

Guidelines for Professional Dance Companies on Healthy Nutrition
From the Dance/USA Taskforce on Dancer Health

(Updated February 2011)

Dance/USA Taskforce on Dancer Health

February 16, 2011

Please find enclosed the *Guidelines for Professional Dance Companies on Healthy Nutrition*. They were developed by the Dance/USA Taskforce on Dancer Health at the request of Dance/USA's Council of Managers in response to the rising incidence of poor nutrition among dancers and young athletes in general.

Please know that the *Guidelines* are not meant to be a nutritional manual with specifics on proteins, carbohydrates and calories. Rather they are a series of recommendations that encourage dance companies to institute a **program** with 3 main goals: the education of both dancers and staff on healthy nutrition; the prevention of nutritional problems before they arise; and the recognition and management of fully developed nutritional disorders. Each area is approached from the unique perspective of a professional dance company. As with all good tools, the *Guidelines* should be a living document that can be revised, expanded and hopefully made better as companies provide us with information on their usefulness.

Like the preventive *Healthcare Screen* developed by the Taskforce on Dancer Health, the *Guidelines* are the product of on-going cooperation between the health care professionals who take care of dance companies. Under the auspices of Dance/USA, the Taskforce is committed to good health for people who dance for a living. This cooperative effort is an historic opportunity to share expertise, to combine data, and to advance our knowledge of the art form of dance while working closely with the dancers, the dancers' union, and company management.

Thank you and best wishes,

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1. Introduction

Good nutrition is only one aspect of a healthy lifestyle for the professional dancer. While several areas of healthy living among advanced dancers merit attention, nutrition is of special concern because of the growing prevalence of unhealthy eating behaviors (*disordered eating*) among athletes and dancers, especially among young women.(1,2) Some studies reveal that up to 70% of female athletes suffer from *disordered eating*.(2) When aberrant eating behaviors are taken to the extreme, life-threatening *eating disorders* such as anorexia nervosa, bulimia nervosa and binge eating disorder can develop.

Professional dance is one of several athletic endeavors in which a relatively thin body habitus is a requirement of the endeavor. Other examples are gymnastics, figure skating, competitive running, horseback riding, crew and male wrestling. For dancers, the need to be relatively thin is driven by the fact that dance is unchangeably a *visual art form*. The concept of line, definition of the limbs in space, and bodies light enough to be lifted overhead are of paramount importance. Some degree of relative thinness is a necessary part of life for the professional dancer, especially females in ballet companies. Of great concern, however, is the danger of dancers becoming too thin and of resorting to aberrant eating behavior to maintain their desired weight. When the keen competition in professional ballet is combined with the unfortunate bias in our culture for women to be super thin, the pressure on young women in dance is especially burdensome.

The following are **Guidelines for Professional Dance Companies on Healthy Nutrition**.

They are suggestions for companies to take *preventive measures* to help stem the rising incidence of disordered eating and eating disorders. The suggestions focus on three basic interventions: 1) Providing education on healthy nutrition to dancers and staff; 2) Identifying and helping those dancers at high risk for nutritional and other health problems; 3) Introducing companies to the current medical standard for identifying and treating fully developed eating disorders. These three concepts are presented in the following sections:

1. Introduction
2. What is a “Reasonable Weight” for the Professional Dancer?
3. Educating Dancers on Healthy Nutrition
4. Educating Company Staff on Healthy Nutrition
5. Providing Alternatives to Rigid Dieting (*Aerobic Exercise*)
6. Recognizing Dancers at High Risk for Nutritional Problems (*Early Season Screening*)

7. Diagnosing Eating Disorders
8. Treatment of Eating Disorders
9. References

Addenda that may be helpful in reading the *Guidelines* include:

1. Diagnostic Criteria for Anorexia Nervosa
2. Diagnostic Criteria for Bulimia Nervosa
3. Met Life Tables of Weight for Height for Women
4. Met Life Tables of Weight for Height for Men
5. CDC Growth Chart for Girls
6. CDC Growth Chart for Boys
7. Suggested Healthcare Screening for Professional Companies*

The *Guidelines* were developed by health care professionals from leading companies brought together by Dance/USA, the national service organization for professional dance. Taskforce members included company physicians, physical therapists, trainers, nutritionists, and dance medicine specialists. Among the companies represented were Alvin Ailey, Ballet Austin, Boston Ballet, Houston Ballet, National Ballet of Canada, New York City Ballet, Paul Taylor Company, Pacific Northwest Ballet, Pittsburgh Ballet Theatre, San Francisco Ballet, and Ballet San Jose. The Taskforce is especially grateful to Dr. Lynn Ponton for sharing her expertise in the areas of eating disorders and risk taking behavior. Dr. Ponton is a Professor of Adolescent Psychiatry at the University of California at San Francisco,

Please note that the *Guidelines* are specifically aimed at professional companies because they are the visible leaders in the field of dance, and because the Dance/USA Council of Managers requested guidance on nutrition. We firmly believe, however, that good nutrition and a healthy lifestyle should be emphasized at the earliest levels of dance training. We must also emphasize that the weight and body composition standards discussed in the *Guidelines* are for *professional dancers and advanced students* ready to enter the professional ranks. Young students who are still growing must follow current recommendations for all children from the pediatric and medical communities.

* In 2005, the Dance/USA Taskforce on Dancer Health developed an early season, post-hire preventive Healthcare Screen for use by professional companies. There are now over 30 companies across the United States and Canada using the screen, sharing expertise, and combining de-identified data where appropriate. Information on the Taskforce and the Healthcare Screen can be obtained at <http://taskforceondancerhealth.com>.

2. WHAT IS A “REASONABLE WEIGHT” FOR THE PROFESSIONAL DANCER?

This is one of the most difficult issues in any discussion of dancer health. The need to be relatively thin in professional dance, especially ballet, is not a notion that can be arbitrarily dismissed. Dance is a visual art form and relative thinness is a functional requirement of artistic directors and choreographers. In no way, however, should we encourage the ultra-thin look that has become fashionable in recent decades. In the interest of dancer health, ultra-thinness should be discouraged while an effort is made to help dancers achieve a reasonable dance physique while maintaining good health. This unavoidably raises the question of how thin can a dancer be and remain healthy? And how do we measure this? The following discussion will emphasize that defining exact numbers for weight and body fat is not the best policy. A dancer’s state of nutritional health is best understood through a comprehensive approach using a variety of measurements.

Until recent times, weight (adjusted for gender, age and skeletal type) has been the measurement most well defined by the medical community in relation to morbidity and mortality. The Metropolitan Life Tables of Weight continue to be accepted by the medical and legal communities as reflecting optimal health for adults. (**Addenda 3 & 4**) For growing children and adolescents, recommended ranges of weight are found on growth curves. (**Addenda 5 & 6**)* Recently, body mass index (BMI), which is derived from height and weight, has become a standard parameter when considering physical growth in humans. The following discussion, however, will refer to weight (in relation to height, gender and age) because it is the parameter that dancers themselves will follow at home. In addition, weight loss and fear of weight gain are among the factors considered in the current psychiatric definition of eating disorders.

Unfortunately, we have very little data to guide us on the question of what dancers can safely weigh. One 1988 survey showed that a number of otherwise healthy ballerinas in America’s four top ballet companies weighed an average of 14 percent less than the minimum weight recommended by medical experts for the general population. (8) It should be noted that since this survey, medical science has *lowered* the range of optimal healthy weights for all adults, so the 1988 survey would now place the same dancers at roughly 7 % less than the optimal ranges currently recommended for all people. Although a number of studies exist on dancers in colleges and schools, the data is likely to be misleading since professional ballet dancers are expected to be working in companies by their late teens. Ballet students who go directly into companies after their training years are very likely to have a different mind-set and different body type than students who select university dance programs. We simply do not have weight data on professional ballet dancers. (Although the Taskforce on Dancer Health is currently assembling the first large amounts of de-identified data on professional dancers.)

One must be cautious, however, in considering single factors such as weight in regard to overall health. In assessing the nutritional status of a dancer, a variety of factors can be considered.(1,6) We now know that body composition, certain metabolic functions and even lifestyle issues are also key considerations in any discussion of nutrition and good health.

Recommendations:

Among the recommendations in the pages that follow is the use of screening and assessing the nutritional health of dancers. To accomplish this, we encourage a comprehensive approach in which *percentage body fat, bone mineral density, selected serum electrolytes, and a history and physical including menstrual history* are possible considerations in addition to *weight*. We recognize that the resources for such a complete assessment are not available to every company. But this should not discourage medical teams from using at least a couple of the simpler tools such as weight, skin fold thickness (reflecting percentage body fat) and patient history, to guide their dancers toward good health.

In regard to setting specific goals for weight and body composition, both the American Academy of Pediatrics and the American College of Sports Medicine discourage defining an ideal level of weight and/or body fat in endeavors such as ballet that favor a relatively thin physique. (3,9,10) Genetic variation in individuals and errors in measurement make specific numbers unreliable. It is preferable to look at dancers and athletes individually, knowing that only a variety of parameters will give a true picture of a dancer's status. For example, the female ballet dancer who weighs substantially less than the minimum on the Met Life Tables may be perfectly fine if her body fat percentage is reassuring, her energy is good, and her menstrual history is not concerning. On the other hand, if both weight and body fat are abnormally low, or she is amenorrheic (reflecting possible low bone mineral density), the medical team needs to explore the possibility of disordered eating and deal with it accordingly.

One notable exception to using specific target numbers is a case in which weight or body fat fall below a rock-bottom threshold. The diagnosis of fully developed anorexia nervosa must be thoroughly considered when weight falls 15 percent or more below the minimum expected weight for age, gender and skeletal type. Although somewhat arbitrary, this is the current medical/legal definition of the weight loss associated with diagnosing anorexia. Although this single factor does not confirm the diagnosis, it certainly warrants a complete assessment of the dancer for an eating disorders or organic illness. (**Addendum 1**)

Lastly, young students of dance should be distinguished from the professional dancer or advanced student on a professional track. In order to maintain adequate growth, caloric requirements for children and growing adolescents are higher than at any other time in life. Given that dance training itself increases the need for calories, students are at risk for compromising normal growth if they restrict caloric intake. Until body growth is completed, it is dangerous to encourage even relative thinness in the student population.

(Reasonable Weight – cont)

In summary, it is important in professional dance, especially ballet, to discourage the ultra-thin ethic. On the other hand, we must recognize the need to be relatively thin. To ignore this fact simply encourages dancers to deal with nutritional issues in secret and on their own. Defining specific targets for weight and/or body fat is not encouraged. It is preferable to assess dancers and students individually using a comprehensive approach involving several parameters. We must always keep in mind that students who are still growing constitute a different population than professional dancers.

***Note:** The *CDC Growth Curves* cover children and adolescents up to the age of 20 years, while the *MetLife Tables* cover adults from 25 to 55 years. Because young adults between the ages of 21 and 24 have normally stopped growing and are in a physiologic steady state for a short number of years, the accepted weight range for 21 to 24 year olds is the same as 20 year olds on the *CDC Growth Curves*.

3. Educating Dancers on Healthy Nutrition

The Taskforce on Dancer Health is unanimous in their recommendation that *education* is the cornerstone of good nutrition and better health. Dance, and especially ballet, is an activity that often does not burn great numbers of calories (discussed in Section 4). It is critical that dancers not turn to disordered eating behaviors such as rigid dieting or purging to maintain their dancing weight. There is clear data showing that nutritional and substance abuse education reduce the incidence of both disordered eating and substance use, especially in the setting of high performance teams.(15). In addition, educational sessions can address related topics that can contribute to a longer healthier life for dancers (e.g., smoking cessation and basic primary care strategies). The Taskforce offers the following recommendations:

1. **Provide Educational Sessions:** The beginning of every season should include several educational sessions on nutrition and other general health issues for the dancer. Optimally, 4 or 5 hours would allow several topics to be covered.
2. **Mid-season Follow Up:** A short review session in the middle of the season is important for reinforcing key points.
3. **Paid Time:** The educational sessions should be paid time for the dancers, not voluntary and not after hours. This critical point cannot be overemphasized. It is essential that the educational sessions have the same importance to both dancer and administration as any paid rehearsal.
4. **Provide Access to a Nutritional Specialist:** In addition to recommending resources in the community, having a nutritional specialist as part of the in-house team would be optimal. The close proximity encourages an on-going dialogue on issues of good health.
5. **Frequency and Suggested Topics:** To maintain the interest of the dancers and to minimize the impact on rehearsal schedules, we envision short sessions every few days, to include the following topics:
 1. Basic Nutrition
 1. Alternatives to restricting calories and rigid dieting should be emphasized.
 2. Handouts for the dancers should include:
 - 1) A list of local nutritionists
 - 2) A list of local specialists in eating disorders. (This information is readily available in most communities. Good resources are the Internet, local medical societies, and the Staff Office of local hospitals.)

(Educating Dancers - continued)

2. Self Awareness and Body Image
 1. What are appropriate self-expectations
 2. What the Artistic Staff expects
 3. The fact that “too thin” will not be tolerated should be clearly stated.

3. Aerobic Exercise
 1. What is aerobic exercise?
 2. What is the value to the dancer?
 3. Do I need cardiovascular conditioning at my age?
 4. How to fit aerobic exercise into a dancer’s schedule

4. Cooking Demonstrations and Workshops on Healthy Food Preparation
 1. A picture is worth a thousand words; also brings fun to the process

5. Smoking Cessation - Is it Possible, and How to do it.

6. How to Handle the Stress and Anxiety of Performing

7. Issues of Special Interest to the Women
 1. Should I be on birth control? Will I gain weight?
 2. Should a woman’s periods be regular?

Speakers to Conduct the Sessions: The first place to identify speakers for the educational sessions is the company medical team. Where they do not feel comfortable speaking on educational topics, excellent community resources include the local Medical Society, the Staff Office of local hospitals, the Sports Medicine Department of local universities, and private Sports Medicine practices. The Internet will also provide local resources. Experts in the community are usually happy to volunteer such a service to arts organizations, especially in return for simple gestures such as invitations to rehearsals or performances. Keep in mind that *Pro bono* lectures for educational purposes are standard in the medical field.

A key point to remember is that guests from outside the ballet are often not aware of the special needs in professional dance, especially the weight expectations in classical ballet. For guest speakers not familiar with ballet world, it is helpful if someone from the “in-house” medical team discusses such issues with them beforehand

3. Educating Company Staff on Nutritional Issues

In addition to measures that educate dancers on healthier nutrition, the company staff needs to know the scope of the problem, the importance of prevention, and how to respond when a nutritional problem is recognized. This can be accomplished with a short seminar or devoting a few minutes to nutritional policy at a regular staff meeting. The Task Force recommends addressing the following topics with company staff:

1. **The Scope of the Problem:** The prevalence of *disordered eating* among dancers is far greater than most companies have recognized. Though far less common, fully developed *eating disorders* such as anorexia nervosa or bulimia nervosa are present in most every professional ballet group. The company staff needs to know that the problem is more prevalent and more serious than previously believed. It is worthy of everyone's attention.
2. **Company expectations regarding weight:** Everyone needs to be on the same page regarding just how thin the dancers should be. Most young female dancers really do believe that "thinner is better". They think they will be rewarded for becoming excessively thin. All company staff should agree that *too thin* is not encouraged, and will not be tolerated when it happens.
3. **Who will talk to a dancer regarding weight and body issues:** Many companies are designating a single person to discuss weight issues with a dancer, whether the subject be weight gain or weight loss. This can be one of the medical team, the Artistic Director, the Ballet Mistress/Master, or someone from administration. We urge that a single person be designated for this task who has given forethought to such issues and is aware of company policy. This insures that such discussions are knowledgeable, tactful, and conform to a thought-out standard in every case. In addition, we advise that a member of the medical team be present when such discussions take place. Handouts on available nutritional counselors should be routine.
4. **What to do when a staff member has concerns over a dancer's weight or health:** It is best that the staff member not address the dancer directly, but rather bring the concern to the designated person discussed above.
5. **Language that should be avoided when referring to weight and body issues:** A dancer should never be shamed, belittled or told they are "too fat". Most people find the subject of their weight and body appearance quite personal. Discussing weight should be done with thoughtful sensitivity, and above all, respect.
6. **The diagnosis of fully developed eating disorders:** This is not something that staff needs to memorize. They simply need to know that anorexia nervosa and anorexia bulimia are true illnesses with well-defined diagnostic criteria and specific medical recommendations for treatment. (See Sections 6 and 7).

5. Providing Alternatives to Rigid Dieting

(Aerobic and Resistance Exercise)

As addressed in the Topics for Education (Section III, Subsection 5), dance in general and certainly classical ballet is often not aerobic. With the exception of an aerobic or jazz class, a traditional dance class and much of the ballet repertoire involve a “stop and start” manner of working. Dance does not have the “continuous moving” aspect of work that can burn more calories. Thus dancers are caught in a dilemma. The professional dancer is required to be relatively thinner than many athletes, yet they do not have the help of a workday that expends a high number of calories. Just as important, the usual dance workday does not provide the cardiovascular benefit of aerobic workouts.

The Task Force recommends that companies provide the opportunity for dancers to participate in some aerobic work. We are not recommending that this be a scheduled part of the workday, other than educational sessions at the beginning of each season. It is simply that dancers should have the opportunity in their free time to do some aerobic work as an alternative to rigid dieting and aberrant eating behaviors. Additionally, there are other bonuses with aerobic work. Experts have long recommended that some aerobic work would help improve dancer stamina and performance ability. There is also a common sense perception that improving stamina will help protect the dancer from injury, though there is currently no data in professional dance supporting this concept.

Recommendations are:

1. **Education:** One of the Educational Sessions at the beginning of the season should be devoted to aerobics and include:
 - A. Explaining aerobic exercise and its value.
 - B. Explaining how aerobics will help burn calories.
 - C. Clarifying which aerobic exercises will not have a negative effect on dance technique (i.e., a stair master appears to over-tighten the quadriceps in some dancers, whereas an exercise bike and the treadmill do not when not overused).
 - D. How *light weight* resistance work may raise one’s metabolic rate and continue burning calories for several hours afterwards.
2. **Providing the Opportunity for Aerobics:** A one-time investment by the company on several pieces of aerobic equipment should give years of return by promoting good health among the dancers, helping to avoid disordered eating, helping improve dancer performance and even reduce injury.
3. **Provide a Dedicated Space for Aerobic Work:** While space is a premium for most professional companies, a small space that accommodates 2 or 3 pieces of apparatus will have a positive return which more than justifies the effort.

6. RECOGNIZING DANCERS AT HIGH RISK FOR NUTRITIONAL PROBLEMS (AN EARLY SEASON HEALTH SCREEN)

We live in the age of preventive medicine, and there is data to show that healthcare screening and addressing health issues can help prevent aberrant eating behaviors.(2,15) An early season assessment has the potential to avoid subsequent suffering and the high cost associated with poor nutrition and aberrant eating behavior. To maximize the success of health screenings in the setting of professional companies, we recommend the following elements:

1. **Timing:** All parties should be clear that such assessments are a *post hire, pre-participation screening* at the beginning of the season. The purpose is not to place a barrier to the dancer's contract, but rather to help the dancer achieve a state of good health and successfully complete the season.
2. **Confidentiality:** Like all medical information, the results of such assessments must be confidential between the medical team and the dancer. No information can be shared with company administration, artistic staff, or any other party. The goal is to prevent serious problems before they develop. Only in cases where a dancer's life is in danger, or where the dancer clearly cannot carry out their function as a dancer (i.e. attempting to work on a fractured bone) should company administration be informed.
4. **Paid Time:** The screening should be on paid company time (i.e. rehearsal time) rather than the dancer's free time. Although mandatory participation is discouraged by the dancers' union (AGMA), incentives such as paid-time and serving lunch can greatly increase dancer participation. In truth, companies who already employ health screens have found that screenings can be scheduled like costumes fittings and worked into the normal rehearsal day without undue expense. In any case, the potential suffering and financial cost that can be avoided by identifying and treating illness and injury before they become active issues will more than justify the cost of a healthcare screen.
5. **Standardized Screening Forms:** In 2005, *the Dance/USA Taskforce on Dancer Health*, in cooperation with Dance/USA Council of Managers and AGMA (the dancers' union), developed a standardized preventive Health Screen that is now being used by 35 professional companies across the United States and Canada. This not only benefits individual dancers, but it allows a degree of cooperation between companies that is long overdue. This effort provides a forum for sharing health and injury prevention strategies, and it permits the collection of data (de-identified for the protection and privacy of the dancers) in numbers large enough to truly advance our knowledge of professional dance and dancer health. The Screen is comprehensive in that it addresses physical, emotional, nutritional and the general health of the dancers. Information on the *Taskforce Screen* can be found on the Taskforce Website (<http://taskforceondancerhealth.com>).

6. **Will Healthcare Screening Prevent Fully Developed Eating Disorders?** As with many illnesses, the greatest risk for developing an eating disorder is a previous history of the same disorder. Unfortunately, patients with eating disorders are extremely secretive.(5,7) Unlike depression or anxiety where people have a greater likelihood of answering direct questions and welcome help, the eating disorder patient most often will not. Direct questions such as, “Do you have a history of an eating disorder,” can drive the patient underground making help less feasible.(13,16). In addition, as addressed in Section 7, the studies we have to date show that preventive efforts can be effective with the more common disordered eating, but they have no affect on the incidence of fully developed eating disorders. This presents a dilemma in regard to early season screening where the goal is to open the door for help with nutrition.

The approach taken in the Taskforce Screen is to ask a different kind of question in regard to nutrition than in the areas of depression and anxiety. Dancers are directly asked if they currently experience or have a history of sadness, depression, or anxiety. Early indications from screening over 30 professional companies reveal that dancers are not afraid to confidentially discuss anxiety or a depressed mood and are open to receiving help. In the area of nutrition, however, the question asked is less direct (“Are you interested in nutritional counseling?”). The number of affirmative answers appears to indicate that this indirect approach is not threatening to the dancer and may provide an avenue for help. (14)

7. Diagnosing Fully Developed Eating Disorders:

Although studies support education and preventive efforts with aberrant eating behavior (disordered eating), there is no evidence that these measures reduce the incidence of fully developed eating disorders. Current recommendations in regard to eating disorders focus on *early detection and appropriate treatment*.(1,5,7,15) Thus, the emphasis is placed on *recognizing* these illnesses, making the education of company teachers and staff a critical part of any program.

Manner of Diagnosis:

Fully developed eating disorders (anorexia nervosa and bulimia nervosa) usually come to the attention of the medical or company staff in one of the following ways:

1. A dancer begins to appear too thin.
2. A dancer displays uncharacteristic weakness.
3. Other dancers report aberrant behavior such as the sound and smell of vomiting in the bathrooms.
4. A dancer excessively exercises in addition to daily dance work.

Once a staff member is aware of a potential case, they should not approach the dancer directly. The suspicion should be taken to the predetermined person or persons who handle these matters. As previously discussed, this may or may not be a member of the medical team and might be a different person in each company. We highly recommend, however, that a member of the medical team be present for this initial discussion with the dancer. Early in the process, a medical expert *experienced in eating disorders* should be consulted. Anorexia and bulimia are complex and life-threatening illnesses; a team of experienced medical professionals normally manages fully developed eating disorders. These are deep-seated illnesses, and one key characteristic is firm denial by the patient or even a lack of awareness that a problem exists. This is not something that a dancer can be “talked out of” by teachers or members of the staff, no matter how well meaning. Casual advice to “go home and eat more” is never effective.

Diagnostic Criteria:

The medical standard of care is to confirm the diagnosis according to criteria found in the *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.(11)** Although the diagnosis should be made by medical specialists with experience in eating disorders, we have enclosed the diagnostic criteria in **Addenda 1 & 2** so that artistic staff and management have a better familiarity with these illnesses.

* The 5th Edition of the *Diagnostic and Statistical Manual of Mental Disorders* is planned for release in May 2013. The preliminary draft of the 5th Edition is similar to the 4th Edition in regard to the diagnostic criteria for eating disorders, except that the focus is on sudden changes in weight rather than a specific percentage of weight loss.

8. Treatment of Eating Disorders

When an eating disorder is identified, the Taskforce recommends that professional companies follow the current medical standard for treatment. The treatment protocol is based on a *team approach* and is outlined below:

The Contract

Because professional dancers and advanced students generally share a true passion for the art form, there is the opportunity to provide incentive for the patient to follow the treatment protocol and improve the odds for recovery. This “carrot and stick” approach is frequently used in other high performance settings where the patient has an overwhelming desire to return to the activity (such as college sports teams). The core of the protocol is a **Contract** between the patient and the organization (in the case of dance, the company) where the privilege of continuing or returning to the given activity is tied to the patient’s mandatory participation in a program of healing. The contract is a powerful tool that greatly aids the dancer’s chance of returning to good health.

Clearly, such a contract would have to be added as a rider to the dancer’s AGMA contract. All parties should realize that the *accepted medical standard* for treating eating disorders in young athletes is **mandatory participation in such a contract. The choice is either try and help them in this way or release them outright.** The worst course, and the one in which all parties may be culpable (the company, the staff, the union) is to allow an individual with a recognized eating disorder to continue with heavy physical labor without treatment.

The Treatment Protocol

A standard program involves a *team of specialists* and requires the patient to participate in the following:

- 1. Weekly Psychotherapy:** Usually managed by a psychiatrist/psychologist experienced in eating disorders. This person is usually the team leader. Recent data has shown that medications may be effective in the treatment of binge-purging type (bulimia), though the data is less clear for anorexia nervosa.(1,4,5,7) The use of medications is a decision made by the psychiatrist and the patient.
- 2. Weekly Nutritional Counseling:** with a certified nutritionist experienced in eating disorders, and preferably familiar with dance.
- 3. Frequent Assessment by a General Physician:** After an initial in-depth evaluation to determine if the patient is medically stable, the physician usually reassessed the patient every two weeks or so to monitor physical status and follow serum electrolytes and other lab tests. If the patient’s weight falls 30% or more below the current standard for height, age and gender, or if the vital signs are affected, the patient is normally hospitalized.

(Treatment – cont)

4. **Family Counseling:** Although there remains much debate on the cause of eating disorders, they are considered a multi-factorial problem that can include development and family issues. When possible, parents and other immediate family members are encouraged to participate in counseling with the patient, especially if still in their teens. In cases where the patient lives long distances from the family, is estranged from the family, or where the family refuses, family counseling may not be possible.
5. **Setting Goals for Re-gaining Weight:** This is a predetermined range decided upon by the medical team. A common stratagem is to add ½ pound each week until a target range is achieved. Setting a range within the patient must eventually remain is less threatening than a specific number. Other factors should be considered such as achieving a minimal percentage body fat and resumption of menstruation.
6. **Weekly Weight Checks:** The patient must expect regular weight checks (on the same scale) to monitor their status. It is routine to weigh the patient twice each week at random times so that the patient may not “load up” on water beforehand (a common technique with eating disorder patients). Every effort should be made to be discrete and not embarrass the dancer.
7. **Rewards for Fulfilling the Contract:** The patient’s incentive to successfully follow the contract is the right to continue participation as a member of the company. In cases where physical labor is a danger to the dancer’s health (as determined by the Treatment Team) and the dancer has been removed from participation, then the incentive becomes the privilege of resuming work once a target weight range is met and body fat returns to a normal range. The right to continue dancing should be dependent on maintaining the target range of weight in addition to continued participation in counseling until released from care by the psychiatrist or psychologist.
8. **Follow-up Weight Checks:** Because eating disorders are a long term problem and subject to relapse, weight checks usually continue for a year or more upon return to work. The Medical Team can determine the optimal frequency of weight checks, with decreasing frequency as time passes.

Payment for Treatment

This is always a difficult issue. A team of specialists as outlined above is the medical standard, but it is expensive. Because patients who suffer from eating disorders usually have deep-seated problems extending into early development and family relationships, it is traditional to seek coverage for the cost of treatment from general health insurance.

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Addendum No. 1: Diagnostic Criteria For Anorexia Nervosa

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current body weight.
4. In postmenarchal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (a woman is considered to have amenorrhea if her periods occur only following hormones - e.g., estrogen - administration.)

Addendum No. 2: Diagnostic Criteria of Bulimia Nervosa

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both the following:
 - A. Eating, in a discrete period of time (e.g., within any 2-h period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
 - B. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
2. Recurrent inappropriate compensatory behavior to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
3. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

SOURCE: *From Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV)**

*Please see footnote on page 15 regarding *DSM-IV*.

Addenda 3, 4, 5 & 6 to be Added (CDC Height & Weight Charts)

Addendum No. 7

The Dance/USA Taskforce on Dancer Health created a preventive healthcare screen for professional companies in 2005. The Taskforce Screen was developed as cooperative effort between the Taskforce, the Dance/USA council of Managers and AGMA (the professional dancers' union). Over 30 professional companies are currently using the Taskforce Screen. Information on the Screen can be found at <http://taskforceondancerhealth.com>.