GUIDELINES
FOR THE OUTPATIENT MANAGEMENT
OF INDIVIDUALS WITH
EATING DISORDERS IN THE UNIVERSITY SETTING

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INTRODUCTION

Clinicians in both university health services and counseling centers recognize the prevalence of eating disorders among female college students; it is estimated that 5-15% of college age women may have a subclinical or clinical eating disorder, with the majority of these students exhibiting symptoms of bulimia nervosa. While students with relatively uncomplicated eating disorders may be seen on college campuses, many students have chronic, complex eating disorders and have never been treated or are experiencing relapse.

In order to address both the educational and treatment issues related to this prevalent problem on campus, a multidisciplinary team, the Eating Disorders Task Force, was established at Northern Illinois University in 1991. The Task Force is composed of individuals representing various professions and offices which have an interest in the student with an eating disorder; the group has changed membership over the years as interested staff learn of the existence of the Task Force. Membership has included individuals from the following disciplines: psychology, family practice, nutrition, psychiatry, athletic training, exercise physiology, student services (residence hall staff, Greek Affairs advisor, Academic Counseling Program for Student Athletes staff), and physical/health education. The group facilitator of ANAD (National Association of Anorexia Nervosa and Associated Disorders) is also a member.

As part of the coordinating role of this group, one of the Task Force goals was to develop guidelines for the outpatient management of individuals with eating disorders in the university setting. From 1992-1994 some members of the Task Force, along with specialists in eating disorders from outside of Northern Illinois University, developed the guidelines presented here; these were revised in 1998. Some of these guidelines provide systematic approaches and procedures for assessment and psychological treatment, while others evaluate and monitor physical, nutritional, and dental health. Two sets of guidelines refer to specific populations of students, student athletes and students in group living environments. The exercise guidelines provide general parameters for individuals with eating disorders.

The development of these guidelines by professionals from a variety of disciplines clearly indicates the importance of multidisciplinary treatment of those with eating disorders and the implementation of a team approach with these students. No one treatment can stand alone for successful resolution of the behavioral and physical symptoms of eating disorders. Whether the consultants of the team are part of the university or from the community, expertise, consistency, and communication between team members is paramount. When trained and experienced professionals are not available, arrangements should be made for the training and supervision of those involved in providing treatment. Periodic review of cases by the team is essential, with feedback conveyed to consultants who cannot attend staffings. Bimonthly staffings for the treatment team occur to enhance communication among the various caregivers and to serve as consultants to each other in the treatment of these students. The release of information and monitoring form utilized for this staffing are in Appendix A and B respectively.

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EATING DISORDERS: DEFINITIONS

The "central and cardinal feature of the eating disorders is the distorted attitude toward weight, eating and fatness that breeds the characteristic fear of fatness" (Hsu, 1990, p. 12) with attendant extreme practices of weight control. Although diagnostic criteria clearly delineate anorexia nervosa and bulimia nervosa as distinct diagnoses, at various points in their histories, those with eating disorders may alternate symptoms of these disorders. Two subtypes of anorexia nervosa have been identified, restricting and bulimic. Up to 50% of those with anorexia develop symptoms of bulimia. Those who are initially diagnosed with bulimia may develop symptoms of anorexia. This fluidity of symptom formation indicates that it is very important to obtain a careful longitudinal history from the student at the onset of treatment.

Eating disorders occur in a heterogenous population and etiologies or disturbances are possible in the psychological, biological, neurochemical, sociocultural, and familial realms. There appears to be an increased risk in those where body attractiveness (e.g., models) and body performance (e.g., athletes) is emphasized, and those with majors in health and food related services (e.g., nutrition, health education, physical education). Often eating disorders are not recognized in older women, ethnic minority individuals, or males. Predisposing, precipitating, and perpetuating factors are discussed by many authors including Davis and Olmstead.

The DSM-IV diagnostic criteria include some important differentiations not present in DSM-III-R. It should be noted that the diagnosis of one disorder does not necessarily exclude features or criteria of another. Furthermore, disordered eating often occurs on a continuum and the disordered eating of a particular student may not meet all criteria for a specific diagnosis; nonetheless, it should not be assumed that the student does not need treatment or monitoring of medical symptomatology if this is the case. The terms "Eating Disorder, Not Otherwise Specified" or "subclinical" are used interchangeably throughout the guidelines to recognize the existence of individuals that fall along a continuum of disordered eating.

DSM-IV Definitions

ANOREXIA NERVOSA (307.10)

A. Refusal to maintain body weight at or above normal weight for age or height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbances in the way one's body weight or shape is experienced, undue influence of body shape and weight on self evaluation, or denial of the seriousness of concurrent body weight.

D. In post-menarcheal females, amenorrhea, i.e., absence of at least 3 consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormones, e.g., estrogen administration.)

SPECIFY TYPE
Restricting Type
During the episode of Anorexia Nervosa, the person does not regularly engage in binge eating or purging behaviors (i.e., self-induced vomiting or the misuse of laxatives or diuretics).

Binge Eating/Purging Type
During the episode of Anorexia Nervosa, the person engages in binge eating or purging behaviors (i.e., self-induced vomiting or the misuse of laxatives or diuretics).

BULIMIA NERVOSA (307.51)

A. **Recurrent episodes of binge eating.**
An episode of binge eating is characterized by both: 1) Eating in a discrete period of time (e.g., in any two hour period), an amount of food that is definitely larger than most people would eat in a similar period of time (taking into account time since last meal and social context in which eating occurred); and 2) A sense of lack of control over eating during the episodes (e.g., a feeling that one can't stop eating or control what or how much one is eating).

B. Recurrent use of inappropriate compensatory behavior to avoid weight gain, e.g., self-induced vomiting.

C. A minimum average of two episodes of binge eating and inappropriate compensatory behaviors a week for at least 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during an episode of Anorexia Nervosa.

SPECIFY TYPE
Purging Type
These individuals regularly purge after a binge is self-induced vomiting or the abuse of laxatives.

Non-purging Type
These individuals do not engage in self-induced vomiting or laxatives. Some may use compensatory methods of dieting and exercising.

EATING DISORDER NOT OTHERWISE SPECIFIED (307.50)

This category is for disorders of eating that do not meet the criteria for any specific eating disorder. Examples include:

1. All the criteria for Anorexia Nervosa are met except the individual has regular menses.

2. All the criteria for Anorexia Nervosa are met except, despite significant weight loss, the

individual's current weight is in the normal range.

3. All the criteria for Bulimia Nervosa are met except binges occur at a frequency of less than twice a week or a duration of less than 3 months.

4. An individual of NBW engages in inappropriate compensatory behavior after eating small amounts of food (e.g., self-induced vomiting after the consumption of 2 cookies).

5. An individual who repeatedly chews and spits, but does not swallow, large amounts of food.

6. Binge eating disorder:
   Recurrent episodes of binge eating in the absence of inappropriate compensatory behaviors characteristics of Bulimia Nervosa (see Appendix for proposed criteria).

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PSYCHOLOGICAL TREATMENT GUIDELINES

Since the psychological treatment of anorexia nervosa and bulimia nervosa is a very complex subject and is tailored to the individual student, the purpose of this section is to present some very general considerations for treatment and is in no way to be considered exhaustive. The Selected Readings Regarding Eating Disorders and Psychological Treatment lists publications containing detailed information about treatment methods and issues with which practitioners should be familiar.

Due to the biological and psychological sequelae of malnutrition that may perpetuate eating disorders and that may lead to serious medical complications, the severely undernourished or underweight student will often need to have her/his weight restored and nutrition rehabilitated in an inpatient setting before outpatient psychotherapy can be effective. Assuming, however, that outpatient psychological treatment has been determined to be the appropriate treatment option by the multidisciplinary team, the emphasis of treatment at any given point will be dependent on the individual being treated. Some students that seek treatment on campus may have been hospitalized or treated in an outpatient setting elsewhere, while others have never sought treatment. Others may have a great deal of knowledge about the symptoms, dynamics, etc. of eating disorders because of readings or psychoeducational treatment, but have not been able to apply these concepts to themselves. Others may be free of symptoms for varying lengths of time. Since these differences will affect the appropriateness of different treatment types and their sequencing, decisions must be made as to what interventions will be most useful for the particular individual.

In addition to resolution of a central dynamic formulation and multi-modal treatment, Andersen (1990) suggests that a sequence of methods meeting client needs is one of the basis of effective psychotherapy. Specifically, his sequence includes supportive and educational psychotherapy, cognitive-behavioral work, psychodynamic therapy, and existential therapy. In general, interpersonal or psychodynamically oriented psychotherapies are utilized by many therapists once symptoms are under control. The educational component will often persist through treatment but is especially crucial early on so that the student can begin to understand her eating disorder and the reason for multidisciplinary treatment. In addition, the cognitive work needed to address the dualistic thinking of the individual with an eating disorder cannot be underestimated and will need to be addressed throughout the course of treatment as this type of thinking is applied by the student to different experiences.

This sequence proposed by Andersen can be used to accomplish the goals of treatment: restoration of healthy eating patterns; restoration of weight; amelioration of dysfunctional thoughts, feelings, and beliefs in order to produce positive feelings and effective and healthy behaviors; promotion of the understanding of the connections between predisposing, precipitating, and perpetuating factors (see Harper-Giuffre & MacKenzie, 1992); treatment of deficits in self concept; improvement of body image disturbances; prevention of relapse; and improvement in associated psychological, family, and social difficulties.

In terms of treatment modalities, much has been written about the effectiveness and efficacy of group therapy, whether psychoeducational, cognitive behavioral, or insight oriented. College age students seem to be especially appropriate for and to respond well to group psychotherapy. While

the engagement of the family in treatment is cited as an important therapeutic goal by many therapists and in the APA's guidelines, this is especially difficult in the university setting. Nonetheless, at least one session with the family, if geographic location permits, is very useful in helping parents understand what their child is experiencing, especially when hospitalization is required.

Support groups, such as those sponsored by the National Association of Anorexia Nervosa and Associated Disorders (1-847-831-343) can be a very useful adjunct to psychotherapy. According to the American Psychiatric Association's guidelines (1992), 12 step programs may also be useful as an adjunct to treatment, but are not recommended as the sole, initial treatment approach. Because of the great variation that occurs in different chapters of a program such as Overeaters Anonymous and individual differences among those with eating disorders, the therapist should monitor involvement in these programs even when used as adjunctive therapy.

It is important that a psychiatrist evaluate the appropriateness of psychotropic medication for individuals with eating disorders. The potential of a comorbid psychiatric disorder such as mood, anxiety (obsessive compulsive, social phobia, panic), impulse or substance abuse disorder is high.

In no case should medications be used routinely or as the sole or primary treatment modality. Many factors specific to the individual must be taken into account when considering the appropriateness and choice of medication. Not only will there be preference for the drug of choice related to symptoms but issues regarding safest choice, interaction with other medication, efficacy, tolerability, compliance and responsiveness must be considered.

Certainly working with students with eating disorders is a challenge. Persistence and consistency in treatment, as well as ongoing communication with other caregivers is crucial. A balance between symptom reduction and interpersonal and intrapersonal growth will be achieved in successful, comprehensive psychological treatment.

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MEDICAL GUIDELINES

The physician/nurse practitioner/physicians assistant who treats college-age students is likely to encounter an individual with an eating disorder. Sometimes these students will identify themselves; at other times they will be referred by a nutritionist, therapist, trainer, or other health care professional. Often, however, students with eating disorders are likely to present with symptoms that trigger investigative and therapeutic modalities that may be expensive and inappropriate because the possibility of an eating disorder has not been identified by the student or explored by the physician. For example, individuals with such disorders may present to a university medical clinic with complaints of syncope, dizziness, nonspecific fatigue, chest pain, palpitations, or abdominal pain. Some may ask specifically for laboratory evaluation because they are unable to lose or maintain weight loss. They may want thyroid medicine or appetite suppressants or vitamins. In the gynecological setting, these students may have amenorrhea or dysfunctional uterine bleeding; they may request diuretics for premenstrual bloating or request a different contraceptive because of an unacceptable five pound weight gain. In the sports medicine or injury clinics, these students may present with stress fractures, slow rehabilitation from musculoskeletal problems, fatigue, or diminished sport performance. Other students will present repeatedly in a variety of clinics with a variety of symptoms.

With busy student schedules, it may seem too time consuming for physicians to inquire about psychological status, nutrition practices, or weight perceptions with such students. Physicians may also feel that they are not qualified or not justified as non-psychiatrists in asking questions that might reveal an eating disorder. Not to do so, however, in situations where the complaints, concerns, physical or laboratory findings are suspicious, will result in higher utilization of medical services in general. Eating disorders need appropriate treatment as they are conditions where morbidity and even mortality is documented.

These medical guidelines are intended for a physician who provides assessment or general medical care for a university student with a known or suspected eating disorder. Once a specific medical problem or concern is identified, care would be rendered as appropriate for the situation. These guidelines emphasize a format for consistent and pertinent history, and physical and laboratory evaluation for initial and follow-up medical assessment. Current treatment issues (i.e., how to increase bone density, how to wean off laxatives, when and how to pharmacologically manage cardiac conditions or gastric emptying problems, how to manage the diabetic who uses insulin as a weight control method) are beyond the intentions and scope of these guidelines. The listed references, as well as other existing references and evolving publications dealing with the medical management of eating disorders, are suggested resources for these concerns.

The student with an eating disorder can be challenging and frustrating, as the physician may encounter denial and destructive health behaviors. In spite of evidence of disordered functioning, laboratory values are usually normal. Thus, the student, the family, the insurance company, and even the physician can be lulled into believing that the student is not at medical risk. This can make the acceptance of and compliance with medical interventions extremely difficult. This reality underlies the importance of utilizing a team approach in the treatment of students with eating disorders since a variety of professionals will be working towards the same treatment goals.

The following guidelines outline subjective and objective medical information to be collected from the student during both initial and follow-up visits. Bold print is utilized to indicate key charting notations. Initial and follow-up assessment and plans are outlined. A flow chart designates decision points in the treatment of students with eating disorders.

SUBJECTIVE

1. Initial visit

HISTORY OF PRESENT ILLNESS

Duration
Age of onset
Any precipitating factor(s)
Weight history

- **Present**
- **Highest/date**
- **Lowest/date**
- **Desired weight**
- **Weight fears going over**
- **Perception of current appearance**
- Weight at last period
- Weight changes in the last six months/one month/any major fluctuations

History of Obesity or Eating Disorder

- Childhood
- Adolescence
- Adult

Diet Behaviors

- Current: number of meals per day; amount of food; kinds of food
- Other ongoing or past diet, whether by self or physician-monitored
- Kind, i.e., low calorie, high protein
- Weight lost
- Duration maintained
- Support program (Weight Watchers, O/A, etc.)
- Food replacement program (kind, date, result)

Purging Behaviors:

Note onset, frequency and complications of following

- None
- Vomiting
- Using Laxatives
- Using Ipecac
- Using stimulants
- Chewing & spitting
- Taking diet pills
- Taking diuretics
- Taking thyroid pills
- Exercising (type of & time spent)
- Chewing gum with sorbitol
- Taking caffeine pills/consuming caffeine

Bingeing Behaviors

- _ None
- _ How student defines binge
- _ Total calories
- _ Dollars spent
- _ Onset
- _ Frequency
- _ Complications
- _ Feelings physically/emotionally post-binge

Restricting Behaviors

- _ None or unable
- _ Total calories
- _ Vegetarian (what type)
- _ Restrictive foods and/or fluids
- _ Total avoidance foods

Other Behaviors

_ Sauna use for weight loss, unusual food combinations, etc.

Past treatment

- _ Inpatient
- _ Outpatient
- _ Physician
- _ Counselor
- _ Nutritionist
- _ Self-help or support

HABITS

- _ Smoking
- _ Drugs
- _ Alcohol
- _ Caffeine

MEDICATIONS

_ Currently prescribed or over-the-counter drugs

ALLERGIES

SURGERIES/HOSPITALIZATIONS

SOCIAL HISTORY

FAMILY HISTORY

Eating disorder

Obesity

Major health problems

- _ Diabetes
- _ Heart disease
- _ Cancer
- _ Stroke
- _ Others

Psychiatric problems

Substance Abuse

REVIEW OF SYSTEMS ("positive" responses listed for Eating Disorders**)**

General	**Weakness**, fatigue, excess energy, coldness
HEENT	Sore throat, swollen or tender glands, cavities, sore tongue, irritated gums, sensitive teeth, headache, dizziness
Skin	Hair brittleness or loss, dry skin, bruising, yellowish cast, increase in fine hair growth on face or arms, increase in darkness of existing body hair
CV/RESP	**Chest pain, palpitations, shortness of breath with exertion, fainting, fainting or lightheadedness or weakness with exertion, swelling of ankles or hands, cough**

GI	**Vomiting, hematemesis, epigastric pain, diarrhea, constipation, melena**, impaired taste, nausea, esophageal or epigastric burning, generalized abdominal pain, bloating, postprandial discomfort, alternating constipation and diarrhea (i.e., irritable bowel), cramping, hunger
Ortho	**Bone pain**, history of fractures
Neuro	**Cramping, numbness of extremities**, muscle weakness, loss of muscle mass, tetany, carpopedal spasms
Psych or Cognitive	**Decreased concentration, memory problems, mood swings, preoccupation with food, weight or body shape, fear of fatness, lack of control over eating behavior, suicidal thinking or hopelessness**, uneasiness with body experience, guilt, shame, irritability, indecisiveness, obsessive thinking, anxiety and fear of loss of control, inability to function at work or school or social activities, impaired inability to experience joy or interest in life, desire or history of hurting oneself (mutilation behavior), denial of problems, fear of or excessive sex, fear of particular people.
GU	**LMP, excessive or infrequent menses, amenorrhea, history of amenorrhea, infertility**, frequent urination, excessive thirst, regression of breast size, dysmenorrhea, pregnancies and live birth complications, abortions, sexually transmitted diseases, increased or decreased libido, sexual abuse, past or present use of contraceptives or hormones, other sexual problems.

2. **Follow-up visit**

   a. **Status of previous symptoms**
   b. **New symptoms**

OBJECTIVE ("positives" listed for Eating Disorders**)**

1. **Initial visit**

Weight	post-voiding and in gown (water weight gain, concealing weights on body)
BP	supine, sitting, standing (orthostatic hypotension)
Pulse	(bradycardia/tachycardia/irregularity)
Temperature	(hypothermia)
Respirations	(tachypnea)

GENERAL APPEARANCE

State of hydration	(dehydrated)
State of nutrition	note if emaciated, low body weight, normal weight, above normal**,** obesity, severe obesity

GENERAL MENTAL STATUS

(Disorientation, confusion, memory impairment)

HEENT

(Lens opacification, enamel erosion, cavities, periodontal disease, parotid/salivary/submandibular gland swelling)

SKIN

(Brittle or hair loss; dry skin; yellowish cast of skin from hypercarotinemia; callus on back of hand; lanugo; ecchymosis; petechiae)

CV/RESP

(Bradycardia, tachycardia, irregular rhythms, mid-systolic click/murmur, rubs, rales, pitting edema, cool cyanotic extremities)

NEURO

(Focal neuro findings)

GI

(Abdominal tenderness, masses, hypo/hyper bowel sounds, stool palpable)

GU

(Amenorrhea, irregular menses, possible concealment of weights in rectum or vagina)

ORTHO and MUSCULOSKELETAL

(Muscle weakness, decreased muscle mass, bone pain, fracture)

PSYCHIATRIC

(Suicidal ideation, depressed, anxious, evidence of self-mutilation)

2. **Follow-up visit**

   a. **Vitals**
   b. **Exam according to status of previous or new symptoms**

LABS

1. **Initial visit**

CBC (anemia, leukopenia, lymphocytosis, atypical lymphocytes, thrombocytopenia, bone marrow suppression from laxatives), electrolytes, including magnesium, calcium, phosphorous, BUN and creatinine (decreased potassium or borderline normal, decreased magnesium, increased phosphorous [with purging], decreased phosphorous (with starvation/refeeding), chem profile (liver function tests usually normal; amylase can be elevated with purging; cholesterol may be increased, not due to normal hyperlipidemia--treatment or restriction of fats not necessary), thyroid (decreased free T_4, decreased T_3, increased reverse T_3, normal TSH)

For anorexia or bulimia with severe restrictive behavior: same labs plus cortisol (elevated cortisol).

If amenorrhea or irregular menses: prolactin, serum pregnancy (if appropriate) in addition to above. May do estradiol (decreased), FSH and LH (both decreased).

Stool for analysis if suspect inflammatory bowel or parasitic disease or if history of blood in stool. Stool for phenolphthalein if suspect laxative abuse.

Amylase may be ordered for work-up of abdominal pain.

Other tests:

Flat plate of abdomen if suspect gastric dilatation.
CT or MRI if focal neurological symptoms or change in mental status.
Bone scan if suspect stress fracture if pain not responding or fracture not evident on plain radiograph.
Bone densitometry – is advisable if amenorrhea > 6 months, or as baseline (especially if past history of anorexia nervosa).
ECHO and/or Holter – for known or suspected ipecac abuse, mitral valve prolapse, EKG's with equivocal or intermittent findings of ischemia or prolonged QT or arrhythmias, atypical chest pain or other symptoms deemed necessary for such evaluation.

2. Follow-up visits

According to status of symptoms, physical exam and previous labs or tests.

ASSESSMENT

Anorexia Nervosa (307.10), DSM-IV criteria, Restricting Type
Anorexia Nervosa (307.10), DSM-IV criteria, Binge Eating/Purging Type
Bulimia Nervosa (307.51), DSM-IV criteria, Purging Type
Bulimia Nervosa (307.51), DSM-IV criteria, Non-Purging Type
Eating Disorder Not Otherwise Specified (307.50), DSM-IV criteria
Apparent eating disorder, specific diagnosis deferred
Specific symptoms, etiology unclear

Differential diagnosis of weight loss:

a. Involuntary with increased appetite:
   Diabetes, thyrotoxicosis, pheochromocytoma, malabsorption, intestinal parasites, exercise, lack of food, diencephalic tumors.

b. Involuntary with decreased appetite:
   Depression, malignancies, Addison's disease, hypercalcemia, systemic illness, pain, gastrointestinal disease, dementia, substance abuse, iatrogenic (i.e. side effects of drugs)

PLAN: INITIAL AND FOLLOW-UP

1. Establish therapeutic alliance and rapport.

2. Assess, treat and/or refer for any nutritional or medical emergencies identified.

A. Make decisions regarding need for hospitalization (This will be affected by the health insurance policies of the student.)

   1) Need for assessment and treatment of serious physical and/or metabolic complications.
   2) Need for renourishment (if a student is more than 15% below healthy body weight or has had rapid, significant weight loss, there will be significant physical compromise, even if EKG, labs and exam seem normal).
   3) Inability to control bingeing and purging after at least 3 months of outpatient psychological treatment.
   4) Need for disengagement from interpersonal system maintaining the disorder.

B. Make decisions regarding signs, symptoms or behaviors that can be managed on an outpatient basis.

3. Establish and/or maintain contact with student's therapist and set parameters regarding weight and eating behavior.

4. Establish and/or maintain contact with student's nutritionist and be involved in setting nutritional goals.
5. Formulate and discuss exercise or activity plan.

6. Educate the student as to medical complications of his/her behavior or disorder.

7. Follow-up medical visits are scheduled at the discretion of the physician or health care provider. Compromised students need to be monitored as closely as medically warranted. Denial of symptoms or reluctance to see a medical professional may unduly delay necessary follow-up. It may be helpful to arrange return appointments in advance or to set clear parameters with the student (i.e., weight, eating behavior, physical symptomatology, athletic performance, request by another member of the treatment team) where appointments would be necessary. The advantages of a team approach (utilizing the expertise of the student's therapist, psychiatrist, nutritionist, and other involved professionals) cannot be overemphasized. This approach can facilitate the assessment of medical needs, as well as facilitate the implementation and effectiveness of medical care.

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NUTRITION GUIDELINES

These guidelines are for use by the registered dietitian or the nutritionist for treatment of students in the university setting who are identified with or suspected to have an eating disorder. These guidelines review the procedures for seeing students who use the university's nutritional services. If the nutritional consultation is obtained from a registered dietitian in private or clinical practice, these individuals would operate on a more independent basis than our employees. At Northern Illinois University the health service employs graduate students majoring in dietetics. Some of these students are registered dietitian eligible and may achieve registration status during their employment. In either case, nutrition education and nutrition intervention is integrated into the team treatment of patients with anorexia nervosa, bulimia nervosa, and binge eating.

1. Nutritionists are provided supervision and medical consultation by a physician coordinator of the area with knowledge of medical and nutritional needs of students with eating disorders. Indirect supervision is also provided by a registered dietitian who has additional training and experience in the treatment of eating disorders. The dietitian is available for consultation with nutritionists and directs them toward additional study of eating disorders as needed. At the present time the dietitian is serving only in a consulting capacity. It is hoped that the health service is able to develop this as a part-time position in order to have a dietitian with expertise in eating disorders available to direct graduate students and provide continuity of care.

2. Nutritionists will see students referred from physicians, mid-level practitioners, and other on-campus staff or agencies. Nutritionists will make certain these individuals are being followed medically, preferably by Health Service staff. If non-Health Service staff are providing medical care, a release of information form must be completed and the student informed that her/his medical information will be reviewed by the physician coordinator of the area.

3. If the nutritionist is asked to see a student from outside agency or physician, the nutritionist will consult with the physician coordinator of the area after seeing the student. It is the dual responsibility of the physician coordinator and nutritionist to make certain that medical, and hopefully psychological care, is being provided to the student. The nutritionist will instruct the student to go to medical records to sign appropriate release of information forms; the student will be informed that this information will be reviewed by the physician coordinator of the area. If the student refuses or if care cannot be coordinated, the physician supervisor will make a decision regarding appropriateness of utilization of Health Service nutritionists for that student. The physician will take necessary steps to ensure that the student is properly informed of the Health Service nutritional guidelines and will explain consultative alternatives.

4. The nutritionist will see "self-referrals" under the following circumstances:

    a. If the student self-identifies as having an eating disorder, the nutritionist will, in the initial visit, explain the need for medical evaluation and refer to the Health Service physician before providing or continuing further nutritional counseling.

    b. If the student self-identifies and does not want to see Health Service staff for medical evaluation, the nutritionist will inform the student that she/he can see an outside physician,

sign appropriate release forms, and inform the student that the student's medical records will be reviewed by the physician area coordinator.

c. If the nutritionist strongly suspects the student has a clinical or subclinical eating disorder, but the student denies and is unwilling to have a medical evaluation by Health Service staff, the nutritionist will advise the physician area coordinator who will make decisions regarding student use of the nutritional services. The physician will properly inform the student as in "3" above.

5. If the nutritionist feels a student with an eating disorder is non-compliant or has multiple DKA's or cancellations or is otherwise uncomfortable with the student, the nutritionist will consult with the physician area coordinator.

6. The nutritionists may consult at any time with the physician area coordinator regarding a student and may request a staffing session.

7. The nutritionist will bring to the immediate attention of appropriate medical or psychological Health Service staff if the student seems in dire medical or psychological condition.

8. The nutritionist will keep a log of eating disorder students seen.

9. The initial visit will be completed on the Nutritional Services Patient Information Record (Appendix E). The nutritionists will chart all entries in SOAP format (Subjective, Objective, Assessment, Plan).

10. The nutritionist will manage students with an eating disorder according to guidelines set forth in the next section, using judgment in approaching individual students and their changing needs.

The next section is intended to assist the nutritionist counseling the student with an eating disorder. **Proper nourishment is the essential medical ingredient upon which the potential success of other therapeutic modalities depend.** This information is not inclusive, but will provide some basic tenets for approaching these particular students.

1. Be familiar with nutritional needs of individuals with eating disorders. Maintain and add reference articles in a nutritional file.

2. Review student's chart before appointment.

3. At the first meeting, develop rapport, explaining your expertise and willingness to assist student in her/his recovery.

4. Interview students at the first meeting, using Nutritional Services Patient Information Record (Appendix E).

a. Allow student to tell you in her/his own words reason for visit.

b. Note weight ranges for "Low Weight and Anorexia Nervosa" and "Near-Normal, Normal, and Over-Weight" adapted from tables developed by the Eating Disorders Program, Dept. of Psychiatry, University of Minnesota Hospital and Clinics (See Selected References).

c. In calculation of optimal or desired body weight, use highest weight before diet, adapted weight ranges from tables noted in "b," BMI, weight at onset of menses, family weight history and other available information.

d. When using Basal Energy Expenditure (BEE) to calculate kcal for optimal or desired body weight, remember that kcal level varies with individual (i.e., body weight, body composition) and adjustments may need to be made (activity factors of 1.2-1.3 for sedentary and 1.4 for active are recommended). Remember an anorexic patient may have a lowered BEE due to starvation.

e. Assessments and plan should be formulated at the first visit. Subsequent visits need to be in SOAP format (Appendix F).

5. Calorie levels should not be routinely discussed. Students should be educated using exchange system and exchanges can be modified as per indicated caloric needs.

   Exchange calculations will be based on standard dietary guidelines for carbohydrates, protein and fat, unless otherwise instructed.

ANOREXIA NERVOSA

Estimate the kcal needed for weight gain. Use 1200-1500 kcal as a base level, adding 200-300 kcal slowly to bring student to desired weight level. Restricting anorectics require the most kcal for weight gain; bulimic anorectics, bulimics and those with a history of obesity require less. Do not exceed a total of 3500 kcal a day without medical consultation. Regaining weight may require calories significantly higher in some individuals due to a "hyper-burn" state. Once goal weight is achieved, decrease calories to a maintenance level.

Individuals may have errors in recall or be unwilling to be candid in revealing intake. With anorectics, start with a low fat, low sodium and low dairy products (low lactose) diet and gradually introduce these foods. It is important to note that raw vegetables, often favored by those with anorexia, may be difficult for them to tolerate because of subsequent bloating and gas.

The goal weight range may be somewhat different than the IBW; the goal weight range and exercise level are medical decisions to be made in conjunction with a physician. Discuss the goal weight range with the referring physician if it is not clear or if it varies greatly from the IBW range. In outpatient treatment, weight gain should be about one to two pounds a week. Weight gain that is excessive may indicate water loading, refeeding edema, rebound edema from vomiting or laxative use, or congestive heart failure. Some individuals may even conceal objects in clothes or body to

weigh heavier on the scale. In general, specific questions from the student regarding exercise level should be referred to the physician.

BULIMIA NERVOSA

Concentrate on regulating eating, not over-emphasizing discussion on binge-purge episodes. After eating is normalized, set adjusted kcal level for appropriate weight gain. Do food diary if requested by counselor, physician or if it seems helpful for the student. Remember that students may feel guilt and shame in regards to eating habits and may be in denial; they may not always admit to intake or purging. Individual meal planning may be helpful. Initially avoid target or "unsafe" foods, but gradually introduce these foods into the diet. As with the anorexia nervosa client, the goal weight range may be different from the IBW. Due to possible medical complications, exercise levels should be set in consultation with the attending physician.

BINGE EATING DISORDER

The cautions, goals and treatment approaches for the anorexia or bulimia nervosa patient will apply to the student with binge eating disorder. Even though the severity and intensity of symptoms is decreased, the nutritionist should advise the student to have a medical evaluation (see guideline 4.c.) if binge eating disorder is suspected.

Many persons seeking nutrition counseling for weight loss meet the criteria for binge eating disorder. Thus, students seeking nutritional counseling for weight loss should be reviewed for *Binge Eating Disorder Not Otherwise Specified*. It is important that the nutritionist use caution in developing any weight loss program for a student. Size acceptance, the problems with weight cycling, and set point theory should be discussed with all clients seeking weight loss.

ATHLETES WITH EATING DISORDERS

The intercollegiate athlete with an eating disorder represents a special case of eating disorders unique to the college campus. It has been our experience that establishing credibility is vital for the successful treatment of these students. The nutritionist must show an understanding of the variability in needs related to training routines, sports performance, and on-the-road events.

VITAMINS AND MINERALS

Supplements may give individuals a false sense of security regarding adequacy of nutrition. Many students may be on herbal or performance supplements as well; the dietitian needs to be aware and knowledgeable of this. Dietary sources of zinc, magnesium, calcium and potassium should be emphasized. A low-dose multivitamin supplement is helpful in chronic anorexia. Calcium needs to be at least 1200 mg a day, but should be 1500 mg a day for low weight or non-menstruating women. If supplements are necessary, explain what kind of calciumis appropriate, and the right time to take it for best absorption.

WEIGHT MONITORING

1. Method of monitoring weight may be suggested by physician or counselor.

2. If nutritionist weighs and precise monitoring of weight is essential, ask student to empty bladder, remove shoes and heavy or bulky clothing (which might conceal weights). If possible, it is preferable to weigh in paper gown and underwear, but lightweight clothing may be more feasible in the office.

STUDENT EDUCATION

1. Assess learner needs/readiness for behavior change.

2. Review common dietary myths. Review set-point theory.

3. For anorectics or restricters, review the metabolic and physical affects of starvation. Explain the need for fat in the diet. Review thermogenesis effect, weight distribution in regaining, and common GI complaints when initially refeeding.
4. For bulimics, review inefficiency of calorie loss from vomiting, laxative, diuretic use. Explain the possibility of rebound edema from above. Explain the metabolic response to weight cycling. Consider educating in terms of how to integrate stimulus control.

5. Discuss individual concerns or symptoms. When necessary, refer to information sources for specific complaints or needs.

FINAL POINTS

- Do not comment on student's weight loss or gain in terms of good or bad.

- Be empathetic, not judgmental regarding relapses.

- Do not allow yourself to become student's therapist.

- Do not engage in a battle of wills.

- The spectrum of anorexia and bulimia nervosa tends to be on a continuum; the nutritionist may well see features of both in the same student.

- Frequency of follow-up visits, as well as the format of the specific visits, may be determined by the nutritionist in conjunction with feedback and recommendations from the student's therapist, physician, or other members of the treatment team. In addition to the prescription of appropriate dietary regimens, the nutritionist has an integral role in student education. The role of the nutritionist is particularly challenging, as food fears and preoccupation are at the core of the student's psychological and physical concerns. Nutritional rehabilitation and restoration of normal patterns of eating are critical for medical and psychological improvement and recovery.

- The nutritional guidelines in the university health care setting should follow those established by the American Dietetics Association. The registered dietitian or the nutritionist providing medical nutrition therapy of the eating disordered client should include an education phase followed by an experimental phase which focuses on specific changes in food and weight related behaviors. It is recommended that references to these objectives be used in chart notes to assist in continuity of care between providers.

  Education Phase Objectives

  1. Collect relevant information;
  2. Establish a collaborative relationship with the client;
  3. Educate in terms of food, nutrition, and weight regulation as needed;
  4. Provide examples of normalized eating and food relationships.

  Experimental Phase Objectives

  1. Separate food and weight related behaviors from feelings and psychological issues;
  2. Change food behaviors in an incremental fashion until food intake patterns are normalized.

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EXERCISE GUIDELINES

Exercise plays a major role in the lives of many individuals with eating disorders. Because exercise has psychological benefits (i.e., reduced depression and anxiety, as well as feelings of enhanced control and well-being) and physiological benefits (i.e., improved cardiovascular fitness, improved lipid status and glucose utilization), it is unrealistic and unwise to assume that those with eating disorders will abolish all physical activities.

Currently, there are no formal exercise guidelines for individuals with eating disorders, especially for those undergoing treatment on an outpatient basis in the university setting. Hospitals with cardiac rehabilitation departments can monitor and supervise student exercise. Obviously in dealing with the university student, the clinician cannot control the student's exercise activity as in a closed setting. It is hoped that educating the motivated and therapeutically engaged student to the benefits and risks of exercise for her/his particular situation will have impact on her/his subsequent exercise behavior. It is the purpose of these guidelines to increase awareness of factors involved in formulating and implementing an exercise plan so that the health care professional can guide the student in making informed decisions about how to proceed in this arena. Students competing in intercollegiate athletics generally have conditioning, practice and performance activities that are formulated by the coaches and training staff; this Exercise Guideline does not apply to those students with eating disorders. However as stated in the Athletic Guidelines, decisions regarding participation are still based on the student athlete's medical condition.

Excessive exercise may be a method used in striving toward a more sculpted, "perfect" body; it may be a form of purging behavior to lower body weight. Individuals may look or feel well and may want to embark or continue with physical activities that are too strenuous for them, potentially causing fractures, hemoglobinuria, worsening of soft tissue injuries, or complications that result from exercise stress coupled with a compromised cardiovascular system. Students may also deny fatigue, pain, or other symptoms in order to continue exercising. Thus, in discussing proposed activities with these students, the health care professional must be mindful of individual nutritional status, the energy expenditure required by the exercise, as well as any concomitant physical conditions, such as problems with bone mineral density or cardiac function.

A number of varied abnormalities can coexist with malnutrition or with the methods used to achieve weight loss. For example, there is evidence of a hypothalamic-pituitary-target organ axis. Disruption of the axis, which can occur in those with eating disorders, can lead to medical signs and symptoms of dysfunction in the target organs, i.e., the adrenals, thyroid, and ovaries. Additionally, there can be mineral deficiencies (i.e., hypochloremia, hypokalemia, hyponatremia, hypomagnesia, hypocalcemia, and hypophosphatemia) resulting from eating disorders. These deficient states can cause cardiac arrythmias, muscle weakness, and mental confusion. Of considerable importance is the evidence that there is a compromised cardiovascular system associated with eating disorders.

Most deaths due to medical reasons in individuals with eating disorders are presumed to be cardiovascular in origin. In bulimia, it may be due to arrhythmias. In anorexia, cardiovascular deaths may occur not only in the initial phase of the illness but often during refeeding, secondary to congestive heart failure. Cardiovascular disturbances include bradycardia, hypotension, and EKG abnormalities. Additionally, echocardiographic studies report diminished chamber size and left

ventricular mass in anorexia, presumably due to starvation.

The health care professional should be familiar with the physiological effects of stretching, aerobic, anaerobic, and strength training exercises. If the attending physician believes an exercise protocol would improve secondary symptoms, then the physician monitoring the student's physical health can suggest the implementation of an exercise plan. For individuals who may be taking medications with possible cardiovascular effects, or for those who exhibit signs or symptoms of cardiovascular abnormalities, a consultation with a cardiologist would be appropriate. It is not the intent of these guidelines to recommend a specific approach for a specific student: all exercise prescriptions for those with eating disorders must be made on an individual basis.

This set of guidelines describes four types of exercise programs (stretching, aerobic, anaerobic and strength training), as well as the benefits of each. The guidelines then describe the development, implementation, and evaluation of exercise plans for individual students with eating disorders.

TYPES OF EXERCISE PROGRAMS

The exercise program should not focus on weight loss or caloric expenditure, but rather on maintenance of cardiovascular, muscular, and metabolic fitness. There are four types of exercise programs that will be described here: stretching, aerobic, anaerobic, and strength training.

Stretching

Generally, stretching alone would not be used with a student with an eating disorder who is being treated as an outpatient. However, with certain medical conditions, this may be the only appropriate exercise for the student to do. It is more likely to be used in combination with the other types of exercise described in these guidelines. The physiological effects of a stretching program include preventing weakening of collagen, increasing lubrication of joints, and minimizing the formation of scarring from overuse or inflammation. A slow stretch of the hamstrings or pectoralis muscles held for 15 seconds for 3 sets of 10 repetitions is an example of a stretch.

Aerobic

Aerobic exercise decreases bodyfat and can cause a slight increase in muscle mass. The cardiovascular and respiratory benefits of an aerobic exercise program include: increasing heart size, heart rate, stroke volume, cardiac output, oxygen extraction from circulating blood, and maximal ventilation of the lungs; it can also decrease heart rate and blood pressure. Physiologically all of these changes interrelate to improve the efficiency of the heart by making it a stronger pumping chamber. After an aerobic training program, the heart is able to pump more blood through the peripheral circulation with fewer heartbeats. This adaptation places less stress on the heart. Additionally there is less peripheral resistance which reduces systolic blood pressure.

Metabolically the benefits of an aerobic exercise program include: increasing the size and number of mitochondria, as well as their aerobic capacity to generate energy (ATP); increasing the myoglobin content of muscles; increasing the body's capacity to mobilize and oxidize fat and to oxidize carbohydrates; and improving glucose tolerance through enhanced insulin sensitivity.

Metabolically, these changes make muscle production more efficient so that the muscle is better equipped to produce more energy.

An aerobic exercise program involves large muscle movement such as walking, jogging, stationary cycling, swimming, and calisthenics. An aerobic exercise prescription may include such activities for 15-60 minutes, 3 times per week, at an intensity of 70-85% maximum heart rate.

Anaerobic

An anaerobic exercise program increases the capacity for an individual to perform and persist in all-out exercise for brief periods of time up to 60 seconds. Sprinting is probably one of the best examples. Anaerobic training increases the enzyme activity of muscle cells so that they are more efficient in producing energy without the presence of oxygen. It is useful for sport performance. It has little impact on cardiovascular and metabolic health and thus would have little value in maintaining fitness in individuals with eating disorders.

Strength Training

Some of the physiological benefits of a strength training program include increased muscle fiber size, ligament and tendon strength, and bone mineral content. A variety of equipment, i.e., Nautilis, free weights, Cybex, offers isotonic resistance, isokinetic resistance or variable resistance. Additionally, isometric resistance develops strength at a specific joint angle and requires no equipment. A program, tailored for a specific muscle group, may use 3 sets of 10 repetitions. The weights for the repetitions are based on 60-85% of a 1 repetition max, which is the greatest amount of weight an individual can move in one lift. To avoid straining, the individual should breathe out when lifting and breathe in when returning to the resting position. Heavier weights with fewer repetitions can increase muscle strength, while lighter weights with more repetitions can increase muscle endurance.

DEVELOPING, IMPLEMENTING AND EVALUATING AN EXERCISE PLAN

As previously indicated, the purpose of an exercise plan is to develop and maintain fitness, not to lose weight. Each plan must be individualized, taking into account the individual's current physical symptomatology, as well as status and progress in recovery from her/his eating disorder.

Developing the plan

In developing an exercise plan, an assessment is made of subjective information (case history) and objective information (clinical evaluation and recommendations). It is often advised that strenuous exercise not be instituted until the student is within 90% of Ideal Body Weight. Other factors which may influence prescribed activity may be EKG status, potential for fractures, and electrolyte stability. Since the focus of the exercise program for those with eating disorders is to maintain fitness, exercising every day is not appropriate. It is important that the health care professional review non-cardiovascular hazards in developing the exercise plan for a given student. For example, individuals with asthma may exhibit bronchospasm in response to exercise or cold. Diabetic individuals may need adjustment of insulin dosage. Hot weather can cause dehydration and

hyperthermia in susceptible individuals; cold weather can cause hypothermia and frostbite. Orthopedic injuries and concussions can occur in contact sports. Blackout and orthopedic injuries may happen in weight lifting, eye injuries may occur in racquetball, etc. Tendinitis and stress fractures can result from overuse or from too aggressive increases in intensity, duration and frequency of exercise.

Implementing the exercise plan

After the plan is developed, determination of procedures and techniques to implement the plan must be discussed with the student. Hopefully, this will maximize compliance and benefits of the individual's program and reduce the potential for injury or complications. In addition to the types of exercise, the frequency (how often), duration (how long), and intensity (how hard) of the exercises need to be tailored for each individual.

It is important to remember that medications such as diuretics, beta blockers, vasodilators, psychotropics, and even anticholinergics (such as found in non-prescription cold remedies) can affect the body's response to exercise.

The inclusion of a "warm-up" prior to exercising has been recommended by some. However, the usefulness of stretching prior to exercise for the prevention of musculoskeletal injuries is unclear. Some evidence does exist to support increasing core body temperature through movement of large muscle groups, such as in jogging, in order to stretch connective tissue (i.e., tendons). However, there is more convincing evidence as to the benefit of pre-exercise gross body movement for the cardiovascular system; a gradual increase in heart rate prior to exercise places less stress on the heart.

A "cool-down" after exercising is extremely important. A gradual decrease in activity over 5 to 10 minutes can help prevent lightheadedness, fainting, and arrhythmias. The cool-down is essential for cardiac-compromised students, as they may be more at risk for sudden cardiac death if they abruptly stop exercise.

Frequency of exercise has been already discussed in general terms. Intensity of exercise is recommended by the effort needed for an individual to attain 70-85% of her/his maximum heart rate; this percentage is referred to as target heart rate. Computation of this target rate is obtained by subtracting an individual's age from the number 220. However, this method may be inappropriate for those with eating disorders. Medical factors or medication may affect the attainment of this rate. Two alternate measures of intensity can be employed. A safe maximal rate may be determined by a physician conducting a cardiac stress test. Another approach is for the individual to determine the intensity at which she/he perceives maximal exertion and then to calculate 70-85% of that maximal heart rate. Duration may be measured in time or in frequency of repetitions. It is noteworthy that exercise of lower intensity over a longer duration can have the same physiological benefits as higher intensity exercise over a shorter duration of time.

Evaluating the exercise plan

Finally, the plan must be evaluated. First, procedures and techniques should be meeting some measurable objectives. The student will be attaining or maintaining physical fitness goals, as well as hopefully experiencing the psychological benefits of the exercise plan. Second, modifications may need to be implemented into the plan, depending on the effects of the exercise program. For example, weight loss or decrease in muscle mass may indicate too strenuous or too intense exercise. Chest pain, weakness or faintness after exertion, dizziness, undo shortness of breath, bone pain, persistent muscle pain or numbness are other symptoms that require a reevaluation of the plan with other physical activities substituted for original activities; for example, non-weight bearing activity such as swimming or stationary cycling may be an alternative if there is lower extremity pain. Periodic evaluation serves not only to identify potential problem areas, but also can motivate the individual to continue with the prescribed exercise plan.

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CAMPUS RECREATION GUIDELINES

An increased concern about the use of the Northern Illinois University Student Recreation Center by patrons suffering with eating disorders, exhibiting excessive compulsive exercise behaviors, or practicing unsafe exercise habits initiated the development of specific procedures in dealing with the safety of such patrons. The Office of Campus Recreation staff, along with professionals across campus with experience and knowledge in the treatment of eating disorders, work together to implement these procedures.

With the increase in popularity of campus recreation programs and the development of new university recreation facilities across the country, campus recreation professionals must take responsibility for the behaviors and attitudes regarding exercise within their facilities. As professionals in campus recreation, we are:

> QUALIFIED to assist with the awareness, education, identification, intervention, recovery, and support of eating disorders.
>
> NOT QUALIFIED to provide treatment. We can recognize, however, the multidisciplinary approaches necessary to assist students with an eating disorder.
>
> RESPONSIBLE for promoting, modeling, and educating the campus community and general public about healthy lifestyles and a lifetime approach to positive physical activity.
>
> REPONSIBLE for becoming involved with national and local eating disorder and body image organizations.

By having a dietitian and personal trainers available for facility patrons, education efforts regarding eating disorders, exercise behaviors, and attitudes can be enhanced. The Office of Campus Recreation offers one-on-one personal training and nutrition services to students and members of the Student Recreation Center. Nutrition programming provides professional information that can assist in improving physical, social and mental well-being. It also promotes healthy eating patterns and positive lifestyle changes by incorporating stress management techniques and physical activity into both individual and group sessions. A registered dietitian is available for NUTRIFIT, a nutrition and fitness class, and personalized counseling. In addition, the OCR and NIU School of Family, Consumer, and Nutrition Sciences work together to provide graduate level dietetic interns who assist in providing nutrition education through presentations, workshops, staff in-services, and special activities.

For personal training, the design of the program and the number of sessions purchased depends on each individual’s needs and interests. During the initial consultation, goals are discussed and the method by which they will be achieved determined. Both a fitness assessment by a certified trainer and a nutrition assessment by a registered dietitian are completed to determine capabilities and to establish a starting point for each client.

Procedures for Patrons with Exercise and Health Risks

1. A Student Recreation Center student employee (facility attendant, general building staff, aerobics instructor, personal trainer) reports concerns to a professional staff member regarding a patron who displays signs or symptoms of an eating disorder or unsafe exercise behaviors. This report should be made as soon as possible after the observation is made.

2. The professional staff member will observe the patron in question. This observation will assist in determining the type of intervention the OCR staff will make with the individual.

3. Following the observation of the patron by the professional staff member, a decision will be made regarding what may be the best way of intervening. The professional staff member may contact the Counseling and Student Development Center for consultation.

4. Ideally, an intervention will be made by someone who has a relationship with the patron, since this will increase the likelihood of a successful intervention.

    a. If the patron in question has a relationship with an OCR staff member, the intervention may be handled by that person or with the assistance of that person.

    b. If no one on the OCR staff has a relationship with the patron, a relationship should be established. For example, the Fitness Coordinator could approach the individual to discuss "general exercise" and his/her use of the Recreation Center.

5. The preliminary intervention should be as minimally intrusive as possible. Several strategies may be used:

    a. After a relationship with the individual is recognized or established, the person handling the intervention will set up a meeting with the patron to discuss his/her behavior/use of the Recreation Center.

    b. A free nutrition consultation or fitness assessment may be offered as a strategy to provide an arena in which the discussion can occur.

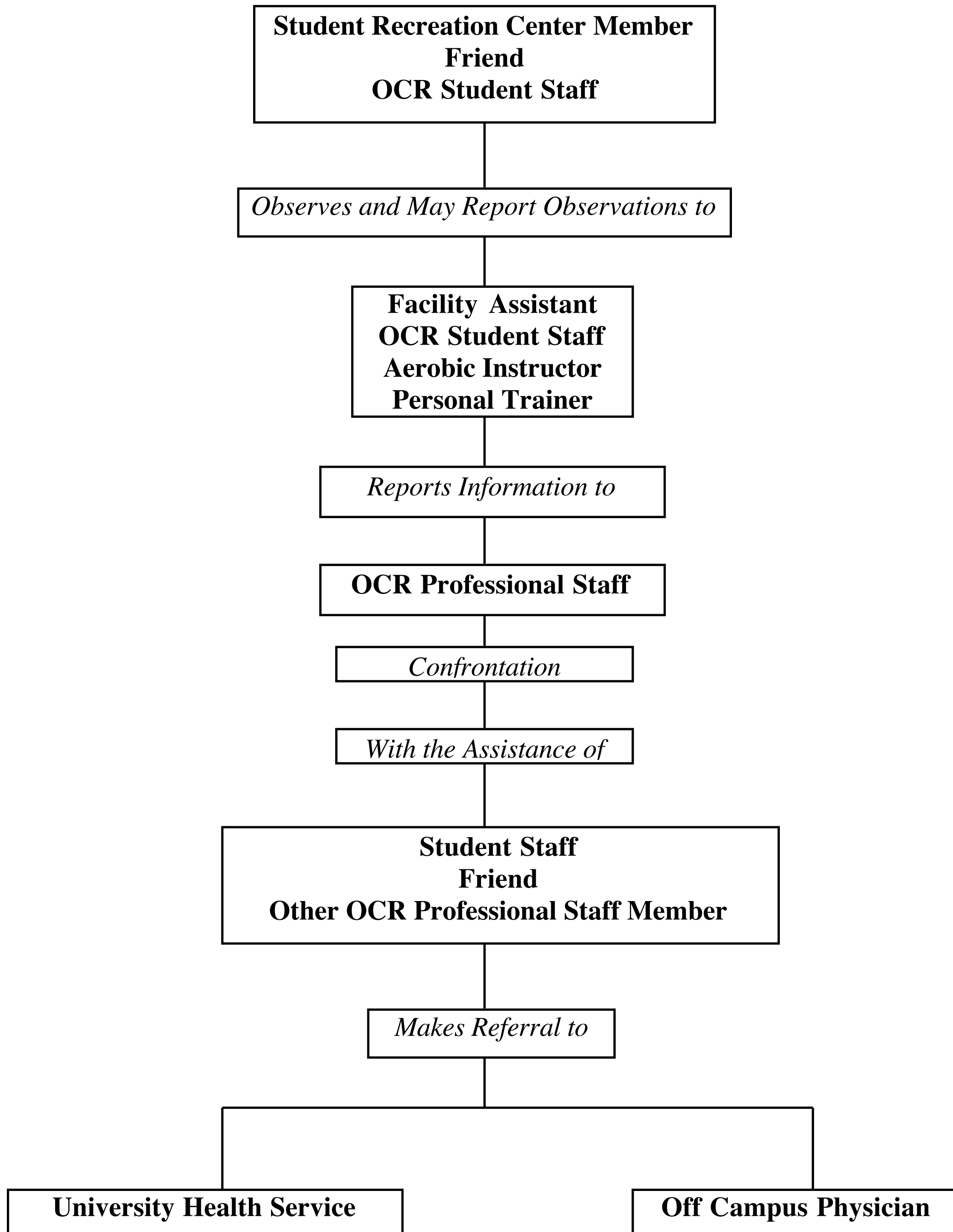
6. If a student patron is identified as potentially having an eating disorder or exercise problem and is willing to seek assistance for the problem, the student will be requested to sign a release of information for Dr. Liston at the University Health Service and a medical evaluation should be scheduled. If the evaluation indicates that exercise could compromise the student's physical well-being, OCR membership privileges will be revoked until medical clearance is obtained. If the student refuses referral to Dr. Liston, a medical clearance for exercise will be required from an outside attending physician.

    If a the patron is not a student, medical clearance for exercise also must be obtained from an outside attending physician.

If the patron refuses to obtain medical clearance, membership privileges can be revoked by the Director of Campus Recreation and the Fitness Coordinator.

It should be noted that revocation of a patron's use of the Student Recreation Center is viewed as the most intrusive of interventions available to staff and is only utilized in this situation to protect the health of patrons. Restoration of the patron's privilege to use the Recreation Center will be based on a medical clearance only.

Office of Campus Recreation Procedures for Patrons Suspected of an Eating Disorder in the Campus Recreation Environment



CARING CONFRONTATIONS GUIDELINES

Confronting an individual suspected of having an eating disorder can be very awkward and requires careful planning by a professional. The following guidelines have been established to assist with one-on-one confrontations.

Before the Confrontation

- Identify the person who has the best rapport with the patron and has the ability/composure to accomplish the goal. (Professional Staff)
- Identify the issues you wish to present to the individual.
- Gather the facts of the situation.
- Practice the confrontation with another professional or fellow staff member.
- Be aware of the resources available to the patron.

Initiating the Confrontation

- The confrontation should take place when you will not feel rushed, will not be interrupted, and in a private setting.
- Approach the patron in an assertive manner.
- Remain calm.
- Communicate and identify your concerns:
  - Identify your behavioral concerns (i.e. "I've noticed you coming to the Rec Center a few times per day." or "I've noticed you taking two or more aerobics classes per day.")
  - Identify statements the individual has made.
  - Identify attitudes the patron has expressed.
  - Identify what has happened to prompt the conversation.
- Be prepared to support the need for concern and action.
- Avoid labels such as, "I know you're anorexic. You're so skinny!"
- Remember this is not a lecture. Keep it brief.

Responding During the Confrontation

- Keep the focus on the possible existence of a serious problem, not the detection of an eating disorder.
- Avoid defensiveness, argument, or scare tactics such as "You're going to die if you don't get help."
- Let the patron respond.
- Listen carefully with empathy and non-judgmentally.
- Communicate care, concern and a desire to talk about the problems.
- Do not promise to keep the matter a secret. You can promise to be discrete.
- Terminate the conversation if it is going nowhere or if either of you is becoming too upset.
- Be knowledgeable about the resources available to the patron. Provide referral names and phone numbers.
- Arrange to follow-up with the individual after your initial discussion.

Before and After the Caring Confrontation

- Identify your own feeling(s), which may include:
  - Anger
  - Helplessness
  - Frustration
  - Fear
  - Concern
- Examine your expectations: are they realistic?
- Debrief with a trusted friend, talk about the confrontation.
- Let go of the need to “fix” the person quickly. Realize change occurs slowly.
- Acknowledge your efforts. By initiating a CAREFRONTATION, you have expressed how much you care about an individual. Be proud of your efforts, you made a difference and your words will influence him/her.

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ATHLETIC GUIDELINES

Many articles in the medical as well as physical fitness literature confirm that eating disorders are a potential condition in the student-athlete. Eating disorders can affect the physical and psychological well-being of the athlete and may become a life-threatening condition. It is our ethical responsibility as athletic trainers, team physicians, coaches, and administrators to be aware of these disorders and help provide our athletes with the appropriate care they need.

In an effort to support student-athletes, Northern Illinois University attempts to help explore or resolve any concerns that may exist regarding eating disorders. On the pre-participation athletic history form there are questions designed to help team physicians determine if a student-athlete may be at risk for an eating disorder. If a team physician determines that an athlete is at risk, he/she will address the situation during the pre-participation physical. Materials are also given to student-athletes throughout the school year regarding disordered eating. The openness of both the materials and pre-participation physical questions acknowledges the possibility of these types of problems and may encourage a student-athlete to seek help.

Throughout the course of a season, athletes are exposed to a variety of team personnel. Athletic trainers, coaches, and support staff observe athlete behavior in the training room, while traveling, and during practices and competition. These staff are in the position to have an objective, yet compassionate impression of the athlete’s condition.

A student-athlete’s criteria for participation is based on overall physical health, not the absence of an eating disorder. Athletes with a suspected or identified eating disorder should be assured that such concern or identification will not be used as a punishment to deny them athletic participation.

Athletic trainers, coaches, and team physicians, as well as ancillary personnel, can have an important role in the prevention, identification, referral, and medical management of eating disorders in the student-athlete. Ways to educate and update knowledge of coaches and athletic trainers should be considered. Preferably this will occur at the beginning of each fall semester.

The following guidelines can help identify student-athletes who exhibit signs of an eating disorder.

1. If an athlete indicates on an initial history form that she/he would like to discuss concerns regarding eating disorders, the examining physician will inform the student of appropriate resources and/or referrals. The physician will facilitate, along with the athletic trainer, any referrals the student is willing to accept.

2. If a coach is approached by the concerned athlete, the coach can inform the athlete's certified athletic trainer, who will meet with student in a non-judgmental, caring, manner to discuss the concern and offer appropriate resources or referrals if the athlete so desires.

3. If a teammate or roommate approaches the athlete's coach, the coach can inform the athlete's certified trainer as above in 2.

4. If an athletic trainer suspects a problem, she/he may meet with the student to discuss in a manner outlined in 2.

5. The athletic trainer can consult with the team or designated physician at any time for assistance in evaluation. If eating disorder signs or symptoms are suspected or recognized by the athletic trainer or the physician, and a concern exists that the student-athlete's physical well-being may be compromised without intervention, an athlete may be mandated by the certified athletic trainer or physician to have a medical assessment in order to continue participating in practice or competition.

The next section of guidelines establishes a mechanism by which to monitor a student athlete with an eating disorder.

1. The athlete must be under the care of a physician, who specifically monitors the eating disorder. If under the care of a non-NIU physician, the athlete must sign a release of information form. This is done for on-going exchange of information between the NIU physician and/or athletic trainer and the student's treating physician.

2. To ensure that there is no medical impairment to sport activity, the athlete must follow through with all assessments recommended by the treating physician. These may include, in addition to others:
   a. Physical examination, labs, and other medical screening deemed necessary;
   b. Nutritional assessment;
   c. Psychological assessment, with optional counseling as desired by athlete.

3. The student-athlete will be requested to sign the Release of Information for the Staffing (Appendix A). If the student-athlete's coach is invited on occasion to the staffing or if a separate meeting is held with some of the treatment team and the coach, releases of information must be signed to specifically include the coach.

4. As with any other condition (i.e., mono, sprained ankle, etc.), approval for competition and practice is determined by the attending NIU physician. Weight determination is a medical issue. Opinion differences will be discuss, the physician has final approval for recommended weight range and target goal.

5. If a non-NIU attending physician is involved in care, the team physician can review the medical status of the athlete with the outside physician. Clearance for practice or participation, however, is the responsibility of the NIU team physician.

6. It is important to note that conflict may occur if decisions are made to restrict an athlete's practice or sport activities due to low weight or physical symptomatology or methods of weight control. It may be more readily accepted as necessary if impaired athletic performance as a result of the above can be documented. However, the pressure for a scholarship or varsity athlete to compete can be intense. With low weight, it may be appropriate to insist that the athlete be 90% of ideal weight before vigorous exercise or competition is allowed; perhaps for some sports a minimum body fat for participation can be employed. However, the athlete and

the circumstances of her/his sport need to be considered on an individual basis. All persons involved with the athlete must be aware that individuals with eating disorders have medical risks which may be accentuated with the stress of physical activity. The welfare of the athlete always takes precedence over the welfare of the coach, the team, or the University.

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GROUP LIVING GUIDELINES

The guidelines for group living were developed in response to the fact that many individuals with eating disorders live in residence halls and Greek organizations or group off-campus housing and their eating disorder is "discovered" in this high density living situation.

Evidence of eating disordered behavior is often first noticed by roommates, friends, floor or suitemates who ask for assistance in handling the situation either directly or indirectly. These guidelines provide a three part training model to prepare staff and student leaders to deal with such situations:

> Part One Staff or student leaders receive information regarding eating disorders. Specific focus is placed on what eating disorders are, who might be affected and how to identify someone who might be suspected of an eating disorder. This training is provided by a professional well versed in the problem of eating disorders.
>
> Part Two Staff or student leaders receive information regarding resources available on campus and in the community. There is a focus on how to make a referral of someone suspected of having an eating disorder or of someone who reports that a friend may have an eating disorder. Part One and Two are completed in one session.
>
> Part Three In a separate training session, staff or student leaders are provided with case studies to role play caring confrontations. Staff or student leaders are encouraged to examine the guidelines and generate a plan of action to address the problems associated with having an individual suspected of having an eating disorder living in a group situation.

Handouts used in this training are presented here and include the guidelines, campus resources, flow chart, sample case studies, and reading list.

CARING CONFRONTATION GUIDELINES

Adapted from the Campus Recreation Caring Confrontation Guidelines

Before the Caring Confrontation

- Identify the person who has the best rapport with the student **AND** one that has the ability /composure to accomplish the goal.
- Identify the issues you wish to present to the individual.
- Gather the facts of the situation.
- Practice the confrontation with a counselor, supervisor, colleague or friend.
- Be aware of the resources available to the student.

Initiating the Caring Confrontation

- Show that you care about the person.
- Approach the student in an assertive manner.
- Remain calm.
- Communicate your concerns:
  - Identify your behavioral observations
  - Identify statements the student has made
  - Identify attitudes the student has expressed
  - Identify what has happened to prompt the conversation
- Be prepared to support the need for concern and action.

Responding during the Caring Confrontation

- Stay problem centered.
- Avoid defensiveness.
- Let the student respond.
- Listen carefully, with empathy, and non-judgementally.
- Communicate care, concern and a desire to talk about problems.
- Be knowledgeable about the resources available to the student.
- Arrange to follow-up with the student after your initial discussion.

Before and After the Caring Confrontation

- Identify your own feeling(s), which may include:
  - Anger
  - Helplessness
  - Frustration
  - Fear
  - Concern

RESOURCES

Counseling and Student Development Center 753-1206
200 Campus Life Building

University Health Services 753-1311

ANAD (Anorexia Nervosa and Related Disorders) Support Group
For information, call 753-1206

Meets at University Resources for Women
105 Normal Road
Mondays at 7:00 pm during Fall and Spring semesters

CASE STUDIES

Claire is a student living on your floor or in your house. For several weeks you have noticed that she is losing weight. One day you meet her in the shower and observe her in a towel. She is obviously quite thin, more so than you noticed when she had her loose fitting clothes on. Claire is not a social mixer on your floor nor does she appear to be with her roommate often.

Sue is a very popular person on your floor or in your house. She is energetic and willing to help you with organizing others to participate in activities. She does not get along well with her roommate. On three occasions over the course of a month you have been in the bathroom and heard someone vomiting. Sue emerged from the bathroom and you would express your concern for her. She dismissed your concern with the explanation that she had a touch of the flu. It occurred to you that each time your encountered Sue it was after a meal.

Gloria, a student on your floor or in your house, came to you with a concern about Frank, a friend. He is on the wrestling team and is very conscious of his weight. He talks regularly to Gloria about nutrition, weight loss, and weight gain. He seems to be able to go for long periods of time when he fasts to lose weight.

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DENTAL GUIDELINES

An on-site or community dentist may be the first health care professional to come in contact or identify a university student with an eating disorder. In addition, other members of a treatment team may encounter signs, symptoms or questions from such an individual regarding her/his dental care.

The following guidelines are particularly intended for the dentist, but will give information for health care professionals who encounter oral problems of students with eating disorders.

In anorexia, as a result of starvation, wasting, and dehydration, oral secretions are reduced. The student may experience a dry mouth and the oral cavity may be more susceptible to acid attack. Slimming foods such as raw citrus and juices can lead to enamel decalcification. This can cause weakened tooth structure and the potential for increased decay. If depression is present, there may be little interest in oral hygiene. Students are more susceptible to infection after oral surgery.

In bulimia, there may be bilateral parotid gland enlargement, usually painless swelling. Occasionally the submandibular glands may be swollen. In a person who is fasting and then binge eating, abrupt stimulation of the pancreas may cause an indirect humoral effect on these glands. Sialoadenosis (diffuse asymptomatic, noninflammatory salivary gland enlargement due to overwork hypertrophy) can exist; gastric irritation may also affect the opening and lining of the ducts. Lingual erosion may be prominent in bulimia (mostly involving the maxillary anterior teeth) due to acidic gastric contents as well as excessive acidic juice intake.

General oral findings may include sensitivity and pain; sclerosed or abscessed nerves; periodontal disease; lingual erosion; and increased decay. Decay depends on oral hygiene and may be affected by cariogenicity of the diet (increased carbohydrates, increased sugar), malnutrition (leading to gum inflammation and bone loss), genetic predisposition, fluoride experience during the tooth-forming years, and medications that alter salivary flow.

The student may provide signs and symptoms of illness without providing or volunteering information of an existing eating disorder. It is important not to alienate a student who might react with anger and denial, and ultimately reject care. Good rapport and a non-judgmental approach are essential.

The following guidelines outline both subjective and objective dental information followed by assessment and treatment recommendations.

SUBJECTIVE

1. **Initial visit**

History of present illness may be provided by student:

- Duration
- Dietary behaviors, including bingeing/purging, excessive cariogenic diet, etc.
- Reduced saliva production (i.e., dry mouth complaints)
- History of parotid gland swelling
- Periodontal changes
  - Bleeding
  - Pain
  - Swelling
  - Redness
- Interest (or lack of) in oral hygiene

2. **Follow up visit**

Review status of previous symptoms
New symptoms

OBJECTIVE

1. **Initial visit**

a. Complete periodontal exam
   - Probe periodontal pockets
   - Bleeding-inflammation
   - Appearance
   - Mobility
   - Erosion
   - Habits

b. Oral exam
   - Decay/increase in decay
   - Plaque
   - Sensitivity/pain due to erosion
   - Nerve problems due to excessive wear and trauma
   - Enamel erosion

c. Head and neck exam
   - Parotid or submaxillary gland enlargement
   - Sialoadenosis
   - Gastric irritation on opening and lining of ducts

2. **Follow up visit**

Monitor previous findings
Note new findings

ASSESSMENT Specifics of any oral changes identified

PLAN Extensive rehabilitation (i.e., crowns) should be postponed until psychiatric and nutritional components have stabilized and regurgitation is stopped or greatly reduced. Treatment for pain, decay, and periodontal maintenance should be initiated. Students with orthodontic appliances need to be especially meticulous in mouth care.

TREATMENT OBJECTIVES FOR ANOREXIA

1. Supportive care
   Educate and encourage good oral hygiene. Help student to feel more in control of her/his own health by instituting and adhering to an effective oral hygiene program.

2. Care
   Daily brushing with fluoride toothpaste, flossing, fluoride mouth rinses, and fluoride application. Fluoride helps remineralize and decrease sensitivity of teeth.

   The dentist or physician can prescribe stannous fluoride gel for daily brushing, as well as the 0.4% gel used in custom trays. Custom trays are specially made for the patient from acrylic or soft plastic from a model of the patient's mouth and would be worn as prescribed by the dentist or physician. The fluoride used in custom trays come in various flavors.

   Saliva substitutes, available without a prescription, can help with the discomfort of dry mouth.

TREATMENT OBJECTIVES FOR BULIMIA

1. Supportive care
   As above for anorexia, with additional education and concerns regarding dental consequences of purging.

2. Care
   Discourage brushing immediately after vomiting.

   Use of sodium bicarbonate or magnesium hydroxide rinses immediately after vomiting may aid in neutralizing gastric acid introduced into the mouth.

   Use of sodium fluoride rinses (0.05%) prescribed by dentist or physician can help remineralize and decrease sensitivity of teeth.

Use of stannous fluoride gel (0.4%), prescribed by dentist or physician, for once a day brushing.

Use of fluoride preparation, prescribed by dentist or physician, in a custom tray.

Use of fluoride toothpaste daily reduces enamel etching and erosion as well as thermal sensitivity. Gastric acid can etch enamel in about 45 seconds. Mouth should be neutralized with the bicarbonate or magnesium hydroxide rinses described above. Then use of a fluoride rinse followed by brushing with a fluoride toothpaste is appropriate.

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SUMMARY

Throughout this document, the importance of collaboration of a variety of professionals in the treatment of students with eating disorders in the university setting has been stressed. The coordinated treatment plan will integrate all of the assessments and will determine and monitor several issues of concern.

Least restrictive setting Determination of the least restrictive setting for care is based on several factors: the severity of eating disorder symptoms, the severity of psychological stress, medical and nutritional stability, motivation and the ability to benefit from treatment, the ability to abide by an individualized contract (which would address goals such as weight gain, alteration of eating and related behaviors, attending required appointments with physician, therapist, nutritionist, support group, etc.), control of impulse behavior, and access to appropriate facilities.

Goals of treatment Each member of the treatment team should be involved in the establishment of the treatment goals for the individual student. Staffings of each student being treated will allow professionals to monitor progress and needed modifications of the goals over time.

Mechanisms for follow up and communication Ongoing communication between members of the treatment team will enhance the possibility of successful treatment for individuals with eating disorders. Staffings will allow structured time during which information such as change in symptoms, current treatment issues, treatment compliance, reporting consistency, and current functioning can be shared. Acute problems, such as those that compromise outpatient treatment, must be handled as soon as they became evident to any one member of the team.

The multidisciplinary team who carefully considers these issues and works together for the well-being of the students will communicate consistent messages as well as enhance their effectiveness in working with students with eating disorders.

APPENDIX A

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION
EATING DISORDER STAFFING

Counseling & Student Development Center
and University Health Service

All students with eating disorders treated at the Counseling and Student Development Center and/or the University Health Service are required to sign an authorization for release of verbal information that allows care givers the ability to exchange necessary information for treatment.

Since 1993, NIU professionals involved in the treatment of students with eating disorders have met on a regular basis to coordinate care. We feel that we can better serve you if we can sit face to face to discuss coordination of care on a regular basis (a staffing). The information discussed in this meeting will not be discussed outside of the staffing group; our commitment to confidentiality is paramount.

The following individuals will usually be present at the staffing:

Also involved will be your individual therapist. If you are a student athlete, a trainer will be present.

We believe that it is in your best interest to have this wide range of professionals involved in your care. In addition, the staffing will broaden our knowledge and help us to serve you better. Please feel free to contact any of the above mentioned NIU staff to discuss concerns you may have.

I understand the above description of the staffing and agree to authorize discussion of my situation in this setting as needed. I understand that this authorization is valid from today's date through <u>May 31, 2001.</u>

____ ____

Student Signature Date

_______ - _______ - _________________

Social Security Number

____ ____

Witness Signature Date

APPENDIX B

MULTIDISCIPLINARY STAFFING FORM

Name__________________________ **Diagnosis**____________ Date___________

Weight Target Range__________ Current__________ Fear__________

Symptoms **Frequency, duration**, etc.

_____ Alcohol/drugs ____
_____ Restricting ____
_____ Binge eating ____
_____ Vomiting ____
_____ Laxative abuse ____
_____ Diuretics ____
_____ Diet pills ____
_____ Chewing/spitting ____
_____ Exercising ____

Previous Treatment History

____
____

Current Treatment Issues

Counseling

____
____

Medical

____
____

Nutritional

____
____

Psychiatric

____
____

Substance Abuse

____
____

Other

____

ANAD Attendance ____

Non-compliance Issues ____
Reporting Consistency ____

Current Functioning

Academic/Vocational ____

Crisis ____

Social/Family ____

Employment ____

Treatment Goals

____

____

Current Treatment Issues: Date__________________

C ____

M ____

N ____

P ____

S ____

O ____

Treatment Goals

____

____

Current Treatment Issues: Date__________________

C ____

M ____

N ____

P ____

S ____

O ____

Treatment Goals

____

____

APPENDIX C
SEMI-STRUCTURED EATING DISORDER QUESTIONNAIRE

I would like you to answer some questions regarding your weight history and any problems you have had with your weight or eating habits.

Weight History

1. What is your present height? _________ weight? _________

   6 months ago? _________ 2 years ago? _________

   average weight? _________

2. What was your highest weight? _________ When? _________________

   Your lowest weight? __________ When? _________________

   Your weight before onset of serious dieting/eating disorder? ___________

3. Recall significant weight changes/changes in eating habits _________________________________

   ____

   ____

   Age _________ Amount of change __________

   Diet/method ____________________________________

   Precipitating factors ____

   Consequences of weight change ____

   Did you maintain the weight change? ________ If yes, for how long? ____________

4. Do you or anyone in your family have a history of obesity? _______ eating disorder? _______

   Explain ____

   ____

Body Shape and Weight Attitudes

1. What are your feelings about your weight/body shape? ____________________________________

   ____

   ____

   ____

2. Are you ____ satisfied with your weight/body shape?

   ____ dissatisfied with your weight/body shape?

   ____ distressed with your weight/body shape?

   ____ other ____

3. What is the primary way you evaluate yourself?

   ____ food

   ____ eating

   ____ weight

   ____ body image

   ____ how others evaluate you

4. Have you ever thought you were too fat or in danger of getting too fat? ______________

   Do you feel that way now? _______________________

5. Have you ever been concerned that you are too thin or have a problem with your eating behaviors?

____

Are you presently concerned? _________________

Have others been concerned? _________________

When?/who?____

6. Do you enjoy losing weight or refusing food? _____________

7. How do you feel when you lose two pounds/gain two pounds? ___________________________

____

8. At what weight do you feel your best? _______________

9. What weight would you like to be? ______________

10. At what weight do you get anxious? _____________

11. What would you consider a healthy weight for someone your age and height? _______

12. Would you consider maintaining that weight? __________

13. What percent of the day are your thoughts occupied with food, eating, body size, or shape? ______

14. How often do you weigh or measure yourself? ____________________

Restricting Behaviors

1. When did weight/dieting first become a problem? _______________________________________

2. What precipitated this? ____

3. Is there pressure to diet? _______ If yes, from whom?
   - _____ family
   - _____ friends
   - _____ vocation
   - _____ self

4. What are your feelings about dieting? ____

____

5. Have you tried to lose weight by dieting within the past year? ________

Did you reduce calories? ______ If yes, number of calories per day? __________

Did you restrict specific foods? ______ List them _______________________________

____

____

6. Do you restrict fat? ______ Number of grams per day? ____________

Do you portion sizes? ________

Do you skip meals? ______ Which meal(s) do you skip? ________________________________

Do you fast? _______

Are you a vegetarian? _______

Do you use diet foods? _______

7. Are there special behaviors which help you restrict your intake (e.g., rapid meals, prolonged meal times, cutting food into small pieces, chewing and spitting food, throwing away foods, eating rapidly)?

____

____

8. Give a detailed description of a typical day of restricted dieting

____

____

____

____

____

Purging Behaviors

Although it is often difficult to think about, it is important that you carefully answer the questions below regarding attempts to control your weight through purging behaviors.

Behavior	Frequency per day	Number of days per week	Past/Present
Vomiting			
Involuntary	_____	_____	_____
Voluntary	_____	_____	_____
Spitting	_____	_____	_____
Laxatives/Diuretics	_____	_____	_____
Diet pills	_____	_____	_____
Ipecac	_____	_____	_____
Exercise	_____	_____	_____

Specific type of exercise ____

1. Are you involved in a situation where exercise or a certain body size or shape is required? _____
2. Do you use it to control weight? _________
3. Have you had injuries? _________
4. Do you _____ enjoy or _____ feel compelled to exercise?
5. What happens if you cannot exercise? ______________________________________

Purging often occurs in relationship to various triggers. If you purge, specify how and when it occurs

Triggers	Check if yes	Type of purge
After normal size meals	______	______________________
Any intake	______	______________________
After a binge	______	______________________
Anytime	______	______________________
Specific foods	______	______________________
Specific feelings	______	______________________

Other ____

What feelings do you associate with purging? ____

____

Bingeing Behaviors

1. Are there times when you

   Eat abnormally large amounts of food? ________

   Within a short period of time? ________

   Feel out of control? ________

2. In the last three months

   Number of binges per day _____ per week _____ per month _____

3. When did your bingeing behavior first begin? __________

4. When do you binge?

   At meals? _______ Which ones? ____

   Throughout the day? _______

   After dinner? _______

   Middle of the night? _______

   Other ____

5. List specific triggers

   Foods ____

   Feelings ____

   Situations ____

   Places ____

   After restricting ____

   Other____

6. Describe a typical binge -- *Be very specific*. (time, specific foods, quantity, where)

   ____

   ____

   ____

   ____

   ____

   ____

   ____

7. How do your binges usually end? ____

   Fall asleep? _____

   Feel full? _____

   Become physically sick? _____

   Social interruption? _____

   Run out of food? _____

   Other ____

8. What feelings do you associate with bingeing? (Common responses may include: relaxed, good, normal, numb, depressed, disappointed, disgusted, angry, helpless, out of control, memory blackout, other)

____

____

Description of a Typical Day

Describe a typical day in detail starting with breakfast.

	Quantity and Kind of Food	Feelings, Thoughts, Behaviors
Breakfast	______________________	______________________
	______________________	______________________
Snack	______________________	______________________
	______________________	______________________
Lunch	______________________	______________________
	______________________	______________________
Dinner	______________________	______________________
	______________________	______________________
Snack	______________________	______________________
	______________________	______________________

2. Approximate daily caloric intake? ____________
3. List specific aversion/fear foods ____

____

4. List safe foods ____

Psychosocial Functioning

Eating disorders and their associated problems can influence every part of your life. It is important that we look at you as a whole person not just as a person with an eating disorder.

Social contacts and activities

1. Describe your living arrangements

____

____

2. Are you involved in extra curricular activities? ___________________________________
3. Do you have friends at school and/or work? _______________________________________
4. Who knows about your eating disorder? ____
   Is this person(s) supportive of you? ____

5. Has your eating disorder interfered with

Family _____ | Leisure time activities _______
Friends _____ | Ability to eat normally in certain places or situations ______
Significant other _____ | Daily living ______
Work/school _____

Other Psychological Symptoms Apart from Eating Disorder

1. Is there a history in your family of psychiatric illness or substance abuse? _____
2. Have these individuals been treated? _______
3. Do you have a history of psychiatric illness? ______

   If yes, describe____

4. Do you have a history of substance abuse? ______

   If yes, describe____

5. Have you been in treatment? ______

   If yes, describe____

6. If you have taken medication for psychiatric illness, list

   ____

   ____

7. Below is a symptom check list. These often occur before, during, or after disordered eating or purging. Please circle all that apply.

   a. Impaired attention, disorganized thinking, memory problems, preoccupation with certain thoughts, recurrent or intrusive thinking, "spacey feelings, difficulties with decision making, mood changes
      Sleep disturbance
      Sexual disturbance
      Appetite changes
      Personality changes
      Fatigue, hyperactivity, agitation
   b. Irritable mood, depressed mood, mood swings, expansive mood
      Feelings or worthlessness, helplessness, ineffectiveness, irrational or distorted style of thinking
      Ruminative thinking, excessive guilt, low self-esteem, body image disturbance
      Suicidal threats, suicidal gestures, suicidal behaviors, self-mutilation
      Excessive involvement in social activity which has high potential for negative and painful consequences
   c. Intense fear of attaining or maintaining normal body weight
      Intense fear of being or becoming fat
      Anxiety/panic disorder symptoms, preoccupation with physical symptoms, ritualistic behaviors, recurrent intrusive thinking
      Social or school avoidant behaviors, phobias
   d. Compulsive gambling or shopping, aggression, intense anger
   e. Unstable interpersonal relationships, impulsivity, emotional instability
   f. Feelings of emptiness, attention seeking behavior, perfectionism, obsessive/compulsive behaviors, ritualistic behaviors

Menses/Sexual

1. Do you have periods? _______ Date of last menstrual period _____________________

   Age of onset? ______ At what weight? __________

   Presently on the pill? _________

   Description of menses ____

2. If stopped, at what weight? __________ age? ______ for how long? _____________

4. If restarted, at what weight? __________ age? ______

5. Have you experienced (please circle all that apply)

   Irregular menstrual cycles, irregular flow, infertility, miscarriages, low birth weight babies, pregnancy, abortions, sexually transmitted diseases, premenstrual tension, premenstrual bingeing

6. What are your attitudes toward sexuality?

   Avoidance ______ Pleasure ______

   Disinterest ______ Preoccupied ______

   Other ____

7. Sexual relationships

   None ______

   Intermittent ______

   Impulsive ______

   Regular ______

   Practice safe sex ______

8. Sexual partners

   None ______

   Single, ongoing relationship ______

   Multiple ______

   Same sex ______

   Abusive ______

9. Have you ever experienced physical, sexual or emotional abuse or trauma? ______

Physical Complications Other Than Menses

1. Have you had any serious medical problems? _______

   If yes, describe____

   ____

2. Have these been related to an eating disorder? _______

3. Have you taken any regularly prescribed medication in the past or present? _______

   If yes, describe____

4. Have you experienced problems with (please circle all that apply)

   a. Dizziness, fainting, shortness of breath, fatigue on exertion, chest pain, slow/irregular pulse, palpitations, low blood pressure, abnormal heart tests

   b. Swelling of cheeks, dental problems, cavities or loss of enamel

c. Stomach pain or discomfort, bloating, sore throat, vomiting blood, gas, belching, constipation, diarrhea, blood in stool, lactose intolerance, frequent urination, dehydration, water retention
d. Loss of energy, dry skin, loss or thinning of hair, feeling cold, fine, baby-like hair on face, blueness or coldness of extremities or lips, change in skin color, potassium or other electrolyte imbalances, low blood sugar, muscle cramping, seizures, tingling, numbness, fractures, muscle loss, weakness, injuries

Thank you for your careful completion of this questionnaire.

APPENDIX D

COUNSELING AND STUDENT DEVELOPMENT CENTER POLICY STATEMENT NORTHERN ILLINOIS UNIVERSITY

While anorexia and bulimia nervosa are psychiatric diagnoses, the range of medical complications of subclinical or clinical eating disorders is extremely diverse in terms of number and kind. As mental health professionals, we have an obligation to protect the welfare of those who seek our services, to make full use of all resources that serve the best interests of our students, and to understand the limitations of our competencies (for example, some individuals with eating disorders may have such severe medical complications that psychotherapy is ineffective during certain time periods.). In addition, we also know that students with disordered eating may reveal either contradictory or new behaviors to one practitioner and not to another (often depending on the type of questions asked and the relationship the student has with the care giver). In order to effectively coordinate quality and informed care of these students, students seeking our counseling service who have a suspected or actual, subclinical or clinical eating disorder must be under the care of a physician with whom we have a release of information that is valid during the course of our treatment with the student. Since students with disordered eating tend to underestimate the extent of their behaviors (i.e., restrictions on eating, bingeing, purging, excessive exercise, chewing and spitting out food, abuse of laxatives, diuretics, etc.), it is important that all students that you suspect of having subclinical or clinical eating disorders be referred for medical assessment.

Specific steps to be taken include:

1. In the case of an identified "problem" with food or an actual eating disorder, the intake counselor should explain to the student seeking counseling the necessity of a medical assessment in order to be seen at CSDC and have her/him sign a release of information for either the Eating Disorder Team at the University Health Service or her/his own physician if so desired; in any case, the treating physician must be aware of the eating disorder when the student is seen for examination. Our preference is that the treating physician be at the University Health Service because of the expertise and interest in treating such individuals and because coordination of care on campus is much easier than with a family physician. The choice remains, however, with the student. At the conclusion of the intake, the student should understand that if s/he does not agree to a medical assessment and any treatment mandated by the assessment that s/he will not be eligible for CSDC services. This should be noted on the release form.

2. The intake counselor should send to the physician the original release of information (indicating "exchange" of information, that is, a two-way release) and a letter outlining the behavior and medical symptomology presented. Be aware that this letter will become a part of the general medical file at the Health Service.

3. The counselor providing ongoing treatment should follow up on the student's compliance with the medical assessment. This assessment must occur within one month of the student's intake (or as soon as an available appointment is available) in order for the student to continue in counseling. This month period allows you to discuss with the resistant student the reasoning for this requirement in detail and her/his hesitation to

follow through with a physician.

4. During the course of counseling the counselor should keep in contact with the treating physician in order to coordinate treatment, share perceptions, and be aware of any potentially dangerous physical problems that may necessitate hospitalization. The treating physician needs to know of any substantial increase in frequency of disordered eating or other problems (canceling appointments frequently). Most of this communication can occur during the scheduled staffings (through a CSDC team member if you cannot attend staffings). When urgent information needs to be conveyed, please contact the physician at the time. The counselor needs to monitor compliance with medical treatment in order to support the physician in her/his work with the student.

APPENDIX E

Northern Illinois University, University Health Service — Name______________________________

ANNUAL NUTRITIONAL SERVICES PATIENT INFORMATION RECORD — SS#______________________________

Date:____ Completed by:____

S: Reason for visit:____

____

____

____

Age:________ Sex:________ Height:___________ Current Weight:___________ Weight patient desires:___________

Lowest weight:__________ when ___________ Highest weight:__________ when __________ How often weighs self __________

Weight at onset of menses _____________ History of: Amenorrhea Yes ____ No _____ BCP? Yes ______ No ______

Exercise (type, frequency, duration):____

____

Residence: Apartment:_____________ Dorm:_____________ Home:_____________

Who shops:_________________________ Who cooks:_________________________ How often eats alone:_____________

How often eats with someone else/with whom:____

Times per week eat out:____________________ Fast food:____________________ Other:____

Money spent on food per week:____

Weight at onset of problem:_____________ Duration of problem:_____________

Family Medical History, including Eating Disorders:____

____

Current or past behaviors (when and frequency):

Vomiting:____ Spitting: ____

Restricting: ____

Bingeing:____

Laxatives:____ Rechewing: _______________________________________

Diet Pills:____ Ipecac:____

Diuretics:____

Alcohol:____ Smoking: ____

Gum: ___________________ Coffee/Tea:________________ Soda:_______________________

Water:___________________ Milk:____________________

Past treatments and results:____

____

____

____

Food Dislikes	**Safe or Favorites Foods**	**Unsafe or Feared Foods**
1. _____________________	1. _____________________	1. _____________________
2. _____________________	2. _____________________	2. _____________________
3. _____________________	3. _____________________	3. _____________________
4. _____________________	4. _____________________	4. _____________________

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Northern Illinois University, University Health Service Name_______________________________

ANNUAL NUTRITIONAL SERVICES PATIENT INFORMATION RECORD SS#_______________________________

Current Medications and Medical Problems:____

Current Symptoms including G.I.:____

Food Allergies/Intolerances:____

Vitamin, Mineral, or Herbal Supplements:____

TYPICAL DAILY INTAKE (OR 24-HOUR FOOD RECALL)

Breakfast Lunch Dinner

Snacks:

Bingeing, Restricting or Weekend Day: (circle all that apply)

Breakfast Lunch Dinner

Snacks:

Binge(s):

O: Estimated caloric intake:____________________ Binge calories:____________________________

IBW Range:_____________________________ % IBW _____________________________ = Actual wt/IBW x 100

BEE________ x AF________=_____________ Est. Protein Intake __________________ Est. Fat Intake _______________

Activity Factors ____

(1.2-1.3 for sedentary, 1.4 for active; may need to be adjusted due to nutritional status, body comp.)

ASSESSMENT:____

____

____

____

____

PLAN:____

____

____

____

____

Exchange Pattern: Milk_____ Fruit_____ Veg_____ Bread_____ Meat_____ Fat_____

Vitamin - Calcium Supplements ____

Nutritionist Signature ___________________________________ Date _____________________________________

UHS 9-33-98 (2) - ANNPATNT - 5/98