# Eating Disorders in Athletes

## Detection & Referral Guidelines for the AASP Certified Consultant

**AASP Eating Disorders Special Interest Group**

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# Detection & Referral Guidelines for the AASP Certified Consultant

Body image concerns, disordered eating, and problematic exercise behaviors are not uncommon in athletes and may be indicative of a clinical eating disorder. The following guidelines are offered to assist the non-licensed practitioner (e.g., AASP Certified Consultant) in detecting the signs and symptoms of an eating disorder and appropriately referring the client-athlete to a licensed mental health professional with training in the treatment of eating disorders. ***Under no circumstances should the non-clinically trained and non-licensed practitioner do more than "recognize and refer,"*** but this recognition and referral process is essential to getting affected athletes the help they need.

## Recognizing the Signs and Symptoms

A critical first step is knowing when a client-athlete may be affected by an eating disorder. This extensive list includes a range of concerns that may or may not be recognizable by observation. If you are concerned about an athlete, inquire about symptoms that you are unable to observe on your own. An athlete struggling with an eating disorder can be medically compromised regardless of the number of signs and symptoms present.

| PHYSICAL | PSYCHOLOGICAL/BEHAVIORAL |
|---|---|
| ☐ *Body weight and mass*<br>• Significant changes in weight<br>• Significant changes in body composition<br>• Evidence of water-loading or unusual dress (e.g., extra layers of clothing or jewelry) before weigh-ins<br><br>☐ *Muscles and bones*<br>• Bone density concerns<br>• Frequent injury (e.g., strains, sprains, stress and other fractures)<br>• Longer recovery time from injury, workouts, competition<br>• Decreased or erratic athletic performance (e.g., decline in energy, muscle function, coordination, speed)<br><br>☐ *Skin and hair*<br>• Carotinemia (yellowish palms or soles of feet)<br>• Lanugo (fine, soft hair on the body and limbs)<br>• Hair breakage and loss | ☐ *Weight control methods*<br>• Frequent dieting<br>• Using diet pills, laxatives, caffeine, diuretics<br>• Restricting food intake<br>• Binge eating and/or feeling out of control when eating<br>• Exercising beyond necessary for sport performance (e.g., train secretly outside of practice, increase load without a clear goal or gradual load progression)<br>• Avoiding foods without medical necessity (e.g., gluten free, low-carbohydrate diets)<br><br>☐ *Ritualistic eating and exercise behaviors*<br>• Discussion of food "rules"<br>• Cutting food into small pieces<br>• Eating slowly<br>• Odd food combinations<br>• Hoarding food<br>• Distress when routine is disrupted<br><br>☐ *Behavior changes around meal time*<br>• Avoiding eating in public/team meals |

| | |
|---|---|
| ☐ *Menstrual cycle*<br>• Delayed onset of first period (age 16 or later)<br>• Missed or cessation of periods<br><br>☐ *Other physical concerns*<br>• Sores/calluses on knuckles or hand<br>• Swollen salivary glands<br>• Hypoglycemia (low blood sugar)<br>• Bloating, stomach complaints<br>• Headaches or dizziness<br>• Weakness, numbness or tingling<br>• Sensitivity to cold<br>• Decreased training response<br>• Decreased coordination<br>• Sleep impairment | • Never eating when other athletes are eating<br>• Disappearing after meals to use the bathroom<br>• Denial of hunger<br><br>☐ *Preoccupation with body, food, or exercise*<br>• Checking reflection in mirrors, windows<br>• Touching body parts to check size, shape<br>• Frequent self-weighing<br>• Obsessing about numbers (e.g., calories, mileage)<br>• Failure to recognize seriousness of low body weight<br>• Claims of feeling "fat" at normal weight despite reassurance<br><br>☐ *Poor psychological adjustment to performance or injury*<br>• Efforts to train when injured, sick, or overly tired<br>• Difficulty with days off, tapering<br>• Maladaptive perfectionism<br>• Poor focus<br><br>☐ *Emotion and mood disturbances*<br>• Irritability, moodiness, or flat affect<br>• Increased impatience, crankiness, isolation<br>• Shame/guilt after eating<br>• Intense fear of weight gain, becoming fat<br><br>☐ *Relationship Issues*<br>• Conflict with coaches or teammates<br>• Social withdrawal |

While these signs and symptoms affect men and women alike, special considerations for male athletes include: preoccupation with masculinity and muscular development, anabolic steroid use, weight cycling (e.g., often observed in wrestling, rowing, and body building), preoccupation with power-to-weight ratio (e.g., often observed in cycling), internalized pressure to "look" like an athlete, binge eating for weight gain, and obesity in certain types of male athletes (e.g., football lineman). Importantly, because male athletes tend to demonstrate subclinical symptoms more frequently when compared to female athletes, awareness and observation of behavior are critical when working with this population.

## Discerning Between the Pursuit of Performance Goals versus the Ideal Body

Successful athletes are compliant with training programs and periodization to achieve athletic goals. Athletes struggling with eating disorders may use their sport training to disguise purging and compulsive exercise behaviors. When athletes use their sport training in this way, their relationship with exercise is symptomatic and needs to be therapeutically addressed. Use the following questions to explore whether athletes are using exercise to engage in an eating disorder. Ask yourself: Do these answers support athletic goals or are they indicative of a preoccupation with body shape and size?

**Critical Questions to Ask**

- *Values + Goals*
  - Why do you participate in your sport?
  - What are your short-term performance goals?
  - What are your long-term goals as an athlete?
  - Regarding priorities, rate body shape and size compared to performance and achievement. Which is more important to you?
  - Which statement better describes your goals?
    (a) I exercise to eat. OR (b) I eat to fuel my body and perform well.

- *Body + Mood*
  - How does your body shape and size relate to your motivation to train as an athlete?
  - How do you feel when your training plan is interrupted (e.g., unable to complete a workout due to family obligations)?
  - How often do you choose training over social events or other important life activities?

- *Training Volume + Intensity*
  - How often do you practice active recovery and/or take complete rest days?
  - Tell me about your training in the off-season.
  - How often do you train? How long is a typical workout?
  - Do you ever complete workouts not on your schedule in addition to prescribed training within the same day or in place of recovery?
  - Do you ever add mileage, sets, or reps to a prescribed workout?
  - Based on Ratings of Perceived Exertion, how does your intensity vary between workouts?
  - How often do you feel pressure to push harder than your coach prescribes?
  - How would you feel if you did not have any numeric way (fitness device, mileage, time, or heart rate) to track your workouts?

*Below are example responses indicative that an athlete is expressing her/his dedication to their sport versus showing signs and symptoms of an eating disorder.*

- Dedicated Athlete:
  *I eat to fuel my body for training and racing but also recognize that maximizing my power-to-weight ratio is a critical aspect of performance. I watch what I eat but allow myself to eat more when I am hungry or my training intensity increases. I eat in preparation of training and eat to recover from training as well.*

- Athlete with Signs & Symptoms of an Eating Disorder:
  *I need to lose weight to be a better athlete. I often feel hungry before workouts and wait until my next meal to eat something, even if I have to wait a couple of hours and feel hungry during that time. I don't use electrolyte replacement drinks because they have too many calories.*

- Dedicated Athlete:
  *It depends on the situation. Sometimes I get frustrated, particularly if the interruption could have been planned for, but I also realize that missing a single workout will not interfere with my overall fitness.*

- Athlete with Signs & Symptoms of an Eating Disorder:
  *I never miss a workout. I always find a way to train, even during family vacations or on travel days.*

## Addressing Concerns

**Facing Your Fears as the Consultant**

Working with individuals with eating disorders can be exceedingly challenging. Not only are such individuals engaged in oftentimes dangerous behaviors, but they may also seem to reject the idea that anything is wrong, even when they are facing significant health concerns. Professionals who work with individuals with eating disorders need to not only be well-versed in what these disorders are and are not, but also able to manage situations that might cause a great deal of discomfort for them. This discomfort can lead to professionals using interventions or making statements that are more about protecting the professional than the client-athlete. For example, it is not uncommon for professionals to feel fear or anger about an athlete's refusal to change or difficulty with changing eating disorder behaviors. This can lead to attempts by the professional to try to "make" the athlete change their behaviors. This section is intended to offer suggestions with respect to how to confront someone who shows signs and symptoms of an eating disorder in a way that conveys both caring and concern.

**Recognizing Your Limits**

It is important to know the boundaries of your professional competence and your personal limits. For example, it may be useful for you to contemplate questions such as:

- How will you respond to a client-athlete who is significantly restricting her/his intake?
- How will you respond to a client-athlete who is regularly engaged in binge eating and purging episodes?
- What are your reactions to "passive" suicidality (e.g., "I wish I would fall asleep and never wake up" or "I wish I would get a terminal illness")?
- What are your reactions to "active" suicidality (e.g., "I want to kill myself")?
- At what point will you "pull the trigger" and break confidentiality?
- What are your reactions to thin bodies?
- What are your reactions to overweight or obese bodies?

Answering these and other questions honestly will allow you to identify aspects of eating disorders that may be challenging for you. You will also have the opportunity to address any concerns via supervision or consultation which will ultimately help you to work more rationally and logically than emotionally with your athletes. When working with someone who has significant body image concerns, is starving, or bingeing and purging multiple times per day, the consultant may feel the impulse to act of out anger or fear. She or he may attempt to control the client-athlete's behavior, doing "whatever it takes" to get them to stop. You do not have to get them to stop. But you will need to intervene firmly and compassionately when client-athletes are in danger and are not willing or able to take care of themselves. This approach is much more likely to result in a client-athlete following through on your recommendations rather than vehemently refusing them.

**Using Caring Confrontation**

A particular skill that is important to master when working with individuals with eating disorders is called "caring confrontation." Being "confrontational" is often confused with being aggressive, mean, or argumentative, but it is none of those things. "Confrontation" merely means that the consultant is direct and firm about her/his concerns, which can be done with sensitivity, care, and compassion.

As part of the caring confrontation approach, it is important to communicate specific observations of concerning behaviors, statements, or attitudes in a nonjudgmental manner. These observations form the basis of sound concerns. It is often helpful to first begin with a broad statement of concern, such as:

> *You just don't seem like your usual self lately. I really hope everything is okay, but it seems like it is not.*

This statement may prompt the client-athlete to elaborate and share her/his struggles or you may be met with some resistance. For example, client-athletes may deny that anything is wrong, and it will then be useful to say specifically why they don't seem like themselves and what precisely has you worried. For example:

> *I'm really worried about you because I've noticed that you seem to have significantly less energy than you used to and that you're not as upbeat.*
>
> *You've had a lot of injuries lately, which makes me worried that something might be going on with your body.*

In the instance of denial or resistance, it may also be helpful to elaborate on your regard for and concern about the client-athlete's health and safety.

> *Right now I am concerned that if you keep up the intensity of your workouts with the amount of calories you are consuming, your body will start to shut down. In fact it has already started to do just that since you are feeling increasingly fatigued after workouts and experiencing frequent injury. This is your body's way of communicating that you cannot sustain what you are currently doing. Are you at all concerned about this?*

In all instances, it is critical that you allow the client-athlete to respond to your concerns and that you listen empathically as she/he does so.

Once you have identified a need for an eating disorder specialist, it will be important to help facilitate a referral for your client-athlete.

> *I'm really worried about you. I want you to see a physician/psychologist* [whomever they are willing to see] *so they can make sure you are okay.*

At this phase, the client-athlete may respond with "no" and you will again be faced with resistance. Maintaining respect for the client-athlete is critical. In the following example, the consultant is demonstrating respect by acknowledging the client-athlete's autonomy.

> *You don't have to go to the appointment with the team physician or the staff psychologist as recommended. It is your choice to keep the appointment or not. The reality is, however, that if you make that choice not to go, I will continue to advocate with* [whoever is influential in the person's life] *that a higher level of care is necessary.*

The client-athlete may also confront *you* about your suspicions of whether or not they have an "eating disorder." It is generally not a good idea for you to suggest that label because the client-athlete may become defensive and "shut down." Moreover, only a licensed medical or mental health care provider can make such a diagnosis. However, if your client-athlete brings up the idea of an eating disorder, you do not have to ignore the label. You can say that you don't know if an eating disorder is present, which is why consulting with a licensed professional is so important as they can rule it out.

> *I don't know if you have an eating disorder, but I'm worried that it is possible which is why I'd like for you to meet with a physician or psychologist who knows about these things and can say for sure one way or another.*

**Remember, It's Not Personal**

Overall, it is important to remember that whatever behaviors are engaged in or whatever things are said, none of it is personal. These are expressions of the eating disorder itself. Being able to see client-athlete behavior in this way, and thereby detaching from the emotional impact of the client-athlete's actions will allow the consultant to engage much more effectively with the client-athlete.

## Making Referrals

**Best Practices**

- Identify eating disorder therapists with appropriate training (see below). Referrals made to specific individuals are typically more successful; therefore it is important to know the resources in your community in advance.
- Help your client-athlete connect with a few different therapists if possible and identify the best fit.
- With the client-athlete's permission, communicate with the therapist to share what you and the client-athlete have discussed.
- When appropriate, have a transition session with the client-athlete and accompany her/him to a therapy appointment.
- If continuing to work with the client-athlete, stay in contact with the therapist, with the client-athlete's permission.

**Making the Referral: Where? Who?**

Ideally, any referral will include a therapist with experience with eating disorders and athletes. Specifically, you would be looking for a licensed mental health professional with the qualifications outlined here.

- **Licensed Professional**
  - Licensed Psychologist
  - Licensed Clinical Social Worker
  - Licensed Professional Counselor

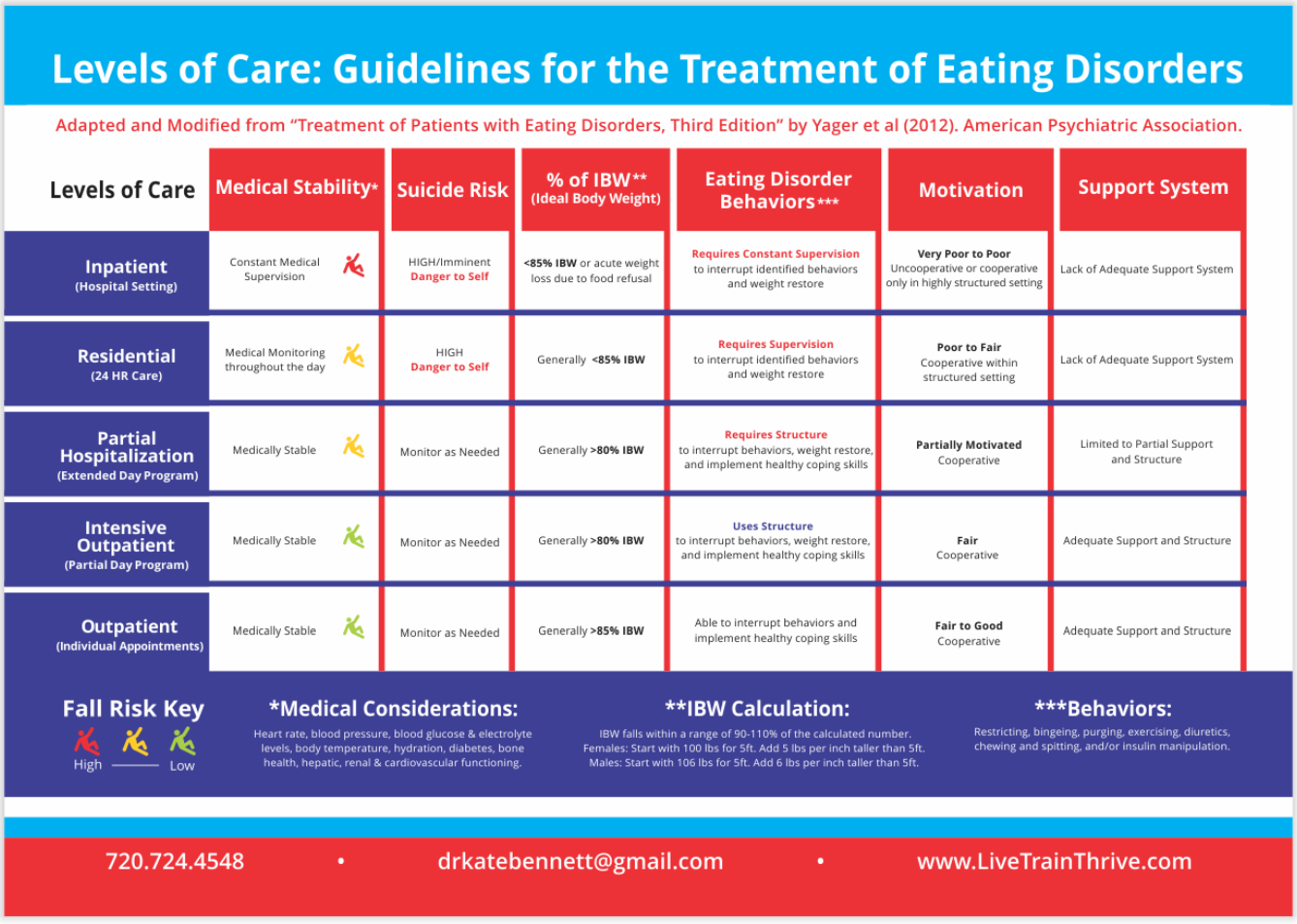
- **Specialized training in treating eating disorders, such as:**
  - Specialized graduate work or practicum with eating disorder patients
  - Internship/Post-doc with eating disorder emphasis
  - Experience in an eating disorder treatment setting
  - Membership in Eating Disorder Professional Organizations
    - International Association of Eating Disorder Professionals (IAEDP)
    - Academy for Eating Disorders (AED)
    - Continuing Education in Eating Disorder Treatment
  - Credentialed as a Certified Eating Disorder Specialist (CEDS)

- **Works with a treatment team, including:**
  - Dieticians
  - Physicians
  - Psychiatrists
  - Strength and Conditioning Coaches

Ideally, this licensed mental health professional would also have specialized training (e.g., CC-AASP) and experience in working with athletes.

**After the Referral: What Happens Now?**

After you have successfully made a referral and assisted your client-athlete in becoming established with a treatment team, the qualified professionals will determine any diagnoses and the level of care needed. The following is a chart that provides information on the levels of care that an athlete may receive while in treatment. ***This chart is provided for informational purposes only.***



## Levels of Care: Guidelines for the Treatment of Eating Disorders

Adapted and Modified from "Treatment of Patients with Eating Disorders, Third Edition" by Yager et al (2012). American Psychiatric Association.

| Levels of Care | Medical Stability* | Suicide Risk | % of IBW** (Ideal Body Weight) | Eating Disorder Behaviors*** | Motivation | Support System |
|---|---|---|---|---|---|---|
| **Inpatient** (Hospital Setting) | Constant Medical Supervision | HIGH/Imminent Danger to Self | **<85% IBW** or acute weight loss due to food refusal | Requires Constant Supervision to interrupt identified behaviors and weight restore | **Very Poor to Poor** Uncooperative or cooperative only in highly structured setting | Lack of Adequate Support System |
| **Residential** (24 HR Care) | Medical Monitoring throughout the day | HIGH Danger to Self | Generally **<85% IBW** | Requires Supervision to interrupt identified behaviors and weight restore | **Poor to Fair** Cooperative within structured setting | Lack of Adequate Support System |
| **Partial Hospitalization** (Extended Day Program) | Medically Stable | Monitor as Needed | Generally **>80% IBW** | Requires Structure to interrupt behaviors, weight restore, and implement healthy coping skills | **Partially Motivated** Cooperative | Limited to Partial Support and Structure |
| **Intensive Outpatient** (Partial Day Program) | Medically Stable | Monitor as Needed | Generally **>80% IBW** | Uses Structure to interrupt behaviors, weight restore, and implement healthy coping skills | **Fair** Cooperative | Adequate Support and Structure |
| **Outpatient** (Individual Appointments) | Medically Stable | Monitor as Needed | Generally **>85% IBW** | Able to interrupt behaviors and implement healthy coping skills | **Fair to Good** Cooperative | Adequate Support and Structure |

**Fall Risk Key** — High ——— Low

***Medical Considerations:** Heart rate, blood pressure, blood glucose & electrolyte levels, body temperature, hydration, diabetes, bone health, hepatic, renal & cardiovascular functioning.

****IBW Calculation:** IBW falls within a range of 90-110% of the calculated number. Females: Start with 100 lbs for 5ft. Add 5 lbs per inch taller than 5ft. Males: Start with 106 lbs for 5ft. Add 6 lbs per inch taller than 5ft.

*****Behaviors:** Restricting, bingeing, purging, exercising, diuretics, chewing and spitting, and/or insulin manipulation.

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Provided with the permission of Dr. Kate Bennett, Athlete Insight, PC.

While the client-athlete is receiving treatment, it will be important to remain in a supportive role. Communicating with your client-athlete and the primary therapist will be important to determine how you can best support your client-athlete in this process. If the client-athlete is continuing to train during treatment, it may be appropriate for them to continue working with the consultant on mental skills. This should be determined by the treatment team and the client-athlete. It is of utmost importance that the consultant follows the recommendations of the eating disorder treatment team and provides a consistent message to the client-athlete at all times. The consultant has a powerful role in aiding treatment and recovery, which is best accomplished through open communication and clear, consistent support.

## To Learn More…

Contact the AASP ED SIG Co-Coordinators for the latest resource list, inclusive of books, videos, documentaries, websites, blogs, and more related to eating disorders, both in general and specific to sport (Dana K. Voelker, PhD, CC-AASP, voelkerd@gmail.com; Amanda Schlitzer Tierney, MS, CFT, amanda@tryteam.com). To get you started, selected resources are provided:

- *American College of Sports Medicine (ACSM)*
  Resources related to athletes with eating disorders including educational brochures and handouts for coaches, athletes, and parents (http://acsm.org)

- *Female Athlete Triad Coalition*
  Joy, E., Souza, M. J., Nattiv, A., Misra, M., Williams, N. I., Mallinson, R. J.,…Borgen, J. S. (2014). 2014 Female Athlete Triad Coalition Consensus Statement on Treatment and Return to Play of the Female Athlete Triad. *Current Sports Medicine Reports, 13*(4), 219-232.

- *Fuel Aotearoa*
  Research-based information for girls and women, coaches, parents, and teachers on the risks of low energy availability and the Female Athlete Triad (http://fuelaotearoa.co.nz/)

- *International Association of Eating Disorder Professionals (IAEDP)*
  Research-based information on the treatment of eating disorders (www.IAEDP.com)

- *International Olympic Committee* (IOC)
  Mountjoy, M., Sundgot-Borgen, J., Burke, L., Carter, S., Constantini, N., Lebrun, C., ...Ljungqvist, A. (2014). The IOC consensus statement: Beyond the Female Athlete Triad – The Relative Energy Deficiency in Sport (RED-S). *British Journal of Sports Medicine, 48*(7), 491-497.

- *National Athletic Trainers' Association* (NATA)
  Bonci, C. M., Bonci, L. J., Granger, L. R., Johnson, C. L., Malina, R. M., Milne, L. W., Vanderbunt, E. M. (2008). National Athletic Trainers' Association Position Statement: Preventing, Detecting, and Managing Disordered Eating in Athletes. *Journal of Athletic Training, 43*(1), 80-108.

- *National Collegiate Athletic Association (NCAA)*
  Information on eating disorders and related concerns specific to collegiate student-athletes (e.g., "Mind, Body, and Sport" http://www.ncaa.org/health-and-safety/sport-science-institute/introduction-mind-body-and-sport)

- *National Eating Disorder Association (NEDA)*
  Webpage on "What Coaches, Trainers, Parents, and Teammates Need to Know" about athletes and eating disorders (https://www.nationaleatingdisorders.org/athletes-and-eating-disorders)

  Toolkits for Athletic Trainers and Coaches, Parents, and Educators on how to support athletes who may be affected by eating disorders (http://www.nationaleatingdisorders.org/toolkits)

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