



Eating disorders in sport: the last taboo in applied sport psychology?

Dr Anthony Papathomas and Louise Capicotto challenge the quick-fire referral drawing upon preliminary qualitative data from an ongoing study exploring sport psychologists' experiences of consulting with athletes with disordered eating.

Eating disorders in sport is a complex phenomenon of particular concern to sport psychologists. Pressures to be thin for performance gains are associated with athlete body dissatisfaction, stringent dieting and sometimes severe conditions such as anorexia nervosa and bulimia nervosa. Typically, female athletes competing in sports that emphasise leanness (e.g. distance running) or aesthetics (e.g. figure skating) are most at risk. No athlete is immune however, with male athletes also experiencing disordered eating (see Papathomas & Lavallee, 2006), as well as athletes in power sports such as tennis and basketball (see Papathomas & Lavallee, 2012; 2014). Exactly how many athletes are affected is unknown as the stigma associated with mental illness makes disclosure difficult. Current best estimates suggest eating disorders may be twice as prevalent in the athletic population compared to the general population (Torstveit *et al.*, 2008). As such, encountering an athlete with eating issues is likely at some point in a sport psychologist's career and almost a certainty for those working in lean and aesthetic sports. Yet, many within the profession are reluctant to engage with what may be a clinical issue and suspected cases are referred to those with appropriate clinical expertise. In this article, we argue that such quick-fire referral may not always be the best option. To support our points, we also draw upon preliminary qualitative data from an ongoing study exploring sport psychologists' experiences of consulting with athletes with disordered eating in the UK.

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Setting the scene

Two contrasting philosophical perspectives underpin sport psychology consulting. One perspective maintains that work should focus exclusively on direct performance enhancement (e.g. mental skills), whereas the other promotes a more holistic approach whereby the wider well-being of the athlete is most critical and not divorced from sport performance (Roberts *et al.*, 2016). Of course, manifold practitioner philosophies exist between these two positions and where a sport psychologist stands will impact if and how they choose to deal with an athlete eating disorder case. Further, the professional path to a career in sport psychology will also shape practitioners' approach to dealing with eating

disorders in sport. Current UK professional routes to applied sport psychology do not include clinical education or training. Therefore, under professional guidelines, sport psychology practitioners cannot address, say, anorexia nervosa, as it falls outside of their boundaries of competence. To go against this would represent unethical practice and a breach of professional standards. This is scary stuff for the practitioner and it is unsurprising that many are quick to play the referral card when it comes to athlete eating disorders. In the following sections, we offer a counter perspective to popular thinking about dealing with eating disorders in sport.

"It's a clinical issue, I'm not qualified for that..."

But is it a clinical issue? The literature suggests most cases of athlete eating disorders are subclinical. Athletes often display disordered eating attitudes and behaviours and some pretty unhealthy weight concerns but full blown bulimia nervosa is relatively rare; anorexia nervosa is rarer still. This isn't to say that subclinical disordered eating behaviours represent easy-fixes, but the prospect of practitioners consulting with athletes with *clinical* life-threatening eating disorders is rare.

What does clinical mean anyway? It's essentially an arbitrary set of diagnostic symptom criteria that is open to scrutiny and interpretation. A narrow focus on "clinical" eating disorders carries the danger of assuming subclinical disordered eating is less problematic and less deserved of support. This may often be the case but it is not always the case. Clinical criteria should guide ethical decision-making but it should not rule it. The sport psychologist must judge each individual on a case-by-case basis and make a vigilant assessment of their own competencies and the demands of the psychological issues before them (clinical or otherwise).

In our interviews with applied sport psychologists, these practitioners often described an initial lack of confidence in their own competencies in providing appropriate support to athletes with disordered eating. One participant stated:

"I didn't feel confident in my ability to treat the disordered eating *per se*, but the athlete and coach approached me to provide some support as they didn't quite meet the requirement for clinical support. I was sceptical at first, but some of the things the athlete needed support with were similar to other issues I've consulted with athletes on, like performance anxiety or relationship difficulties." (Sport Psychologist, 4 years' consultancy experience)

Here, a non-clinical diagnosis rendered this sport psychologist's athlete ineligible for clinical referral. The sport psychologist

had to confront their competency doubts and provide the only psychological support the athlete would receive. The consultant came to realise that they were equipped to deal with issues frequently related to disordered eating (such as relationship difficulties).

If applied sport psychologists narrow their services to performance-related issues they risk reducing themselves to mental skills gurus and this undermines the profession. Anyone with a weathered copy of Weinberg and Gould can set a decent goal. Five minutes online and you can locate a half-decent pre-match imagery script. This cannot be all we do. You didn't study for a decade to pin up posters of motivational quotes to the 1st team changing room wall. Facetiousness aside, sport psychology practitioners must be able and willing to offer more than the bread and butter.

“Ok, but I wouldn't know where to start...”

Learn. If you're regularly working in a sport considered high-risk for disordered eating (triathlon or gymnastics for example) then you should be prepared. Child psychologists have a decent run on ADHD and other conditions that typically cause difficulties in young people, so why should we expect any less from sport psychologists? Educate yourself on disordered eating; the early signs, the symptoms, the risk factors...there are plenty of resources out there. The knowledgeable sport psychologist has a key role in identifying eating problems and facilitating help seeking among athletes. Educate others too. It is the responsibility of the practitioner to provide support to both the athlete and the coach. In our research, we found examples of good practice in terms of sport psychologists' efforts to deliver education on disordered eating:

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“I thought educating the athlete's coaches about disordered eating, plus pitching the athlete's eating issues to them in a way that appealed to the coaches' performance-driven philosophy may have encouraged them to take this issue more seriously. You know, if they saw it was detrimental to performance, they might see that it wasn't acceptable to ignore the issue anymore.” (Sport Psychologist, 5 years' experience)

Encouraging open conversations about eating behaviours and mental health more broadly is a proactive action that all sport psychologists can implement. In this particular example, the sport psychologist uses their awareness of the performance-oriented sporting culture as a strategy to bring attention to a disordered eating issue.

“Right, I'll learn more, but my athlete is self-starving now...” (refer, but stay involved, sport performance knowledge is important)

If you're worried about an athlete who is engaging in dangerous eating behaviour, draw upon your professional network and make an appropriate referral. This is absolutely the right thing to do. But to refer is not to retreat; you're not done yet and you should remain an integral cog in the treatment process. Your athlete is likely to have a more mature relationship with you than their clinical psychologist and so they may still see you as their primary contact for psychological issues. Further, the research suggests that athletes often resent clinical psychologists' lack of insight into sporting demands and the underappreciation of their athletic identity (see Sherman & Thompson, 2001). Sport psychologists can be an important source of insight into the world of sport as part of a team-based approach to treatment. Willingness to collaborate with a clinical specialist may offer the athlete psychological support that

is clinically informed yet athlete sensitive. So although it is ethical to ask what clinical psychology can do for you, also ask what you can do for clinical psychology.

Conclusion

Sport psychologists should continue to refer athletes with clinically severe eating disorders but this does not mean they have no role to play in supporting such athletes. Eating disorders negatively impact general psychosocial well-being and sport psychologists *can* support athletes in this regard. Further, a sport psychologist's unique appreciation of the cultural demands associated with competitive sport is an invaluable commodity and one that clinical psychologists may not always possess. Sport psychologists often “get it” when it comes to disordered eating in sport and athletes think this is important. Finally, as the majority of athletes' disordered eating experiences are actually subclinical, referring too quickly may inadvertently delay or cut-off an important source of psychological support. Overriding all this, sport psychologists have a duty to engage in the necessary professional development to ensure that they are sufficiently competent on issues related to eating disorders. Where sport psychologists are working in eating disorder high-risk sports, this duty becomes an imperative. ■



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