



National Eating Disorders Association

Coaches & Trainers TOOLKIT



NEDA TOOLKIT for Coaches and Trainers

Table of Contents

| | | |
|-------------|--|-----------|
| I. | Introduction | 3 |
| II. | About Eating Disorders | 4 |
| | Types of eating disorders | 5 |
| | Frequently asked questions | 8 |
| | Common myths about eating disorders | 11 |
| | General emotional and behavioral signs of eating disorders | 14 |
| | General physical signs of eating disorders | 15 |
| | Eating disorder signs and symptoms specific to an athletic setting | 17 |
| | The physiological impact of eating disorders on athletic performance | 18 |
| | The Female Athlete Triad | 20 |
| III. | Prevention | 22 |
| | Factors that put athletes at risk for eating disorders | 23 |
| | Encouraging healthy and appropriate exercise and training for athletes | 24 |
| | Eating disorders prevention in the middle or high school athlete | 25 |
| | Coach's guide to sports nutrition | 26 |
| IV. | Early Intervention | 28 |
| | The potential role of the coach | 29 |
| | Tips on how to positively intervene | 30 |
| | Tips on how to provide a healthy sport environment conducive to recovery | 32 |
| | Confidentiality issues | 34 |
| V. | Personal Stories | 35 |
| | Nutritionists' stories | 36 |
| | Coaches' stories | 38 |
| | Psychologists' stories | 42 |
| | Athletes' stories | 44 |
| VI. | Resources | 49 |
| | Glossary | 50 |
| | References | 58 |

NEDA TOOLKIT for Coaches and Trainers

Introduction

The benefits of sport are well recognized: organized athletics builds self-esteem, promotes physical conditioning, enhances skills, teaches the value of teamwork and sets a foundation for lifelong physical activity. Athletic competition, however, can also cause severe psychological and physical stress that is amplified in individuals struggling with anxiety, depression, and perfectionism. When the pressures of sport competition are added to cultural ideals that emphasize thinness or a certain body type, the risks increase for athletes to develop disordered eating (irregularities in eating patterns and behaviors that may or may not develop into an eating disorder).

Body image problems, disordered eating and full-blown eating disorders are common among athletes, a fact that only in recent years has become more widely recognized. A study of Division 1 NCAA athletes found that more than one-third of female athletes reported attitudes and symptoms placing them at risk for anorexia nervosa. Athletes who engage in disordered eating but fall short of the diagnosis of a full-blown eating disorder are still at risk for serious health consequences, and disordered eating itself is a risk factor for a full-blown eating disorder.

Though most athletes with eating disorders are female, male athletes are also at risk — especially those competing in sports that tend to emphasize diet, appearance, size and weight. In weight-class sports (wrestling, rowing, horseracing) and aesthetic sports (bodybuilding, gymnastics, swimming, diving) about 33% of male athletes are affected. In female athletes in weight class and aesthetic sports, disordered eating occurs at estimates of up to 62%.

These risks and consequences, however, should in no way be misconstrued to suggest that girls and women, or any susceptible person, for that matter, should avoid sport participation. Because the many and varied benefits of sport listed above outweigh its risks, it is not sport participation that should be avoided, but rather the risks to disordered eating that are too often a part of the sport environment.

As coaches and trainers, you play a pivotal and influential role in the lives of young athletes and are ideally positioned, along with their families, to detect these risks — or an eating problem in its early stages— and serve as positive influences in turning around such a situation. It's important to remember that eating disorders can happen to athletes with the best of coaches. Rather than worrying and blaming yourself, focus on helping the athlete return to health.

Eating disorders are challenging and difficult enough for trained professionals to deal with, so we know how important it is to provide you with resources to help you to handle disordered-eating situations that may arise. Experts in the field have contributed to the Coach and Trainer Toolkit, which we hope will provide the information and resources you need to confidently face any situation involving disordered eating or an eating disorder in your sport environment.

About Eating Disorders

NEDA TOOLKIT for Coaches and Trainers

Types of eating disorders

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Anorexia Nervosa is defined by the following criteria:

- Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Either an intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain (even though significantly low weight).
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Anorexia nervosa is then subdivided into a restricting type and a binge eating/purging type.

Bulimia Nervosa is defined by the following criteria:

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- These behaviors do not occur exclusively during episodes of anorexia nervosa.

Bulimia nervosa is subdivided into purging and non-purging types.

Athletes suffering from bulimia nervosa may have some or all of the general disordered eating signs and symptoms, but also are at higher risk for esophageal tears from vomiting, gastrointestinal complications such as diarrhea or constipation, and dental caries and calluses on their hands from induced vomiting.

Binge Eating Disorder (BED) is characterized by the following:

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- The binge eating episodes are associated with three or more of the following:
 - eating much more rapidly than normal
 - eating until feeling uncomfortably full
 - eating large amounts of food when not feeling physically hungry
 - eating alone because of feeling embarrassed by how much one is eating
 - feeling disgusted with oneself, depressed or very guilty afterward
- Marked distress regarding binge eating is present
- Binge eating occurs, on average, at least once a week for three months
- Binge eating is not associated with the recurrent use of inappropriate compensatory behaviors (methods to compensate for overeating, such as self-induced vomiting) as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

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Avoidant Restrictive Food Intake Disorder (ARFID) is defined by the following criteria:

- An eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
 - Significant loss of weight (or failure to achieve expected weight gain or faltering growth in children)
 - Significant nutritional deficiency
 - Dependence on enteral feeding or oral nutritional supplements
 - Marked interference with psychosocial functioning
- The behavior is not better explained by lack of available food or by an associated culturally sanctioned practice.
- The behavior does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way one's body weight or shape is experienced.
- The eating disturbance is not attributed to a medical condition or better explained by another mental health disorder. When it does occur in the presence of another condition/disorder, the behavior exceeds what is usually associated with the condition, and warrants additional clinical attention.

Other Specified Feeding or Eating Disorder (OSFED), formerly known as Eating Disorder Not Otherwise Specified (EDNOS), is a term used in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders to describe feeding or eating behaviors that cause clinically significant distress and impairment in areas of functioning, but do not meet the full criteria for any of the other feeding and eating disorders.

A diagnosis might then be allocated that cites a specific reason why the presentation does not meet the criteria of another disorder (e.g., bulimia nervosa – low frequency). The following are further examples of OSFED:

- **Atypical Anorexia Nervosa:** All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range.

- **Binge Eating Disorder** (of low frequency and/or limited duration): All of the criteria for BED are met, except at a lower frequency and/or for less than three months.
- **Bulimia Nervosa** (of low frequency and/or limited duration): All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behavior occurs at a lower frequency and/or for less than three months.
- **Purging Disorder:** Recurrent purging behavior to influence weight or shape in the absence of binge eating
- **Night Eating Syndrome:** Recurrent episodes of night eating. Eating after awakening from sleep, or excessive food consumption after the evening meal. The behavior is not better explained by environmental influences or social norms. The behavior causes significant distress/impairment. The behavior is not better explained by another mental health disorder (e.g., BED).

In addition, there are some unofficial terms, some of which have been popularized by the media, which are sometimes used in the sports community:

- **Anorexia athletica:** a term used for a sub-group of athletes with eating disorder symptoms that do not permit a diagnosis of anorexia nervosa or bulimia nervosa, and would therefore fall within OSFED.
- **Orthorexia nervosa:** a term used to describe individuals who take their concerns about eating "healthy" foods to dangerous and/or obsessive extremes.
- **Diabulimia:** the manipulation of insulin by diabetics for the purpose of losing weight.
- **Drunkorexia:** self-imposed starvation or bingeing and purging, combined with alcohol abuse.

While anorexia nervosa and bulimia nervosa are terms most people have heard of, there is a growing body of research that points to the destructive consequences of disordered eating. An athlete may not meet the criteria for full-blown anorexia nervosa or bulimia nervosa, but his/her habits and patterns can negatively affect performance, team dynamics, and health.

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Disordered eating may consist of food restriction, excessive avoidance of certain types of food, or consuming fewer calories than needed for basic daily functions and sports activity. Disordered eating may include bingeing and purging and the abuse of medicines and supplements, such as laxatives, diuretics, stimulants, and appetite suppressants. Athletes suffering from disordered eating can experience chronic and substantial distress and impairment.

We know that some people can be genetically more susceptible to anorexia nervosa and bulimia nervosa than other people are. However, there are many people who suffer from disordered eating who do not have this susceptibility.

A word about obesity: The increased attention to the high rate of obesity in America has raised some troubling questions. While reducing childhood obesity is an important goal, it needs to be done in a manner that does not increase risk for eating disorders and weight stigmatization, or provoke anxiety among children about weight, size and shape. Try to shift the paradigm to promote health and fitness rather than a desirable size or shape. For more information on this topic, read the Academy for Eating Disorders' position paper on childhood obesity prevention programs.

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Frequently asked questions

What is an eating disorder?

Eating disorders are serious but treatable illnesses with medical and psychiatric aspects. The eating disorders most commonly known to the public are anorexia and bulimia. There are also other eating disorders, such as binge eating disorder. Some eating disorders combine elements of several diagnostic classifications and are known as “other specified feeding and eating disorders (OSFED).” Eating disorders often coexist with a mental illness such as depression, anxiety or obsessive-compulsive disorder. People with an eating disorder typically become obsessed with food, body image and weight. The disorders can become very serious, chronic and sometimes even life-threatening if not recognized and treated appropriately.

Who gets eating disorders?

Males and females may develop eating disorders as early as elementary school. While it’s true that eating disorders are more commonly diagnosed in females than in males, and more often during adolescence and early adulthood than in older ages, many cases are also being recognized in men and women in their 30s, 40s and older. Eating disorders affect people of all socioeconomic classes, although it was once believed that they disproportionately affected upper socioeconomic groups. Anorexia nervosa ranks as the third most common chronic illness among adolescent U.S. females. Recent studies suggest that up to 7% of U.S. females have had bulimia at some time in their lives. At any given time an estimated 5% of the U.S. population has undiagnosed bulimia. Current findings suggest that binge eating disorder affects 0.7% to 4% of the general population. (Smink, van Hoeken and Hoek, 2012)

Can eating disorders be cured?

Many people with eating disorders who are treated early and appropriately can achieve a full and long-term recovery. Some call it a “cure” and others call it “full remission” or “long-term remission.” Among patients whose symptoms improve — even if the symptoms are not totally gone (called a “partial remission”) — the burden of the illness can be greatly diminished. This can encourage increased happiness and productivity, a healthier relationship with food, and an improved quality of life. Treatment must be tailored to the individual patient and family.

Controversy exists around the term “cure,” which can imply that a patient does not have to be concerned with relapse into the disorder. Many clinical experts prefer the term “remission” and look at eating disorders as a chronic condition that can be very effectively managed to achieve complete remission from signs and symptoms. Patients may, however, be at risk of a relapse in the future. Many patients in recovery agree that remission more accurately describes their recovery, because they need to continuously manage their relationship with food, concepts about body image, and any coexisting mental condition, such as depression.

What if I say the wrong thing and make it worse?

Family, friends, school staff and coaches often express concern about saying the wrong thing and making the eating disorder worse. Just as it is unlikely that a person can say something to make the eating disorder significantly better, it is also unlikely that someone can say something to make the disorder worse. Sometimes not saying anything can be worse than almost anything one could say. Individuals with eating disorders sometimes interpret unresponsiveness by significant others as “not caring.” See “[Tips on how to positively intervene](#)” in this toolkit for a sample conversation with an athlete you are concerned about.

I know someone who exercises for three or four hours every day. Is this considered a sign of an eating disorder?

Perhaps. If the person is not training for a rigorous athletic event (like the Olympics) and the exercise has become compulsive, either to improve performance or burn calories, then yes, exercise is likely a dimension of an eating disorder. If you know the person well, talk to him/her about the reasons he or she exercises so much. If you are concerned about their weight or the rationale behind the excessive exercise regime, lead the person to information and resources that could help.

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A group of athletes is dieting together. What should we (coaches/trainers) do?

Seeing an athlete develop an eating issue or disorder can sometimes lead other athletes to feel confused, afraid, or full of self-doubt. They may begin to question their own values about thinness, healthy eating, weight loss, dieting and body image. At times athletes may imitate the behavior of their teammates. Imitating the behavior may be one way of dealing with fear, trying to relate to the teammate with the eating disorder, or trying to understand the illness. In other cases, a group of athletes dieting together can create competition around weight loss and unhealthy habits. If dieting is part of the accepted norm of the team, it can be difficult for any athlete seeking peer acceptance to resist joining the behavior. Approaching an athlete who is imitating the behavior of a teammate with an eating disorder should be similar to approaching an athlete with a suspected eating problem.

I'm noticing some changes in weight, eating habits, exercise, etc., with an athlete, but I'm not sure if it's an eating disorder. How can I tell?

Unless you are a qualified professional, you can't make a diagnosis, but you can refer the athlete to appropriate resources that might help. Keep in mind, however, that denial is typically a big part of eating disorder behavior and an athlete may be unreceptive to the suggestion that anything is wrong. Often it takes several conversations before the athlete is ready to listen to your concerns.

What should be done when rumors are circulating about a student with an eating disorder?

If a student has an eating disorder and other students are talking about it to the point where the student with the eating disorder is uncomfortable coming to school, a strategy should be implemented to deal with the gossip. When a student is suspected of having or is diagnosed with an eating disorder, fellow students may have different reactions. Rumors often develop that further isolate the student experiencing the eating disorder. Rumors can also be a form of bullying. Here are some suggested strategies:

- Assess the role of the rumors. Sometimes rumors indicate students' feelings of discomfort or fear.

- Demystify the illness. Eating disorders can sometimes become glamorized or mysterious. Provide accurate, age-appropriate information that focuses on several aspects of the illness such as the causes as well as the social and psychological consequences (not only the extreme physical consequences).
- Work privately with students who are instigating and/or perpetuating rumors: talk about confidentiality and its value. For example, promote the idea that medical information is private and therefore no one's business. Without identifying the students as instigators of the rumors, encourage them to develop strategies for dealing with the rumors by establishing a sense of shared concern and responsibility. For example, "Can you help me work out a way of stopping rumors about (student's name), as he/she is finding them very upsetting?"

What's the difference between overeating and binge eating?

Most people overeat now and then, but binge eating is distinguished by eating an amount of food within a specified time that is larger than the amount that most people would consume during a similar time and circumstance, and feeling out of control during the binge. A binge is also generally followed by extreme emotional distress, including guilt and shame.

Are the issues different for males with an eating disorder? What do I say?

Some aspects may be different in males. Important issues to consider when talking to or supporting a male who may have an eating disorder include the following:

- Stigma. Eating disorders are promoted predominantly as a female concern. Males may feel a greater sense of shame or embarrassment.
- It may be even more important not to mention the term "eating disorder" in the discussion, but rather focus on the specific behaviors you have noticed that are concerning.
- Keep the conversation brief and tell him what you've directly observed and why it worries you.

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- Eating disorder behavior presents differently in males. Although the emotional and physical consequences of eating disorders are similar for both sexes, males are more likely to focus on muscle gain, while females are more likely to focus on weight loss.

Can't people who have anorexia see that they are too thin?

Most cannot. Body image disturbance can take the form of viewing the body as unrealistically large (body image distortion) or of evaluating one's physical appearance negatively (body image dissatisfaction). People with anorexia often focus on body areas where being slim is more difficult (e.g., waist, hips, thighs). They then believe they have "proof" of their perceived need to strive for further weight loss. Body image dissatisfaction is often related to an underlying faulty assumption that weight, shape, and thinness are the primary sources of self-worth and value. Adolescents with negative body image concerns may be more likely than others to be depressed, anxious, and suicidal.

I know someone who won't eat meals with family or with friends. How can he/she not be hungry? Does he/she just not like food?

Most likely, the person is overwhelmingly preoccupied with food. A person with an eating disorder does not like to eat with others, does not like anyone questioning his/her food choices, and is totally consumed with refraining from eating. Is the person hungry? Yes! But the eating disorder controls the person.

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Common myths about eating disorders

This information is intended to help dispel all-too-common misunderstandings about eating disorders and those affected by them. If your family member has an eating disorder, you may wish to share this information with others (i.e., other family members, friends, teachers, coaches, family physician)

Eating disorders are not an illness.

Eating disorders are actually complex medical and psychiatric illnesses. The American Psychiatric Association classifies five different types of eating disorders in the Diagnostic and Statistical Manual, 5th Edition (DSM-5): anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder (ARFID) and other specified feeding or eating disorder (OSFED). Several decades of genetic research show that biological factors play a significant role in who develops an eating disorder. EDs can co-occur with other mental illnesses like major depression, anxiety, social phobia and obsessive-compulsive disorder.

Doesn't everyone have an eating disorder these days?

Although our current culture is highly obsessed with food and weight, and disordered patterns of eating are very common, clinical eating disorders are less so. A 2007 study asked 9,282 English-speaking Americans about a variety of mental health conditions, including eating disorders. The results, published in *Biological Psychiatry*, found that 0.9% of women and 0.3% of men had anorexia during their life, 1.5% of women and 0.5% of men had bulimia during their life, and 3.5% of women and 2.0% of men had binge eating disorder during their life. The consequences of eating disorders can be life-threatening, and many individuals find that stigma against mental illness, and eating disorders in particular, gets in the way of timely diagnosis and adequate treatment.

It's just an eating disorder. That can't be a big deal.

Eating disorders have the highest mortality rate of any psychiatric illness. Up to 20% of individuals with chronic anorexia nervosa will die as a result of their illness. Community studies of anorexia, bulimia, and eating disorder not otherwise specified (EDNOS, now called OSFED) show that all eating disorders have similar mortality rates. Besides medical complications from binge eating, purging, starvation and over-exercise, suicide is also common among individuals with EDs because of the severe psychological distress that accompanies the disease. People who struggle with eating disorders also have a severely impacted quality of life.

Anorexia is the only serious eating disorder.

When researchers looked at the death rates of individuals with any eating disorder diagnosis who were being treated as outpatients, they found that bulimia and EDNOS (now OSFED) had the same mortality rate as anorexia nervosa. During the study, roughly 1 in 20 people with eating disorders died as a result of their illness. Individuals who abuse laxatives or diuretics or force themselves to vomit are at significantly higher risk of sudden death from heart attacks due to electrolyte imbalances. Excessive exercise also can increase the risk of death in individuals with eating disorders by increasing the amount of stress on the body.

Strict rules about eating or fad diets aren't a problem.

What appears to be a strict diet on the surface may actually be an eating disorder in disguise, or the beginnings of one. Even if it isn't a clinical eating disorder, disordered eating can nonetheless have serious medical consequences, such as anemia and bone loss. Individuals dealing with serious disordered eating may benefit from intervention and treatment to address their concerns before it becomes a full-blown eating disorder. Chronic dieting has been associated with the later development of an eating disorder, so addressing these issues right away may prevent a full-blown eating disorder.

As long as someone isn't emaciated, they are not that sick.

Most people with an eating disorder are not underweight. Although most people with eating disorders are portrayed by the media as emaciated, you can't tell whether someone has an eating disorder just by looking at them. These perceptions can allow eating disorders to linger for years, and can cause distress in eating disorder sufferers for fear of not being "sick enough" or "good enough" at their disorder to deserve treatment. Just because a sufferer is no longer emaciated doesn't mean they are recovered. Someone can experience a severe eating disorder at any weight.

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If an athlete insists they are fine, I should believe them.

Problems with accurate self-awareness are one of the hallmarks of EDs, so an athlete may not currently have the self-awareness required to recognize a problem. Thus, someone may genuinely believe they are fine when they are acutely ill. Other people may deny the presence of an eating disorder even when they know they are ill because they are afraid of treatment. Regardless of the reason, it is important to insist on regular medical follow-up with a physician who is well-versed in eating disorders.

Eating disorders occur only in females.

Eating disorders can affect anyone, regardless of their gender or sex. Although eating disorders are believed to be more common in females, researchers and clinicians are becoming aware of a growing number of males who are seeking help for eating disorders. A 2007 study by the Centers for Disease Control and Prevention found that up to one-third of all eating disorder sufferers are male. It's currently not clear whether eating disorders are actually increasing in males or if more males who are suffering are seeking treatment or being diagnosed. Because physicians don't think of eating disorders as occurring in males, their disorders have generally become more severe and entrenched at the point of diagnosis. There may be subtle differences in eating disorder thoughts and behaviors in males, who are more likely to be focused on building muscle than weight loss. They are also more likely to purge via exercise and misuse steroids than females.

Men who suffer from eating disorders tend to be gay.

Although gay, bisexual, and transgender males are more likely to develop an eating disorder than straight males, the vast majority of male eating disorder sufferers are heterosexual.

Subclinical eating disorders are not serious.

Although a person may not fulfill the diagnostic criteria for an eating disorder, the consequences associated with disordered eating (e.g., frequent vomiting, excessive exercise, anxiety) can have long-term consequences and require intervention. Early intervention may also prevent progression to a full-blown clinical eating disorder.

Eating disorder behaviors only focus on food.

Individuals with eating disorders generally have an unhealthy focus on food and weight, but the symptoms of an eating disorder can extend far beyond food. Numerous scientific studies have shown links between eating disorders, perfectionism, and obsessiveness, which can lead to a fixation on grades or sports performance. Although many sufferers report that eating disorder behaviors initially help them decrease depression and anxiety, as the disorder progresses, the malnutrition caused by eating disorder behaviors paradoxically increases depression and anxiety that can affect all aspects of life.

Dieting is normal adolescent behavior.

While fad dieting or body image concerns have become "normal" features of adolescent life in Western cultures, dieting can be a risk factor for developing an eating disorder. It is especially a risk factor for young people with family histories of eating disorders and depression, anxiety or obsessive-compulsive disorder. A focus on health, wellbeing and healthy body image and acceptance is preferable. Any dieting should be monitored.

Anorexia is "dieting gone bad."

Anorexia is not an extreme diet. It is a life-threatening medical/psychiatric disorder.

A person with anorexia never eats at all.

Most anorexics do eat; however, they tend to eat smaller portions, low-calorie foods or strange food combinations. Some may eat candy bars in the morning and nothing else all day. Others may eat lettuce and mustard every two hours, or only condiments. The disordered eating behaviors are very individualized. Total cessation of all food intakes is rare and would result in death from malnutrition in a matter of weeks.

Only people of high socioeconomic status get eating disorders.

People of all socioeconomic levels have eating disorders. The disorders have been identified across all socioeconomic groups, age groups, races, ethnicities and genders.

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You can tell if a person has an eating disorder simply by appearance.

You can't. Anorexia may be easier to detect visually, although individuals may wear loose clothing to conceal their body. Bulimia is harder to "see" because individuals often have normal weight or may even be overweight. Some people may have obvious signs, such as sudden weight loss or gain; others may not. People with an eating disorder can become very effective at hiding the signs and symptoms. Thus, eating disorders can go undetected for months, years or a lifetime.

Eating disorders are about appearance and beauty.

Eating disorders are a mental illness and have little to do with food, eating, appearance or beauty. This is indicated by the continuation of the illness long after a person has reached his or her initial 'target' weight.

Eating disorders are caused by unhealthy and unrealistic images in the media.

While sociocultural factors (such as the 'thin ideal') can contribute or trigger development of eating disorders, research has shown that the causes are multifactorial and include biologic, social and environmental contributors. Not everyone who is exposed to media images of the "thin ideal" develops an eating disorder. Eating disorders such as anorexia nervosa have been documented in medical literature since the 1800s, when social concepts of an ideal body shape for women and men differed significantly from today — long before mass media promoted thin body images for women or lean, muscular body images for men.

Eating disorders are an attempt to seek attention.

Far from being a desire for attention, many who experience eating disorders often go to great lengths to conceal it due to an inability to recognize the illness, fear of what might happen if the behaviors are stopped, a desire to continue behaviors and/or feelings of shame.

Purging is only throwing up.

The definition of purging is to evacuate the contents of the stomach or bowels by any of several means. In bulimia, purging is used to compensate for excessive food intake. Methods of purging include vomiting, enemas and laxative abuse, insulin abuse, fasting

and excessive exercise. Any of these behaviors can be dangerous and can lead to a serious medical emergency or death. Purging by throwing up also can affect the teeth and esophagus because of the acidity of purged contents.

Purging will help with weight loss.

Purging does not result in ridding the body of ingested food. Half of what is consumed during a binge typically remains in the body after self-induced vomiting. Laxatives result in weight loss through fluids/water and the effect is temporary. For these reasons, many people with bulimia are of average or above-average weight.

Kids under age 15 are too young to have an eating disorder.

Eating disorders have been diagnosed even in very young children. Often the precursor behaviors are not recognized until middle to late teens. Although the majority of people with eating disorders report the onset of symptoms by age 20, some people do not seek treatment until later in life.

Achieving normal weight means the anorexia is cured.

Weight recovery is essential to enabling a person with anorexia to participate meaningfully in further treatment, such as psychological therapy. Recovering to normal weight does not in and of itself signify a cure, because eating disorders are complex medical/psychiatric illnesses.

Recovery from eating disorders is rare.

Recovery can take months or years, but many people eventually recover after treatment. Recovery rates vary widely among individuals and between different eating disorders. Early intervention with appropriate care can improve the outcome regardless of the eating disorder. Although anorexia nervosa is associated with the highest death rate of all psychiatric disorders, research suggests that about half of people with anorexia nervosa recover, about 20% continue to experience issues with food, and about 20% die in the longer term due to medical or psychological complications.

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General emotional and behavioral signs of eating disorders

- An intense fear of gaining weight
- A negative or distorted self-image
- Frequent checking in the mirror for perceived flaws
- Self-worth and self-esteem depend on body shape and weight
- Fear of eating in public or with others
- Preoccupation with food
- Obsessive interest in cooking shows on television and collecting recipes
- Hoarding food
- Only eating “safe” or “healthy” foods
- Making excuses for not eating
- Irritability
- Self-harm (cutting, etc.)
- Substance abuse (alcohol, marijuana, cocaine, heroin, methamphetamines)
- Rigidity in behaviors and routines, and extreme anxiety if these are interrupted
- Cooking elaborate meals for others, but refusing to eat them themselves
- Eating strange combinations of foods
- Elaborate food rituals
- Withdrawing from normal social activities
- Wearing baggy or layered clothing
- Flat mood or lack of emotion; alternately, extreme mood swings

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General physical signs of eating disorders

General Signs

- Avoiding eating with others
- Hoarding and hiding food; eating in secret
- Unusual food rituals (cutting food into small pieces, chewing each bite an unusually large number of times, eating very slowly, consuming unusual combinations of foods)
- Cutting out entire food groups (no sugar, no carbs, no dairy, vegetarianism/veganism)
- Large changes in weight, both up and down
- Excessive exercising; exercising even when ill or injured, or for the sole purpose of burning calories
- Stomach cramps, other non-specific gastrointestinal complaints (constipation, acid reflux, etc.)
- Menstrual irregularities—missing periods or only having a period while on hormonal contraceptives (this is not considered a “true” period)
- Difficulties concentrating
- Abnormal laboratory findings (anemia, low thyroid and hormone levels, low potassium)
- Sleep problems

Signs of binge eating disorder

- Evidence of binge eating (eating in a discrete period of time an amount of food that is much larger than most individuals would eat under similar circumstances), including the disappearance of large amounts of food in short periods of time or lots of empty wrappers and containers indicating consumption of large amounts of food; feeling a lack of control over the ability to stop eating
- Developing food rituals (e.g., eating only a particular food or food group [e.g., condiments], excessive chewing, not allowing foods to touch)
- Stealing or hoarding food in strange places
- Hiding body with baggy clothes
- Creating lifestyle schedules or rituals to make time for binge sessions
- Skipping meals or taking small portions of food at regular meals
- Periods of uncontrolled, impulsive or continuous eating beyond the point of feeling comfortably full
- Does not purge
- Engaging in sporadic fasting or repetitive dieting
- Body weight varies from normal to mild, moderate or severe obesity

Signs of anorexia nervosa and other restrictive eating disorders

- Marked weight loss
- Little concern over extreme weight loss
- Dressing in layers to hide weight loss or stay warm
- Preoccupation with weight, food, calories, fat grams and dieting
- Refusing to eat certain foods, progressing to restrictions against whole categories of food (e.g., no carbohydrates)
- Eating tiny portions or refusing to eat
- Making frequent comments about feeling “fat” or overweight despite weight loss
- Complaining of constipation, abdominal pain, cold intolerance, lethargy and excess energy
- Denying feeling hungry
- Developing food rituals (e.g., eating foods in certain orders, excessive chewing, rearranging food on a plate)
- Cooking meals for others without eating
- Consistently making excuses to avoid mealtimes or situations involving food
- Maintaining an excessive, rigid exercise regimen despite weather, fatigue, illness, or injury; the need to “burn off” calories taken in
- Hyperactivity and restlessness (inability to sit down, etc.)
- Withdrawing from usual friends and activities and becoming more isolated, withdrawn, and secretive
- Behaving concerned about eating in public
- Limited social spontaneity
- Resisting maintaining a body weight appropriate for their age, height and build
- Intense fear of weight gain or being “fat,” even though underweight
- Disturbed experience of body weight or shape, undue influence of weight or shape on self-evaluation, or denial of the seriousness of low body weight
- Losing menstrual period (applicable to post-puberty females)
- Thinning of hair on head, dry and brittle hair
- Muscle weakness
- Cold, mottled hands and feet or swelling of feet
- Impaired immune functioning; poor wound healing
- Displays feelings of ineffectiveness and need for control
- Overly restrained initiative and emotional expression

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Signs of bulimia nervosa

- In general, behaviors and attitudes indicating that body weight and shape, weight loss, dieting and control of food are becoming primary concerns
- Evidence of binge eating (eating in a discrete period of time an amount of food that is much larger than most individuals would eat under similar circumstances), including the disappearance of large amounts of food in short periods of time or lots of empty wrappers and containers indicating consumption of large amounts of food; feeling a lack of control over the ability to stop eating
- Evidence of purging behaviors, including frequent trips to the bathroom after meals, signs and/or smells of vomiting, presence of wrappers or packages of laxatives or diuretics
- Appearing uncomfortable eating around others
- Developing food rituals (e.g., eating only a particular food or food group [e.g., condiments], excessive chewing, not allowing foods to touch)
- Skipping meals or taking small portions of food at regular meals
- Stealing or hoarding food in strange places
- Drinking excessive amounts of water
- Using excessive amounts of mouthwash, mints and gum
- Hiding body with baggy clothes
- Maintaining an excessive, rigid exercise regimen despite weather, fatigue, illness, or injury; the need to “burn off ” calories
- Unusual swelling of the cheeks or jaw area
- Calluses on the back of the hands and knuckles from self-induced vomiting
- Discolored, stained teeth
- Creating lifestyle schedules or rituals to make time for binge-and-purge sessions
- Withdrawing from usual friends and activities
- Bloating due to fluid retention
- Frequently dieting
- Puffy face
- Thinning hair
- Has secret recurring episodes of binge eating
- Body weight is typically within the normal weight range; may be overweight

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Eating disorder signs and symptoms specific to an athletic setting

As coaches and trainers, you are on the front lines of your athletes' lives, and often the first to notice subtle changes in mood, behavior and performance that may indicate an eating disorder. The following information will help you more readily identify an athlete with an eating disorder and know what steps to take to address the problem.

It is important to identify disordered eating, excessive exercise or an eating disorder as soon as possible, as early detection is one of the best predictors of full recovery. Including the athlete's parent or guardian in this discussion is recommended. The longer an eating disorder persists, the more difficult the recovery. Another reason for early intervention is that if not addressed early on, disordered eating habits can become pervasive on a team.

Symptoms you may notice include

- Decreased concentration, energy, muscle function, coordination, speed
- Increased fatigue and perceived exertion
- Longer recovery time needed after workouts, games, races
- More frequent muscle strains, sprains, and/or fractures
- Slowed heart rate and low blood pressure
- Reduced body temperature and increased sensitivity to cold—cold hands and feet
- Complaints of light-headedness and dizziness
- Gastrointestinal complaints such as nausea, constipation, abdominal pain and fullness
- Poorer interaction with coaches/teammates
- Perfectionism
- Increased impatience, crankiness
- Increased isolation
- Difficulty with days off and tapering
- Avoidance of water or excessive water intake
- Preoccupation with one's own food
- Preoccupation with other people's food
- Ritualistic eating and/or avoidance of certain foods
- Excessive concern with body aesthetic
- Decrease in performance, especially when combined with other signs
- Prolonged or additional training above and beyond what is required for sport (e.g., extra sit-ups and laps, extra workouts)
- Athletes on the team reporting concern about an individual

Athletes may also work very hard to hide their struggles. Personality shifts may occur, ranging from being more withdrawn and isolated to acting out excessively.

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The physiological impact of eating disorders on athletic performance

The physiological impact of an eating disorder is related to its severity and duration, as well as to the athlete's overall health, age, body stature and genetics.

Athletes are often not taught that ideal body fat levels are not a one-size-fits-all formula. The athlete's own body type, genetics and fitness level should all be considered. It is important to convey to athletes that a thin athlete is not necessarily a strong athlete. In fact, too much weight loss can result in the athlete's loss of power and strength.

An athlete suffering from an eating disorder may suffer from the following physiological conditions:

- Fatigue
- Malnutrition
- Dehydration
- Low heart rate (bradycardia)
- Low blood pressure (orthostatic hypotension)
- Electrolyte imbalance
- Osteoporosis
- Loss of endurance
- Loss of coordination
- Loss of speed
- Muscle cramps
- Overheating

Many female athletes suffer from the Female Athlete Triad, which is a combination of disordered eating, absent or irregular menstrual periods and low bone density. Inadequate food intake to fuel workouts, as well as low body fat, is thought to be the driver of menstrual issues. Regular menstrual periods are crucial to the development and maintenance of adequate bone density.

Even short-term weight loss can hurt performance

Some athletes may only engage in eating-disordered behaviors during their competitive seasons. Even a short period of weight loss will often result in a decrease in water weight, and this can leave the athlete dehydrated. When athletes in weight-class sports restrict carbohydrate intake to make weight goals, they may suffer a decline in strength, speed or stamina. Tell your athletes that restricting fluid or food intake to make weight does not optimize performance, and may in fact hurt it.

Medical problems that can arise from specific eating disorders

Although the following medical complaints may not all affect athletic performance, they are further signs that an athlete may be suffering from an eating disorder and is in a compromised medical state.

Low resting heart rate is a frequent sign of many eating disorders, and is frequently missed in young athletes because physicians and other clinicians assume that the low pulse is due to fitness rather than cardiac issues. If a resting heart rate is less than 60 beats per minute and there are ANY signs of an eating disorder, the athlete could be at high risk for cardiac arrest and an eating disorder evaluation by a qualified provider should occur before the athlete returns to practice or competition.

Anorexia Nervosa

- Heart failure. This can be caused by slow heart rate and low blood pressure. Those who use drugs to stimulate vomiting, bowel movements or urination are also at high risk for heart failure. Starvation can also lead to heart failure, as well as brain damage.
- Brittle hair and nails; dry skin. Skin may dry out and become yellow, and the affected person can develop a covering of soft hair called lanugo.
- Mild anemia
- Swollen joints
- Reduced muscle mass
- Osteoporosis

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Bulimia Nervosa

- Erosion of tooth enamel from the acid produced by vomiting
- Inflammation of the esophagus
- Enlarged glands near the cheeks (giving the appearance of swollen cheeks)
- Damage to the stomach from frequent vomiting
- Irregular heartbeat
- Heart failure
- Electrolyte imbalances (loss of important minerals like potassium) that can lead to sudden death
- Peptic ulcers
- Pancreatitis (inflammation of the pancreas)
- Long-term constipation

Binge Eating Disorder

- High blood pressure
- High cholesterol
- Fatigue
- Joint pain
- Type II diabetes
- Gallbladder disease
- Heart disease

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The Female Athlete Triad

By Kathryn Ackerman, MD, MPH

The Female Athlete Triad (the Triad), a term coined in 1993 by the American College of Sports Medicine, refers to a syndrome commonly seen in athletic women. It involves the interrelated symptoms of disordered eating, menstrual irregularity and low bone mass. Although the exact prevalence of the Triad is unknown, studies have found that nearly three-quarters of female athletes have at least one sign of the Triad, according to a 2009 study in the *Clinical Journal of Sports Medicine*.

The idea of the Triad has evolved to include different stages of a continuum on which many of our athletes live. At one end of the spectrum are athletes with mildly disordered eating (e.g., missing certain nutrients, skimping on calories) who have irregular periods (oligomenorrhea) and/or possibly experienced a stress fracture. At the other end are women who have eating disorders such as anorexia or bulimia, have long-standing amenorrhea and have bone density in the osteoporosis range. Low bone mass results in bones that are easily fractured. For an athlete, apart from being painful, such injuries can impair or even put an end to a promising athletic future.

The interrelationship between food intake, menstrual dysfunction and poor bone health is still being elucidated. In general, when an athlete eats too few calories, it causes brain hormone levels to change, disrupting signals to the ovaries to produce estrogen, which helps build and maintain bones. Studies in individuals with anorexia have shown that the restoration of normal menstrual periods via the normalization of food intake and reduction of exercise is the only effective way to begin improving bone density.

This is particularly important in adolescent girls, as 90% of peak bone mass is attained by age 18, with only mild gains up to age 30. This means that disrupting the menstrual cycle during adolescence and early adulthood has a profound effect on bone health. If caught early, however, some of the deleterious effects of the Triad on bone health may be corrected. Through their 30s, women's bone densities tend to plateau if diet and exercise are adequate. Bone density then declines abruptly around menopause and usually remains on a modest decline through the rest of the lifespan. If young female athletes begin good habits early, their peak bone mass is expected to be higher

than that of their sedentary counterparts, thus greatly reducing the risk of osteoporosis later in life.

Causes of the Triad

Recent research has helped increase understanding of what causes the Triad. One factor is the maintenance of adequate body fat levels. Although some athletes mistakenly believe that leaner is always better, this isn't the case. If an athlete tries to maintain a body fat percentage that is too low for her individual genetic makeup, it can result in hormonal abnormalities that lead to Triad symptoms.

However, low body fat alone doesn't cause the Triad — in fact, symptoms have been documented in females with adequate body fat. The triggering factor appears to be prolonged inadequate energy intake, even without any weight loss. The stress of strenuous physical activity without sufficient energy replacement can cause the body to shut off reproductive functions, as it doesn't have the energy to maintain a pregnancy. Therefore, increasing nutritional intake and/or decreasing activity should be the first line treatment for athletes with Triad symptoms.

How do you detect the Triad?

The signs and symptoms of the Triad are very broad, and they involve all of its three components: eating and exercise habits, menstrual irregularity and poor bone health.

- **Low bone mass** may manifest as stress fractures or full fractures (e.g., in a long bone such as the tibia or fibula or as a compression fracture in the spine). Some stress fractures are secondary to overuse and sports technique (such as an uneven running gait), while others, such as lumbar and femoral stress fractures, are highly correlated with disordered eating. Fractures are often early signs of low bone density. Other low bone mass risks include a history of malabsorption (e.g., Crohn's disease, ulcerative colitis, celiac disease), low calcium and/or vitamin D intake, excessive alcohol consumption, steroid use, and those with either or both of the other two aspects of the Triad. Low bone density can be detected by a dual x-ray absorptiometry (DXA) scan.

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- **Disordered eating**
- **Menstrual irregularity** is not usually detectable by a coach, but it is important to let your athletes know that missing menstrual cycles is not normal and they should feel comfortable going to student health or a specialist to have this addressed. Missed cycles in athletes are not always an indication of the Triad, so it is important to have the athlete evaluated by a doctor for other medical problems that may cause amenorrhea (e.g., polycystic ovarian syndrome or a pituitary tumor). This evaluation involves various laboratory tests and sometimes imaging. Once other causes are ruled out, treatment can proceed with dietary and exercise adjustments.
 - Female athletes taking oral contraceptive pills (OCP) may be unaware of menstrual irregularities or think the artificial period created by the pills will protect her from decreased bone density. More recent studies show that this is not the case. Only natural menstruation produces the right hormones at the right levels to build bone mass.

Sample Female Athlete Triad scenarios, with potential responses

A college freshman cross-country runner increases her mileage abruptly but does not increase her caloric intake to compensate for increased training. She is also experiencing stresses in school. She suffers a tibial stress fracture.

- Changes in routine and new stresses, both mental and physical, can take a toll on an athlete. Talk to new team members early on about the changes they may experience and how to cope with them. If you know an athlete is under mental or physical stress, encourage her to make use of your school's counseling services and/or suggest sports nutrition counseling, both of which can help improve physical and mental well-being.
- Prevent this situation by gradually increasing training during the preseason, as well as stressing the need for dietary adjustments and increases to account for the increase in caloric expenditure.

- Send the athlete to a medical professional to assess her fracture as well as review her diet, menstrual history and fracture history. A doctor may decide a DXA scan is warranted, depending on other risk factors present.

You overhear some seniors on your high school volleyball team discussing one of their teammates, who has never gotten her menstrual cycle.

- Send the athlete to a sports medicine specialist for evaluation. No cycle by the age of 16 is considered primary amenorrhea (versus secondary amenorrhea, where a female has begun menses that later stop).
- If a medical cause such as a tumor or polycystic ovarian syndrome is discovered, it can be managed by a doctor such as primary care doctor, endocrinologist or OB/GYN.
- If delayed menses due to extreme exercise and/or diet (the Triad) is diagnosed, the athlete's physician and a dietitian should address the problem immediately, as she is missing important estrogen exposure and dietary support for skeletal development and bone density.

What are the Triad treatments?

Therapy for the Female Athlete Triad involves a multidisciplinary approach that includes the coach, parents, medical professionals, dietitians, psychological support (e.g., psychiatrist, psychologist, therapist) and sometimes teammates.

The basis of all Triad treatment is diet and exercise modification. If the athlete is underweight, energy balance and weight gain are crucial to treatment success. The athlete needs to gain an understanding of the relative number of calories she is burning and the types of nutrients her body needs.

She may also need counseling to help return to healthier eating and exercise habits and coping with the range of emotions that this entails. She may also benefit from therapies that challenge unhealthy ways of thinking and promote developing better coping skills.

The most important help you as a coach can provide is to recognize the warning signs and know where to go to for help.

Prevention

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Factors that put athletes at risk for eating disorders

Listed below are recognized risk factors to be watchful for in the athletic environment:

Personal factors that may create risk for an athlete

- Inaccurate belief that lower body weight will improve performance. In fact, under-eating can lead the athlete to lose too much muscle and bone tissue, resulting in impaired performance.
- Imbalance between energy input and output resulting in weight loss. This is especially a risk for athletes who burn high levels of energy in their sport, such as distance runners.
- Athletes with perfectionism, unreasonably high standards for themselves, a history of depression or anxiety, and/or a family history of eating disorders.
- The risk of disordered eating increases when a coach employs a “win at all costs” approach rather than emphasizing skill development.
- Performance anxiety and fear of failure. Athletes who feel they are not performing at their peak capability may turn to altering their body compositions to bridge the gap. If no improvement in performance results, they may believe they didn’t lose enough weight or body fat and they may step up their efforts even more.
- Social influences, including family and peer/teammate pressure about athletic ability and performance.
- Inadequate intake relative to energy output. Especially in growing teen and young adult athletes, energy needs can be very high, which requires planning on the part of the coach, the athlete, and his/her family to make sure energy needs are met.

Specific sports that can create risk for developing an eating disorder

- Gymnastics, swimming, diving, rowing, body-building and wrestling, because athletes must “make weight” or maintain a certain body size to stay competitive.
- Aesthetic or endurance sports such as gymnastics, figure skating, dance, swimming, diving, cross-country or track and field, because they focus on appearance and on the individual rather than on the entire team.
- Multiple team or sport participation without adequate recovery time and/or fueling opportunities.
- Eating disorders can develop in any genetically predisposed person playing any sport, especially when they go through periods of negative energy balance (inadequate fueling for activity).

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Encouraging healthy and appropriate exercise and training for athletes

Successful athletes are motivated by a desire to excel. Proper coaching can build on this motivation by helping young people develop good training habits, hone technical skills and work as part of a team. However, because top athletes are often driven perfectionists, it is not uncommon for them to take practices and workouts to unhealthy extremes. Such behavior can mark the first steps on the road to an eating disorder. If the athlete resets weight goals to a lower weight or if their weight drops to a level lower than is necessary for adequate sports performance, be vigilant; those can be signs of trouble. Other signs and symptoms that bear watching:

- Training more than coach recommends
- Overuse injuries
- Muscle weakness
- Exercising seemingly without enjoyment
- Training in dangerous situations, such as running alone at night or when injured or sick
- High level of anxiety when unable to practice or train
- Frequent weighing
- Negative comments about weight or being “fat”

The following are tips on how to promote healthy and appropriate practices and workouts among your athletes.

- Tell your athletes that good sport performance is like most human behaviors in that it is determined by numerous factors. Good health is probably the most important factor other than genetics, and the most important contributor to good health (other than genetics) is good nutrition.
- Remind athletes that sports should be for fun, fitness and healthy competition. Additional reasons to participate or compete include improved health and learning to be a team player.
- Promote realistic goals to avoid physical and mental burnout. Motivate your athletes to make the most of their ability and their sport experience by encouraging good nutrition and healthy training.
- Encourage athletes to view sports as a lifetime pursuit, which means caring for their bodies over a lifetime. Remind them that they only have one body, so it behooves them to take good care of it.
- Healthy and appropriate exercise should improve your athlete’s alertness and ability to relax, not exhaust them.
- Encourage flexibility in scheduling workouts and training sessions. Athletes need to stick to a regular practice schedule but sometimes unforeseen events occur, and missing a practice or two is inevitable. Encourage your athletes to strive for balance between exercise and other activities, and also between exercise and eating.
- Encourage athletes to learn how to do their chosen activity properly, and to rely on you, their coach, trainer or other trusted sources for information.

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Eating disorders prevention in the middle or high school athlete

By Lois M. Neaton, PT

Because athletes are now being groomed at a younger age for varsity sports, physical therapist Lois Neaton believes it is important to start thinking about prevention at the middle school level. Here is her advice to coaches and trainers of young athletes:

- The more activities a child is exposed to, the broader his or her physical and mental development will be. Instead of locking the sixth grader into basketball year round, keep your eyes open to the actual interests of the child. Explore lots of different activities.
- When girls who are in 8th grade are invited to participate in varsity sports, especially in speed sports such as cross country or skiing, the burden of a high level of training is being put on an immature skeleton. Be aware of this, as well as of the social aspect of putting a middle schooler in with high school athletes, and adjust your demands accordingly.
- Younger team members may worry that although they are fast now, going through puberty will slow them down. Reinforce that it is normal for athletes to have menstruation and growth for a healthy life.
- Be observant. Are your athletes developing? Some of the kids I see have not grown in a year; an athletic 13-year-old who is losing weight when she or he should be growing is a travesty. When the gang is going out for pizza, do your players all eat? What is the conversation about at the table? In the locker room?
- Get to know your athlete outside of your sport. When I ask eating disordered athletes “what would have made a difference?” this is the comment I hear most often: “My coach has no clue about the rest of my life.” Do you know their other life interests? Do you know their parents or guardians?
- Give every player equal attention and meet with them individually at the beginning of the season. Make direct eye contact when you speak to them, if culturally appropriate. Find out what they want to work on. Make training about succeeding both in their sport and in their life beyond sport.
- Be specific and precise in defining your expectations. Instead of telling a player “run on the weekends,” or “don’t eat junk food,” spell out exactly what you mean. There is going to be the kid who decides “if it’s not organic, it’s junk” or the kid who decides he needs to run 20 miles on the weekends.
- Be vigilant if you have an athlete who is always doing “extra.” He or she is the one who, whenever everyone else is running five laps, is running six.
- Tell your athletes what “going too far” means. Give them limits. Respect your athletes’ bodies and teach them to do the same. If a coach says, “This is the point in training when you are going to feel nauseous,” kids believe this is the gold standard of training. Help them know what overtraining looks like and how to avoid it.
- Be clear about the need for adequate restorative sleep and at least 1-2 rest days, and explain how it improves performance.
- Follow up on any injuries. Shin splints and stress fractures should not be shrugged off as an expected runner’s hazard.
- Coaching should be about performance, not perfection. Explain that it’s not about weighing 10 pounds less; it’s about extending the foot another half inch to get that extra speed, or developing strategies to strengthen mental focus.
- Many athletes get so hooked on the cardio aspect of their sport they are afraid of bulking up through strength training. Explain that core training will not make them overweight, but may make them stronger competitors. Challenge their perceptions of the ways they can excel, beyond just speed or weight.
- Know when to drive a point home in the heat of the moment, but balance that with hanging back and getting your athlete’s feedback when possible. Remember that building mutual respect is the foundation of a healthy coach-athlete relationship.
- If you have concerns about nutritional support, act on your instincts and seek professional help. Focus on guiding the athlete to outside resources, and make those available.
- Be aware of your own food and fitness attitudes and behaviors. If you are struggling in these areas, keep those struggles to yourself both in word and in deed before your athletes.

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Coach's guide to sports nutrition

By Andrea Kurilla, RD, LD, MPH and Marcia Herrin, EdD, MPH, RD

Coaches play an influential role in the way his or her athletes think about nutrition, body weight and the way they eat. When presenting nutritional messages avoid judgmental statements such as “good” or “bad” food. Emphasize that “all foods fit!” Athletes should never restrict their eating or be advised to eat only low-fat or fat-free foods, count their calories or lose weight. Keep information simple and remind athletes that proper nutrition is intended to support the body's basic physical needs, prevent illness and injury, speed recovery between workouts, maintain a healthy body weight and composition and improve performance.

Nutrition for physical activity

Athletes do not always experience the hunger cues telling them to consume enough calories to compensate for their level of exercise. Remind athletes that:

- They must have at least three meals and supportive snacks throughout the day. A pre-event meal is recommended 3-4 hours before the event and a small snack can be consumed within an hour before exercise. Many athletes do best with three meals and three snacks a day.
- Glycogen is the stored form of energy and primary fuel of muscles during intense activity. The body makes glycogen from carbohydrates found in foods such as complex carbohydrates (e.g., breads, bagels, granola bars), calcium-rich foods (e.g., milk, yogurt, calcium-fortified orange juice), and fruits.
- Food choices before and after activity need to be tailored to individual tolerances.
- Adding protein after exercise helps repair muscle, particularly after high-intensity exercise.
- Repairing muscle and restoring glycogen is most important when athletes have more than one training session per day or the next training session is within eight hours.

Snack ideas for before and after practice/competition

The pre-event and post-event meal and snack should be rich in carbohydrates. Some athletes may benefit from a small amount of protein as well.

Snack ideas:

- Bagel or toast with peanut butter (honey or jam can be added on top of but not as a substitute for the peanut butter)
- ½ cup oatmeal with milk or nuts
- Yogurt with fruit
- 1-2 cups chocolate milk
- Granola or energy bar containing nuts, if possible
- Yogurt and granola
- Dried fruit and nuts mix

Meal ideas:

- Pasta with meat or meat sauce
- Peanut butter and jelly sandwich

Eating before practice/competition

- Athletes need to remember that food and drink consumed before exercise is a source of readily available energy. Performance is compromised when energy stores are low.
- Recommend that an hour before exercise, athletes eat a snack that is primarily carbohydrate (grain, fruit or dairy) but also includes a small amount of protein, and that they drink at least 7-16 oz. of water, juice or sports drink.

Eating after practice/competition

- After exercise, muscle and liver glycogen stores need to be replenished in order to repair and provide energy for future exercise. A post-event snack should be consumed within 30 minutes of the activity, if possible, followed by recovery snacks and meals for 4-6 hours to replenish glycogen stores.

Hydration

Adequate hydration is critical for cooling the body and maintaining normal physiological functions. Our bodies are more physically stressed during exercise, and impaired performance (i.e. decreased heart pumping capacity, slowed pace, less endurance) may result. Hydration can counter these impairments.

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Symptoms of dehydration

- Thirst
- Muscle cramps
- Nausea
- Weakness
- Dizziness
- Fatigue
- Headaches

Tips for rehydrating

- Drink fluids regularly during exercise.
- Good sources of fluid include water, sports drinks, juices, soups, smoothies, fruits and vegetables.
- Rehydrate after exercise by drinking enough water or sports drinks to replace fluid lost during exercise.
- For short-duration (<60 minutes), low- to moderate-intensity activity, water is a good choice to drink before, during and after exercise.
- Sport drinks containing 6-8% carbohydrates are good options for moderate- to high-intensity activity lasting longer than 60 minutes, especially if your goal is to replace carbohydrates and electrolytes. These drinks can also be helpful if carbohydrate stores are low prior to the event (i.e., a high school athlete who was not able to eat lunch due to scheduling issues).

- For those who experience high sodium losses during exercise, include salty foods in pre-exercise meals or add salt to sports drinks consumed during exercise.
- Replace fluid and sodium losses with watery foods that contain salt (soup, vegetable juice, pickles).
- Replace fluid and potassium losses by consuming fruits (including juices and smoothies) and vegetables.

It is not recommended that athletes calculate their sweat rate to determine the amount of fluid that should be replaced after exercise. This may put an emphasis on weight and/or weight loss from exercise. A sports dietitian can help athletes develop a personalized hydration plan that considers thirst, urine color and body weight changes if needed, especially for those who engage in high-intensity or long-duration exercise in hot and humid environments.

Some athletes take advice to “eat healthy” to extremes, which can then lead to eating problems. Remind athletes that moderation is a key part of their regimen.

Early Intervention

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The potential role of the coach

As a coach or trainer, you play a significant role in the physical and psychological health of your athletes. You are a key figure in creating training environments conducive to successful athletic performance as well as emotionally rewarding sport experiences.

It is often coaches or trainers—before friends or even family—who first notice physical changes or shifts in unhealthy attitudes and behaviors.

If you think an athlete might be at risk for disordered eating or in the midst of an eating disorder, you are in a position to help. Remember to involve the athlete's family members whenever appropriate. Take warning signs and eating-disordered behaviors seriously. Eating disorders are the most deadly of all mental illnesses. A 2011 study in *JAMA Psychiatry* found that a young person with anorexia, for example, is **twelve times** more likely to die than his or her healthy classmate. Cardiac arrest and suicide are the leading causes of death among people with eating disorders, the researchers concluded in the same study.

What should you do if you are concerned about an athlete?

Don't try to manage the situation alone! Here are some people and resources to involve.

Parents/guardians

Informing an athlete's parent/guardian should be your first step. Parents can play a crucial role in helping their child recover from an eating disorder, even if they are a young adult.

Health Services at your school

They can help by:

- Connecting the athlete with a doctor for examination
- Monitoring an athlete for weight and vital signs
- Weighing in athletes for weight-restricted sports
- Giving a talk to your team

Mental Health Services

They can help by:

- Connecting the athlete with a therapist
- Talking to the team if there is a designated specialist
- Informing you of the school's policy on eating disorders
- Aiding in handling athletes who refuse to seek treatment or address the problem

Nutritionists

A registered dietitian or Certified Specialist in Sport Dietetics can help by:

- Ensuring that the athlete is consuming enough energy or calories to support daily demands
- Giving an athlete a meal plan
- Talking to the team about supportive eating for performance

Trainers

They can help by:

- Having a good enough rapport with athletes to sit a player down and express concern
- Giving a talk on the importance of nutrition in strength and endurance building

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Tips on how to positively intervene

- **Approach your athlete sensitively and in private,** while being as direct and straightforward as possible; use “I” statements to cite the evidence you see for disordered eating and the impact of his or her behaviors on both individual and team performance, while also expressing your concern for the athlete’s health and well-being.
- **Do not judge or criticize your athlete.** The goal is to help the athlete tell his or her parent/caregiver about the disordered eating, if he or she has not already done so.
- **Seek help as soon as possible.** Make a prompt and appropriate medical referral to a healthcare specialist familiar with treating eating disorders (e.g., physician, therapist, eating disorder specialist or dietitian). Voice your concerns to a responsible family member or caregiver and to the school’s student assistance program or health services. Early detection increases the likelihood of successful treatment and decreases the likelihood of serious or long-term medical and psychological consequences; left untreated a problem that begins as disordered eating may progress to an eating disorder.
- **Be prepared for denial.** Many people with eating disorders and disordered eating do not recognize that they have a problem, or they suffer from intense shame about their behaviors. Many will insist that nothing is wrong with them. Encourage a medical workup regardless—the worst that can happen is that they see a physician.
- **Encourage your athlete to seek treatment.** Ideally, an athlete can stay involved in his or her sport while seeking treatment; however, when their physical health is at risk, be prepared to encourage the athlete to abstain from participation until they are given a doctor’s permission to return to sport participation. Consider the whole person when making decisions about an athlete’s level of participation in sport: physical, emotional and mental health.
- **If your athlete is unable to follow treatment recommendations, consult with the treatment team about suspending participation until the athlete is willing to comply.** This course of action may seem harsh. Tell the athlete that the suspension may feel like a punishment but is actually a protective action to guard against possible physical and psychological harm. It is a communication that says that health is more important than sport. Even though this communication is a positive one, it still should be approached cautiously. Reassure the athlete that his position on the team will not be jeopardized by seeking treatment.
- **Be open and cooperative with the treatment team.** The most effective treatment for an eating disorder is to utilize a collaborative treatment approach consisting of a team of health professionals (e.g., physician, therapist or dietitian). As a coach, your support of, trust in, and cooperation with the team’s treatment plan will be critical to your athlete’s successful recovery.
- **As a coach, your involvement and positive communications are very important for your athletes.** Be a source of support. Try to maintain open lines of communication with athletes dealing with eating issues and support them in their recovery. Ask them what they need and what might be helpful in their recovery. Be as sensitive and understanding as possible. With adolescent athletes, be alert to changes in self-esteem that can make their recovery effort more difficult.

NEDA TOOLKIT for Coaches and Trainers

Sample conversation with an athlete you are concerned about:

“Sarah, I really value you as a team member and appreciate x, y, and z about you. I am concerned because I have noticed you are having a hard time focusing, you aren’t as social with your teammates, and I’m worried that you are becoming overly restrictive in your eating and are training to the point of diminishing returns. I think you could really benefit from seeing a dietitian and someone at health services for an evaluation to determine if there is a problem. Would you be willing to explore this idea with me? ”

Make it clear to the athlete that you are concerned, that the conversation will not stop here, and that you will be taking your concerns further. The athlete may agree or may deny that there is a problem. Either way, as a coach you can be helpful. If he/she denies a problem, simply say that you hope he/she is correct, but that the only way to know for sure is to be evaluated by an appropriate healthcare professional. Tell the athlete that you hope the evaluation indicates that there is no cause for alarm. In that case, you as the coach and everyone concerned about him/her will breathe a sigh of relief. Add, however, that if the evaluation indicates a problem, you very much want the athlete to seek appropriate treatment.

If an athlete continues to deny a problem and refuses to get help, options include contacting your school’s psychological services or an eating disorders specialist to guide you through the next steps. Sometimes withholding sport participation until the athlete has been evaluated will motivate him or her to have the evaluation. Withholding such participation indicates to the athlete that his/her health is more important than sport participation. An evaluation should also include a decision regarding whether training and competition can continue without increasing the risk to the athlete. That decision is made by the treatment team and can be adjusted as necessary as the athlete’s treatment progresses.

It is important for you, the athlete, the parents and the team to realize that there are resources and support networks to help.

NEDA TOOLKIT for Coaches and Trainers

Tips on how to provide a healthy sport environment conducive to recovery

Provide athletes and their families with accurate information on eating disorders, healthy weight, good nutrition (and the impact of bad nutrition) and sports performance. Information should include common myths about eating disorders and challenges to unhealthy practices but should not emphasize specific eating disorder symptoms. Such an emphasis can actually make athletes aware of pathogenic weight control methods that they might then try. Stay with the positives of good nutrition and health.

- If you have access to a dietitian who specializes in treating eating disorders, ask her or him to speak to your athletes about healthy eating to maximize performance. For the eating-disordered athlete, a dietitian can provide a meal plan and nutritional counseling.
- Make use of your school's mental health services, if available. They can help by connecting your athlete with a therapist; assigning a specialist to talk to the team; informing you of the school's policy on eating disorders, and aiding in handling athletes who refuse to seek treatment.
- Make use of local health professionals with expertise in eating disorders and athletics who can help educate athletes. Consider posting a referral sourcebook listing centers where they can seek help; they may be more comfortable first addressing the issue on their own, outside of school. Keep this list available for you to use when discussing the need for evaluation and treatment with an athlete. A referral to a specific person you have recommended is more apt to be accepted.
- Be aware of and banish negative messages your sport environment communicates about weight/size/appearance and dieting to your athletes. This will create a healthier environment for your disordered eating athlete and aid in preventing relapse and future cases of disordered eating.
- Emphasize the health risks of low weight, especially for female athletes with menstrual irregularities or those who have stopped having periods completely. Refer athletes for medical assistance in these cases.
- Be especially vigilant if your sport is high-risk for the development of disordered eating (e.g., sports with weight classifications, aesthetic judging or endurance variables). Work especially hard to counter triggering messages.
- Be aware of possible discomfort on the part of your female athletes regarding their uniforms. Some sport attire is revealing, either in terms of their form fitting nature or in amount of skin exposed. Such uniforms may increase body consciousness and body dissatisfaction, as well as facilitate unhealthy body comparisons.
- Pay attention to your own comments and behaviors about size/shape, as well as those of team members, especially body comparisons between/among athletes. Eliminate derogatory comments or behaviors about weight — no matter how subtle, light or “in good fun” they seem. Understand your role in promoting a positive self-image and self-esteem in your athletes.
- Coaches should strive not to emphasize weight for the purpose of enhancing performance (e.g., by weighing, measuring body fat composition and encouraging dieting or extra workouts). Even the slightest comment, direct or indirect, made by an influential coach to an athlete suggesting that their weight is too high can motivate an athlete to engage in unhealthy dieting behaviors. Performance should not come at the expense of the athlete's health.
- In sports where weigh-ins are required, such as wrestling or crew, they should be done in an open and transparent manner, in a supportive environment where athletes are provided nutrition and eating disorders prevention education. Athletes should understand that engaging in eating disordered behavior will not be tolerated.
- Discourage dieting, which is the primary precursor to disordered eating. Being stuck in a pattern of disordered eating can create mental and emotional turmoil. This can easily offset any potential performance enhancement that might be achieved through a reduction in body weight or fat.

NEDA TOOLKIT for Coaches and Trainers

- Look for ways of enhancing performance that do not focus on weight, e.g., strength, endurance and physical skills training, as well as trainings that emphasize mental and emotional aspects of performance.
- Enlist the help of trainers, who often have good rapport with athletes, and who may be the best people to first sit an athlete down to express concerns. Qualified trainers may also be able to talk to athletes about the importance of nutrition in strength and endurance training.
- Avoid comparing athletes' bodies to one another, especially if the athlete of comparison has an eating disorder. Coaches should also discourage body comparisons among and between teammates, as well as "fat talk" (interactions between teammates that involve negative body talk). This kind of dialogue can trigger "competitive thinness" in some athletes.
- Provide factual and scientifically supported nutrition information, not personal opinion or fad diets.

NEDA TOOLKIT for Coaches and Trainers

Confidentiality issues

Issues of confidentiality can be difficult when dealing with disordered eating in athletes. You may seek accurate information about the health and well-being of your athlete and find you are not allowed access to the same information (medical records) or disclosure as that of legal guardians. A useful resource for coaches who have an athlete with an eating disorder is the *NCAA Coaches Handbook: Managing the Female Athlete Triad*.

Here are some tips on how to fulfill your job as coach while honoring confidentiality:

- Familiarize yourself with HIPAA (the 1996 Health Insurance Portability and Accountability Act), which protects the privacy of insured patients. Healthcare professionals are not at liberty to talk with you about an athlete's condition because they are legally and ethically bound to protect confidentiality. Confidentiality is important because it allows the athlete to be honest with their treatment team, knowing that a provider can only release information to others with the written consent of the athlete.
- Consider asking the athlete if he or she feels comfortable sharing their treatment progress with you. If they would rather keep their treatment/recovery private, do not be dismayed.
- Be willing to communicate your thoughts/ observations to the treatment team even if you are not formally included in the treatment planning. This can be tough for a coach, especially if you feel you know your athlete well. Often, however, you may have important information for the treatment team on the health of your athlete and it is important to convey that, invited or not. Even though the healthcare professionals treating the athlete cannot talk with you about his/her condition or treatment, they can listen to what you have to report.
- Be accepting and understanding of the complexities and challenges of treating an eating disorder. Encourage and support appropriate treatment.

Personal Stories

NEDA TOOLKIT for Coaches and Trainers

Nutritionists' stories

Dealing with weight, weight limits, and recruiting in the athletic setting

Talking with Marcia Herrin, EdD, MPH, RD, Founder, Dartmouth College eating disorders program and co-author, *The Parent's Guide to Eating Disorders: Supporting Self-Esteem, Healthy Eating & Positive Body Image at Home*

In sports where there are weight restrictions, I like the approach that one small New England liberal arts college takes. Coaches hold unscheduled, random weight checks so that an individual athlete might get weighed once or twice a season. The weight check only evokes a response from the coach if the athlete is losing weight. This approach is positive (to safeguard the health of athletes) and not punitive (to punish them for their weight); athletes know it's just a routine check that is part of being on the team.

Even in sports with no weight limits, my advice to coaches is to be so careful and circumspect about broaching the topic of size and weight that before you approach the athlete, you ask yourself whether the athlete's current body size makes them a good fit for the team. If you feel the athlete weighs too much, she may be in the wrong boat, or the wrong sport.

Weight is what it is, and it's up to the coach to position athletes appropriately, instead of having athletes strive to manipulate their weight.

Although eating disorders are in part genetically determined, meaning one can inherit a predisposition to them, there can also be a kind of "contagion effect," a spreading of eating-disordered behaviors among teammates. What I see even more than this, though, is the kind of stress an eating-disordered member can create on the team. I see team members really worried about a fellow athlete. They may be asked to keep secrets, or cover for the eating-disordered person in some way. This can be very anxiety-producing for team members and is another reason to carefully consider adding an eating-disordered member to your team.

Reconciling an eating disorders recovery meal plan with athletic life, the dangers of weigh-ins

Talking with Andrea Kurilla RD, LD, MPH

For athletes, one of the hardest parts of battling an eating disorder is following a meal plan when the athlete has not talked about the problem with his or her coach and teammates. Recovery meal plans are pretty structured and include at least one dessert a day, which helps to normalize eating and de-stigmatize forbidden or "binge" foods. Often, though, this directly contradicts the coach's nutritional advice to the team to cut out sugar in an effort to enhance performance. Athletes are caught between the conflicting philosophies of their treatment team and their coaches. Team dinners, where there is constant talk and comparisons made about food and eating, can also be hard.

The best thing for you to do as a coach or trainer is to foster an environment where an athlete feels safe and able to — if not openly share his or her eating disorder with the team — at least have your support. You might not feel able to tell your team, as we do, that "no food is forbidden," but you can at least support your athlete in following his or her meal plan.

As a former college lightweight rower, I know that in some sports weigh-ins are inevitable. If that is the case with your sport, try to keep them as free of stigma as possible. An athlete may just need to lose a few pounds to make the team, but it's very easy to slip into a dangerous mentality about food and weight. A health professional or a trainer should initiate and monitor weigh-ins, and, if they are part of team protocol, food records. Although I believe food records are more dangerous than not, if you do use them make sure that it is not a teammate who is monitoring them, but a trainer or dietitian.

There is a difference between promoting healthy eating and promoting restriction; a trained expert can counsel athletes who are not getting adequate amounts of iron, protein, fat or calories. Young female athletes, in particular, often don't believe their calorie requirements are as high as they are. Try setting a minimum standard for food intake rather than a punitive upper limit.

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Although access to trained health professionals can be difficult in some situations, there are an increasing number of sports dietitians. If there is no such professional affiliated with your team or school, look for someone in your community who is a board-certified specialist in sports dietetics (CCSD) or an RD, and make this reference available to your athletes. The Sports, Cardiovascular, and Wellness Nutrition (SCAN) dietetic practice group represents members of the Academy of Nutrition and Dietetics who specialize in sport. Their website, www.scandpg.org, can help you find an expert in your area.

Effects of Insufficient Intake of Calories

Decreases in

- Strength
- Endurance
- Speed
- Coordination
- Motivation
- Confidence and self-esteem
- Growth and development
- Reproductive function
- Achievement of performance goals

Increases in

- Preoccupation with food and body
- Anxiety
- Agitation and irritability
- Fear
- Risk of injury
- Risk of upper-respiratory tract infections
- Fractures
- Impaired bone health in later life

NEDA TOOLKIT for Coaches and Trainers

Coaches' stories

Replace negative weight talk with fueling education, two-way communication

Talking with Joshua D. Adam, Assistant Coach, Women's Rowing, Washington State University

Like long-distance running, rowing emphasizes athletes who are very tall, very lean and yet extremely powerful. Not surprisingly given these demands, eating disorders can become a serious problem among lightweight and open-weight rowers.

"Lightweight women have to be very, very careful about how much food they take in, and whether they are taking in enough food," says Joshua D. Adam, assistant women's rowing coach at Indiana University. "They get extremely careful about food intake, almost always to a fault." (Although women's lightweight rowing is not an NCAA sport, many schools field varsity lightweight women's rowing teams.)

The nature of the sport puts enormous pressure on coaches to be vigilant to signs of eating issues on their teams and to promote healthy eating. Adam explains that while the calorie needs of rowers are enormous, many athletes don't know how to fill those needs or how much food is enough.

"Talking openly and candidly about fueling gives the athlete an opening to say, 'Hey coach, I don't think I'm getting enough food,' or to feel comfortable saying 'I eat three bowls of cereal a day, is that enough?'" says Adam. "Sometimes it just comes down to ignorance."

A rigorous week of training, for example, might include a 20-minute morning warm-up followed by 12 kilometers of high-intensity rowing, 10 minutes cool-down, then a 50-minute afternoon weightlifting session of mid-weight, high-repetition sets. "The caloric expenditure for a workout like this could go as high as 1,800 calories," explains Adam. "Add that number to a person's basal metabolic needs and you have a large demand for calories that some athletes just do not fulfill."

Emphasizing proper fueling to create a healthy, high-performing athlete can take the place of negative talk about weight. Comments such as, "Well, we might be moving faster if you weren't so big," can cause the athlete "to get stuck inside their own head," and body image issues can take over the athlete's thoughts, Adam warns.

One athlete Adam worked with felt safe enough to bring up her eating problems in the context of the pressure of her first year at college. Adam arranged for her to see the athletic trainer, who brought in a nurse.

"Most of the time, it's the athletic trainer who is going to be having that conversation with the athlete" and then they will inform the coach, he notes.

Blood values revealed that the athlete was experiencing kidney and liver failure due to her eating disorder. She was immediately benched and told that until her blood work improved, she would not be rowing. Adam, the athletic trainer, the nurse and the athlete's therapist all kept in close contact and put together a treatment plan.

"It was humbling from the point of view of the coach. I can't fix this so I have to be open to learning," recalls Adam. "So many times we as coaches are so controlling. We want to fix and take care of events. As coaches, we know we have to learn to stay competitive. And it helps to take on the aspect of learner: if I approach this to learn, I may keep one or two athletes I might have otherwise lost."

Another point Adam makes is that "if an athlete walks away from a very successful program and you're painted as humane, that's going to help you in recruiting. Kids are going to go back and tell their club and their old classmates, 'Hey, this is a nurturing environment.'"

Joshua Adam's tips for preventing eating disorders among athletes

- Strive to create a culture of trust on the team; open the lines of communication.
- Educate athletes on the fueling demands of your sport; emphasize good nutrition.
- Make clear a zero-tolerance policy for eating disorders.
- Set up a system where athletes come in just to chat with you at the beginning of the season.
- Approach the conversation from a caring standpoint.

NEDA TOOLKIT for Coaches and Trainers

No one is blaming your sport!

Talking with Keith Jefferson, Head Rowing Coach, Seattle Pacific University

For Keith Jefferson, it was important to come to grips with the criticism his sport has faced for its weight restrictions. “The idea that gymnastics is just evil, or that lightweight rowing should not be allowed, I didn’t buy that,” says Jefferson, head rowing coach at Seattle Pacific University. A coach for 22 years, he has seen the evolution of awareness about eating disorders over time. In the early days of eating disorders prevention activity, it was not always made clear to coaches that the risks found in the sport environment were the problem, not the sport itself.

“When I learned that this is an actual disorder,” he says, “it was a relief to know that my sport in and of itself was not evil.” He learned that anorexia, bulimia, binge eating and other types of eating disorders are actual mental disorders not caused by his sport.

“It’s important for coaches to know that right off the bat because you’re not going to be highly motivated to solve a problem when somebody tells you your sport is wrong and bad. When you start from the proper posture, you can bore down to what the issues really are,” Jefferson says. Through his university’s eating disorders awareness events, he realized that the problem was bigger than just sport. “There’s an epidemic going on in our dorms,” he notes, and not just among athletes concerned about meeting weight restrictions.

Jefferson has also learned from experience that disordered eating and eating disorders don’t just materialize when an athlete joins his team. In every case he’s seen among athletes, he says, there were other factors that predisposed an athlete to developing an eating disorder that “eventually revealed itself” in the team setting.

“Once you have the context” of eating disorders right, Jefferson notes, “you can deal with the problem at its basis rather than trying to fiddle around with the symptoms. That was helpful for me. It allowed me to get over the fear of eating disorders, because when

you see it for the first time on a team, the coach’s first reaction is often one of fear: You’re responsible for these athletes, and when you spend enough time with them, you love them.”

Jefferson likens the discovery that an athlete on his team is struggling with an eating disorder to experiences he has had dealing with a difficult athlete whom he later learned suffered from ADHD (attention-deficit/hyperactivity disorder). “When I found that out, I was suddenly relieved, I could understand why he or she was giving me these weird behaviors. Instead of getting mad, I could put it into context.”

Keith Jefferson’s tips for dealing with a weight-based sport

- Be clear with athletes that in a sport like rowing that is a performance sport, not a skill sport, you might be able to hide an eating disorder for a short while, but the performance degradation that will result from poor nutrition and fueling habits will eventually make disorders apparent. If the treating doctor advises it, the eating-disordered athlete should be relegated to the bench as the athlete, coach and the treatment team work together to meet treatment goals.
- Make sure your team captains are well-informed about the dangers of eating disorders, are in agreement with you that there is no place on the team for such disorders, and that they trust you and are trusted by their teammates. Have them monitor team members who you think may be at risk.
- Focus on performance from a health and nutrition perspective rather than from a weight perspective.

NEDA TOOLKIT for Coaches and Trainers

Preventing eating disorders among dancers

Talking with Kate Thomas, Director, The School at Steps Dance School, New York City

About three years ago, we had an outbreak, almost an epidemic of eating disorders. Almost every other day, it seemed, a teacher would come in and say “I want you to come in and look at this kid.” Girls who left in the spring rosy-cheeked would come back gaunt, with their shoulder blades sticking out. Of course, their friends’ reactions were “You look so great,” which was completely supportive of this behavior. In some cases, I had to contact the parents because the child was so weak.

If a student is too thin and teachers know they lack the strength and muscle to handle our rigorous programs, they will be eliminated during auditions. Parents can get defensive, but we will not let students join our program until they have reached a healthy weight. In some cases being told that being underweight will not help the child in her attempts to turn professional will trigger the motivation to get better.

Eating disorders and the team dynamic

By Whitney Post, *Life Alive Coaching*

When one or two athletes on a team are struggling with an eating disorder, it can dramatically affect the whole squad. A coach may feel unsure about how to address the issue; it involves weight and body size, which are sensitive topics. As hard as it is, it is best to discuss your concern with the athlete, for the following reasons:

- The contagion effect. Studies have shown that eating disorders and disordered-eating patterns can be contagious – especially in groups of young women and girls. Teams often eat together and change together, and the body size and meal portions of teammates are constantly being observed, sometimes even scrutinized.

Kate Thomas’s tips for promoting self-esteem and healthy body image among dancers:

- Never tell a dancer to lose weight. Instead, say, “There are a lot of ways to dance. Let’s find a dance style that fits your body, instead of trying to force your body to fit the dance style.”
- Promote the goal of “be the best that your body can be, not the best that ever walked the stage.”
- Studies have shown that artists or those with artistic natures are often riddled with self-doubt. Train dancers to take disappointment well. It’s going to be a long haul; help your dancers learn healthy coping skills.

- Athletes who are showing signs of an eating disorder may assume that what they are doing is okay if an adult does not intervene and tell them otherwise. Other athletes may interpret a coach’s silence the same way.
- Athletes are highly attuned to their teammates and gossip is a common pastime on teams. Often athletes will discuss their concerns about a team member with other athletes. They may become distracted by their worry about their teammate(s) and their uncertainty over how to deal with the problem. This takes their focus away from their sport and athletic goals.
- Athletes struggling with disordered eating may put themselves at risk for injury.

NEDA TOOLKIT for Coaches and Trainers

How to approach an athlete on your team whose eating behaviors are disrupting the team

- Arrange a meeting with the athlete and let her or him know your concern. Talk about behaviors and performance rather than the athlete's weight and eating habits. Example: "I've noticed that you don't have as much energy and your performances aren't what they used to be. You are a valuable member of this team and I'm concerned." Refer her/him to health services for an assessment. (For more on this topic, see "Sample conversation with an athlete you are concerned about" in this toolkit.)
- Communicate directly with their health providers. Sometimes athletes will not be truthful about following through on appointments, in hopes that they can maintain both their eating disorder and a spot on the team. Follow up to make sure they are complying with your recommendations.
- Treat the eating disorder as you would an injury on the team, for example a fractured rib or a torn ACL (anterior cruciate ligament), instead of viewing it as an emotional issue. Explain to the athlete that you cannot let her or him practice unless she/he is healthy.
- Come up with clear boundaries about athletic participation and make being in good standing with team dietitians or doctors a prerequisite for practicing and competing with the team. (For more on broaching the subject of an eating disorder with an athlete, see "Tips on how to positively intervene" in this toolkit.)

Captains and communication

- If eating concerns are present on your team it can be helpful to create a team policy or a plan around it at the beginning of the year or season. Try to involve captains, who are often the first people with whom team members will report or discuss a concern. A team policy might look like this:
 - Anyone concerned about a teammate should let the captain know about it.
 - The captain will then either talk to the athlete or see if anyone close to her/him has done so.
 - If the athlete of concern is approached and denies a problem or refuses to seek help, the captain can then approach the coach with her/his concern.
 - The coach addresses the problem from there.

There are many variations on this but if your plan is created in collaboration with the team at the beginning of the season and each team member agrees to it, it will be much more powerful when you need to enforce it.

Notes on recovery

For many athletes, recovering from an eating disorder is both difficult and scary, in part because the athlete's weight, shape and physicality are often closely tied to his or her identity. The idea of having to give up control of training and weight can be terrifying. Recovery also involves addressing underlying feelings, fears and insecurities that the eating disorder served to distance them from. Eating-disordered athletes may find the recovery experience overwhelming at first. For all these reasons, it is important to be sympathetic, and to connect at-risk athletes to services and support systems that will help them recover. It is also important to keep them connected to their teammates. Very often their team is one of their primary support systems. Even if an athlete is not competing, it is a good idea to involve her or him in the day-to-day life of the team as much as possible.

NEDA TOOLKIT for Coaches and Trainers

Psychologists' stories

How to work effectively with your athlete's treatment team

Talking with Carlin M. Anderson, PhD

Carlin M. Anderson, PhD, is a sport psychologist at the University of Minnesota who works frequently with eating-disordered athletes, their coaches and families.

For coaches used to being the primary guiding force in athletes' lives while they are engaged in their sport, the sudden intrusion of other professionals into the picture can be off-putting and a difficult adjustment. This is the frequent scenario the coach or athletic trainer encounters when an athlete is diagnosed with an eating disorder: the athlete's meal plan, training, playing schedule and priorities are often altered dramatically, upsetting the natural coach-athlete relationship.

Having an athlete in treatment for an eating disorder can be both a relief and a challenge for a coach. It can be a relief that your athlete is getting help, but also difficult to know how to work with your athlete's treatment team. Trust issues between coaches and eating disorder specialists are more common than many people realize. When I work with coaches, one of the first things I talk about is where they fit in and the role they can play in their athlete's recovery. It's hard when the coach feels left out of the process and/or unsure of how treatment might affect the athlete's performance. An athlete in recovery from an eating disorder needs both a treatment team and a management team. A treatment team is composed of health care professionals, and it might include a therapist, dietitian, physical therapist, family members and medical doctor. A management team includes the coach, athletic trainer and family, who help manage and carry out the plan of the treatment team. Although many medical doctors and therapists do not include coaches in management of the athlete, if you are able to establish a rapport with the treatment team, you can play an important role in the management of your athlete's recovery.

Athletes will have different degrees of comfort in sharing information with their management teams. Most athletes are willing to share treatment progress, such as "I'm meeting with my therapist twice a week, and things are going okay," but they are usually less comfortable sharing personal details, such as body image concerns, feeling unmotivated at school, or dealing with depression. I try to encourage athletes to clarify what they feel comfortable sharing with their coach in a release of information form, so that the coach can be kept up to date on the athlete's progress

without the athlete feeling as though his or her confidentiality is being jeopardized. For example, if your athlete is not showing up for a therapist's or doctor's appointment, the coach is informed. The coach can talk to the athlete about the missed appointment, just as one might when an athlete misses an appointment with an academic tutor.

It can be extremely hard for coaches to make training decisions for an athlete with an eating disorder when they are not privy to the decisions of the treatment team, and I sometimes see coaches who feel frustrated and shut out. You might feel that treatment providers have forgotten about your important role in the athlete's life, or that they think you won't understand the medical issues. Often legal confidentiality issues prevent you as coaches from having the degree of access you would like. However, if you are aware of the legal constraints from the beginning, it is possible to forge a good relationship with the treatment team.

The best approach is to be proactive in your efforts to work with your athlete's treatment team. Good rapport with the treatment team will make it easier to get the information you need. Voice an interest in his or her treatment plan. Find out more about the professionals on your athlete's treatment team. Ideally, a member of the treatment team will talk to the athlete's coach to learn more about the sport and its demands, and will speak with the athletic trainer about how the athlete should be training. If you are a trainer, you may feel you need more information in order to tailor practices for your athlete. Ask questions. Should you have him or her run as hard as everyone else? To what degree can you push your player and what can you expect from this person in a game or meet? The treatment team may inform you that your athlete is in danger and needs to stop participating in their sport for a while. You may feel that the athlete is performing better than ever. There are situations where, yes, an eating disordered athlete's performance improves in the short run, but the behaviors the athlete is engaged in will eventually result in impaired performance and potentially serious physiological problems. Pulling an athlete from a team is a difficult decision. I have never worked with a treatment team that takes this decision lightly. If your athlete is young and still growing, the team may be more cautious in allowing continued participation, whereas with a collegiate athlete on scholarship, the team may want to keep him or her in as long as

NEDA TOOLKIT for Coaches and Trainers

possible. In general, however, the decision should be made on an individual basis.

Incentives or consequences such as telling an athlete “You can’t drop below a certain weight or you won’t be participating in the next game” can be effective in the short term because athletes will usually do the bare minimum to stay on the team. Although this is usually not a long-term solution, it is a strategy that allows you as a coach to collaborate with the treatment

Finding the right balance between weight and performance: tips from a sport psychologist

Talking with Sandy Dupcak, PsyD, sport psychologist

Dr. Dupcak works with athletes, coaches and parents on issues related to performance enhancement, confidence, anxiety and self-esteem. Struggles with depression and eating disorders are commonly embedded in these performance issues.

Both disordered eating (i.e. poor food choices and inaccurate beliefs about nutrition and weight) as well as clinical eating disorders are common among athletes. However, disordered eating that goes unidentified is far more common than full-blown eating disorders. Distorted thoughts about food, weight and body image may be more dangerous than actual poor eating behaviors.

Actual eating disorders, however, stem from this kind of distorted thinking. Coaches can unwittingly contribute to this transition from distorted thinking to distorted eating behaviors by making comments such as, “So-and-so does this so much faster,” or “So-and-so has the perfect body for this sport.” An athlete will twist even a casual coach remark, apply it to him or herself, and all of a sudden you’ve got a new set of problematic eating behaviors.

Complicating matters, young athletes generally do not have the appropriate knowledge and they are often not directed to a dietitian, so their attempts to lose weight can make the athlete weaker and compromise his or her performance. As this happens, athletes can become more confused and vulnerable to additional distorted thinking about weight, performance, and body image.

One of the most challenging aspects for coaches and athletes is finding the right balance between weight and performance. Every athlete has a different muscle

team. I recommend that athletes be open with their teammates if possible, and make them a source of support. If an athlete is missing practice or not doing everything that the rest of the team is doing, there needs to be some sort of communication with the team to explain why this is happening. You may want to take this opportunity to educate your team about disordered eating and how the rest of the team can help in their teammate’s recovery.

composition, and there’s no simple formula that tells you what an optimal weight is. It is the level at which the athlete is healthy in terms of looking good, feeling his or her strongest, and able to execute the sport skills to his or her maximum ability. Finding that balance can be a challenge for both coaches and athletes, and may involve a bit of experimentation with optimal weight and performance.

Dr. Dupcak’s tips for middle and high school coaches concerned about disordered eating

- Recognize the enormous power you have over your athletes. Coaches chronically underestimate the power and influence that they have over the decision making and behavior of their athletes.
- Know your athletes. Be especially careful with athletes who have low self-esteem, are highly perfectionist or are self-critical. They will distort your comments and do what they think they need to do to please you.
- After speaking with your athlete about your concerns, sit down with his or her parents to get everyone working together as a team.
- Be aware of the secretive nature of eating disorders. Athletes will try to hide their disordered eating behaviors. Resist the temptation to look the other way when you suspect there is a problem. This is especially true if the behaviors have not yet begun to negatively affect performance. The earlier an eating disorder is treated, the better the chances of recovery.

NEDA TOOLKIT for Coaches and Trainers

Athletes' stories

The stigma of male eating disorders: Disorders can happen in “non-high-risk” sports, too

Talking with Patrick Bergstrom, eating disorders advocate, speaker and writer, founder of *I Chose to Live*

As a star high school lacrosse player, Patrick Bergstrom stood out, on and off the field. He was handsome and excelled academically, socially and athletically. Coaches told him he was too small to play college lacrosse, but he was determined to prove them wrong. He set numerous records in lacrosse and weightlifting, played on the Maryland Senior All-State team and was nominated for the award of Maryland Public School Player of the Year.

“When I wasn’t training, I was the life of the party,” Bergstrom recalls. I had a boyish charm and confidence that could win over any girl. There wasn’t ever a time where I wasn’t dating an eye-catching female. I loved attention, popularity and stardom.”

All of that changed when he went off to college. Bergstrom suffered a string of injuries, went through five different coaches at two universities and drank to excess to numb the pain of his fall from athletic grace. In an effort to regain his high school magic, he began to work out more and eat less. Yet because he was still excelling in class and producing on the field, no one seemed to notice the pain he was in. The death of his coach and mentor in a freak accident during his sophomore year accelerated Bergstrom’s fall and triggered his eating disorder. His new coach didn’t believe in his ability and kept Bergstrom on the bench for most of his final season. “That was devastating to me,” he recalls.

He continued abusing alcohol, living off energy drinks, and began eating less than a meal a day, all while juggling two girlfriends. His playing began to falter and his life, he says, “kind of went chaotic from there.” College, he adds, “is the ideal place for an athlete to have an eating disorder.” Athletes find themselves on their own for the first time. Many know little about nutrition, and intensive training, partying and studying can allow room for disordered eating or an eating disorder to thrive.

Two years after graduating, a therapist diagnosed alcohol abuse and depression, and Bergstrom began seeing a counselor. He assumed he was fixed, yet the true cause of his poor health — his eating disorder — had not even been diagnosed yet. Bergstrom thought marriage might set him straight. By then he was pale, weak, and experiencing fainting spells.

A month before his wedding was to take place, he found himself lying on the ground, crying out for help. Two weeks later, after four years of suffering from anorexia nervosa, he was finally given a proper diagnosis. He entered an eating disorders treatment center and his fiancée walked out of the relationship.

Bergstrom is an eating disorders activist, speaker and writer, and heads an educational and advocacy organization, *I Chose to Live*. He’s heard from hundreds of men and boy athletes suffering from eating disorders. Most of the time, he says, the stories are similar to his own: perfectionist, popular, athletic, and smart people whose identities and self-esteem are completely tied up with their success as athletes. Bergstrom is also proof that any athlete, not just those in high-risk sports such as gymnastics or rowing, can become eating disordered.

Bergstrom notes that in two important ways, however, his own story is typical of male athletes with eating disorders: First, “I wanted to be bigger, stronger, faster,” says Bergstrom. The “ripped six-pack and a muscular build” are the typical body ideal for the male athlete. Second, his disorder was diagnosed very late, when it had reached a crisis stage and hospitalization was essential. The extreme stigma faced by males with eating disorders makes them experts at covering up the disease, and their denial of the problem extreme. My biggest fear, he says, “was the reaction others would have when they found out I had an eating disorder.”

Patrick Bergstrom’s Tips for Coaches

- Coaches are athletes’ greatest teachers.
- Coach to instill life lessons in your athletes that will help them succeed off the field.
- Teach athletes to accept failure, to learn from their losses.
- Coach to win, but also teach athletes that sport does not equal life; they need to cultivate other sources of self-worth and satisfaction.
- Encourage athletes to play hard, but without losing sight of the fun of sport.
- Remember that most athletes aren’t going to continue their sport after high school or college; be sensitive to the whole athlete, including academics and non-athletic interests.
- Teach athletes to know the difference between “being the best you can be” and “being the best.”

NEDA TOOLKIT for Coaches and Trainers

A runner's story

Talking with Diane Israel, former triathlete and star of the documentary film *Beauty Mark*

Diane Israel was a highly successful triathlete for 15 years, the Colorado mountain running champion and a world-class racer. She was also anorexic from about the age of 12 until well into her twenties. She did not have a period until she was 30, and as a result, her bones weakened, leading to 17 stress fractures. Diane knew what she was doing to her body. Yet the combination of the teen's belief that she was invincible and her fear that the added weight of womanhood would put an end to her running greatness made it easy to ignore the warning signs of a serious eating disorder. The 2007 documentary film *Beauty Mark* told Diane's story and looked at the effects of popular culture on different athletes' self-images.

The truth for Diane and for many eating-disordered athletes is that, "we don't know how to handle being and staying a great athlete as our body changes," says Diane, who is now a practicing psychotherapist in Boulder, CO. Coaches, she believes, must be educated so they can help the eating-disordered athlete "make the transition into adulthood while remaining a great athlete."

At the root of all eating disorders, Diane believes, is a "lack of a sense of self," what she calls the "self-esteem piece." She didn't feel okay about who she was; finding something she could control — how much she ate — numbed her feelings of self-hate and made her feel safer. It helped her make order out of what felt like a chaotic life.

Diane urges coaches to learn more about eating disorders so that they can avoid the mistakes her own coaches made. She likens the tremendous influence that a coach has over an athlete to a parent-child or

sibling relationship. Many coaches "have this belief that if you're thinner you'll be better, in gymnastics, swimming, running," Diane says. "We have to teach coaches that thinner doesn't mean better."

She counsels coaches to learn how to view the athlete as a complete person, not just as an athlete who must be groomed to perform. The coach needs to care about the athlete's family life, his or her emotional state, and service to the planet, in other words, "to honor the whole human being," not just the athletic being, according to Diane.

The coach also has to be able to voice concern over worrying symptoms. "If somebody had come up to me in the locker room and said, 'I'm really worried about you,'" says Diane, "I probably would have denied [being anorexic] but I would have known that at least someone cared about me. Nobody ever did that for me." She urges coaches and any loved ones to "speak from your own immediate pain. Don't focus on their problem. Don't say, 'You look so sick or skinny.' Say, 'I'm worried about you. Fear comes up for me when I think of you.'"

Another pointer: "A huge thing when you are sick is that you feel crazy," says Diane. The athlete needs to hear from a coach, family member or friend, "There is support, and you are not crazy."

NEDA TOOLKIT for Coaches and Trainers

Hidden in plain sight: A champion rower's quest for perfection and a sense of belonging leads to bulimia

Talking with Whitney Post, *Life Alive Coaching*

From the outside, my life looked like an athletic success story. I was captain of my open-weight college rowing team, which placed third at the NCAA Division I national championships. As a lightweight athlete I became a four-time US Rowing national team member, a four-time national champion, a world champion, and an alternate for the 2000 Olympic team. During this entire time, I struggled with an eating disorder.

As a girl and young woman, I struggled to feel that I fit in. At a young age I began wishing my body was smaller, more “acceptable.” Around the time I went to college my mother developed breast cancer and underwent multiple surgeries, my parents got divorced, and my father disappeared. I arrived at college hungry; hungry to belong, to be noticed. I found what I was looking for in rowing, and, along with it, a workout regimen to aid me in my desperate pursuit of thinness. I fell in love with the sport. I excelled at it and my ability to perform earned me a place in a community of which I desperately wanted to be a part. I dated a star of the men's rowing team; I had the loudest laugh; and I got good grades. I did it all with an eating disorder.

Despite the thrill of rowing, deep down I felt lost, unseen, angry and depressed. I found solace on the water and in the dining hall. Each day was about surviving until dinner. I knew nothing about nutrition. I thought protein made you fat and that lunch was for people who had a lot of time on their hands. I exhausted myself each day at practice and looked forward to rewarding myself with a warm, soothing and filling dinner. The beliefs that organized my world were played out through my body: thinness is rewarded by society; food relaxes and soothes me; the more I work out, the more I can eat; the more I work out, the better I am at my sport. The problem with this formula was that the more I worked out, the more food I needed to restore energy and numb the pain. The result: bulimia.

I was never confronted by anyone on my team about my disorder, but I worried constantly that my secret would be discovered. I was deeply ashamed of it. My coach did comment occasionally that I didn't look well, or noticed when my strength waned as I lost weight for lightweight competitions, and he would appropriately call me out on it. It meant a lot to me that he noticed, and his comments would scare me into eating disorder-free periods. As soon as it began, I sought therapy for my eating disorder at the school counseling center.

Because my therapist didn't specialize in eating disorders and knew nothing about athletes' struggles with them, however, the sessions did little to stop the disorder. Most people, including me, thought my overtraining was the normal behavior of a driven athlete.

My college and post-college rowing years on the national team remain murky memories. When I should have been enjoying the athletic results of my hard work and the adventures and opportunities it afforded me, I was too distracted by my disorder and my underlying unhappiness. In retrospect, what would have helped me is access to resources—information, referrals and support—and permission to use those resources. An acknowledgement that, “Hey, this is something you may be struggling with and here is where you can get some help for it,” would have gone a long way toward helping me get better. It is terrifying to seek help within the culture of one's sport because there is so much shame and judgment associated with eating-disordered behaviors. My deep fear was of not belonging or being valuable to the team. Bringing resources to the team increases the chance that a struggling athlete will get help.

Another important piece, especially for weight-restricted sports, is to talk about the weight-making process. Educate your athletes and provide resources outlining the best ways to make weight. Alert them to the physiological consequences of doing it the wrong way. Some weight-making processes adhere to secretive practices unofficially passed on among athletes and coaches. Everyone wants to make it look easy, so they downplay the extremes they put their bodies through.

I know I would have performed significantly better as an athlete and made different life choices after my competitive rowing career was over had I not been trapped in the physical, mental and emotional quagmire of an eating disorder. For coaches, athletes and teammates, eating disorders are messy, complicated and confusing; it is easier to avoid addressing the problem. The disorder will not go away by itself, though, and most people are not equipped to tackle these issues alone. As a coach, the best thing for you to do is to take action: start asking questions, find professionals who can help, and show that you care.

NEDA TOOLKIT for Coaches and Trainers

The challenge of making it to the top in an aesthetic sport

Talking with Former competitive diver and 2004 Olympian Kimiko Soldati

Kimiko Soldati is an elite athlete who struggled with an eating disorder and is now involved in the sport from the coaching side. She is married to Purdue University head women's and men's diving coach Adam Soldati, and serves as volunteer assistant coach for the Purdue teams.

From where I am now, looking back, I see how horribly entrenched my eating disorder was; it was like being sucked into something and struggling just to breathe. I dealt with bulimia and excessive exercise for about 10 years. In diving, you're out there by yourself in a swimsuit being judged by what you look like. As in gymnastics and other aesthetic sports, your body is your tool and your means of performance and the goal is perfection. Being in a sport like that, my body was constantly at the forefront of my mind. It definitely contributed to developing an eating disorder, and it was exhausting.

It is difficult for athletes and coaches to draw that line between being as physically fit as possible and maintaining peak performance, but keeping on this side of obsession and compulsion. For me that line was completely blurred. Any athlete with an eating disorder has the attributes coaches love: they are coach-pleasing; they have high pain tolerance; they are driven to succeed; they are perfectionists and control freaks. They are very coachable, and coaches love that. It's frightening for coaches to think, "If I change this person, it's going to change those characteristics, and I really like those traits." Coaches are in the hardest position, because their job is to produce champions.

Eating disorders in my sport are more prevalent than even statistics show. You have the diving competition, and then you have the underlying body competition: who's skinny, who's fat, who's five pounds over. It's the first thing that comes to divers' minds when they walk into the pool.

While I never thought my eating disorder was affecting my performance, I look back and realize it did. I struggled with injuries my whole career, underwent five shoulder surgeries and did not heal properly. I was also an emotional train wreck because my identity was totally wrapped up in my sport. Seeking treatment with a therapist and the strength I drew from my faith eventually helped me overcome my disorder.

My coach didn't know about my disorder at first. I remember being terrified before I told him. I felt like I was letting him down; I was embarrassed. But it was a road we traveled together, and it helped for me to communicate to him what was helpful to me and what wasn't.

Here are some helpful strategies, some of which my coach used with me during my recovery, and some of which my husband, who was with me throughout my recovery, now uses with his diving teams:

- Validate your female athletes' feelings, a lot. It will feel redundant and obvious to say, "I understand how you're feeling," or to point out daily areas an athlete is doing well in, not just those that need improvement. But your athlete will be better equipped to do the hard work you are asking of her if she feels understood and appreciated.
- If you notice odd behaviors, ask how your athlete is doing. "What's going on? Are you stressed about a meet?" Try to go deeper than just focusing on the behaviors themselves. Ask, "What can I do to help you relieve the anxiety?"
- Be honest with yourself. Are you in this sport for yourself, or for your athletes? Obviously, you want to win, but are you willing to compromise an athlete's emotional and physical well-being to attain those results?
- Take the time to speak one-on-one with your athletes about their goals. If meeting those goals will require a reduction in weight, talk about how to do this gradually, with the help of a sports nutritionist, and in a way that will not trigger unhealthy behaviors.
- When you do deliver a critique or comment touching on weight, size or shape, follow it up with, "How did you interpret what I just said?" You may be shocked at how a female athlete has completely misinterpreted your remark.
- Enlist team leaders to help create a healthy eating environment so athletes aren't competing to see who can eat the least. When it comes to healthy eating and body image, peer communications are often better received than coaches' pronouncements.

NEDA TOOLKIT for Coaches and Trainers

Running in the family: Together, a family fights eating disorders

Talking with The Walker Family*: Athletes Emma and Sharon talk with their mother Laura about competition, eating disorders and how coaches can help athletes struggling with eating problems.

Sisters Emma and Sharon Walker are both three-sport athletes. Both also battled eating disorders that began with their attempts to “eat healthy” in order to maximize their performances in running, cross-country, skiing and soccer. After Emma became concerned about slaughterhouse practices, cutting out meat was easy. Her weight loss was gradual and went undetected for many months.

Emma, like many athletes, was “so competitive and perfectionistic,” she says, “that I didn’t want to do anything that was going to hurt my performance.” But her good intentions spiraled into self-starvation, amenorrhea and extreme fatigue. Eventually her running times began to suffer, and Emma would faint occasionally after races.

Sharon became eating disordered later, ironically, as she tried to help her sister recover. She read books on nutrition and became overly careful about her own food intake. Laura didn’t notice the gradual changes in her daughters’ eating habits. First they cut out sweets, which she thought was healthy. Next, they cut out fats, and eventually reduced carbs and protein as well, until they were eating mostly fruits and vegetables.

“The top runner on our team was extremely thin and I equated being thin with being fast,” explains Emma. She adds, “The biggest thing coaches need to know is that this doesn’t happen to athletes because they want to be skinny; they want to perform better.” She would like coaches to tell their athletes “that you don’t have to be stick thin to be a great athlete; proper nutrition is what is going to make you a strong athlete.”

“It’s a psychological more than a physical thing,” Emma explains. The under-eating “starts to become normal to you, and you’re not even aware that there’s anything wrong.” What helped her was her coach’s emphasis on the need for her to become stronger by fueling herself

properly. “He used the analogy of a car, and how if it doesn’t have gas in it, it’s not going to run. It was the same with an athlete, he said. If you don’t fuel properly, you’re not going to be able to compete at the level you want to. My motivation for recovering was mostly that I wanted to be able to compete well.”

The Walker family suggests:

Words for coaches to use in training athletes

- Being a great athlete is about being strong, not about being thin.
- Losing weight might initially make your times faster but the fatigue and weakness that result will eventually make your times fall apart.
- There are no “good foods” or “bad foods.” It’s fine to eat sugary foods in moderation.
- Missing regular periods is not acceptable.

Approaches for coaches to take with athletes

- Focus on the performance decline resulting from weight loss, not the weight loss itself, which can encourage athletes to want to lose more.
- Educate athletes about the long-term consequences of amenorrhea.
- Use the athletes’ natural desire to compete and win as leverage to motivate them to recover from an eating disorder.
- Be vigilant in the off-season; eating-disordered athletes often have a harder time motivating themselves to eat enough when there is no sport they need to fuel for.

*Names have been changed to protect anonymity.

Resources

NEDA TOOLKIT for Coaches and Trainers

Glossary

This eating disorders glossary defines terms you may encounter when seeking information and talking with care providers about diagnosis and treatment of all types of eating disorders. It also contains some slang terms that may be used by individuals with an eating disorder.

Alternative Therapy In the context of treatment for eating disorders, a treatment that does not use drugs or bring unconscious mental material into full consciousness. For example, yoga, guided imagery, expressive therapy and massage therapy are considered alternative therapies.

Amenorrhea The absence of at least three consecutive menstrual cycles.

Ana *Slang* for anorexia or anorexic.

ANAD (National Association of Anorexia Nervosa and Associated Disorders) A nonprofit corporation that seeks to alleviate the problems of eating disorders, especially anorexia nervosa, bulimia nervosa and binge eating disorder.

Anorexia Nervosa A disorder in which an individual is unable to maintain a healthy body weight through self-starvation, excessive activity, and/or purging. Many (but not all) individuals have a distorted body image and have difficulty recognizing the seriousness of the illness.

Anorexia Athletica The use of excessive exercise to lose weight.

Anticonvulsants Drugs used to prevent or treat convulsions.

Antiemetics Drugs used to prevent or treat nausea and vomiting.

Anxiety A persistent feeling of dread, apprehension, and impending disaster. There are several types of anxiety disorders, including: panic disorder, agoraphobia, obsessive-compulsive disorder, social and specific phobias, and posttraumatic stress disorder. Anxiety is a type of mood disorder.

Arrhythmia An alteration in the normal rhythm of the heartbeat.

Art Therapy A form of expressive therapy that uses visual art to encourage the patient's growth of self-awareness and self-esteem to make attitudinal and behavioral changes.

Atypical Antipsychotics A new group of medications used to treat psychiatric conditions. These drugs may have fewer side effects than older classes of drugs used to treat the same psychiatric conditions.

B&P An abbreviation used for binge eating and purging in the context of bulimic behavior.

Behavior Therapy (BT) A type of psychotherapy that uses principles of learning to increase the frequency of desired behaviors and/or decrease the frequency of problem behaviors. When used to treat an eating disorder, the focus is on modifying the behavioral abnormalities of the disorder by teaching relaxation techniques and coping strategies that affected individuals can use instead of not eating, or binge eating and purging. Subtypes of BT include dialectical behavior therapy (DBT), exposure and response prevention (ERP), and hypnotherapeutic therapy.

Binge *Slang.* For binge eating episode or binge eating disorder.

Binge Eating (also Bingeing) Consuming an amount of food that is considered much larger than the amount that most individuals would eat under similar circumstances within a discrete period of time. Also referred to as "binge eating."

Binge Eating Disorder (BED) A type of eating disorder that is characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.

Beneficiary The recipient of benefits from an insurance policy.

Biofeedback A technique that measures bodily functions, like breathing, heart rate, blood pressure, skin temperature, and muscle tension. Biofeedback is used to teach people how to alter bodily functions through relaxation or imagery. Typically, a practitioner describes stressful situations and guides a person through using relaxation techniques. The person can see how their heart rate and blood pressure change in response to being stressed or relaxed. This is a type of non-drug non-psychotherapy.

NEDA TOOLKIT for Coaches and Trainers

Bipolar and Related Disorders A group of related mental disorders listed in the DSM-5. These disorders include bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder.

Body Dysmorphic Disorder or Dysmorphophobia A mental condition defined in the DSM-5 in which the patient is preoccupied with a real or perceived defect in his/her appearance. (See DSM-5.)

Body Image The subjective opinion about one's physical appearance based on self-perception of body size and shape and the reactions of others.

Body Mass Index (BMI) A formula used to calculate the ratio of a person's weight to height. BMI is expressed as a number that is used to determine whether an individual's weight is within normal ranges for age and sex on a standardized BMI chart. The US Centers for Disease Control and Prevention website offers BMI calculators and standardized BMI charts.

Bulimia Nervosa A disorder defined in the DSM-5 which a patient binges on food an average of once weekly in a three-month time period, followed by compensatory behavior aimed at preventing weight gain. This behavior may include excessive exercise, vomiting, or the misuse of laxatives, diuretics, other medications, and enemas.

Case Management An approach to patient care in which a case manager mobilizes people to organize appropriate services and supports for a patient's treatment. A case manager coordinates mental health, social work, educational, health, vocational, transportation, advocacy, respite care, and recreational services, as needed. The case manager ensures that the changing needs of the patient and the family members supporting that patient are met.

COBRA A federal act in 1985 that included provisions to protect health insurance benefits coverage for workers and their families who lose their jobs. The landmark Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) health benefit provisions became law in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act to provide continuation of employer-sponsored group health

coverage that otherwise might be terminated. The US Centers for Medicare & Medicaid Services has advisory jurisdiction for the COBRA law as it applies to state and local government (public sector) employers and their group health plans.

Cognitive Therapy (CT) A type of psychotherapeutic treatment that attempts to change a patient's feelings and behaviors by changing the way the patient thinks about or perceives his/her significant life experiences. Subtypes include cognitive analytic therapy and cognitive orientation therapy.

Cognitive Analytic Therapy (CAT) A type of cognitive therapy that focuses its attention on discovering how a patient's problems have evolved and how the procedures the patient has devised to cope with them may be ineffective or even harmful. CAT is designed to enable people to gain an understanding of how the difficulties they experience may be made worse by their habitual coping mechanisms. Problems are understood in the light of a person's personal history and life experiences. The focus is on recognizing how these coping procedures originated and how they can be adapted.

Cognitive Behavior Therapy (CBT) A treatment that involves three overlapping phases when used to treat an eating disorder. For example, with bulimia, the first phase focuses on helping people to resist the urge to binge eat and purge by educating them about the dangers of their behavior. The second phase introduces procedures to reduce dietary restraint and increase the regularity of eating. The last phase involves teaching people relapse-prevention strategies to help them prepare for possible setbacks. A course of individual CBT for bulimia nervosa usually involves 16- to 20-hour-long sessions over a period of four to five months. It is offered on an individual, group, or self-managed basis. The goals of CBT are designed to interrupt the proposed bulimic cycle that is perpetuated by low self-esteem, extreme concerns about shape and weight, and extreme means of weight control.

Cognitive Orientation Therapy (COT) A type of cognitive therapy that uses a systematic procedure to understand the meaning of a patient's behavior by exploring certain themes such as aggression and avoidance. The procedure for modifying behavior then focuses on systematically changing the patient's beliefs related to the themes and not directly to eating behavior.

NEDA TOOLKIT for Coaches and Trainers

Comorbid Conditions Multiple physical and/or mental conditions existing in a person at the same time. (See Dual Diagnosis.)

Crisis Residential Treatment Services Short-term, around-the-clock help provided in a nonhospital setting during a crisis. The purposes of this care are to avoid inpatient hospitalization, help stabilize the individual in crisis and determine the next appropriate step.

Cure The treated condition or disorder is permanently gone, never to return in the individual who received treatment. Not to be confused with “remission.” (See Remission.)

Dental Caries Tooth cavities. The teeth of people with bulimia who use vomiting as a purging method may be especially vulnerable to developing cavities because of the exposure of teeth to the high acid content of vomit.

Depression (or Major Depressive Disorder) A condition characterized by one or more major depressive episodes consisting of two or more weeks during which a person experiences a depressed mood or loss of interest or pleasure in nearly all activities. It is one of the mood disorders listed in the DSM-5. (See Mood Disorders.)

Diabetic Omission of Insulin A purging method to compensate for calorie intake that may be used by a person with diabetes and an eating disorder.

Dialectical Behavior Therapy (DBT) A type of behavioral therapy that views emotional deregulation as the core problem in bulimia nervosa. It involves teaching people with bulimia nervosa new skills to regulate negative emotions and replace dysfunctional behavior. A typical course of treatment is weekly two-hour group sessions lasting 20 weeks. (See Behavioral Therapy.)

Disordered Eating Term used to describe any atypical eating behavior.

Drunkorexia Behaviors that include replacing food consumption with excessive alcohol consumption and/or consuming food along with sufficient amounts of alcohol to induce vomiting as a method of purging and numbing feelings.

DSM-5 The fifth (and most current as of 2015) edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association (APA). This manual lists mental diseases, conditions and disorders, and also lists the criteria established by APA to diagnose them. Several different eating disorders are listed in the manual, including anorexia, bulimia, and binge eating disorder.

DSM-5 Diagnostic Criteria A list of symptoms in the Diagnostic and Statistical Manual for Mental Disorders 5 published by the APA. The criteria describe the features of the mental diseases and disorders listed in the manual. For a particular mental disorder to be diagnosed in an individual, the individual must exhibit the symptoms listed in the criteria for that disorder. Many health plans require that a DSM-5 diagnosis be made by a qualified clinician before approving benefits for a patient seeking treatment for a mental disorder such as anorexia, bulimia or binge eating disorder.

Dual Diagnosis Two mental health disorders in a patient at the same time, as diagnosed by a clinician. For example, a patient may be given a diagnosis of both bulimia nervosa and obsessive-compulsive disorder or of anorexia and major depressive disorder.

Eating Disorders Anonymous (EDA) A fellowship of individuals who share their experiences with each other to try to solve common problems and help each other recover from their eating disorders.

Eating Disorder Inventory (EDI) A self-report test that clinicians use with patients to diagnose specific eating disorders and determine the severity of a patient’s condition.

Ed *Slang.* Eating disorder.

ED Acronym for eating disorder.

Electrolyte Imbalance A physical condition that occurs when ionized salt concentrations (commonly sodium and potassium) are at abnormal levels in the body. This condition can occur as a side effect of some bulimic compensatory behaviors, such as vomiting.

Emetic A class of drugs that induces vomiting. Emetics may be used as part of a bulimic compensatory behavior to induce vomiting after a binge eating episode.

NEDA TOOLKIT for Coaches and Trainers

Enema The injection of fluid into the rectum for the purpose of cleansing the bowels. Enemas may be used as a bulimic compensatory behavior to purge after a binge eating episode.

Equine/Animal-assisted Therapy A treatment program in which people interact with horses and become aware of their own emotional states through the reactions of the horse to their behavior.

Exercise Therapy An individualized exercise plan that is written by a doctor or rehabilitation specialist, such as a clinical exercise physiologist, physical therapist, or nurse. The plan takes into account an individual's current medical condition and provides advice for what type of exercise to perform, how hard to exercise, how long, and how many times per week.

Exposure and Response Prevention (ERP) A type of behavior therapy strategy that is based on the theory that eating disorder behaviors serve to decrease negative emotions, which creates a cycle of negative reinforcement. The goal of ERP is to modify the association between the relief of these emotions and the eating disorder behaviors by encouraging someone to refrain from behaviors until the negative emotions subside. (See Behavioral Therapy.)

Expressive Therapy A nondrug, non-psychotherapy form of treatment that uses the performing and/or visual arts to help people express their thoughts and emotions. Whether through dance, movement, art, drama, drawing, painting, etc., expressive therapy provides an opportunity for communication that might otherwise remain repressed.

Eye Movement Desensitization and Reprocessing (EMDR) A nondrug and nonpsychotherapy form of treatment in which a therapist waves his/her fingers back and forth in front of the patient's eyes, and the patient tracks the movements while also focusing on a traumatic event. It is thought that the act of tracking while concentrating allows a different level of processing to occur in the brain so that the patient can review the event more calmly or more completely than before.

Family Therapy A form of psychotherapy that involves members of a nuclear or extended family. Some forms of family therapy are based on behavioral or psychodynamic principles; the most common form is based on family systems theory. This approach regards the family as the unit of treatment and emphasizes

factors such as relationships and communication patterns. With eating disorders, the focus is on the eating disorder and how the disorder affects family relationships. Family therapy tends to be short-term, usually lasting only a few months, although it can last longer depending on the family circumstances.

Guided Imagery A technique in which the patient is directed by a person (either in person or by using a tape recording) to relax and imagine certain images and scenes to promote relaxation, promote changes in attitude or behavior, and encourage physical healing. Guided imagery is sometimes called visualization. Sometimes music is used as background noise during the imagery session. (See Alternative Therapy.)

Health Insurance Portability and Accountability Act (HIPAA) A federal law enacted in 1996 with a number of provisions intended to ensure certain consumer health insurance protections for working Americans and their families, establish standards for electronic health information and protect the privacy of individuals' health information. HIPAA applies to three types of health insurance coverage: group health plans, individual health insurance, and comparable coverage through a high-risk pool. HIPAA may lower a person's chance of losing existing coverage, ease the ability to switch health plans, and/or help a person buy coverage on his/her own if a person loses employer coverage and has no other coverage available.

Health Insurance Reform for Consumers Federal law has provided to consumers some valuable—though limited—protections when obtaining, changing or continuing health insurance. Understanding these protections, as well as laws in the state in which one resides, can help with making more informed choices when work situations change or when changing health coverage or accessing care. Three important federal laws that can affect coverage and access to care for people with eating disorders are listed below. More information is available at:

http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Mental Health Parity Act of 2014 (MHPA).

NEDA TOOLKIT for Coaches and Trainers

Health Maintenance Organization (HMO) A health plan that employs or contracts with primary care physicians to write referrals for all care that covered patients obtain from specialists in a network of healthcare providers with whom the HMO contracts. The patient’s choice of treatment providers is usually limited.

Hematemesis The vomiting of blood.

Hypno-behavioral Therapy A type of behavioral therapy that uses a combination of behavioral techniques such as self-monitoring to change maladaptive eating disorders and hypnotic techniques intended to reinforce and encourage behavior change.

Hypoglycemia An abnormally low concentration of glucose in the blood.

In-network benefits Health insurance benefits that a beneficiary is entitled to receive from a designated group (network) of healthcare providers. The “network” is established by the health insurer that contracts with certain providers to provide care for beneficiaries within that network.

Indemnity Insurance A health insurance plan that reimburses the member or healthcare provider on a fee-for-service basis, usually at a rate lower than the actual charges for services rendered, and often after a deductible has been satisfied by the insured.

Independent Living Services Services for a person with a medical or mental health-related problem who is living on his/her own. Services include therapeutic group homes, supervised apartment living, monitoring the person’s compliance with prescribed mental and medical treatment plans, and job placement.

Intake Screening An interview conducted by health service providers when a patient is admitted to a hospital or treatment program.

International Classification of Diseases (ICD-10) The World Health Organization lists international standards used to diagnose and classify diseases. The listing is used by the healthcare system so clinicians can assign an ICD code to submit claims to insurers for reimbursement for services for treating various medical and mental health conditions in patients. The code is periodically updated to reflect changes in classifications of disease or to add new disorders.

Interpersonal Therapy (IPT) IPT (also called interpersonal psychotherapy) is designed to help people identify and address their interpersonal problems, specifically those involving grief, interpersonal role conflicts, role transitions, and interpersonal deficits. In this therapy, no emphasis is placed directly on modifying eating habits. Instead, the expectation is that the therapy will enable people to change as their interpersonal functioning improves. IPT usually involves 16 to 20 hour-long, one-on-one treatment sessions over a period of 4 to 5 months.

Ketosis A condition characterized by an abnormally elevated concentration of ketones in the body tissues and fluids, which can be caused by starvation. It is a complication of diabetes, starvation and alcoholism.

Level of Care The care setting and intensity of care that a patient is receiving (e.g., inpatient hospital, outpatient hospital, outpatient residential, intensive outpatient, residential). Health plans and insurance companies correlate their payment structures to the level of care being provided and also map a patient’s eligibility for a particular level of care to the patient’s medical/ psychological status.

Major Depressive Disorder A condition characterized by one or more major depressive episodes that consist of periods of two or more weeks during which a patient has either a depressed mood or loss of interest or pleasure in nearly all activities. (See Depression)

Mallory-Weiss Tear One or more slit-like tears in the mucosa at the lower end of the esophagus as a result of severe vomiting.

Massage Therapy A generic term for any of a number of various types of therapeutic touch in which the practitioner massages, applies pressure to, or manipulates muscles, certain points on the body or other soft tissues to improve health and well-being. Massage therapy is thought to relieve anxiety and depression in patients with an eating disorder.

Maudsley Method A family-centered treatment program with three distinct phases. The first phase for a patient who is severely underweight is to regain control of eating habits and break the cycle of starvation or binge eating and purging. The second phase begins once the patient’s eating is under control, with a goal of returning independent eating to the patient. The goal of the third and final phase is to address the broader concerns of the patient’s development.

NEDA TOOLKIT for Coaches and Trainers

Mealtime Support Therapy Treatment program developed to help patients with eating disorders eat healthfully and with less emotional upset.

Mental Health Parity Laws Federal and State laws that require health insurers to provide the same level of healthcare benefits for mental disorders and conditions as they do for physical disorders and conditions. For example, the federal Mental Health Parity Act of 1996 (MHPA) may prevent a group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower, or less favorable, than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Mia Slang. For bulimia or bulimic.

Monoamine Oxidase Inhibitors A class of medications used to treat depression.

Movement/Dance Therapy The psychotherapeutic use of movement as a process that furthers the emotional, cognitive, social, and physical integration of the individual, according to the American Dance Therapy Association.

Motivational Enhancement Therapy (MET) A treatment based on a model of change, with focus on the stages of change. Stages of change represent constellations of intentions and behaviors through which individuals pass as they move from having a problem to doing something to resolve it. The stages of change move from “pre-contemplation,” in which individuals show no intention of changing, to the “action” stage, in which they are actively engaged in overcoming their problem. Transition from one stage to the next is sequential, but not linear. The aim of MET is to help individuals move from earlier stages into the action stage using cognitive and emotional strategies.

Nonpurging Any of a number of behaviors engaged in by a person with bulimia nervosa in order to offset potential weight gain from excessive calorie intake from binge eating. Nonpurging can take the form of excessive exercise, misuse of insulin by people with diabetes, or long periods of fasting.

Nutritional Therapy The goal of this therapy is to support the nutrition rehabilitation process that proceeds in stages. It includes CBT, behavioral therapy, transtheoretical stages of change, the Health Belief Model and Social Learning Theory. Specific recovery outcome measures are employed to assist the client with change, taking nutrition risks, exploring limits

and boundaries, and challenging unsupported beliefs surrounding nutrition, weight and body image.

Obsessive-compulsive Disorder (OCD) Mental disorder in which recurrent thoughts, impulses, or images cause inappropriate anxiety and distress followed by acts that the sufferer feels compelled to perform to alleviate this anxiety. Criteria for obsessive compulsive and related disorder diagnoses can be found in the DSM-5.

Opioid Antagonists A type of drug therapy that interferes with the brain’s opioid receptors and is sometimes used to treat eating disorders.

Orthorexia Nervosa An eating disturbance in which a person obsesses about eating only “pure” and healthy food to such an extent that it interferes with the person’s life. This eating disturbance is not a diagnosis listed in the DSM-V.

Osteoporosis A condition characterized by a decrease in bone mass with decreased density and enlargement of bone spaces, thus producing porosity and brittleness. This can sometimes be a complication of an eating disorder, including bulimia nervosa and anorexia nervosa.

Other Specified Feeding and Eating Disorder (OSFED) Any disorder of eating that does not meet the criteria for the other feeding and eating disorders in the DSM-5.

Out-of-network benefits Healthcare obtained by a beneficiary from providers (hospitals, clinicians, etc.) that are outside the network that the insurance company has assigned to that beneficiary. Benefits obtained outside the designated network are usually reimbursed at a lower rate. In other words, beneficiaries share more of the cost of care when obtaining that care “out of network” unless the insurance company has given the beneficiary special written authorization to go out of network.

Parity Equality (see Mental Health Parity Laws).

Partial Hospitalization (Intensive Outpatient) For a patient with an eating disorder, partial hospitalization is a time-limited, structured program of psychotherapy and other therapeutic services provided through an outpatient hospital or community mental health center. The goal is to resolve or stabilize an acute episode of mental/behavioral illness.

NEDA TOOLKIT for Coaches and Trainers

Peptic Esophagitis Inflammation of the esophagus caused by reflux of stomach contents and acid.

Pharmacotherapy Treatment of a disease or condition using clinician-prescribed drugs.

Pre-existing Condition A health problem that existed or was treated before the effective date of one's health insurance policy.

Provider A healthcare facility (e.g., hospital, residential treatment center), doctor, nurse, dietitian, therapist, social worker, or other professional who provides care to a patient.

Psychoanalysis An intensive, nondirective form of psychodynamic therapy in which the focus of treatment is exploration of a person's mind and habitual thought patterns. It is insight-oriented, meaning that the goal of treatment is for the patient to increase understanding of the sources of his/her inner conflicts and emotional problems.

Psychodrama A method of psychotherapy in which patients enact the relevant events in their lives instead of simply talking about them.

Psychodynamic Therapy Psychodynamic theory views the human personality as developing from interactions between conscious and unconscious mental processes. The purpose of all forms of psychodynamic treatment is to bring unconscious mental material and processes into full consciousness so that the patient can gain more control over his/her life.

Psychodynamic Group Therapy Psychodynamic groups are based on the same principles as individual psychodynamic therapy and aim to help people with past difficulties, relationships, and trauma, as well as current problems. The groups are typically composed of eight members plus one or two therapists.

Psychoeducational Therapy A treatment intended to teach people about their problem, how to treat it, and how to recognize signs of relapse so that they can get necessary treatment before their difficulty worsens or recurs. Family psychoeducation includes teaching coping strategies and problem-solving skills to families, friends, and/or caregivers to help them deal more effectively with the individual.

Psychopharmacotherapy Use of drugs for treatment of a mental or emotional disorder.

Psychotherapy The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth.

Purging To evacuate the contents of the stomach or bowels by any of several means. Methods of purging include vomiting, enemas and excessive exercise.

Relaxation Training A technique involving tightly contracting and releasing muscles with the intent to release or reduce stress.

Remission A period in which the symptoms of a disease are absent. Remission differs from the concept of "cure" in that the disease can return. The term "cure" signifies that the treated condition or disorder is permanently gone, and will never reoccur in the individual who received treatment.

Residential Services Services delivered in a structured residence other than the hospital or a client's home.

Residential Treatment Center A 24-hour residential environment outside the home that includes 24-hour provision or access to support personnel capable of meeting the client's needs.

Selective Serotonin Reuptake Inhibitors (SSRI) A class of antidepressants used to treat depression, anxiety disorders and some personality disorders. These drugs are designed to elevate the level of the neurotransmitter serotonin. A low level of serotonin is currently seen as one of several neurochemical symptoms of depression. Low levels of serotonin in turn can be caused by an anxiety disorder, because serotonin is needed to metabolize stress hormones.

Self-directedness A personality trait that comprises self-confidence, reliability, responsibility, resourcefulness and goal orientation.

Self-guided Cognitive Behavior Therapy A modified form of cognitive behavior therapy in which a treatment manual is provided for people to proceed with treatment on their own, or with support from a nonprofessional. Guided self-help usually implies that the support person may or may not have some professional training, but is usually not a specialist in eating disorders. The important characteristics of the self-help approach are the use of a highly structured and detailed manual-based CBT, with guidance as to the appropriateness of self-help, and advice on where to seek additional help.

Self-report Measures An itemized written test in which a person rates his/her feeling towards each question; the test is designed to categorize the personality or behavior of the person.

State Mandate A proclamation, order or law from a state legislature that issues specific instructions or regulations. Many states have issued mandates pertaining to coverage of mental health benefits and specific disorders the state requires insurers to cover.

Substance Abuse Use of a mood or behavior-altering substance in a maladaptive pattern resulting in significant impairment or distress of the user.

Substance Use Disorders The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a substance use disorder as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period: (1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home; (2) Recurrent substance use in situations in which it is physically hazardous; and (3) Recurrent substance-related legal, social and/or interpersonal problems.

Subthreshold (or Subclinical) Eating Disorder Condition in which a person exhibits disordered eating but not to the extent that it fulfills all the criteria for diagnosis of an eating disorder.

Supportive Therapy Psychotherapy that focuses on the management and resolution of current difficulties and life decisions using the patient's strengths and available resources.

Telephone Therapy A type of psychotherapy provided over the telephone by a trained professional.

Therapeutic Foster Care A foster care program in which youths who cannot live at home are placed in homes with foster parents who have been trained to provide a structured environment that supports the child's learning, social and emotional skills.

Thinspiration *Slang.* Photographs, poems, or any other stimuli that aim to influence a person to strive to lose weight.

Third-party Payer An organization that provides health insurance benefits and reimburses for care for beneficiaries.

Thyroid Medication Abuse Excessive use or misuse of drugs used to treat thyroid conditions; a side effect of these drugs is weight loss.

Treatment Plan A multidisciplinary care plan for each beneficiary in active case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, all funding options, treatment goals and assessment of the beneficiary environment. The plan is updated monthly and modified when appropriate.

Trigger A stimulus that causes an involuntary reflex behavior. A trigger may lead to the return of eating disorder behaviors in someone in recovery.

Usual and Customary Fee An insurance term that indicates the amount the insurance company will reimburse for a particular service or procedure. This amount is often less than the amount charged by the service provider.

Vocational Services Programs that teach skills needed for self-sufficiency.

Yoga A system of physical postures, breathing techniques and meditation practices to promote bodily or mental control and well-being.

NEDA TOOLKIT for Coaches and Trainers

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