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Psychotherapeutic Interventions for the Treatment of Eating Disorders Among Athletes & Performers

Presented by: The AASP Eating Disorder SIG Leadership

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Psychotherapeutic Interventions for EDs Among Athletes & Performers:

Introduction

Athletes and performers, more than non-athletes, are at increased risk for eating disorders (EDs) and the associated medical and psychological maladies . EDs pose negative health conditions including functional hypothalamic hypogonadism, osteoporosis, soft tissue injuries and reproductive compromise.

Athletes have substantial ED risk. Those with anorexia are at greater risk of poor mental health and death by suicide compared to non-athletes.

Little formal training for treatment among athletes who may be members of a minority or marginalized population, ie., LGBTQ+.

Given the potential risk to health, well-being, and performance, it is vital to improve ED awareness and effective treatment.

Walsh et al.,2020, Moore, et al., 2021, Nattiv et al., 2021, Joiner, T., 2022).

Psychotherapeutic Interventions for EDs Among Athletes & Performers:

Purpose

Since many therapists, dietitians, physicians, coaches, and athletic trainers receive little or no formal training in treatment strategies for EDs among athletes & performers, the purpose of this workshop is:

- to preserve health and optimal performance among athletes and performers.
- to inform attendees of effective interventions, their therapeutic underpinnings and relevant case examples.
- invite attendee's participation in small group discussion, following a brief introduction to the topic.

Goals
To Improve:

 # 1 awareness, prevention, and treatment effectiveness.

 # 2 awareness of **interventions for underrepresented groups** within athletics and performance (e.g., transgender; BIPOC athletes, international students) regarding specific interventions.

 # 3 awareness of **interventions that approach athletes/performers** with cultural humility and sensitivity.

Psychotherapeutic Interventions for EDs Among Athletes & Performers:

Focus

This workshop will highlight interventions shown to enhance motivation for ED recovery and decrease risk of poor mental health, self-harm, EDs and suicide risk.

The interventions selected will prioritize strengthening interpersonal connection, belonging, personal agency, autonomy, and emotion regulation shown to be associated with resilient mental health and will be evidence-based, such as Acceptance and Commitment Therapy (ACT), CBT & DBT for EDs. [5, 6]

Joiner, T., 2022, Juarascio et al., 2017

Abstract

Components of Successful Psychotherapy Process for EDs

Several components of successful psychotherapeutic processes for the treatment of EDs have been identified. These include but are not limited to:

1	Conduct Continuous Re-Evaluation	**5**	Identify “wants” and “needs” (CBT)
2	Incorporate Motivational Interviewing	**6**	Reduce Perfectionistic Thinking & Behavior
3	Engage Dialectical Thinking & Planning	**7**	Avoid False Assumption & Bias
4	Engage Acceptance & Commitment Theory	**8**	Improve Comfort in the Therapeutic Process

Components of Successful Psychotherapy Process for EDs

1. Engage in Continuous, Comprehensive, and Multidisciplinary Re-evaluation

a. Adopt a strength based and values-oriented process. (Behavior Therapy) & (Acceptance & Commitment Theory)

b. Cultivate avenues of belonging with oneself and other people, experiences, and purpose. (Relational Theory)

c. Be cautious regarding the amount of exposure to numbers or data.

2. Incorporate Motivational Interviewing

a. Align and inform throughout the therapeutic process. (Motivational Interviewing)

b. Work within a multi-disciplinary team with transparent and ongoing communication to build trust.

3. Engage in Dialectical Thinking (DBT) and Planning

a. Employ dialectical thinking and planning, endeavoring resolute versus absolute decision making.

b. Consider that very different influential forces are continuously and simultaneously occurring.

Miller & Rollnick, 2023

Components of Successful Psychotherapy Process for EDs

4. Interpret and Understand the Silence

a. Regard thoughtfully what is both said and not said via language & behavior.
b. Think metaphorically.
c. Discover and articulate what is vital and correct about all emotional experience. (CBT: Identifying Wants and Needs)
d. Cultivate connection and sense of belonging.
e. Titrate and manage silence throughout the process.

5. Reduce the Need for Perfection by Informing, Validating and Normalizing

a. Create safe space for “uncertainty” and “not knowing”.
b. Cultivate courage in taking risks and approaching novel tasks.
c. Build skills for improved tolerance, coping with errors & or disappointment.

6. Avoid assumption, stigma, and mental health bias

a. False Assumptions: Eating disorders only exist in emaciated bodies.
b. Folks with EDs are suffering from vanity.
c. Folks with EDs could recover if they wanted to.
d. Folks cannot recover from EDs.
e. Eating Disorders are only about the food.

Components of Successful Psychotherapy Process for EDs

7. Establish and Maintain the Therapeutic Connection

a. Conserve energy for the psychotherapy process by purposefully organizing and triaging the therapeutic elements.

b. Matters of diversity must be respected.

c. Approach psychotherapeutic decisions and strategies with cultural humility and sensitivity.

d. Sustain hope in the treatment process, recovery, and the future. (Positive Psychology)

8. Reduce Discomfort Associated with the Therapeutic Process

a. Attend to ethical guidelines for mental health care but get creative.

b. Incorporate experiential therapies (i.e., music, art, & movement therapy)

c. Attend to and respect cultural norms and needs.

d. Be a participant in the process, rather than the leader.

e. Sustain trust in the treatment process and care providers.

f. Monitor and evaluate change and/or progress frequently.

Successful Psychotherapeutic Interventions for EDS

9. Be reminded that many EDs have features that are similar to those of OCD. At times, other OCD conditions or behaviors unrelated to the ED may co-occur.

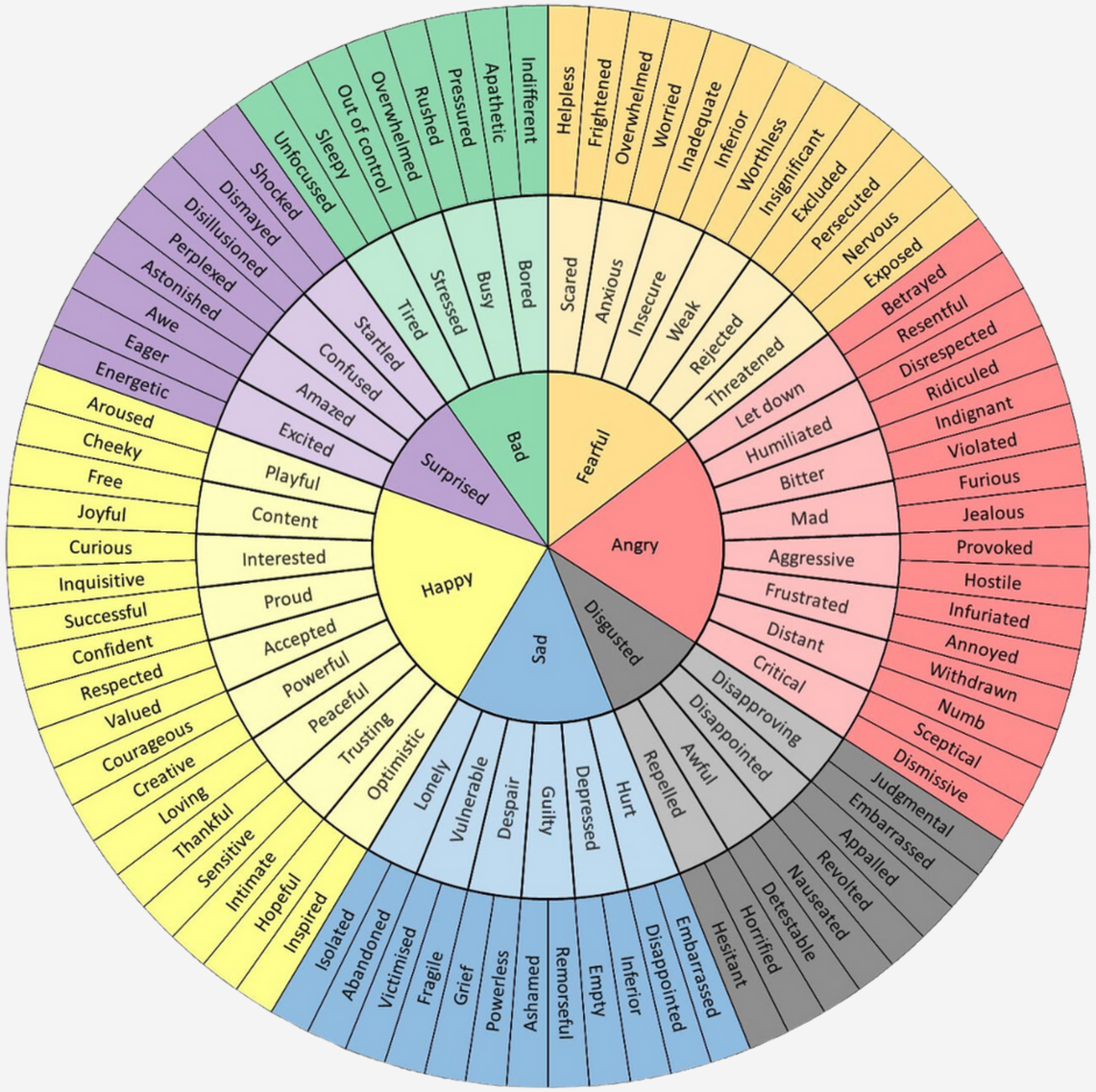
Therefore, keep in mind:

- One cannot “force” change or the discontinuation of problematic behavior.
- Think and work “holistically”.
- Avoid use of contracts with the client.
- Expect gradual change via small steps.
- Consider “exposure work” or collaborate with an OCD specialist.
- Collaborate with psychiatry for medication support.

Feelings Wheel

A Tool Beneficial in
Optimizing the Effectiveness
of the Therapy Process:

feelingswheel.com



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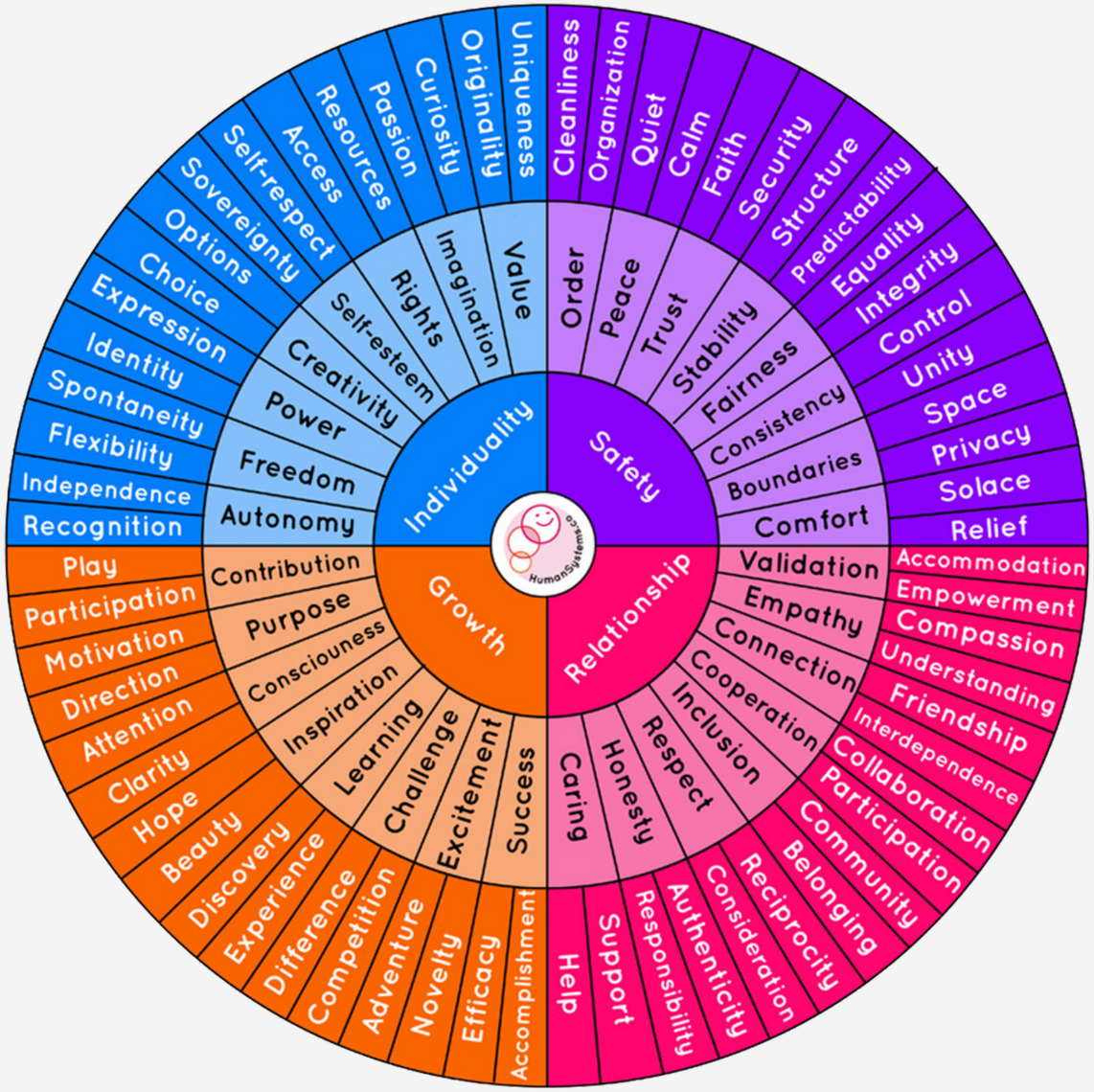
Needs Wheel

A Tool Beneficial in
Optimizing the Effectiveness
of the Therapy Process:

humansystems.com



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Psychotherapeutic Interventions for Optimal Performance

The identification of the function of ED and ED behaviors throughout the treatment process is vital to targeting interventions and finding progress in recovery.

Consider the Life Sustaining Function of EDs

James, Claude Bernard, referred to the phrase *milieu intérieur*, indicating that man's internal, biochemical, and neurological environments must maintain stability and regularity to sustain life.[8, 9]

To be effective in body regulation, Walter Cannon (1929) advised that adjustments within the system needed to occur automatically in response to changes in the internal and external environments to maintain equilibrium or establish homeostasis.

The ability of the body to adapt and preserve well-being under physical and psychological stress through changing conditions, was coined allostasis.

Earliest research investigated '**unidirectional processes**' concerning the impact of physical and psychological stress. Later, researchers understood that these factors, and others, interact and act back on the system.

Bernard, 1974, Sterling, 2012. Sterling & Eyer, 1988

EDs Provide Life Sustaining Functions

Hans Selye (1936) originally explained stress in terms of its physiological effects on the body and later explained the effects of stress on both physiological and psychological states.

And by 1966, **Lazarus, added mental and cognitive processes** to the list of factors which influence the homeostatic state. He highlighted “cognitive appraisal”, believing that people are continually assessing and surveying their surrounding environment for possible threats, to one’s safety and in needing self-preservation. He believed that cognitive appraisals were influenced by both historical and anticipated experience.

.Bernard, 1974, Sterling, 2012. Sterling & Eyer, 1988

EDs Provide Life Sustaining Functions

Today, we are proposing that ED behavior and illness have vital homeostatic function necessary for survival.

Indeed, man's neuro-endocrine system responds rapidly, and repeatedly, to both physiological mechanisms and psychosocial influences (Henry & Grim, 1990), to preserve regulation. These neuro-biochemical and behavioral responses are not choices. EDs are driven by automated, reflexive, and protective mechanisms.

.Bernard, 1974, Sterling, 2012. Sterling & Eyer, 1988

Psychotherapeutic Interventions for Optimal Recovery & Performance

The identification of the “function” of ED and ED behaviors throughout the treatment process is vital for targeting interventions and finding progress in recovery.

Identifying the function of the EDs:

Example #1

A freshman and member of the cheer team loses 30 percent of her body weight in 6 weeks after being drugged and sexually assaulted on campus.

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A freshman and member of the cheer team loses 30 percent of her body weight in 6 weeks after being drugged and sexually assaulted on campus.

Needing to alert others to the wants or needs not otherwise verbalized or understood. Too thin may scream, “I am not ok”.

Identifying the function of the EDs:

Example #2

A 10-year-old, soccer star, stops eating, is in a hospital for 9 weeks and does not want to be alive, after parent's pile on expectations for excelling in school and being the best on her team. She steps up to weather classroom changes, school changes, playing up a year and finally assigned to the boys' team before she "gives up".

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Needing to cope with early sport specialization, an intensely competitive sport culture and persistently escalating expectations for outstanding performance. She is hungry but not for food.

Identifying the function of the EDs:

Example #3

The high school football player who cannot escape the sense that his skin is crawling, and mood has slumped, slips into weight, body and bulimic patterns after locker room hazing and body related shaming, leaves him feeling unsafe. This experience reawakens other similar history.

Identifying the function of the EDs:

Example #3

The high school football player who cannot escape the sense that his skin is crawling, and mood has slumped, slips into weight, body and bulimic patterns after locker room hazing and body shaming leaves him feeling unsafe. This experience reawakens other hurtful history.

Needing to hide for safety, security, protection and/or survival.

Identifying the function of the EDs:

Example #4

He was known to be a scholar and a talented singer. But as a gay male growing up in a small town, his parents struggled to understand and support him. Kids at school taunted him and teased him. He hid in closets and stopped eating.

Identifying the function of the EDs:

Example #4

He was known to be a scholar and a talented singer. But as a gay male growing up in a small town, his parents struggled to understand and support him. Kids at school taunted him and teased him.

Needing to defer or deny emotional needs given absent, misinformed, or unavailable emotional support from others, he silenced himself to avoid shame and hurt. Anorexia and later bulimia were things he knew he could get right.

Identifying the function of the EDs:

Example #5

The Ivy League graduate and athlete, excelling in all spheres of life except unable to find a means of curbing binge eating and weight gain knowing that her larger frame stands in defiance of her mother's life-long insistence that she be thin to be successful and accepted by others.

Identifying the function of the EDs:

Example #5

The Ivy League graduate and athlete, excelling in all spheres of life except unable to find a means of curbing binge eating and weight gain knowing that her larger frame stands in defiance of her mother's life-long insistence that she be thin to be successful and accepted by others.

Needing to voice objection, express dissatisfaction or reject that which is overcontrolling, overpowering or punishing.

Identifying the function of the EDs:

An essential component of a successful treatment is the ability to identify the “function” of the ED and/or ED Behaviors and to orient the treatment process accordingly. In doing so, the care providers and the treatment process will both respect and support recovery for the athlete or performer:

Need for:

- control
- agency
- validation
- safety
- respectful regard
- self-regulation

Psychotherapeutic Approaches-1

Optimizing the Treatment of Eating Disorders (EDs)

ED BEHAVIOR	RELEVANT HISTORY	EMOTIONAL STATE	PROTECTIVE FUNCTION	INTERVENTIONAL APPROACH	REFERENCE
ANOREXIA NERVOSA (RESTRICTIVE TYPE)	NEGLECT, ABUSE, TRAUMA	NEEDING TO HIDE	SAFETY, PROTECTION, SECURITY	IMPROVE ALTERNATIVE COPING CONSIDER MEDICATION FOR PTSD, MOOD, OR ANXIETY.	HERMAN, POLIVY AND BAUMEISTER, (1989)
	ABANDONMENT & BETRAYAL	NEEDING CONTROL. BROKEN TRUST	NO ONE CAN TAKE THIS AWAY, MORE CONTROL	PROCESS GREIF & LOSS, REDUCE SELF-BLAME	OBJECT RELATIONS THEORY
	PARENT/FAMILY SYSTEM EXPECTING PERFECTION, OBEDIENCE & ACHIEVEMENT.	CONFLICTED. STRUGGLE TO BE ONESELF IN CONFLICT WITH FAMILY EXPECTATIONS.	ARRESTS INDIVIDUATION AND SILENCES AWARENESS AND EXPRESSION OF AUTONOMOUS THINKING AND BELIEVING.	IMPROVE AWARENESS OF FUNCTION OF THE ED. FACILITATE GRADUAL AND SAFE SEPARATION/INDIVIDUATION.	SEPARATION-INDIVIDUATION THEORY HILDA BRUCH, 1977

(*NOTE: THE INFORMATION PROVIDED ABOVE ARE “EXAMPLES” OFFERED FOR TRAINING PURPOSES ONLY. THIS INFORMATION IS NOT AN EXHAUSTIVE AND/OR COMPREHENSIVE DATA BASE. EACH CLIENT IS UNIQUE AND ALL TREATMENT DECISIONS ARE SPECIFIC TO THE CLIENT’S UNIQUE NEEDS, CIRCUMSTANCES, HISTORY AND THE THERAPY PROCESS.)

Psychotherapeutic Approaches-2

Optimizing the Treatment of Eating Disorders (EDs)

ED BEHAVIOR	RELEVANT HISTORY	EMOTIONAL STATE	PROTECTIVE FUNCTION	INTERVENTIONAL APPROACH	REFERENCE
ANOREXIA NERVOSA	DISAVOWAL & INVALIDATION	SILENCE & HOPELESSNESS	PREVENT DISAPPOINTMENT OR DISAVOWEL	LEARNING TO TRUST & EXPRESS ONESELF	H. BRUCH, 1977
	ALONE OR WITHOUT SUPPORT	ISOLATION	PREVENT ADDITIONAL HURT OR DISSAPPOINTMENT	CULTIVATE OPPORTUNITIES FOR MEANINGFUL BELONGING	WHY PEOPLE DIE BY SUICIDE, BY THOMAS JOINER, 2007
	EARLY SPORT SPECIALIZATION	EMPTINESS & UNCERTAINTY, ARRESTED IDENTITY DEVELOPMENT	INSUFFICIENT INTERNAL AWARENESS	TOLERATE UNCERTAINTY & FOSTER IDENTITY DEVELOPMENT	BRENNER, ET AL, 2019

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Psychotherapeutic Approaches-3

Optimizing the Treatment of Eating Disorders (EDs)

ED BEHAVIOR	RELEVANT HISTORY	EMOTIONAL STATE	PROTECTIVE FUNCTION	INTERVENTIONAL APPROACH	REFERENCE
BINGE EATING	HISTORY OF BLAME, SHAME & REPRIMAND	DYSREGULATION	AFFECT REGULATION	SELF-MONITORING & COGNITIVE RESTRUCTURING,CBT	BANDURA, (1986), HEATHERTON & BAUMEISTER, (1991)
	HISTORY OF RESTRICTION AND/OR DEPRIVATION	FEELING DEPRIVED	HAVING CHOICE OR FREEDOM	PLAN FOR SELF CARE, INDULGENCE AND AMPLE REWARD	PECSOK, E. H., & FREMOUW, W. J., (1988)
	HISTORY OF FOOD SCARCITY OR INSECURITY	FEELING UNSAFE, INSECURE, PERSISTENT WORRY	INDULGE, COMPENSATORY EATING	REGULATE & NORMALIZE EMOTIONAL STATES & EATING PATTERNS. REDUCE FEAR OF SCARCITY	HAZZARD, V., M., et AL, 2020

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Psychotherapeutic Approaches-4

Optimizing the Treatment of Eating Disorders (EDs)

ED BEHAVIOR	RELEVANT HISTORY	EMOTIONAL STATE	PROTECTIVE FUNCTION	INTERVENTIONAL APPROACH	REFERENCE
BINGE EATING	HISTORY OF EXPOSURE TO DIETING OR A DIET CULTURE	GUILT ASSOCIATED WITH EATING & DISSATISFACTION WITH BODY WEIGHT.	PREVENT WEIGHT GAIN AND ASSOCIATED REPRIMAND & SHAME	REDUCE RESTRICITON, HUNGER & ELIMINATION OF SELECTED FOODS. DIET RELATED PSYCHOEDUCATION CONSIDER MEDICATION	JOHNSON ET AL, 1986
	HISTORY OF BEING OVER-RULED OR DISAVOWED, OR SILENCED	LOW SELF WORTH, LOW SELF ESTEEM, LOSS OF VALUE	SELF EXPRESSION, GETTING WHAT YOU WANT	SURROUNDED BY PEOPLE WHO LISTEN & SUPPORT YOU AS YOU ARE	GARFINKEL & GARNER, 1982
	FEELING LIKE A FAILURE DESPITE EXTRAORDINARY STANDARDS AND ACCOMPLISHMENTS	AFFECT DYSREGULATION, EXCESSIVE GUILT	PUNISH OVEREATING WITH OVEREATING	RE-ASSIGN BLAME & RE-ADJUST EXPECTATIONS	KALUCY, ET AL, 1977

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Psychotherapeutic Approaches-5

Optimizing the Treatment of Eating Disorders (EDs)

ED BEHAVIOR	RELEVANT HISTORY	EMOTIONAL STATE	PROTECTIVE FUNCTION	INTERVENTIONAL APPROACH	REFERENCE
BULIMIA	UNFAIR OR WRONGFUL TREATMENT	FLUCTUATING EMOTIONS: NUMB TO ANGER	EXPRESSION OF & REGULATION OF ANGER	IMPROVE COPING SKILLS AND ADVOCACY	JOHNSON & CONNORS, 1986
	ABUSE OR EMOTIONAL NEGLECT	HIGH CONFLICT & LOW SELF EXPRESSION	CRY FOR EMOTIONAL CARE TAKING, COMFORT	IMPROVE ORGANIZATION, EMOTION IDENTIFICATION, AND SELF EXPRESSION	ORDMAN, FAMILY ADAPTABILITY (1985)
	EMOTIONAL PAIN OR LOSS	SAD, ALONE, HURTING, NOT UNDERSTOOD.	NEED FOR NURTURING & COMFORT	EXPRESSION AND PROCESSING OF GRIEF & LOSS	ACCEPTANCE & COMMITMENT THERAPY (ACT)

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Psychotherapeutic Approaches-6

Optimizing the Treatment of Eating Disorders (EDs)

ED BEHAVIOR	RELEVANT HISTORY	EMOTIONAL STATE	PROTECTIVE FUNCTION	INTERVENTIONAL APPROACH	REFERENCE
BULIMIA	**CRITICAL OR DANGEROUS FAMILY ENVIRONMENT.**	**EXCESSIVE GUILT, FEEL UNDESERVING.**	**SOURCE OF SELF-INDULGENCE AND SELF-PUNISHMENT.**	**REDUCE SELF-BLAME REPRIMAND & REPROACH**	**PALAZZOLI, S., 1978**
	IMMESHEMENT, RIGIDITY, POOR FAMILY BOUNDARIES	**LITTLE TRUST IN RELATIONSHIPS. AVOID INTERPERSONAL INTERACTION.**	**ALONE ENSURES SAFETY FROM ADDITIONAL LOSS OR DISSAPPOINMENT.**	**IMPROVE AFFECT IDEN TIFICATION, EXPERIENCE AND EXPRESSION. REDUCE SELF BLAME. BOUNDARY AWARENESS (DBT)**	**MINUCHIN, S., ET AL, 1978**
	EMOTIONAL PAIN OR LOSS	**SAD, ALONE, HURTING, NOT UNDERSTOOD.**	**NEED FOR NURTURING & COMFORT**	**EXPRESSION AND PROCESSING OF GRIEF & LOSS**	**ACCEPTANCE & COMMITMENT THERAPY (ACT)**

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Psychotherapeutic Approaches-6

Optimizing Treatment

ED BEHAVIOR	RELEVANT HISTORY	EMOTIONAL STATE	PROTECTIVE FUNCTION	INTERVENTIONAL APPROACH	REFERENCE
COMPULSIVE OVER EXCERCISE	THREAT TO PHYSICAL & / OR EMOTIONAL SAFETY, OTHER	ANTICIPATORY FEAR	INCREASE CALM & DECREASE WORRY	DELIBERATE AND PURPOSEFUL DECISIONS FOR SELF-CARE AND SELF-PROTECTION	MARTENSTYN, ET AL, 2022
	LOSS OF POWER IE. ALCOHOL OR SUBSTANCES IN THE FAMILY SYSTEM	FEELING HELPLESS	FEELING EMPOWERED	RESPECT SMALL STEPS, GRADUAL CHANGE, REBUILD CONFIDENCE, IMPROVE SELF-COMAPRISON.	COGNITIVE BEHAVIOR THERAPY (CBT) & DIALECTICAL BEHAVIOR THERAPY (DBT)
	OCD, ADDICTION &/OR TRUMA	DYSREGULATION	DOPAMINE SURGE	ALTERNATIVE MEANS OF AFFECT REGULATION/CONSIDER MEDICATION	MARTENSTYN, ET AL, 2022

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Optimizing the Therapeutic Process for Athletes/Performers with EDs.

The identification of the function of ED and ED behaviors throughout the treatment process is vital to targeting interventions and finding progress in recovery.

Alicia, a 21-year-old junior, is an accomplished collegiate track and field team member competing in the 100 and 200-yard dash, on a full athletic scholarship. Despite her skill level, Alicia has faced persistent challenges related to her weight since childhood, beginning when a Middle School coach told her that unless she was “more petite”, she would never excel as an athlete, among other negative sentiments. Driven by her passion for her sport, Alicia secured a spot on her D2 university team, where the intense demands of the sport have further contributed to a complex relationship with food. In the fall semester of her junior year, Alicia experienced an unexpected and severe car accident that resulted in significant physical injuries and the loss of a close friend who was also a teammate. Her weight, already above what is typically considered the norm for her sport, became a source of heightened distress after the accident. The trauma intensified her pressures to conform to athletic body ideals, and she began to cope with the emotional aftermath through secretive binge-eating episodes. Post-binge, Alicia experiences overwhelming guilt, shame, and a sense of loss of control, leading her to adopt behaviors such as restrictive diets and excessive exercise. Friends and teammates observe Alicia's heightened distress about her body image, and she expresses reluctance to wear athletic attire while becoming increasingly withdrawn. Lastly, friends and teammates frequently find empty food containers in Alicia's living space, which she denies are hers.

Discussion Questions:

1. How could teammates express their concern to Alicia, knowing both that she has struggled with her weight for a long time/it is a sensitive topic, and that they are grieving alongside her?
2. What type of intervention can take place within the team, led by the coach or the medical staff, to increase solidarity and address concerns?
3. What are some things you would say to Alicia, as the team sport psychologist, to encourage her to seek help and recognize these compensatory behaviors?
4. When would you refer out?
5. In an institution with less funding and fewer resources, how could we support Alicia in her recovery?

James is an international student-athlete who participates in middle-distance track, competing on both the track and cross-country teams at his mid-sized university. During his freshman year, James scheduled an appointment with the team's registered dietician (RD) and asked her how to lose weight. Within the first three months of being in the United States, his weight increased, and he was teased by his teammates. His coach commented about his notable weight gain. Due to these social pressures, James decided to stop eating and dropped from 160lbs to 149lbs. but wanted the RD to help him get down to at least 140lbs (or less). James said he felt humiliated by his initial weight gain and since then, restricted his caloric intake, trained excessively, and self-weighs daily in order to continue losing weight. Since dropping weight, teammates, coaches, and family/friends praised his weight loss and commended him for his dedication to the sport. During her initial conversations with James, the RD learned that James has body dysmorphia and fat phobia. He constantly compares his body to the bodies of his teammates and attributes success and failure to his body size and food intake. The RD is alarmed at James's request to continue losing weight and wonders how to best approach the situation. James appears to be obsessive about weight loss and body image, and unfortunately, his coach reinforces these obsessive thoughts, telling James that his lackluster performances are due to weight. James does not want to let his team down, and, due to being an international student-athlete on scholarship, he does not want to jeopardize his position on the team. He is not concerned that his weight loss has resulted in episodes of passing out, as, overall, he has experienced success in his sport, receiving numerous first place finishes and awards. James's university has a multidisciplinary sports medicine team in place that includes sport medicine, sport psychology, and sport nutrition professionals.

Discussion Questions:

1. What steps should the RD take to help James in this scenario?
2. How might she and the sport psychologist on staff work together to solve this issue?
3. What type of intervention could take place with James's teammates or his coach, who have made it a point to tease him due to weight or blame his weight on poor performances?
4. What are some things you might say to James regarding his belief that weight correlates to performance?
5. What can we do to support international student-athletes in their transition into college life?

Katrina, an 18-year-old freshman, is a member of the women's D-1 soccer team at University X on a full scholarship. Over Thanksgiving break, she put on a pair of jeans from her senior year of high school and they split down her inner thigh from her groin to her kneecap. Her mother saw this and began inquiring about what Katrina was eating at college. When she returned to school after Thanksgiving break, the team upperclassman began joking with her, saying that she "looked like she had a delicious" break. Katrina felt mortified, and intense guilt and shame. Despite her 2-a-day practice schedule, she immediately put herself on a 1,200-calorie diet that was Keto-friendly (i.e., no/low carbs) and began losing weight. In early February, her BMI had moved from 23.5 to around 18.5. Friends and teammates noticed that Katrina was moody, irritable, and withdrawn.

She seemed not to have energy for practice and would tire easily. Additionally, Katrina began having obsessive thoughts about food.

Discussion Questions:

1. What warning signs and symptoms you are noticing, and what you might SAY (as the teammate here, hypothetically) to the athlete?
2. How might you facilitate the referral? How would this differ if you were a teammate? Dietitian? Coach?
3. If you were a treating psychologist, how might you begin approaching this client in session?

AASP

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ASSOCIATION for APPLIED SPORT PSYCHOLOGY℠

Psychotherapeutic Interventions for the Treatment of Eating Disorders Among Athletes: Best Practices

Saturday, October 21, 3:00 - 04:15 PM

Thank you

for your kind attention

The AASP Eating Disorder SIG Leadership

References

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Psychotherapeutic Interventions for the Treatment of Eating Disorders Among Athletes:

AASP Abstract

Athletes and performers, more than non-athletes, are at increased risk for eating disorders (EDs) and the associated medical and psychological maladies (Walsh et al, 2020). EDs pose risk of negative health conditions including functional hypothalamic hypogonadism, osteoporosis (Moore, et al, 2021), soft tissue injuries and reproductive compromise (Nattiv et al, 2021). Further, recent findings indicate that athletes with anorexia, more than non-athletes, are at greater risk of poor mental health and death by suicide (Joiner, 2022). Given the potential risk to health, well-being, and performance, it is vital to improve ED treatment effectiveness. Best practice recommendations are available for ED detection and referral, among athletes (Conviser et al, 2018). Unfortunately, many therapists, dietitians, physicians, coaches, and athletic trainers receive little formal training in intervention. Further, little research exists on treatment effectiveness for underrepresented populations within athletics (i.e., transgender; BIPOC athletes). Therefore, all individuals in the treatment setting must be approached with cultural humility and sensitivity. This workshop will highlight interventions shown to enhance motivation for ED recovery and decrease risk of poor mental health, self-harm, and suicide risk among athletes. All attendees will receive intervention decision trees (electronic and/or printed) to assist in analyzing intervention choices, risks, objectives, needs and gains. Those interventions prioritized will strengthen interpersonal connection, belonging, agency, autonomy, and emotion regulation shown to be associated with resilient mental health (Joiner, 2022) and will be evidence-based, such as Acceptance and Commitment Therapy (ACT) (Juarascio et al, 2017). The purpose of this workshop is to better inform treatment teams, improve treatment effectiveness, preserve health, and foster optimal performance. Licensed and experienced workshop leaders will teach strategies for selecting interventions, timing interventions, understanding the therapeutic underpinnings, and language necessary for artful application. Workshop leaders will participate in small group discussion and respond to questions from attendees.