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## Eating Disorders In Athletes

### How to Identify Pathogenic Weight Control Behavior

Female athletes have gone to extraordinary lengths to lower their body fat stores in an effort to improve performance. A pattern of eating disorders has emerged from this desperate, health-threatening situation. The following protocol was developed to identify symptoms in athletes who suffer from one or more features of pathogenic behavior. ***Many of the items do not by themselves prove the presence of an eating disorder. But identification of one or more may justify further attention to the possible presence of a problem.***

Reports or observations of the following signs or behaviors should arouse concern:

1. Repeatedly expressed concerns by an athlete about being or feeling fat even when weight is below average.
2. Expressions of fear of being or becoming obese that do not diminish as weight loss continues.
3. Refusal to maintain even a minimal normal weight consistent with the athlete's sports, age, and height.
4. Consumption of huge amounts of food not consistent with the athlete's weight.
5. Clandestine eating or stealing of food (eg many candy wrappers, food containers, etc., found in the athlete's locker, around his or her room); repeated disappearance of food from the training table.
6. A pattern of eating substantial amounts of food followed by promptly by trips to the bathroom and resumption of eating shortly thereafter.
7. Bloodshot eyes, especially after trips to the bathroom.
8. Vomitus or odor of vomit in the toilet, sink, shower, or wastebasket.
9. Wide fluctuations in weight over short time spans.
10. Complaints of light-headedness or disequilibrium not accounted for by other medical causes.
11. Evidence of use of diet pills (e.g. irritability fluctuating with lethargy over short periods of time).
12. Complaints or evidence of bloating or water retention that cannot be attributed to other medical causes (e.g. premenstrual edema).
13. Excess laxative use of laxative packages seen in the athlete's area, locker, wastebasket, etc.
14. Periods of severe calorie restriction or repeated days of fasting.
15. Evidence of purposeless, excessive physical activity (especially in a thin athlete) that is not part of the training regimen.
16. Depressed mood and self-deprecating expression of thoughts following eating.
17. Avoiding situations in which the athlete may be observed while eating (e.g. refusing to eat with teammates on road trips, making excuses such as having to eat before or after a team meal).
18. Appearing preoccupied with the eating behavior of other people such as friends, relatives, or teammates.
19. Certain changes in physical appearance (e.g. rounding or pouch-like dilation at or just under the angle of the jaw, ulceration or sores at the corner of the

- mouth or on the tongue, thinning or loss of hair).
20. Known or reported family history of eating disorders or family dysfunction.

***If an athlete who seems to have an eating disorder is practicing one or more pathogenic weight control techniques, the following recommendations are in order:***

1. The coaching or training staff person who has the best rapport with the athlete should arrange a private meeting with him or her.
2. The tone of the meeting should be entirely supportive. Express concerns for the best interests of the individual and make it clear that this concern transcends the issue of the individual as an athlete.
3. In as nonpunative manner as possible, indicate to the athlete what specific observations were made that aroused your concern. Let the individual respond.
4. Affirm and reaffirm that the athlete's role on the team will not be jeopardized by an admission that an eating problem exists. Participation on a team should be curtailed only if evidence shows that the eating disorder has compromised the athlete's health in a way that could lead to injury should participation be continued.
5. Try to determine if the athlete feels that he or she is beyond the point of being able to voluntarily abstain from the problem behavior.
6. If the athlete refuses to admit that a problem exists in the face of compelling evidence, or if it seems that the problem either has been long-standing or cannot be readily corrected, consult a clinician with expertise in treating eating disorders. Remember, most individuals with this problem have tried repeatedly to correct it on their own and failed. Failure is demoralizing to athletes, who are constantly oriented towards success. Let the individual know that outside help is often required and that this need should not be regarded as a failure or lack of effort.

7. Arrange for regularly scheduled follow-up meetings apart from practice times, or, if the athlete is seeing a specialist, obtain advice as to how you may continue to help.
8. Be aware that most athletes resorting to pathogenic weight-control techniques have been told at various times that they had a weight problem. It is important to know what role, if any, past or present coaches or trainers may have played in the development of the problem. Let the athlete know that you realize the demands of the sport may well have played a role in the development of this behavior.

***What not to do:***

1. Question teammates instead of talking directly to the athlete.
2. Immediately discipline the athlete if you find evidence that a problem exists.
3. Indicate to the athlete that you know what's going on, but tell nothing as to how or why you became suspicious.
4. Tell the athlete to straighten up and that you'll be checking back from time to time.
5. Conclude that if the athlete really wants to be okay, he or she will make it happen, and failure to improve shows lack of effort.
6. Dissociate yourself and the demands of the sport from any aspect of the development of the problem.
7. Refuse to obtain outside assistance, but rather "keep it in the family."

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