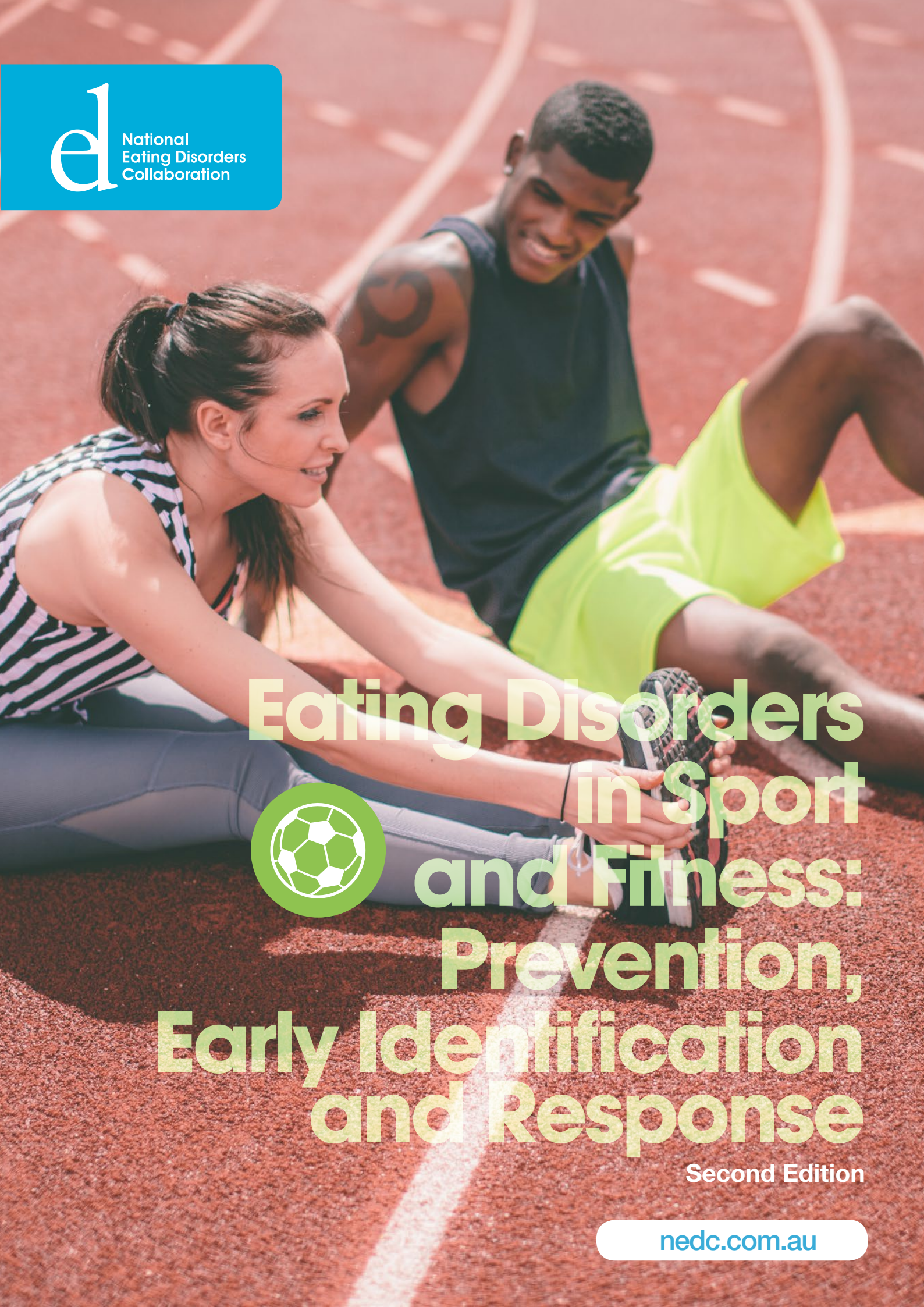
National Eating Disorders Collaboration



Eating Disorders in Sport and Fitness: Prevention, Early Identification and Response

Second Edition

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INTRODUCTION

General information about eating disorders

Eating disorders are serious mental illnesses that are associated with significant physical complications. Eating disorders not only involve considerable psychological impairment and distress, but they are also associated with major wide-ranging and serious medical complications, which can affect every major organ in the body. Eating disorders are frequently associated with other psychological disorders such as depression, anxiety, substance abuse and personality disorders. A person with an eating disorder may experience long term impairment due to social and functional roles and the impact may include psychiatric and behavioural effects, medical complications, social isolation, disability and an increased risk of death. The mortality rate for people with eating disorders is the highest of all psychiatric illnesses, and over 12 times higher than that for people without eating disorders. While estimates of the incidence of eating disorders vary between countries and studies, there is agreement that eating disorders, disordered eating and body image issues have increased worldwide over the last 30 years.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) lists all the Feeding and Eating Disorders that are diagnosed by psychologists. Of these there are four specified eating disorders; Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and Other Specified Feeding and Eating Disorder (OSFED). Fact sheets about disordered eating, body image and each of the eating disorders are available at www.nedc.com.au/fact-sheets

Eating disorders in Australia

Eating disorders have a significant and underestimated impact on Australian society.

- About one in 20 Australians has an eating disorder and this rate is increasing
- Approximately 15% of Australian women experience an eating disorder during their lifetime
- Anorexia Nervosa and Bulimia Nervosa affect between 2% and 4% of the population
- Binge Eating Disorder is estimated to affect approximately 3% of the population

Research conducted with young people in 2010 on behalf of the NEDC indicated that:

- most young people know at least one other young person who they think might have an eating disorder
- 84.3% of respondents said they know one person who may have an eating disorder
- 62.8% said they know up to five people who may have an eating disorder
- These figures do not take into account the frequent under-reporting and under-treatment of eating disorders.

Eating disorders and mortality

All eating disorders come with severe medical complications and increased mortality rates. The risk of premature death in people with eating disorders relates in part to medical complications associated with the disorder; however suicide has also been identified as a major cause of death in people with eating disorders. In fact, 1 in 5 individuals with Anorexia Nervosa who die prematurely have committed suicide. Research on suicide in people with Bulimia Nervosa and EDNOS is less available; however rates of suicide in Bulimia Nervosa and EDNOS are higher than in the general population.

Eating disorders and adolescents

Eating disorders can occur in people of all ages; however adolescents and young people are increasingly at risk.

- Eating disorders represent the third most common chronic illness for young females
- Eating disorders represent the second leading cause of mental disorder disability for young females
- Adolescents with diabetes may have a 2.4-fold higher risk of developing an eating disorder
- Adolescent girls who diet at a severe level are 18 times more likely to develop an eating disorder within 6 months - this risk increases to a 1 in 5 chance over 12 months

Studies of body dissatisfaction in adolescence have found varying but consistently high levels:

- 70% of adolescent girls have body dissatisfaction
- Body dissatisfaction is identified in the Mission Australia Youth Survey (2013) as one of the top ranked issue of concern for young people

The long term health consequences of eating disorders

The consequences of an eating disorder are not limited to acute episodes of illness but may also be long term. Only 46% of patients fully recover from Anorexia Nervosa while 20% remain chronically ill for the long term. Binge Eating Disorder is more common than Anorexia Nervosa or Bulimia Nervosa and is at least as chronic and stable as these disorders.

The financial consequences of eating disorders

The cost of care for a person with an eating disorder is substantial. Eating disorders are the 12th leading cause of mental health hospitalisation costs within Australia. The expense of treatment of an episode of Anorexia Nervosa has been reported to come second only to the cost of cardiac artery bypass surgery in the private hospital sector in Australia. Bulimia Nervosa and Anorexia Nervosa are the 8th and 10th leading causes, respectively, of burden of disease and injury in females aged 15 to 24 in Australia. This is measured by disability-adjusted life years.

Common misconceptions about eating disorders

To read more about the following misconceptions, where they come from and why they are not true visit www.nedc.com.au/myths-about-eating-disorders

Myth: Eating disorders are a lifestyle choice, not a serious illness

There is a generally low level of mental health literacy in the community which affects community responses to eating disorders and leads to underestimation of the seriousness

of these illnesses. The truth is that eating disorders are serious mental illnesses; they are not a lifestyle choice or a diet gone 'too far' and people can't 'just stop' their eating disorder. People with eating disorders require treatment for both mental and physical health addressing the underlying psychological issues and the impact on physical health.

Myth: Eating disorders are a cry for attention or a person 'going through a phase'

Research conducted with young people in 2010 on behalf of the NEDC indicated that 51.3% of 12-17 year olds agreed that a person with an eating disorder should 'snap out of it, there are more important things in life to worry about'. However, an eating disorder is not a phase and it will not be resolved without treatment and support. People with eating disorders are not seeking attention. In fact, due to the nature of these illnesses a person with an eating disorder may go to great lengths to hide, disguise or deny their behaviour, or may not recognise that there is anything wrong.

Myth: Eating disorders are about vanity

The association between body dissatisfaction and eating disorders can lead people to mistakenly believe that eating disorders are about vanity. In truth, no one can be blamed for developing an eating disorder. There are genetic and personality vulnerabilities as well as social and environmental triggers. Eating disorders are not just about food or weight, vanity, will power or control. They are fuelled by distress, anxiety, stress and cultural pressures. Eating disorders are serious and potentially life threatening mental illnesses, in which a person experiences severe disturbances in eating and exercise behaviours because of distortions in thoughts and emotions, especially those relating to body image or feelings of self-worth.

Myth: Families, particularly parents, are to blame for eating disorders

A common misconception is that family members can cause eating disorders through their interactions with a person at risk. While there are environmental triggers which may impact on the development and maintenance of an eating disorder, there is no evidence that a particular parenting style causes eating disorders. Clinical guidelines for best practice in managing eating disorders encourage the inclusion of families at each stage of treatment for adolescents, from the initial assessment to providing recovery support. The impact of an eating disorder is not only felt by the individual, but often by that person's entire family or circle of support.

Myth: Dieting is a normal part of life

According to research conducted with young people in 2010 on behalf of the NEDC, young people recognise that eating disorders are potentially harmful; however they also accept body 'obsession' and dieting as normal parts of growing up. While moderate changes in diet and exercise have been shown to be safe, significant mental and physical consequences may occur with extreme or unhealthy dieting practices. Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating. Dieting is also associated with other health concerns including depression, anxiety, nutritional and metabolic problems, and contrary to expectation, with an increase in weight.

Myth: Eating disorders only affect white, middle class females, particularly adolescent girls

Adolescent females are one group with a high risk of eating disorders. However, eating disorders are not limited to any one group of people and the prevalence of eating disorders in specific high risk groups should not distract the community from the importance of recognising eating disorders in other populations. People from all age groups and cultural or socioeconomic backgrounds experience eating disorders. Eating disorders affect both men and women.

The benefits of sport

Physical activity and sporting environments play an important role in influencing how people perceive their own bodies. While there appear to be circumstances under which sports participation is a risk factor for eating problems, there are also situations where participating in sport may be a protection against body dissatisfaction and eating problems. For example, young people engaging in non-elite sports, especially in high school, have shown a reduced risk of eating problems compared to their peers and body image has been found to differ significantly among girls participating in different types of sport, and between those who participate in sport and those who do not. Encouraging females to participate in physical activity which focuses on what the body can do (function) rather than on appearance has been found to enhance body satisfaction.

Research shows a decline in physical activity levels during adolescence, particularly among females. Reported barriers to participation include: feeling self-conscious or uncomfortable about their bodies; lack of confidence, influence of peers, parents and teachers, and body-image issues. The perceived barriers to participation in sport and the association with body dissatisfaction suggest that social-environmental strategies to promote engagement in both formal and informal sporting activity could be helpful in reducing the risk of body dissatisfaction and disordered eating provided that sports and other physical activities also adopt appropriate eating disorder prevention responses.

The association between sport, disordered eating and eating disorders

Eating disorders and disordered eating may occur in people who are regarded by society as being extremely fit and healthy. Both males and females engaged in competitive physical activities, including sports, fitness and dance, have increased rates of body dissatisfaction, disordered eating and eating disorders. Physical activity and sporting environments play an important role in influencing how people perceive their own bodies.

High levels of exercise have been identified as a potential risk factor for eating disorders. A study of adolescent athletes (mean age 14.0 ± 2.2 years) found that changes in the desire to be leaner to improve sports performance were associated with changes in disordered eating. “Dieting” or “dietary restriction” is recognised as a precursor for eating disorders. Athletes are more at risk for disordered eating if they believe it is possible to enhance their sports performance through weight regulation. For example, athletes who believe their performance is directly affected by their body type often experience body dissatisfaction which can lead to disordered eating or eating disorders (e.g. bodybuilders, wrestlers, boxers, jockeys, rowers). Aesthetic sports which focus on appearance (e.g. figure skating, dancing, diving, gymnastics) and endurance sports which focus on individual performance, rather than the entire team (e.g. track and field, cycling, swimming) are also associated with an increased risk of eating disorders. For more information on the characteristics of sports which may increase the prevalence of eating disorders visit http://www.lboro.ac.uk/research/nceds/downloads/uksport-ed-guidelines.pdf (to access UK Sport ‘*Eating disorders in sport*’). While disordered eating more frequently affects athletes in sports that emphasize a thin size or a low weight, than in other sports, no sports are exempt. Although some instances of disordered eating may directly relate to the sport, more often the individual athlete has other risk factors in their lives and may have been likely to engage in disordered eating without participation in a sport.

What is disordered eating and why is it a problem?

Disordered eating is when a person regularly engages in unhealthy and destructive eating behaviours such as restrictive dieting, compulsive eating or skipping meals. Disordered eating can include behaviours which reflect many but not all of the symptoms of an eating disorder. Severely restrictive diets can be a very dangerous practice. When the body is starved of food it responds by reducing the rate at which it burns energy (the metabolic rate), this can result in overeating and binge eating behaviours that can lead to weight gain and obesity. Feelings of guilt and failure are common in people who engage in disordered eating. These feelings can arise as a result of binge eating, 'breaking' a diet or weight gain. A person with disordered eating behaviours may isolate themselves for fear of socialising in situations where people will be eating. This can contribute to low self esteem and significant emotional impairment. Disordered eating and dieting behaviour are the most common indicators of the development of an eating disorder. Disordered eating can have a destructive impact upon a person's life and has been linked to a reduced ability to cope with stressful situations. There is also increased incidence of suicidal thoughts and behaviours in adolescents with disordered eating.

Examples of disordered eating include:

- Fasting or chronic restrained eating
- Skipping meals
- Binge eating
- Self induced vomiting
- Restrictive dieting
- Unbalanced eating (e.g. restricting a major food group such as fats or carbohydrates)
- Laxative, diuretic, enema misuse
- Steroid/creatine use - supplements used to enhance performance and alter physical appearance
- Using diet pills

Disordered eating can affect every aspect of an athlete's life, including:

- Academic, especially concentration
- Athletic, when malnutrition and dehydration lead to poor energy stores and muscle weakness
- Psychological, especially causing negative moods
- Physiological (e.g. weight gain, muscle loss, osteoporosis, constipation and/or diarrhoea, headaches, muscle cramps, dizziness or fainting, fatigue and poor sleep quality)
- Social, leading to withdrawing from others

Disordered eating has the potential to cause additional negative health outcomes in female athletes. Low energy availability that may have been caused by disordered eating can lead to menstrual dysfunction and impaired bone health, and has become known as the Female Athlete Triad. To read more about the Female Athlete Triad visit www.nedc.com.au/sport-fitness-industry (to access Inclusive Learning Unit Education Queensland 'Good Enough to Eat' and Marks & Harding, 2004), http://www.lboro.ac.uk/research/nceds/downloads/uksport-ed-guidelines.pdf (to access UK Sport 'Eating disorders in sport') and www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit').

HOW TO PROMOTE HEALTH AND WELLBEING WITHIN YOUR SPORT OR CLUB

Sports associations play a large and ongoing role in the influence of people engaging in competitive physical activity and are therefore instrumental in delivering positive messaging about body image, healthy eating and exercise behaviours within a high risk community. Coaches and other sports professionals are amongst the most important and influential role models in the lives of the athletes they interact with, and as such, these people are in a strong position to assist in the prevention, early identification, intervention and management of eating disorders.

Promote mental health awareness

People who are identified and treated early in the course of an eating disorder have a significantly better chance of recovery when compared with those who have been living with an eating disorder longer; this is particularly relevant for young people. However, the median duration of treatment delay is extraordinarily long (10 years for those meeting criteria for bulimia nervosa and 15 years for those meeting criteria for anorexia nervosa). This suggests that people with eating disorders experience significant barriers to seeking help. One principal barrier has been identified as the stigma that exists around eating disorders. To reduce the stigma associated with eating disorders, there needs to be a shift in the attitudes and knowledge of the general community about eating disorders. In Australia there has been a growth in mental health awareness and active efforts by government, media and the wider community to reduce stigma and improve mental health literacy. Awareness of eating disorders appears to be increasing in sport, fitness and dance, which is important because sports professionals are in a powerful position to help with efforts to promote mental health awareness by modelling appropriate attitudes and behaviours.

Understand Eating Disorders

The key to prevention of eating disorders for people engaged in competitive physical activity is education and support for their coaches, teachers, parents and other adults who interact with these people at high risk. Training in eating disorders is not usually included in the accreditation training for sports coaches, fitness instructors or dance teachers. However, prevention in the context of physical activity requires teachers/leaders that are knowledgeable about the issue and able to role model healthy attitudes and behaviours rather than, for example, promoting the belief that weight loss is an indicator of successful training or an essential aesthetic for specific sporting activities. To access more educational resources about eating disorders in the sport and fitness industries visit www.nedc.com.au/sport-fitness-industry. To find out about training events and opportunities for professional development visit www.nedc.com.au/research-resources.

Implement an effective prevention strategy

Strategies for the promotion of health and wellbeing in the sport and fitness industries should include a strong focus on proactive approaches to promoting resilience rather than focusing solely on identification of people with eating disorders.

The most effective eating disorder prevention strategies:

- Use a health promotion approach, focusing on building self-esteem, positive body image, and a balanced approach to nutrition and physical activity
- Focus on reducing risk factors (e.g. 'ideal body type' internalization, body dissatisfaction, peer pressure, bullying and fat talk, perfectionism) and on strengthening protective factors (e.g. self esteem, social support, non competitive physical activity, healthy eating behaviours and attitudes, respect for diversity, coping strategies, media literacy)
- Utilise interactive approaches and develop social and relational practices that incorporate the person's support network
- Are age appropriate and socio-culturally relevant to the target audience
- Follow a multisession structure, allowing for both direct experience and time between sessions for reflection, and include a long-term follow-up

It is important to ensure that your prevention strategy is age appropriate. In general, children under the age of 12 years do not need information on eating disorders. Communication with children should focus on positive behaviours such as good health, body image and self esteem and general mental health literacy. Transitional years of puberty are a critical period and prevention strategies for young people aged 12 – 15 should focus on self esteem, perfectionism, media literacy, 'ideal body type' internalisation, healthy eating, risks of dieting, natural changes and variations in body shape, standing up to peer pressure and building a peer environment that supports positive body image. For young people aged 15-18 and adults, information about eating disorders may contribute to recognition of risk factors in themselves and others and the development of supportive community environments. These age groups may be at higher risk, having already engaged in disordered eating behaviours. Messages should include ways to challenge the thin ideal and should be tailored to meet the needs of high risk audiences. For adults awareness of eating disorders is required to enable peer support and messages may target specific interest groups at high risk, including athletes.

For any prevention initiative to be successfully implemented on a consistent basis it requires the support of the whole organisation or sporting code and therefore must be integrated into policy, training and measurement of outcomes. One evidence informed resource which could be utilized as the basis of prevention interventions in physical activity is the Fitness Australia Guidelines available at www.nedc.com.au/sport-fitness-industry. There is also an example of an evidence informed prevention program designed specifically for athletes (Athletes Targeting Healthy Exercise and Nutrition Alternatives, or ATHENA) available at the same location. For information specific to the prevention of eating disorders in athletes within a school setting visit www.nedc.com.au/sport-fitness-industry (to access NEDA 'Educators toolkit') or www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit').

Any prevention strategy should take the following issues into consideration:

High risk periods

Three key periods have been identified as representing increased risk for people involved in competitive physical activity: the development stage, non-competition periods, and retirement or cessation of intense physical activity.

Broad concerns have been expressed in NEDC consultations about sub-elite athletes and dancers who aspire to the body shape of elite performers but do not have access to the medical and nutritional support services to help them achieve this in a safe and healthy way.

Other specific risk periods for people participating in sport and dance were identified as

retirement, when people are no longer in a regulated environment, and non-competition periods when some people gain weight which they subsequently have to lose in order to compete.

Choosing the right activity
Sports and dance often require very specific body shapes or weights. People who do not naturally have those body shapes but who strive to attain them are at greater risk of developing an eating disorder. Matching physical activity to body shape would presumably reduce some of the risks.

In order to enable parents to support their children there is also a need for parents to understand the culture and physical requirements of any specific sport or dance activity that their children engage in. Parents need to be equipped to help their children select appropriate activities.

Peer pressure
Peer pressure can contribute to both risk and protective factors. It is an issue for anyone engaging in group training where body comparison becomes a part of the group culture. In this context, advice given to one person about exercise or weight loss may be transferred to all members of the group, leading to people engaging in inappropriate activities for their health needs. For example, when one person receives advice to lose weight this may lead to all members of a group trying to lose weight regardless of their need to do so.

Implement an appropriate intervention strategy

For early intervention to occur, people at risk of eating disorders and those in their circle of support, need to be able to recognise and respond to signs of distress, reduced functioning, and other indicators that present early in the development of an eating disorder. A person who has, or is at risk of developing an eating disorder can often feel high levels of shame, ambivalence and denial. As a result of this, that person may need guidance and support from those around them to take the first steps towards preventing or treating an eating disorder. It is therefore very important that sports professionals work to deepen their level of understanding about eating disorders. Learn more about how to identify eating disorders in the next section, HOW TO RECOGNISE AND RESPOND TO EATING DISORDERS.

Some opportunities for intervention include:

- Introduction of specific policies regarding eating disorders, their risk factors and prevention in sport, fitness and dance organisations and programs
- Screening for compulsive exercise or excessive exercise as a means of weight control and nutritional imbalance
- Training programs that take age and body shape into consideration
- Support for open dialogue about unrealistic appearance expectations
- Focus in sport on functional achievement rather than appearance
- Regular health checks for children and adolescents engaged in competitive sport including screening for eating disorders

Communicate appropriately about eating disorders

Eating disorders are often misunderstood and underestimated in our society. Mistaken beliefs that eating disorders are about vanity, a dieting attempt gone wrong, an illness of choice, a cry for attention, or a person 'going through a phase' are common. Appropriate messages can be combined with effective engagement strategies to help educate your sporting community about eating disorders. No single communication approach to eating disorders is likely to reach all targeted audiences or achieve all desired outcomes in terms of reduced risk and stigma, and earlier identification and intervention. Hence, eating disorders communication strategies require a multi-strand approach. To read some coaches own

stories about two-way communication visit http://www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit').

Communication about eating disorders should:

- Be developmentally appropriate for the intended audience
- Support understanding of eating disorders as serious, complex illnesses, not a lifestyle choice
- Provide accurate, evidence-based information
- Respect the experience of people who have eating disorders
- Assist people in making appropriate decisions about help seeking
- Balance representation of males and females and diverse cultures and age groups (unless specifically addressing a single target audience)
- Be reviewed for ambiguity and possible risk of harm
- Be monitored and evaluated on an ongoing basis to ensure the continuing safety and appropriateness of content

Communication about eating disorders should not:

- Describe details of how to engage in eating disorder behaviours
- Use or provide information on personal measurements in relation to people who have experienced an eating disorder (e.g. weight, amount of exercise, number of hospital admissions)
- Normalise, glamorise or stigmatise eating disorder behaviours
- Use judgemental or value-laden language
- Motivate people to act based on fear or stigma

Do no harm

Care must be taken in promoting information about eating disorders in order to ensure positive outcomes rather than accidental harm. The challenge is similar to that faced by health promotion and prevention campaigns for other health issues such as illicit drug use and binge drinking. There is a potential for harm in talking about eating disorders in a detailed way to people at risk. Without due caution, highlighting the symptoms or effects of eating disorders may increase the prevalence of the disorder. It is recommended that key messages are tailored and tested for audiences, especially in the case of messages for those at risk of developing an eating disorder. All communication about eating disorders should contribute to one or more of these goals:

- **Recognition** – broad community awareness and understanding of eating disorders as a priority mainstream health issue to increase support and reduce stigma
- **Resilience** – ability to resist pressures towards high risk behaviours for eating disorders
- **Help seeking** – eating disorders and risk factors are identified at an early stage leading to early intervention and reduction in the impact of the illness

Understand the relationship between eating disorders and obesity

Contrary to what many people think, obesity and eating disorders share many common factors. People who are overweight and obese have a higher risk of developing disordered eating and eating disorders than the general population. In addition, young people and adults who diet and use unhealthy weight-control practices gain more weight over time and are at higher risk of becoming overweight or developing obesity.

The prevalence of comorbid obesity and eating disorder behaviours has quadrupled in the last decade, which is a much greater increase than that seen in either eating disorders or obesity alone. This extreme rise illustrates the urgent need to address the relationship between eating disorders and obesity, and the research-based recommendations of health promoting activities. At present, the health promotion strategies for obesity and eating disorders tend to be separate; however, there is growing evidence to suggest that a shared approach could be of benefit. Obesity and eating disorders may be viewed as occurring at the same end of a spectrum from healthy beliefs, attitudes, and behaviours at one end to problematic beliefs, attitudes, and behaviours at the other end.

Obesity and eating disorders: a shared approach

Coordinated and consistent messaging promoting health outcomes for overweight and eating disorder problems is possible, especially in the area of prevention. Focusing on the risk and protective factors that are common to eating disorders and obesity presents an opportunity to collaborate and redirect people in a positive direction. Weight and eating-related conditions often occur in an environment where ambiguous and opposing demands and messages are present, for example, 'taking diet pills will help you lose weight and are therefore good for your health' is often presented in the same space as warnings to the effect of 'diet pills are unhealthy and dangerous.' A first step to reducing the risks and increasing the protective factors for both eating disorders and obesity is to recognise that we all aspire to a healthy, disease-free population who eat well, are physically active, and are satisfied with their bodies.

Shared risk factors:

- Being overweight in childhood
- Weight bias and stigmatisation
- Childhood weight-related teasing
- Amount of time spent watching television/using the internet/playing video games
- Media and marketing exposure
- Dieting and disordered eating
- Poor body image
- Depressive symptoms and anxiety
- Family talk about weight, parent weight-concern & weight-related behaviours (e.g. dieting)

Shared protective factors:

- Enjoying physical activity
- Positive body image
- High self-esteem
- Eating breakfast, lunch and dinner every day
- Family modelling of healthy behaviours (e.g. avoiding unhealthy dieting, engaging in physical activity, having regular and enjoyable family meals)

The boomerang effect

Despite having the best intentions, occasionally health promotion efforts cause unintended harm. When attitude and behaviour change occurs in the direction opposite to that which was intended, it is known as the 'boomerang effect.' Very little research has been done in the eating & weight fields to ascertain whether obesity prevention strategies may be harmful in relation to eating disorders, and vice versa.

Public health messages should avoid:

- The measurement of weight/BMIs – this should be avoided unless absolutely essential to your sport and if unavoidable care should be taken not to place a positive or negative value on weight/BMIs but simply to place an outcome on the measurement if necessary (e.g. size class, competition category)
- Moralisation of eating (e.g. labelling foods as 'good', 'bad', 'right' or 'wrong')
- The possibility for weight bias and stigmatisation
- Nutritional advice that may encourage food fears and unhealthy dieting
- Inappropriate messages that may increase body dissatisfaction, dieting, and use of unhealthy weight control practices

Public health messages designed to reduce eating disorder prevalence should follow these guidelines:

- Interventions should focus on health, not weight, and be delivered from a holistic perspective with equal consideration given to social, emotional and physical health
- Weight is not a behaviour and therefore not an appropriate target for behaviour modification; interventions should focus only on modifiable behaviours (e.g. physical activity, eating habits, time spent watching television)
- People of all sizes deserve a nurturing environment and will benefit from a healthy lifestyle and positive self-image
- The ideal intervention is an integrated approach that addresses risk factors for the spectrum of weight-related problems, and promotes protective behaviours
- Interventions should honour the role of parents and carers and support them to model healthy behaviours at home without overemphasising weight
- Representatives of the community should be included in the planning process to ensure that interventions are sensitive to diverse norms, cultural traditions and practices
- It is important that interventions are evaluated by qualified health care providers and/or researchers, who are familiar with the research on risk factors for eating disorders

Be a positive role model

Remember that athletes often look up to sports professionals and coaches as mentors and place a high value on the example they set and advice they give. For this reason those who work with athletes are in a position to encourage positive beliefs and prevent disordered eating behaviours.

To model positive beliefs and behaviours sports professionals should:

Understand

- Weight is a sensitive, personal issue for athletes (both male and female) and negative weight or body composition related comments or behaviours will likely have a damaging impact on them
- Under-eating will not improve performance and can in fact impair performance by causing muscle loss, dizziness, fainting and lack of energy
- The optimal weight and body composition for the performance of one athlete will not be the same as for another athlete
- Athletes who burn high levels of energy (e.g. long distance runners and swimmers, endurance performers such as iron men and women) must take care to balance their energy output and input to maintain their health and wellbeing
- Losing weight rapidly prior to competitions and regaining it afterwards threatens both the health and the performance of the athlete
- Athletes will not maintain peak performance throughout their careers, their capability will naturally drop off, plateau and improve periodically

Promote

- Encourage athletes to eat regular, nutritionally balanced meals and snacks that are appropriate to supporting their training
- Emphasise factors that contribute to personal success (e.g. motivation, enthusiasm), promote healthy attitudes towards size and shape and focus on each athlete as a whole person, rather than on their performance or success
- Ensure any specific nutritional program undertaken by an athlete is carefully supervised by someone qualified to do so (e.g., a nutritionist or dietician)

Avoid

- Weighing or measuring athletes unless absolutely essential to their sport and current training or competition program. Never place a positive or negative value on weight/ BMI – simply place an outcome on the measurement if necessary (e.g. size class, competition category)
- Sharing weight or measurements in front of athletes' team mates, staff or the public or compare athletes bodies to each other
- Commenting on weight or body composition when discussing ways that athletes can improve their performance - instead focus on constructive outcomes such as strength, flexibility, physical conditioning and mental and emotional coping skills
- Supporting athletes to engage in fad diets (e.g. avoiding food groups such as fats and carbohydrates).

For more information about how you can encourage healthy and appropriate exercise and training for athletes and for information about appropriate nutrition and hydration for athletes and nutritionists own stories visit www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit') and http://www.lboro.ac.uk/research/nceds/downloads/uksport-ed-guidelines.pdf (to access UK Sport 'Eating disorders in sport').

"It is important to refrain from making comments of any kind about an athlete's 'looks' due to how sensitive individuals can be to comments about their appearance. It is possible that your athlete may hear what you have said in a negative light (your comment may be heard as a criticism) even if you think you are paying your athlete a complement. Alternatively, your well intentioned comment may reinforce an athlete's eating-disorder behaviours (i.e., "If I look good, what I'm doing must be working!)"

(Selby & Reel, 2011)

HOW TO RECOGNISE AND RESPOND TO EATING DISORDERS

How to recognise when an athlete may have, or be developing, an eating disorder

Anyone can experience an eating disorder. Being as informed as possible about how to recognise eating disorders will help you identify the warning signs in someone you are concerned about. It is also important to talk to a professional with specialised knowledge about eating disorders who can give advice, information and support. It is not easy to detect who may have an eating disorder as eating disorders cannot be identified by someone's size or shape. A person with an eating disorder may have disturbed eating behaviours coupled with extreme concerns about weight, shape, eating and body image. However, people with eating disorders may go to great lengths to hide, disguise or deny their behaviour, or may not recognise that there is anything wrong. This may make the characteristic behaviours of the illness difficult to identify and it is often very difficult for people with eating disorders to ask for help. The following information can help you to recognise existing issues.

Understand who is most at risk

While research into the causes of eating disorders continues, this remains an area that is not well understood. No single cause has been identified; however, there are many risk factors that increase the likelihood that a person will experience an eating disorder at some point in their life. Knowing who is most at risk of developing an eating disorder can help sports professionals know who will benefit most from preventative interventions.

The risk factors for eating disorders include:

Biological

- Gender
- Early onset of puberty
- Genetic susceptibility

Psychological

- Overvaluing body image in defining self-worth
- Personality traits such as perfectionism, obsessive-compulsiveness, neuroticism
- Low self-esteem
- Anxiety
- Depression
- Feeling 'out of control'
- Stress
- Trauma

Socio-cultural

- Involvement in a sport or industry with an emphasis on a thin body shape and size (e.g. athlete, ballet dancer, gymnast, model)
- Societal pressure to achieve and succeed
- Internalising the western beauty ideal of thinness, and muscularity and leanness
- Peer pressure
- Teasing or bullying (especially when based on weight or shape)
- Troubled family or personal relationships

To read about athlete specific risk factors visit www.nedc.com.au/sport-fitness-industry (to access Inclusive Learning Unit Education Queensland 'Good enough to eat'), http://www.lboro.ac.uk/research/nceds/downloads/uksport-ed-guidelines.pdf (to access UK Sport 'Eating disorders in sport') and www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and Athletic Trainer Toolkit').

Some protective factors which make some people more resilient to eating disorders than others include:

Individual

- high self-esteem
- positive body image
- critical processing of media images (i.e. media literacy)
- emotional well-being
- being self-directed and assertive
- possession of good social skills and social functioning
- problem solving and coping skills

Family

- family connectedness
- belonging to a family that does not overemphasise weight and physical attractiveness
- eating regular meals with the family

Socio-cultural

- involvement with sport or industry with no emphasis on physical attractiveness or thinness

- peer or social support structures and relationships where weight and physical appearance are not of high concern
- belonging to a less westernised culture that accepts a range of body shapes and sizes

High risk groups that you may be in contact with as a sports professional

Eating disorders occur in both males and females; in children, adolescents, adults and older adults; across all socio-economic groups and cultural backgrounds. Within this broad demographic however some groups have a particularly high level of risk. High risk groups that sports professionals might encounter include:

Athletes - People engaged in competitive fitness, dance and other physical activities where body shape may be perceived as affecting performance have a high level of risk of eating disorders.

People who are interested in weight loss - eating disorders almost invariably occur in people who have engaged in dieting or disordered eating.

Adolescents - The peak period for the onset of eating disorders is between the ages of 12 and 25 years, with a median age of around 18 years.

Women, particularly during key transition periods (e.g. from school to adult life, pregnancy and menopause) - Women with high weight and shape concerns, a history of critical comments about eating, weight and shape, and a history of depression are at a higher than average risk for eating disorders.

Young people with Diabetes or Polycystic Ovary Syndrome - Adolescents with diabetes may have a 2.4-fold higher risk of developing an eating disorder, particularly Bulimia Nervosa and Binge Eating Disorder, than their peers without diabetes. Polycystic Ovary Syndrome is associated with body dissatisfaction and eating disorders.

People with a family history of eating disorders - There is evidence that eating disorders have a genetic basis and people who have family members with an eating disorder may be at higher risk of developing an eating disorder themselves.

Eating disorders in males

A focus on specific groups at high risk should not distract from the prevalence of eating disorders in other populations. In particular, there is growing awareness of eating disorders occurring amongst males. There is a fact sheet about eating disorders in males at www.nedc.com.au/fact-sheets. Population studies have suggested that males make up approximately 25% of people with Anorexia or Bulimia and 40% of people with Binge Eating Disorder. In a recent study lifetime prevalence for Anorexia Nervosa in adolescents aged 13 - 18 years found no difference between males and females. The number of males may be underrepresented in clinical samples, because in comparison to females, men are less likely to seek help, and more likely to be misdiagnosed with other mental health problems. One unique difference between males and females with eating disorders is that men often engage in compulsive or excessive exercise as a compensatory behaviour, typically with the aim of achieving a more muscular, and not just slender, body type. Compulsive or excessive exercise describes a rigid, driven urge to exercise, which can be difficult to identify in athletes. To read about the signs of excessive exercise visit www.nedc.com.au/sport-fitness-industry to access Marks & Harding, 2004. This is a serious health concern that often requires the intervention of someone close to the individual, such as a family member, friend or coach who recognises these warning signs and encourages professional help.

To read some athlete's (both male and female) own stories visit http://www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit').

Recognise the warning signs

Warning signs that can signal the onset or the presence of an eating disorder include:

Physical warning signs

- Rapid weight loss or frequent changes in weight
- Fainting or dizziness
- Always feeling tired and not sleeping well
- Feeling cold most of the time, even in warm weather
- Swelling around the cheeks or jaw, calluses on knuckles, damage to teeth and bad breath which can be signs of vomiting
- Loss of or disturbance of menstrual periods in girls and women

Psychological warning signs

- Preoccupation with eating, food, body shape and weight
- Black and white' thinking (e.g. rigid thoughts about food being 'good' or 'bad')
- Feeling anxious around meal times
- Feeling 'out of control' around food
- Using food for comfort (e.g. eating as a way to deal with boredom, stress or depression)
- Using food as self punishment (e.g. not eating for emotional reasons like depression/ stress)
- Having a distorted body image
- Changes in emotional and psychological state (e.g. depression, stress, anxiety, irritability, low self esteem)

Behavioural warning signs

- Compulsive or excessive exercising (e.g. exercising in dangerous conditions, continuing to exercise when sick or injured or against professional advice, and experiencing distress if exercise is not possible)
- Dieting behaviour (e.g. fasting, counting calories, avoiding food groups such as fats and carbohydrates)
- Eating in private and avoiding meals with other people
- Evidence of binge eating (e.g. disappearance or hoarding of food)
- Frequent trips to the bathroom during or shortly after meals
- Vomiting or using laxatives, enemas or diuretics
- Making lists of good or bad foods
- Suddenly disliking food they have always enjoyed in the past
- Secretive behaviour around food (e.g. saying they have eaten when they haven't, hiding uneaten food in their rooms)
- Obsessive rituals around food preparation and eating (e.g. eating very slowly, cutting food into very small pieces, insisting that meals are served at exactly the same time everyday)
- Changes in clothing style (e.g. wearing baggy clothes)
- Extreme sensitivity to comments about body shape, weight, eating and exercise habits

It is common for someone to display a combination of these symptoms. It is important

to remember that due to the nature of an eating disorder some of these characteristic behaviours may be concealed. To read about athlete specific warning signs visit http://www.lboro.ac.uk/research/nceds/downloads/uksport-ed-guidelines.pdf (to access UK Sport 'Eating disorders in sport') and www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit').

What to do if you suspect an athlete has an eating disorder

Be familiar with Mental Health First Aid

The Mental Health First Aid guidelines for eating disorders, which are available at www.mhfa.com.au/documents/guidelines/8244_MHFA_eatdis_guidelines_Sep09.pdf provide evidence based recommendations about how to help a person developing or experiencing an eating disorder.

Be prepared

There is no 'right' or 'wrong' way to talk to someone with an eating disorder. However, it is important to be prepared. The person may be experiencing high levels of anxiety, shame, embarrassment, guilt or denial, or may not recognise that anything is wrong. It is important to take this into consideration. Any approach needs to be made in a caring manner in an environment which can support an open and calm conversation. Avoid broaching the topic if you are around food, or in situations in which either of you are angry, tired or emotional. If you are approaching someone with an eating disorder you need to take into account their fear of disclosing their behaviours. Be prepared for the person to respond with anger or denial. This does not mean they do not have a problem. Let them know that you care about them and want to support them through every stage of their process.

If you are planning to talk to an athlete about a potential eating disorder, here are some questions to ask yourself first:

- Have you documented the place and time of the specific behaviours you have witnessed which lead you to suspect the athlete might be suffering from an eating disorder?
- Are you the best person to approach the athlete or is there a member of staff who might have a better rapport with them or be experienced in dealing with eating disorders?
- If you are the best person to speak with the athlete, would they respond better to a one-on-one chat or is there another member of staff who could be present to provide support?
- Do you know your clubs policy for mental health interventions and the appropriate next steps (e.g. Who should you report the issue to? Who will speak with the athlete's family if this is necessary and appropriate?)
- What would be the best time and place to approach the athlete in a way to which they would be most receptive?
- How will you respond if the athlete is defensive and not willing to admit there is an issue (make sure they know you care about them and are happy to talk at any time in the future)?
- What is your aim (this should be to encourage the athlete to seek help)?

(adapted from CEED/EDV (2004), which you can access at www.nedc.com.au/for-schools)

Remember to approach the athlete tactfully because you only suspect and do not actually know whether or not they have an eating disorder.

For an example of an organisational policy for interventions, including scripted dialogues and resources such as forms for recording relevant information, visit www.nedc.com.au/sport-fitness-industry (to access Marks & Harding, 2004). Further scripted examples and tips on how to positively intervene can also be found by visiting www.nationaleatingdisorders.org/coach-trainer (to access Inclusive Learning Unit Education Queensland 'Good Enough to Eat') and www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit').

Express your care and concern

The first steps toward treatment and recovery from an eating disorder are often very hard to take. A person with an eating disorder may feel embarrassed, scared or afraid. They may feel like they have their problem 'under control,' or they may not feel like they have a problem at all. However, if you suspect that one of your athletes has an eating disorder it is important that they seek help immediately. The sooner a person starts treatment for an eating disorder, the shorter the recovery process will be. Seeking help at the first warning sign is much more effective than waiting until the illness is in full swing.

Some helpful tips when talking to someone you suspect may have an eating disorder:

- Try to use 'I' statements (e.g. 'I care about you,' 'I'm worried about you')
- Help them to feel it is safe to talk to you
- Ask them how they feel
- Give them time to talk about their feelings
- Listen respectfully to what they have to say
- Encourage them to seek help

Some things to avoid:

- Avoid putting the focus on food - try talking about how the person is feeling instead
- Do not use blame (e.g. instead of 'You are making me worried' try 'I am worried about you')
- Avoid taking on the role of a therapist - you do not need to have all the answers, rather it is most important to listen and create a space for them to talk
- Steer clear of manipulative statements (e.g. 'Think about what you are doing to me...')

To read recommended guidelines for approaching an athlete visit http://www.lboro.ac.uk/research/nceds/downloads/uksport-ed-guidelines.pdf (to access UK Sport 'Eating disorders in sport').

Seek help early

The perceived complexity of eating disorders and the associated stigma can act as a barrier to intervention. Sports professionals are often concerned that they lack knowledge about how to respond to situations, and are concerned for the consequences if an athlete is 'labelled' as having an eating disorder. This contributes to a culture of 'not noticing' potential eating disorder risks and symptoms. It is important to take the warning signs of eating disorders seriously and act quickly. Cardiac arrest and suicide are the leading causes of death for people with eating disorders.

A person with an eating disorder may also show resistance to getting help. Sometimes they do not want to get well as they are ashamed of their eating and exercise behaviours and fear anyone knowing about them. You can help them by remaining supportive, positive and encouraging. The importance of seeking help early cannot be overstated. The earlier an intervention occurs, the shorter the duration of the eating disorder, and the greater the likelihood of full recovery, especially in children and younger adolescents.

Involve the family whenever possible

Decisions about when to pass confidential information about a young athlete's health and wellbeing on to their parents can be complicated. For example, school teachers coaching sports teams in a school setting should be aware that not all schools are covered by the same privacy legislation or guidelines. In general sports professionals should refer to their own organisation's privacy policy and codes of practice to inform their decisions about communicating with parents. Factors to consider in making your decision include the age of the athlete, their own thoughts about involving their parents, the severity of their physical and psychological condition and the resulting level of risk to their health and safety.

From a recovery perspective there are many potential benefits of involving the family of an athlete of any age who has an eating disorder. Family and friends play a crucial role in the care, support and recovery of people with eating disorders. Clinical guidelines for best practice in managing eating disorders encourage the inclusion of families at each stage of treatment, especially for adolescents with eating disorders, from the initial assessment to providing recovery support. For adolescents, Family Based Treatment is currently the treatment with the strongest evidence base.

Families are generally the people in the best position to encourage children and young adults to seek professional medical and psychological help quickly and on an ongoing basis. It is important that anyone with an eating disorder gets a professional diagnosis. Only eating disorders specialists should assess and diagnose athletes for eating disorders. While GPs may not be formally trained in eating disorder, they are a good 'first base' and can refer patients on to a range of clinicians with specialised knowledge, including medical doctors, psychiatrists, psychologists, nurses, dieticians, counsellors and occupational therapists who are specifically trained to help people with eating disorders.

The correct procedure for contacting families with regards to an athlete's welfare will depend on your particular organisation's policies and procedures. For example, in a school setting the responsibility for liaising with the parents of an athlete at risk might fall to The School Councillor once a coach has reported the problem via the appropriate channels within their school's structure.

Maintain your professional boundaries

It is important to maintain a normal professional relationship with your athlete and not become too involved with them personally. If the issue is affecting you on a personal level talk to your colleagues about getting some support and assistance in setting boundaries.

Establish a support network

An athlete places a huge amount of trust in any person they choose to disclose a mental health issue to, and so it is important to respect that trust and respond appropriately to any such disclosure. One element of an appropriate response is the need to respect the confidentiality of the athlete. However, this need can be difficult to balance with your duty of care to the athlete, your organisation's policies and procedures for responding to athlete welfare issues and requirements such as mandatory reporting legislation. If the athlete is ready to acknowledge the problem and seek help they may be responsive to you explaining the benefits of involving a number of different parties who can play different roles in a support network. If not you may have to explain to the athlete that you are obliged to share the information with certain parties, particularly if the athlete is a child who is at risk of harm. Always be upfront and honest about your duty of care and any responsibility you may have to report issues to other members of staff, the athlete's family or any external authorities. Ideally you should obtain the athletes permission to pass their information on, but if this is not possible be clear about who you are going to tell and why.

If a person you suspect is developing an eating disorder is reluctant to involve other parties then try to minimise the number of people who are told to show them you are trustworthy and are respecting their privacy. However, if the athlete is receptive to help, then assist them in establishing a support network. Friends and team mates can be a strong source of support if the athlete is comfortable with this and these individuals are mature and well informed

enough to provide assistance without causing any detrimental effects to themselves or the person with an eating disorder. If other sporting staff who interact with the athlete are made aware of the issue they can also help to promote positive messages and support recovery. Management may also benefit from being aware of mental health issues within their sports setting so that, for example, they can respond to any issues that are becoming increasingly common within the sporting community. The particular details of the support network will depend on your organisation's policy and the individual's needs, as well as confidentiality issues and the readiness of the individual to accept help. Including a number of different staff members in the support network reduces the stress experienced by each individual.

Guiding principles for the support team can be found by visiting http://www.lboro.ac.uk/research/nceds/downloads/uksport-ed-guidelines.pdf (to access UK Sport 'Eating disorders in sport').

Other people who may need support - Friends, team mates, siblings and children or parents of a person with an eating disorder may need support in adjusting to the situation and their role in supporting the person they care about. These people can become confused about their own body image and ideas about diet and exercise. For more information about eating disorders and the team dynamic visit http://www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit').

Be aware of relevant legislation

Legislation in some states requires sports professionals to report the disclosure of eating disorders under some circumstances. For example, The Government of South Australia's Department of Education and Child Development website www.families.sa.gov.au/pages/protectingchildren/IndicatorsOfAbuse currently lists eating disorders as an indicator of emotional abuse. This is important because in South Australia all employees and volunteers of government or non-government organisations that provide sporting or recreational services wholly or partly for children are mandatory notifiers who are required by law to make a report if they suspect on reasonable grounds that any person aged under 18 years is being abused or neglected and this suspicion is formed in the course of their paid or voluntary work. Many symptoms of eating disorders, such as significant weight loss, persistent fatigue and the wearing of baggy clothing that hides the body, can be difficult to distinguish from indicators of other reportable scenarios, such as neglect or abuse. The following contacts can provide more information on the reporting requirements of each state. Things to consider if a report needs to be made include who the appropriate person is to make the report and whether or not it is appropriate for the parents to be informed (some states have strict guidelines about this).

ACT: Office for Children, Youth and Family Support - Care and Protection Services
24 hours: 1300 556 729 (public), 1300 556 728 (mandatory)
Website: www.communityservices.act.gov.au/ocyfs/services/care_and_protection

NSW: Department of Family and Community Services
24 hours: 132 111 (public), 133 627 (mandatory)
Website: www.community.nsw.gov.au/welcome_to_docs_website.html

NT: Department of Children and Families
24 hours: 1800 700 250
Website: www.childrenandfamilies.nt.gov.au/

QLD: Department of Communities, Child Safety and Disability Services
Office hours: contact details for your local Child Safety Services Centre are available on the website
Out of Hours: 07 3235-9999 or 1800 177 135
Website: www.communities.qld.gov.au/childsafety

SA: Families South Australia
24 hours: 13 14 78
Website: www.families.sa.gov.au/

TAS: Department of Health and Human Services – Child Protection Services
24 hours: 1300 737 639
Website: www.dhhs.tas.gov.au/children/child_protection_services

VIC: Department of Human Services – Child Protection
Office hours: contact details for your local government area are available on the website
Out of hours: 131 278
Website: www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection

WA: Department for Child Protection and Family Support
Office hours: 08 9222 2555 or 1800 622 258
Out of hours: 08 9223 1111 or 1800 199 008
Website: www.dcp.wa.gov.au/Pages/Home.aspx

"Although only licensed mental health and medical professionals should assess, diagnose and treat athletes with an eating disorder, it is important for coaches and sport professionals to recognize signs and symptoms of eating disorders and to understand how to most effectively approach an athlete who is exhibiting eating disorder tendencies."

(Selby & Reel, 2011)

HOW TO WORK SAFELY WITH AN ATHLETE WHO HAS AN EATING DISORDER AND SUPPORT THEIR RECOVERY

Recovering from an eating disorder is often a slow process and can take many years. Each stage brings triumphs and challenges to both the person with an eating disorder and their carers. Having a good understanding of eating disorders will help you to identify what is happening to the person you are supporting through recovery from an eating disorder.

Remember recovery is possible

Eating disorders are serious, potentially life threatening mental and physical illnesses, however with appropriate treatment and a high level of personal commitment, recovery from an eating disorder is achievable. The path of recovery from an eating disorder is a personal journey, unique to each individual. There is no set time for recovery and it is not uncommon for the process to slow down, or to go sideways or backwards. While this may seem frustrating, it can help to remember that with recovery as the ultimate goal even the setbacks can be a valuable part of the journey. It may take time to find the right treatment and the right therapist to meet the needs of the person with an eating disorder and their family or carers. Everyone responds differently to different types of treatment and no one treatment suits all. You can offer support by giving the person with an eating disorder the time they need to find and respond to the recovery program that best suits them. The best type of treatment is one that is long term and focussed on the needs of the person with the eating disorder and their family or circle of support, with recovery as the ultimate goal. For some people, recovery signifies an end to eating disorder attitudes and behaviours and the development of a healthier physical and psychological state of being. This can include returning to social activities, discovering a sense of purpose, and integrating back into daily life.

Understand the recovery process

Focusing on the process of recovery from an eating disorder can feel less overwhelming than focusing on the end result, which may feel far away and unattainable. Many people who have recovered from eating disorders have identified the following themes which have helped them through their journey of recovery:

- **Support** – feeling supported by those around them helps a person's treatment and recovery. A circle of support also decreases the isolation often experienced by people with eating disorders.

- **Hope and motivation** – having a strong sense of hope coupled with the motivation to change eating disorder behaviours is the foundation of recovery.
- **Healthy self esteem** – remembering they are worthwhile reminds a person recovery is too.
- **Understanding and expressing emotions** – it is normal for a person with an eating disorder to feel a range of emotions and it is helpful for them to acknowledge and express these feelings.
- **Acknowledging set-backs** – with the focus on recovery, even taking a step backwards can still be making progress.
- **Coping strategies** – developing a list of coping strategies that calm a person down and help them regulate their emotions can help them during stressful or triggering situations.
- **Engaging in activities and interests** – revisiting the things a person enjoyed before their eating disorder will build self-esteem and reconnect the person with the world around them (e.g. if a person used to enjoy drawing, taking a pencil and paper to their favourite place can be a helpful, and enjoyable experience).

Anyone can experience an eating disorder. Being as informed as possible about how to recognise eating disorders will help you identify the warning signs in someone you are concerned about. It is also important to talk to a professional with specialised knowledge about eating disorders who can give advice, information and support. It is not easy to detect who may have an eating disorder as eating disorders cannot be identified by someone's size or shape. A person with an eating disorder may have disturbed eating behaviours coupled with extreme concerns about weight, shape, eating and body image. However, people with eating disorders may go to great lengths to hide, disguise or deny their behaviour, or may not recognise that there is anything wrong. This may make the characteristic behaviours of the illness difficult to identify and it is often very difficult for people with eating disorders to ask for help. The following information can help you to recognise existing issues.

Understand the stages of change

Motivation is a very important part of the treatment and recovery process for eating disorders. Changes need to be made to the attitudes and behaviours that prevent a person from achieving good physical and mental health. The Stages of Change model can be applied to eating disorders to explain why some people may feel more ready than others to introduce changes that lead to recovery from eating disorders. This model seeks to understand a person's motivation towards achieving change and recovery and is made up of five stages of change that people may move through. Everyone is different, and some people may pass backwards and forwards between these stages. Throughout each stage there may be behavioural signs which will help you identify what stage the person is in and how you can best approach them.

Pre Contemplation

In the pre-contemplation stage a person with an eating disorder will most likely be in denial that there is a problem. You may have noticed some of the warning signs and feel concerned about the person, but they will have little or no awareness of the problems associated with their disordered eating. Instead, they may be focused on controlling their eating patterns. A person with an eating disorder in this stage may not be willing to change or disclose their behaviour and may be hostile, angry or frustrated when approached. This is because the person's eating disorder is currently serving as a way to control or avoid strong, unpleasant emotions. The person may feel unwilling or afraid to let go of these behaviours.

What you can do:

- Stay calm and try to see things from their point of view
- Show compassion and understanding
- Take the focus off their disordered eating - talk about their interests, goals in life and the things they may be missing out on as a result of the eating disorder

Contemplation

A person with an eating disorder in the contemplation stage will have an awareness of their problems and may be considering the benefits of changing some of their behaviours. They swing between wanting to change and wanting to maintain their disordered eating habits. This can be difficult and confusing for you and the person you are caring for.

What you can do:

- Demonstrate that you are listening to what the person has to say, and you understand their struggle - you can even say it back to them (e.g. 'I hear you saying that part of you feels like you want to change, while another part of you feels scared of changing...')
- Show them you respect their ideas, particularly the ones in favour of change
- Try to boost their self esteem and confidence - this will help them believe they can change

Preparation/Determination
In this stage the person with the eating disorder has decided they want to change their behaviour and is preparing to make these changes.

What you can do:

- Be informed- learn as much as you can about the steps you and the person you are caring for need to take in order to recover
- Work with the person to identify their goals and develop a detailed approach of how you will manage the changes together

Action

A person with an eating disorder in the action stage has decided they want to change and will need support to help them take the first steps towards recovery. The person can move backwards and forwards in their development during this stage and relapse can be common.

What you can do:

- Acknowledge how difficult it is to change and recover from an eating disorder
- Support the person through challenges and let them know you believe in them - this will help build their confidence

Maintenance

In the maintenance stage a person with an eating disorder will have changed their behaviour and may be focusing on maintaining their new, healthier habits while learning to live without an eating disorder. This takes time and requires commitment. It is still possible for a person with an eating disorder to relapse at this stage.

What you can do:

- Work together with the person to identify triggers that may impact their recovery
- Put systems and strategies in place to help avoid relapse
- Show care, patience and compassion

Remember who the person is

Do not let the eating disorder take over the person's identity. Remember that they are still the same person they have always been. Separating the person from the illness can help you and the person with an eating disorder.

Be patient

People with eating disorders can experience a range of different and conflicting emotions all in one day. This can be hard to manage in a sporting environment. The road to recovery is littered with emotions and setbacks and can be a long journey. It is important to be as calm and patient as possible throughout their recovery and remember that there is no quick fix. Recovery takes time and patience.

Communicate

Communicate openly, without judgement or negativity and allow the person to express how they are feeling. Avoid focussing on food and weight and instead try to talk about the feelings that may exist beneath the illness. Pay attention to the person's nonverbal reactions and body language and encourage them to trust and speak openly with you.

Be positive

Draw attention to the person's positive attributes. Talk about things they enjoy and are good at. Reminding a person of life outside of their eating disorder helps them realise there is more to them than an eating disorder.

Develop a care plan for supporting the athlete's recovery

The path to recovery from an eating disorder is long and challenging but sporting organisations can help to support athletes along this path. Eating disorders profoundly affect every aspect of an athlete's life, including their academic and athletic performance, psychological and physiological wellbeing, and social functioning. To read more about the effects of eating disorders on athletes visit www.nedc.com.au/sport-fitness-industry (to access Inclusive Learning Unit Education Queensland 'Good Enough to Eat' and NEDA 'Educators toolkit'), www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit') and www.thevictoryprogram.com/for-coaches-trainers-and-professionals.html.

The physical, psychological and behavioural effects of eating disorders will limit an athlete with an eating disorder's ability to function to their full capacity within the sporting environment. Feeling like they are falling behind or not fitting in can contribute to some of the mental health issues that an athlete with an eating disorder may be experiencing. Hence, it is important that sporting professionals be flexible and supportive of the athlete, and their friends and family, as they are recovering from their eating disorder. Remember that rather than being accommodating of the eating disorder itself, the aim should be to support the athlete in their recovery from the eating disorder. This can be achieved in a number of different ways.

If an athlete in your organisation is diagnosed as having an eating disorder the organisation should develop an individual care plan detailing the ways in which particular members of the sporting community can provide ongoing support as the athlete seeks help and undergoes treatment for their eating disorder. The care plan should include details such as who will be the primary support person that communicates with the athlete, who will liaise with the athlete's family (if confidentiality permits), who will communicate with treating health care professionals and the hospital, in the case of hospitalisation (if confidentiality permits), how the organisation will assist the athlete in setting realistic goals and continuing to participate in their sport at an appropriate level and how the organisation can scaffold the athletes return after a period of absence from sport by supporting the needs of the athlete and their family. An example of guidelines regarding appropriate levels of exercise for people recovering from an eating disorder can be found by visiting www.nedc.com.au/sport-fitness-industry (to access Marks & Harding, 2004). It is always important to consider the athlete's emotional health, as well as their physical health, when determining what level of sport

participation will be appropriate during the recovery period. Further tips on how to provide a healthy sport environment conducive to recovery and on how to work effectively with your athlete's treatment team can be found by visiting http://www.lboro.ac.uk/research/nceds/downloads/uksport-ed-guidelines.pdf (to access UK Sport 'Eating disorders in sport') and www.nationaleatingdisorders.org/coach-trainer (to access NEDA 'Coach and athletic trainer toolkit').

WHERE TO LEARN MORE ABOUT EATING DISORDERS

Where to go for more information

The National Eating Disorders Collaboration (NEDC) is an initiative of the federal Department of Health. It is a collaboration of people and organisations with an expertise and / or interest in eating disorders. Our purpose is to develop a nationally consistent, evidence based approach to the prevention and management of eating disorders in Australia. The NEDC constantly reviews research evidence on eating disorders. Recent research can be found at www.nedc.com.au/research-resources Each of the publications of the NEDC also draws on an extensive review of evidence and expert opinion. NEDC publications and their bibliographies can be found at: www.nedc.com.au/nedc-publications

Where to go for professional development

Within Australia there are opportunities for professionals to advance their knowledge and expertise in the field of eating disorders. You can find information about professional development and upcoming events at the NEDC's knowledge hub: www.nedc.com.au/research-resources

Where to find resources

You can find a database of resources available for the sports and fitness industry at www.nedc.com.au/sport-fitness-industry. These resources have been assessed for relevance to the prevention, identification, early intervention, management or care of eating disorders.

Resources for dancers with eating disorders

For information specific to the dance community visit http://ausdance.org.au/articles/details/eating-disorders-and-dancers (to access Ausdance National, 2010).

Where to find help

To find help in your local area visit www.nedc.com.au/helplines or call the National Support Line: 1800 ED HOPE (1800 33 4673)

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Online resources referred to in this resource

ACT Office for Children, Youth and Family Support – Care and Protection Services:
www.communityservices.act.gov.au/ocyfs/services/care_and_protection

NSW Department of Family and Community Services:
www.community.nsw.gov.au/welcome_to_docs_website.html

NT Department of Children and Families: www.childrenandfamilies.nt.gov.au

QLD Department of Communities, Child Safety and Disability Services:
www.communities.qld.gov.au/childsafety

SA Families South Australia: www.families.sa.gov.au/

TAS Department of Health and Human Services – Child Protection Services:
www.dhhs.tas.gov.au/children/child_protection_services

The Mental Health First Aid Training and Research Program's Mental Health First Aid guidelines for Eating Disorders:
www.mhfa.com.au/documents/guidelines/8244_MHFA_eatdis_guidelines_Sep09.pdf

The National Eating Disorders Association (USA) - Toolkits:
http://www.nationaleatingdisorders.org/toolkits

The National Eating Disorders Collaboration - Common Misconceptions:
www.nedc.com.au/myths-about-eating-disorders

The National Eating Disorders Collaboration - Fact Sheets:
www.nedc.com.au/fact-sheets

The National Eating Disorders Collaboration - Helplines: www.nedc.com.au/helplines

The National Eating Disorders Collaboration - Publications:
www.nedc.com.au/nedc-publications

The National Eating Disorders Collaboration - Resources for Schools:
www.nedc.com.au/for-schools

The National Eating Disorders Collaboration - Resources for the Sport and Fitness Industries:
www.nedc.com.au/sport-fitness-industry

The Victory Program at McCallum Place (Eating Disorder Treatment for Athletes) – For Coaches, Trainers and Professionals:
www.thevictoryprogram.com/for-coaches-trainers-and-professionals.html

VIC Department of Human Services – Child Protection:
www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection

WA Department for Child Protection and Family Support:
www.dcp.wa.gov.au/Pages/Home.aspx

National
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The National Eating Disorders Collaboration is a collaboration of people and organisations with expertise in the field of eating disorders, individuals from a range of healthcare and research sectors and people with a lived experience of an eating disorder.

Through the contribution of its members, the NEDC has the resources to lead the way in addressing eating disorders in Australia.

nedc.com.au brings research, experise and evidence from leaders in the field together in one place.

It's a one stop portal to make eating disorders information a lot more accessible for everyone.

Become a member

We welcome individuals and organisations to become members of the NEDC. As a member you can get involved in one of the working groups and contribute to project deliverables. You will also be informed on collaboration activities and receive access to the members only area of the website.
Join the collaboration: www.nedc.com.au/become-a-member

Sign up for the NEDC monthly e-Bulletin

If you would like to keep up to date with what is happening in the wider eating disorders sector including the latest evidence based research on eating disorders you can register to receive our monthly e-Bulletin.
Subscribe to the e-Bulletin: www.nedc.com.au/subscribe

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For a downloadable copy of this resource visit:
www.nedc.com.au/sport-and-fitness

The National Eating Disorders Collaboration (NEDC) is an initiative of the Australian Government Department of Health.