things like, *"I noticed you sat alone and didn't eat anything at team dinner last night. What's going on?"* or *"You looked really fatigued at practice this afternoon, and your energy level seems low. Is there something bringing you down?"*
- **Expect short and dismissive answers.** Expect resistance. Anticipate that the athlete is afraid to say too much, so be as neutral and non-judgmental as possible. You don't even have to use the words "eating disorder" in this conversation. In fact, you probably want to avoid this terminology. If the athlete uses that phrase, posing a question (*"Are you asking me if I have an eating disorder?"*) or in a statement of denial (*"I don't have an eating disorder, if that's what you think!"*), tell them, *"I do not have all the information needed to determine that. I am just telling you what I've observed and that I am concerned. It is my job to connect you to help, and I can only help if I know what you are going through."*

Eating Disorders in Collegiate Sport (cont.)

- **Try to "normalize" the situation yet firmly show your concern.** Avoid blaming the athlete by saying things like, "Athletes who train as hard as you do in sport sometimes need help to be sure they are taking the best care of themselves and are getting enough nutrition. I'm concerned that maybe you're not giving your body what it needs. Would you be open to talking to someone about it?" Or in the case of an injured athlete, "I'm concerned that you're not getting proper nutrition to heal from your surgery." Or for the athlete who is compulsively over-exercising, "I am concerned that you are not taking rest days and are over-training."
- **Avoid piling on second-hand information** that will feel like accusations or could cause the athlete to feel ganged up on, as if everyone is talking about him/her and "everyone knows." This approach could increase social isolation, increase despair and also lead to resistance in coming forward to ask for (or accept) help.
- **Play on the fact that the athlete trusts you.** If you tell them that in your opinion you believe this other professional could help them be the best athlete they can be, they will most likely take your advice and act on your referral. Remind the athlete that you believe in them and in their potential to be a great contributor to your team. Make sure you acknowledge how much you value them as an athlete and care about them as an individual. Tell them that you are as invested in their health and wellness as you are in their athletic performance. These are very important points to communicate! Tell them that you understand what they are up against and that you want to help. Remind them of their strength, courage, and ability to face adversity – these are the qualities of a great athlete, and the qualities required to accept help when needed.
- **Make the referral to a qualified professional with training in sports and eating disorders.** The Athletic Trainer (AT) or sports medicine doctor can do a more thorough assessment of the situation and can collect additional clinical data. The case manager on your team can determine what appropriate next steps should be taken and can make referrals to on-campus healthcare practitioners or off-campus community providers.
- **Conclude the meeting by making a plan to follow up.** Restate your concern for the athlete and your commitment to being a source of support for them. Plan to follow up in a couple of days (be specific) to set the expectation that you are holding them accountable to follow through and report back to you on the agreed-upon action plan.
- **Remain open, supportive, positive, and confidential** in your ongoing interactions with the athlete while he/she works with qualified professionals who will manage their needs.

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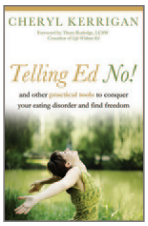
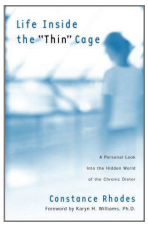
Associate Professor and Chair, Department of Health Sciences, Programs in Nutrition, Boston University

Recommended Reading

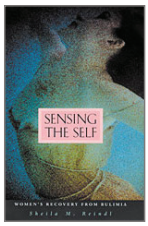
FOR STUDENTS



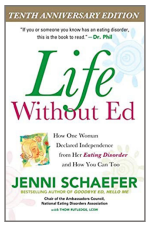
Telling Ed No! And Other Practical Tools to Conquer Your Eating Disorder and Find Freedom (Cheryl Kerrigan)



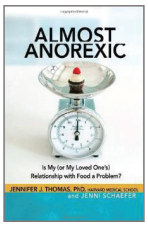
Life Inside the "Thin" Cage (Constance Rhodes)



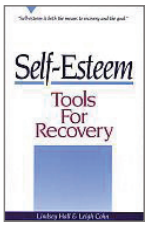
Sensing the Self: Women's Recovery from Bulimia (Sheila Reindl)



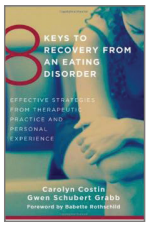
Life Without Ed: How One Woman Declared Independence from Her Eating Disorder and How You Can Too (Jenni Schaefer with Thom Rutledge)



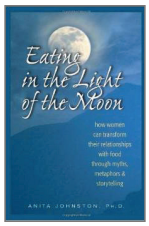
Almost Anorexic: Is My (Or My Loved One's) Relationship with Food a Problem (The Almost Effect) (Jennifer Thomas & Jenni Schaefer)



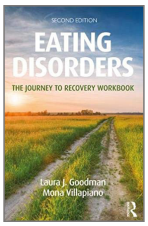
Self-Esteem: Tools for Recovery (Lindsey Hall & Leigh Cohn)



8 Keys to Recovery from an Eating Disorder: Effective Strategies from Therapeutic Practice and Personal Experience (Carolyn Costin)

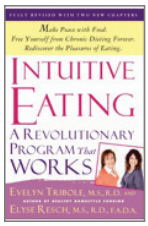


Eating in the Light of the Moon: How Women Can Transform Their Relationships with Food through Myths, Metaphors and ... (Anita Johnston)

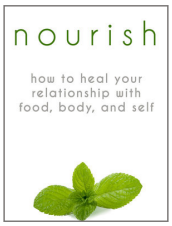


Eating Disorders: The Journey to Recovery Workbook (Laura J. Goodman & Mona Villapiano)

The Ritteroo Journal for Eating Disorders Recovery (Lindsey Hall)

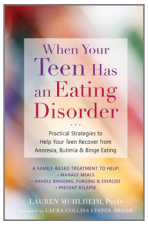


Intuitive Eating: A Recovery Book for the Chronic Dieter (Elyse Resch & Evelyn Tribole)

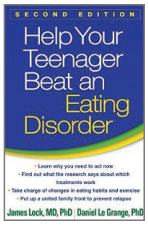


Nourish: how to heal your relationship with food, body, and self (Heidi Schauster)

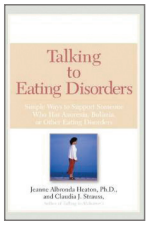
FOR FAMILIES



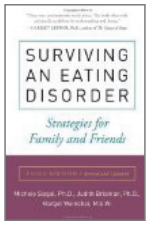
When Your Teen Has an Eating Disorder (Lauren Muhlheim)



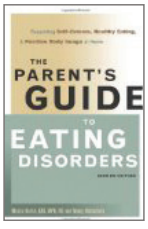
Help Your Teenager Beat an Eating Disorder (James Lock & Daniel LeGrange)



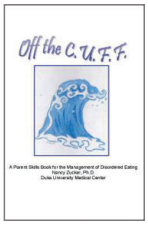
Talking to Eating Disorders: Simple Ways to Support Someone with Anorexia, Bulimia, ... (Jeanne Albronda Heaton & Claudia J. Strauss)



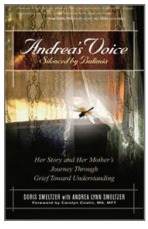
Surviving an Eating Disorder: New Perspectives and Strategies for Family and Friends (Michelle Siegel, Judith Brisman & Margot Weinshel)



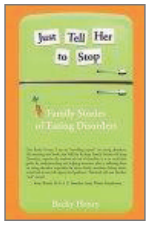
The Parent's Guide to Eating Disorders (Marcia Herrin & Nancy Matsumoto)



Off the C.U.F.F.: A Parents Skills Book for the Management of Disordered Eating (Nancy Zucker)



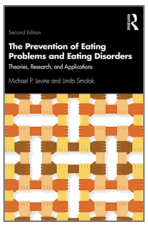
Andrea's Voice...Silenced by Bulimia (Doris Smeltzer with Andrea Lynn Smeltzer)



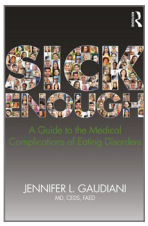
Just Tell Her to Stop: Family Stories of Eating Disorders (Becky Henry)

Recommended Reading

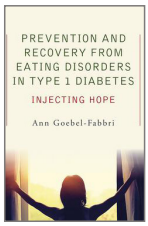
FOR PROFESSIONALS



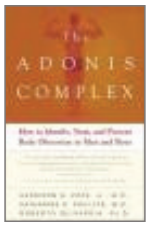
Prevention of Eating Problems and Eating Disorders (Michael Levine & Linda Smolak)



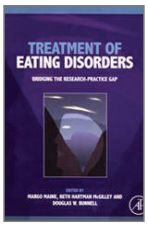
Sick Enough: A Guide to the Medical Complications of Eating Disorders (Jennifer L. Gaudiani)



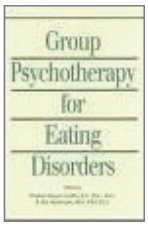
Prevention and Recovery from Eating Disorders in Type 1 Diabetes (Ann Goebel-Fabbri)



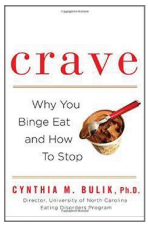
The Adonis Complex: How to Identify, Treat, and Prevent Body Obsession in Men and Boys (Harrison Pope, Katharine Phillips & Roberto Olivardia)



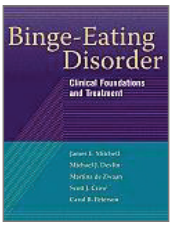
Treatment of Eating Disorders (Margo Maine & Beth Hartman McGilley)



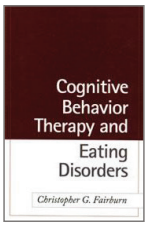
Group Psychotherapy for Eating Disorders (Heather Harper-Giuffre)



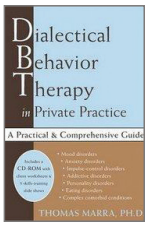
Crave: Why You Binge Eat and How to Stop (Cynthia Bulik)



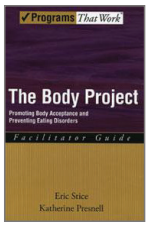
Binge-Eating Disorder: Clinical Foundations and Treatment (James Mitchell & Carol Peterson)



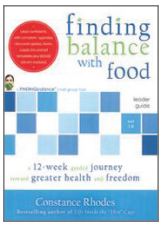
Cognitive Behavioral Therapy and Eating Disorders (Christopher Fairburn)



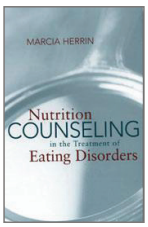
Dialectical Behavior Therapy in Private Practice (Thomas Marra)



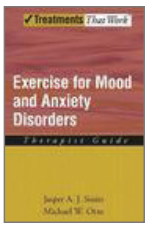
The Body Project: Facilitator's Guide (Eric Stice & Katherine Presnell)



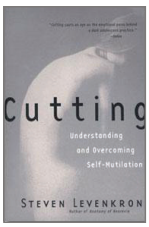
Finding Balance with Food: Leader Guide & CD (Constance Rhodes)



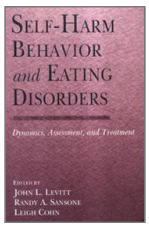
Nutrition Counseling in the Treatment of Eating Disorders (Marcia Herrin & Maria Larkin)



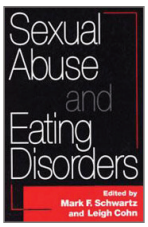
Exercise for Mood and Anxiety Disorders (Michael Otto & A.J. Smitts)



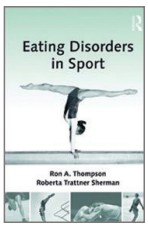
Cutting: Understanding and Overcoming Self-Mutilation (Steven Levenkron)



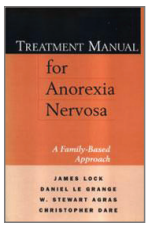
Self-Harm Behavior and Eating Disorders (John Levitt & Randy Sansone)



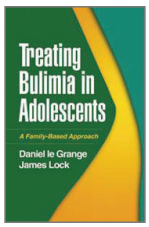
Sexual Abuse and Eating Disorders (Mark Schwartz & Leigh Cohn)



Eating Disorders in Sport (Ron Thompson & Roberta Sherman)



Treatment Manual for Anorexia Nervosa: A Family-Based Approach (James Lock, Daniel LeGrange, W. Stewart Agras & Christopher Dare)



Treating Bulimia in Adolescents: A Family-Based Approach (Daniel LeGrange & James Lock)

EATING Recovery CENTER Foundation

Eating Disorders Information Gateway

Online Eating Disorder Research At Your Fingertips

Expand your knowledge. Visit the Gateway today.
www.EatingRecoveryCenter.com/EDIG

A database designed to advance knowledge and awareness of eating disorders, their treatment and relevant research.

Topics indexed:

- All official eating disorder diagnoses, including anorexia, bulimia, EDNOS and binge eating disorder
- Other disordered eating behaviors and syndromes, including night eating, pica and Prader-Willi Syndrome
- Related areas of study, including body image and body dysmorphia, self-esteem, weight-based bullying and Health at Every Size®

Types of resources indexed:

- Articles from medical journals
- Articles from organizations and treatment centers
- Books/Monographs
- Informational handouts
- Policy papers
- Creative works
- Documentaries and other educational videos

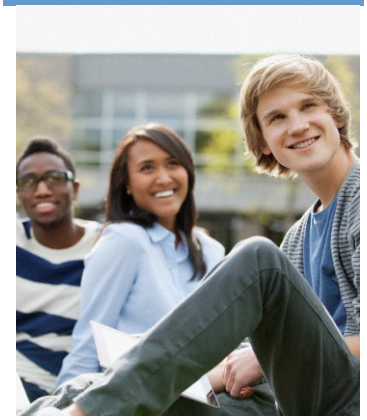
THE HEALTHY MINDS NETWORK (HMN)

FOR RESEARCH ON ADOLESCENT AND YOUNG ADULT MENTAL HEALTH

ABOUT HMN

Based at the University of Michigan School of Public Health, the Healthy Minds Network is dedicated to improving the mental and emotional wellbeing of young people through innovative, multidisciplinary scholarship. HMN addresses the connection between the mental health of adolescents and young adults and their health behaviors, physical health, and social, educational, and economic outcomes. Taking a public health approach, HMN focuses on three main objectives: (1) producing knowledge (***research***), (2) distributing knowledge (***dissemination***), and (3) using knowledge (***practice***). Through its rich array of projects, including its campus mental health survey research, the network serves as a resource for secondary and higher education administrators, researchers, clinicians, policymakers, and the public.

HMN SURVEY RESEARCH



THE HEALTHY MINDS STUDY (HMS)

Annual web-based survey examining mental health and related issues (depression, anxiety, eating disorders) and service utilization among college students. HMS began in 2007 and has been conducted at hundreds of colleges and universities across the country and abroad. Participating campuses can customize the survey by choosing 2 elective modules in addition to the 3 standard modules that all campuses cover (Demographics, Mental Health, and Service Utilization). Based on feedback from campus practitioners and others, elective modules cover a wide array of topics, including eating and body image, sleep, sexual assault, overall health, and student retention.

HMN survey research is available for implementation at all types of higher and post-secondary institutions, including international colleges and universities.

Uses of HMN Survey Data

- Strengthen grant applications
- Advocate for mental health services and programs on campus
- Evaluate programs
- Assess need for programs and services
- Raise awareness of mental health and campus resources
- Make comparisons with peer institutions

www.healthymindsnetwork.org | healthyminds@umich.edu

Body Project

OVERVIEW

The Body Project is a dissonance-based body acceptance program designed to help high school girls and college-age women resist cultural pressures to conform to an appearance ideal standard of female beauty and reduce their pursuit of thinness.

The Body Project, which is run in small groups, is supported by more research than any other body image program.

BACKGROUND

The Body Project Collaborative was formed in 2012 by Drs. Eric Stice and Carolyn Becker to create new training opportunities for people interested in facilitating the Body Project.

Dr. Stice created the Body Project and Dr. Becker pioneered the strategy of training collegiate peer-leaders to facilitate Body Project groups in university settings.

To date, the Body Project has been used by numerous high schools and over 130 college campuses in the US and Canada, and has been implemented in over 10 countries.

Research supports the use of the Body Project not only with those who have elevated body dissatisfaction, but also in more diverse groups of adolescent girls and young women that include those with lower levels of body dissatisfaction.

RESEARCH SUPPORT

Randomized controlled trials conducted by over 10 independent research labs have shown that the Body Project reduces:

- Appearance ideal internalization
- Body dissatisfaction
- Negative mood
- Unhealthy dieting
- Eating disorder symptoms

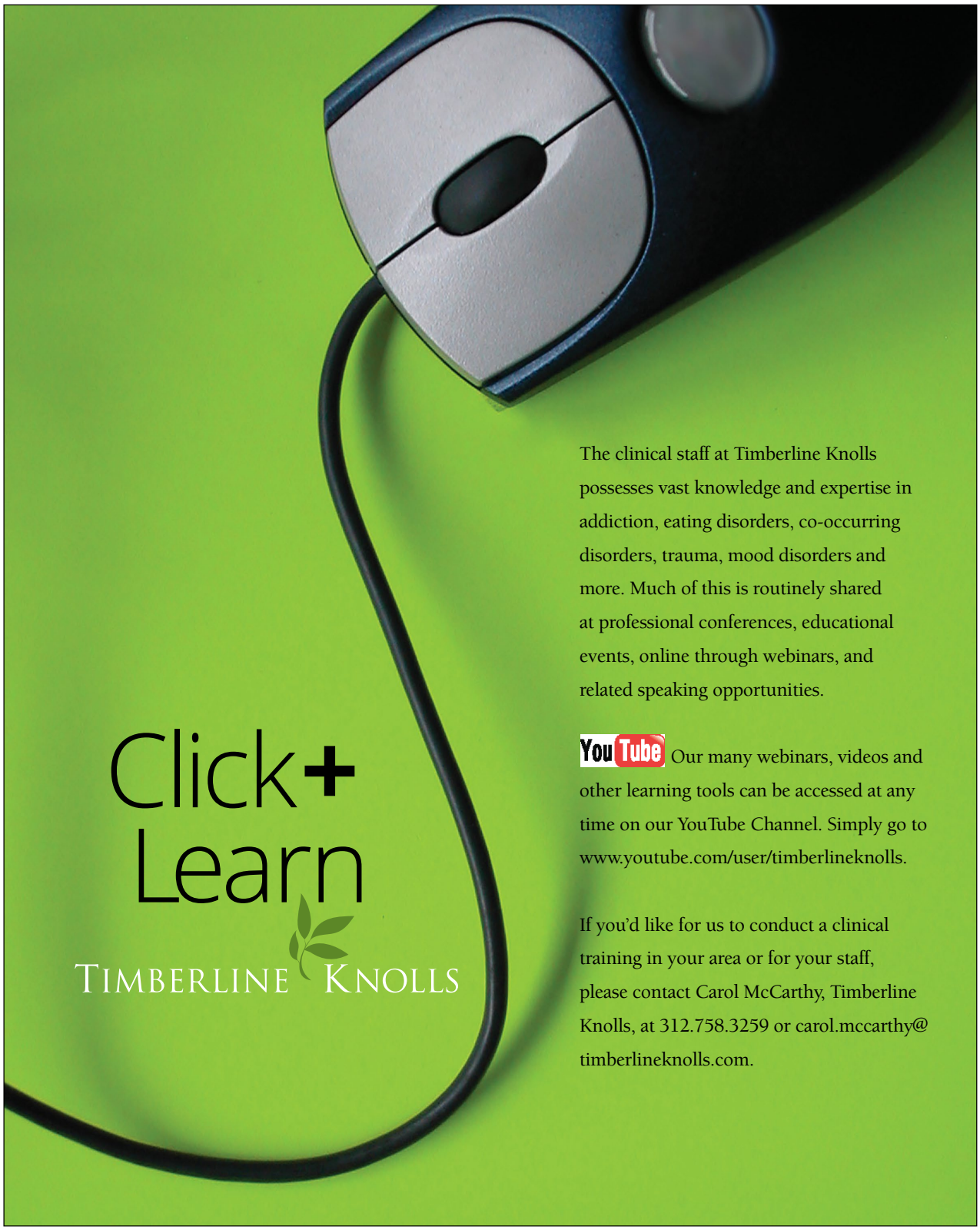
In addition, there is evidence that the Body Project reduces the risk for future onset of obesity, results in improved psychosocial functioning, and reduces mental health care utilization.

Lastly, the Body Project has been found to reduce risk for future onset of eating disorders, which means the Body Project can prevent at least some eating disorders.

VISIT OUR WEBSITE:

www.bodyprojectcollaborative.com

/ BodyProjectCollaborative



The clinical staff at Timberline Knolls possesses vast knowledge and expertise in addiction, eating disorders, co-occurring disorders, trauma, mood disorders and more. Much of this is routinely shared at professional conferences, educational events, online through webinars, and related speaking opportunities.

YouTube Our many webinars, videos and other learning tools can be accessed at any time on our YouTube Channel. Simply go to www.youtube.com/user/timberlineknolls.

If you'd like for us to conduct a clinical training in your area or for your staff, please contact Carol McCarthy, Timberline Knolls, at 312.758.3259 or carol.mccarthy@timberlineknolls.com.

TIMBERLINE KNOLLS RESIDENTIAL TREATMENT CENTER

40 Timberline Drive | Lemont, Illinois 60439 | 877.257.9611 | www.timberlineknolls.com

Timberline Knolls is a residential treatment center located on 43 beautiful acres just outside Chicago, offering a nurturing environment of recovery for women ages 12 and older struggling to overcome eating disorders, substance abuse, mood disorders, trauma and co-occurring disorders. By serving with uncompromising care, relentless compassion and an unconditional joyful spirit, we help our residents help themselves in their recovery.

For more information:

EATING DISORDERS INSTITUTE
CERTIFICATE PROGRAM

Program Director:

Mardie Burckes-Miller, Ed.D. CEDS, CHES, FAED
Certified Eating Disorders Specialist, Fellow,
Academy of Eating Disorders

Phone: (603) 535-2515
Email: margaret@plymouth.edu
Website: plymouth.edu/grad

Program Partner Site:
Remuda Ranch, Wickenburg, Arizona

Plymouth State
UNIVERSITY

PLYMOUTH STATE UNIVERSITY EATING DISORDERS INSTITUTE GRADUATE CERTIFICATE PROGRAM

Welcome to the beginning of an exciting, rewarding career specializing in eating disorders.

The Eating Disorders Institute Graduate Certificate Program at Plymouth State University offers a 15-credit graduate program. Additionally a M.Ed. in Health Education or a Certificate of Advanced Graduate Studies (CAGS) with Educational Leadership, Curriculum and Instruction, and focused electives of the 15-credit Eating Disorders Institute.

Program benefits:

- Provides professionals with research-based tools, techniques and strategies to use in medical treatment, mental health counseling, nutrition counseling or education and outreach work.
- Four 3-credit graduate courses are offered in an intensive two-and-a-half-day residential format with an online component plus a 120 hour capstone experience in eating disorders.
- Meets the needs of health and mental health professionals, dietitians, school professionals and others across the country with an interest in this unique specialization. It is also for those interested in becoming a Certified Eating Disorders Specialist in behavioral health, nutrition, or nursing.

Plymouth State University has the only graduate program in the country offering this innovative Master's program.

PLYMOUTH STATE UNIVERSITY
EATING DISORDERS INSTITUTE GRADUATE CERTIFICATE PROGRAM

Required Courses:

The EDI certificate can be completed in 8 months to one year.

		credits
HL 5151	Eating Disorders Clinical	3
HL 5160	Eating Disorders: Awareness, Prevention, and Education	3
HL 5170	Treatment Modalities for Eating Disorders	3
HL 5180	Nutrition: Education and Counseling	3
HL 5190	Medical and Physiological Aspects of Eating Disorders	3
	Total EDI Certificate:	**15**

Benefits:

- Members of the faculty have 100 years of combined experience in the eating disorders field
- Low residence schedule to accommodate working professionals and out-of-state students
- Capstone personalized in the clinical or education/ outreach area to meet student's interests and needs
- Approved site to offer the core eating disorders curriculum that satisfies the International Association of Eating Disorders Professionals (IAEDP) requirement for future certification

EATING DISORDERS INSTITUTE FACULTY

Mardie Burckes-Miller – Ed. D. CHES, CEDS, FAED
Founder and Director Eating Disorders Awareness, Clinical /Capstone

Kari Anderson – DBH, LCMHC, CEDS
Treatment Modalities

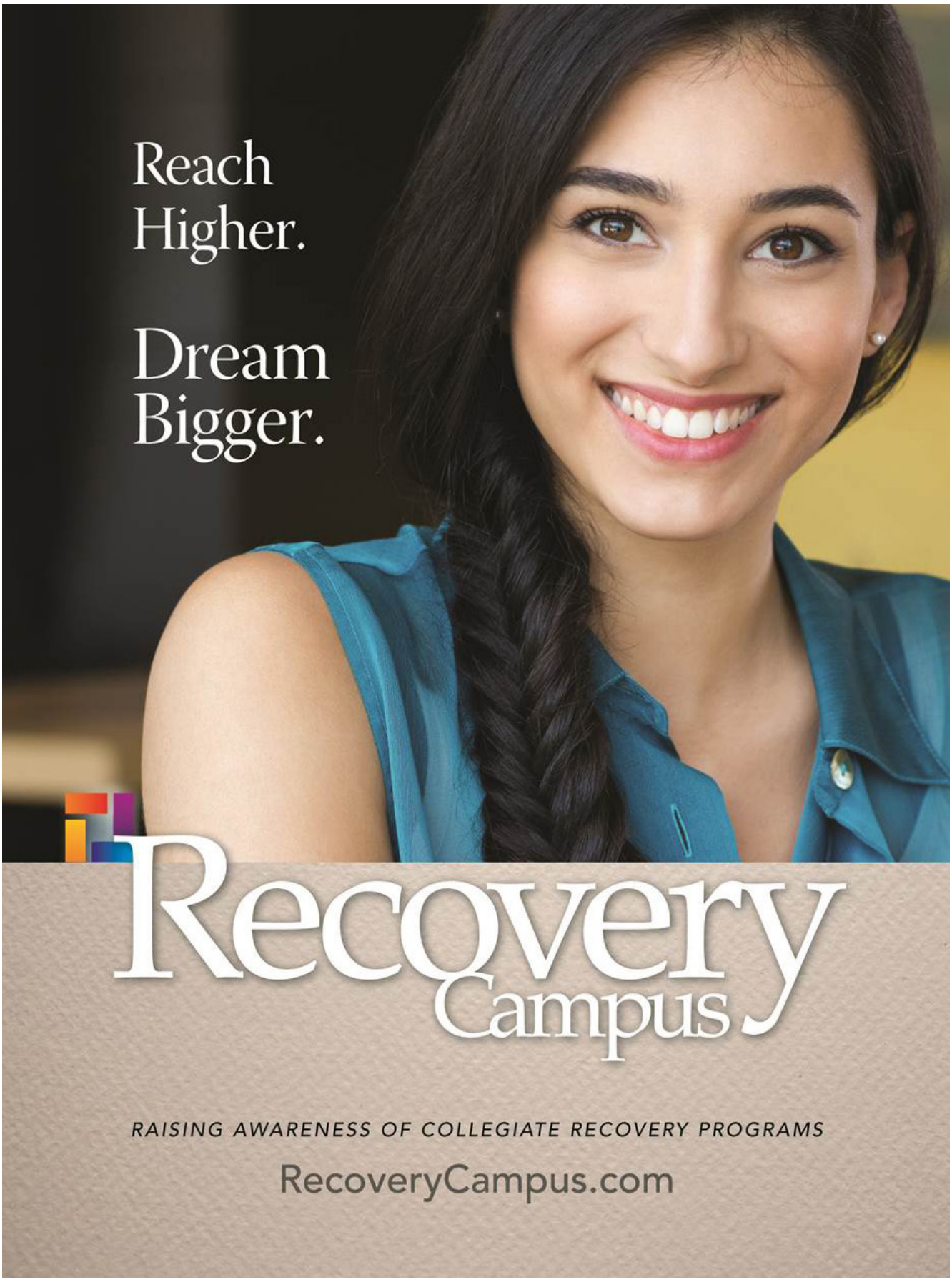
Suzanne Dooley-Hash – MD
Medical Aspects of Eating Disorders

WHAT ARE PEOPLE SAYING ABOUT THE PROGRAM?

Craig Johnson
Chief Science Officer and Director, Family Institute at Eating Recovery Center

"There are very few training opportunities for professionals seeking specialization in the treatment of eating disorders. The Eating Disorders Institute (EDI) offers a unique, multidisciplinary training program. I hope this becomes a model program that other universities will adopt."

Plymouth State UNIVERSITY
Eating Disorders Institute


Reach
Higher.
Dream
Bigger.
Recovery
Campus
RAISING AWARENESS OF COLLEGIATE RECOVERY PROGRAMS
RecoveryCampus.com

INTRODUCING THE

Addiction Treatment Directory

produced by

HynesRecoveryServices
let the healing begin

in partnership with

TIMBERLINE KNOLLS

Finding effective treatment for a student in your care can often be a challenging process. Whether this is the first time a student is seeking help, or an individual with an addiction history, college students often report feeling quite overwhelmed during this time. However, it's important for them to know that many treatment options are available.

To guide university staff in securing treatment for their students, Hynes Recovery Services developed a comprehensive directory of addiction resources throughout the Northeast area. And in those cases where a higher level of care is warranted, this directory also includes information on residential treatment throughout the country.

Timberline Knolls Residential Treatment Center is proud to be the exclusive sponsor of this publication.

VIEW/ DOWNLOAD DIRECTORY

Questions, contact:

Carol McCarthy, MBA, RN
Professional Outreach Representative
Northeast Region
Timberline Knolls
312.758.3259
carol.mccarthy@timberlineknolls.com

TIMBERLINE KNOLLS RESIDENTIAL TREATMENT CENTER

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www.hynesrecovery.com

design by Gates Studio | www.gatestudio.com