Athletic Eating Disorder Policy

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I. Introduction and Philosophy

The Department of Athletics at Purdue University advocates the development of healthy and responsible lifestyles for Purdue student-athletes, with the goal of long-term enrichment and enhancement of their lives. One behavior that threatens a healthy lifestyle is disordered eating. The manifestations of eating disorders reflect the interaction of biological, psychological, and sociological factors in both the development of eating disorders and their treatment. Student-athletes are at an increased risk of developing or maintaining patterns of disordered eating due to their participation in elite, college sports.

The effects of disordered eating can range from mild to severe; depending on the extent of the disorder and the length of time the individual has engaged in such behaviors. Medically, disordered eating can have short-term and long-term consequences ranging from an increased level of sport related injury to death. There is a potential for serious consequences in every system of the body. Psychologically, individuals with an eating disorder have an increased risk of depression and suicide. Eating disorders are often associated with low self-esteem, obsessive thinking, and feelings of isolation. Recovery from eating disorders can be a difficult process that takes time. In general, the greater the duration and frequency of disordered eating the longer it will take for recovery.

Each student-athlete has a unique body type that is largely influenced by genetics. We wish to emphasize healthy personal improvement in nutrition, body composition, and fitness level, recognizing individual differences. The goal is for athletic department staff to recognize individual differences instead of relying on pre-published group norms.

II. Goals

1. To implement an effective multidisciplinary approach to the prevention, identification, and treatment of eating disorders. The treatment team will consist of the team physician, dietitian, athletic trainer and psychologist.
2. To diagnose and provide treatment plans for student-athletes struggling with eating disorders.
3. To provide medical, nutritional, and/or psychological services to the student-athlete while respecting his/her privacy.
4. To establish an eating disorders management team. This team will consist of the dietitian, psychologist, team physician and athletic trainer. The team may include the specific coach and associate athletic director as necessary for each student-athlete. The management
team will meet with the student-athlete to oversee his or her compliance with treatment, if necessary.

III. Prevention of Eating Disorders

1. Prophylactic nutrition and psychological education will be available and encouraged to sports teams identified as “high risk” for eating disorders. For example:
   a. Swimming
   b. Running (track and cross country)
   c. Diving
   d. Wrestling
   e. Cheerleading
   f. Volleyball
   (PLEASE note: Student-athletes from all sports are at risk for developing eating disorders. Male athletes are increasingly at risk for negative body image and disordered eating)

2. Education seminars about eating disorders will be provided for professionals working with student-athletes including:
   a. Coaches
   b. Athletic Trainers
   c. Strength & Conditioning coaches
   d. Academic Counselors
   e. Administrators
   f. Athletic Training students

3. Weight and body composition goals and measurements
   a. Sport coaches should bring their concerns about student-athletes’ body weight/composition to the athletic trainer and/or dietitian. The athletic trainer, dietitian and student-athlete will set goals together regarding student-athlete’s weight and body composition. The addition of physicians, strength & conditioning coaches, and psychologists may be included in the goal setting process. The dietitian should be involved with any student-athletes’ attempts to lose or gain weight in order to avoid unhealthy eating behaviors.
   b. Athletic department staff should consider each student-athlete’s weight and body composition individually, and refrain from setting group goals.
   c. Sport coaches should not weigh student-athletes, measure their body composition or share weight/body composition information publicly.
   d. Frequent measuring of weight and body composition can be harmful to student-athletes. The dietitians will be responsible for setting the DEXA schedule and taking measurements for training programs effectiveness. Measures will be taken in a manner conducive to protecting the privacy of each student-athlete.
e. The administrator in charge of the particular sport will be consulted if staff members do not follow these guidelines.

4. A yearly nutritional screen will be used to screen for eating disorders. If a student-athlete has had a history of disordered eating they may be asked to sit down with the dietitian, team physician or sport psychologist.

IV. Treatment and Intervention

1. Appropriate intervention involves an expression of concern that the student-athlete is displaying specific eating behaviors that may interfere with his/her health and athletic performance. If an athletic department staff member witnesses or has reports of a student-athlete displaying signs or symptoms of an eating disorder (see “Behavioral Signs of Eating Disorder”), then he or she is to approach a sports medicine staff member and is encouraged to speak to the student-athlete if comfortable. If a teammate witnesses a student-athlete engaging in disordered eating behaviors, the teammate should inform a staff member about the observed behaviors. The staff member will request that the student-athlete meet with team physician, psychologist, or registered dietitian for assessment.

2. If the treatment team concludes that the student-athlete is in need of medical, nutritional, or psychological intervention, then they will develop a treatment plan for the student-athlete. Elements of the treatment plan may include:
   a. Required visits with the psychologist, registered dietitian, and team physician
   b. Weight checks
   c. Limitation of physical activities
   d. Outpatient or inpatient treatment referrals
   e. Attendance of on-campus eating disorder support group
   f. Any other intervention deemed medically or psychologically necessary
   g. Signing any release of information that is applicable

3. The management team will meet with the student-athlete, to oversee his or her compliance with the treatment plan (which will be developed by the treatment team). The student-athlete will be required to sign a contract agreeing to the terms of the treatment plan. If he or she refuses to attend the meeting or to comply with the plan, consequences will be followed that are outlined in the plan of care contract.

4. The treatment team and management team will review the student-athlete cases periodically and provide further intervention as needed (See “Levels of Care”) and provide decisions on reinstatement of student-athletes.

5. If the student-athlete does not seek help independently and the disordered eating behaviors continue, the staff member will notify the student that he or she is referred to the eating disorders management team.
Eating Disorder Screen

- No Signs of Eating Disorder
- Potential ED

Athlete with suspected Eating Disorder

MD referral for further Evaluation

- Yes
- No

Meet with Nutrition and Sports Psych

Sign Contract for Treatment and Release of Information

Determine Level of Care and Provide Treatment

- Continue sport with plan of care
- No sport with plan of care
- In patient care needed
- Not willing to undergo care

Consequences as outlined in Plan of Care
Definitions of Eating Disorders

The following are based on the criteria in the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-V)

Anorexia Nervosa

- Diagnostic Criteria (DSM-5):
  - Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
  - Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
  - Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation or persistent lack of recognition of the seriousness of the current low body weight.
  - 2 subtypes: restricting & binge-eating/purging
  - Recent change is eliminating Amenorrhea (absence of three-plus consecutive menstrual periods) as a diagnostic criteria

Bulimia Nervosa

- Diagnostic Criteria (DSM-5):
  - 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 two-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 behaviors in order to prevent weight gain
    - Purging Type - Self-induced vomiting
    - Non-Purging Type
      - Misuse of laxatives, diuretics, enemas, other meds
      - Excessive exercise
      - Fasting
Binge eating and compensatory behaviors occur on average one time per week for three months

- Previous diagnostic criteria was two times a week
- Self-evaluation is unduly influenced by body shape and weight

Binge-Eating Disorder

Diagnostic Criteria (DSM-5):

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - Eating, in a discrete period of time, an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances
  - A sense of lack of control over eating during the episode
- Three or more of the following
  - Eating more rapidly than normal
  - Eating until uncomfortably full
  - Eating large amounts of food even when not hungry
  - Eating alone because embarrassed about the amount one is eating
  - Feeling guilty, disgusted, depressed about amount of food
- Marked distress regarding binge eating is present
- Binge eating occurs, on average, at least once a week for three months

Other Specified Eating Disorder

- Atypical Anorexia Nervosa
- Bulimia Nervosa (of low frequency and/or limited duration)
- Binge-Eating disorder (of low frequency and/or limited duration)
- Purging disorder

Unspecified Eating Disorder

- Those who do not meet full criteria for other disorders
- Most prevalent diagnosis
Behavioral and Physical Signs of an Eating Disorder

The following list may serve as a guideline for the recognition of disordered eating behaviors. Any one symptom alone may not indicate an eating disorder. Careful observation and awareness of a student-athlete’s behavior will guide identification of an eating problem.

I. Anorexia
   a. Behavioral Signs
      i. Reports feeling “fat/heavy” despite low body weight
      ii. Obsessions about weight, diet, appearance
      iii. Ritualistic eating behaviors
      iv. Avoiding social eating situations, social withdrawal
      v. Obsession with exercise; hyperactivity – may increase workouts secretly
      vi. Feeling cold
      vii. Perfectionism followed by self-criticism
      viii. Seems anxious/depressed about performance and other events
      ix. Denial of unhealthy eating pattern – anger when confronted with problem
      x. Eventual decline in physical and school performance
   b. Physical signs
      i. Amenorrhea (lack of menstrual periods)
      ii. Dehydration (not related to work-out or competition)
      iii. Fatigue (beyond expected)
      iv. Weakness, dizziness
      v. Overuse injuries, stress fractures
      vi. Yellow tint to hands
      vii. Gastrointestinal problems
      viii. Lanugo (fine hair on face and arms)
      ix. Hypotension (low blood pressure)
      x. Thinning hair
      xi. Cracked or brittle nails

II. Bulimia Nervosa
   a. Behavioral signs
      i. Excessive exercise beyond scheduled practice
      ii. Extremely self-critical
      iii. Depression and mood fluctuations
      iv. Irregular weight loss/gain; rapid fluctuations in weight
      v. Erratic performance
      vi. Low self esteem
      vii. Drug or alcohol abuse
viii. Binges or eats large meals, then disappears

b. Physical Signs
   i. Callous on knuckles
   ii. Dental and gum problems (bad breath)
   iii. Red, puffy eyes
   iv. Swollen parotid glands (at the base of the jaw)
   v. Edema (bloating)
   vi. Frequent sore throats
   vii. Low or average weight despite eating large amounts of food
   viii. Electrolyte abnormalities
   ix. Diarrhea, alternating with constipation
   x. Dry mouth, cracked lips
   xi. Muscle cramps or weakness
**Levels of Care**

<table>
<thead>
<tr>
<th>Color</th>
<th>Description</th>
<th>Green: Outpatient care appears to be a good fit base on most recent assessment</th>
<th>Yellow: outpatient care may not be sufficient to meet treatment needs over time, ability to meet treatment needs with outpatient care to be frequently re-evaluated with referral to higher level of care if needed</th>
<th>Red: outpatient care cannot meet current treatment needs, referral to higher level of care is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Status</td>
<td>Medically stable</td>
<td>Medically stable to the extent that frequent medical monitoring is not needed</td>
<td>*HR&lt;40bpm; BP&lt;90/60 mmHg; glucose&lt;60 mg/dl; potassium &lt;3 mEq/L; electrolyte imbalance; temperature&lt;97.0 F; dehydration; hepatic, renal or cardiovascular organ compromise requiring acute treatment; poorly controlled diabetes</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>&gt;17</td>
<td>&gt;16</td>
<td>&lt;16</td>
<td></td>
</tr>
<tr>
<td>Motivation for recovery</td>
<td>Fair-Good: client adheres to treatment recommendation and is engaging in treatment processes</td>
<td>Fair: client generally adheres to treatment recommendations but may at times need additional encouragement/structure</td>
<td>Poor-very poor: unable to adhere to treatment recommendations or engage in treatment planning, needs highly structured treatment</td>
<td></td>
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<tr>
<td>Eating Behaviors</td>
<td>Able to follow meal plan on their own, does not need added structure</td>
<td>Occasional difficulty adhering to meal plan</td>
<td>Needs supervision/structure/support at all meals or will restrict eating</td>
<td></td>
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<tr>
<td>Compensatory Behaviors: Exercise</td>
<td>Can control compulsive exercise</td>
<td>Occasional difficulty controlling compulsive exercise</td>
<td>Structure consistently needed to prevent compulsive exercise</td>
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<tr>
<td>Compensatory behaviors: Purging (self-induced vomiting, laxative, diet pill and diuretic use)</td>
<td>Mild (1-3x week); able to significantly reduce purging behaviors with minimum structure</td>
<td>Moderate (4-7x week); inconsistency in ability to reduce purging behavior, at time may need additional structure/support</td>
<td>Severe (8-13 x week) or extreme (&gt;14 x week); Needs supervision during and after meals, and in the bathroom, to prevent purging behaviors</td>
<td></td>
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<tr>
<td>Comorbidity, including but not limited to suicidality</td>
<td>Severity of comorbid condition can always influence level of care; no suicidal intent or plan</td>
<td>Severity of comorbid condition can always influence level of care; no suicidal intent or plan</td>
<td>Severity of comorbid condition indicates a need for hospitalization; suicidal intent and/or planning</td>
<td></td>
</tr>
<tr>
<td>Cognitive status</td>
<td>No signs/symptoms of cognitive impairment secondary to ED</td>
<td>No signs/symptoms of cognitive impairment secondary to ED</td>
<td>Evidence of cognitive dysfunction secondary to ED</td>
<td></td>
</tr>
<tr>
<td>Response to Treatment (used at reassessment)</td>
<td>Symptoms have improved or stabilized</td>
<td>Symptoms have worsened over time (for re-</td>
<td>Long ED history with past difficulty attaining and/or</td>
<td></td>
</tr>
</tbody>
</table>

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*HR* = Heart Rate; *BP* = Blood Pressure; *BMI* = Body Mass Index; *ED* = Eating Disorder.
| and if applicable at initial assessment | assessment); inconsistent or unclear response to past outpatient treatment (if prior treatment history) | maintaining response after specialized intensive ED treatment |

*Presence of any of these acute medical complications indicates a need for urgent medical treatment outside of Purdue Sports Medicine regardless of whether any other criteria are met.*
Treatment Contract (SAMPLE)

______________________________ (Athlete Name)

Multidisciplinary Team:
__________________(Physician) _________________(Mental Health Provider)
__________________(Sports Dietitian) ___________________ (Athletic Trainer)

Requirements:
■ Meet with _________________ (Mental Health Provider) ____ time per week, or as recommended by mental health provider.
■ Meet with __________________(Sports Dietitian) ____ time per week, or as recommended by dietitian.
■ Meet with Dr. ____________ _____ times per month, or as recommended.
■ Follow daily meal plan as outlined by Sports Dietitian.
■ Keep daily workout log updated with specific type of workout, length, and effort level.
■ Weight gain of _____ lbs per week.
■ Weekly weigh-in with ____________ (Team Member) or at time intervals of every _____ weeks.
■ Must achieve minimal acceptable body weight of _____ lbs by _____ (Date).
■ After reaching minimum weight, must maintain weight at or above this minimal acceptable body weight.
■ Limit of _____ workout sessions per week with no one session being more than _____ minutes in length. All activities count including biking, running, weight lifting, and swimming.

Positive Consequences:
If ALL requirements are met, then clearance to participate in team activities and use of athletic facilities will:
■ Be granted  ■ Continue

Negative Consequences:
If ANY requirement(s) are not met, then clearance to participate in team activities and use of athletic facilities will be revoked. Re-instatement will be at the discretion of the Team Physician and Multidisciplinary Team.
I, ________________________ have read this contract and all of my questions were answered.

______________________________ (Athlete Name)   ___________ (Athlete Signature)   ___________ (Date)

______________________________ (Team Physician Name)   ___________ (Team Physician Signature)   ___________ (Date)