

Prevention, identification and action on disordered eating: Extracts from current working policies and research

This document offers information and recommendations for the creation of policies to promote healthy eating and to help prevent and manage disordered eating and eating disorders in dance training and professional environments. The content herein is drawn from policies currently being used in dance companies and schools within the UK, generously shared with One Dance UK to improve practice across the sector. **Example Approaches** provide evidence-based suggestions for implementing advice into practice.

This document is not exhaustive nor is it meant to replace the advice of qualified health professionals. Dance schools and companies must aim to promote health and not merely to avoid eating disorders.

Many thanks to all the schools, companies and professionals that contributed to this document. For more information on specific references within the document, please contact One Dance UK's Healthier Dancer Programme at hdp@onedanceuk.org or 0207 713 0730

Contents

- Definitions
- Policy creation
- Prevention
- Identification
- Confidentiality
- Action
 - Auditioning
 - Limiting participation in dance
- Resources and Help

Definitions:

“Eating disorders are serious mental illnesses that involve disordered eating behaviour. This might mean limiting the amount of food eaten, eating very large quantities of food at once, getting rid of food eaten through unhealthy means (e.g. purging, laxative misuse, fasting, or excessive exercise), or a combination of these behaviours. It’s important to remember that eating disorders are not all about food itself, but about feelings. The way the person interacts with food may make them feel more able to cope, or may make them feel in control.

Eating disorders include anorexia, bulimia, and binge eating disorder. It’s also common for people to be diagnosed with “other specified feeding or eating disorder” (OSFED). This is not a less serious type of eating disorder – it just means that the person’s eating disorder doesn’t exactly match the list of symptoms a specialist will check to diagnose them with anorexia, bulimia, or binge eating disorder.

It’s also possible for someone to move between diagnoses if their symptoms change – there is often a lot of overlap between different eating disorders. The aim behind diagnosis is to ensure that the person is getting the most appropriate treatment for their illness.”

(bEAT, <https://www.beateatingdisorders.org.uk/types>)

Resources to reference for definitions:

- Feeding and Eating Disorders, fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)
- NHS Choices website: <https://www.nhs.uk/conditions/eating-disorders/>
- bEAT website: <https://www.beateatingdisorders.org.uk>

Policy Creation:

The way in which you create your policy is of utmost importance. Please see below guidelines to assist you with policy writing.

- Policies need to be constructed by a group, and not just by one individual. Those who shape the policy will be more likely to own it and be concerned to see that it is made effective (One Dance UK). A policy should help to ensure that all team members are consistent with messages getting across to their dancers.
- It may be best to include the following persons within the core group: the director or head of the school or company, the teachers, the pastoral care or tutorial staff, a dietician, a physiotherapist, a doctor or eating disorders specialist, and the head of catering. In more general terms, the group should include representatives of all those who can make a difference to the dancer's care. The status, enthusiasm and persistence of this group will determine its success.
- With smaller schools and companies, creating a document with a group can prove difficult. If creating a document alone, always ensure that you share the information within it with someone that you work with professionally. You may also consider contacting One Dance UK and/or Beat to ensure that your policy is consistent with the best practice guidelines for the sector.
- Define eating disorders and disordered eating. There may be misinterpretations and confusion around the differences between eating disorders and disordered eating, so it may be helpful for schools/companies to include clinical definitions (included above) in their policies to ensure understanding.
- The policy needs to define who will take responsibility for each issue and outline when to act.
- It is important to highlight in your eating disorders policy that the school/company will respect confidentiality as far as possible. The matter will need to be shared between the dancer, their parents (if under 16) and the 'need to know' group.
- Policies that embrace the whole organisation, rather than seek to address only people with eating disorders will be most effective and easiest to implement. They will have the additional benefit of reducing the sense of stigma and shame a person with an eating disorder may feel because of their illness(bEAT).
- You may want to include in your policy that dancers with a suspected eating disorder will not be blamed or otherwise punished. Instead, they will be supported both within the school/company and in the seeking of dance specific care or outside help (e.g. GP referral).

Prevention:

Below is a list of extracts from policies that outline preventative mechanisms in place in dance schools/companies. It is imperative that a section on prevention is included within a healthy eating/eating disorders policy.

- Most successful eating disorder and disordered eating prevention and intervention programmes in the research literature have targeted eating disorder and disordered eating risk factors, such as self-esteem (Piran, 1999)
- Encourage an atmosphere of supportive openness where it is recognised that dancers sometimes struggle with food and eating, but dancers can feel sure that they will get support if problems do occur, and where people know where to find help if they have any concerns (Nordin, 2009).
- Encourage dancers to ask for advice regarding healthy eating when required and to share any concerns they have regarding their peers' eating habits with a designated and educated member of staff.
- Promote healthy eating through the provision of adequate breaks for re-fuelling and hydration. Encourage dancers to take onboard healthy amounts and types of fluids and food before, during and after dancing (Nordin, 2009).
- Provide regular education and frequent reminders and updates for staff and teachers, dancers, parents and catering services regarding nutrition and healthy eating; eating disorders, prevention and management; and how to motivate people to get help.

This type of education can be devised by the school or company with support from:

- Beat - a national support organisation for the prevention and treatment of eating disorders. www.b-eat.co.uk
- One Dance UK Healthier Dancer Programme – a support organisation promoting dancers' health and wellbeing through education, advice, advocacy and research. <http://www.onedanceuk.org/programme/healthier-dancer-programme/>
- Loughborough University Centre for Research into Eating Disorders – research centre dedicated to eating disorders in active populations providing information for athletes and coaches on eating disorders, prevention, and management, including how to motivate people to get help. <http://www.lboro.ac.uk/departments/ssehs/research/research-centres/eating-disorders-research/>

Example Approach

Education for staff:

Inset day for artistic and support staff and catering services to meet their local GP, nutritionist, counsellor and an eating disorders specialist. Education could be offered regarding eating disorders and disordered eating; what is appropriate for teachers to say and how to deal with these issues; as well as basic nutritional education for teachers for them to be able to provide support to dancers if an individual approaches them with a problem. Interaction between school or company staff and external health professionals will build or reinforce links to seek information or referral in the case of any issues arising.

Education for dancers:

Talks and workshops specifically tailored for dancers can be delivered by the school or company or external professionals or organisations (listed below.) The presentation could vary depending on the focus of the workshops. For example: fuel for dance, e.g. what the dancers body needs and why, what may happen if fuel needs are not met and who dancers can approach/talk to if they are struggling with this. These may include an informal opportunity to ask questions as well as signposting to online or external resources.

Dancers are practical learners and may 'switch off' during lectures if they do not see how the information is relevant to them. Workshops should involve practical elements, giving dancers ideas of quick snacks for between classes/rehearsals, shopping and meal ideas, how to prepare food pre-performance and post-performance, and tips for eating at restaurants.

Framing this nutritional education as 'food education' may also make the topic more approachable and easier for dancers and staff to discuss. This sort of education could eventually become more dancer-led with dancers putting forward suggestions of times when they don't know what to eat or things they would like to know how to prepare. It may be useful to plan in induction event involving local dance specific practitioners/GPs to come and talk to dancers about what they do and how they can help dancers. Dancers may not approach their GP for nutritional concerns or may not be sure how their GP could help – so an explanation of what the GP can do for dancers would be beneficial.

(Mitchell, 2012)

- Make literature on healthy eating habits, disordered eating and eating disorders and possible triggers for concerns about weight and shape should be available for all dancers to easily access. This information should be visible and accessible by different age groups (Nordin, 2009). This information could include:
 - Healthy eating habits
 - One Dance UK information sheets about nutrition, hydration, bone health, and hormones
 - International Association of Dance Medicine and Science Resource Papers on nutrition and bone health
 - Healthy recipes (examples can be found on One Dance UK's website: http://www.onedanceuk.org/resource_category/recipes/)
 - Information and articles about eating disorders and disordered eating
 - Contact information for local professionals and contacts able to offer advice and further information on healthy eating and disordered eating and eating disorders
 - Material on related issues such as performance anxiety, competitiveness and audition pressures and how these may trigger disordered eating
- To facilitate accessibility, these could be kept in a resource file or information board in the library or relaxation area and the staff room
- Provide healthy food options to purchase within the canteen. Where this is not possible, dancers should be encouraged and guided on what to bring for their own healthy meals or snacks.

Example Approach

Aim: "to reduce body weight and shape preoccupation through creating a school environment where students felt comfortable with the processes of puberty and growth and believed in their right to feel both safe and positive in their diverse bodies." (Piran, 1999, p 79)

Focus groups with administrators, teachers, students

Key components:

- Emphasis on stamina and conditioning; NOT shape
- Teachers prohibited from making evaluative shape comments
- A staff member appointed as the "go-to" for students to discuss body image concerns
- Staff educated on body shape prejudices, adults' responsibility to students' self-esteem
- Student focus groups (2-6 times annually) – to discuss experiences of body shape and weight at the school, and suggest solutions to resolve it; education on health and development
- Resulted in significant reduction in number of students reporting disordered eating, bingeing, vomiting, laxatives and restrictive eating

(Piran, 1999)

Identification:

*With this sensitive issue, the identification process may be the most fragile. It is imperative to think carefully about how your organisation would like to identify issues of disordered eating/eating disorders. **Importantly, companies and schools are not responsible for diagnosing or treating disordered eating.***

- All staff plays a role in the identification of disordered eating. This includes teachers, managers, other support personnel (e.g. administration, wardrobe), dancers, and parents. It is valuable for everyone to have a basic level of awareness of disordered eating and to feel confident that reporting any suspected problems will be dealt with sensitively and professionally (Nordin, 2009).
- BMI
 - Body Mass Index (BMI) is a statistical measure to determine the amount of body fat, involving a calculation based on weight and height. It can be used by women and men aged 18 and over to assess their weight in relation to the general population. (NOTE when interpreting body mass index for children, age and gender need to be considered using growth diagrams). **BMI should not be used in isolation when assessing an individual's health status.**
 - There is no single tool for effective and reliable assessment the nutritional status of a dancer and the serious implications of low body weight, binge eating, purging, laxative abuse and vomiting. Medical professionals may use multiple assessments and other indicators such as
 - **Growth charts:** indicate where there may be issues with the maturation process, which could arise from an imbalance between energy intake and expenditure.
 - **Gynaecological history:** For young women, the stage of pubertal development and frequency of menstruation is assessed. Delayed onset of puberty, infrequent periods (oligomenorrhoea) or absence of periods (amenorrhoea) can all be related to poor nutritional status.
 - **Eating attitude test:** This simple to complete test, validated throughout the world, indicates where risk of eating disorders is present.
 - (Bagutti, 2010)
 - **Blood tests:** these tests can indicate symptoms of malnutrition, assess the function of major organs especially affected by poor nutrition, and other factors associated with vomiting, laxative abuse and low body weight - <http://www.news-medical.net/health/Eating-Disorders-Diagnosis.aspx>
- **Body Composition:** Body composition describes the percentage of muscle, bone and fat that make up the total mass of the body. It is usually expressed as a percentage of lean mass (muscle, bone, skin, internal organs and water) and fatty mass (fat under the skin and between the organs.) Body composition can be an especially helpful method to help

differentiate between weight and leanness when assessing a dancer's physical fitness or health status. Body composition can be assessed by trained health professionals, including sports/dance science professionals, GPs, nutritionists. Measurements can be taken by hand, measuring subcutaneous fat levels (skin folds); and using specialist equipment: bioelectrical impedance analysis (BIA); air displacement plethysmography (ADP); Dual energy X-ray absorptiometry (DEXA), MRI and CT scans. (Mitchell, 2012)

- Frequently educate all staff on psychological, physical and behavioural warning signs that indicate a dancer may be experiencing difficulties that could lead to an eating disorder.

Psychological Signs

- Preoccupation with food
- Sensitivity about eating
- Denial of hunger despite lack of food
- Feeling distressed or guilty after eating
- Body dissatisfaction
- Overly body conscious (in relation to their usual self)
- Self-worth linked to their body weight and/shape
- An over-importance placed on the control of their weight and shape.
- Mood swings. Changes from the norm over a prolonged period are perhaps better indicators of an underlying problem.
- Excessive perfectionism – specifically, an overly self-critical stance, not just on body weight and/or shape.
- Compulsive exercise – an urge to exercise (in addition to their training programme), and a fear of what may happen if they do not do this exercise.

Physical warning signs (Dawson, Rist, Bull, Smook 2012)

- Any significant change in weight, whether loss or gain
- Loss of muscle strength
- Dizziness, tiredness (sleep problems), fainting
- Feeling cold
- Hair becomes dull and lifeless
- Discoloured or swollen hands and feet
- Callused knuckles
- Tension headaches
- Sore throats/mouth ulcers
- Tooth decay
- Swollen stomach, constipation
- Loss of concentration/inability to focus
- Recurrent illness or injury

Behavioural signs:

- Wearing baggy clothing or several layers of clothing
- Excessive chewing of gum/drinking of water

- Visiting bathrooms/toilets after meals
- Increased conscientiousness
- Isolation/not mixing with other dancers
- Low self-esteem
- Excessive exercise
- Self-harm
- When challenged, refusal to accept there is a food issue

Be aware that some traits of good dancers can be similar to eating disordered behaviour, and thus identifying underlying behavioural signs may be difficult.

Good athlete / dancer

Mental toughness
Commitment to training
Commitment to diet
Pursuit of excellence
Coachability
Unselfishness
Performance despite pain

Anorexic patient

Self-denial
Excessive exercise
Food restriction
Perfectionism
Over-compliance
Selflessness
Denial of discomfort

(Thompson & Sherman, 1999)

Action:

*It is important to address problems as soon as possible with correct care and advice, to increase the likelihood that a disordered eating pattern resolves without major health issues. **However, companies and schools are not responsible for diagnosing or treating disordered eating.** This is a complex issue and, in most cases, will require the advice of a doctor. The points below outline ways in which schools and companies may take positive action to identify a dancer with potential eating problems. The action that one school/company takes may differ greatly from another. The advice below is by no means the only method but is offered as an example of good practice.*

Duty of Care for the School or Company:

Dancers may likely be secretive or deceitful about their struggles with disordered eating or eating disorders, especially with artistic staff whom they respect. They may also feel a great deal of shame.

- Initial conversation. One-to-one meeting with the dancer as soon as possible after concerns have been raised. This is an informal conversation to reassure the dancer that the organisation will help support the dancer in the best way possible. It may be best for the member of staff who has the best relationship with the dancer in question to undertake the initial approach.
- Information provision. Information and advice will also be passed to the dancer so that they, and/or their parents, can seek further help themselves.
- Second conversation. If the student is older than 16 years of age and has given their consent for parents or guardians to be involved, a second, separate conversation will be held with them and the dancer. If the dancer is under 16 years of age, parents or guardians can be contacted without the student's consent. Legally, confidentiality is only required up until 16 but this should be discussed with the students individually. This meeting would also be a follow up to see whether the dancer has taken on board the issue and begun to seek advice.
- Recommending Referral. If the dancer does not appear to be seeking help and symptoms are remaining constant or becoming worse, onward referral to a qualified professional is imperative. The professional may depend on the nature of the situation. It is recommended that all dancers be registered with a GP, and the name and address and phone number of this doctor need to be known by the school or company. Going to a GP to talk about disordered eating can be a daunting prospect. In addition, the dancer's GP may have little or no understanding of eating disorders and the related specific concerns of dance training and careers. To support this process, it sometimes helps to bring a letter outlining the basic issues. This letter should outline the importance of early intervention for a dancer suffering from concerns about weight and shape, given their chosen activity or profession. The specific physical, psychological and aesthetic demands of the dancer's training should also be outlined. It is vital for GPs with little experience treating dancers to

understand these issues. A member of staff may also choose to contact the patient's GP and offer information regarding problems. Whilst GP's are unable to give information to the school or company without consent of the patient, they can receive it.

- Follow-up meetings. Depending on progress and the resources of the school/company, it may be possible to provide on-going support, for example, by having the dancer meet with a staff member that the dancer feels happy to discuss with (e.g. personal tutor, health professional). Even if the dancer is already obtaining external medical or dietary advice, this may help to ensure the issue is kept in the open and continues to be addressed.
- People with eating problems present with a high level of ambivalence about changing or not changing. It will not be uncommon for dancers with eating problems to lack the motivation to change and ask for help. There is now good evidence that professionals (health and non-health) and family members are in a good place to help people with eating problems to increase their motivation to change. A specifically designed motivational style for approaching dancers with eating problems could be taught to professionals working in the dance world.

Confidentiality:

It is essential to consider confidentiality when dealing with the sensitive issue of disordered eating/eating disorders. The age of your dancers may influence your ability to consult with guardians. Different organisations take different approaches – it is therefore important to consider this area very carefully.

- All matters should be dealt with sensitively and appropriately, and the dancer's right to confidentiality will be respected at all times. However, dancers need to be made aware that it may not be possible for staff to offer complete confidentiality (Walker, 2011). **If you consider a dancer is at serious risk of causing himself or herself harm, then confidentiality cannot be kept.** It is important not to make promises of confidentiality that cannot be kept even if a dancer puts pressure on you to do so. Any sufferer should be made aware of limited confidentiality and who would become aware of their information. It is necessary to explain procedures and steps to be taken and to reassure the sufferer that they are believed, taken seriously and will be helped.

The 'Need to Know' Group

- Within your organisation, define a 'need to know' group. This group will discuss, as required, any dancers identified with weight or size changes and decide upon how to best act to help the dancer. These actions will foster an open approach to disordered eating and eating disorders and remove the pressure from any one person dealing with these issues alone.
- Having a designated staff member or members with training around healthy eating habits, disordered eating and eating disorders and possible triggers for concerns about weight and shape is vital for other staff to signpost dancers to and ensure that each issue is handled in a more consistent and appropriate way.
- The 'need to know' group can help with adopting an open approach to healthy eating and eating disorders, whilst also respecting confidentiality regarding peers.
- Any policy needs to make clear that confidentiality must belong to the staff 'need to know' group as a whole and not to any one selected individual (One Dance UK).
- The 'need to know' group can help with adopting an open approach to healthy eating and eating disorders, whilst also respecting confidentiality with regard to peers.
- If staff or dancers observe any behaviour of concern, they should report that to the 'need to know' group. No one should approach the individual directly and it is essential that this area be dealt with sensitively and by a trained person. Concerns will be noted and passed on. Feedback is very important in identifying pupils of concern. At all times the individual will be cared for and the primary goal is about supporting and facilitating recovery. For this reason, the importance of confidentiality will be stressed to all concerned (Dawson, Rist, Bull, Smook 2012)

- Members of the group:
 - Health professionals - It may be appropriate to involve a health professional where one is attached to or known by the school/company.
 - Artistic staff - Dancers may likely be secretive or deceitful about their struggles with disordered eating or eating disorders, especially with artistic staff whom they respect and wish to impress. They may also feel a great deal of shame about struggles with weight and shape. For these reasons, artistic staff, teachers, choreographers, and directors may not be involved “by default”. Instead, neutral, easily accessible and confidential individuals may be the most effective and successful to receive reports of any worries, and deal with the necessary one-to-one meetings with dancers and parents (where appropriate).
 - Parents – We believe parents of students would like to know if their child is facing these issues. However, legally speaking, persons under 16 who are considered mature enough to understand what an illness and treatment entail have a lawful right to consent to treatment on their own, without involving parents.¹ However, the dancer may be relieved to know that parents have been informed of the issue, even if they do not wish to share more detailed information discussed in meetings with teachers and medical professionals. In addition, parents may be less likely to react negatively or withdraw the dancer from the school if lines of communication and trust have been built. (From the Eating Disorders Association. (2005). What you need to know when creating your eating disorders policy.)
 - Staff - Dancers may choose to confide in a member of organisation staff if they are concerned about their own welfare, or that of a peer (Dawson, Rist, Bull, Smook 2012).
 - Others - Outside of the ‘need to know’ group it may be important to inform some relevant staff members (e.g. those teaching the dancer) on a need-to-know basis so that they may support the dancer appropriately. This most likely extends only to those tutors who teach the dancer directly. The dancer should always be told if, when, and why staff feel that they need to inform others, before actually doing so (Nordin, 2009).

¹ **Gillick competence** is a term originating in [England](#) and is used in [medical law](#) to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

The standard is based on a decision of the [House of Lords](#) in the case *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL). The case is binding in England and Wales, and has been approved in Australia, Canada and New Zealand. Similar provision is made in Scotland by The Age of Legal Capacity (Scotland) Act 1991. In Northern Ireland, although separate legislation applies, the then Department of Health and Social Services Northern Ireland stated that there was no reason to suppose that the House of Lords' decision would not be followed by the Northern Ireland Courts.

Limiting or stopping a dancer's participation in classes/performance:

It is difficult to establish at what point a dancer with disordered eating is putting himself or herself at risk by doing physical activity (including dance). There are many possible approaches for schools/companies. Outlined below is a variety of approaches. These approaches may guide you in your own policy creation and are in no means exclusive; you can borrow ideas from the different approaches.

Approach 1:

If sufficient concerns are raised about a dancer's ongoing safe participation, the school/company may reserve the right to ask the dancer to provide a certified record of physiological indicators of nutritional health (see Identification, above) from a qualified medical professional. You may also ask that the dancer cooperate in seeking confirmation from appropriately qualified medical professionals that they are able to participate safely on the programme. If a dancer fails to cooperate, you may want to highlight in your policy that the dancer will be asked to defer/withdraw from the course. Being withdrawn from dance may be a valuable incentive to encourage dancers to seek help (Walker, 2011).

Approach 2:

Although this is a difficult task, it is important to have an open discussion about when dancing should cease or reduce, because at very low weights or because of drastic weight change, the dancer is at risk of serious physical problems including

- Cardiac arrhythmia and risk of heart attack
- Kidney failure
- Reduced bone health and risk of stress fractures and osteoporosis
- Reduced or impaired fertility
- Suppressed immune system, leading to risk of infection
- Hair thinning and loss
- Skin problems

Teachers who feel that a dancer is too weak (physically or mentally) to partake in classes have a right to limit participation but will clearly explain this in the open discussion with a designated member of staff. Because it is not the teacher's role as non-professionals to diagnose or treat, the best way to monitor participation may be to establish good lines of communication with a health professional (e.g. the GP involved in the dancer's referral or staff from the clinic at which a dancer is undergoing treatment). This way appropriate, on-going advice may be obtained as to whether the dancer should be allowed to dance. A health professional could, for instance, be able to advise as to whether the dancer's weight or weight change is so rapid as to put the person at risk.

Dancers should in most cases be encouraged to continue to attend class if they wish, although not necessarily be physically involved. This helps the dancer understand that your organisation takes the issue seriously, while valuing them as people; allows them to gain

some benefits from the classes (e.g. observe, practice via imagery based on the current exercises taught, and be involved in peer feedback); and facilitates inclusion by seeing friends and having emotional support. Having the dancer attend class can help the staff to keep an eye on the dancer (e.g. to prevent excessive exercising outside of dance); to support the dancer's learning in whatever way possible; and to provide appropriate emotional support (Nordin, 2009).

Despite all these potentially positive reasons, attending class when not being able to take part physically can also be very stressful and may result in feelings of jealousy and anger. Therefore, the dancer should be told about the reasons as to why they are encouraged to attend but will ultimately be given the choice (perhaps in consultation with their parents if dealing with under 16's) (Nordin, 2009).

Returning to Dance:

It is important to think about how a dancer will be reintroduced into dance once it has been established by a health professional that it is safe to do so. Dancers should have a graduated return to dancing organised by the 'need to know' group once it has been established that it is safe to do so. Advice from medical practitioners involved in the dancer's case will be taken, but the final decision for timetabled activity will rest with the 'need to know' group

Auditions:

Disordered eating and eating disorders may be of some concern from the very first audition. It is important to include a section within your policy that guarantee that dancers are only admitted with the candidates' best interests and health in mind. The below includes two different approaches to dealing with the audition process.

Approach 1:

- The basic purpose of auditions is to admit dancers who not only appear talented/as having exceptional potential, but also for whom the training appears to be in their best interest at that time. This **best interest** is regarding enjoyment, performance and career goals, but also health, safety and well-being. It may be best to define a policy around whether to admit dancers who appear to suffer from disordered eating or related problems.
- However, dancers being considered for the scheme that display overt signs of disordered eating at audition may be approached and a conversation held. If the dancer and her/his parents are aware of the issue, treatment is already being sought, and an agreement can be reached regarding, for instance, weight and health targets, the dancer may be admitted. If any of these are not in place, admission may be denied (possibly with a recommendation to re-audition in the subsequent year) (Nordin, 2009).

Approach 2:

Prior to audition, as part of the application form, the dancer completes a Medical Questionnaire that includes a self-certified record of height, weight and BMI (body composition instead?) and a query as to any history of weight issues and/or menstrual health.

At the time of the primary audition:

- prior to starting the classes, mention is made of our Eating Disorders policy, to both candidates and any accompanying parents/guardians

At the recall audition

- Any concerns raised as a result of the application form or at the primary audition, are discussed, openly and supportively, with the candidates at the time of interview

A physical assessment may be the best time to gather information and screen for potential risk of eating problems. Having it as part of a wider, more general health screening/assessment minimises any possible stigma and places it within the wider concerns for the health of the dancer, which the organisation should prioritise. During the physical assessment, physiological indicators of nutritional health may be recorded by a qualified health professional. Female dancers are queried on their menstrual health. Should any issues become known, it is recommended that the dancer discuss these with their registered general practitioner.

Recovery and Return to Dance

The recovery from disordered eating and eating disorders is most often a slow process. The average time for recovery from a serious eating disorder is 5-7 years. Although therapy may not be required for all this time, short term interventions may not always be enough. However, returning to activities about which the dancer is passionate (even if this is not dance) can provide focus and positive motivation.

- Although weight may stabilise, this does not necessarily indicate a full recovery.
- Those supporting the recovering dancer need to be aware of the inherent social, physical and psychological pressures associated with returning to a regular school or professional environment following treatment.
- Dancers will need support and sensitivity from staff, peers, family and friends during this period, either to feel 'normal' and accepted in their return, or to discuss difficult emotions that may come up. Support from others may help the dancer feel more relaxed and less isolated.
- The Need to Know Group should continue to communicate with each other, any staff and any personal contacts (parents, friends or family) involved with the dancer during this period, not only to continue to monitor health and wellbeing, but also to support the dancer. <http://www.anorexiabulimiare.org.uk/assets/files/schoolsAndEDs.pdf>

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