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Eating Disorder Programming in Four-Year College Recreation Wellness Centers

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EATING DISORDER PROGRAMMING IN FOUR-YEAR COLLEGE
RECREATION/WELLNESS CENTERS

by

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A Scholarly Project
Submitted to the Graduate Faculty
of the
University of North Dakota
in partial fulfillment of the requirements
for the degree of
Doctor of Physical Therapy

Grand Forks, North Dakota
May
2006
This scholarly project, submitted by Tiffany Anderson and Amanda Gulka in partial fulfillment of the requirements for the Degree of Doctor of Physical Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Chairperson

Graduate Advisor
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ABSTRACT

Eating disorders are more prevalent in the college-age group when compared to the lifetime prevalence. Because of this increased prevalence, college recreation/wellness center staff should be aware of their clients in terms of the increased risk for eating disorders. College wellness/recreation centers, while serving the campus community, also serve the individuals within this community diagnosed with or at-risk for an eating disorder. Through survey research, we show who is employed at wellness/recreation centers, what type of training they receive regarding eating disorder, how this training is provided along with its content, and what method of public awareness on eating disorders is utilized within the facility.

Directors of 686 wellness/recreation centers listed in the 2005 NIRSA Recreational Sports Directory were contacted via internet survey. The response rate was 25.0%. The data evaluation (using SPSS) included descriptive statistics to summarize the overall number and percentage of responses.

Results indicated that less than half (44%) of the staff at recreation/wellness centers receive training on eating disorders. For individuals who received training, the focus was in the following categories: identification of red flags (73%), general education on eating disorders (65%), and appropriate referral sources (60%). Minimal training appears to be provided on how to
provide appropriate intervention (29%). In an attempt to minimize the pressure of environmental interactions that may exacerbate an eating disorder, a majority of facilities have a client dress code, promote a healthy body image, and promote eating disorder awareness to the campus community.

As noted, there is an increased prevalence of eating disorders in college-age individuals. There is a low amount of staff training in wellness/recreation centers which illustrates the need for improvement. We recommend an overall increase in eating disorder training, especially with regard to appropriate interventions that should take place within these facilities.
CHAPTER I
INTRODUCTION
Problem Statement

There is an increased prevalence of eating disorders in college-aged individuals that is being under-diagnosed and treated. Many of these individuals who are at risk for or diagnosed with an eating disorder use their college’s recreation/wellness center. It is unknown how the staff in these facilities are trained on recognizing eating disorders and whether or not they have the appropriate knowledge and training to effectively interact with these individuals. The interactions with staff and other exercisers are critical to individuals with eating disorders and individuals on the way to developing eating disorders.

Purpose of the Study

The purpose of this study is to determine what is happening within recreation/wellness centers relative to eating disorders. More specifically, which professionals are employed by college campus recreational/wellness centers and whether or not formal training on eating disorders for employees takes place within the facility. If there is formal training within the facility, what is its content, the types of policies and procedures in place relative to individuals with eating disorders, and the method of public awareness on eating disorders utilized within the facility.
Significance

This study is important specifically to health and fitness professionals. They need to be prepared to recognize and identify the common warning signs and symptoms of individuals, specifically college-aged individuals, who are at risk for developing or already have been diagnosed with an eating disorder. Health and fitness professionals' awareness of these warning signs and symptoms will help them to not reinforce the negative behaviors of these individuals and help clients recognize the positive attributes of their physical appearance, promoting a healthy lifestyle. There is a specific need in the order of prevention of the development of eating disorders.
CHAPTER II
LITERATURE REVIEW

The literature review presented in this study will discuss the following topics: eating disorders defined, eating disorder epidemiology, risk factors for eating disorders, college-aged females and eating disorders, and college wellness/recreation centers and eating disorders. The purpose of this study will again be stated.

Eating Disorders Defined

At the turn of the millennium, the diagnoses of anorexia nervosa and bulimia nervosa were well defined as was the research enterprise. But a clear understanding of the source of the disorders or how to prevent or treat them remains elusive. Diagnostic criteria of three specific eating disorders are listed in Table 1 – Anorexia nervosa, Bulimia Nervosa, and Eating Disorders Not Otherwise Specified (EDNOS).

In the late 1960s, the previously obscure and extremely rare disorder anorexia nervosa had become much more prevalent. Anorexia is a Greek word meaning “loss of appetite,” which is misleading because only in the late stages of starvation do people in fact lose their appetites. Instead, an intense fear of weight gain leads anorexics to routinely and vehemently deny their hunger.
Table 1. Diagnostic Criteria for Anorexia Nervosa, Bulimia Nervosa, and Eating Disorders Not Otherwise Specified

Anorexia Nervosa
- Refusal to maintain body weight at a level expected for age and height (more specifically, a body weight 15% below that expected)
- Intense fear of gaining weight, even when extremely underweight
- Disturbance of body image in which there is “undue influence of body weight or shape on self-evaluation” or “denial of the seriousness of the current low body weight”

Bulimia Nervosa
- Repeated episodes of binge eating, characterized by eating an extreme amount of food in a “discrete period of time” and a feeling of lack of control over eating
- Compulsive behavior in order to prevent weight gain following binges (e.g., vomiting, fasting, excessive exercise, and laxative/diuretic abuse)
- The binge/purge behavior occurs at least twice per week for three months
- “Self-evaluation is unduly influenced by body shape and weight”
- The binge/purge episodes do not occur “exclusively during episodes of anorexia nervosa”7

Eating Disorders Not Otherwise Specified
The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific eating disorder.
- For females, all the criteria for Anorexia Nervosa are met except that the individual has regular menses.
- All the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual’s current weight is in the normal range.
- All the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
- The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of 2 cookies).
- Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
- Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa.
The following decade, a new eating disorder diagnosis, bulimia nervosa, emerged. Young women alternated self-starvation and binging following by purging. In bulimia nervosa, individuals exhibit recurrent episodes of binge eating engage in inappropriate behavior to avoid weight gain, and are overly concerned with body shape and weight.³ The diagnosis of EDNOS includes pathological eating that does not meet the criteria for any specific eating disorder. EDNOS is included with this project due to the increasing prevalence of its diagnosis. It is the most common eating disorder seen in outpatient settings, yet no studies of its treatment have been done to date. The clinical descriptors for this diagnosis are those that closely resemble descriptors seen in anorexia nervosa and bulimia nervosa but are present in slightly different levels or different combinations. The majority of cases of EDNOS are young women, just as in anorexia nervosa and bulimia nervosa.⁴

A fourth eating disorder diagnosis also not currently identified in the DSM-IV is anorexia athletica. The concept of anorexia athletica has been introduced due to the population of athletes with eating problems or pathological exercise habits. Anorexia athletica identifies athletes with symptoms of eating disorders who do not meet all diagnostic criteria for anorexia nervosa or bulimia nervosa. The athlete with anorexia athletica demonstrates an intense fear of gaining weight or becoming fat, even though the individual is underweight (at least 5% less than expected normal weight for age and height for the general population). This low body weight is attained by a reduction in energy intake, excessive exercising (more than is required to improve performance), or both.⁵ The
athletes with sub-clinical eating disorders, such as EDNOS or anorexia athletica, may show evidence of common psychological traits associated with the clinical eating disorders, such as high achievement orientation, obsessive-compulsive tendencies, and perfectionism. However, these traits are generally expected and usually essential for competing successfully.

Eating Disorders Epidemiology

The eating disorders, anorexia nervosa and bulimia nervosa, are far more common in females than in males. Ninety percent of individuals who are on their way to developing an eating disorder or who have been diagnosed with an eating disorder are female. Most studies focus exclusively on females. In fact, the DSM-IV syndromes of anorexia nervosa and bulimia nervosa have been defined on the basis of the clinical presentation in female patients. However, treatment centers have experienced an increase in requests for treatment by men over the past two decades. In the absence of epidemiologic data over time, it is unclear whether this reflects a true increase in the incidence and prevalence of eating disorders among men. Excessive exercise is said to be a prominent problem among men with anorexia nervosa. Although this symptoms is also present in many women with anorexia nervosa, excessive exercise and its negative health outcomes have been studied far less than the more typically “feminine” symptoms, such as over-valuation of weight or fear of weight gain.

Eating disorders most commonly occur in adolescents and young adults, specifically college-aged individuals, and are ten times more common in females than in males. They occur in all ethnic groups, but are most common among
whites in industrialized nations. In young women, the lifetime risk of developing anorexia nervosa is between 0.5% and 1%, and morality is estimated at between 4% to 10%. In the same population, the lifetime risk of developing bulimia nervosa is between 2% and 5%. As many as 15.4% of female high school and college students meet the clinical criteria for an eating disorder and many more have sub-clinical symptoms including body dissatisfaction and an obsession with dieting. In 1999, the Young Risk Behavior Surveillance Survey reported that 58% of students in the United States had exercised to lose weight, and 40% of students had restricted caloric intake in an attempt to lose weight. Disordered eating patterns can have a significant adverse impact on health.

Many of the epidemiologic studies on eating disorders in the United States yield consistent prevalence rates. For anorexia nervosa, an average prevalence rate of 0.3% was found for young females. The reported prevalence rate of bulimia nervosa was 1% in young women. Most studies found much higher prevalence rates for partial syndromes of anorexia nervosa. Two-stage surveys in Europe using DSM-IV criteria for anorexia nervosa identical to DSM-III-R criteria reported an average prevalence rate of 0.29% for anorexia nervosa. In 1990, a review took place regarding the prevalence studies on bulimia nervosa. This review yielded the generally accepted prevalence rate of 1% among young females for bulimia nervosa diagnosed according to the prevailing criteria at that time. Research suggests that about 1% of female adolescents are diagnosed with anorexia nervosa. That means that about 1 out of every 100 young women between 10 and 20 are starving themselves, sometimes to death. Anorexia
nervosa and bulimia nervosa primarily affect people in their teens and twenties, but studies report both disorders in children as young as 6 and individuals as old as 76.²

The overall incidence of anorexia nervosa is at least 8 per 100,000 individuals per year and the incidence of bulimia nervosa is at least 12 per 100,000 individuals per year. The incidence rate of anorexia nervosa, particularly in 15- to 24-year-old females, definitely increased over the past century.¹⁰

Unfortunately, only a minority of the people who meet stringent diagnostic criteria for eating disorders receive mental health care; the majority lack adequate treatment.¹⁰ Without treatment, up to 20% of people with serious eating disorders die. With treatment, mortality drops to between 2% and 3%. With treatment, 60% of people with eating disorders recover and 20% make partial recoveries. These latter individuals remain too focused on food and weight to make a full recovery.¹¹

Studied have suggested a higher frequency of eating problems in athletes than in non-athletes, particularly in athletes competing in sports that emphasize leanness or a low body weight.⁶ Athletes make up a unique population, and the impact of factors such as training, eating patterns, extreme diets, restriction of food intake, and psychopathological profile must be evaluated differently from this impact in non-athletes. At any given time in the U.S., 0.5% to 3% of individuals have an eating disorder; for the college population, this number increases to 15.4%. The prevalence for eating disorders in college-age women
and men is 4.5% of women and 1.4% of men. The percentages of students at risk for an eating disorder are 10.9% of women and 4% of men.²

Risk Factors for Eating Disorders

There are many common risk factors of each diagnosis that have been proposed as contributors to the development of eating disorders. Interpersonal experiences include abuse, trauma, and past histories of being teased or made-fun-of relative to one’s body shape or appearance. Stress in life and difficulties linked to low self-esteem, depressed mood, anhedonia, general anxiety, and irritability are also factors that take part in the risks of developing an eating disorder.¹ Risk factors that are more specific to college-aged females and athletes will be described in the next section.

Some additional risk factors include puberty, the thin-ideal, body dissatisfaction, and dieting. Puberty is associated with a considerable increase in body fat in females and other bodily alterations due to increase in estrogen levels.¹² Some studies have found a positive correlation between early puberty, body dissatisfaction, and eating pathology.¹³ The avoidance of fat and weight gain and the desire to be thin make puberty a risk factor for developing an eating disorder.¹⁴

The thin-ideal has been widely studied. Body image, or the mental picture one has of one’s body, includes the attitudes, feelings, and perceptions about one’s body size, shape, and symmetry. Dissatisfaction with physical appearance, known as negative body image, is associated with negative affect, poor self-esteem, restrictive eating, and, in severe forms, eating disorders.
Negative body image often emerges in early adolescence when girls have a clearly defied schema of an unrealistically lean "ideal" female form and begin to compare themselves to this often unattainable ideal. For many girls, negative body image worsens as they progress through adolescence into young adulthood. Negative body image among late-adolescent and early-adult women is associated with a variety of eating disturbances, such as counting calories, eating low-calorie foods, skipping meals, and dieting continuously.¹⁵

Many theorists believe that the ultra-thin ideal body image portrayed in the media has contributed significantly to the increase of eating disorders. The thin-ideal women often seen in the media is typically 15% below the average weight of women, representing an unrealistic standard of thinness.¹⁶ Some women perceive the media as the main source of pressure to be thin. The greater the amount of exposure women have to the media, the more likely they are to develop eating disorder symptoms.¹⁷ Women with pre-existing body image dissatisfaction and increased negative feelings about their appearance are more sensitive to the adverse effects of media images.¹⁷ One study compared college women’s exposure to two types of media, entertainment and sports media, and looked for possible associations with body image distortions and eating disorders. Females who were exposed to "thin-ideal" on television scored fairly high on the eating-disorder subscales.¹⁸ At the opposite end of the spectrum, women with very healthy body images and who have respect for themselves appear to be immune to the harmful effects of media exposure. Women who are exposed to images of heavy models report less body image disturbance than
women who are exposed to images of thin models representing the media’s ideal of feminine attractiveness.\textsuperscript{16}

Body dissatisfaction “reflects the belief that specific parts of one’s body, related to shape, are unacceptable because they are ‘too large’ or ‘too fat’.”\textsuperscript{14} Body dissatisfaction is a precursor to unhealthy eating behaviors and it is the strongest predictor of the severity of eating problems and other behaviors or risk factors that may precede eating disorders.\textsuperscript{13,14,20,21} Body dissatisfaction has also been found to be present in all individuals with diagnosed eating disorders.\textsuperscript{19} For individuals who perceive their bodies as less than ideal, especially when those perceptions are internalized, the likelihood of body dissatisfaction increases.\textsuperscript{22} However, if body dissatisfaction is reduced, it may result in a lowered participation in disordered eating behaviors.\textsuperscript{21}

Dieting has often been associated as a precursor to and is seen prior to the development of eating disorders.\textsuperscript{13,23} More abnormal eating attitudes and behaviors are seen in dieters than in non-dieters.\textsuperscript{14} One study found that females who dieted at a severe level were 18 times more likely to develop an eating disorder than those who did not diet, and female subjects who dieted at a moderate level were 5 times more likely to develop an eating disorder than those who did not diet.\textsuperscript{24} Dieting has been associated with an increase in abnormal eating behaviors, poor self-esteem, body dissatisfaction, and disordered eating.\textsuperscript{13,14}
College-aged Females and Eating Disorders

For college individuals, exercise is easily recognized as a healthy behavior. Recent research suggests that it might also be used as a coping mechanism to manage stress and promote psychological health. Conversely, exercise can become a compulsive behavior which then might limit its effectiveness in enhancing psychological states, especially for women who are diagnosed with an eating disorder or are at-risk. As mentioned earlier, the number of college-age women with eating disorders and the percentage of college students at risk for an eating disorder are much higher than in the general public. Risk factors that especially affect this group include but are not limited to perfectionism, social pressure, culture of college, coaches, and athletes who participate in endurance or appearance sports.

Perfectionism does not have a lot of research support to be a risk factor on its own for eating disorders, but when it is present with other risk factors, it can become one. Athletes show higher perfectionism than non-athletes and perfectionism is a trait more positively correlated with eating disorders in athletes than in non-athletes. Hopkinson and Lock found that disordered eating attitudes increased with perfectionism in both recreational and varsity college athletes. While athletics are commonly associated with perfectionism, it is possible that the personal expectation of high performance in combination with a high-pressure environment is the major risk factor for the development of an eating disorder.
Social pressure that influences the development of eating disorders comes from a variety of sources including peers, culture, and the media. The greater the pressure, the greater the presence of eating disorders.\textsuperscript{14,19} Individuals with a higher body mass index than their peers, even if their own body was within a healthy range, felt greater body dissatisfaction and may have a higher tendency for disordered eating.\textsuperscript{19} Women who report having more friends who diet have more eating disorder symptoms than those who do not have many friends dieting.\textsuperscript{14}

In today's American culture, thinness is glamorized.\textsuperscript{14} Being very thin is associated with sex appeal, popularity, status, self-esteem, happiness, control, achievement, and an enhanced quality of life.\textsuperscript{27} This message appears to be much stronger for females than males and is seen all over television and magazines.\textsuperscript{28} Entertainment television, movies, and fashion advertisements have long been linked to disordered eating in women.\textsuperscript{18} An analysis of 40 prime-time programs aired during the fall 2001 suggested that the shows college women are frequently watching involve "thin" female characters.\textsuperscript{18} Similar results were reported with women who reported reading magazines categorized as "thin-ideal."\textsuperscript{18} Women exposed to the "thin-ideal" were more likely to exhibit disordered-eating characteristics such as bulimia, anorexia, and a drive for thinness. These women also reported increased dissatisfaction with the way they looked and may even have taken dangerous steps to modify their body shape.\textsuperscript{18}
The culture of college itself may intensify the pressure to be thin, thus making it a risk factor for developing an eating disorder. College may overwhelm students with new and stressful events and emotions. In an attempt to manage these feelings, some students turn to disordered eating habits, such as starvation, binging, overeating, purging, and/or obsessive exercise because these are things that can be directly controlled by the student.

Coaches may also be a source of social pressure for the athletic population. A significant number of female athletes who dieted to help improve their performance had been told by a coach to lose weight or did so on their own in an attempt to meet the expectations of their coach. What a coach says, whether it is intended to or not, may reinforce disordered eating behaviors and unhealthy, low body weights. A comment that was intended to be harmless about a female athlete's shape or weight may cause the athlete to engage in unhealthy eating behaviors to prove otherwise.

Female athletes, whether they are serious or recreational athletes, are at an increased risk for eating disorders. The risk may be as much as six times greater than the general public. Athletes who participate in endurance sports in which excess body weight may hinder performance, or sports in which performance is judged by the participant's physical appearance, are considered to be at high risk for eating disorders. These types of athletes include but are not limited to dancers, gymnasts, figure skaters, long-distance runners, swimmers, divers, and cheerleaders. Guthrie stated that the highest distributions of binge eating were in female gymnasts (64%), cross-country
runners (54%), and swimmers and divers (49%). The highest distributions of purging were in female gymnasts (55%), cross-country runners (31%), and swimmers and divers (27%). Hopkinson and Lock\cite{26} found that 7.8-17.6% of varsity female athletes and 17.6-33.8% of recreational female athletes were at risk for an eating disorder, especially those with an obligatory attitude towards exercise. Finally, competition anxiety is significantly correlated with unhealthy dieting practice that may lead to disordered eating.\cite{19}

College Wellness/Recreation Centers and Eating Disorders

There is an increasing concern regarding the safety of individuals who are at-risk or already diagnosed with an eating disorder who utilize wellness/recreational facilities on college campuses. Many individuals on college campuses use the recreational/wellness centers for fitness including those individuals at risk for an eating disorder and those individuals with a diagnosed eating disorder. In addition to the general campus community, college athletes may be utilizing the facilities.\cite{34} It has been reported that 44.6% of athletes exercise outside of their regular team practice.\cite{20}

Many studies have been done on eating disorder behaviors in college-aged females and athletes, but minimal if any research has been done on how it carries over into a college recreation/wellness facility. Research also recommends that increased efforts be made to educate sports and fitness personnel in the recognition and prevention of eating disorders.\cite{12,16,26,35-38} One study goes as far as recommending that sports and fitness personnel practice
healthy exercise behaviors themselves and serve as role models for those around them.\textsuperscript{39}

Tylka and Subich\textsuperscript{37} report that when women use maladaptive techniques to control their weight, 27.7% use heavy exercise in addition to disordered eating behaviors and view these behaviors as safe with few consequences to their physical health. Calogero and Pedrotty\textsuperscript{40} found that “exercise abuse, in some form, appears to be an underlying commonality across all eating disorder diagnoses.” If not treated or intervened upon, these habits may exacerbate into many medical complications including but not limited to bone loss, amenorrhea, cardiac problems, and potentially, death. One study reported that 13% of female college exercisers workout 450 minutes per week (90-minute workouts 5 times per week or 60-minute workouts 7 times per week) and 7% of women work out over 600 minutes per week (> 90-minute daily workouts).\textsuperscript{20}

The interactions that individuals at risk for or diagnosed with eating disorders experience with other fitness goers and staff may promote the exacerbation of an eating disorder. The existence of excessive exercisers, interactions between wellness/recreation center staff and clients, interactions between clients, high-risk individuals, and individuals diagnosed with anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified is what increases the concern within college wellness/recreation centers. In sport and exercise environments, women may perceive that others are evaluating them physically which may lead to increased exercise.\textsuperscript{41} Women who are dissatisfied with their bodies are at increased risk for developing disordered eating and
exercise habits.\textsuperscript{42-43} Staff needs to recognize even subtle cues to help clients recognize the positive attributes of their physical appearance, promoting self-efficacy, reduced internalization or acceptance of the thin-ideal, and facilitating the rejection of the thin-ideal.\textsuperscript{21}

Young adult females frequently participate in “fat talk” and make disapproving remarks about their own and other’s bodies, which suggests a perceived cultural message that females dislike their bodies and should attempt to change them.\textsuperscript{28} This type of conversation is accepted in many circles and increases the risk of eating disorders. Staff may also make sure certain conversations including “fat talk” within the facilities do not promote eating disorders by intervening, redirecting, and stopping the conversations when the conversations are inappropriate.

The ‘at risk’ individual may visualize how he or she wants to look by looking and comparing him/herself to their personal trainer, for example, or other clients at the gym.\textsuperscript{20} When 40\% of aerobic instructors have experienced a history of eating disorders, these interactions may be feeding into these individuals and helping promote or reinforce the eating disorders.\textsuperscript{44}

As mentioned earlier, body dissatisfaction is the strongest predictor of developing an eating disorder. Although body dissatisfaction is a strong predictor of disordered eating, it can be beneficial. A certain amount of it is often a helpful and necessary motivator for healthy weight loss and exercise in many individuals.\textsuperscript{46} Individuals who exercise in an environment in which the focus is general health and well-being instead of shape or size develop a more positive
body image, increase their self-acceptance, and decrease their risk for developing eating disorders.36

Thus, the purpose of this study is to determine what is happening within recreation/wellness centers relative to eating disorders. More specifically, which professionals are employed by college campus recreational/wellness centers; whether or not formal training on eating disorders for employees takes place within the facility; if so, what is the content of a formal training offered within the facility; the types of policies and procedures in place relative to individuals with eating disorders; and the method of public awareness on eating disorders utilized within the facility will be reviewed.
CHAPTER III

METHODS

The following methodology includes subject selection, survey development and contents, and procedures. Data analysis and reporting are also provided.

Subject Selection

The sample used for this study came from the 2004 NIRSA Recreational Sports Directory. Every four-year institution listed in the directory that listed a wellness/recreation director as part of the sample. The e-mail address for each director was obtained from the directory, from the institution's web site, or by contacting the institution and requesting the contact information for the specified director. Based on the population and type of survey, a return rate of 39.6 ± 19.6% was needed to provide an ideal number of surveys for analysis.

Survey Development and Contents

The survey was developed by means of a literature review and with input from faculty and staff at the University of North Dakota. Individual's utilized include physical therapy instructors, wellness director, Eating Disorder Intervention Team (EDIT) staff, counseling center staff, the Office of Medical Education statistician, and Dr. James E. Mitchell, Professor and Chair, Clinical Neuroscience. The survey had 19 closed-ended questions in 4 categories with a
few options for open-ended responses. Please refer to Appendix A for a copy of the internet survey used.

The first section asked questions pertaining to the institution’s demographics. Questions were asked regarding regional location, enrollment, and type of institution (public, private, professional). The second section asked questions pertaining to the recreation/wellness center demographics. Questions were asked regarding number of users per week and number of visits made by those users per week. Questions were also asked about staff training with regard to eating disorders. The third section asked questions to determine how in-house training on eating disorders is accomplished in these facilities if it is in place at all. Questions were asked regarding who provides the training, the content, and the length of training. The final section asked questions to determine if and how these facilities minimize pressure on individuals at risk for and/or diagnosed with eating disorders. Questions were asked regarding policies and procedures, body composition assessments, excessive exercise habits, dress code, and promotion of eating awareness to the public.

Respondents were also asked to provide any policies and procedures they had for their facility regarding eating disorders and excessive exercise they were willing to share. Participants were given the option in another database to request study results and copies of any policies and procedures shared during the course of the study.
Procedures

The survey was created in the form of an internet survey with the help of the Office of Medical Education. It was reviewed numerous times by University of North Dakota faculty and many revisions were made. Once the final revision was made, a link to the survey was sent to individuals with a cover letter explaining the purpose of the study. Please refer to Appendix B for all cover letters. Numerous e-mails were returned after the first mailing and corrections were made to the e-mail addresses (group 2) and were re-sent with the initial cover letter. A reminder letter was sent to the individuals who received the initial mailing (group 1) two weeks after the initial mailing. A final reminder letter was sent to group 1 two weeks after the first reminder was sent. A first and only reminder letter was sent to group 2 two weeks after the initial letter was sent. Only one reminder was sent to group 2 due to the time constraints of the study. The reminder letters were sent to increase the response rate.

Data Analysis and Reporting

All responses were entered into a database at the time the survey was submitted. Using the statistical program SPSS, the information in the database was analyzed using descriptive statistics. Responses within all the text boxes were compiled and categorized.

Results of this survey will be reported to the University of North Dakota Physical Therapy Department, University of North Dakota Wellness Center, and any individual who requested the information during the process of completing the survey.
CHAPTER IV
RESULTS

Six-hundred eighty-six internet surveys were sent through the United States of American to four-year college wellness/recreation directors for this study. Thirty-one surveys were undeliverable, resulting in 655 surveys being delivered. In the time allotted, 164 surveys were returned, resulting in a response rate of 25.0%. Seventy-nine of the respondents requested a copy of the results. Eighty-nine of the respondents requested a compilation of policies and procedures submitted during the survey process. Results will be reported in the following categories: respondent demographics, recreation/wellness center demographics, staff training relative to eating disorders, and minimizing the pressure of environmental interactions that may exacerbate an eating disorder.

Respondent Demographics

Respondents were asked to identify the region in which their college/university was located. Twenty-four percent of the total respondents (n = 164) were from the Southeast region, while 20% were from the Southern-Midwest region. For complete distribution of respondents see Figure 1. The on-campus student enrollment for the colleges/universities surveyed is listed as follows: < 2,500 is 22%, 2,501-15,000 is 46%, > 15,001 is 32% (Fig. 2). One hundred seven of the colleges/universities were public and 51 were private. Of
Figure 1. Location of the respondents' university.

Figure 2. On campus enrollment of 4-year universities.
these, 37 of the public and private schools offered graduate or professional education (Fig. 3).

![Figure 3. School type.](image)

**Recreation/Wellness Center Demographics**

In order to determine how much and how often recreation/wellness centers are utilized, respondents were asked how many individuals visited their facility in a week and the total number of visits by those individuals in a week. Respondents indicated users per week was 2,501-5,000 (33%), followed by 501-1,000 users (29%) (Fig. 4). Respondents indicated individuals use these facilities greater than or equal to 5,001 total visits per week (33%), followed by 1,001 to 2,500 and 2,501 to 5,000 visits per week (both at 21%) (Fig. 5).

**Staff Training Relative to Eating Disorders**

Results reported in this section will include identification of employees who receive training, the content of the training, and the format in which the
Figure 4. Numbers of individuals who use the wellness/recreation center per week.

Figure 5. Total number of visits made to the wellness/recreation center per week.
content is delivered. Less than half (44%) of all staff at a recreation/wellness center have received training on eating disorders. Of the identified employees, 80% of health/wellness coordinators are trained, along with 70% of registered dietitians, 59% of athletic trainers, and 58% of exercise physiologists. In contrast, only 6% of receptionists, 12% of massage therapists, 21% of gym supervisors, and 32% of physical therapists have received training (Table 2). For those who have training prior to their employment, the most frequently trained are the health and wellness coordinators, directors, assistant directors, and athletic trainers. Those least likely to receive pre-employment training were the massage therapists, receptionists, physical therapists, and gym supervisors. Those who received in-house training most frequently were the directors, assistant directors, group exercise instructors, and health and wellness coordinators. Those who received in-house training least frequently were the massage therapists, physical therapists, receptionists, and strength and conditioning trainers.

For the employees who receive training, respondents were asked to identify the content including general education on eating disorders, identification of red flags, appropriate intervention strategies, and appropriate referral mechanisms. For the individuals who received training, the greatest emphasis in descending order was on identification of red flags (73%), general education on eating disorders (65%), and appropriate referral mechanisms (60%). Minimal training appears to be provided on appropriate intervention strategies (29%).
Table 2. Staff Training Relative to Eating Disorders

<table>
<thead>
<tr>
<th>Position</th>
<th>Yes (n/%)</th>
<th>No (n/%)</th>
<th>Eating Disorder Overview</th>
<th>Red Flags</th>
<th>Appropriate Intervention</th>
<th>Appropriate Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>56 (40)</td>
<td>85 (60)</td>
<td>77%</td>
<td>82%</td>
<td>27%</td>
<td>77%</td>
</tr>
<tr>
<td>Assistant Director</td>
<td>56 (48)</td>
<td>60 (52)</td>
<td>84%</td>
<td>93%</td>
<td>27%</td>
<td>71%</td>
</tr>
<tr>
<td>Athletic Trainer</td>
<td>33 (59)</td>
<td>23 (41)</td>
<td>76%</td>
<td>85%</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>Exercise Physiologist</td>
<td>22 (58)</td>
<td>16 (42)</td>
<td>68%</td>
<td>77%</td>
<td>55%</td>
<td>73%</td>
</tr>
<tr>
<td>Group Exercise Instructor</td>
<td>49 (45)</td>
<td>61 (55)</td>
<td>53%</td>
<td>76%</td>
<td>14%</td>
<td>63%</td>
</tr>
<tr>
<td>Gym Supervisor</td>
<td>20 (21)</td>
<td>76 (79)</td>
<td>45%</td>
<td>80%</td>
<td>15%</td>
<td>65%</td>
</tr>
<tr>
<td>Health/Wellness Coordinator</td>
<td>75 (80)</td>
<td>18 (20)</td>
<td>69%</td>
<td>71%</td>
<td>35%</td>
<td>63%</td>
</tr>
<tr>
<td>Massage Therapist</td>
<td>5 (12)</td>
<td>37 (88)</td>
<td>20%</td>
<td>60%</td>
<td>0%</td>
<td>60%</td>
</tr>
<tr>
<td>Personal Trainer</td>
<td>42 (47)</td>
<td>47 (53)</td>
<td>62%</td>
<td>76%</td>
<td>12%</td>
<td>60%</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>9 (32)</td>
<td>16 (68)</td>
<td>56%</td>
<td>44%</td>
<td>22%</td>
<td>44%</td>
</tr>
<tr>
<td>Receptionist</td>
<td>5 (6)</td>
<td>73 (94)</td>
<td>100%</td>
<td>80%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Registered Dietitian</td>
<td>30 (70)</td>
<td>13 (30)</td>
<td>73%</td>
<td>77%</td>
<td>77%</td>
<td>73%</td>
</tr>
<tr>
<td>Strength/Conditioning Trainer</td>
<td>24 (48)</td>
<td>25 (52)</td>
<td>58%</td>
<td>54%</td>
<td>29%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Total Percent of Training        | 44%       | 66%      | 65%                      | 73%       | 29%                      | 60%                  |
This trend appears to be consistent across staff positions. For a complete listing of all positions and training relative to eating disorders, see Table 2.

Of the four-year institutes that provide in-housing training on eating disorders, the vast majority of the length was 0-1 hours (61%) and 2-3 hours (34%). The content of the in-house training focused primarily on general education on eating disorders (52%), identification of red flags (50%), and appropriate referral mechanisms (47%). Very few facilities focused on interventions for inappropriate exercise patterns (31%), and even less on interventions for inappropriate conversations (13%). For a complete listing regarding in-house eating disorder training, see Table 3. Respondents were asked to explain the format of their in-house training. There were 31 narrative responses; most commonly eating disorder training was provided during general staff training (n = 8) and/or by Student Health Services and Counseling Staff (n = 8). Five facilities report using literature and journal articles, 4 use workshops, 3 use staff meetings, and 2 use staff group discussions. See Appendix C.

The original plan was to compare these data across regions; however, the responses for all the positions were too low to analyze except for 2 of the positions, director and assistant director. For the director, there was no significant difference in whether or not they receive training among regions ($\chi^2 (5) = 6.339, p = .275$), and for the assistant director, there was no significant difference in whether or not they receive training among regions ($\chi^2 (5) = 2.935, p = .709$).
Table 3. In-house Training Relative to Eating Disorders

<table>
<thead>
<tr>
<th>Provider of In-house Training</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department Staff</td>
<td>35 (26%)</td>
</tr>
<tr>
<td>Staff from Other Departments</td>
<td>55 (41%)</td>
</tr>
<tr>
<td>Consultants</td>
<td>9 (7%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training Content</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>General Education on Eating Disorders</td>
<td>70 (52%)</td>
</tr>
<tr>
<td>Diagnostic Criteria</td>
<td>26 (19%)</td>
</tr>
<tr>
<td>Identifying</td>
<td></td>
</tr>
<tr>
<td>Red Flags</td>
<td>67 (50%)</td>
</tr>
<tr>
<td>Inappropriate exercise patterns</td>
<td>60 (44%)</td>
</tr>
<tr>
<td>Inappropriate conversations between staff and clients</td>
<td>40 (30%)</td>
</tr>
<tr>
<td>Inappropriate conversations between exercisers</td>
<td>17 (13%)</td>
</tr>
<tr>
<td>Intervention</td>
<td></td>
</tr>
<tr>
<td>Inappropriate exercise patterns</td>
<td>42 (31%)</td>
</tr>
<tr>
<td>Inappropriate conversations</td>
<td>18 (13%)</td>
</tr>
<tr>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>Policy/Procedures</td>
<td>63 (47%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training Format</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readings</td>
<td>15 (11%)</td>
</tr>
<tr>
<td>Lecture</td>
<td>9 (7%)</td>
</tr>
<tr>
<td>Seminar</td>
<td>6 (4%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Hours</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 hour</td>
<td>51 (61%)</td>
</tr>
<tr>
<td>2-3 hours</td>
<td>28 (34%)</td>
</tr>
<tr>
<td>4-5 hours</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>6-7 hours</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>8+ hours</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

The number of responses for the second page of the survey dropped from 164 to 130. This page requested information regarding student vs. professional employee, full-time vs. part-time employee, and whether eating disorder training occurs prior to employment or in-house. All of the directors were professional
and full-time employees. Eighteen had eating disorder training as part of their degree or prior to employment and 38 received in-house training. Most of the health and wellness coordinators were professional and full-time employees. Twenty-two had training on eating disorders as part of their degree or prior to employment and 22 received in-house training. A majority of the group exercise instructors were students and part-time employees. Ten had eating disorder training as part of their degree or prior to employment and 28 received in-house training. A majority of the gym supervisors were students and part-time employees. Three had eating disorder training as part of their degree or prior to employment and 10 received in-house training. While gym supervisors and personal trainers have minimal eating disorder training as part of their degree or prior to employment, they tend to participate in in-house training at a greater frequency than do other positions in which minimal training occurs prior to employment. For a complete listing, see Table 4.

Minimizing the Pressure of Environmental Interactions

That May Exacerbate an Eating Disorder

Environmental factors that exacerbate eating disorders include pictures, media, and conversation. Respondents were asked how facilities attempt to minimize the pressures of these factors. Thirty-eight percent of the facilities have a policy/procedure for referring or providing intervention for individuals and/or situations in which eating disorders are suspected or known. The most frequent description of this was to refer the individual to student Health Services or Counseling Center (35 facilities). In 11 facilities, the staff talks with the
Table 4. Type of Position and Specialized Training Specific to Eating Disorders

<table>
<thead>
<tr>
<th>Position</th>
<th>Student</th>
<th>Professional</th>
<th>Full-time</th>
<th>Part-time</th>
<th>Prior to Hire/Degree</th>
<th>In-house Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>0</td>
<td>66</td>
<td>66</td>
<td>2</td>
<td>18</td>
<td>38</td>
</tr>
<tr>
<td>Assistant Director</td>
<td>2</td>
<td>53</td>
<td>55</td>
<td>2</td>
<td>18</td>
<td>35</td>
</tr>
<tr>
<td>Athletic Trainer</td>
<td>7</td>
<td>24</td>
<td>25</td>
<td>4</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>Exercise Physiologist</td>
<td>3</td>
<td>15</td>
<td>12</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Group Exercise Instructor</td>
<td>37</td>
<td>15</td>
<td>10</td>
<td>36</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Gym Supervisor</td>
<td>27</td>
<td>10</td>
<td>10</td>
<td>18</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Health/Wellness Coordinator</td>
<td>3</td>
<td>36</td>
<td>35</td>
<td>2</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Massage Therapist</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Personal Trainer</td>
<td>27</td>
<td>9</td>
<td>5</td>
<td>27</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Receptionist</td>
<td>13</td>
<td>11</td>
<td>13</td>
<td>9</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Registered Dietitian</td>
<td>2</td>
<td>9</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Strength/Conditioning Trainer</td>
<td>5</td>
<td>14</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>
individual in question. Three facilities require physician clearance to use the facility and 2 revoke facility privileges. In addition, 2 facilities noted that they are not legally allowed to interfere with student use privileges.

A majority of the facilities offer body composition assessments, but less than half of the facilities monitor the number of times the individual has their body composition assessed and only 27% have a mechanism for referral if body composition falls outside that recommended for the age group and gender. For a complete listing, see Table 5.

Forty-eight percent of the facilities identify individuals with low body weight, but only 20% actually manage these individuals. Individuals are identified most frequently by staff observation (17 facilities). Eight facilities perform fitness assessments and 5 keep administrative reports and records to identify at-risk individuals. If a concern is present, 15 facilities refer the individual to Student Health Services and Counseling Center. A few facilities require physician clearance prior to using the facility. Other facilities monitor the individual’s usage and/or visit with the individual when there are concerns. See Table 5 and Appendix C.

Fifty-four percent of the facilities identify individuals with excessive exercise habits, but only 30% actually manage these individuals. Individuals are identified most frequently by staff observation (27 facilities). Ten facilities identify individuals by monitoring facility usage records and reports. When facilities have concerns, many approaches are used. The most frequent approaches include conversations with the individual (n = 12), referral to Student Health Services and
Table 5. Ways Facilities Minimize Pressure That May Cause or Exacerbate an Eating Disorder.

<table>
<thead>
<tr>
<th>Facility/Measure</th>
<th>Yes (n/%)</th>
<th>No (n/%)</th>
<th>Yes (n/%)</th>
<th>No (n/%)</th>
<th>Yes (n/%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/procedure for referral/intervention</td>
<td>58 (38%)</td>
<td>93 (62%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body composition</td>
<td>58 (38%)</td>
<td>93 (62%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor number of times</td>
<td>109 (69%)</td>
<td>48 (31%)</td>
<td>54 (44%)</td>
<td>68 (66%)</td>
<td></td>
</tr>
<tr>
<td>Guidelines for referral</td>
<td>32 (27%)</td>
<td>87 (73%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify individuals with low body weight</td>
<td>75 (48%)</td>
<td>82 (52%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manage individuals with low body weight</td>
<td>31 (20%)</td>
<td>125 (80%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify individuals with excessive exercise habits</td>
<td>86 (54%)</td>
<td>72 (46%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manage individuals with excessive exercise habits</td>
<td>47 (30%)</td>
<td>108 (70%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff dress code</td>
<td>39 (25%)</td>
<td>118 (75%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client dress code</td>
<td>105 (66%)</td>
<td>53 (33%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote health body image</td>
<td>98 (63%)</td>
<td>57 (37%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote eating disorder awareness to the public</td>
<td>97 (61%)</td>
<td>61 (39%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posters</td>
<td></td>
<td>60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotional materials</td>
<td></td>
<td>57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brochures</td>
<td></td>
<td>68</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Word of mouth</td>
<td></td>
<td>42</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Campaigns</td>
<td></td>
<td>39</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Love Your Body Week</td>
<td></td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community resources list</td>
<td></td>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Counseling Center (n = 11), reporting of the incident to other department to get help with the intervention (n = 7), having time and usage limits (n = 6), client education (n = 2), and medical clearance to use the facility (n = 2). See Table 5 and Appendix C.

To promote a healthy environment, 22% of the facilities have a staff dress code and the majority of facilities have a client dress code. Staff dress codes include a staff t-shirt or uniform (13 facilities) and the prohibition of revealing attire (13 facilities). As for client dress codes, there are some common basic ideas provided by respondents. Full shirts and no short shorts are frequently required. However, the rules are in place for client safety, hygiene, and equipment preservation, not eating disorder prevention (30 facilities). Many facilities stated that a bare midriff was unacceptable (clothing included sport bra tops and tank tops), but few reasons were given as to why (37) facilities. Some reasons for instilling a client dress code include increasing comfort levels of neighboring exercisers. Two facilities had rules that were specific to avoiding eating disorders, including no excessive clothing or layers are allowed. The rules on client dress code are implemented upon entrance to the facility or during room monitoring (21 facilities). If client dress code rules are not abided by, individuals are asked to change or leave (20 facilities) or a verbal warning or explanation of the rules may be provided (15 facilities). See Appendix C for the complete list of responses to dress code policies.

Sixty-three facilities reported that they promote a healthy body image, and 61% reported that they promote eating disorder awareness to the college.
community. The most common ways they promote eating disorder awareness to the campus were through posters and brochures. This promotion is done more by other departments but is also done interdepartmentally. Some activities are also used, such as a no scale policy in the building and National No Diet Week. See Table 5 and Appendix C.
CHAPTER V
DISCUSSION

The following discussion includes information regarding response rate of the survey, respondent demographics, staff training relative to eating disorders, minimizing the pressure of environmental interactions that may exacerbate an eating disorder. Limitations and future research implications are also provided.

Response Rates

In comparison to other internet survey response rates, 39.6 ± 19.6%, the response rate for this survey was average, 25.0%. In a meta-analysis by Cook, Heath, and Thompson, 5 categories were discussed in regard to their impact on response rate in web-based surveys: number of contacts, use of a personalized transmission letter, pre-contact, survey salience, and incentives offered. In this study, return of surveys may have been enhanced if all recipients had received two reminder e-mails instead of some receiving only one. Lack of a personalized transmission letter may have decreased the response rate. Our letter was generalized (i.e., to Dear Director), but with a personalized letter, the response rate may have increased by 10%. If we had pre-contacted individuals, our response rate may have increased slightly. Through the literature search and communications with staff at the University of North Dakota's Wellness Center and the Eating Disorders Intervention Team, we feel the survey was very salient.
to the individuals surveyed. Incentives were offered – policy and procedure recommendations and a copy of the research results. Incentives sometimes give a response rate of less than 30%; the use of incentives may have actually lowered the response rates in this survey. In conclusion, our response rate was lower than we desired; however, it was less than one standard deviation below the mean reported by Cook, Heath, and Thompson.

Respondent Demographics

The response rate from each region was representative when compared to the total percentage of four-year colleges in each region. The Northeast region was slightly under represented and the Southern Midwest was slightly over represented. The actual percentage of colleges in each region followed by the region’s response rate is as follows: Northeast - 27%/18%, Southeast - 25%/24%, Great Lakes - 15%/17%, Southern Midwest - 14%/20%, Northern Midwest - 8%/9%, and West - 11%/11%.

Staff Training Relative to Eating Disorders

Studies have shown clinicians have a general lack of training, competence, and confidence working with individuals with eating disorders. Some professionals of recreation/wellness centers who have training receive it as part of their degree or certification. Even so, Jones et al report that curriculum content for professionals often lacks a structured and focused approach relative to eating disorders. Inclusion of learning opportunities on eating disorders relies on expressions of interest from students and the availability of an equally interested and knowledgeable clinician to deliver the
Employees may also receive training as continuing education requirements.

Staff of wellness/recreation centers should be trained to approach individuals of concern and feel confident in doing so. Approaching the client may be challenging if staff are not educated on how to have conversations in a professional, confident, sincere, and non-threatening manner. When a professional initiates conversation with an at-risk client, the client may feel comforted or threatened. The client may be only in the beginning stages of the disorder and the intervention could be seen as prevention to exacerbation, or the individual may already be in the denial stages of the eating disorder and further action will be warranted. In this study, only 11 facilities stated they start a direct conversation with the client in which red flags are identified. In this study, it is uncertain whether this low number ($n = 11$) is due to survey question design, deliberate policy and procedure guidelines, or as noted earlier, a lack of training and confidence of staff.

As previously noted, results show that little training is being done within facilities. Professionals who are higher in the organization (directors, assistant directors, and health and wellness coordinators) are most frequently trained prior to employment in the facility. They receive the most in-house training as well. The floor staff had the least training prior to hiring as well as the least amount of in-house training. Thirteen respondents described the format of their in-house training as being part of their general staff training or periodic staff meetings.
The content of the in-house training is provided in a general manner. For example, general education on eating disorders, identification of red flags, and referral mechanisms were most often addressed, leaving the topic of intervening in inappropriate conversations or inappropriate exercise patterns the least discussed. Interactions between fitness staff and clients may reinforce disordered ways of thinking (e.g., body dissatisfaction) or ways individuals identify themselves (e.g., “I need to look like . . .”), especially for the at-risk individual as well as the individual already diagnosed with an eating disorder. Each topic relative to content of eating disorder and its complexity should be addressed with each employee as specific to their role. For example, receptionists are the least likely to have training on eating disorders, but the receptionist is most often the first employee to be in contact with the client when he/she enters the facility. The receptionist’s role may be to observe the way the client is dressed or perhaps the fact that the individual has already been to the facility multiple times that day. Receptionists may often hear conversations between clients relative to disordered eating and it is recommended that intervening upon inappropriate conversations may prevent exacerbation. The receptionist may also pass his or her concerns to a supervisor. This example demonstrates the fact that each employee has his/her own role in promoting health and alerting others of concerns relative to eating disorders.

Most of the training in the responding facilities is very short in length, as 95% of the training is between 0 and 3 hours long. A three-hour training session may limit the amount of information given on the complex discussion of eating
disorders. The short length of training sessions may be a factor in the lack of general training overall.

Minimizing the Pressure of Environmental Interactions That May Exacerbate an Eating Disorder

An environmental factor that exacerbates eating disorders is conversation. Conversation between staff and clients or conversation between clients can reinforce an eating disorder already diagnosed or exacerbate an at-risk individual. In order to prevent or intervene upon inappropriate conversations, facilities must have a policy and procedure in place so all staff members are prepared and competent when situations arise where intervention is appropriate.

In this study, less than half (38%) of the facilities say they have a policy and procedure in place for intervention and referral purposes. Thirty-five respondents described their own policy as referring the individual to a student health facility or a counseling center. But before a referral can be made, identification of the client must first occur.

Identification is the activation point of the intervention process. The results indicated that 48% of the facilities identify clients with low body weight and 54% of the facilities identify clients who excessively exercise. Forty-seven respondents reported they identify these individuals by staff observation; documentation of intensity, frequency, and length; followed by alerting a supervisor. Soon after identifying the client, intervention must take place with the at-risk individual. Only 20-30% of the facilities actually do something about these individuals after they are identified. Specific says facilities manage individuals
with low body weight or exercise habits were referral to a physician and medical clearance for use of the facility. Some facilities stated that they are not allowed to interfere with student usage privileges. They also stated "someone with an eating disorder is classified as someone with a disability, so not allowing them to participate in programs or use the facility would be like not letting someone with a disability use the facility."

Participants were also asked about whether or not their facility provides body composition assessments. Results of body composition assessments can be a red flag is and when the individual is not within the normal ranges relative to their age and gender. In this study, less than one-third of the facilities who provided body composition assessments reported a mechanism for referral if the individual is not within recommended range relative to age and gender.

Individuals with eating disorders, more specifically anorexia nervosa, are striving toward a "perfect" body. In turn, individuals may compulsively want their body composition assessed, thus monitoring the number of times an individual requests his/her body composition assessed may be considered another red flag.

In addition to identifying the at-risk client on an individual basis, there are environmental factors that may exacerbate or reinforce eating disorders. Females are conditioned to make constant social comparisons between themselves and the highly reinforced cultural models of the ideal body type. It has been shown that the ultra-thin ideal-body image portrayed in the media has contributed significantly to the increase in eating disorders. Magazines,
posters, people on TV, or even the way staff members or other clients are dressed may intensity the pressure to meet the “ideal.”

Having a client and staff dress code may be a way to minimize some pressure within recreation/wellness centers. Majority of the facilities say they do employee a client and/or staff dress code. Some facilities have policies that could prevent the development of eating disorders. Some of these comments included: “No [we do not have a dress code] - but we do have ‘policy, standards, and guidelines’ that our fitness area staff is prepared to enforce if the clothing is not appropriate for the activity, environment, or such that places the customer at risk (as in the case of revealing or altered clothing),” and “Shorts with a minimum of 2" inseam and shirts that fully cover the torso are required. Excessive clothing (multiple layers, hoods, rubberized or neoprene-type clothing) is not permitted.”

Another way to prevent eating disorders or exacerbation of eating disorders is to promote awareness to the public. Many facilities stated that they promote a healthy body image and promote eating disorder awareness to the campus community. A majority of the respondents use posters and brochures as a means of promoting eating disorder awareness to the public. Sending this survey out to 686 facilities has also sparked increased awareness relative to eating disorders and what is being done to prevent further exacerbations. An example from one facility relative to staff in-house training stated, “Recreation center student employees do not receive formal training (although this questionnaire may change that), but numerous times they are the ones who identify excessive exercisers to professional staff.”
Limitations

There are many factors that may have played a role in limiting the results of this study. The lack of a clear definition of "discipline specific interventions" within the survey may have contributed to the low percentage rate of responses in that field. "Interventions" could have been interpreted as a group therapy outside of the facility, instead of direct interventions that occur within the facility in order to cease inappropriate conversations or approaching the at-risk individual.

In the section of the survey that asked the question about "specialized training specific to eating disorders," the numbers rarely added up to the number listed in the "type of position" section. With regard to the number of answers given for specific type of training, the responses may not have been consistent because of the instructions to check all the apply. This lack of congruence may have made the listing of the results inaccurate and the question could have been better worded. The numbers themselves may not be a good representative of what is actually going on because we did not specify and, therefore, do not know, if the training that occurs takes place prior to employment, in-house, or both.

Another limitation may have been the length of the survey. The survey is three pages long, which may have led to the decreased responses on the second and third pages. There were 18 text boxes on the first page, nine of which required short answers. The remaining 9 text boxes required lengthy descriptions. The multitude of these text boxes within the survey may have
increased the time it took to complete the survey making time an issue. The time issue, in turn, may have decreased the willingness of the respondents to complete the survey in full.

We had a number of failed e-mails due to inaccurate e-mail addresses that were found in the 2005 NIRSA Recreational Sports Directory. Because of the number of failed e-mails, this may have decreased the number of surveys sent out which may have decreased the number of responses received.

Future Research Implications

Similar research should be done in the future since this was a pilot study. It would be interesting to see if other researchers get the same or different results. Future research could also include finding out more specifically what facilities are doing to promote eating disorder awareness and how this corresponds with current literature recommendations and guidelines.
CHAPTER VI
CONCLUSION

This study looked at eating disorder programming in four-year college wellness/recreation centers. Less than half of all staff at recreation/wellness centers have received training on eating disorders, whether it is prior to employment or through in-house training. The content of the training most frequently included identification of red flags, general education on eating disorders, and appropriate referral mechanisms. There is minimal training on appropriate intervention strategies. Ninety-five percent of the training is between 0 and 3 hours in length.

Overall, an increase in staff training at all levels of employment in wellness/recreation centers is needed. Each employee should have a specific role in providing the appropriate intervention for each situation he/she may encounter. Some staff may be responsible for reporting to a supervisor if they notice an individual who demonstrates at-risk behaviors for the development of an eating disorder. Other staff may be responsible for interacting with the individual at risk or be aware of all the referral sources in the area. It is the responsibility of all staff, no matter what level, to promote health and wellness for all individuals at-risk or diagnosed with an eating disorder. In addition to the
promotion of health and wellness, the prevention of injuries due to eating disorders cannot be accomplished without a team effort.
APPENDIX A
1. Where is your college or university located? Select one.
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6

2. What is the on-campus enrollment of your college or university? Select one.
   - Less than or equal to 2,500
   - 2,501 to 15,000
   - Greater than or equal to 15,001

3. Is your school... Check all that apply.
   - Public
   - Private
   - Graduate/Professional

Recreation/Wellness Center Demographics

4. How many unique users (separately identified individuals) do you average in a week during the academic year?
   - Less than or equal to 500
   - 501 to 1000
   - 1001 to 2500
   - Greater than or equal to 2501

5. How many total visits are made to your fitness area in an average week during the academic year?
   - Less than or equal to 500
   - 501 to 1000
   - 1001 to 2500
   - 2501 to 5000
   - Greater than or equal to 5001

6. Of the following list, which staff, if any, are trained to manage individuals with eating disorders that are suspected or known?

<table>
<thead>
<tr>
<th>Position</th>
<th>Staff Training</th>
<th>If 'Yes' on training, check all that apply level of training specific to eating disorders.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>Yes</td>
<td>Education: eating disorders overview</td>
</tr>
<tr>
<td>Assistant Director</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Athletic Trainer</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Equipment Manager</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Exercise Physiologist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Group Exercise Instructor</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gym Supervisor</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health &amp; Wellness Coordinator</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Massage Therapist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Personal Trainer</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Receptionist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Registered Dietician</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Strength and Conditioning Trainer</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If your center provides in-house training on eating disorders, please answer the following questions.

7. Who conducts the eating disorders training for your staff? Check all that apply.
   - Professional staff within your department
   - Staff from other department(s)
   - Consultant(s)

8. What is the content of the training? Check all that apply.
   - Education
     - Eating disorder overview
     - Diagnostic criteria for eating disorders
   - Identifying
     - Red flags of eating disorders
     - Inappropriate exercise patterns
   - Inappropriate conversations between staff and clients (Ex: excessive focus on body image/lean body mass)
   - Inappropriate conversations between exercisers
   - Interventions
     - For inappropriate exercise patterns
     - For inappropriate conversations
   - Referrals
     - Policies and procedures for referral

9. What is the format of your facility’s in-house training? Check all that apply.
   - Readings
   - Lecture
   - Seminar
   - Other
   
   Please explain.

10. What is the length of training in hours? Select one.
    - 0 to 1
    - 2 to 3
    - 4 to 5
    - 6 to 7
    - 8 or more

11. Are there refresher courses or updates for employees who have already participated in the initial eating disorders training?
    - Yes
    - No
    
    If 'No,' please skip to Question 12.
    
    Who conducts the eating disorders refresher course or updates for your staff? Check all that apply.
    - Professional staff within your department
    - Staff from other department(s)
    - Consultant(s)

    What is the content of the refresher course or updates? Check all that apply.
    - Primarily refresher
    - Updates on previous training
    - Policy and procedure updates

    What is the format of the refresher course or updates? Check all that apply.
    - Staff meetings
    - Mandatory training sessions
    - Continuing education

    What is the length of the refresher course or updates in hours? Select one.
    - 0 to 1
    - 2 to 3
    - 4 to 5
    - 6 to 7
    - 8 or more

Strategies for minimizing pressure on individuals at risk for and/or diagnosed with eating disorders.

12. Does your facility have a policy/procedure for referring or providing intervention for individuals and/or situations in which eating disorders are suspected or known?
    - Yes
    - No
    
    If yes, please describe.

13. Does your facility provide body composition assessments?
    - Yes
    - No
    
    If ‘No,’ please skip to Question 14.
    
    Do you monitor the number of times an individual has their body composition assessed as a possible red flag for an eating disorder and therefore initiate a referral?
    - Yes
    - No

    Do you have a protocol for referring individuals whose percent body fat falls below the minimal recommended percent body fat for their gender?
    - Yes
    - No

14. Do you identify individuals with excessively low body weight?
    - Yes
    - No
    
    If yes, describe how you identify these individuals (i.e., staff observation, administrative reports, etc.).

14a. Do you have any mechanism in place to manage users that are at an excessively low body weight?
    - Yes
    - No
15. Do you identify individuals with excessive exercise habits?
   - Yes
   - No
   If yes, describe how you identify these individuals (i.e., staff observation, administrative reports, etc.).

15a. Do you have any mechanism in place to manage users that are excessively exercising?
   - Yes
   - No
   If yes, please describe.

16. Is there a fitness instructor/group exercise instructor/personal trainer dress code in your fitness area that considers how dress affects individuals at risk for eating disorders?
   - Yes
   - No
   If yes, please describe.

17. Is there a client dress code in your fitness area?
   - Yes
   - No
   If yes, please describe.

If there are dress codes in place, how are they enforced?

18. Do you make a conscious effort to promote a healthy body image with the selection and placement of art work and promotional materials?
   - Yes
   - No

19. Do you promote eating disorder awareness to the general public in your fitness area?
   - Yes
   - No
   If 'Yes,' check all that apply:
   - Posters
   - Promotional Material
   - Brochures
   - Word of Mouth
   - Campaign for Eating Disorder Awareness
   - Love Your Body Week
   - List of Community Resources
   - Other
Please provide additional information regarding personnel who receive training.

<table>
<thead>
<tr>
<th>Position</th>
<th>Type of position: Check all that apply.</th>
<th>Specific to Eating Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Student</td>
<td>Professional</td>
</tr>
<tr>
<td>Director</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Assistant Director</td>
<td>☐</td>
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<tr>
<td>Athletic Trainer</td>
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<tr>
<td>Equipment Manager</td>
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<tr>
<td>Other</td>
<td>☐</td>
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<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Submit Reset
We would like to compile a number of policies and procedures regarding eating disorder staff training from multiple facilities. If you would be willing to share your policy and procedure information please send it as an attachment to the following undpt_medline@medicine.nd.edu

This information is collected on a separate page in a separate database to ensure that your contact information cannot be connected to any of your previous data or comments.

☐ If you would like a copy of the policy and procedure compilation, please check here.

☐ If you would like a copy of the study results, please check here.

Contact information:

This information is collected on a separate page in a separate database to ensure that your contact information cannot be connected to any of your previous data or comments.
APPENDIX B
September 7, 2005

Dear Recreation/Wellness Center Director,

Because you have an intimate knowledge of the recreation and wellness facility(ies) on your campus, we are sending you this e-mail and asking for your help.

Individuals with multiple desires, needs, and goals visit your facility. Specifically, it is likely that individuals with, or at risk for, eating disorders exercise at your facility. It is also possible that interpersonal interactions while there impact the individuals’ approach to exercise. We invite and encourage you to complete the survey (link below) regarding staff training, facility policies and procedures, and methods of education that take place within your facility as pertaining to eating disorders.

Because of the prevalence of diagnosed eating disorders in college age individuals (15.4% for college females, as opposed to 5% nationally), the research findings will be meaningful exercising individuals and to colleges and universities throughout the United States. EVERY 4-year institution listed in 2005 NIRSA is being contacted. We are hoping for a 70+% return rate. Your response is important!

Your participation in this study is voluntary and no penalties will result from refusal to participate. If you do choose to complete this survey, it will take approximately 10 minutes of your time. Please submit the completed survey no later than October 1, 2005. If you feel that you do not have the information available to you to complete this survey, please pass it on to the most qualified person in your department.

Little risk is involved in filling out this survey. All responses will be kept confidential and stored in an electronic database for three years before they are destroyed. Return of the submitted survey will be considered your informed consent. If you would like the results of this research, check the appropriate box at the end of the questionnaire. Please note that your request is sent to a site separate from your responses.

This questionnaire is from the University of North Dakota Department of Physical Therapy and the University of North Dakota Wellness Center. This Project is in partial fulfillment of the requirements for a Doctoral degree in Physical Therapy.

If you have any questions or concerns, please contact one of the researchers listed.
  Tiffany Anderson at (701) 741-1596 or tschloner@medicine.nodak.edu
  Amanda Gulka at (218) 779-4817 or agulka@medicine.nodak.edu
  Renee Mabey, PhD, PT at (701) 777-4854 or rmabey@medicine.nodak.edu

Thank you very much for your response!

Sincerely,

Tiffany Anderson, SPT   Amanda Gulka, SPT   Renee Mabey, PT, PhD
Associate Professor
Advisor, Scholarly Project

Survey:https://med.nodak.edu/pted/edisordpt1.asp
September 7, 2005

Dear

This is a follow-up letter/reminder to an internet survey sent out by the University of North Dakota Department of Physical Therapy and the University of North Dakota Wellness Center.

Many wellness/recreation directors have already completed and returned the survey found at the website listed below; however, it is very important that all others do so as well.

For those of you who have completed the survey, we would like to thank you for your assistance.

For those of you who have not yet had the opportunity to complete the survey, we encourage you to please do so no later than October 1, 2005.

If you have any questions or concerns, please contact one of the researchers listed.
Tiffany Anderson at (701) 7401-1596 or tschlomer@medicine.nodak.edu
Amanda Gulka at (218) 779-4817 or agulka@medicine.nodak.edu
Renee Mabey, PhD, PT at (701) 777-4854 or rmabey@medicine.nodak.edu

Thank you very much for you response!

Sincerely,

Tiffany Anderson, SPT         Amanda Gulka, SPT         Renee Mabey, PT, PhD
Associate Professor
Advisor, Scholarly Project

Survey: https://med.nodak.edu/pted/edisordpt1.asp
APPENDIX C
#9 (What is the format of your facility’s in-house training? Explain)

**Student Health Services and Counseling Center**

- We bring in staff from our Health Services and from Counseling Services to work with us.
- Collaborations with numerous campus partners within Student Health, residential Life, School of Medicine, and Medical Center
- We have the qualified specialist in Health Services talk to our staff.
- In the works but collaborates with Psychological Services, Community Health, Health Services
- A specialist in the University Health Service presented the information to the staff.
- A department on campus (CAPS) speaks to our staff about how to approach someone that you may have a concern about and where to refer them if they are interested.
- We will have counselors from UCPS - come and provide educational information as well as provide workshops/resources that are available on campus.
- Psychologist comes to discuss eating disorders with rec staff.
- Attending workshops at conferences, reading the latest material on the subject, discussion between counselor, student health and wellness coordinator.

**General Staff Training**

- It is part of the training for personal trainers and professional staff in the fitness area.
- Usually held within staff training meetings. Some years it might be a focus topic.
- Lecture: all group fitness instructors and personal trainers go through in-house fitness program for one semester. Within the lecture of nutrition is the topic of eating disorders. In another lecture we also talk about overtraining and the female athlete triad.
- Group fitness instructors, personal trainers and fitness/wellness student assistants receive info during training. Rec. Center student employees do not receive formal training (although this questionnaire may change that) but numerous times they are the ones who identify over exercisers, etc to professional staff.
- Literature is reviewed by Fitness Coordinator, Director and Wellness Education Coordinator; training sessions include overview, ID and referrals; this is part of general training and not part a separate in-service session
- During regular staff training discussions are held concerning identification and referrals.
- Included in staff training and academic class offerings.
- It is part of staff training.

**Literature / Journals**

- Literature is reviewed by Fitness Coordinator, Director and Wellness Education Coordinator; training sessions include overview, ID and referrals; this is part of general training and not part a separate in-service session
- Attending workshops at conferences, reading the latest material on the subject, discussion between counselor, student health and wellness coordinator.
- Try to send any articles related to eating disorders to all staff which comes from the university or outside resources. Mini lectures for students and staff from the university health center.
- It is informal training based on reading articles in professional journals.
- In-house CE ranges from once a semester to once a year and articles are disseminated as well as more formal workshops are held. One-on-one Q & A in my office is a more informal method of educating my staff.

**Workshops**

- Workshops w/ RD's specializing in eating disorders
- Attending workshops at conferences, reading the latest material on the subject, discussion between counselor, student health and wellness coordinator.
- small workshops
- In-house CE ranges from once a semester to once a year and articles are disseminated as well as more formal workshops are held. One-on-one Q & A in my office is a more informal method of educating my staff.

**Staff Meetings**

- in-formal at our meetings, pamphlets and dietician
- Procedures discussed at weekly management meeting.
- staff meeting session

**Staff Group Discussions**

- Those "involved" with disordered eating get together and work on policies, red flags, etc. It isn't an all campus activity.
- A group discussion with employees past experiences after red flags and overview are concluded.
Other

- we show a video on eating disorders to our staff.
- Fitness/Wellness Director
- We don't offer any training in our department
- Special programs are trained in this area.
- Provided by consultant.

#12 (Does your facility have a policy/procedure for referring or providing intervention for individuals and/or situations in which eating disorders are suspected or known? Describe.)

Refer to Student Health Services / Counseling Center (35)

- The procedures for identifying/documenting individuals whom staff suspect may have an eating disorder/exercise addiction. Once behavior is noticed, the Director will speak with the individual and express concern (may request a physician consent form to be completed). Individuals asked to have physician consent will not be able to use the facility until the consent form is returned. Physician will refer to psych services and nutritionist.
- We attempt to begin a dialogue with the individual and assist them in seeking help from trained counseling professionals. As appropriate we have referred the names of individuals we suspect of eating disorders to our Counseling Center.
- If student is an athlete, the athletic trainer or the coach might need to refer to counseling services.
- speak with the person and refer to health center
- Yes but informal. The fitness coordinator asks all fitness staff to refer problematic participants to fitness coordinator, or encourage them to get some feedback from the counseling center.
- Student is referred to Assoc, Asst Director or Coordinator of Fitness/Wellness who talks with individuals. A set procedure was developed for student athletes and it is fairly well followed if a student voluntarily goes to either Student Health or the Student Counseling however, there is no way to make students seek help nor is there a way to exclude them from Rec Center usage at our institution.
- We work very closely with Student Health Education and Student Psychological Services
- Screening process if suspected and referred to appropriate counselor or dietician.
- Developmental. Currently includes referrals, physician clearance, facility access revoked (in rare cases).
- Exercise Physiologist and Registered Dietician can recommend referral to Student Health and Student Counseling Services. Staff cannot "report" concerns to Student Services or the Dean in their role as Fitness Center employees. If staff members are also students, they can make this report in the capacity of concerned peer.
- The individual will generally be referred to me (Director) and then I will refer to Health Services.
- Referral to student counseling services or outside counseling facility
- Contact Counseling Center for help with individual. Each situation varies and we use our on campus resources.
- Referral to our Counseling Center that has a trained counselor for this type of disorder.
- Contact medical department on campus
- Refer to the registered dietician at the wellness center. also refer to the exercise psychologist in the ESS dept.
- refer to counselor at the Student health services.
- Refer to Counseling Center
- Contact counselor and student health.
- four staff suspects someone with an eating disorder we refer them to the counseling office on campus. Their department handles eating disorders.
- Refer to health center
- Not a written policy, but referrals are made to the campus counseling office.
- Contact the Director for health Education Services. She takes individual to private office to talk.
- The process includes documentation and call university health center for counsel.
- Confer with Student Health Center and then approach student to request a screening.
- Individuals are referred to Student Health & Counseling Services.
- Through Student Health Services
- individual is referred to Dean of Students then to Health and Counseling Services.
- Refer individuals to supervisor(s). Individuals are then referred to University Counseling Center and/or Medical Center.
- Report to and advise with our Curry Student Health Service
- refer to health and counseling center on campus.
• We refer our clients to the counseling center on campus
• refer to counseling center
• Individuals are confronted by Fitness Manager and referred to the University Counseling Department for further information.
• Inform the Fitness Director. An intervention will take place with the counseling center, medical staff representative, associate director, and fitness director.
• In general, referral to the counseling center

Staff Talks with the Individual (11)
• The procedures for identifying/documenting individuals whom staff suspect may have an eating disorder/exercise addiction. Once behavior is noticed, the Director will speak with the individual and express concern (may request a physician consent form to be completed). Individuals asked to have physician consent will not be able to use the facility until the consent form is returned. Physician will refer to psych services and nutritionist.
• We attempt to begin a dialogue with the individual and assist them in seeking help from trained counseling professionals. As appropriate we have referred the names of individuals we suspect of eating disorders to our Counseling Center.
• Yes but informal. The fitness coordinator asks all fitness staff to refer problematic participants to fitness coordinator, or encourage them to get some feedback from the counseling center.
• Student is referred to Assoc. Asst Director or Coordinator of Fitness/Wellness who talks with individuals. A set procedure was developed for student athletes and it is fairly well followed if a student voluntarily goes to either Student Health or the Student Counseling however, there is no way to make students seek help nor is there a way to exclude them from Rec Center usage at our institution.
• Staff is directed to keep a good working relationship with the client in question and notify the Fitness Director or Director who will then consult with a team from the university Health Center on steps to take going forward with that student or client.
• Any guest that appears to have an eating disorder is referred to our Assistant Director of Group Fitness. Upon this person being identified it will become the Assistant Director of Group Fitness to evaluate and make any recommendations.
• Refer to the registered dietician at the wellness center. Also refer to the exercise psychologist in the ESS dept. refer to counselor at the Student health services.
• Refer individuals to supervisor(s). Individuals are then referred to University Counseling Center and/or Medical Center.
• if a participant is suspected of having an ED or of excessive exercise, Fitness Director is notified and initial information sharing between university departments in direct contact with suspect (housing, athletics, stud counseling) begins. Based on the information, the next steps are decided.
• individuals who are suspected to have an eating disorder meet with the director, have their rec privileges suspended until they get medical clearance.
• Inform the Fitness Director. An intervention will take place with the counseling center, medical staff representative, associate director, and fitness director.

Physician Clearance Required (3)
• The procedures for identifying/documenting individuals whom staff suspect may have an eating disorder/exercise addiction. Once behavior is noticed, the Director will speak with the individual and express concern (may request a physician consent form to be completed). Individuals asked to have physician consent will not be able to use the facility until the consent form is returned. Physician will refer to psych services and nutritionist.
• Developmental. Currently includes referrals, physician clearance, facility access revoked (in rare cases).
• individuals who are suspected to have an eating disorder meet with the director, have their rec privileges suspended until they get medical clearance.

Facility Privileges Revoked (2)
• The procedures for identifying/documenting individuals whom staff suspect may have an eating disorder/exercise addiction. Once behavior is noticed, the Director will speak with the individual and express concern (may request a physician consent form to be completed). Individuals asked to have physician consent will not be able to use the facility until the consent form is returned. Physician will refer to psych services and nutritionist.
• individuals who are suspected to have an eating disorder meet with the director, have their rec privileges suspended until they get medical clearance.

Other
• We obtain their names and ID# to the counseling center. They make the initial contact.
very informal.

Yes, we have a collaborative protocol that includes personnel in the rec center, office of student life, and counseling center.

We are legally not allowed to interfere based on conversations with Legal Counsel. Someone with an eating disorder is classified as someone with a disability. So not allowing them to participate in programs or use the facility would be like not letting someone with a disability use the facility. That is at least what our legal counsel has told us.

The campus has instituted a student safety referral form on line, students receive training regarding the appropriate use of the forms and also are asked to report concerns to Coordinator of Fitness Programs, Coordinator of Wellness Education or the Director.

all students must be seen by the residential dean's offices if identified as having concerns.

We are working on simplifying the policy regarding individuals - working with residence life, campus life, counseling and the fitness/wellness folks.

In the works... Should implement this Fall 2005.

No official policy but staff members who suspect an eating disorder are expected to intervene in some manner, either themselves, someone on the staff, or within the campus that may be more comfortable discussing the concern with the patron.

see Campus Recreation Website, individuals at high risk policy, www.unl.edu/crec.

The person is given a packet of information with referral info and resources. If the person appears to be at risk, then medical clearance is required before they can access the building again.

We have a referral network process between that Health Fitness Connection service providers. This is tracked by each provider.

We refer them to Campus Life.

Currently, individuals are provided information about services at Health & Wellness & Counseling (where appropriate - which is the challenge).

Not a written policy - however, a verbal "feel comfortable" to inform a professional staff member of the Dept. of Campus Recreation.

Presently we have a hands-off policy....we do not approach individuals suspected of having eating disorders. If they approach us we do have a plan that is implemented through the Body Image and Health Task Force.

#14 (Do you identify individuals with excessively low body weight? Describe.)

**Staff Observations** (17)

- Staff Observation and administrative reports
- Staff observations and informs fitness director. Amount of time working out is recorded and what they did (ie. cardio vs. resistance training)
- Staff observation
- Staff observation, referral to student life and counseling services
- staff observation, reporting to the director
- Through fitness assessments, observation of fitness and strength and conditioning student employees, wellness education consultations, personal trainer observations, and self-reporting
- Observation and with test results if applicable.
- Mostly by staff observation based on training
- Red flag individuals through staff observation to other departments (i.e. Psychological Services, Health Services, Community Health)
- Staff Observations, follow up by administrators' reports
- Observations, coaches concerns, assessments, discussions about eating and exercise habits with person.
- staff observation & peer observation (students have come forward to express concern about roommates/classmates.
- More from visual and exercise behaviors / patterns.
- Staff observation referral to Health Center
- staff/patron observation and administrative reports
- observation, physical exam by nurse
- Staff observation over a period of time. Also consider the intensity, frequency and length of workouts.
Fitness Assessments (8)
- Only in personal training - bmi is calculated, and under 18.5 requires physician's referral.
- Through fitness assessments, observation of fitness and strength and conditioning student employees, wellness education consultations, personal trainer observations, and self-reporting
- Observation and with test results if applicable.
- Via Fitness testing or personal training tests or conversations
- after the referral, the RD usually contacts the fitness director to set an appt for body comp.
- Observations, coaches concerns, assessments, discussions about eating and exercise habits with person.
- Weigh in part of the physical readiness test
- observation, physical exam by nurse

Administrative Reports / Records (5)
- Staff Observation and administrative reports
- Staff observations and informs fitness director. Amount of time working out is recorded and what they did (ie. cardio vs. resistance training)
- Staff Observations, follow up by administrators' reports
- staff/patron observation and administrative reports
- Staff observation over a period of time. Also consider the intensity, frequency and length of workouts.

ther
- We have not had anyone.
- Physician on campus
- discussion items of team meetings, emails to school administrators,
- Referred to Assistant Director of Group Fitness
- We are lucky to not have had any of these
- The trainers would then notify the Fitness Manager for follow-up.
- Case by case rather than a guideline or process

4a (Do you have any mechanism in place to manage users that are at an excessively low body weight? Describe.)
Referral to Student Health Services / Counseling Center (15)
- Referral to Counseling.
- it is done through health services and monitored by the fitness director
- refer to health center
- Primarily referrals, and requiring physician clearance prior to utilizing the facility and programs.
- After referral and subsequent review by Counseling Center or Response Team members, an evaluation may be required (depending on situation) and activities may be limited or prohibited depending on findings. This is determined on a case by case basis.
- Referral to appropriate counseling or dietician
- We refer to Health services and then they come up with a plan of if and how the person may use the fitness facility.
- thru counseling center, student health, sport medicine, and the dean's offices
- Physician on campus
- Red flag individuals through staff observation to other departments (i.e. Psychological Services, Health Services, Community Health)
- Refer to medical department on campus
- Refer to student health center for evaluation.
- Student health Services, dieticians, Counseling Center
- Consult with Student Health Center
- Report to Curry Health Service

Physician Clearance Prior to Use (3)
- Primarily referrals, and requiring physician clearance prior to utilizing the facility and programs.
- After referral and subsequent review by Counseling Center or Response Team members, an evaluation may be required (depending on situation) and activities may be limited or prohibited depending on findings. This is determined on a case by case basis.
- yes, they must provide medical clearance prior to exercising in our buildings.
sage Monitored (2)
• An individual's usage can be monitored through the club access software program at the front desk. The software has been used for some individuals that were suspect of overuse.
• All members can only be on a piece of cardio equipment for 30 minutes.

alk with Individual (2)
• We have a protocol that starts with a conversation and leads to more aggressive interaction involving the office of student life and an eating disorders team.
• in general, discussion for those willing to talk and referral

other
• We do not have the expertise on our staff to handle eating disorder diseases
• Yes and No. Identified students may give student Health services permission to utilize fitness expertise of Rec Sports Fit/Well professional staff to assist these students. Otherwise, no.
• We work in consultation with above mentioned groups.
• No official policy.
• This is entirely based on the case by case evaluation of the individual in question in consultation with our Health and Counseling Center representatives.
• Just the mechanisms listed above.
• Referred to Assistant Director of Group Fitness
• Referral system.
• Have not had to deal with them yet, should get a policy in place though
• recommend attending Eating Disorder Support group
• luckily this has not occurred

15 (Do you identify individuals with excessive exercise habits? Describe.)

staff Observation (27)
• Visual observation, staff reports
• staff observation
• staff observation, but it is difficult if the individuals come in at different times of the day.
• Currently, staff reports it as they see the same people during certain shifts and often see when someone’s exercise time and intensity increase to an unsafe amount.
• Begins by staff observation, then goes to a call to the Counseling/Health Services Offices for follow-up.
• Staff observation only. More people fall through the cracks than we’d like, and we’re currently revamping fitness monitors’ training to better address this. The PsyD eating disorders specialist on campus will be helping with this.
• Staff Observation. Our university has stated that since students pay fees, they cannot be denied admittance to our facility.
• Observation only - currently no formal process in place for tracking or identifying user patterns.
• staff observation, reporting to the director
• Referrals, observations by student employees and staff, and self-referrals
• observation - I can go into our database and see how frequently they are visiting
• staff observation. We then pass the information onto the dean of student life. They monitor with the other reports they may be getting from dining services or residence life.
• Staff observations and referral to assistant director.
• Red flag individuals through staff observation to other departments (i.e. Psychological Services, Health Services, Community Health)
• staff observation, data usage reports
• Staff observation and referral to Counseling Center
• Observation by coordinator, friends, staff; discussion on habits with the individual.
• staff observation & peer concern
• staff observation, swipe counts
• Student and staff observations then documenting
• staff observation and administrative notification
• anecdotal observation by staff
• staff observation, administrative reports
• Observation and reports.
- **staff observation**, report to Assistant Director Fitness
- **staff observation**, facility usage reports
- **Staff observation** over a period of time.

**Usage Records / Reports (10)**
- Visual observation, staff reports
- observation - I can go into our database and see how frequently they are visiting
- staff observation, **data usage reports**
- we limit the time of use for all fitness machines
- Fitness record unusual, excessive, and obsessive patterns. Fitness Director follows up with observations and report.
- **staff observation, swipe counts**
- Student and staff observations then documenting
- staff observation, **administrative reports**
- Observation and reports.
- **staff observation, facility usage reports**

**Other**
- it's obvious, they are always in the gym and annoying everyone
- in my 13 years as director, I have on occasion seen individuals who appear thin, but the students who use our fitness facility for the most part are of an appropriate weight. We are separate from athletics and when I was coaching, I had to deal with some players with eating disorders.
- Referred to Assistant Director of Group Fitness
- Only if these individuals are instructors at the facility.
- Advise and Report
- The trainers would then notify the Fitness Manager for follow-up.

#15a (Do you have any mechanisms in place to manage users that are excessively exercising? Describe.)

**Conversation with Individual (12)**
- **Personal Training contact and discussion**
- We have a protocol that starts with a conversation and leads to more aggressive interaction involving the office of student life and an eating disorders team.
- Yes, they are asked to speak to Fit/Well prof staff but they can choose to do nothing at this point.
- **Staff consultations**
- Not an official policy but staff members are expected to intervene in extreme cases.
- Fitness Coordinator will identify individuals at risk or patterns that flag exercise addiction. Friendly discourse is initiated inquiring about goals and motivation. Literature is provided.
- **Discussion with athletic trainer, wellness coordinator, or student health.**
- set up meeting with individual. Counsel on what are our observations. Suggest a counsel with health center professional
- **intervention by Assistant Director**
- We will approach the individual if we feel there is a concern about their health.
- Typically, if a participant is suspected of this, we do an initial non-confrontational questioning of the habit to identify possibility of training for elite event. If this is not the case, we note the conversation and call our ED unit in to discuss the next step.
- it would be handled on an individual basis. I would be alerted, I would check with other colleagues to get their feedback and then we would visit with the individual.

**Refer to Student Health Services / Counseling Center (11)**
- it's basic, I encourage my staff to make a private log and present it to me. I evaluate what I learn and make a point to notice the individual and try to refer them to our counseling center.
- refer to health center
- **Referrals, Consultations, and in some situations we require a physicians clearance if we determine a substantial risk exists, without which the participant cannot use the facility or programs.**
- We refer them to Campus Health.
- We refer to Health Services and can limit the number of times they can check in to the facility / or how long they are here
• Work with Counseling Center on each case.
• refer to medical department on campus
• observe, get to know the person, gain trust, then refer
• Counseling Center, Student Health Services
• set up meeting with individual. Counsel on what are our observations. Suggest a counsel with health center professional
• referral to Student Health physician to require consent

Reporting to Other Departments for Help with Intervention (6)
• report to the office of health services and they help with the intervention
• counseling
• We have a protocol that starts with a conversation and leads to more aggressive interaction involving the office of student life and an eating disorders team.
• We report to dean of student life and they place on file along with the other reports they may be getting.
• Red flag individuals through staff observation to other departments (i.e. Psychological Services, Health Services, Community Health)
• identify possibility of training for elite event. If this is not the case, we note the conversation and call our ED unit in to discuss the next step.

Time / Usage Limits (6)
• Staff Observation/Use of Equipment/Visits to the Gym
• We refer to Health Services and can limit the number of times they can check in to the facility / or how long they are here
• Maximum exercise guidelines are set for instructors - following ACSM Guidelines.
• Time limits on cardio equipment
• An individual’s usage can be monitored through the club access software program at the front desk. The software has been used for some individuals that were suspect of overuse.
• The 30 minutes limit and the fitness director will approach them with

Education (2)
• Again working with above mentioned groups, we attempt an educational approach
• Fitness Coordinator will identify individuals at risk or patterns that flag exercise addiction. Friendly discourse is initiated inquiring about goals and motivation. Literature is provided.

Medical Clearance Required (2)
• Referrals, Consultations, and in some situations we require a physicians clearance if we determine a substantial risk exists, without which the participant cannot use the facility or programs.
• yes, they must also get medical clearance

Other
• We address on a case-by-case basis when we are concerned about someone.
• it is not an issue
• Same identification method as above and decision based on case by case situation.
• report format
• identification usually comes through staff observation as well as fellow patrons to the facility. We try to build a relationship with anyone that is identified as potentially being at risk for a health issue (we do not diagnose or assume).
• Referred to Assistant Director of Group Fitness
• Observation and reports.
• Yes, but only if they are also underweight.
• recommend attending Eating Disorder Support group

#16 (Is there a fitness instructor/group exercise instructor/personal trainer dress code in your facility that considers how dress affects individuals at risk for eating disorders? Describe.)

Staff T-shirt or Uniform (13)
• Must wear staff t-shirt while instructing.
• Dress code is "wear whatever you’d like as appropriate to the class but don’t look sloppy." The closest thing to a uniform is a wicking t-shirt given to every instructor. Fitness coordinator makes it a point to denounce the idea that instructors must wear form-fitting small clothing to instruct.
• Uniform must be worn.
• Department issued shirts for floor staff. Appropriate clothing guidelines for instructors in cardio classes.
• We want our staff to dress professionally - nothing overly revealing - appropriate shirts & shorts or pants and appropriate workout attire.
• Our dress code is a staff t-shirt and appropriate sweats or shorts - but we didn't design that with eating disorders in mind.
• We require tee shirts with sleeves in our facility. No tank tops, sports bras or cut off shirts.
• All instructors and fitness professionals are dressed appropriately for activities, including t-shirts with department name as well as athletic attire.
• Trainers and fitness staff have standard dress codes and uniforms that are appropriate for the job and not geared to a body image or type.
• Uniforms for personal trainers and front line staff, appropriate coverage for group ex instructors
• Must wear department issued t-shirts. Other clothing must be appropriate.
• Uniforms are worn by professional staff and student staff.
• Appropriate clothing, nothing too revealing. Staff t-shirts and khaki shorts or pants for trainers. Have not had instructors dressing inappropriately so no strict policy. We have discussed appropriate attire for group fitness instruction though.

Nothing too Revealing (13)

• Dress code is "wear whatever you'd like as appropriate to the class but don't look sloppy." The closest thing to a uniform is a wicking t-shirt given to every instructor. Fitness coordinator makes it a point to denounce the idea that instructors must wear form-fitting small clothing to instruct.
• no bare midriff
• Program Instructors' attire should not offend or cause discomfort to participants of the classes (i.e. sport bras worn as a top, short shorts, etc).
• Yes - all Personal Trainers and Group Fitness Instructors have a specific dress code that is designed to foster professionalism, freedom of movement, and promote diversity respective to the body types/shapes of staff members.
• We want our staff to dress professionally - nothing overly revealing - appropriate shirts & shorts or pants and appropriate workout attire.
• We require tee shirts with sleeves in our facility. No tank tops, sports bras or cut off shirts.
• Each are expected to dress appropriately for job/tasks to successfully complete duties, job, etc. No GFI dresses in sport bra only or is bare back. All are clothed in workout attire.
• uniforms for personal trainers and front line staff, appropriate coverage for group ex instructors
• Polo style shirts, no "skimpy clothes"
• encouraged to dress in professional attire ..... nothing too revealing and/or baggy.
• Appropriate clothing, nothing too revealing. Staff t-shirts and khaki shorts or pants for trainers. Have not had instructors dressing inappropriately so no strict policy. We have discussed appropriate attire for group fitness instruction though.
• Proper non-revealing attire is required.
• Professionally dress-no jog bras-must wear a shirt

Not Addressed from Eating Disorder Prevention Standpoint (5)
• we have a dress code but eating disorders was not part of the consideration
• Dress code for PT's is such that they could not dress inappropriately but it is not stated from the standpoint of affecting eating disorders.
• There is a dress code for all instructors and staff yet this does not pertain to eating disorder risk prevention.
• Our dress code is a staff t-shirt and appropriate sweats or shorts - but we didn't design that with eating disorders in mind.
• A dress code is in place but the primary focus is not to base it on how dress affects individuals at risk.

Other
• for the fitness & wellness staff, logo t-shirts & fitness shorts (not tights) Instructors typically wear a logo sleeveless tank top. Wellness staff wear fleece jackets with khaki pants.
• we dress according to acceptable professional levels
• Asst Dir of Rec (fitness) will take the referral
• Yes require a professional attire
However the staff is aware the ED individuals usually wear baggy clothes.

#17a (Is there a client dress code in your fitness area? Describe.)

Nothing too Revealing (37)

- All users are required to wear full-length, short-sleeve, t-shirts and regular gym shoes. No sandals, bare feet, or street shoes.
- Sleeveless shirts are not permitted, proper foot wear, pants/short.
- We only require closed toed shoes and guys have to have some form of a shirt on except when on the BBall court.
- Full t-shirts are required (sleeves can be cut off) with shirts/sweats pants and athletic shoes (no sandals, flip flops, etc.)
- No bare midriff
- In weight room only: full shirt with sleeves, workout pants or shorts (no short shorts). There is not a dress code for the cardio areas in our facility.
- Full t-shirts only. Shoes required. No sports bras only. No half t-shirts.
- No - but we do have "policy, standards and guidelines" that our fitness area staff is prepared to enforce if the clothing is not appropriate for the activity, environment, or such that places the customer at risk (as in the case of revealing or altered clothing)
- We require shirts, no sports bras as single coverage, sweats, or shorts, sneakers. No street clothes
- Shorts with a minimum of 2" inseam and shirts that fully cover the torso are required. Excessive clothing (multiple layers, hoods, rubberized or neoprene-type clothing) is not permitted.
- Dress code is based on appropriate clothing and shoes for a workout area - no skimpy shirts/shorts, no open toed shoes, no layers of sweats...
- Shirts and athletic shoes required in open exercise areas. Shoes not required in Yoga room and shirts not required on basketball court (shirts vs. skins). These are in place for hygiene and safety purposes.
- No Tank Tops, Jeans, or open toe shoes.
- Shirts must be worn (no sports bras or "muscle t's")
- Nothing to revealing, keep shirts on at all times, no jeans, proper attire at all times.
- Yes, full shirts, shorts, sweats, tennis shoes, etc are required.
- Closed toe shoes, and respectable attire.
- Appropriate athletic attire, no bathing suits for both men and women and a shirt has to be worn at all times.
- Sports bra tops are allowed.
- Speedo's are to stay in pool area.
- Shirts required; closed shoes; no jeans (zippers, rivets, etc.)
- Full shirt or tank top that cover shoulders, close toe shoes, appropriate pants, shorts (no jeans, work boots)
- Everyone must have a shirt on in the weight room.
- Shoes in free weight area, shirts must be worn.
- Full shirts.
- Appropriate workout attire. Shirts and closed toed shoes must be worn. Shirts must cover the shoulders no bare tops or sport bras allowed.
- No jeans, no tank tops.
- No sport bras. At a minimum t-shirts must be worn and proper footwear.
- Full t-shirts, towels required, proper footwear, no zippers.
- No boots, no jeans, no open toe shoes, no bra tops or sports bras.
- Full t-shirt policy when using equipment and no jeans.
- All users must wear suitable work out attire and are required to wear a shirt at all times.
- Shirts must cover entire back, chest and torso.
- Must have back and midriff covered. No working out in only sports bras for women or no shirts for guys.
- Shirts, shoes, and shorts required at all times and no sport bras or bras.
- Proper non-revealing attire is required.
- It is a recommended code to wear shirts as a courtesy to others. Also to wear shoes for safety reasons.
- Shirts must be worn (men and women), no sports bras with out a shirt, or something to cover midriff, sneaker, no sandals.

Dress to Protect Equipment & User Safety (30)

- Must wear clothing that allows for the protection of the individual and equipment.
All users are required to wear full-length, short-sleeve, t-shirts and regular gym shoes. No sandals, bare feet, or street shoes.

Shirts required, no jeans or scrubs, proper footwear

Full t-shirts are required (sleeves can be cut off) with shirts/sweats pants and athletic shoes (no sandals, flip flops, etc.)

Proper Fitness Center Attire Required: T-shirts, shorts/sweats, athletic shoes. No belt buckles, cleats/sandals. No jeans, zippers, bare skin.

Content of the dress code is not driven by this issue but by protection of exercise equipment and sanitation.

work out clothing and tennis shoes, no street clothing

Shirts have to have backs and fronts. Sleeveless is OK but no mesh shirts. These are for sweat on machines—not eating disorders.

Appropriate attire is necessary while using the equipment in the Weight Training Room. This includes gym style clothing and gym shoes. Street shoes, pants/shorts with zippers, belts, or metal items and denim pants/shorts are prohibited. Closed toe athletic shoes are required. Sandals, "flip flops", dress shoes and boots are prohibited. For safety reasons, it is recommended that hats and jewelry not be worn during any activity. Street clothing is not generally advised during activities, as it can be dangerous and confining.

We require shirts, no sports bras as single coverage, sweats, or shorts, sneakers. No street clothes

No Tank Tops, Jeans, or open toe shoes.

nothing to revealing, keep shirts on at all times, no jeans, proper attire at all times

No jeans or jean shorts allowed

Dress code is based on safety, hygiene, and reasonableness. The code doesn't prevent certain types of clothing (body armor, form fitting, etc) and does encourage dress the make the exerciser comfortable. This code could be re-evaluated in terms of body image.

shirts required; closed shoes; no jeans (zippers, rivets, etc.)

Full shirt or tank top that cover shoulders, close toe shoes, appropriate pants, shorts (no jeans, work boots)

No street worn clothing or shoes. Work out attire is required.

Per safety regulations

No jeans, no tank tops

Full t-shirts, towels required, proper footwear, no zippers.

No boots, no jeans, no open toe shoes, no bra tops or sports bras

The typical safe dress for an exercise area. Closed toe, athletic shoes, shirt and shorts or exercise pants, etc.

Shirts required; no jeans, cargo pants or baggy pants; no boots, no open-toed or open-heeled shoes

Full t-shirt policy when using equipment and no jeans.

must wear a shirt that covers body from contact with equipment.

No jeans, no sandals

no jeans, slippers, clogs, or open-toed shoes

it is a recommended code to wear shirts as a courtesy to others. Also to wear shoes for safety reasons.

Athletic clothing only, no jeans, sandals etc.

Eating Disorder – No Excessive Clothing (2)

Shorts with a minimum of 2" inseam and shirts that fully cover the torso are required. Excessive clothing (multiple layers, hoods, rubberized or neoprene-type clothing) is not permitted.

Dress code is based on appropriate clothing and shoes for a workout area - no skimpy shirts/shorts, no open toed shoes, no layers of sweats...

Other

Shirt and closed toed shoes required.

shorts or sweat pants, athletic shoes, t-shirt or work-out shirt

tank tops and sports bras must be appropriate

T-shirt and loose fitting shorts/pants

Appropriate athletic attire, such as t-shirts, shorts, warm-up suits, sweat suits or aerobic clothing, is recommended at all times during recreation.

Shirts and shoes are required except in locker rooms and the pool.

Appropriate athletic footwear is required in all activity areas.

Shirts have to have backs and fronts. Sleeveless is OK but no mesh shirts. These are for sweat on machines—not eating disorders.
General guidelines are posted
appropriate workout clothes and must have tennis shoes
Shirts and shoes must be worn.
shirts required in strength training area
Athletic attire, white soled sneakers, cotton, sneakers in special area
workout attire only (shirt, shorts, shoes, warm-ups)
shirts, shoes required
shirts required
athletic attire required
closed toed shoes in weight room
Shirt & athletic shorts/pants, and athletic shoes required (women can wear tanks/sports bras)
instructors with staff shirts that state "Staff" on the chest.
shirts and shoes at all times
Staff shirt appropriate to the particular area. Intramurals is different then customer service due to the nature of the jobs.
Must be in workout clothes
No cut offs, no open toed shoes
Must wear a shirt, athletic shoes, appropriate work out attire.
Very informal. Only requires proper footwear and shirts.
Shirts must be worn
Standard Midshipman workout gear
Work out clothes
Sort of..."Appropriate shirt and shoes are required."
Proper workout attire. No sandals.
T-shirt, shoes, in weight rooms
appropriate attire for a family venue
No shirt, No shoes, No weights!
Athletic attire required. Shirts required.
short, shirt (t-shirt or tank top), closed toe shoes
common sense approach
Must wear appropriate footwear and shirts.
Sneakers, shorts or sweats and T-shirts
work-out attire sneakers
for the fitness & wellness staff, logo t-shirts & fitness shorts (not tights) Instructors typically wear a logo sleeveless tank top. Wellness staff wear fleece jackets with khaki pants.
They must wear a t-shirt.

#17b (If there are dress codes in place how are they enforced?)
Upon Entrance / Room Monitoring (21)

- The fitness center staff and our building supervisors (student employees primarily) enforce the dress code in the fitness areas. The other areas of the recreation center we only require gym shoes.
- at the entrance, on walk-thru's
- room monitors, peers
- front desk staff
- Student staff monitor the area and ask patrons not in compliance to go change.
- Floor staff
- By the students Fitness staff on the fitness floor
- By individuals monitoring facilities or instructors teaching recreational classes
- Managers and fitness operators will make sure that participants are dressed appropriately even before using the facility or taking a group exercise class.
- admission is denied if they are not dressed correctly
- the dress code is printed in the student handbook and all facility printed materials. Facility supervisors and area attendants are responsible for enforcement.
- Front desk clerk as they enter.
Student Staff in facility areas
All full time staff monitor and each area documents inappropriate dress.
Wellness Staff enforces our policies at the front entrance.
Facility supervisors monitor exercise areas.
Check in desk and spot checks
Publications and front desk personnel
upon entry
Fitness Area monitors enforce so members are compliant with rules

Change or Leave Facility (20)
- Facility staff enforces all dress codes. They either change or leave.
- People are asked to leave the facility.
- Student staff monitor the area and ask patrons not in compliance to go change.
- If someone is not within dress code they are asked to come into dress code. If they refuse a supervisor will ask them to leave.
- Participants not adhering to the code are asked to leave the facility.
- People are asked to leave the facility.
- See above. Customers are asked to correct the situation prior to returning to the activity. Staff is not allowed to work if they do not meet the dress standard.
- Staff request that members comply or they are asked to leave.
- Staff stops the user as they enter the facility. If they come in without a tee shirt, we issue one from our clean "lost and found" shirt pile.
- Staff observation, asked to leave if not obeyed
- Admission is denied if they are not dressed correctly
- Dress that is deemed inappropriate is enforced through verbal warning and written report. If it violates safety the user is prevented from continuing.
- Closed toe shoes, shirts, "tasteful." Violators are kicked out.
- Participants is asked to change or leave if not in proper attire.
- Observation, conversation and ask individual to leave facility if needed.
- Participants are not allowed into the Fitness Center if not dressed appropriately.
- Violators are given option of getting their own shirt or checking one out
- Staff asks explains to the offender that he/she must either put on a shirt (or shoes) or leave the Exercise Center.
- When we see it, we ask them to change or leave
- Front-line staff confronts individuals who are not compliant and are asked to rectify the situation.

Verbal Warning / Explanation (15)
- Director explains policies to students
- Signs posted. Personal contact with offending individuals explaining policy.
- Supervisors of the activity area enforce the dress code verbally. Repeated need to contact an individual regarding the same infraction are reported and handled by the professional staff as a disciplinary issue. Referrals are made as red flags are identified.
- Word of mouth and posted rules
- Staff stops the user as they enter the facility. If they come in without a tee shirt, we issue one from our clean "lost and found" shirt pile.
- Staff regulates the codes and will ask the patron about it
- Counseling is done by discussing with the participant first.
- Dress that is deemed inappropriate is enforced through verbal warning and written report. If it violates safety the user is prevented from continuing.
- Instructors are asked to wear shirts and are reminded if they do not wear them. It has not been a problem with staff not wearing shirts.
- Speak to person not meeting the code
- Central Staff addresses the subject with the individual.
- Observation, conversation and ask individual to leave facility if needed.
- Verbal reminders.
- Clients are written up by attendants if they fail to adhere to policies
- Staff approaches individual who are not in compliance.
Front-line staff confronts individuals who are not compliant and are asked to rectify the situation.

Other

- Staff monitored and maintained
- by student staff and professional staff
- enforced by student supervisors
- staff and student employees
- student staff enforce
- Student employee supervisors
- Staff supervision
- Our Recreation facility however does not have a dress code, users will often times wear little clothing.
- Fitness assistant on duty will address or call the facility supervisor
- On duty employees.
- Student supervisors enforce the policy.
- by fitness staff
- Staff enforcement. We would like to receive a copy of the survey results.
- Staff observation
- haven't had a problem since shirts required does not get into any other specifics
- Then action is taken if needed by higher management.
- Yes. All fitness staff must dress professionally. No open toe shoes, cut off shoes or jeans. Instructors must not show their mid-drift.
- Staff insure that the dress code is enforced.
- staff interaction
- thru signage and staff
- Supervisor
- By student staff
- On-site staff
- Staff enforcement
- weight room staff, this is not a real issue in our facility, the bigger issue is close toed shoes.
- Staff addresses any issues
- student staff
- Weight Room Attendant
- Consistency.
- staff enforced
- Building or activity area supervisors
- The person in leadership roll
- Everyday
- Staff enforced
- By staff on an as need basis if their complaints.
- By staff

#19 (Do you promote eating disorder awareness to the general public in your fitness area? Other.)

Other Departments (9)

- work group on campus
- most is done through another department
- wellness fairs
- our wellness center (student health services) promote this event
- Student org. dedicated to positive body image
- university services
- we work with the wellness center and post their latest info
- Separate On-Campus Wellness Dept
- Body Image and Health Task Force

In Department (5)

- No Scale in Building policy - accompanying literature explains why
Weekly 'health updates given by all fitness instructors may address this topic
National "No Diet" Week
Displays
announcements in group exercise classes

Activities (3)
- wellness fairs
- No Scale in Building policy - accompanying literature explains why
- National "No Diet" Week

Other
- Weekly 'health’ updates given by all fitness instructors may address this topic
- Occasionally

Situations in which the University Doesn’t Allow Intervention (2)
- We are legally not allowed to interfere based on conversations with Legal Counsel. Someone with an eating disorder is classified as someone with a disability. So not allowing them to participate in programs or use the facility would be like not letting someone with a disability use the facility. That is at least what our legal counsel has told us.
- Staff Observation. Our university has stated that since students pay fees, they cannot be denied admittance to our facility.
REFERENCES


35. Thompson RA, Sherman RT. “Good athlete” traits and characteristics of anorexia nervosa: are they the same? Eating Disord. 1999;7:181-190.


