Specialty Treatment for Athletes with Eating Disorders

Now that we have the rationale, what can we achieve?

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Today’s Agenda

- Characterize the unique risk factors for eating disorders in sport
- Identify best practices for treating eating disorders in sport
- Describe characteristics of athletes who present for treatment
- Demonstrate treatment outcomes of athlete-specific treatment
- Discuss the role of exercise in eating disorder treatment
Nutrition for the Athlete

- Increased nutritional needs
- Adequate hydration
- Optimal performance
- Training & recovery demands
- Support immunity
- Prevent injury
- Faster recovery
- Mental focus
Common Obstacles to Good Nutrition

- Not eating enough
- Not drinking enough
- Skipping meals
- Missing out on recovery nutrition
- Uninformed vegetarianism
- Dieting
- An obsession with the scale or with body image
- Unhealthy relationship with food
- Schedules, commitments, and demands on time
- A failure to plan...
Contributors to Eating Disorders

Environment
- Home
- Sport
- Academic
- Campus
- Work
- Society
- Trauma

Personal

Genes

Psychosocial

Culture
Why are Athletes at Risk?

Internal Factors
- Drive & commitment
- Perfectionism
- Beliefs & attitudes
- Coexisting mood disorders
- Knowledge
- Behaviors
- Transitional life stage

External Factors
- Home environment
- College environment
- Sport environment
- Training demands
- Teammates/Coaches
- Pressure to perform
- Pressure of comparison
- Sociocultural pressures
- Diets & Misinformation

Arthur-Cameselle & Quatromoni, 2011
Disordered eating among female athletes in any sport is predicted by **two main factors**: desire to enhance sport performance by losing weight, and negative emotions about missing training sessions (Krentz & Warschburger, 2011).

<table>
<thead>
<tr>
<th>Themes</th>
<th>Primary Codes</th>
<th>Athletes</th>
<th>Non-Athletes</th>
<th>Secondary Codes (disproportionately affecting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Factors</td>
<td>Low Self Worth</td>
<td>100%</td>
<td>88%</td>
<td>Poor body image similarly affected 5 of 6 women</td>
</tr>
<tr>
<td></td>
<td>Co-morbid Diagnoses</td>
<td>67%</td>
<td>76%</td>
<td>Feeling inadequate (athletes)</td>
</tr>
<tr>
<td></td>
<td>Perfectionism/Control</td>
<td>42%</td>
<td>24%</td>
<td>Anxiety (athletes)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Depression (non-athletes)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Learning disabilities (non-athletes)</td>
</tr>
<tr>
<td>Physical/ Behavioral</td>
<td>Changes in Weight</td>
<td>47%</td>
<td>71%</td>
<td>Dieting practices similarly affected 2 in 5 women</td>
</tr>
<tr>
<td>Factors</td>
<td>Rigid Eating/Dieting</td>
<td>41%</td>
<td>41%</td>
<td>Rapid weight changes (athletes)</td>
</tr>
<tr>
<td></td>
<td>Injury/Ilness</td>
<td>33%</td>
<td>0%</td>
<td>Puberty body changes (non-athletes)</td>
</tr>
<tr>
<td>Relationship Factors</td>
<td>Peer Issues</td>
<td>75%</td>
<td>94%</td>
<td>Peers role modeling EDs (athletes)</td>
</tr>
<tr>
<td></td>
<td>Family Issues</td>
<td>50%</td>
<td>77%</td>
<td>Others controlling food intake (athletes)</td>
</tr>
<tr>
<td></td>
<td>Other Relationships</td>
<td>33%</td>
<td>6%</td>
<td>Bullying/Fitting in (non-athletes)</td>
</tr>
<tr>
<td>Environmental Factors</td>
<td>Sport Environment</td>
<td>67%</td>
<td>18%</td>
<td>Performance pressures (athletes)</td>
</tr>
<tr>
<td></td>
<td>Cultural Thin Ideal</td>
<td>17%</td>
<td>18%</td>
<td>Team weigh-ins (athletes)</td>
</tr>
</tbody>
</table>
The Realities...

• Pressures are exceedingly high
• Nutrition knowledge is low
• Misinformation is abundant and targeted
• Access to nutrition professionals is limited
• Knowledge does not translate to healthy behaviors
• Unhealthy behaviors are contagious
Warning Signs

- Eating too little, exercising too hard, overtraining or compulsive exercise
- Increased focus on weight or body shape, size, image
- Underweight, rapid or recent weight loss
- Dieting, binge/purge or binge/diet cycling
- Stress fractures or recurrent overuse injuries
- Extremist thinking, rigid behaviors, highly self-critical
- Dissatisfied with performance
- Supplements valued, food distrusted
- Overly restrictive diets, veganism, extreme clean eating, orthorexia
- Difficulty coping with stress... sports, academics, family, coach, peers, bullying
Relative Energy Deficiency in Sport

RED-S
A clinical syndrome that also affects males

RELATIVE ENERGY DEFICIENCY IN SPORT

EFFECT ON ATHLETE HEALTH
- Immunological
- Gastrointestinal
- Menstrual function
- Bone health
- Endocrine
- Metabolic
- Haematological
- Psychological
- Growth & development

EFFECT ON ATHLETE PERFORMANCE
- Decreased endurance performance
- Decreased muscle strength
- Decreased glycogen stores
- Depression
- Irritability
- Decreased concentration
- Increased injury risk
- Decreased training response
- Impaired judgement
- Decreased coordination

Source: http://health4performance.co.uk/
• Low awareness that behaviors are a “problem”
• Culture of sport accepts, endorses, praises and sometimes demands disordered behavior
• So secretive, you think you’re the only one, or that you’re “broken”
• Poor understanding of what an eating disorder is or who is affected
• Stereotypes – “Athletes don’t get eating disorders”
• Stigma – “It’s a woman’s disease”
• Perception problem – “I’m not THAT sick!”
• Fears tied to identity, masculinity, playing time, scholarships, or sport being taken away
• Limited/No access to counselors or RDs inside athletics – Who to turn to? Who to trust?
• Do traditional eating disorder treatment programs/providers understand athlete needs?
Our mission is to equip athletes with the mental and nutritional skills to achieve their full athletic potential and sustain a positive mindset.
Walden GOALS

Multidisciplinary team
3 nights/wk IOP
Adult competitive athletes
Group & Individual sessions
Shared dinner meal
Therapeutic food exposure

Information and Referrals
Emily Slager, 781-899-2460 ext. 4022
ESlager@WaldenBehavioralCare.com
GOALS Five Pillars of Strength

- Fueling for Sport & Life
- Eating Competence
- Body Esteem
- Recovery Skills
- Resiliency
Risk Assessment Tools

- Eating Disorder Examination Questionnaire (EDE-Q)
- Female Athlete Screening Tool
- Eating Competence
- RED-S Clinical Assessment Tool (RED-S CAT)  
  *Mountjoy, Br J Sports Med 2015*
Queries ED symptoms in past 28 days

- Overall score
- Four subscales
  - Restraint
  - Eating concerns
  - Shape concerns
  - Weight concerns

Maximum Score for each = 6
Female Athlete Screening Tool

- Weight/Body Image Satisfaction
- Attitudes, Beliefs, Thoughts, Worries, Guilt
- Self-worth, Perfection
- Food & Alcohol Behaviors
- Dieting Practices
- Training & Performance Habits
- Injury

McNulty et al, JADA 2001;101:886
Female Athlete Screening Tool

Healthy Score < 77
Subclinical Score 77-94
Clinical Eating Disorder > 94

Minimum Score = 33
Maximum Score = 130

McNulty et al, JADA 2001;101:886
ecSatter Eating Competence Tool

ecSI 2.0

Below are statements about your eating. Think about each one, then choose the best response for you.

A = Always   O = Often   S = Sometimes   R = Rarely   N = Never

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>O</th>
<th>S</th>
<th>R</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am relaxed about eating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I am comfortable about eating enough.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I have regular meals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. I feel it is okay to eat food that I like.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16 items
Maximum Score 48
Eating Competent ≥ 32

Available at: ellynsatterinstitute.org

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Eating Competent Athletes

- Feel good about eating
- Are reliable about feeding themselves
- Choose foods that give them pleasure
- Eat as much as they are hungry for
- Will not overeat in the presence of big servings
- Will eat it all if they want to; will not if they don’t
- Will allow “forbidden foods” at meals and snacks, making them ordinary foods that they can eat in ordinary ways

Adapted from: ellynsatterinstitute.org
## Patient Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean ± SD or Percentage</th>
<th>Sport</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yrs)</td>
<td>20.9 ± 5.2</td>
<td>X-C/Track</td>
<td>40% (6)</td>
</tr>
<tr>
<td>Age range (yrs)</td>
<td>17 – 35</td>
<td>Ball Sports(^2)</td>
<td>27% (4)</td>
</tr>
<tr>
<td>Sex (% female)</td>
<td>100%</td>
<td>Ice Hockey</td>
<td>13% (2)</td>
</tr>
<tr>
<td>Diagnosis(^1)</td>
<td>5 AN, 1 BN, 9 OSFED</td>
<td>Bodybuilding</td>
<td>13% (2)</td>
</tr>
<tr>
<td>Length of stay (d)</td>
<td>25 ± 11 (8 weeks)</td>
<td>Triathlon</td>
<td>7% (1)</td>
</tr>
</tbody>
</table>

\(^1\)AN, anorexia nervosa; BN, bulimia nervosa; OSFED, other specified feeding/eating disorder

\(^2\)Tennis (2), Basketball (1), Lacrosse (1)
## Treatment Outcomes

15 patients, 19 admissions

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Max. Score</th>
<th>On Admission to GOALS</th>
<th>On Discharge from GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean ± SD</td>
<td>Range</td>
</tr>
<tr>
<td>Weight (lbs)</td>
<td>-</td>
<td>128 ± 13</td>
<td>98 - 153</td>
</tr>
<tr>
<td>Body Mass Index (BMI)²</td>
<td>-</td>
<td>21.4 ± 2.6</td>
<td>16.3 – 27.8</td>
</tr>
<tr>
<td>Percent Ideal Body Wt. (%)</td>
<td>-</td>
<td>98 ± 8</td>
<td>78 - 109</td>
</tr>
<tr>
<td><strong>Eating Competence³</strong></td>
<td>48</td>
<td>17.8 ± 11.5</td>
<td>5 – 45</td>
</tr>
<tr>
<td>Eating Attitudes</td>
<td>15</td>
<td>4.5 ± 3.7</td>
<td>0 – 12</td>
</tr>
<tr>
<td>Food Acceptance</td>
<td>9</td>
<td>2.1 ± 2.5</td>
<td>0 – 9</td>
</tr>
<tr>
<td>Food Regulation</td>
<td>9</td>
<td>3.4 ± 2.8</td>
<td>0 – 9</td>
</tr>
<tr>
<td>Contextual Skills</td>
<td>15</td>
<td>7.9 ± 4.5</td>
<td>1 – 15</td>
</tr>
<tr>
<td><strong>Athlete Behavioral Risk⁴</strong></td>
<td>130</td>
<td>86.8 ± 14.6</td>
<td>59 – 111</td>
</tr>
</tbody>
</table>
On discharge, one-third of all patients achieved eating competence.

Clinical ED behaviors were largely extinguished; 2/3 of clients scored in the healthy range on the discharge behavioral assessment while weight remained relatively stable through treatment.
ED symptoms improved

<table>
<thead>
<tr>
<th>Eating Disorder Examination Questionnaire (EDE-Q)</th>
<th>On Admission to GOALS</th>
<th>On Discharge from GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDE-Q Total Score</td>
<td>2.72 ± 1.34</td>
<td>1.90 ± 1.37</td>
</tr>
<tr>
<td>Restraint score</td>
<td>2.34 ± 1.96</td>
<td>1.51 ± 1.54</td>
</tr>
<tr>
<td>Eating Concern score</td>
<td>2.46 ± 1.34</td>
<td>1.48 ± 1.37</td>
</tr>
<tr>
<td>Shape Concern score</td>
<td>3.37 ± 1.68</td>
<td>2.63 ± 1.55</td>
</tr>
<tr>
<td>Weight Concern score</td>
<td>2.72 ± 1.44</td>
<td>1.94 ± 1.41</td>
</tr>
</tbody>
</table>

- Shape and weight concerns dominated the EDE-Q scores at baseline
- The GOALS program developed recovery skills and resulted in positive shifts in all outcome measures including EDE-Q scores and sub-scores
Goals & Accomplishments

- Mental health/mindset
- Food/feeding behavior
- Body image
- Sport
- Physical health
- Confidence
- Self-worth
- School
- Social

Recovery-focused

“What I hope to gain”

Symptoms-focused

“What I hope to fix”

Treatment-related
Practice Implications

• Athlete-specific treatment had positive, measurable effects of increased eating competence and reduced ED behaviors

• The common OSFED presentation makes identification, diagnosis and referral for treatment challenging

• Access to expert ED treatment providers who intimately understand sport drew clients into treatment

• Research that evaluates the impact of interventions on clinical, behavioral, psychosocial and sport performance outcomes will inform best practices
Introduction

• Umass Amherst BS. - Kinesiology
• Columbia University MS. - Applied Exercise Physiology and Nutrition
• Brigham and Women’s Hospital - Dietetic Training
• Certified Strength and Conditioning Specialist
• Lifelong Competitive Athlete
• Lead Dietitian and Exercise Science Advisor - Walden GOALS Program
• Walden Behavioral Care’s Sport Nutrition and Exercise Science Specialist

www.waldeneatingdisorders.com
The Neglected “Cinderella” of ED treatment?

Is the neglect of exercise in anorexia nervosa research a case of “running out” of ideas or do we need to take a “LEAP” of faith into the future?

Stephen Touyz, Phillipa Hay, and Melissa Nemer

Running on empty – a nationwide large-scale examination of compulsive exercise in eating disorders

Elin Morel, Johanna Levallius, Emma Forsen Maretta, and Andreas Birgisdóttir

Relationships between compulsive exercise, quality of life, psychological distress and motivation to change in adults with anorexia nervosa

Sarah Young, Stephen Touyz, Caroline Meyer, Jan Anckars, Paul Rhodes, Jane Madden, Kathleen Peile, Evelyn Nilo, Rosa C. Goolby, and Phillipa Hay

How to integrate physical activity and exercise approaches into inpatient treatment for eating disorders: fifteen years of clinical experience and research

Mark Dittman, Gryllynd Re, and Sigrid Bjelland
Past Paradigm

- ED treatment programs lacked appropriate tools to identify and treat problematic physical activity
- Past available diagnostic criteria were ill-defined
- Physical activity was frequently misunderstood
- Problematic physical activity considered a threat to treatment goals and stability
- Behavior was often conceptualized as a tool for the eating disorder
- The GOALS program treats athletes, but is limited to competitive athletes and the IOP level of care
- Safest risk management approach involved imposing activity restriction during treatment
Problems with Exercise Restriction

- Exercise restriction can temporarily decrease overall immediate risk factors, but generates new problems.
- How does the patient understand the appropriate use of exercise for health benefits while recognizing when exercise is becoming a problem?
- How does one develop healthy attitudes and exercise behaviors?
- How does one develop body awareness and best understand various physiological states, injury, and pain?
- How does one develop an enjoyment of exercise and exercise for fun as opposed to a tool for maintaining an eating disorder?
- How does one understand their exercise identity and identify factors related to overtraining and burnout?
- Research indicates lack of physical activity increases morbidity and mortality.

Failure to address these issues during treatment can increase dissatisfaction and risk of relapse after discharge.
Benefits of Exercise in Treatment

Patients can experience a wide range of benefits including but not limited to:

• Decreased obligatory exercise attitudes and behaviors
• Reduced drive for thinness and bulimic symptoms
• Decreased body dissatisfaction
• Increased weight gain in individuals with anorexia nervosa
• Increased strength, endurance, and overall fitness
• Increased function for activities of daily living and decreased risk of injury
• Reversed cardiac abnormalities in individuals with severe anorexia
• Possible Postural Orthostatic Tachycardia Syndrome (POTS) prevention
• Better modulate nervous system, hormonal system and heart rate for decreased morbidity and mortality
• Maintain muscle mass for ADLs and improved overall quality of life


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Problematic Physical Activity

- Problematic Physical Activity is a Behavioral Addiction
- Behavioral addiction is a compulsion to continually engage in behaviors despite the negative impact on one's healthy or daily life.
- Inappropriate physical activity can negatively affect both an individual’s physiology and psychology
- Higher doses of exercise can mimic substance use addiction (Salience, conflict, euphoria, tolerance, withdrawal, relapse)
- Exercise activates the dopaminergic, endocannabinoid, catecholamine and thermoregulatory systems and can result in euphoria, reward, mood improvements and decreased somatic anxiety
- Mindset and relationship to activity determines how it is expressed
- Various mindsets and relationships are prone to behavioral addiction
- Dose, context, and relationship determines benefits and costs
- Problematic Physical Activity Tool helps Walden identify consults

PHASES OF EXERCISE ADDICTION

1. **Phase 1: Recreational Exercise**
   - Motivation for exercise is enjoyment & or fitness improvement; no negative outcomes or consequences.

2. **Phase 2: At Risk Exercise**
   - Reliance on the mood altering effects of exercise. Negative outcomes such as repetitive use injuries are possible.

3. **Phase 3: Problematic Exercise**
   - Life is rigidly scheduled around exercise. Motivation is a desire to escape withdrawal symptoms. Social & physical negative outcomes.

4. **Phase 4: Exercise Addiction**
   - Life revolves around exercise. Frequency, volume & intensity increases to achieve the same degree of satisfaction. Training goes on in spite of injuries & there is little control over being able to stop. Clinical depression may occur.


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Physical Roadmap to Recovery
Hormesis = Response varies based on dose

- **Exercise** = Stress
- **Insufficient Stress** = No response, possible detraining
- **Appropriate Stress** = Good stress, **Positive** adaptation.
- **Excess Stress** = Harmful stress, **Negative** adaptation.

Outcome is Dose Dependent, Context Specific. Simulate don’t Annihilate!

• Acute stress is the key to the sweet spot
• Chronic stress lowers threshold to harmful dose
• Major Factors that can increase chronic stress
  Internal:
  • Inadequate nutrition
  • Disease and injury
  • Poor sleep
  • Psychological stress (perception is reality)
  • Undesired repetition (boredom)
  • Psychiatric disorders
  • Trauma and loss
  • Substance use
  • Perceived isolation and lack of human connection
  • Physical activity beyond capacity to recover
  External:
  • Environmental stressors
  • Poor support systems
Dose Determines Response

Overtraining, Stealing Our Gains

(Exceptionally High Volume)

Increased Life Stressors Decrease the Training Stress You Can Handle and Your Potential for Progress

Grading:
- Max Recovery
- Impaired Recovery
- Significantly Impaired Recovery (Eating Disorder)

Economics is the allocation of scarce resources

Key Point: A calorie deficit is a recovery deficit!


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Safety

Research and experience indicate these programs are safe as long as:

- Nutritional needs are met
- The team is multidisciplinary
- The team employs a thoughtful evidence-based approach

Exercise in Eating Disorders Treatment: Systematic Review and Proposal of Guidelines

Brian J. Cork, Stephen A. Wonderlich, James E. Mitchell, Jon Thompson, Roberta Shipherd, and Emerald Englund

California State University, Fullerton, CA; Arizona State University, Tempe, AZ; University of Maryland School of Medicine and Health Sciences, Baltimore, MD; University of Arizona, Tucson, AZ; Tufts University, Medford, MA; Stony Brook University, Stony Brook, NY; Washington University, St. Louis, MO

ABSTRACT

Cork and colleagues propose a systematic review of evidence-based exercise interventions for eating disorders. Their research objectives are to identify effective and safe exercise interventions for eating disorders and to propose a guidelines for their implementation. The research team conducted a systematic review of the literature and synthesized the findings to develop a comprehensive set of guidelines for the use of exercise as an ancillary treatment for eating disorders. The guidelines are based on a comprehensive review of the literature, including randomized controlled trials, observational studies, and expert consensus. The guidelines include recommendations for exercise frequency, intensity, and duration, as well as considerations for moderate exercise, intensity, and duration. The guidelines are intended to be used by healthcare professionals to improve the treatment outcomes for individuals with eating disorders. The guidelines are available online at www.waldeneatingdisorders.com.
The Recipe is the First Step

- A recipe alone is not enough
- Same recipe can differ greatly in outcome
- Major factors that can influence outcomes include:
  - Mindset
  - Skill
  - Experience
  - Environment
  - Access to trusted experts
Understanding Mindset

The difference between passion and addiction is that between a divine spark and a flame that incinerates.

- Gabor Mate, Physician and Addiction Expert

- Behavior can serve positive adaptive function
- Appropriate physical activity improves quality of life
- Behavior can also function as a Maladaptive Coping Skill
- Ritualized compulsive comfort-seeking
- Dose and context determines risk/reward
- Collaborative harm reduction approach is key
Compulsive Exercise

• Compulsive Exercise Test (CET) is a test designed to assess the psychopathology of compulsive exercise

• 24 Questions and 5 domains
  1. Avoidance and rule-driven behavior
  2. Weight control exercise
  3. Mood improvement
  4. Lack of exercise enjoyment
  5. Exercise rigidity

2019 Athlete’s relationship with training scale (ART) is one of the first self-report tools that was developed in a sample of athletes to identify unhealthy training.

The ART may be used to:

(A) Screen athletes for EDs/disordered eating within a sport context by sport medicine staff or sport psychologists

(B) Monitor how unhealthy training behaviors and beliefs change over the course of ED treatment

(C) Research unhealthy training behaviors and beliefs in athletes.
Psychological Roadmap to Recovery
Applying Harm Reduction

1. First, do no harm
2. Reaffirm addiction is a biopsychosocial phenomenon
3. Apply lens that addiction is initially adaptive (maladaptive coping skill)
4. Reaffirm there is no inevitable progression from use to dependence
5. Reaffirm the right to sensitive treatment
6. Collaborate to develop a needs hierarchy
7. Reaffirm that active behavior users can and do participate in treatment
8. Success is related to self-efficacy
9. Understand behavior, set and setting: the client’s unique relationship with each behavior used
10. Any reduction in addiction-related harm is a step in the right direction
Regression and Progression

Physical Activity

Nutrition

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### Behavioral Experiment Record Sheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Target Thought(s)</th>
<th>Experiment</th>
<th>Prediction(s)</th>
<th>Outcome</th>
<th>What I Learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/23</td>
<td>What thought, assumption or belief are you testing?</td>
<td>Design an experiment to test the belief (e.g. fabric a situation you would feel anxious, dropping a precaution, behaving in a new way)</td>
<td>What do you predict will happen?</td>
<td>What actually happened?</td>
<td>Describe what you learned from the experiment</td>
</tr>
<tr>
<td></td>
<td>Can I go to the gym just to engage socially with friends?</td>
<td>Go early to the gym. Holiday workout to socialize with friends before they partake in the workout.</td>
<td>I will feel awkward and be calling more attention to myself by not participating in the workout.</td>
<td>I will be jealous of my friends because they can participate.</td>
<td>He easier to be social when I was more excited to see them. I hoped they had an amazing workout. Does it feel as awkward as I expected? I attempted to appear confident but I was a bit disappointed. My friends weren't more excited to see me. Was I more jealous of my friends? But worked to change that mindset into excitement for them. To instruct the mindset further, I texted my friends afterwards to let them know I was happy to see them. I hoped they had an amazing workout. I didn't feel as awkward as I usually do in the gym. I took a picture of the workout in hopes that I can do it when I am able to return to the gym.</td>
</tr>
</tbody>
</table>
|       |                   |            |               |         | Compassion towards others. Put myself in their shoes to understand how I should act in response to their feelings. I have in the present moment. My declining body image is impacting my confidence.
Decisional Balance For Athletes

**Learning Objective:** Understand and apply a skill used to resolve ambivalence for a nutrition quality you desire to change.

What is a dietary behavior or quality you want to change that can help you better fuel for your sport or improve your relationship with food?

Using the chart below, fill in the costs and benefits of changing and not changing this current behavior or quality:

<table>
<thead>
<tr>
<th>Change: Reach 100% IBW</th>
<th>Stay the Same: Stay at current BW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefits (good)</strong></td>
<td><strong>Cost (not so good)</strong></td>
</tr>
<tr>
<td>Body will return to homeostasis (get out of survival mode)</td>
<td>Physical discomfort carrying extra weight</td>
</tr>
<tr>
<td>Physical body functions will return (menstrual cycle)</td>
<td>Clothes don’t fit as I want them to</td>
</tr>
<tr>
<td>Hormones will be regulated</td>
<td>Fuller face</td>
</tr>
<tr>
<td>Health longevity</td>
<td>No muscle definition</td>
</tr>
<tr>
<td>Increased, sustainable energy</td>
<td>&quot;Normal body type&quot;. Nothing special about appearance</td>
</tr>
<tr>
<td>Stable, increased resting HR</td>
<td>Forcing myself to eat 100% of meal plan</td>
</tr>
<tr>
<td>Don’t look sick; look more &quot;alive&quot; especially in color and face</td>
<td>Heightened desire to loose extra BF</td>
</tr>
<tr>
<td>More content with physical appearance</td>
<td>If I return to a low BF, not sustainable</td>
</tr>
<tr>
<td>~95% of IDW and at a &quot;Normal&quot; BMI</td>
<td>Bone density more at risk</td>
</tr>
<tr>
<td>More intuitive eating to maintain current BW that doesn’t feel forced</td>
<td>Fertility more at risk</td>
</tr>
<tr>
<td>Healthier and more stable (vs being in ED)</td>
<td></td>
</tr>
<tr>
<td>Increased energy</td>
<td></td>
</tr>
</tbody>
</table>

**On a scale of 1-10, how ready are you to make this change?**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unready</td>
<td>X</td>
<td>Somewhat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ready</td>
</tr>
</tbody>
</table>

**Why did you pick that rating?**

I want to maintain my current BW. While the benefits of 100% IBW are convincing, I feel as though I will eventually reap most of those benefits at my current BW in time. I don’t want to gain any more weight or deal with the “costs” that will arise from them. I don’t understand why you need to accept something that you are not happy with, especially if it is something you have control of and can change. I’m not placing all my eggs into this one basket as my one source of happiness; I just feel as though being happy in this area will supplement my life even more. I want it all and believe that I can have it all, especially if it is within my control.

**On a scale of 1-10, how confident are you that you can make this change?**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not</td>
<td>X</td>
<td>Somewhat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Confident</td>
</tr>
</tbody>
</table>

**Why did you pick that rating?**

Same reasoning as above. If I wanted to make the change, I would be confident in my ability to make the change, but I do not want to make the change.

**What or who can help you become more ready to achieve this behavior change?**

- I would consider making the change if I had the ability, support and resources to go back to my current BW if I reach 100% and decide I don’t want the extra weight. I would be more willing to make the change if I had a healthy plan in place for returning to my current BW.
- I would be more willing to make the change if I was able to return to the gym to complete more adequate workouts with the goal of turning the extra fat into muscle.
- A million dollars (just kidding LOL)

**What or who can help you become more confident in your ability to achieve this behavior change?**

- I know I could do it if I wanted to, but I don’t want to.


