Resource Guide for Collegiate Athletes

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Introduction

In the university setting, campus providers should be prepared to screen for all mental health concerns, including eating disorders - a potentially life-threatening illness. Paula Quatromoni, DSc, RD, LDN shares a comprehensive overview of this at-risk group, as well as guidelines specifically for athletic departments on how they can most effectively address any concerns with their student-athlete.

Once diagnosed, the next step is to create an individualized treatment plan which may involve one or more of the following objectives: referring to an on-campus psychotherapist (or sports psychologist if available), setting up bi-weekly weigh-ins with a nurse practitioner, consultation and weekly appointments with a sports dietitian, contacting family members to assist with developing a treatment contract and/or facilitating admission to a higher level of care (if clinically indicated).

Identifying resources can be quite difficult and at times feel overwhelming. It is imperative that students find the best clinical options quickly, as research indicates that early and aggressive treatment results in improved outcomes. For those returning to campus from a higher level of care, the hope is that recovery will continue, with minimal chance of relapse. Implementing additional supports at this time (peer mentors, recovery coaches and/or family therapists) can help to minimize the stress and anxiety associated with discharge, thus increasing the likelihood that gains made throughout treatment are maintained.

RISE is honored to be collaborating with providers who have both a passion for and expertise in treating collegiate athletes with body image and/or eating concerns. To identify resources most effectively for yourself, a loved one, or student in your care, our team can provide on-going guidance during the process of securing a highly skilled outpatient team in your geographical area (many of our recommended providers are elite athletes themselves).

It is equally important to ensure those in crisis are aware of higher level of care facilities providing evidence-based treatment. With this in mind, we have partnered with a select group of thoroughly vetted programs which can support any college student seeking mental health care. During this process, our role may also involve connecting with your personal and professional supports, as well as facilitating admission when requested. Each student will have access to our provider database, which is comprised of over a thousand treatment options throughout the country.

Please note that RISE is also available to assist university-based health care practitioners and athletic staff who may be seeking additional providers for a student's outpatient treatment team.

The content of this guide is for informational purposes only. It is not intended to be a substitute for professional medical advice, diagnosis, or treatment, and we do not warrant or represent in any way the accuracy or medical approval of any of these treatment resources. Always seek the advice of your physician or other qualified health provider with any questions you may have regarding a suspected or actual medical condition and its treatment.

Eating Disorders in Collegiate Sport: Unique Risks, Policies and Procedures

Athletes at Risk for Eating Disorders

While athletes have increased nutritional needs to support growth, development, training, competition, and post-work-out recovery nutrition, most athletes do not have ready access to nutrition professionals inside their athletics department. Nutrition knowledge is often low for the college-age population and misinformation abounds in the sport environment. As such, athletes are at increased risk for disordered eating and eating disorders (ED). Like in the general public, athletes are susceptible to a variety of predisposing factors: interpersonal characteristics that determine communication and coping skills, psycho-social stress, low self-esteem or poor body image, cultural factors, beliefs, attitudes, and societal pressures including the glorification of the thin ideal and potent pressures to diet. Pre-existing mental health conditions such as anxiety, depression and obsessive-compulsive disorder increase risk, as does trauma. Environmental influences in the home or on campus can contribute to ED risk, and the transition from life at home to life on campus can trigger an eating disorder in the college-aged population. Athletes have an additional environment and an extra "family" in sport that exposes them to unique risk factors. Performance pressures (often tied to scholarships), authoritative coaching styles, vulnerability to overtraining and under-fueling, injury, competitive drive for perfection, and revealing uniforms that accentuate body shape and size are known risk factors. Practices inside athletics that value weight, shape or size over performance, reinforced by frequent or public team weigh-ins, send direct or covert messages to athletes that promote dieting and other restrictive eating behaviors that are role modeled by teammates. In addition, athletes are targeted by a supplement and functional food industry that preys on their unrelenting pursuit of the competitive edge. Both the thin ideal and the muscular ideal are perpetuated in sport culture and are tied to athlete identity. Inside most collegiate sport settings, there is limited access to nutrition professionals to provide education, accurate information, and individualized nutrition recommendations to help athletes understand their distinct nutritional needs, further increasing an athlete's vulnerability to an eating disorder.

What makes EDs in athletes particularly challenging is the reality that athletes are more likely to underreport their symptoms, considering them benign or "not bad enough" that they would require intervention. Others view the symptoms as a sign of their commitment to sport or consider their burden a badge of honor as an elite athlete. Male athletes may be less likely to report eating concerns or even consider that what they are dealing with is an eating disorder because of stigma or the common misperception that only women get eating disorders. Similarly, those suffering from binge eating disorder are more likely to go undiagnosed because they may be at what appears to be a healthy weight or even in a larger body size, not visibly wasting away like someone suffering from anorexia. Once known as the Female Athlete Triad, the concern over low energy availability (as seen in athletes who diet or have disordered eating), amenorrhea, and compromised bone integrity has been expanded and rebranded as a Relative Energy Deficiency in Sport (RED-S). The RED-S model makes it clear that the physiologic and metabolic derangements associated with eating disorders in sport affect males as well as females, and also affect nearly all organ systems of the body, not just bone.

Eating Disorders in Collegiate Sport (cont.)

Goals of the Eating Disorder Program in Sport
The goal of an eating disorder program in athletics is to ensure that treatment is provided to all individuals in need and that treatment is not delayed so that recovery is maximized and the athlete experiences a full return to sport participation. Not only are we concerned about the physical well-being of the athlete and the threat to sport performance, but the emotional despair and suicide risk associated with eating disorders demand swift and appropriate intervention. Waiting to intervene when an eating disorder is deeply entrenched and the athlete demonstrates overt signs and symptoms including repeated stress fractures and other injuries is considered a missed opportunity with dangerous, possibly deadly, consequences.

The goal of early identification and treatment applies to males and females, to those in weight-sensitive or traditionally "lean" sports as well as in ball sports, and to those suffering from anorexia, bulimia, binge eating disorder, or other types of eating disorders or sub-clinical disordered eating. This goal requires the following components: (1) ongoing screening and assessment to allow early identification of athletes who are at risk or in crisis, (2) timely intervention that is comprehensive and endorsed by all members of the sport leadership team and (3) ongoing prevention activities that include nutrition education and promotion of athlete mental health.

The use of a treatment contract is recommended, particularly for cases that meet diagnostic criteria and for athletes who are determined to be medically ineligible to train and/or compete. The contract outlines the recommended action plan, specifies treatment providers and treatment frequency, and identifies a schedule for ongoing monitoring and reassessment to determine readiness to return to sport. Signed by the athlete and the sports medicine doctor (or athletic trainer), the contract holds the athlete accountable for engagement in treatment and specifies consequences of non-compliance.

Policies and Procedures in Collegiate Athletics: The Eating Concerns Team
A multidisciplinary team inside the Athletics department on campus is the ideal configuration for an Eating Concerns Team. This provides access to a visible, identifiable and consistent set of professionals who form a circle of trust for the athlete. If this is not possible, a tight network of expert providers in the community is needed to augment the work of the on-campus sports medicine team. Collaborative communication is essential.

The team works collectively to set policies and procedures and to track data on athlete outcomes and well-being. Policies and procedures should be reviewed annually and revised/updated as informed by outcomes achieved and emerging new guidelines that identify best practices. The team must act with authority to recognize and act on eating concerns. Experts are advocating for eating disorders to be treated as seriously and as swiftly as other sport injuries, like concussions, categorizing an eating disorder as a metabolic injury that can sideline an athlete if not taken seriously and treated appropriately.

Eating Disorders in Collegiate Sport (cont.)

Services delivered by the Eating Concerns Team need to be conveniently located, easily accessible, and in a setting that is private, confidential and trusted in order for athletes to access them. Members of the team include the sports medicine doctor, certified athletic trainer, sport psychologist, behavioral health expert or licensed mental health counselor, and a sport nutritionist. It is essential to clearly identify the point person who will serve as case manager for all athletes with an eating disorder concern or diagnosis. This assigns oversight responsibility so that athletes are appropriately followed. This is typically the sports medicine physician or a senior athletic trainer on campus. Within their respective scopes of professional practice, all members of the team should have training and expertise in eating disorder risk assessment and treatment, and all should be intimately aware of the unique demands of the sport environment and the unique needs of student-athletes. Supporting athletics staff to engage in professional development and/or annual in-service education with expert consultants is a wise allocation of administrative resources to support student-athlete mental health.

Prevention Strategies

Team culture goes a long way in supporting self-care habits and a healthy mindset. On the contrary, team culture can contribute to the spread of disordered eating beliefs and behaviors. Zero tolerance for body shaming, public commentary on athlete's weight, or judging personal food choices can be enforced by coaches, assistant coaches, captains and teammates by addressing locker-room talk, meal-time talk, and other sources of negative energy that chip away at an athlete's body image, self-worth or self-esteem. Use of punishment techniques to motivate selected athletes to lose weight or whip into shape by imposing extra work-outs such as timed cycling regimens added on top of a grueling practice schedule (sometimes referred to by coaches and/or athletes as Chub Club) contribute to public humiliation over body size and reinforce a value system centered on weight loss and dieting. Resources available from the NCAA in its detailed report on student-athlete mental health entitled, *Mind, Body and Sport*, can assist coaches and athletics administrators with programs and policies to enact on campus to promote positive psychology in sport and a healthy culture inside athletics.

Policies that identify how often athletes are weighed or undergo body composition analysis (by Bod Pod or skinfold caliper assessment), who performs those assessments, and who has access to those data can assist ED prevention efforts. It is recommended that only the sport nutritionist perform those assessments and have conversations with athletes about weight. In collegiate settings, weight (if required or justified for a weight-class sport like crew or wrestling) should be monitored by a nutrition professional, sports medicine doctor, athletic trainer, or perhaps a strength and conditioning coach. Since not all collegiate athletic departments employ registered dietitians, these practices are highly variable. However, most sports medicine professionals agree that to avoid contributing to weight bias, stigma, body image concerns, dieting or disordered eating or exercise behaviors, coaches should not be given information about athletes' weights.

Eating Disorders in Collegiate Sport (cont.)

Weight concerns should be managed by a qualified nutrition professional, not a coach. If a coach has a concern about an athlete's weight, he/she should express that concern to the nutrition professional (not to the athlete) and let the nutritionist assess the athlete, determine whether weight change is appropriate, and initiate a proper plan of nutrition intervention. The work between the nutritionist and the athlete should remain private and confidential, with the coach placing full trust that the nutritionist is managing the case and monitoring the athlete's progress towards goals. This allows the coach to focus interactions with the athlete on skill, technique and training, not on weight.

It is particularly dangerous for a coach to comment on an athlete's weight or tell an athlete to lose weight without providing access to an expert who can safely help the athlete achieve that goal. First and foremost, it is not in the coach's professional scope of practice to assess the appropriateness of weight loss for an athlete or to make well-informed, holistic recommendations for diet or for weight loss. Nor is the coach in the position to educate and guide the athlete on how to lose weight safely and effectively, while fueling adequately for sport. A coach cannot safely monitor an individual athletes' diet quality, nutritional adequacy, behavioral practices, trajectory of weight loss, or emotional mindset that ensues in response to their advice to lose weight. As such, a coach who tells an athlete to lose weight places the athlete at risk. A coach who gives weight loss advice without, at a minimum, connecting the athlete to a nutritional professional potentially does more harm than good. The authoritative power of the coach over the athlete naturally creates a dynamic that can undermine the athlete's emotional and physical well-being.

Annual training for coaches, strength and conditioning coaches, and athletic training staff is essential to ensure ongoing education, continuing professional development, and enforcement of policies and procedures. Coaches need to know more than just the signs and symptoms of eating disorders; they need annual refreshers on policies, procedures, action plans, and prevention strategies, and they need an opportunity to ask questions and have access to nutrition and mental health professionals for open discussions. Annual education for athletes provided by mental health experts, sports psychologists, and sports nutritionists is also recommended. Athletes need permission and guidance to develop the necessary life skills to practice and sustain self-care in the intensely demanding competitive sport environment. Availability of the multidisciplinary team of providers on campus ensures ongoing access for athletes to receive on-demand individualized services. This is a more effective model than simply bringing in experts to give talks from time to time without them being available to the athletes when they need them.

Screening

Annual screening for eating disorder risk is recommended as a part of the pre-participation physical, yet this is not necessarily done inside most athletics departments using anything more than an assessment of weight (using BMI criteria) and amenorrhea in female athletes. Sometimes, only freshmen are screened comprehensively – leaving athletes vulnerable beyond that freshman screen. Any time an athlete comes to attention for displaying disordered eating behaviors, visible signs or clinical symptoms of an eating disorder, a full assessment should be done.

Eating Disorders in Collegiate Sport (cont.)

Though the SCOFF and EAT-26 are useful screening instruments, these can be somewhat limiting, when used with athletes. This is likely in large part due to its simplicity and ease of use in the sport setting. Some versions recommend that any athlete who scores 1 point should be referred for further evaluation. Normally, the SCOFF recommends referral with a score of 2 or more; therefore, the threshold triggering action may be lowered for the collegiate athlete population. It should be noted, however, that the wording on the SCOFF is not necessarily appropriate or most relevant to athletes' experiences and, for this reason, risk could be under-appreciated perhaps even more so by male athletes. For instance, athletes may not consider themselves "fat" but simply may have low body esteem and not consider their body shape or size lean enough or muscular enough for their sport or their position in sport. As well, the SCOFF screening question on weight loss may fail to identify the risk in an athlete whose weight may be stable but has been either chronically too low or at weight that appears "desirable" but not acceptable to the athlete (or the coach) causing the athlete to chronically engage in a binge and purge cycle over many years of their sport career.

The importance of customizing screening tools and interview questions cannot be overstated when interacting with athletes. Few athlete-specific validated tools exist. Interview questions must reflect an awareness of sport-specific risk factors, an appreciation for the demands, pressures and expectations on competitive athletes, and a sensitivity to the stigma and fear associated with disclosing an ED in the collegiate sport setting.

The Female Athlete Screening tool provides a validated assessment of eating disorder risk factors unique to the sport environment, but currently there is no companion version for male athletes. While body image disorders are not routinely screened for in an athletics setting, the Female Athlete Screening Tool and the EAT-26 both include the thin ideal construct. There are other tools that specifically assess body dissatisfaction or body dysmorphia that may be used by an ED specialist upon referral. The EC-Satter tool identifies individuals with low eating competence and can identify ED risk in an athlete who has high nutritional needs but is not competent in feeding self-care. Finally, the Clinical Assessment Tool put forth by the RED-S model (REDS-CAT) is designed for use with athletes identified by other screening tools as being at increased risk for eating disorders.

Referral

A strong referral network of providers on campus (as in the Student Health Center if not in Athletics) and in the local community who have expertise in treating eating disorders and in working with athletes is essential for every college athletics department to establish. Behavioral health programs inside college health services may or may not employ a dietitian. Many are set up simply to conduct mental health assessments and triage care to outside providers. Campus counselors and dietitians may or may not have eating disorder expertise and most cannot provide the duration of treatment required to appropriately break the cycle of disordered eating or treat an entrenched eating disorder.

Eating Disorders in Collegiate Sport (cont.)

In the absence of a complete team of ED experts on campus or inside athletics, outpatient providers in the community will be providing treatment to any athlete identified at high risk or with an ED diagnosis. The outpatient treatment team includes, at a minimum, a licensed mental health professional and a registered dietitian/nutritionist (RDN). Additional collaborators in the referral network might include pediatricians or internal/family/sports medicine physicians with ED expertise, and certified strength and conditioning coaches or fitness professionals who are trained in working with ED clients. Some yoga instructors and personal fitness trainers work on mind-body connections with clients healing from eating disorders and body image issues. If an athlete needs a higher level of care than can safely be provided on campus or by an outpatient provider, an eating disorder treatment program that offers residential treatment, partial hospitalization programs (PHP) or intensive outpatient programs (IOP) is required. Level of care is determined by the degree of medical instability and is best determined by the team physician or a licensed mental health professional who evaluates vital signs (heart rate, pulse, blood pressure) along with physical, behavioral and emotional signs and symptoms of the disorder.

Treatment

Treatment frequency and duration are dictated by the level of care required to address the acuity of the athlete's physical and emotional state. These decisions are made by the physician overseeing the case, in cooperation with the mental health professional assisting with the diagnosis. Depending on the athlete's clinical health indicators, behavioral patterns, level of care required, and compliance with the treatment plan, the athlete may or may not be allowed to train or compete during ED treatment. It is absolutely essential that the treatment plan and recommendations be endorsed by all members of the treatment team to send a unified message to the athlete about expectations and return-to-play criteria. For this reason, effective communication between team members and outside providers is critical.

Collegiate athletes may or may not want their parents, or their coaches, involved or even aware of the diagnosis and treatment plan. As such, protecting privacy and confidentiality is essential unless the situation is life-threatening. There are many barriers to treatment for athletes, including stigma surrounding mental health conditions in general and eating disorders in particular. Working to break down stigma and make treatment providers accessible will increase the likelihood of an athlete complying with referrals and appointments. The treatment contract helps with this, along with on-campus providers who are inside the athlete's circle of trust.

The case manager on the athletics Eating Concerns Team coordinates communication with the various off-campus providers and follows the athlete's progress in treatment. The RED-S model provides a set of guidelines for Return-to-Play that are used in conjunction with treatment compliance to determine when the athlete can safely resume training and competition. An athlete on scholarship who needs to take a break from training and competition should be eligible for a medical red-shirt. Eating disorders are mental health conditions and, as such, student-athletes should be supported by the Office of Disability Services on campus to help them negotiate their needs and their rights with regards to athletics and academics. A reduced course load and/or an academic leave of absence may be necessary for the student to engage in a higher level of care or for a longer duration of care.

Eating Disorders in Collegiate Sport (cont.)

Approaching a Student-Athlete about an Eating Disorder Concern
Athletes are at increased risk for eating disorders. No sport, position or individual is immune to the risks. The transitional life stage of the collegiate athlete further increases risk. A comprehensive, ongoing, pro-active eating disorders response plan across the entire athletics department will need to address policies, protocols, coach education, documented action plans and accountability. This is necessary to help avoid stereotypes, stigma and bias in practices related to prevention, screening, identification and intervention efforts. A multidisciplinary team approach built on direct communication and proper evaluation of athletes displaying risk is required to achieve early intervention and the best possible outcomes in terms of physical health, emotional well-being, academic success and performance in sport.

- **Know the signs and symptoms of an eating disorder.** Have objective data and personal observations that align with those warning signs documented for your discussion. Do not act on hearsay or second-hand information that could be false or inaccurate.
- **Discuss your concerns with the Athletic Trainer** who can provide validation, ask insightful questions for clarification, share additional observations, provide clinical input, and help you decide who on the Eating Concerns Team should have this difficult conversation with the athlete. The power dynamic between the head coach and the athlete may necessitate that an assistant coach or an AT be the one to speak with the athlete.
- **Set up a private meeting** with the athlete to discuss your concerns. Do not have this conversation in public, during a heated moment (like when an athlete has a bad race or suffers an injury) or without some purposeful advance preparation.
- **Establish rapport** by asking the athlete how he/she is doing and how things are going. This opens the floor for the athlete to confide in you, but don't be surprised if they don't. You may get *"just fine!"* in response. It is unlikely that they will open up willingly, even if they are struggling and want help. Athletes fear the consequences of such disclosure.
- **Start by expressing your concern for the athlete.** Then tell them what you've observed. Stick to the facts; things like, *"I noticed you sat alone and didn't eat anything at team dinner last night. What's going on?"* or *"You looked really fatigued at practice this afternoon, and your energy level seems low. Is there something bringing you down?"*
- **Expect short and dismissive answers.** Expect resistance. Anticipate that the athlete is afraid to say too much, so be as neutral and non-judgmental as possible. You don't even have to use the words "eating disorder" in this conversation. In fact, you probably want to avoid this terminology. If the athlete uses that phrase, posing a question (*"Are you asking me if I have an eating disorder?"*) or in a statement of denial (*"I don't have an eating disorder, if that's what you think!"*), tell them, *"I do not have all the information needed to determine that. I am just telling you what I've observed and that I am concerned. It is my job to connect you to help, and I can only help if I know what you are going through."*

Eating Disorders in Collegiate Sport (cont.)

- **Try to "normalize" the situation yet firmly show your concern.** Avoid blaming the athlete by saying things like, "Athletes who train as hard as you do in sport sometimes need help to be sure they are taking the best care of themselves and are getting enough nutrition. I'm concerned that maybe you're not giving your body what it needs. Would you be open to talking to someone about it?" Or in the case of an injured athlete, "I'm concerned that you're not getting proper nutrition to heal from your surgery." Or for the athlete who is compulsively over-exercising, "I am concerned that you are not taking rest days and are over-training."
- **Avoid piling on second-hand information** that will feel like accusations or could cause the athlete to feel ganged up on, as if everyone is talking about him/her and "everyone knows." This approach could increase social isolation, increase despair and also lead to resistance in coming forward to ask for (or accept) help.
- **Play on the fact that the athlete trusts you.** If you tell them that in your opinion you believe this other professional could help them be the best athlete they can be, they will most likely take your advice and act on your referral. Remind the athlete that you believe in them and in their potential to be a great contributor to your team. Make sure you acknowledge how much you value them as an athlete and care about them as an individual. Tell them that you are as invested in their health and wellness as you are in their athletic performance. These are very important points to communicate! Tell them that you understand what they are up against and that you want to help. Remind them of their strength, courage, and ability to face adversity – these are the qualities of a great athlete, and the qualities required to accept help when needed.
- **Make the referral to a qualified professional with training in sports and eating disorders.** The Athletic Trainer (AT) or sports medicine doctor can do a more thorough assessment of the situation and can collect additional clinical data. The case manager on your team can determine what appropriate next steps should be taken and can make referrals to on-campus healthcare practitioners or off-campus community providers.
- **Conclude the meeting by making a plan to follow up.** Restate your concern for the athlete and your commitment to being a source of support for them. Plan to follow up in a couple of days (be specific) to set the expectation that you are holding them accountable to follow through and report back to you on the agreed-upon action plan.
- **Remain open, supportive, positive, and confidential** in your ongoing interactions with the athlete while he/she works with qualified professionals who will manage their needs.

Paula Quatromoni, DSc, RD, LDN


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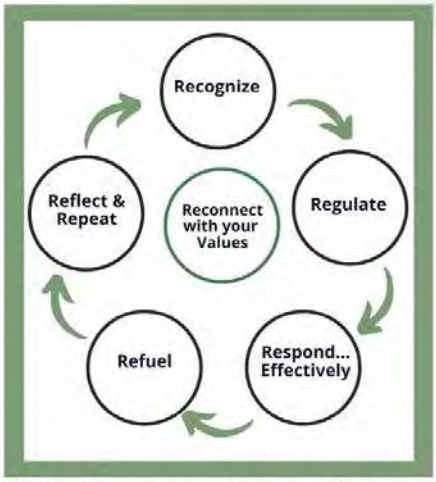

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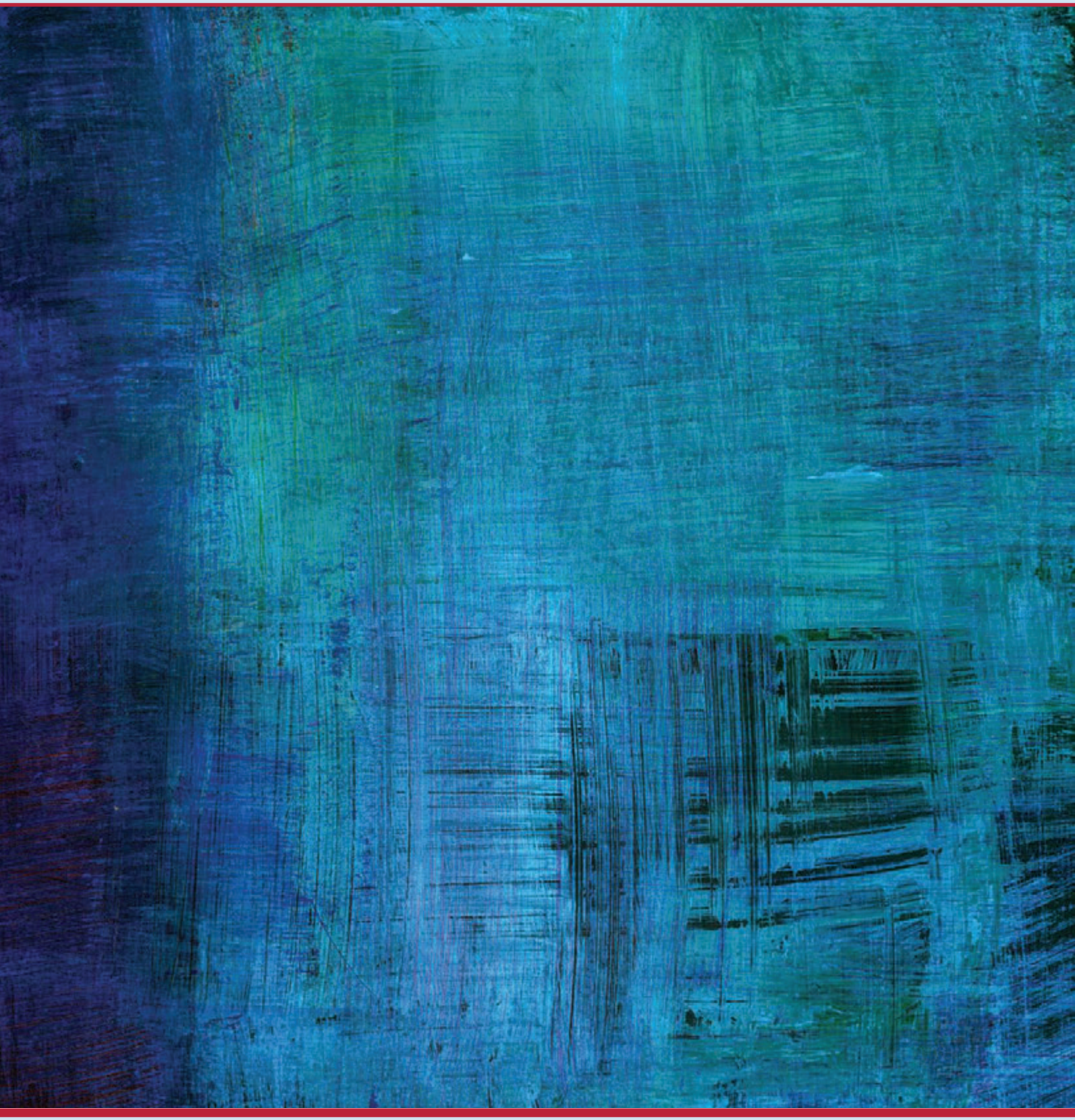

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