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GROWING AN ATHLETIC PROGRAM WITHOUT STARVING
ATHLETES:
AN EXAMINATION OF EATING DISORDER POLICY FORMATION
IN INTERCOLLEGIATE ATHLETICS

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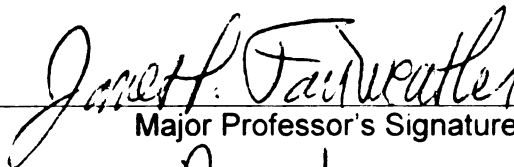
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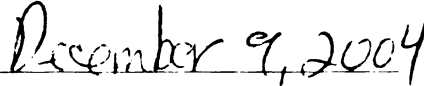
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GROWING AN ATHLETIC PROGRAM WITHOUT STARVING ATHLETES:
AN EXAMINATION OF EATING DISORDER POLICY FORMATION IN
INTERCOLLEGIATE ATHLETICS

By

Anne Marie Monroe

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ABSTRACT

GROWING AN ATHLETIC PROGRAM WITHOUT STARVING ATHLETES: AN EXAMINATION OF EATING DISORDER POLICY FORMATION IN INTERCOLLEGIATE ATHLETICS

By

Anne Marie Monroe

The purpose of this investigation is to examine the policy decision-making process in intercollegiate athletics. This study will identify the policies and practices of athletic departments at NCAA Division I institutions; compare the policies and practices across the institutions; and examine the roles of institutional administrators and students in decision-making processes regarding policies related to disordered eating within the student athlete population. This investigation examines Division I institutions that offer both women's gymnastics and men's wrestling, sports that have been identified as having a greater at-risk athletic population. The 31 Division I institutions that met these criteria were selected to participate in the preliminary questionnaire administration of this investigation, which assessed the state of policy and practice at each institution.

Results of the questionnaire were sorted, placing institutions into one of three categories: unrealized policy, partially realized policy, and realized policy. Upon evaluation and categorization, three institutions were selected for case studies of the decision-making process involved in either creation or non-creation of policy to better understand the complexity involved with decision making to actualize policy aimed at disordered eating among student athletes. In general, the concept of complex organizational decision-making processes embedded in culture and values was confirmed. Four broad themes emerged from the qualitative data across all institutions: 1)

Policy decisions are reactive; 2) Eating disorders are a female medical issue; 3) Loyalty to the athletics family is important; 4) A champion with expertise is needed. Implications and future directions for institutional, NCAA, and national public policy and research are discussed.

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List of Commonly Used Abbreviations

ACSM	American College of Sports Medicine
ATC	Athletic Trainer
CSMAS	Committee on Competitive Safeguards and Medical Aspects of Sports
COGME	Council on Graduate Medical Education
<i>DSM-IV</i>	Diagnostic and Statistical Manual of Mental Disorders, 4th edition
EDNOS	Eating Disorder Not Otherwise Specified
EDT	Eating Disorder Treatment Team
NCAA	National Collegiate Athletic Association
NIH	National Institutes of Health
SAAC	Student Athlete Advisory Council
SWA	Senior Woman Administrator
TP	Team Physician

Chapter 1: Rationale and Purpose

In recent years there has been a marked increase in research on eating disorders and other weight-controlling activities in various populations. Disordered eating behaviors are of great concern to many healthcare professionals, especially those who regularly work with young women. Evidence clearly indicates that disordered eating has a variety of psychological, physiological, social, and cultural causes and linkages (Moriarty & Moriarty, 1997). Eating disorders, as defined clinically differs from the definition of disordered eating behaviors. The two terms are defined in Chapter 2, but for the purposes of this investigation, the presence of *either* eating disorders or disordered eating behaviors in student athletes is considered. One group that has been increasingly identified as at risk for developing such disorders is college student athletes.

Student athletes face numerous, often competing demands upon entry into higher education. The transitions of student athletes from high school to higher education include many of the same moral, cognitive, personal, and professional development dilemmas that other students face, but in a different context. Although each group struggles with the same developmental issues and concerns, student athletes are a unique population because of their roles on campus, their atypical lifestyles, and their special needs (Etzel, Ferrante, & Pinkney, 1996). They are responsible for fulfilling their academic responsibilities as well as achieving and maintaining National Collegiate Athletic Association (NCAA) eligibility standards. Unlike other students, student athletes must cope with public scrutiny and extensive time demands together with regular class work. In addition, the pressures of maintaining a high level of performance, coping with the prospect of injury, and meeting external demands from others may potentially

influence an athlete's self-perceptions (Carodine, Almond, & Gratto, 2001; Etzel et al., 1996; Parham, 1993). This combination of academic and athletic requirements can cause intense stress.

One of the primary stressors facing student athletes is performance. Modified nutritional intake and low body fat composition have been linked to enhanced performance (Thompson & Sherman, 1993a). As a result, athletes are being asked to lose weight to perform at a higher level. Unfortunately, most athletes take this to mean dieting, and are left on their own to pursue methods of weight loss with no nutritional guidance. This initial dieting behavior is the precursor to more serious eating disorders.

Female athletes, in particular, experience an environment where not only sport-specific skill and overall athleticism, but also their bodies, are put on display. Constantly subjected to the same social pressure to be thin that affects all females in Western culture, they also must function in an athletic arena that places strong value on performance, low body fat, and ideal body shape and appearance. Female athletes have been linked to disordered eating by personality types (Moriarty & Moriarty, 1997) and by added pressure from coaches and the level of performance expectations (Picard, 1999). In addition, particular sports such as swimming, running, gymnastics, or figure skating emphasize and reward the lean body type, creating more pressure.

Several factors have been linked to the development of eating disorder symptoms in both male and female student athletes, including but not limited to body image concerns, social pressure for thinness, self esteem, and family relationships (Garfinkel & Garner, 1982; Polivy & Herman, 2002; Thompson & Sherman, 1993a). Another important factor that has been linked to the development of eating disorders is

participation in athletics (Hausenblas & Carron, 1999). There are pressures on athletes concerning body composition, shape, size, and weight specific to athletic participation, in addition to the general societal pressure for thinness. These additional pressures have led to research examining the impact of athletic participation on the development of eating disorders. It is generally agreed that athletic participation is part of a larger etiology for eating disorders, and that athletic participation does not in and of itself cause eating disorders. However, a meta-analysis of the published literature on the prevalence rates of eating disorders among student athletes found that levels of anorexic and bulimic symptoms in athletes are higher compared to their non-athlete counterparts (Hausenblas & Carron, 1999).

The rise in eating disorders among active women, and the realization that these disorders have future health implications, has prompted the sports medicine community to examine issues of eating disorders among athletes. The consequences of eating disorders to the health and well-being of student athletes cannot be understated. The physical and psychological damage left even after treatment can have a devastating impact that continues on far beyond the college years (Kelly, 2003; Thompson, 2003; Thompson & Sherman, 1993a). Tragic consequences, including stress fractures, reproductive damage, even death can occur in athletes with eating disorders (Otis & Goldingay, 2000; Thompson & Sherman, 1993a). In response to a noted alarming trend, the Women's Task Force of the American College of Sports Medicine (ACSM) called a consensus conference in 1992 (Otis & Goldingay, 2000). Sports medicine experts, along with coaches, athletes, and administrators, defined the syndrome that was causing serious health problems among active women as the *female athlete triad*. The triad is comprised

of three interrelated problems: eating disorders, osteoporosis, and amenorrhea. It was named at a time when it was first identified in young female athletes, but it is acknowledged that the triad can affect a wide variety of active women. If a female student athlete is using disordered eating practices, she is constantly in a state of energy drain (insufficient caloric intake to support body functions). The low body weight and low body fat can lead to amenorrhea. Amenorrhea (absent menses) means she lacks the hormones necessary to build bone; thus, the onset of osteoporosis can occur in a young, active, seemingly healthy female student athlete.

Despite the global attention that eating disorders, and the female athlete triad in particular, have received recently, they remain a serious problem among the athlete population. Leading experts agree that the key to stemming the growing prevalence of eating disorders and their associated problems is identification and early intervention (Sanborn, Horea, Siemers, & Dieringer, 2000). In 1997, the American College of Sports Medicine (ACSM) issued a position stand calling for the development, implementation and monitoring of strategies specific to eating disorder prevention, surveillance, research, health consequences, medical care, and public and professional education (Otis, Drinkwater, & Johnson, 1997)

In the last 15 years, researchers have made numerous attempts to identify and quantify the prevalence of disordered eating behaviors in athletes, with mixed results. Findings concerning prevalence rates of eating disorders and disordered eating among athletes are equivocal, primarily due to differences in definitions, measures, and methodology. A 1999 study conducted by the National Collegiate Athletic Association (NCAA) reported that up to 25% of the female athletes were at risk for developing an

eating disorder (Johnson, Powers, & Dick, 1999). Regardless of exact prevalence rates, we must move beyond quantifying behaviors in athletes, and acknowledge eating disorders as a widespread concern.

Prevalence rates aside, eating disorders among student athletes are common enough to be recognized by the major regulatory body of collegiate athletics, the NCAA. Unfortunately, many in athletics appear to be looking the other way (Bickford, 1999). In a survey sent to senior woman athletic administrators in 1990, only 491 of the 803 member institutions responded, although each had already received educational materials on eating disorders from the NCAA, and should have perceived that eating disorders are a serious problem in intercollegiate athletics. In fact, 64% of the responding institutions indicated that at least one eating disorder of a student athlete had occurred (Dick, 1990). Given that athletic populations report a higher incidence of eating disorders than the general population, it is unclear why more than one-third of the intercollegiate programs in the country did not respond to the survey. One conclusion is they are ignoring this serious problem facing student athletes (Overdorf, 1991; Stephenson, 1991).

Research has consistently shown that while diagnosis and treatment are viable options after disordered eating is recognized, education and prevention are the primary tools for minimizing the risk of eating disorders (Johnson, 1994; Sundgot-Borgen, 1994a; Thompson & Sherman, 1993a, 1993b, 1999; Turk, Prentice, Chappel, & Shields, 1999). Prevention programs are available in numerous forms, including screening athletes for disorders; eliminating mandatory weigh-ins; providing nutrition education; training coaches, administrators, and sports medicine staff in recognizing signs and symptoms; and hiring additional staff such as a team nutritionist or a sports psychologist.

That it is important for governing organizations to take a stand on issues of health and safety for athletes has been established. For example, organizations that govern amateur and professional sports alike agree that drug and steroid use is dangerous, and have acted strongly in an effort to control and eliminate such use by athletes (Thompson & Sherman, 1999). Very few of these groups have taken a stand on restrictive dieting, the use of pathogenic weight loss methods, excessive exercise, or disordered eating in athletes, nor the pressures that would lead athletes to engage in such behavior (Thompson & Sherman, 1999). The NCAA is one group that has responded by providing materials such as videos, brochures, and checklists for identifying eating disorders and by endorsing the eating disorder screening program on its Web site (Dent, 2002; NCAA, 1989, 1991).

Support and endorsement of such measures by the NCAA does not equal regulation and control of individual institutions, nor does it mean that the NCAA intends to develop or implement policy on prevention or treatment of eating disorders. The NCAA, by its very organizational structure, promotes self-regulation. Institutions are left on their own to make decisions accordingly. Thus, colleges and universities must take responsibility for prevention and treatment of eating disorders among athletes.

The enactment of policy is a viable and important option through which athletic departments and institutions can choose to address eating disorders in student athletes. If health and safety issues alone are not justification enough, then perhaps protection from legal liability is. The issue of legal liability was first addressed in 1999 by Barbara Bickford, and put forth to the NCAA as an important concern necessitating policy development by athletic departments. Bickford (1999) argues that athletic departments

must enact policies. "To show that they have acted prudently to satisfy the duty of ordinary care under the circumstances, the college should have a comprehensive education, intervention, treatment and prevention program" (p. 104). The policy of the athletic department must mandate that coaches "put the health and well being of their athletes first, above all other concerns including win/loss records, championships and their own personal coaching reputation" (Alkema, 1994, p. 4). The athletic department should also have a written protocol for use by personnel to confront an athlete once eating disordered behavior is detected (NCAA, 1991).

Despite these calls to action, little has been done, and the consequences are beginning to mount. In March 2004, in a case of first impression in New Jersey, a jury awarded a judgment of \$1,470,000 to former West Windsor-Plainsboro High School student Jennifer Besler against her former high school basketball coach, the high school principal, the superintendent, and the school district, because she developed an eating disorder as a result of comments made by the coach and because the school did not address his known behavior. This landmark case is the largest verdict ever in the U.S. dealing with abusive coaching conduct at the high school level (Fleming & Wong, 2004). Colleges and universities owe this same duty of care to their athletes, and may also be found negligent if they do not make attempts to educate their employees to recognize the signs and symptoms of eating disorders and create a plan for education, intervention, treatment and referral (Bickford, 1999).

Although both the NCAA and institutions claim to support forming policy and educational programs, the enactment and enforcement of institutional policy with regard to eating disordered behaviors in student athletes remains problematic. Policies already

exist to enforce satisfactory academic progress, eliminate banned substances, and allow drug testing of intercollegiate athletes, so why not a policy covering measures to identify, prevent, or treat eating disorders? What is it about eating disorders and student athletes that has not pushed this issue to the forefront of policy development and implementation?

One explanation for the lack eating disorder policies (or information about such policies) in athletics may be the culture and environment of athletic departments, and their placement within the organizational structure of higher education institutions. Ultimately, the president of the institution is responsible for the integrity of the athletics department, and the reporting lines of the athletic department must end up in the president's office. However, there are many different paths to this endpoint (Duderstadt, 2000). Some institutions place the reporting line from the athletic director directly to the president. Many others put the reporting line of the athletic director and athletic department with a provost, vice president for academic affairs, or vice president of finance. In general, most presidents believe that athletics is far too visible and politically sensitive to have it simply managed as another student activity.

Although many institutions are decentralized, there is generally a set of controls that provides guidance to most academic and administrative units. Yet in many colleges and universities, the athletic department is allowed to operate relatively autonomously, outside of these checks and balances (Duderstadt, 2000). This autonomy is illustrated by athletics administrators bypassing affirmative action policies to hire star coaches or coaches ignoring conflict of interest rules to benefit personally from commercial endorsements. Athletic departments that are allowed to operate in such independence from the institution can threaten its overall integrity and academic mission (Duderstadt,

2000). This independence and autonomy is likely to be one reason why limited information about athletic policy is available outside of the boundaries of the athletic department or individual institutions.

Contribution and Purpose of the Current Study

The purpose of this investigation is to explore, describe, and explain the decision-making processes undertaken by institutions and key administrators in the adoption or abandonment of student-athlete eating disorder policy within intercollegiate athletics and the higher education environment. Specifically, this study:

- identified the policies and practices of athletic departments at selected NCAA Division I institutions;
- compared the policies and practices across the institutions;
- examined the roles of various actors in the decision-making process (which may include the president, athletic directors, other athletics administrators, coaches, athletic trainers, faculty representatives, and student athletes);
- examined the alternatives considered when making decisions; and
- examined the changes resulting from the implementation of policies and practices.

Theoretical Framework

Informing this investigation is general research identifying the complexity of the decision-making process. Organizational decision making focusing on the choice, process, and change model (Chaffee, 1983) provides a conceptual lens for this study. *Choice* is based on the values of the organization and the participants within it, the

alternatives considered, and the premises directing such consideration. *Process* involves timing, interaction among important actors in the decision, and institutional policies guiding decisions and feedback. *Change* is the result of the decision: what changes occur in the organization as a result of the decision, and is the result considered in future decisions? Organizational decisions also occur within the institutional and athletics culture. The culture may reflect ambiguity, historical contexts, incentives and penalties, repeated decisions, conflict, and power (Shapira, 1997). It is within this multidimensional framework that decision making about eating disorder policy was studied.

Research Questions

To explore, describe, and explain the decision-making process utilizing the overarching decision-making theoretical framework of choice, process, and change, which is embedded in the educational and the athletics environments, the following research questions were addressed.

1. Do the culture and values of athletics play a greater role than the culture of the institution in the policy decision-making process?
2. Does the level of understanding and knowledge of eating disorders affect the decision-making process?
3. Who are the important decision makers in eating disorders athletic policy? At what level in the organization do they reside?
4. What has prompted discussions about developing and/or implementing eating disorders policy?
5. What affects the alternatives considered when making policy decisions about student athletes with eating disorders?

6. Is there evidence of a rationale in justifying adoption of or abandonment of eating disorder policy?
7. Does communication of the policy or measurement of its effect on eating disorders in student athletes (if adopted) occur?

Chapter 2: Review of the Literature

A limited amount of literature explores eating disorders among athletes, most of which focuses on prevalence rates, signs, and symptoms of eating disorders, and some literature on prevention and treatment of eating disorders in athletes. There is even less literature addressing decision making in intercollegiate athletics or the role of eating disorder policy and its formation in intercollegiate athletics. This chapter will review the literature detailing identification, prevalence, and prevention of eating disorders in athletes and education about these disorders. Next, related research addressing the governance structure of athletics and important players will be reviewed, followed by literature on organizational decision making. Before delving into the literature, definitions of important terms relevant to this study are provided.

Definitions

Eating disorders consist of clusters of symptoms that include behavioral, cognitive, psychological, and physiological components. Strictly speaking, the term *eating disorders* refers to the clinical diagnosis of two syndromes, *anorexia nervosa* and *bulimia nervosa*. The *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* [4th ed.], 1994) also includes the category of *eating disorder not otherwise specified* (EDNOS), which includes binge-eating disorder. These three eating disorder categories will be defined using the criteria of the *DSM-IV*.

Anorexia Nervosa

The term anorexia means loss of appetite, and is a misnomer for this disorder, as loss of appetite is rare. The essential features of anorexia nervosa are refusal to maintain a minimally normal body weight, an intense fear of gaining weight, and a significant disturbance in the perception of the size or shape of the individual's body. Also, postmenarcheal females with the disorder are amenorrheic. Refer to Appendix A, Table A1, for the diagnostic criteria.

Bulimia Nervosa

Essential features of bulimia nervosa are binge eating and inappropriate compensatory methods to prevent weight gain. Also, the self-evaluation of individuals with bulimia nervosa is excessively influenced by body shape and weight. Refer to Appendix A, Table A2, for the diagnostic criteria.

Eating Disorder Not Otherwise Specified

The DSM-IV term for those who have serious symptoms but who fail to meet all of the criteria needed for a formal diagnosis of anorexia or bulimia nervosa is eating disorder not otherwise specified. Examples of EDNOS are listed in Appendix A, Table A3.

Disordered Eating

Disordered eating is a behavior pattern itself; however, the definition differs from the traditional definitions identified in the *DSM-IV*. Disordered eating refers to those who exhibit subclinical forms of eating disorders that meet some but not all of the formal diagnostic criteria of anorexia nervosa, bulimia nervosa, and eating disorders not

otherwise specified (Leon, 1991; Sundgot-Borgen, 1993). Appendix A, Table A4, outlines disordered eating behaviors.

Athletic Policy

Sound, workable, and effective policies can lead to consistency in athletic administration and eliminate the need for making new decisions each time a situation occurs. Athletic policy provides an effective means of communicating philosophy and objectives to and serves as a guide for coaches, staff, student athletes and others involved in a particular problem (Steitz, 1971). There is a tendency to use the term *policy* in a variety of senses, and it is often confused with philosophy, objectives, strategy, and procedures. Various characteristics of policies can be noted. Policies have wide ramifications across an organization, both internally and externally; they involve standing decisions on recurring matters and are designed to have an effect over an extended period of time; involve critical resources (human or financial); involve significant decision making; are aimed to take a stand or solve a problem; and are directed toward a dynamic social process in a changing environment (VanderZwaag, 1998). One important distinction in athletic policy is the use of the term *guideline*.

Athletic Guidelines

Guideline is a term used in the athletics culture that would be considered a policy by many in the business or academic culture. The term guideline is often used in athletics to refer to a particular policy. For example, the NCAA issues numerous guidelines to govern behaviors by institutions and individuals (eligibility guidelines, recruiting guidelines), but it also issues guidelines that are simply meant to be informative (nutritional guidelines). There are times when athletics staff use the terms *guideline* and

policy interchangeably. There are other times, generally when referring to NCAA guidelines or policy, that the terms are not used interchangeably.

Eating Disorders Among Student Athletes

In the last 15 to 20 years, there has been increased interest in examining issues relating to eating disorders and the athletic population. Early interest in this research began in the 1980s with anecdotal reports and press accounts, mainly seen in the form of case studies (Byrne & McLean, 2001). Since then, studies have examined causes and correlates of eating disorders in athletes in an attempt to establish prevalence rates in this group.

In general, studies suggest a higher frequency of eating problems in athletes than in nonathletes (Byrne & McLean, 2001). There are pressures on athletes concerning body composition, shape, size, and weight specific to athletic participation, in addition to the general societal pressure for thinness. These additional pressures have led to research examining the impact of athletic participation on the development of eating disorders. While not all of the researchers agree, a recent meta-analysis of the published literature on the prevalence rates of eating disorders among student athletes concluded that levels of anorexic and bulimic symptoms in athletes are higher than in their nonathlete counterparts (Hausenblas & Carron, 1999).

It is not surprising that many student athletes suffer from eating disorders. The competitive athlete can be described as perfectionistic, goal oriented, competitive, and intensely concerned with performance (Wilmore, 1995). These characteristics have also been linked to individuals with eating disorders (Byrne & McLean, 2001). Thus, the very

qualities that make an individual an excellent athlete may also contribute to the development of eating disorders.

In addition to the psychological makeup of athletes, the sociocultural climate of the athletics environment has an impact. Beyond the general societal demand on individuals to achieve a thin body ideal, athletes are subject to increased pressure to conform to an ideal body shape (Byrne & McLean, 2001). Some athletes face even greater pressure, depending on their sport. This is especially evident in athletes competing in sports in which low body weight or low body fat is required for performance or appearance, such as ballet, gymnastics, track and field, wrestling, swimming, or diving (Garner, Rosen, & Barry, 1998; Petrie, 1993; Sundgot-Borgen, 1993; Sundgot-Borgen & Corbin, 1987).

The pressure and climate of athletics can lead athletes with eating disorders to use athletic participation to legitimize them (Thompson & Sherman, 1993a). The preoccupation with weight and appearance, in addition to the dedication and self-discipline required to comply, makes it easy for athletes to hide eating disorders. They may often receive praise for the self-control they exhibit. In addition, because coaches, trainers, and other personnel are not trained to recognize the signs and symptoms prevalent in student athletes with eating disorders (Rockwell, Nickols-Richardson, & Thye, 2001; Turk, et al., 1999), they have opportunities to make excuses and hide the disorder, especially if they continue to perform well.

In addition to the climate in athletics, the desire student athletes have to be “good” or to please others, such as a coach or other teammates, can also perpetuate eating disorders. This desire to be thin and to please others, in addition to strict self-discipline,

often leads student athletes to believe that restricting food is good. If one is good for long enough, athletic performance will improve, the team will win more often, and the athlete will achieve glory and success (Thompson & Sherman, 1993a). In reality this is not true, but for a time, athletes can survive on sheer will alone and often do achieve greater success initially. They end up in a state of denial, believing and telling others, “How can I be sick? Just look at all my medals, awards, trophies, etc.” Eventually performance will suffer, but the athlete will still not recognize that malnourishment is the problem, and instead will insist on losing even more weight to achieve the previous levels of success.

Athletes with anorexia can come up with myriad excuses why they are not eating, if someone should point it out, or to justify it to themselves. Some of these include the many competitions, the training schedule and practices, and the travel. All of this, in addition to schoolwork, means there is not enough time to eat. Or student athletes may insist that eating before competition makes them sick because they are nervous or that eating makes them feel heavy and slow; eating afterwards may leave them feeling nauseated. They place restrictions on the types of food they can eat (e.g., no fat), which also eliminates entire food groups that may be necessary for performance in the long run.

Finally, anorexic student athletes are like nonathletes in wanting to be thin and in feeling better about themselves when they are thin (Thompson & Sherman, 1993a). However, the student athlete identity is much more linked to performance in the sport. The sport defines who the student athlete is, and this is likely to be an area where he or she feels the most competent. Thus, even student athletes who may recognize they have a problem will not report it for fear of being eliminated from the team or jeopardizing their position on the team (Thompson & Sherman, 1993a).

Student athletes with bulimia have the same fears and beliefs about thinness and sport performance and identify with their sport just as much as those with anorexia, but the means they employ to lose weight is much different. Bulimics often eat nothing all day, and then, when they are so hungry, they binge when no one else can see. This may mean that at night, when roommates are not around, they may hide food in their car or eat in the bathroom or a closet. Bulimic student athletes justify the restriction during the day by stating that it makes them slow at practice or performance. These binges are primarily triggered by hunger, but for many, the binge is a result of an emotional state. Student athletes may try to comfort themselves after a defeat, or try to ease depression by bingeing on high-fat foods which are generally forbidden (Thompson & Sherman, 1993a).

Student athletes with bulimia have a hard time eating with others, especially their teammates. Where an anorexic student athlete may push food around on his or her plate and eat literally nothing, a bulimic may avoid eating by making excuses and leaving early, or eating and then leaving to continue with a binge followed by purging. Bulimics usually use vomiting or laxatives as a means to purge, and the guilt and shame they feel associated with being discovered is tremendous (*DSM-IV*; Thompson & Sherman, 1993a). It is difficult for student athletes to hide the products of purging, especially on team trips, since so much is shared. The bulimic student athlete may spend hours planning out how to find time and privacy to obtain binge food, eat it, and purge it.

Anorexia and bulimia are the two eating disorders with the most frequently recognized diagnoses, but they do not make up the majority of what is seen in the field in terms of disordered eating. The third diagnosis, EDNOS, acknowledges the existence and

importance of a variety of eating disturbances (*DSM-IV*; Thompson & Sherman, 1993a). Eating disorders occur on a continuum, so many student athletes exhibit some signs (restrictive eating, excessive exercise, etc.) of eating disorders but not all. A primary issue is not whether a student athlete meets all of the specific diagnostic criteria of an eating disorder, but rather the extent to which the eating-related symptoms interfere with daily functioning. Also, from a treatment perspective, it is important that treatment begin before a student athlete has a full blown, diagnostically identified eating disorder (Thompson & Sherman, 1993a).

Identification of Eating Disorders

Understanding the problem is the first step in the identification of eating disorders. Although many contributing factors are common across all types of sports and levels of competition, each situation involves an individual and is unique. Recognizing the nature of the problem as it exists in different athletic settings is integral to the identification and management of eating disorders in athletes (Ryan, 1992). However, in the arena of competitive athletics, several barriers exist. It is important to be aware of these barriers in order to move into the management and treatment stage. Barriers common to athletics generally involve the beliefs and attitudes of important individuals in the athlete's life, including coaches, teammates, athletics administrators, parents, and the athlete himself or herself (Ryan).

Identifying eating disorders is problematic, and there is no one single method that works in every case. However, several methods in combination have proven successful. These include screening through using surveys and questionnaires, observing the population, talking with athletes in individual or group interviews, conducting written

interviews, and offering anonymous response processes. Combining the process of talking with athletes about their perceptions of the situation with observing athletes to identify behaviors is the most useful method to identify and determine the type or severity of an eating disorder that may exist (Ryan, 1992).

Prevalence of Eating Disorders

Researchers and therapists alike have indicated that athletes are a group at high risk for developing eating disorders (Byrne & McLean, 2001). The prevalence of disordered eating has been identified as especially high in sports in which weight and small body size is deemed necessary for performance success (Garner et al., 1998; Petrie, 1993; Sundgot-Borgen & Corbin, 1987). Although athletes exhibiting disordered eating behaviors are more prevalent in some sports than in others, the NCAA survey reported that eating disorders were evident in almost every sport; no activity was exempt from this issue (Dick, 1991). In the most recent NCAA study, 70% of responding institutions reported at least one case of an eating disorder, with 90% of those cases appearing in female sports, a significant increase from an earlier study (Dick, 1993).

Prevalence of eating disorders has varied widely from study to study, largely because of the varying definitions used and the different instruments employed to measure them. Prevalence estimates varied from 1% for anorexia nervosa to 30% for bulimia nervosa (Johnson et al., 1999.). The current diagnostic criteria for the two mainstream eating disorders (anorexia nervosa and bulimia nervosa) according to the stringent *DSM-IV* standards are very narrow, so prevalence rates in studies using these criteria to identify eating disorders are generally very low. As an example, Guthrie (1991) found that 7% of the athletes were identified as weight preoccupied according to the

Eating Disorders Inventory. In addition, although only 8% met the strict criteria for bulimia in the *DSM-III*, 41% of the athletes reported binge eating tendencies, 16% purged though vomiting or use of laxatives or diuretics, and 47% reported using excessive exercise as a part of athletic training (Guthrie).

A more recent study by Johnson et al. (1999), in collaboration with the NCAA, further illustrated the difficulty of diagnosing an eating disorder. In their study, the researchers identified four categories of classification—*DSM-IV*, clinically significant, self-identified, and at risk. Based on the *DSM-IV* criteria alone, no males or females would have been diagnosed with anorexia nervosa, and only 1.1% of females (and no males) would be diagnosed with bulimia nervosa. However, using less stringent criteria of body mass index (BMI) ratings for anorexia, 2.85% of females had clinical symptoms, and using less stringent criteria for bulimia of binge eating and purging monthly, 9.2% of females and .005% of males had clinical symptoms (Johnson et al.). Further, in examining “at risk” athletes in this study, 25% of female athletes and 9.5% of male athletes were considered at risk for anorexia nervosa, and 58% of females athletes and 38% of male athletes were considered at risk for bulimia nervosa (Johnson et al.). This study emphasized the importance of not simply focusing only on those athletes with clearly identified and defined eating disorders. It is also critical to examine athletes whose behaviors do not necessarily meet the formal diagnoses. Disordered eating behaviors are far more prevalent, and in combination with formal diagnoses of traditionally defined eating disorders, the problem reaches into the lives of many student athletes. By including those athletes who engage in a multitude of disordered eating

behaviors, it may be possible to intervene and thereby prevent the subsequent deleterious physical and psychological damage that can result.

Education for Prevention of Eating Disorders

Education is the central aspect of addressing and managing eating disorders in the athletic setting and should not be focused just on athletes, but also on coaches, parents, and support program. The most effective way to reduce the incidence of disordered eating among athletes is to prevent it. Successful treatment of eating disorders lies in their prevention, and prevention ultimately depends on widespread educational efforts (Otis et al., 1997). All athletic departments should have a treatment protocol and policy in place with regard to eating disorders. An eating disorders prevention and nutrition education program directed toward athletes addresses the duty of institutions to exercise ordinary and reasonable care for the safety of student athletes under their authority, as well as the assumption of risk and contributory negligence in determining what athletes know or should have known (Bickford, 1999). Such a program includes:

- an education program for athletic department personnel to meet the duty to provide competent coaching, proper supervision, and training.
- A preparticipation physical examination or screening program for student athletes to meet the duty to prevent injured or unfit athletes from participating.
- An intervention protocol and treatment plan to meet the duty to provide medical assistance.

Referral, Management, and Treatment of Eating Disorders

Once an athlete has been identified as having an eating disorder, immediate referral and treatment are necessary because of the life-threatening nature of eating

disorders. One leader in the formation of an Eating Disorder Team (EDT) is the University of Cincinnati. Following recommendations of the NCAA and the American College of Sports Medicine, the university created the EDT to manage eating disorders in the student-athlete population. The EDT includes a team physician, staff or head athletic trainer (only one), dietitian, and psychologist (Baer, Walker, & Grossman, 1995). Each member of the team has specific responsibilities, including monitoring and assessing medical status of the student athlete, diagnose eating disorders, making referrals to other EDT members, making decisions about participation status, monitoring eating habits, providing nutritional education, developing psychological treatment plans, and ensuring compliance with the treatment recommendations (Baer et al.).

The University of Texas at Austin's Performance Team has also successfully developed and implemented comprehensive eating disorder identification and treatment protocols (Ryan, 1992). The Performance Team brings together experts in the fields of orthopedics, endocrinology, exercise physiology, body composition, cardiology, pharmacology, psychology, sociology, allergy and immunology, physical therapy, and athletic training. The Performance Team protocols have been successful in protecting the health and well-being and enhancing performance of elite athletes.

Organizational Structure of Athletics Within Higher Education

There are almost as many different organizational structures for athletic departments as there are institutions of higher education. Several reasons for this circumstance exist. In intercollegiate athletics, especially highly visible Division I athletics, numerous areas of the institution are interested, involved, and invested in the athletic program (Duderstadt, 2000; Sperber, 2000; Steitz, 1971). Students from various

disciplines participate in sports, and it often happens that particular academic departments or faculties become loyal to athletics if one of their members is a star athlete. Student groups become involved because of their loyalties and friendships with athletes and the success of the teams. The band participates in a very visible way in athletics and members of the band spend much time getting ready for big athletic events. Student newspapers devote a great deal of space in reporting athletic event scores and stories. Athletic budgets become important in financial considerations of the institution. Often, athletics is a showpiece for the institution, the alumni, and others in the larger community. These factors often result in an atypical organizational structure of athletic departments (Sperber, 2000).

Governance of Athletics

The conference structure and the NCAA are important elements in the current organization and culture of college athletics, but so too are the internal controls that universities utilize to govern their athletic programs. Intercollegiate athletics is a highly political enterprise, with a continuously fluctuating balance of power and control involving coaches, athletic directors, faculty, presidents, governing boards, alumni, media, the entertainment industry, government, and public opinion, as well as the athletic conferences and NCAA.

National Collegiate Athletic Association

In order to understand how decisions are made involving student athletes in higher education, one must first examine the governing body of college athletics, the NCAA. The NCAA is an unincorporated voluntary association of over 1,000 member

institutions. These include four- year colleges and universities and athletic conferences in each of the United States. According to its constitution, the purposes of the NCAA are:

- To initiate, stimulate and improve intercollegiate athletics programs for student athletes and to promote and develop educational leadership, physical fitness, athletics excellence and athletics participation as a recreational pursuit;
- To uphold the principle of institutional control of, and responsibility for, all intercollegiate sports in conformity with the constitution and bylaws of this Association;
- To encourage its members to adopt eligibility rules to comply with satisfactory standards of scholarship, sportsmanship and amateurism;
- To formulate, copyright and publish rules of play governing intercollegiate athletics;
- To preserve intercollegiate athletics records;
- To supervise the conduct of, and to establish eligibility standards for, regional and national athletics events under the auspices of this Association;
- To cooperate with other amateur athletics organizations in promoting and conducting national and international athletics events;
- To legislate, through bylaws or by resolutions of a Convention, upon any subject of general concern to the members related to the administration of intercollegiate athletics; and

- To study in general all phases of competitive intercollegiate athletics and establish standards whereby the colleges and universities of the United States can maintain their athletics programs on a high level. (NCAA, 2002a, p. 1)

The NCAA is an association for members and of members, and its responsibilities are to provide direction, guidance, and resources for individual institutions. Each institution has a council to advise the president, who is the voting member at NCAA conventions. This council generally consists of at least the athletic director, the senior woman (athletic) administrator (SWA), a faculty representative, and a compliance officer to deal with accreditation issues and NCAA mandated self-study reports. The NCAA is primarily a body that exists to meet the needs of its members. The formal governance structure and decision-making authority of the NCAA have changed radically over the last 10 years (Duderstadt, 2000; Fleisher, Goff, & Tollison, 1992; Katz, 1995; VanderZwaag, 1998). For many years, decisions were made at the annual convention, where all members had an opportunity to enact legislation dealing with student athletes. All NCAA legislation was adopted by a vote of the active members.

In 1996, the NCAA passed legislation at its 19th convention changing the way it conducts its business. This legislation, in the form of Proposal 7, was a restructuring plan that provided for a federated association and placed university presidents and chancellors in all the top decision-making positions. This controversial legislation, which went into effect in August 1997, replaced the separate entities of the NCAA Council and President's Commission with one 16-member Executive Committee and three separate boards representing the three divisions within the NCAA. This structure gives each division autonomy in conducting its business (VanderZwaag, 1998), and provides an

even further separation between Division I athletics and other divisions. In the current system, entire conferences get only one vote. For example, if there are 13 member institutions in a conference, all of the institutions may select a position on an issue. However, whether the vote is 12 to 1 or 7 to 6, the same single vote from the conference is reported, eliminating the individual voice institutions once had. This realignment has been a serious controversy for the last four years, and because many institutions lost their individual voice in the process, it was decided at the 2003 convention that NCAA will return to a mixed method version in 2004, combining the current structure with an opportunity for all member institutions to vote once again, though not all institutions will be weighted equally in the process (Brand, 2003).

The NCAA as an organization has been referred to by economists as a cartel (Fleisher, et.al., 1992) where reform and policy making work to support maintaining the status quo of the organization. As Fleisher et al. stated, “looking to the NCAA itself as a source of potential reform of college athletics is equivalent to putting the fox in charge of the henhouse” (pp. 145-146). Participants in this cartel schematic include coaches, faculty, presidents, fans, the media, athletic personnel, and even the United States legal system. Examination of how changes in policy decisions are made in athletics reveals that they are almost always initiated by the NCAA itself as an attempt at internal regulation. Even the 22-member Knight Commission, which appeared to many to be an outside agency studying the organization, included 15 commission members who were present or former executive officers or board members of universities, plus the NCAA executive director (Fleisher et al.). The largest reform that was initiated as a result of the

commission's 1990 report was that college presidents would assume responsibility for and control of athletic policies, personnel, and finances.

This same system is still in place today, as institution presidents are the voting members of the NCAA on all policy changes at the national level. Currently, a committee structure exists at most Division I institutions whereby various faculty and athletic staff representatives meet to discuss upcoming issues for the presidential vote at NCAA. To inform the president of what the institution's position should be on various decisions, the members of this committee try to assess what will be best for the institution, the conference, and division.

Athletic Conferences

Athletic conferences such as the Big Ten are supposed to operate within faculty control, with faculty members from the conference universities controlling both the conference and the athletic departments on their campuses. Yet, the real power has traditionally resided with the coaches and the athletic directors (Duderstadt, 2000). Originally, athletic conferences were organized by university presidents, and decisions were made by a conference commissioner with athletic directors and faculty representatives at each institution. Now, however, the presidents have both the responsibility for and authority over the conference functions.

Important Individuals in Athletic Governance and the Life of Student Athletes

Coaches

At the individual and team competitive levels, the responsibility for program control rests on the shoulders of the coach. In fact, many coaches attempt to maintain total control over their athletes in all areas of their lives. Coaching, by its very nature,

generally attracts those who are driven to win by extreme expectation levels for both themselves and their players (Duderstadt, 2000). Because of this intense pressure to win, coaches' decisions are governed by totally different objectives than that of the university.

The role of the coach in the life of an athlete cannot be understated. Researchers from the fields of nutrition, athletics, and clinical eating disorders agree that while coaches do not cause eating disorders, they do have considerable power and influence with their athletes, and can be part of the precipitation, perpetuation, prevention, and treatment of eating disorders (Garner et al., 1998; Sherman & Thompson, 2001; Sundgot-Borgen, 1994; Thompson, 2003). The NCAA recently sent a survey to coaching staff to examine their knowledge and practices with regard to eating disorders and their athletes. The results will not be available until 2004 (Wilfert, 2003), but the fact that coaches are now being included in this research from the highest levels of the organization further indicates their important role.

Athletic Directors

The athletic director in a college or university represents not only the athletic department, but the entire institution. The athletic director is responsible for personnel decisions, budgetary management, facility management, communication with internal and external constituencies, formulation and implementation of policies and procedures, protection of athletes and coaches, adherence to rules and regulations, and the attainment of the aims, goals, and objectives of the institution (Duderstadt, 2000; Miller, 2002). In reality, the athletic director is held accountable for the number of games won and lost, as well as satisfying internal and external constituents. These pressures often push athletic directors to take a dictatorial approach to management, which sharply contrasts with the

consultative, collegial, and sometimes anarchical culture of the academic units of the university (Duderstadt, 2000).

Athletic Trainers and Medical Staff

Safety, physical and emotional, is often left in the hands of the medical staff in athletics. There are NCAA guidelines on nutrition and athletic performance, measuring body composition, and menstrual dysfunction, all of which are published in the *NCAA Sports Medicine Handbook* (NCAA, 2002b, pp. 26-35).

The Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS) is the division of the NCAA whose mission is to “provide expertise and leadership to the Association in order to promote a healthy, safe environment for student athletes through research, education, collaboration and policy development” (NCAA, 2003a, p. 1). There are two subcommittees, the Drug-Education and Drug-Testing Subcommittee and the Sport Sciences Safety Subcommittee. The latter provides guidance on sports specific research and policy issues and edits the *NCAA Sports Medicine Handbook* (NCAA, 2002b). This subcommittee is responsible for the area that includes eating disorders. According to CSMAS bylaws, members of this subcommittee represent doctors, athletic trainers, other health care personnel, coaches, SWAs, athletic directors, and students (NCAA, 2003a). The CSMAS utilizes the athletic trainers at institutions as the primary point of contact (Wilfert, 2003).

The importance of athletic trainers and other medical personnel in the lives of student athletes, particularly with regard to nutrition and eating disorders, is documented (Biesecker & Martz, 1999; Hornak & Hornak, 1997; Parr, Porter, & Hodgson, 1984; Rockwell et al., 2001; Turk et al., 1999). Additionally, in the athletic environment, it is

the responsibility of medical personnel (trainers and physicians) to respond to health related issues, including eating disorders (Andrews, 2002; Parr et al., 1984; Rockwell et al., 2001). Although the medical staff is relied upon for knowledge in this area, it is not clear where their connection to the governance of athletics fits in.

Faculty

To the extent that intercollegiate athletics is supportive of the educational mission of the university, there should be some role for faculty. When athletics first became a part of higher education in the 1800s, faculty were often coaches and managers of athletics teams, though their roles are much diminished today. Few have time to learn the intricacies of contemporary intercollegiate athletics. Most universities allow faculty to have a role in one of two areas: governing or advisory bodies associated with athletic departments or as the faculty athletics representative to the conferences and NCAA.

Students

“In considering the various internal and external constituencies either determining or threatening institutional control of intercollegiate athletics, there is one group conspicuously absent from most discussions: students” (Duderstadt, 2000, p. 249). Universities often have students represented on major university committees, including searches for key positions at the institution and on advisory boards for the development of institutional policies and activities affecting students. However, student involvement in either governance or policy development in intercollegiate athletics is absent or weak. Conferences and the NCAA have made an attempt to include students by forming advisory groups of student athletes in recent years, but their voice is rather muted when it comes to key policy matters or decisions (Duderstadt).

The President

Presidential involvement in athletics varies depending on the type, values, and mission of an institution, the importance of athletics to the overall success of the institution (as defined by the institution), and the many other demands on the president's time. As a result, committees and athletic councils are developed on the institutional level. It is also common for athletics staff to try to shield the president from making decisions on what they feel are trivial matters in an attempt to save their time with him or her for more important matters. Much of this depends on the organizational structure and communication procedures at the institution (Alden, 2001).

Ultimately, the final responsibility and authority for intercollegiate athletics rests with the university president, an authority reinforced in recent years by changes in the governance of athletic conferences. However, while this responsibility is consistent with the president's other duties, it is clear that control depends on the delegation of authority to key leaders and the establishment of a system for monitoring compliance with institutional, conference, and NCAA policies (Duderstadt, 2000). However, this approach is somewhat new to athletics, and the president must continually be cognizant of the long tradition of athletic departments' relative independence from the rest of the university and of the numerous external forces that influence college sports.

Policy Formation in College Athletics—An Example Using Supplements

Few detailed guidelines are available in the literature to help in developing institutional policies and procedures for athletes with eating disorders. Often, administrators simply borrow policies from other institutions that may or may not fit their situation. However, in an attempt to assist those in athletics to create appropriate policies

for their institutions, Conn and Malloy (1990) suggest four main considerations. The first is defining the educational philosophy of the institution and community, reflecting the goals through the actions of the leadership, and integrating goals with the requirements of local, state, and national agencies. Second is establishing a unified system of personnel, facility, and safety management. Third is ensuring compliance with recognized rules of play, scheduling, and event management. Last is complying with the instructional, supervisory, and safety procedures directed by athletic staff. Conn and Malloy further suggest that in order to write effective athletic policy, it is necessary to identify the structure of the athletic administration, recognize the multiple sources of authority, and define the institution's athletic goals. They advocate the involvement of many stakeholders in this process, including the Board of Trustees, institutional administration, athletics administration and staff, and faculty.

Although the literature contains limited research on the development of athletic policies, it is helpful to review suggestions for policy approaches in other areas related to the health of athletes. In addition, examining an area similar to eating disorders, where the ultimate governing body of athletics, the NCAA, has not mandated policy, may help in understanding how policy is formed in the absence of external regulation. One such area that has recently received attention is the use of supplements by student athletes. In a recent article addressed to athletics administrators, Rochman (1999) outlines the processes by which some institutions have addressed the issue of forming, reforming, and issuing policies on supplements. In this scenario, he examined institutions that adopted a policy to disallow supplements and those that adopted a policy to allow supplements with regulation.

The issues of eating disorders and supplement use are similar in a number of areas. In both eating disorders and supplement use, the collegiate governing bodies have considered formulating their own policies, but have not yet adopted any policies. In the case of supplement policy, institutions formed committees responsible for obtaining research on the topic. These committees generally consisted of athletic directors, athletic trainers, coaches, team physicians, nutritionists, and exercise scientists (Rochman, 1999). Then the athletic departments examined their mission statements within this context to evaluate whether allowing supplements fell within the values and goals of the department. Depending on the resulting decision, institutions communicated their policy stance in a unified voice, both orally and in writing, to students and parents alike. They also adopted educational programs for student athletes on supplements.

The major differences among the policy decisions were first, the initial decision to examine the policy, and then the types of institutions that elected to ban supplements and those that allowed them. Some institutions decided to look at their policies after critical incidents (the deaths of three wrestlers) occurred. For some administrators, it was the death of the third wrestler that served as a wake-up call (Rochman, 1999). As one administrator, Janet Kittell of Syracuse University, stated, “My position was that even though there was no obvious proof (that supplements caused the deaths) ... we could not afford from a health and safety issue—nor from a liability issue—to allow creatine (Rochman, p. 19). Two major considerations, health and safety of athletes and risk management and liability, prompted this institution to action. In other instances, the deaths were not the impetus for examining the policy issue, but liability was. As one trainer at a Division I school at stated, “We stressed to the coaches that they shouldn’t tell

players to take these supplements, and that if the athletes did use them, it should be purely voluntary (Rochman, p. 19).” The institution did not want to be responsible or liable if something negative were to happen as a result of the athlete taking supplements.

In contrast to their Division I counterparts, Division II and III institutions of the NCAA came together to agree to make some supplements a nonpermissible expense year round, meaning that they cannot hand out supplements. Division I institutions are still debating the issue (Rochman, 1999) and many do still distribute supplements. It is possible that this type of decision reflects the different value systems inherent in lower division athletics, where students are not on scholarship; such institutions may tend to focus less on performance and more on the student aspect of student athletes, and less on the economic success and vitality of the athletic departments (Sperber, 1990).

Organizational Decision Making

Five organizational theories of decision making as identified by Chaffee (1983)—rational, collegial, political, bureaucratic, and organized anarchy—have informed both the design and instrumentation of this investigation. Decisions made at multipurpose organizations, including institutions of higher education, are a result of a process that takes into account the values of the institution and the key decision makers. These values, in turn, affect the alternatives considered, the choice made, and how implementation occurs. The results of the decision, the feedback mechanism, and the consequences of further changes or choices drive the decision-making process in a recurring cycle (Chaffee). These concepts of choice, process, and change are present throughout the various decision-making models. Decisions are also affected by a number of background

issues, including the historical or longitudinal context, ambiguity, incentives or punishments, repeated decisions, and conflict (Shapira, 1997).

The rational model of decision making was highlighted early by Frederick Taylor, who took a Scientific Management approach to the workplace as he sought to yield “optimally efficient production” (Schon, 1983, p. 237). Later, Herbert Simon made major contributions to this model, incorporating three phases into the decision making process – intelligence activity, design activity, and choice activity (Simon, 1960). Simon’s work has formed the basis of many of the contemporary models used by business and corporations. Rational decision making is a concept easily accepted by those of us in the Western culture because we tend to use logic, rationality and science when we think about concepts such as decision making (Owens, 1995).

In this model, all possible options or approaches to solving the problem under investigation are identified, and the costs and benefits of each option are assessed. The option that promises the greatest benefit overall is selected. A basic premise of this approach is that those making the decisions act in a rational way, that they have all of the information about each alternative, and that they will behave in a nonemotional, non political manner (Slack, 1997) The rational model also assumes a set of common goals shared by the individual actors and congruency in their ideas or attitudes about achieving them.

Rational decision making is characterized by a series or pattern of sequential steps to make decisions. Enactment of the policy decision requires a series of actions, committees, votes, or other machinations. A benefit of this model is that it has the possibility to unify the actors in the process. It also requires a degree of technical

competence on the part of individual actors in order for complex relationships within the decision to be understood (Chaffee, 1983). However, it is most often referred to as a method by which decisions ought to be made, rather than how they actually are made.

In the collegial model, which many assert best characterizes institutions of higher education (Chaffee, 1983), the concept of shared responsibility is important. According to the collegial model, the faculty direct institutions, acting as “peers who reason together toward their common goals (Chafee, 1983, p. 15).” The collegial model relies on consensus building with a system of shared governance that directs decisions. Participants must be willing to explain and receive information, take time for discussion and be willing to compromise for the betterment of the institution as a whole.

Success using this model in an organization requires consensus on fundamental principles, time and opportunity for discussion, and participants with open minds and respect for one another (Chaffee, 1983). At some level, the decision must be satisfactory to all the participants. Thus, implementing a policy requires both input and agreement from all the decision makers around the table.

The political decision-making model centers on power and conflict. Conflict resolution, the basis of political decision making, is arguably present in most organizational decisions (Chaffee, 1983; Shapira, 1997). Political decision making is common in higher education, and is often evidenced when several parties have an interest in the outcomes of the choices made. These interested parties usually disagree about the choices and as such, they begin to undertake visible political activities to influence the decision. These ‘tactics’ include argument, assembling experts, coalition formation, and bargaining (Shapira, 1997).

However, in some instances, the power and politics of external constituencies force a decisionless choice to be made. A decisionless choice is a situation in which a decision maker faces more than one choice, but is not free to choose any other than one alternative because of real or perceived pressure or coercion (Shapira, 1997). Policy decisions are impacted by such stakeholders, either externally or interdepartmentally. The concept of how a multipurpose organization resolves the conflict between the needs of one department and that of the entire institution is important.

Bureaucratic organizations are characterized by great attention to precise and stable delineation of authority among subdivisions and among the officials who comprise them. Mintzberg (2000) described the professional bureaucracy as an organization with a tightly knit configuration of design parameters. This organization relies on the standardization of skills and its associated design parameters, training and indoctrination. This model exhibits a highly hierarchical structure to achieve systematic decisions and to institutionalize organizational learning.

Historical alternatives are important in bureaucratic decision making. A previously successful policy decision is used to justify the replication of the decision (Shapira, 1997). In addition, procedure sometimes obscures substance in this model of decision making, adding to the importance of predictability of decisions.

Finally, this investigation is framed by the organized anarchy or “garbage can” model in terms of accidents, incidents, timing, and interest. Cohen and March (1974) suggest there is no logical sequence in the decision making process because many different things are happening within the organization simultaneously. Decision making in this model is an outcome of four independent streams of events – problems, choice

opportunities, participants, and solutions. The existence of these streams leads to a process of decision making that is random. Other characteristics of this model are a diversity of goals, ill-understood technology, and scarce time and resources (Chaffee, 1983). One determinant of the choice is who makes her or his concerns most known in the decision-making process. Decisions in this model are more a result of chance and coincidence than of any systematic, rational, or intentional choice. As a consequence, some problems are never solved, solutions may be brought forward before a problem has been identified, and choices are often made before problems are understood.

Decision Making in College Athletics

At first glance, the numerous committees, advisory boards, conferences, and university structures indicate a rather mechanical decision-making process, through which information is gathered at the coach's level and passed to the athletic director and on to the president, and decisions are made in a methodical, top-down fashion. However, the reality is that decision making in college athletics is not well understood. The very nature of university athletics is embedded in competition—for students, for wins, for financial gains, for public recognition and more. This cutthroat environment of current athletics, combined with the multifunctional nature of the modern university, compounds the issue of decision-making strategy and process. Additionally, the literature in the field of sport and athletic management is not at the same stage as some other areas of higher education policy.

Decision making in any organizational context is often looked at as a rational, coherent process in which alternatives and perspectives are considered in an orderly fashion and the most beneficial alternative is selected (Shapira, 1997). The reality is that

decision-making processes in organizations, including intercollegiate athletics, seldom fit such a narrow description. Moreover, decision making in intercollegiate athletics involves several suborganizations operating within an institutional context.

Intercollegiate athletics is also an organization with a separate governing body, the NCAA. Although the individual departments and teams operate within the parameters of the institution, they must also operate within the NCAA (Slack, 1997). It is the latter that is truly the conundrum in understanding the decision-making processes of higher education and intercollegiate athletic departments. When do the departments abide by the regulations of the institution and when do they conform to the NCAA guidelines? If the two are not in agreement on an issue, to which organization does the athletic department claim its allegiance?

The process of decision making in any organizational context involves some of the same parameters and characteristics. Any decision (organizational or individual) involves choice, process, and change (Chaffee, 1983). Even though organizations may experience the process of decision making as a result of an external, uncontrollable event or agency, the organization still has the choice of the reaction or alternative in response. For example, the NCAA may impose regulations such as the minimum seating capacity of the football stadium required for an institution to be a member of Division I. The university still must choose— is it that important to be Division I? According to Chaffee, choice has three underlying features and three consequences. The three underlying features are the values of the organization and the actors within it, the alternative courses of action considered, and the premise directing the consideration of alternatives. After a choice is made, the outcomes involve implementation of action or procedure for the

choice to come to fruition. The results of the choice include change, both externally and internally, and feedback or evaluation of the change caused by the choice.

Based on this scenario of choice, process, and change, understanding decision making in intercollegiate athletics appears somewhat easy. All that is necessary to understand the choice made is to understand the values, alternatives, and premises on which it is based. Following this model, a process is in place to make the choice, processes occur during the implementation of the choice, and consequences and changes are associated with the implementation of the choice. However, this simplistic model must be adapted to include the institutional and athletic culture, where some parameters are not known even to the participants in the decision-making process.

It is within the culture of the organization and embedded within the choice, process, and change of decision making that uncertainty and assumptions lie. Organizational decision making is characterized by ambiguity, historical context, incentives and penalties, repeated decisions, and conflict (Shapira, 1997). In any organization, ambiguity is pervasive. Information, preferences, and interpretations of past decisions are often not clear to some or all of the people in a position to make decisions. Decision making in organizations is embedded in a historical context. Within organizations that have been in existence for any period of time, participants remember how decisions were made in the past, and these memories play a role in the future decisions and their consequences. Incentives and penalties also play a role in organizations, with ramifications that may have long-lasting effects. Consider, for example, institutions that have been put on notice by the NCAA as a result of players cheating in courses or having others complete their coursework. The players, coaches,

staff, athletic department, and ultimately the university's integrity and reputation will pay a price in the eyes of not only the NCAA, but also the public.

In addition, within organizations, decisions must often be made repeatedly in similar situations. One example of repeated decision making is considering students' requests to make up work or retake exams. Faculty members are in a position to consider a decision like this many times throughout their careers. As a result, those making the decisions often have a false sense of confidence or control over the situation, when in actuality the decisions are made following institutional practice rather than relying on the skills of the decision maker(s). Conflict is also pervasive in the organizational setting (Shapira, 1997). Oftentimes, power considerations determine decisions, rather than considering options or calculating cost-benefit analyses.

Much of the literature in the area of organizational decision making in athletics and sport management has focused on relatively narrow and incomplete views of how organizations function. The two dominant perspectives in the literature have been to look at organizations from either the mechanistic or systems theory approach. Although such approaches can be useful, they are limited because they fail to recognize the ability of organizations to change as their situations change. They also ignore issues of power and politics, thus presenting only a partial view of sport organizations and their management (Slack, 1997).

Work that looks at sport organizations in their context as both unique entities and cultures and as a part of the larger higher educational system would help shed light on important issues in the field. Such a framework would require a different research technique than that prevalent in current sport management literature. Olafson (1990) has

demonstrated that survey-type studies have dominated the field. New research to explore different theoretical approaches will require different research designs and modes of analysis not commonly used to study sport organizations. Qualitative approaches are noticeably absent from the academic sport management literature, and need to be more frequently employed to help researchers understand that different approaches explain different parts of the reality of sport and athletic organizational life within higher education (Slack, 1997). This investigation will explore the decision-making process in athletics, keeping these considerations in mind, by examining decision making through a combination of Chaffee's (1983) model with Shapira's (1997) five characteristics of organizational decision making. This framework is illustrated in Figure 2.1.

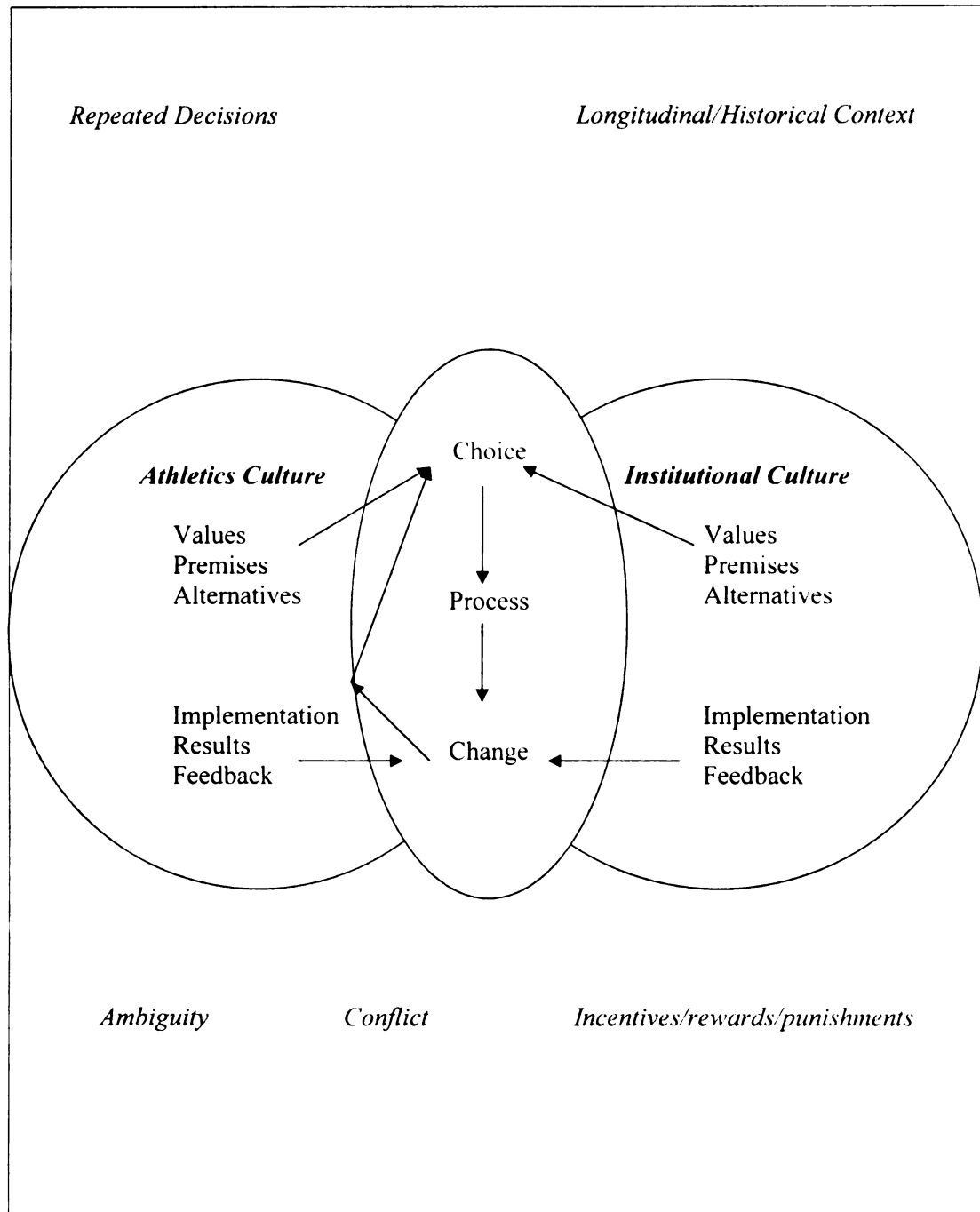


Figure 2.1. The decision-making theoretical framework as adapted from Chaffee (1983) and Shapira (1997).

Chapter 3: Methodology

Conceptual Framework and Research Questions

Five organizational theories of decision making as described in Chapter 2—rational, collegial, political, bureaucratic, and organized anarchy—have informed both the design and instrumentation of this investigation. Decisions made at multipurpose organizations, including institutions of higher education, are a result of a process that takes into account the values of the institution and the key decision makers. These values, in turn, affect the alternatives considered, the choice made, and how implementation occurs. The results of the decision, the feedback mechanism, and the consequences of further changes or choices drive the decision-making process in a recurring cycle (Chaffee). These concepts of choice, process, and change are present throughout the various decision-making models. As mentioned in Chapter 2, decisions are also affected by a number of background issues, including the historical or longitudinal context, ambiguity, incentives or punishments, repeated decisions, and conflict (Shapira, 1997).

These five models helped me formulate the design of this study to meet the objective of exploring, describing, and explaining the organizational decision-making process concerning policy for student athletes with eating disorders. This investigation focuses on how decisions actually happen in organizations, not on how they should be made. I asked the following research questions, informed by the previously stated decision-making perspectives, keeping in mind that all decision-making processes have a core framework consisting of choice, process and change (Chaffee, 1983).

1. Do the culture and values of athletics play a greater role than the culture of the institution in the policy decision-making process?

2. Does the level of understanding and knowledge of eating disorders impact the decision-making process?
3. Who are the important decision makers in eating disorders athletic policy? At what level in the organization do they reside?
4. What has prompted discussions about developing and/or implementing eating disorders policy?
5. What affects the alternatives considered when making policy decisions about student athletes with eating disorders?
6. Is there evidence of a rationale in justifying the adoption of or abandonment of eating disorder policy?
7. Does communication of the policy or measurement of its effect on eating disorders in student athletes (if adopted) occur?

The following five sections describe the development and rationale behind the study design; the instrumentation; the selection of sites and participants for the study; the analytical strategy, as well as instruments and analytical procedures; and finally, issues of trustworthiness and the limitations of this investigation.

Study Design

I examined the decision-making process of choice, process, and change (Chaffee, 1983) and recommendations for athletic department policy formation (Conn & Malloy, 1990) in the context of history, ambiguity, incentives or punishments, repeated decisions, and conflict (Shapira, 1997).

The initial step was to administer a questionnaire focused first on identifying whether or not an institution had an eating disorder policy in place or under consideration

or development (see Appendix B). The analysis utilizes numerical data gleaned from the questionnaire administration phase of the investigation. Data on the number of institutions with a policy and the degree of policy implementation were used both to select a set of institutions for further study and to describe national trends. Also of interest were how and to whom the policy is communicated (as indicated by Rochman, 1999) and the content of the policy.

As a part of the questionnaire administration, institutions with a policy were asked to submit a copy. Document analysis provided additional insights into the formulation of the policy and aided in answering the research questions. This instrument was sent to individuals in athletics administration and those in charge of medical standards and safety.

Finally, the questionnaire was used to identify three case study sites for the second phase of the investigation. After evaluating questionnaire responses, I placed institutions into one of three categories reflecting the level of development of eating disorder policy. The process of site categorization is described later in this chapter.

For the case studies, I used an ethnographic case study approach to gather information, because so little information is available on policy formation in intercollegiate athletics. I collected documents, conducted semistructured interviews with key decision makers and focus group interviews with student athletes, and took field notes of what I observed as well as casual conversations I had with people while I was on each campus. The case study offers a means of investigating a complex social unit, such as an institution of higher education or an athletic department, which consists of multiple

variables of potential importance in understanding a phenomenon like policy decision making (Merriam, 1998).

The qualitative case study approach fits best for this investigation because I am interested in discovery and interpretation as opposed to hypothesis testing (Merriam, 1998). By focusing on a single phenomenon (policy decision making), I can uncover the interactions of significant factors that are characteristic of this phenomenon. As Yin (1994) observes, the case study design is particularly suited to this investigation because it is impossible to separate the phenomenon's variables from their context. Further support for this design is the fact that case studies focus on a particular situation, event, program, or phenomenon. This "specificity of focus makes it an especially good design for practical problems—for questions, situations, or puzzling occurrences arising from everyday practice" (Merriam, 1998, p.29). This investigation is focused on the process of decision making about policy. The case study design is particularly well suited to answer the research questions and help understand the process by exploring, describing, and explaining policy decision making. Finally, since little is known about how this phenomenon occurs, this approach is a good choice because numerous and conflicting variables are so embedded in the situation that they are difficult to clearly identify ahead of time (Merriam, 1998).

This investigation also used a multiple site, or cross case, analytical procedure. According to Miles and Huberman (1994),

By looking at a range of similar and contrasting cases, we can understand a single-case finding, grounding it by specifying *how* and *where* and, if possible,

why it carries on as it does. We can strengthen the precision, the validity, and the stability of the findings. (p. 29)

I used individual interviews, focus group interviews, document collection, and field notes of observations to collect data for the case studies. Through this process, I looked for issues regarding leadership roles (internal and external); governance structures and processes (within the institutions and local and national athletic organizations); compliance or accreditation issues; issues of authority, power, and conflict; references to institutional values, missions, and goals (espoused or actual); athletic department values and goals; legal and liability concerns; the occurrence of some precipitating event; the organizational level at which policy discussion or formation occurs; and how communication occurs (formal or informal).

Instrumentation

Individual Interviews

I conducted semistructured interviews with key decision makers, including senior woman administrators, team physicians, coaches, team nutritionists, staff psychologists, athletic trainers, academic advisors, and faculty members. Because decisions are made differently from campus to campus, the important actors were identified through a “snowball” effect by asking initial contacts in the interview process who else on their campus is part of the process. The interviews concentrated on the discussions and decision to develop and implement policy within the context of higher education and athletics. Semistructured interviews allowed me the opportunity to explore the topic in depth, gain the perceptions and observations of what has transpired in the participants’ views, and learn of other possible sources of information.

The individuals interviewed may each approach the decision-making process from a different conceptual lens. The questions developed for the interviews related directly to the seven research questions (refer to Appendix C for the interview protocol). First, who has been making the decisions about athletics policy? This question addresses the level at which decisions have been made. Second, how have those decisions been made? What alternatives have been considered and by whom? How have the actors framed the issue, advanced their interests, and defended their points? Have discussions focused on empirical analysis, personal considerations, a critical incident, liability, institutional values, health and safety of athletes, or other issues? Third, how has this policy been considered, implemented and institutionalized over time? The questions developed in the interview process focus heavily on the process that important actors followed in the consideration of the issue and policy.

In developing the interview questions, I first examined the impetus for the initial consideration of policy formation on eating disorders in athletes—that is, the choice to make a decision about this matter. In higher education, the complex and often conflicting roles of academic and athletic organizations and the leaders within them may in some cases lead decision makers to become reactive. I therefore considered as possible reasons for the initial discussions an external trigger or critical incident such as a parental phone call, as was in the case of USA Gymnastics (Kelly, 2003), the death of an athlete at their institution or another institution, the passing of an article to the president by a Board member, or the uprising of the student athletes. Following the patterns of other known decisions in intercollegiate athletics, this external trigger or critical incident is usually something brought to the attention of an upper level administrator (possibly the Board of

Trustees or president), passed down to the athletic director and distributed from there to the appropriate personnel.

Questions in the interviews also focused on the consideration of alternatives. Important in this area are the values of the institution, athletic departments, and individual personnel. I looked for references to such consideration of values from individuals within the organization, although they would likely be conflicting, since individuals would have their own perspectives and values. For example, in considering a policy, the members of the institutional administration may overtly state that the protection of the health and safety of their student athletes (a value) is important, but the consideration and final decision may have been based on other values (fiscal responsibility, liability avoidance). Even more confounding is the variance of values and relative importance held by members of the administration, and their role in the decision-making process. It is possible to find variability in the influence over the decision depending on administrative rank (Slack, 1997). I examined the level at which decisions are made through the interview process, addressing any conflicts by further probes of other individuals or following up with the same individual if conflicting views emerged.

To examine the process, I asked questions about the various leadership roles held by the important actors to obtain clues on how the decision-making process works. For example, I was not certain what to expect from the role of the president. Knowing that the nature of the presidential role at Division I institutions tends to reflect multiple demands, I took into account references indicating that the president may simply be informed that the athletic department is adopting a policy, and his or her role may be minimized in the actual process other than to give the final stamp of approval.

Committee development to address an issue or study a problem is common in both the academic and athletic worlds (Slack, 1997). These committees tend to include a number of staff members and student representatives, on both the institutional and NCAA level, so I expected to find decision making through committee formation as a common practice. Knowing that both athletic trainers and medical staff are primarily and often equally, responsible for the health and safety of athletes, as seen by both institutions and the NCAA, I expected to find participation of both groups on the committee to be necessary. I also expected these two groups to play a large part in the actual policy development, writing, and implementation.

Another important consideration is the historical aspect of the institutional policy formation process. Knowing that institutions have numerous policies and procedures in place for how decisions are made—who is involved, what procedural elements exist for developing and adopting policies—an important consideration for decision makers is how the process occurs at the institution; that is, how have past decisions been made. This line of inquiry seeks to understand the historical context and the notion of repeated decisions and how these factors may impact the process of decision making, either in the choice, process, or change areas.

The effect of the decision making process on the resulting policy - whether it is adopted in some form, abandoned, or still under discussion - will likely be different on different campuses. It may result in a written policy or procedure manual, or provide increased funding to hire sport nutritionists, psychologists or other health care professionals. It may mean the adoption of educational programs for athletes or staff. It

may simply mean an increased awareness of the problem among university administrators, athletics personnel, faculty, or athletes.

Focus Group Interviews

I also conducted focus group interviews with student athletes serving on the Student Athlete Advisory Committee at the selected institutions. The student focus group interview questions followed a similar line of inquiry, although the concentration was on a slightly different aspect of the decision-making process. The questions asked focus on the participants' attitudes toward the issue of eating disorders, knowledge of the policy decision, the process, and subsequent changes that may result from the implementation or institutionalization of the policy. In this group, I was looking most for evidence of cultural impact, inclusion or exclusion from decision-making discussions, and communication patterns.

I chose to use focus group interviews for two reasons. First was for the convenience factor of gathering groups together. This process saved time and researcher expense in collecting information. Second, because of the sensitivity of this issue to many involved, focus groups serve to create a social situation and lighten the atmosphere, creating less pressure for any one individual to respond. The assumption is that an individual's attitudes and beliefs do not form in solitude—people often need to listen to others' opinions to form their own (Marshall & Rossman, 1999). The intent was to promote self-disclosure among the participants. This informal, interactive environment gave even the most reserved person the chance to talk in a relatively low-risk setting (Krueger, 1988). Finally, this group of actors may be personally affected by the policy process.

Document Collection

Institutional documents provide the history and context in which decisions are made and assist in the triangulation of data. They help illuminate what was important to the author(s) of such documents. They also may represent institutional or departmental values, such as the importance of communication of particular topics. Documentation collected in this study includes student-athlete handbooks, departmental research reports suggested by important actors, which they considered or utilized in their decision-making process, and pamphlets and leaflets from student-athlete advising and medical offices.

Field Notes from Observation

Finally, I spent varying amounts of time on each campus (ranging from 12 to 36 hours and from 1 to 5 visits). I took field notes on what I observed during my time in various offices, buildings, and waiting rooms, and from conversations with department secretaries and other people I encountered during my visits. The field notes assisted in making sense of the data from the documents, interviews, and focus groups.

Selection of Sites and Participants

Site Selection

Research indicates that any student athlete is potentially at risk for developing disordered eating, but the evidence strongly suggests that athletes competing in sports in which weight and physical appearance are important face the greatest risk (Thompson & Sherman, 1993a). As outlined in Chapter 2, sports with a higher prevalence of disordered eating behaviors include gymnastics, figure skating, cross country, wrestling, and swimming. To obtain a large enough yet manageable sample of institutions, I examined institutions hosting two of these high-risk sports: women's gymnastics and men's

wrestling. I further limited the sample to Division I institutions (which generally have more resources and a more competitive environment) that host both women's gymnastics and men's wrestling. The 31 Division I institutions that met these criteria were selected to participate in the preliminary questionnaire administration of this investigation.

Participant Selection

Although the NCAA's responsibilities are to provide direction, guidance, and resources for individual institutions, there are some similarities in the governing bodies and committees at each institution that help in determining the key players. These key players were selected for individual interviews in this study because of their involvement in student athletics. Each institution has a council to advise the president, who is the voting member at NCAA conventions. As described earlier, this council generally consists of at least the athletic director, the senior woman (athletic) administrator, a faculty representative, and a compliance officer to deal with accreditation issues and self-reports. The SWA is important because she is generally the initial point of contact used by the NCAA for issues related to nutrition and eating disorders (S. Appelbaum, personal communication, June 2003; M. Weston, personal communication, February 2003). The SWA received the initial questionnaire as well as an interview. Medical personnel are responsible for all aspects of athlete health, safety, and well-being. Athletic trainers and team physicians were selected to receive the preliminary questionnaire along with the senior woman administrator.

Limited work has been done to develop eating disorder treatment teams on campuses. One study defines a success story of the Eating Disorder Team at the University of Cincinnati, following recommendations from both the NCAA and the

American College of Sports Medicine (ACSM). The members include the team physician, head or staff athletic trainer, dietician and psychologist (Baer et al., 1995). Recommendations for future development of campus eating disorder treatment teams for athletes support the inclusion of individuals within the athletic environment, such as coaches and athletic trainers, and health care professionals, including psychologists, physicians, and dieticians (Sherman & Thompson, 2001). These members, if available at the selected institutions, were interviewed as a part of this investigation.

Lastly, the Student Athletic Advisory Committee (SAAC) is the mechanism that gives a voice to student athletes on their campuses and within the NCAA. The grass-roots push of students on the SAAC brought nutritional concerns to the Committee on Competitive Safeguards and Medical Aspects of Sports, which ultimately led to the development of the Nutrition and Performance Web site, hosted on the NCAA Web site in the spring of 2002 (Cutchall, 2000; Dent, 2002; Wilfert, 2003). The focus groups for this study were based on the individual campus SAAC groups.

I sent the head athletic trainer, team physician and senior woman administrator at each of the 31 institutions the disordered-eating policy evaluation questionnaire (see Appendix B) to assess the level of policy and practice at each institution. Results of the questionnaire were evaluated and institutions were sorted into one of three broad categories—unrealized, partially realized, realized—based upon their responses to specific questions on the survey instrument for the case study investigation.

Site Categorization

The three broad categories are defined as follows:

1. **Unrealized policy:** There is no written formal policy; no or some informal practices occur, which may or may not be communicated to athletic personnel or athletes.
2. **Partially realized policy:** There is no formal written policy, but consistent practices are followed and communicated to athletic personnel and athletes; *or* a formal written policy is in place but it is not communicated to athletic personnel or athletes.
3. **Realized policy:** There is a written formal policy; actual practices and communication may vary. Practices may include the following (based on Bickford, 1999, and Thompson and Sherman, 1993a):

- A mandatory education program for athletic department personnel.
- A mandatory education program for athletes, including proper nutrition information, contact information for referrals and treatment, and participation in the nutrition and eating disorder education portion of the NCAA Life Skills program.
- A preparticipation physical examination and/or screening program for student athletes.
- Elimination of group weigh-ins.
- A clearly articulated and communicated intervention protocol and treatment involving a team of qualified professionals, including psychologists, physicians, coaches, dietitians, and athletic trainers.
- Policy and guidelines on the above practices, clearly written in an athlete handbook and communicated to all athletes on an annual basis.

I sent a one-page questionnaire to 111 individuals in 31 Division I institutions (see Appendix B). It consisted of two questions, each with subcategories to qualify the responses into the policy categories. The first question was, *Is there a written policy at your institution for athletes and eating disordered behaviors?* Answer choices were as follows:

- (a) *yes*. If a respondent selected this option, he or she was asked to return a copy of the policy document with the survey. I asked for the document to confirm that the policy actually existed and also to use it later in the document analysis to compare policies across institutions. The respondent was also asked whether the policy was published in the student-athlete handbook (yes or no). I asked

this question to try to assess the level of communication between those forming the policies and those affected by the policies.

(b) *no*. There were two follow-up questions to this response choice. The first was, *If no, is there a process for identification/ management / treatment that is routinely followed but not written into policy?* For a *yes* answer, a space was provided for an open-ended response to describe the process and who is made aware of it and how (answer 1.b.1). I included this open-ended response because of the lack of clarity in the literature and in the field between an eating disorder policy and a process with guidelines. In addition, I wanted to start collecting information about the actual process of managing eating disorders within this population, and did not want to limit responses if the respondent did not view his or her institution as having a policy. The second choice to this process question was simply *no* (answer 1.b.2.).

(c) *we are in the process of developing a written policy and/or protocol for athletes with eating disordered behaviors*. Again, I wanted to recognize that policy formation is a process, and that an institution might be in a state of flux with its decision-making or policy formation process.

Question 2 on the questionnaire asked respondents to *Please indicate which of the following practices your institution participates in/utilizes (check all that apply)*. There were 8 choices for responses derived from the limited literature on formulating policy and practice for student athletes and eating disorders (Bickford, 1999; Thompson & Sherman, 1993a). The categories are: the use of group weigh-ins, individual weigh-ins, eating disorder screening program (if *yes*, respondents were asked to list which one),

having a nutritionist on staff, a psychologist or counselor on staff, using the NCAA Life Skills nutrition programming, using educational programs for coaches or other staff (if yes, is it mandatory [yes or no]), and finally, using an eating disorder treatment team (if yes, respondents were asked who is on the team, with space to list the positions).

I used the following classification schematic to place institutions into a policy category:

- An institution was categorized in the *unrealized* group if the respondent(s) answered no to having a policy and no to having any process in place.
- An institution was categorized in the *partially realized* group if the respondent(s):
 - answered yes to having a policy but did not include the document upon returning the survey; or
 - indicated that there was no policy, but there was a process that was followed within the department; or
 - indicated there was no policy or procedure, but there were practices that indicated some action was being taken (such as hiring staff or using screening procedures) to identify, manage, or treat athletes with eating disorders; or
 - indicated that policy formulation is currently under discussion or consideration.
- An institution was placed in the *realized* category if they indicated and verified that a policy document exists.

If different responses were received from members of the same institution, their responses were combined and averaged. Conflicting responses (e.g., one respondent selects *yes* and includes the policy upon return while another selects *no*) were dealt with on a case-by-case basis. In each instance, the responses of the head athletic trainer and team physician were weighted most heavily and the senior woman administrator second, based upon the aforementioned research indicating that athletic trainers are the front-line staff when dealing with health and safety concerns.

Case Study Site Selection

After categorization into policy levels, I separated the institutions by location, division, conference, Carnegie classification, and number of respondents. In addition, I looked at the response sheets. In three instances, the respondent indicated a willingness to participate further. Only two institutions were in the unrealized policy category. I contacted one of the two based on geographic location, institution division, type, and conference first. Initially, I sent an inquiry packet (refer to Appendix C) via mail to the respondent, who was the senior woman administrator from this institution. Next, I sent an inquiry packet to the respondent from the realized policy institution, because this individual indicated on the questionnaire an interest in participating further. I followed up via telephone with this athletic trainer and received verbal and then e-mail confirmation that this institution would be willing to participate. Finally, I sent inquiry packets to respondents from three of the partially realized institutions. Two were senior woman administrators and one was a team physician. Of these, only one indicated a willingness to participate at a minimal level. The other two never responded. I then selected one more partially realized policy institution, based on location, size, and the fact that three

members from this institution sent back a survey with incongruent responses. I sent an inquiry packet to the senior woman administrator at this institution and followed up with a telephone call. She confirmed that the institution would participate. Thus, three institutions, one at each level of policy, were selected for the second phase of the investigation involving individual interviews, student focus group interviews, and document collection.

Pretesting

Central Michigan University (CMU) was selected as the pretest site. CMU represents the type of institution sampled for this study. CMU is a Division I, Mid American Conference, and Carnegie Doctoral/Research University–Intensive institution offering both wrestling and gymnastics. The athletic department is in the process of developing a new student-athlete policy on eating disorders (M. Weston, personal communication, February 2003). The pretest focused on the best methods to attain access to the participants, the relative importance of particular staff, the participants' understanding of the questions, and effectiveness of the interviews. I conducted interviews with the head athletic trainer, the university president, an affiliated nutritionist, and two focus groups, each with five student athletes. The information gained resulted in minimal changes to the way in which questions were asked and the order in which they were asked. The results provided further insight into with whom and at what level was I likely to find those with knowledge of policy decision making. As a result of the pretest, I eliminated interviews with the institutional presidents and athletic directors, finding that these individuals were not a part of the decision-making process, nor were they likely to be at similar institutions. The pretest also confirmed the difficulty in recruiting student

athletes to participate in focus groups and the need to involve someone from the athletic department to assist in this recruitment effort in order to have enough student athletes to make up a focus group.

Analytical Strategy

Questionnaire

Data collected from the questionnaire were analyzed by calculating frequencies of responses to the various categories of policy development and departmental practices utilized. A chi-square test was conducted to perform a bias analysis by type of institution and respondent role group. These data are presented in a series of tables in Chapter 4, categorized by type of institution and type of respondent.

Policy Document Analysis

I use the term *document analysis* based on Altheide's (1996) definition of "an integrated and conceptually informed method, procedure, a technique for locating, identifying, retrieving, and analyzing documents for their relevance, significance and meaning" (p. 236). These policy documents are essential as evidence that a decision has been made, and are primary documents in this investigation. As with many research approaches, using the texts in an attempt to understand the authors' motivations can be problematic if they are the only type of evidence. The policy documents are considered only as one part of the evidence to understand the historical, cultural, and organizational contexts from which policy was formed.

I utilized ethnographic content analysis on the policy documents to develop some inferences and generalizations about the policies. I chose this approach because, unlike traditional quantitative content analysis, this process allows the researcher to be a part of

the reflexive nature of the process. Categories and variables initially guide the study, but others are allowed to emerge. Thus, the ethnographic content analysis approach involves focusing on and collecting numerical and narrative data rather than forcing the data into predefined categories (Altheide, 1996). This process also allows the data to be conceptually coded, which is important because one item may be relevant for several purposes. In short, items and topics can be counted, they can be placed in preselected and emergent categories, and good descriptive information can be provided.

This process began with identifying the units of analysis. I used individual words and word phrases, and highlighted these as they appeared throughout the policy documents. I wrote notes in the margins of the policy documents so I could refer back later to identify initial emergent topics. Initially, the words and word phrases I chose were based on Bickford's (1999) recommendations for athletic department policies, which included the following:

- the use of a preparticipation examination or screening for eating disorders;
- an identification process for approaching the athlete;
- communication about signs and symptoms;
- a system of medical referral;
- a comprehensive diagnostic evaluation procedure;
- diagnosis by a physician or psychologist;
- the use of a multidisciplinary treatment team;
- a method for determining continued participation in the sport;
- the establishment of a program addressing nutritional needs and caloric expenditure;

- a monitoring system for the athlete's progress;
- recognition that eating disorder treatment plans should be unique to the individual; and
- formal or informal educational programming for student athletes and other athletic personnel.

In addition, I referenced Conn and Malloy's (1990) recommendations for general policy formation in athletics, and included defining the mission or philosophy of the department within the policy as well as a periodic review of the policy document.

Using the concepts indicated above, in combination with what emerged out of the policy documents, I created a classification system of 48 codes and counted the use of their word permutations or theme similarity. I reread the policy documents looking for more occurrences of words, word phrases, and theme concepts I may have missed the first time. Because I had only seven documents, I continued to use a process of hand coding, by highlighting particular passages within the documents and making notes in the margins. I then counted the incidence, and used the frequency of high-incidence words and phrases to collapse the initial key-word, phrase, and theme codes into broader categories. After I collapsed the categories, I created a matrix of these broader categories by frequency, using the number of references of particular codes across the documents to come up with a total of 11 major content descriptor phrases (refer to Appendix D for the coding schematic). The policy document analysis will be presented primarily by frequency of important themes that emerged from this reflexive process.

Interviews, Focus Groups, Document Collection, and Field Notes

All interviews (individual and focus group) were tape recorded and transcribed. I created case files for each institution, which included the transcripts, documents, and field notes. Initially, I read and reread all of these items without making notes in order to become familiar with the totality of the items representing the institutions. Next, in an approach similar to the policy document analysis, I used ethnographic content analysis to analyze interview and focus group transcripts, documents collected on site, and field notes. This procedure allowed both predetermined concepts and emergent themes to be utilized. I established an original set of codes based on the concepts outlined in the theoretical framework (Chaffee, 1983; Shapira, 1997) and the seven research questions I was investigating. These included words and phrase codes, including choice, process, change, cultural contexts of values, premises, alternatives, implementation, results, feedback, historical context, conflict, ambiguity, repeated decisions, incentives, rewards, and punishments. The seven research questions I asked included many of the phrases and words above, but also asked about the importance of knowledge and understanding of eating disorders, important actors, the level of the important actors, discussion prompts, critical incidents, rationale or justification, and communication.

Next, I read and reread the transcripts numerous times, making notes in the margins, highlighting the key phrases from the predetermined codes, and tabbing pages that appeared to indicate an emergent theme. I identified themes based on the approach of Miles and Huberman (1994) by placing evidence within a categorical matrix, calculating the frequency of various events, and utilizing the sequential scheme of chronological order to organize the information. I created a spreadsheet for each of these three cases

with the codes, and calculated the frequencies of various words, phrases and themes, and then did this same calculation across all three cases in order to collapse the individual codes into categories. I revised the initial codes to include elements from the decision-making matrix, the research questions, the responses, and the information that emerged from interviews, and reorganized them into the collapsed categories. I reread the interview and focus group transcripts again, and then read the field notes and documents collected, using the revised set of codes and categories as a guide. Themes that emerged from the interviews were compared with documentation and field notes, resulting in alterations of the original themes and the development of new categories within themes. In total, there are 152 codes organized into eight categories from which the themes for individual cases and the cross case analysis emerged. Refer to Appendix E for this coding schematic.

The themes are categorized, and data are presented in the form of separate institutional cases illustrating themes unique to each institution. I also prepared a cross case analysis that illustrates themes appearing across institutions. The interview transcripts, field notes and documents are kept in electronic and paper files until completion of this research project. They will be destroyed after the completion of the research to protect confidentiality. A chain of evidence has been maintained throughout this study to ensure the integrity of the evidence and to permit the procedures used in collecting evidence to be easily traced backwards.

Trustworthiness and Limitations

Trustworthiness

Controls that contribute to internal validity and trustworthiness of findings are emphasized over those that enhance external validity, because generalizability is not an immediate purpose of my study. Document collection and focus groups are means that I employed to increase the trustworthiness of my findings. Additionally, I developed rapport with each of the participants, adding to the data's trustworthiness (Glesne & Peshkin, 1992). I also audio recorded all interviews and transcribed the recordings. Throughout the research process, I presented my preliminary concepts to selected participants for verification and clarification (Glaser & Strauss, 1967). To further enhance trustworthiness of my findings, I used an outsider audit (Lincoln & Guba, 1985) by presenting my findings to two professionals who work directly with Division I student athletes. These auditors were drawn from the membership of the NCAA; both work at Division I institutions that meet the criteria for case selection in this investigation. Multiple data sources—interviews, focus groups, field notes, and document analysis—allow for triangulation of findings. This tactic, as suggested by Glense and Peshkin, provided a means for me to differentiate between findings that might be a product of my unconscious wish to uncover them and discoveries that are actual products of the data.

Researcher's Role

The role of the researcher in this qualitative investigation is to serve as the primary instrument for data collection. The assumptions and biases of the researcher need to be clearly identified. My perceptions of the decisions made by higher education and athletics administrators have been shaped by my personal experiences in working with

both athletes and students who have had eating disorders. I believe this experience has enhanced my awareness of the prevalence of eating disorders, especially in college student athletes, and certain biases and assumptions exist in my mind. Although every effort was made to ensure objectivity, these biases may have shaped the way I perceived and interpreted the data. I approached this study with the perspective that eating disorders are not only prevalent in athletics, but are often encouraged or exacerbated by coaches and others with the power to select athletes and determine their participation. I also strongly believe that institutions of higher education, athletic departments, and the NCAA have a duty to take action to diminish this phenomenon among student athletes.

Limitations

Although this research design has some limitations, it is well suited to the purpose of my study. The qualitative approach allows me to better understand and provide meaning to student-athlete eating disorder policy decisions. One limitation of the study is that I work professionally in a college setting as an academic and career advisor, often with student athletes. My experiences with student athletes may contribute to the possibility of making a priori assumptions. My experiences, however, provide me with a degree of qualitative researcher advantage (Kuh & Andreas, 1991), because I have gained insight into some of the issues facing student athletes in their pursuit of academic, personal, and athletic success.

Another limitation is the intentional selection of Division I institutions offering both wrestling and gymnastics. It is important to note that these institutions do not, and are not meant to, represent all institutions or athletic departments. In addition, the selection of cases by means of geographic convenience and willingness to participate

may be a further limitation in the purpose of this study. The findings are representative only of the three cases.

Chapter 4: Results

This study examined in detail the decision-making processes undertaken by institutions and key administrators in developing and implementing policies about student-athlete eating disorders within the context of intercollegiate athletics and the higher education environment. This chapter identifies the policies and practices in athletic departments at select NCAA Division I institutions; compares the policies and practices across the institutions; and describes the decision-making processes by identifying themes within individual institutions and across institutions. Finally, the chapter answers the seven research questions posed in Chapter 1.

Phase I: Institutional Policy Questionnaire

Starting with the 117 NCAA Division I institutions that offered either women's gymnastics, men's wrestling, or both, for the questionnaire survey I focused on universities offering both sports. These criteria narrowed the pool of eligible institutions from 117 to 31. Table 4.1 illustrates the population of NCAA Division I institutions divided by sport--men's wrestling and women's gymnastics. Table 4.2 further breaks down this sample by Carnegie classification, notably with the most total and sampled institutions falling into the Doctoral/Research University -Extensive category. Table 4.3 illustrates the Division I institutions by athletic conference. The most prevalent type of institution hosting women's gymnastics and/or men's wrestling overall is the Doctoral/Research University -Extensive institutions. Although about 20% of the institutions are independent (no conference affiliation), no independent institution hosted both sports under study. Table 4.4 illustrates the sample of 31 institutions broken down

by both Carnegie classification and athletic conference, and compares the sampled institutions to the percentage of institutions in each category by type. This table highlights the prevalence of the Doctoral/Research University-Extensive classification across all athletic conferences. The most prevalent type of institution surveyed was a Big Ten, Doctoral/Research University–Extensive institution.

Table 4.1

NCAA Division I Institutions Offering Selected Sports

N = 117 institutions		
Sport Type	n	%
Only Women’s Gymnastics	33	28.20
Only Men’s Wrestling	53	45.30
Both	31	26.50

Table 4.2

NCAA Division I Institutions by Carnegie Classification

	Total (N = 117)		Sampled (N = 31)	
	n	%	n	%
Doctoral/Research University- Extensive	68	58.12	25	80.65
Doctoral/Research University-Intensive	10	7.43	1	3.23
Masters College & University I	28	23.93	4	12.90
Masters College & University II	3	2.02	0	0.00
Baccalaureate/Associate Colleges	1	.68	0	0.00
Baccalaureate College-Liberal Arts	3	2.02	0	0.00
Other Specialized Institutions	3	2.02	1	3.23
Not Available	1	.68	0	0.00

Table 4.3

NCAA Division I Institutions by Athletic Conference

	Total Institutions (N = 117)		Sampled Institutions (N = 31)	
	n	%	n	%
Atlantic Coast	6	5.12	3	9.68
Big Ten	11	9.40	7	22.58
Big 12	5	4.27	4	12.90
Big East	3	2.56	3	9.68
Big West	2	1.71	2	6.45
Colonial Athletic Association	9	7.69	1	3.23
Eastern	3	2.56	0	0.00
Eastern Intercollegiate Wrestling	5	4.27	0	0.00
Eastern Wrestling League	5	4.27	0	0.00
Independent (no conference)	25	21.37	0	0.00
Ivy Group	4	3.42	3	9.68
Mid American	9	7.69	4	12.90
Mountain Pacific	2	1.71	0	0.00
Mountain West	1	.85	1	3.23
PAC 10	13	11.11	4	12.90
Pennsylvania State Athletic	1	.85	0	0.00
Southeastern	7	5.98	0	0.00
<u>Southern</u>	6	5.13	0	0.00

Table 4.4

Sampled Institutions by Carnegie Classification and Athletic Conference (n = 31)

Compared to All Institutions (N = 108) and Total Percent by Type

<u>Carnegie Classification</u>												
<u>Conference</u>	<u>DRU-Ext.^a</u>			<u>DRU-Int.^b</u>			<u>MCU I^c</u>			<u>Specialized^d</u>		
	<u>n</u>	<u>N</u>	<u>%</u>	<u>n</u>	<u>N</u>	<u>%</u>	<u>n</u>	<u>N</u>	<u>%</u>	<u>n</u>	<u>N</u>	<u>%</u>
Atlantic Coast	3	10	90.90	0	1	9.09	0	0	0.00	0	0	0.00
Big Ten	7	11	100.00	0	0	0.00	0	0	0.00	0	0	0.00
Big 12	4	11	91.67	0	1	8.33	0	0	0.00	0	0	0.00
Big East	3	8	61.54	0	3	23.08	0	2	15.38	0	0	0.00
Big West	0	6	54.55	0	1	9.09	2	4	36.36	0	0	0.00
Colonial	0	3	30.00	0	5	50.00	1	2	20.00	0	0	0.00
Ivy Group	3	7	87.50	0	1	12.50	0	0	0.00	0	0	0.00
Mid American	2	6	42.86	1	6	42.86	1	2	14.28	0	0	0.00
Mtn. West	0	6	75.00	0	1	12.50	0	0	0.00	1	1	12.50
PAC 10	3	10	100.00	0	0	0.00	0	0	0.00	0	0	0.00
*Totals	25	78	72.22	1	19	17.59	4	10	9.26	1	1	.93

^aDRU-Ext. (Doctoral/Research University–Extensive)

^bDRU-Int. (Doctoral/Research University–Intensive)

^cMCU I (Masters College and University I)

^dSpecialized (Other Specialized Institutions–Specialized Institution)

* % indicates percentage of total institutions in conferences by Carnegie classification

Of the 31 completed and returned surveys, 21 different institutions were represented or 67.74%. One respondent from an institution returned the questionnaire, indicating that the institution did not want to participate in the study any further. Table

4.5 illustrates the breakdown of sampled institutions and institutions represented by respondents. Overall, the largest group represented both in surveyed and respondent groups is the Big Ten, Doctoral/Research University–Extensive institution.

Table 4.5

Questionnaire Response Rates of Institutions by Carnegie Classification and Athletic Conference—Surveyed (S), Responded (R)

	<u>Carnegie Classification</u>									
	DRU-Ext. ^a		DRU-Int. ^b		MCU I ^c		Specialized ^d		Totals	
<u>Conference</u>	<u>S</u>	<u>R</u>	<u>S</u>	<u>R</u>	<u>S</u>	<u>R</u>	<u>S</u>	<u>R</u>	<u>S</u>	<u>R</u>
Atlantic Coast	3	2	0	0	0	0	0	0	3	2
Big Ten	7	6	0	0	0	0	0	0	7	6
Big 12	4	2	0	0	0	0	0	0	4	2
Big East	3	1	0	0	0	0	0	0	3	1
Big West	0	0	0	0	2	0	0	0	2	0
Colonial Athletic	0	0	0	0	1	0	0	0	1	0
Ivy Group	3	3	0	0	0	0	0	0	3	3
Mid American	2	2	1	1	1	1	0	0	4	4
Mountain West	0	0	0	0	0	0	1	1	1	1
PAC 10	3	2	0	0	0	0	0	0	3	2
Totals	25	18	1	1	4	1	1	1	31	21

^aDRU-Ext. (Doctoral/Research University–Extensive)

^bDRU-Int. (Doctoral/Research University–Intensive)

^cMCU I (Masters College and University I)

^dSpecialized (Other Specialized Institutions–Specialized Institution)

Bias Analysis—Institutional

A chi-square test for goodness of fit (Howell, 1997) on the institutions overall indicates that the respondents represent the sampled population in terms of Carnegie classification, $\chi^2(3, N = 21) = 1.45, p = .69$, and in terms of athletic conference, $\chi^2(9, N = 21) = 4.31, p = .89$. This analysis of institutions separated by Carnegie classification and conference may not be accurate, as the chi-square calculations are only reliable when all the expected values are 5 or higher. This assumption is violated by the data, so the *P* value may not be very accurate. Tables 4.6 and 4.7 show these chi-square tests for goodness of fit. To account for this minor discrepancy, a similarity trend of sampled and responded institutions is given. Figure 4.1 illustrates the representation of those sampled and respondents by Carnegie classification. In addition, the conference similarity trend is illustrated in Figure 4.2.

Table 4.6

Chi-Square Test for Bias—Institutional Respondents by Carnegie Classification

	Observed	Expected
Doctoral Research Extensive	18	16.93
Doctoral Research Intensive	1	.68
Masters Comprehensive I	1	2.71
Specialized	1	.68
Total	21	21

Table 4.7

Chi-Square Test for Bias—Institutional Respondents by Athletic Conference

	Observed	Expected
Atlantic Coast	2	2.03
Big 10	6	4.64
Big 12	2	2.71
Big East	1	2.03
Big West	0	1.36
Colonial Athletic	0	.68
Ivy Group	3	2.03
Mid American	4	2.71
Mountain West	1	.68
PAC 10	2	2.03
Total	21	21

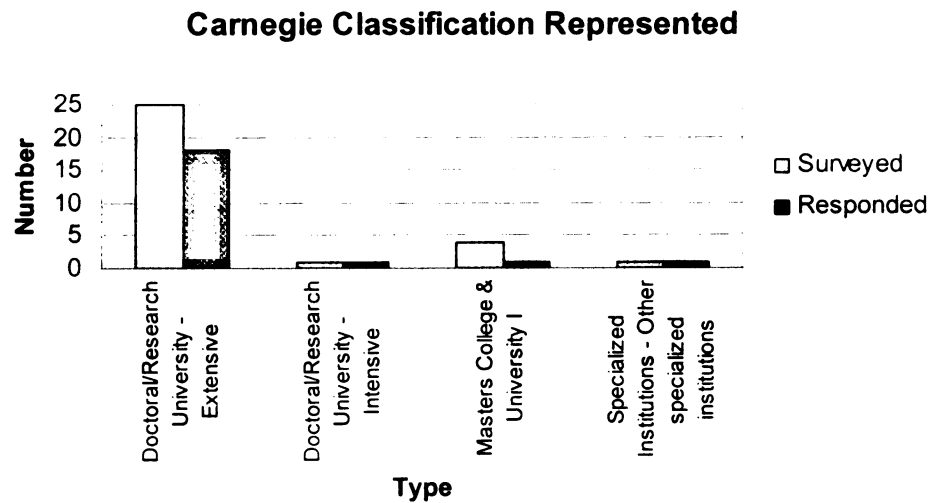


Figure 4.1. Survey sample and institutions by Carnegie classification.

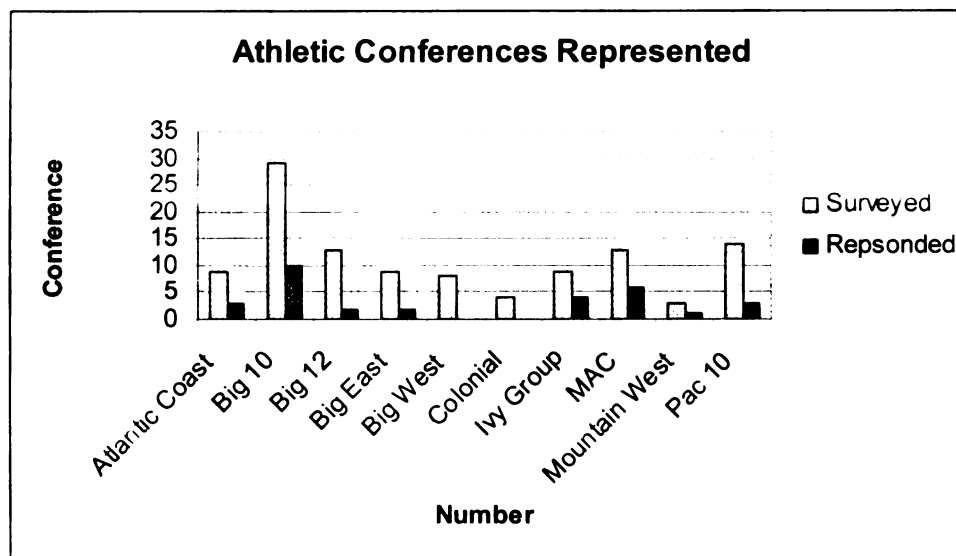


Figure 4.2. Survey sample and institutions by athletic conference.

At each institution, the senior woman administrator, a head athletic trainer (or equivalent) and the team physician(s) were sent the questionnaire. In some cases, exactly three questionnaires were sent; in others, more than three were sent to accommodate the variance in the number of athletic trainers and/or team physicians indicated. In total, 111 questionnaires were sent out. Nine (8.11%) were returned for bad addresses, 71 (63.96%) were not returned, and 31 (27.92%) completed questionnaires were returned. Thus, 102 questionnaires will be used for the total N of this investigation. Table 4.8 illustrates the overall response rates by role group. The questionnaire was most often returned by a member of the athletic training staff, then by the senior woman administrator, and least often by a team physician. Overall, the athletic trainers were the largest group who were sampled and who responded. The senior woman administrators and team physicians were sampled equally, with more senior woman administrators returning the survey. Table 4.9 illustrates the breakdown of respondents by role group. The low physician response rate could be a result of several factors, including the circumstance that more surveys sent to physicians were returned for bad addresses ($n = 8$, 7.21%) and that in some cases, the team physician is not directly affiliated with the institution or does not have an office there. The senior woman administrator at two separate institutions notified me by e-mail that another member of her staff was filling out the questionnaire and would send it in. The head athletic trainer at one institution telephoned to let me know that his school was not interested in participating.

Table 4.8

Overall Questionnaire Response Rates (N=111)

	Sent		Completed		Returned to Sender	
	n	%	n	%	n	%
Senior Woman Administrator	31	27.92	11	9.90	0	0.00
Athletic Trainer	49	44.14	14	12.61	1	0.90
Team Physician	31	27.92	6	5.40	8	7.21

Table 4.9

Questionnaire Respondents by Role Group (N=31)

	n	%
Senior Woman Administrator	11	35.48
Athletic Trainer	14	45.16
Team Physician	6	19.35

Bias Analysis—Individual Respondents

As mentioned earlier, the largest group that was surveyed, and that also had the highest response rate, was the athletic trainers. Tables 4.8 and 4.9 illustrate the numbers and percentages of both the surveyed and respondent groups. A chi-square test for goodness of fit on this population indicated that the respondent group is representative of the entire group, $\chi^2(2, N = 102) = .43, p = .81$. Refer to Table 4.10 for the chi square test on this population.

However, the more important issue for this investigation is the institutional representation. My goal was to have someone from an institution respond, so I sampled more than I needed to in the hope that at least one person from the institution would return it. Having respondent position representation was not an immediate concern. I intentionally chose three different groups of individuals to receive the questionnaire, because there is not one individual or position across all campuses who may have knowledge of eating disorder policy.

Table 4.10

Chi-Square Test for Goodness of Fit—Individual Respondents

<u>Position</u>	<u>Questionnaire Completion</u>	
	<u>Observed</u>	<u>Expected</u>
SWA	11	9.42
ATC	14	14.59
TP	6	6.99
Total	31	31

Site Categorization Based Upon Questionnaire Criteria

As described in Chapter 3, answers to selected questions in the initial questionnaire were used to categorize institutions into three levels of policy formation, based upon respondent answers to selected questions in the questionnaire. Refer to the Site Categorization section of Chapter 3 for the methodology. Broadly, these three levels are as follows:

1. **Unrealized policy:** There is no written formal policy; no or some informal practices occur, which may or may not be communicated to athletic personnel or athletes.
2. **Partially realized policy** There is no formal written policy, but consistent practices are followed and communicated to athletic personnel and athletes; *or* a formal written policy is in place but it is not communicated to athletic personnel or athletes.
3. **Realized policy:** There is a written formal policy; actual practices and communication may vary.

Nine of the 21 institutions returned more than one questionnaire. In three cases, individual answers did not match answers from others from the same institution. In two cases, the responses were combined and averaged because they were not extremely different. In one case, extremely conflicting responses were reported by three individuals from the same institution. The team physician indicated the institution did have a policy, the senior woman administrator did not answer this question, and the athletic trainer indicated that there was no policy at all, but rather a practice that was followed. This institution was categorized as partially realized, as were most institutions. Table 4.11 summarizes the responses by policy category, highlighting the result that most institutions, $n = 13$, 61.90 %, were categorized as *partially realized*.

Table 4.11

Institutional Policy Category (N = 21)

	<u>n</u>	<u>%</u>
Unrealized	2	9.52
Partially Realized	13	61.90
Realized	6	28.57

In addition to the institutional policy category, I examined respondents by position in an effort to understand who most often answered on behalf of the institution. The questionnaire was sent to at least three individuals at each institution, the senior woman administrator, the head athletic trainer, and the team physician, in an effort to increase response rates and representation of institutional policy and practices. In general, the head athletic trainer most often sent back the responses across policy categories, accounting for 45.16% of all respondents. Table 4.12 delineates the respondents by institutional policy category across categories.

Table 4.12

Institutional Policy Category and Respondent Position Across Categories (N = 31)

<u>Position</u>	<u>Unrealized</u>		<u>Partially Realized</u>		<u>Realized</u>	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
Senior Woman Administrator	2	6.45	7	22.58	2	6.45
Athletic Trainer	0	0.00	9	29.03	5	16.13
Team Physician	0	0.00	4	12.90	2	6.45

The two unrealized policy institutions each had only one respondent. Both were sent by the senior woman administrator, accounting for 100% of the responses within the category and 6.45% of the total responses. There were a total of 20 responses for the 13 partially realized policy institutions. Of these, the most common respondent was the athletic trainer (ATC) with 9, followed by the senior woman administrator with 8. The most common combination of respondents from one institution in the partially realized category was the senior woman administrator and the head athletic trainer (n = 4, 30.77%). Finally, there were 9 respondents representing the 6 realized policy institutions. Of these, the 50.00% (n = 3) were sent by the head athletic trainer only. Table 4.13 shows respondents by policy category within categories.

Table 4.13

Institutional Policy Category and Respondent Position Within Categories (N = 21)

<u>Respondent Type</u>	<u>Unrealized</u>		<u>Partially Realized</u>		<u>Realized</u>	
	N = 2		N = 13		N = 6	
	n	%	n	%	n	%
SWA Only	2	100.00	3	23.08	1	16.66
ATC Only	0	0.00	2	15.38	3	50.00
Physician Only	0	0.00	1	7.69	0	0.00
SWA & ATC	0	0.00	4	30.77	1	16.66
SWA & Physician	0	0.00	0	0.00	0	0.00
ATC & Physician	0	0.00	2	15.38	1	16.66
SWA, ATC, & Physician	0	0.00	1	7.69	0	0.00

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Practices Across Institutions

The second question asked respondents if their institution participated in any of eight practices: group weigh-ins, individual weigh-ins, eating disorder screening, nutritionist on staff, psychologist/counselor on staff, NCAA Life Skills programming, education for coaches and other staff members, and the use of an eating disorder treatment team. As mentioned earlier, these eight practices were selected based on recommendations in the literature. Suggested practices (Bickford, 1999; Thompson and Sherman, 1993a) include: mandatory education programs for athletics department personnel and for athletes, including proper nutrition and contact information for referrals and treatment; participation in the nutrition and eating disorder education portion of the NCAA Life Skills program; utilizing a preparticipation physical examination and/or screening program for student athletes; the elimination of group weigh-ins as a practice; developing a clearly articulated and communicated intervention protocol and treatment plan which includes a multi-faceted team of qualified professionals including psychologists, physicians, coaches, dietitians and athletic trainers. The eight categories were taken directly from these recommendations, with the exception of individual weigh-ins, which I added based on the fact that selected sports such as wrestling commonly use individual weigh-ins as a routine part of the sport. Results are shown in Table 4.14.

Table 4.14

Practices Across Institutions (N = 21 institutions)

<u>Practice</u>	<u>n</u>	<u>% N institutions</u>
Group Weigh-Ins	6	28.57
Individual Weigh-Ins	16	76.19
NCAA Life Skills Nutritional Programming	11	52.38
ED Screening	11	52.38
Nutritionist on Staff	12	57.14
Psychologist on Staff	15	71.43
ED Treatment Team	15	71.43
Educational Programs	14	66.66
<u>Mandatory Education</u>	<u>6</u>	<u>28.57</u>

Group weigh-ins. Group weigh-ins in athletics generally consist of gathering a team in the training room area and weighing individuals in a group setting, so that everyone knows what each person weighs. Some coaches have been known to post a weight chart in the locker room that tracks the weight of individuals over time. This practice has been discouraged, partially in an attempt to stymie eating disorders in student athletes. It is well documented that an important part of preventing eating disorders is deemphasizing the importance of weight (Thompson & Sherman, 1993a). The simplest tactic is not to weigh athletes. Group weigh-ins are especially discouraged by professionals who treat eating disorders, even though group weigh-ins have been commonplace in the athletic environment. For an individual with an eating disorder,

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group weigh-ins constitute public humiliation and exacerbate the problem. According to Thompson and Sherman (1993a),

Any coach or athletic trainer who routinely weighs athletes either publicly or privately should seriously consider why weighing is necessary. If it cannot be determined that this information is helpful in some regard or if it is not going to be used to benefit the athlete, then weighing – especially group weighing – should be avoided. (p. 159)

According to the respondents, conducting group weigh-ins was the least utilized practice. In light of the recommendation to eliminate group weigh-ins, this finding indicates that communication about elimination of this practice is widespread enough that this practice is less common among these institutions. Although this was the least utilized practice overall, four of the six realized policy institutions indicated they used this practice. This finding illustrates a disconnect between establishing a policy and following actual practices. Although these athletic departments have made progress on paper toward addressing eating disorders, simply having a policy does not mean that change is realized through actual practice.

Individual weigh-ins. Although experts recommend eliminating group weigh-ins, there has been less attention to the individual weigh-in process. In truth, there are some sports, including wrestling, where weight is the primary factor used for competition purposes. For institutions not using group weigh-ins in this sample ($n = 15$), eight use individual weigh-ins (53.33%); of these, four indicated that individual weigh-ins were used for particular sports only. One institution noted that individual weigh-ins were a part of the initial physical at the beginning of the year. The fact that individual weigh-ins were

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the most widely used practice is not surprising, especially since all of these institutions host wrestling, a sport that requires a weight class measurement for competition. However, it is somewhat contradictory that only 16 of the 21 institutions indicated the use of individual weigh-ins, since they all host wrestling. This disparity may be explained by the way in which the respondents interpreted the question on the survey. The question was asked in a way that would require an answer only if the entire department followed a practice. In fact, some respondents answered the question, clarifying by writing in the margin that particular practices were followed only for one or two sports.

Eating Disorder Screening. Screening for student athletes at risk is imperative for early intervention. In addition, a tool that is efficient, cost effective, and valid for the student athlete population is important (DePalma, Koszewski, Domani, Case, Zuiderhof, & McCoy, 2002). A number of tools are available to assist in screening for eating disorders, such as the Eating Disorder Examination–Questionnaire (EDE–Q), the Eating Disorders Inventory 2 (EDI 2), the Bulimia Test Revised (BULIT–R), and the Eating Attitudes Test (EAT), all of which have been shown to be reliable and valid in the general population and are frequently used by health professionals (McNulty, Adams, Anderson, & Affenito, 2001) but are not specific to student athletes. More recently, two other tests—the Survey of Eating Disorders Among Athletes (SEDA) and the Female Athlete Screening Tool (FAST) have been tested and validated among college student athletes (DePalma et al., 2002; McNulty et al., 2001). In addition, the NCAA has encouraged its members to participate in the National Eating Disorders Screening Program (NEDSP) since 1996, posting links on its Web site and publishing articles in the *Sports Sciences Newsletter* (Deutsch, 1997). The responses to my survey indicate that

more than half of the institutions, 52.28%, use some form of eating disorder screening, and that exactly half of the realized policy institutions used a screening tool. It is not surprising that neither of the unrealized policy institutions used a screening tool, but it is notable that more of the partially realized policy institutions, 61.54%, used a screening tool than the realized policy institutions, indicating the regular use of procedures without a policy document.

NCAA Life Skills. In 1991, the NCAA Foundation initiated efforts to create a total development program for student athletes. This effort came to fruition in 1994 with the creating of the NCAA CHAMPS/Life Skills program (Challenging Athletes' Minds for Personal Success) (NCAA, 2003b), referred to in this investigation as the Life Skills program. There are five key commitments to the program—academic excellence, athletic excellence, personal development, career development, and service. The Commitment to Personal Development includes a section on nutrition. In an attempt to assist with the identification, education, prevention, management, and treatment of eating disorders, the NCAA launched a nutrition and performance component to its overall Life Skills program in 2002. NCAA member institutions are encouraged but not required to participate. The program is designed to allow each member institution to tailor the program to meet the needs of its student athletes. As of August, 2002, there were a total of 407 institutions participating, 275 (67.07%) of which are Division I institutions (NCAA, 2003c). Of the 21 institutions surveyed here, 11 reported participating in this component; this figure appears low, given the overall percentage. Of the responding institutions, 20 of 21 are listed as participating members of the Life Skills program. The discrepancy between the actual and reported participation rates in Life Skills most likely

occurred because the Life Skills program encompasses more than just the nutritional component, which was asked for here. Athletic departments can be participating members in other aspects of the Life Skills program without participating in every component, including nutrition and performance.

Nutritionist on staff. Athletic departments are starting to recognize the importance of employing a sports nutrition professional to provide clinical services to athletes and nutrition education to teams, coaches, and trainers. One institution represented in this study was the leader in developing such a global approach to serving students, beginning with a program in 1985. In addition, having a nutritionist available as a part of an eating disorder treatment team is widely recommended (Thompson & Sherman, 1993a), and has been found to be successful in increasing the nutrition knowledge of athletes when these professionals are integrated into the athletic department (Baer et al., 1995). In this study, 57.14% of the institutions have a nutritionist on staff, all at either partially realized or realized policy institutions. This finding is encouraging, given the importance of nutrition to the performance of student athletes.

Psychologist/counselor on staff. An equally important member of an eating disorder treatment team, who can also address the mental health issues of student athletes in general, is a psychologist or counselor knowledgeable about sports-specific issues. Successful programs that incorporate this professional into the athletics staff have been found to be important in educating coaches and athletes, as well as in identifying behaviors that may warrant a referral (Baer et al., 1995). Fifteen, or 71.43%, of the institutions responding have a psychologist on staff. This finding is especially important in view of the new generation of students, who are entering institutions of higher

education with higher rates of depression and other psychological disorders than ever before. More incoming freshman, nearly 30%, report frequently feeling overwhelmed, and 85 % of college counseling centers report a rise in the number of students with “severe psychological disorders” versus only 56% in 1988 (Howe & Strauss, 2003).

Eating Disorder Treatment Team. The multidisciplinary eating disorder treatment team generally recommended involves several professionals including psychologists, physicians, athletic trainers, nutritionists or dieticians, and sometimes coaches (Thompson & Sherman, 1993a). Again, a majority of the institutions, 71.43%, indicated the use of such a team. A secondary response item here asked for a listing of the professionals on the team. *All* of the respondents listed a psychologist, dietician, and athletic trainer and/or physician. The following were listed once, by different institutions: coach, dentist, orthopedist, director of eating disorders, and one listed “other university support staff.” These responses are encouraging because these institutions recognize the importance of a multidisciplinary approach to the identification, management, and treatment of the eating disorders in athletes.

Education for coaches and others. It is clear that coaches and other sport personnel, including athletic trainers, need basic information about eating disorders, and that these individuals influence the lives of student athletes (Beals, 2003; Thompson & Sherman, 1993a; Vaughn, King, and Cottrell, 2004). In her article addressing the legal liability of institutions for student athletes with eating disorders, Bickford (1999) calls for mandatory education for both athletes and athletic personnel. The results of this study show that a small majority, 66.66% of the institutions, offer educational programs. Of those with educational programs, 6 of 14, or 42.86% are mandatory. This finding

supports conclusions of previous work that educational programming is a pressing need among college athletic departments (Beals, 2003).

Utilization of these eight practices by institutional policy category is shown in Table 4.15.

Table 4.15

Practices by Institutional Policy Category (N = 21)

<u>Practice</u>	<u>Unrealized</u>		<u>Partially Realized</u>		<u>Realized</u>	
	N = 2		N = 13		N = 6	
	n	%	n	%	n	%
Group Weigh-ins	1	50.00	1	7.69	4	66.67
Individual Weigh-ins	2	100.00	9	69.23	5	83.33
NCAA Life Skills	0	0.00	6	46.15	5	83.33
ED Screening	0	0.00	8	61.54	3	50.00
Nutritionist on Staff	0	0.00	8	61.34	4	66.67
Psychologist on Staff	0	0.00	11	84.62	4	66.67
ED Treatment Team	0	0.00	9	69.23	6	100.00
Educational Programs	0	0.00	8	61.54	6	100.00
Mandatory Education	0	0.00	5	38.46	1	16.67

Comparison of Policy Documents

I collected documents on seven policies in this investigation. Six were returned with the original questionnaires, and one was collected through the interview process

when it was later identified. In total, 11 key themes and 48 codes were identified and used in the analysis. Refer to Chapter 3 for the methodology used to analyze the policy documents.

The policies varied from one paragraph and a flow chart to 41 pages in length. Six policies were from athletic departments. One was an institutional policy with sections designated for student athletes as a separate group. In general, most of the policies reflected the idiosyncrasies of local institutions and athletic departments. Few commonalities existed in overarching policy format, structure, or even content. One key finding in all seven policies was a reference to the athletic training and/or medical staff as the point of contact for referral of an athlete with either a suspected or identified eating disorder. In addition, this staff member is responsible for coordinating the referral, management, and treatment of the athlete. The only other common connection across the seven policies was a reference to a nutritionist or registered dietician being involved in the process, although the way in which this person was involved differed. Only one policy referred to its existence for the health and well-being of student athletes. One policy made reference to protecting the university from liability as a reason for enactment. One policy referred to campus resources available for assistance.

The one institutional policy with separate sections addressing student athletes covered items not addressed by any other policy. These include academic regulations applicable to a student in treatment and the level of involvement and responsibilities of the Office of Student Life and University Food Services Personnel in identification and referral. Table 4.16 identifies some key themes from the analysis, in descending order of prevalence.

Table 4.16

Eating Disorder Policy Comparisons

<u>Theme</u>	<u>n</u>	<u>%</u>
Medical staff (ATC or physician) involvement	7	100.00
Counselor/psychologist involvement	7	100.00
Includes definitions of eating disorders	5	71.43
In identification, athlete assessment mandatory	4	57.14
Team treatment approach	4	57.14
Mission/philosophy of athletics department	3	42.86
Lists signs & symptoms of eating disorders	3	42.86
Guidelines for how to approach athlete	3	42.86
Departmental stance on weigh-ins addressed	3	42.86
Preparticipation screening used	3	42.86
Patient confidentiality addressed	3	42.86
Referral process outlined	3	42.86
Reference to the use of educational programs	3	42.86
Provisions on play time and participation	3	42.86
In treatment, family consult used	2	28.57
In identification, guidelines for suspected ED	2	28.57
In identification, guidelines for identified ED	2	28.57
If ED identified, not a reason for punishment	2	28.57
Physician makes participation decision	2	28.57
Athlete suspended if non compliant with treatment	2	28.57
Cost and payment for services addressed	2	28.57
Policy review and revisions addressed	2	28.57
<u>Medical/referral forms included</u>	<u>2</u>	<u>28.57</u>

The documents analysis reveals that eating disorders are primarily considered a medical issue dealt with by medical and health professional staff members. The documents analysis primarily addressed identifying and referring or treating student athletes, while omitting the details about who is involved, how to pay for it, what happens to the student athlete in terms of play time, cost, and so forth. Although these institutions have policies, they tend to omit details on process and accountability. This finding confirms the lack of attention paid to liability (Bickford, 1999) and the ambiguity (Shapira, 1997) and lack of knowledge of eating disorders as issues.

Phase II: Case Studies

Selection of Cases

I selected three institutions, one from each policy category, for case studies to better understand the complexity of decision making involved in the attempt to identify, educate, prevent, and manage eating disorders and disordered eating among student athletes. All were Doctoral/Research Universities–Extensive according to the Carnegie classification. One was from the Big Ten, one from the Big 12, and one from the Mid-American Conference. Refer to Chapter 3 for the selection process.

Across the three case-study institutions, I interviewed 22 professionals of varying titles, including three senior woman administrators, two associate athletic directors, four athletic trainers, two team physicians, four coaches, two academic advisors, two nutritionists, two counselors, and one faculty member. The one commonality among the institutions was interviews with the senior woman administrator and medical staff (athletic trainers and/or physicians). The types of positions held at these institutions

differed (for example, the unrealized policy institution did not have a nutritionist or a counselor), so there is some variance in the role groups interviewed. In addition, the ease of access to various personnel in the institutions with unrealized and realized policies made it much easier to increase the numbers of those interviewed. One limitation in the partially realized group was that I did not have an opportunity to interview a coach. Table 4.17 illustrates the breakdown of interview type by position and policy level category.

Through the focus group interview process, a total of nine students (three from each institution) participated. Eight women and one man participated, which may be a limitation. However, since eating disorders are primarily a female issue (as discussed in more detail later), this result is not surprising. The students represented various cultural and demographic backgrounds, and represented both men's and women's gymnastics, and women's track and field, tennis, soccer, basketball and rowing. Table 4.18 lists student participation by institutional policy category.

Table 4.17

Individual Respondents by Role Group and Policy Category: Case Studies

	<u>Institutional Policy Category</u>				
	Case 1:	Case 2:	Case 3:	Total (N = 22)	
	Unrealized	Partially Realized	Realized		
<u>Role Group</u>	n	n	n	n	%
Athletic Trainer	1	1	2	4	18.18
Coach	3	0	1	4	18.18
Senior Woman Administrator	1	1	1	3	13.64
Physician	0	1	1	2	9.09
Athletics Assoc. Director	1	0	1	2	9.09
Academic Advisor	1	0	1	2	9.09
Nutritionist	0	1	1	2	9.09
Counselor	0	1	1	2	9.09
Faculty Representative	0	0	1	1	4.55
Totals	7	5	10	22	100.00

Table 4.18

Focus Group Student Type by Institutional Policy Category: Case Studies

<u>Student Type</u>	<u>Institutional Policy Category</u>							
	<u>Unrealized</u>		<u>Partially Realized</u>		<u>Realized</u>		<u>Total</u>	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
Sex								
Male	0	0.00	1	33.33	0	0.00	1	11.11
Female	3	100.00	2	66.67	3	100.00	8	88.89
Ethnicity								
African American	0	0.00	1	33.33	1	33.33	2	22.22
Caucasian	3	100.00	2	66.67	2	66.67	7	77.78
Sport								
W Track	1	33.33	0	0.00	1	33.33	2	22.22
M Gymnastics	0	0.00	1	33.33	0	0.00	1	11.11
W Gymnastics	2	66.67	0	0.00	0	0.00	2	22.22
W Tennis	0	0.00	0	0.00	1	33.33	1	11.11
W Soccer	0	0.00	0	0.00	1	33.33	1	11.11
W Basketball	0	0.00	1	33.33	0	0.00	1	11.11
W Rowing	0	0.00	1	33.33	0	0.00	1	11.11
	3		3		3		9	

What cannot be extracted from Table 4.18 is that all of the students had dealt with eating disorders in some manner. One student athlete disclosed her own disorder, three

were on teams who were currently struggling with teammates that had either suspected or identified eating disorders, and the remaining five had interacted with friends on other teams or other athletes at their institutions who had struggled with eating disorders.

Early in the interview process I recognized that the level of knowledge of the decision-making process among participants varies widely. Responses to the questions indicate this variation. For example, some interviewees were ancillary to the actual decisions made, and merely offered opinions on what they hoped would happen, or their perceptions of what might happen. These responses were often led by a phrase such as, “Well, I was not involved with the formation of this policy, but I would guess or hope that X happened or was considered.” Responses of this nature were not counted in the category responses because there was no direct knowledge of the actual decision-making process.

A total of 152 codes were identified in the analysis of the transcripts, documents, and notes. A total of 966 responses were coded and categorized from the three institutions. The results from the interviews, focus groups, document collection, and field notes are presented here, first by individual institution cases by policy type (unrealized, partially realized, realized), which presents themes that emerged from the particular institution. General descriptions of the institutions are included as a backdrop, but specific details are left out to protect privacy. The second section is a cross case analysis with themes found across all three institutions, some of which directly address the research questions identified in Chapter 1. The final section addresses the seven research questions. The theme’s relevance to the decision-making process (choice, process, and

change) and other considerations of the context of organizational decisions (ambiguity, longitudinal, incentives, repeated decisions, and conflict) are addressed.

Case Studies—Themes at Individual Institutions

This section provides a narrative description of the individual institutions according to level of policy formation. It highlights findings unique to each institution and presents exemplars of the themes identified.

Theme at institution with unrealized policy: Ambiguity paralyzes the decision-making process. This institution is a public, midsized, Midwestern Division I institution that considers itself a mid-major school in Division I in terms of size, finances, and competitive advantage. It is in the Mid American Conference. Its Carnegie classification is Doctoral/Research University–Extensive. It is an institution with just over 20,000 students, primarily from within the state; many are first generation and middle class. The athletic department, including arenas, training room, coaching offices, administrative offices, student-athlete study facilities, and practice facilities, are located primarily in one area on campus, although some of the competition fields are located across campus (football, for example). All athletics administrators are in adjoining offices in this facility. I spent two days on the campus and in the community, and spent 12 hours inside the places where student athletes and staff spend their time.

As this was the only institution without a policy, I chose to focus on the premise behind the choice to try to dissect what led this institution to have no policy. It became clear that the choice here was different—it was not about deciding to have a policy or not to have a policy. The decision was fundamentally about what to consider as viable alternatives in dealing with an unknown entity, eating disorders. The theme of ambiguity

focuses on what Shapira (1997) describes as the backdrop for decision making. In this institution, underlying the decision-making process is lack of clarity, and much ambiguity, about eating disorders in general.

In examining how decisions are made at this institution, I realized that the overarching theme here was ambiguity. I use this term to encompass the lack of knowledge and clarity about eating disorders, the prevalence of eating disorders among student athletes, and the extent of the problem on the campus. I also use this term to encompass the general unknown nature of eating disorders. This theme of ambiguity emerged from interviews with the coaching staff, the athletic medicine staff, the administrative staff, students, documents collected, and the physical surroundings and décor in which the athletic department resided. It was clear that the staff and students here are not *ignorant* of eating disorders. However, it became evident after further investigation that the student athletes felt it to be a larger problem than the coaches or administrative staff.

In general, neither the coaching staff nor the administrative staff considered eating disorders when thinking about what they did on an everyday basis. In addition, there was a lack of awareness about a policy. I was often asked, “Do we have a policy on this?” The ambiguity at this institution is manifested in eating disorders not being addressed as a topic, thereby not validating their existence. This finding was confirmed by looking at the brochures and hand outs available to athletes on a variety of topics, including alcohol, drugs, time management, and performance. There was only one half-sheet brochure, buried in the back of a rack on nutrition, eating disorders, and counseling services. In addition, a poster in the student athlete academic center listed several activities athletes

could do to achieve balance in their lives and increase their performance, but not one suggestion mentioned nutrition or psychological health.

Another illustration of the ambiguity theme centers on differing levels of awareness. Administrators, coaches and medical staff indicated that a few problems existed, eating disorders in athletes were handled case by case, and these problems were manageable. The Associate Athletic Director's comment below is an example:

"I can't say that I have been aware of any eating disorders. There were a few that I had been aware of in a couple of different sports. I would say there has been maybe a half of a dozen in the five years that I have been here that I am personally aware of."

Conversely, the student athletes indicated numerous instances of their fellow teammates with either full-blown eating disorders or patterns of disordered eating. One student athlete commented,

"I have witnessed several times, and we have had a lot of people with problems ... not just eating disorders but there is disordered eating which is also a big problem."

The following quote from a coach illustrates a common response given by many at the institution when asked to characterize the general history of eating disorders among student athletes at the institution:

"I honestly don't know if I really thought about it. I don't know if there is a perception about it. I can probably honestly say that I have never put enough thought into it, or I haven't seen enough things out there to make me think about it terms of if there is a problem or isn't."

Since this institution has no policy, I asked, “How have discussions about eating disorder policy generally come about?” At this institution, policy discussion of eating disorders has not come about at all. When disorders were discussed, it was brought up by the coaching staff to either administrative or medical staff.

The purpose of this question was to explore the choice and process elements of the decision. Choice here is predicated upon an acute awareness of an issue that may need a decision. If a coach brings up an issue that is not a frequent occurrence, the issue is often forgotten or buried. Process, on the other hand, deals with what happens after a decision is made. The responses here indicated that the choices made in this athletic department—for example, what to do with x student if he or she is suspected of having a problem—are highly individualized.

It is clear that ambiguity is one of the fundamental reasons that this institution does not have a policy. Additionally, there has been no general discussion about policy for eating disorders at the institution. Conflicting levels of awareness have led to confusion about the prevalence of a problem and to the feeling that the problem is not large enough to warrant consideration for a policy. All of the respondents indicated that no recent discussions on developing a policy have taken place. Although one may assume that this case-by-case decision making is a result of an intentional decision not to have a policy, this is not the situation here. The process was started once, but only one member of the administrative team, the senior woman administrator, was aware of it. She commented:

“I know that we tried to do this probably five or six years ago. It was very hard.

And I am a fairly organized person. But it was very hard to get everybody on the

same page as far as what we needed to do ... we were not so much looking for a policy but a process that we could follow. And we just could not come up with something that was very effective. So we just end up dealing with it case by case.”

This comment illustrates what Shapira (1997) describes as decision making embedded in a longitudinal context. That is, participants are involved in an ongoing process that is history-dependent. The department has tried before and failed. This finding relates to the premise of Chaffee’s decision elements in the choice phase. Guiding the choice is the premise that it is too hard to get everyone together on the same page.

The other phenomenon of interest is the case-by-case handling of problem athletes. The decision about what to do with student athletes suspected or identified with eating disorders has been made –handle them on a case-by-case basis. The choice has nothing to do with having a policy, but rather with how to handle student athletes who have suspected or identified eating disorders. The way the department has continued to deal with this issue points to the notion of repeated decisions (Shapira, 1997). Since the case-by-case model has been followed, people within the athletic department may have a false sense of using their skills to make a decision, and thus a faulty sense of having control of the situation. It is not that the values are different from other institutions. It is also not that alternatives have not been considered. Rather, it is the *premise* of uncertainty and ambiguity that has shut down the consideration of alternatives and muted the discussion.

Theme at institution with partially realized policy: Decentralization hampers full development. This large public institution is known globally for producing both excellent

research and excellent athletic teams. The student population exceeds 30,000. It is a Big Ten athletic conference school and has a Carnegie classification of Doctoral/Research University–Extensive. The campus is large and spread across several miles. The many athletic facilities are spread across the campus. The athletics administrators are housed in a variety of buildings, primarily by sport. The medical and student-athlete counseling staff is in a separate complex from the athletic training and nutritional counseling staff. This institution has many separate facilities, study areas, resources, and staff in place for its student athletes. To an outsider, it is a rather intimidating environment. I found myself lost on many occasions, confronting signs on building entrances and parking lots that were off limits or for particular personnel only.

The academic culture of the institution is highly competitive. It attracts a very diverse group of students, many from out of state or other countries. It is home to several nationally ranked undergraduate, graduate, and professional academic programs, including a medical school. I traveled to this institution on five separate occasions to conduct the interviews and collect documents, spending a total of eight hours with a variety of individuals and four hours on my own in various campus offices and athletic facilities. ⁴

The primary reason I chose this institution was that I received three questionnaires from three individuals here—the senior woman administrator, a team physician, and an athletic trainer—all with different responses about an eating disorder policy. The physician indicated that there was a policy but did not send a copy of it. The SWA and trainer indicated there was no policy but described a procedure. It was not until I interviewed the physician that I received a copy of the actual policy document, which is

located on a shared network drive in the athletic department. The policy itself is half a page long with an attached diagram depicting the referral process.

The decision to create a policy was a reaction to pressing concerns by the team physician about a disparity in the medical care and attention received by male and female athletes. The department formed a committee composed of the medical staff and athletics administrators to address this issue. As a result, the athletic department, with the leadership of a new senior woman administrator, conducted a study surveying its female athletes and coaches of female sports. A concern about eating disorders on all levels was the major finding of this study. What followed were two decisions: the formation of the policy by this committee and the recommendation to hire staff. The decision to hire a full-time counselor and part-time nutritionist within the department was supported by the athletic director. Currently, the team of physicians is primarily responsible for reviewing the policy.

After analyzing responses from the interviews, looking through documents, and reviewing my notes, I found that the institution's highly decentralized structure adversely affects achievement of a fully realized policy. The athletics department had numerous offices in a group of buildings located in its own physical area of campus, separated from the academic buildings and the main campus. The athletic department is highly decentralized, similar to a town within a city. The department has its own versions of everything the rest of the campus has for the rest of the students, including medical, study, and practice facilities, as well as nutritional and psychological resources. The athletics personnel are in several locations, and the various health professionals dedicated to athletics are also not located together.

The counselor here describes the situation like this:

“And also I think our whole department is somewhat decentralized. And I think in all of the other universities that I have worked at a major Division I and minor Division I there is a sense of it being more centralized. And I think that because they are not as often times the building houses everybody, administrators, and coaches. As you noticed we are scattered all over the place and that contributes to us being decentralized ... and that is not to say that there isn’t control. We do have control. But it is just there is more autonomy in terms of the decision making. So in terms of like a formal policy, yes, there is this sketch of a policy. But somebody is not controlling that particular – there is like just way too much going on. So, yes, we are doing our piece and the nutritionist I guess is doing her piece. Do I really know what she is doing? No. I am assuming that she is doing what she is supposed to do in terms of education and nutritional education. And she is probably assuming that I am doing what I am supposed to be doing in terms of mental health therapy. And the doctors are doing what they are supposed to be doing in terms of assessing and identifying. The coaches are supposed to be doing their coaching and training. Strength and conditioning, I am not really sure what they are doing. They are in another building altogether. And the administrators are scattered between four buildings – five buildings.”

Athletics is an extremely valued entity of this institution, generating substantial positive public relations and revenue streams. Thus, it has “earned” the right to be its own watchdog here and is allowed to function on its own for the most part.

This decentralization has led to a lack of formal and informal communication between entities. Although this decentralized organizational structure did not deter the initial policy creation, it has hampered further development or refinement because only one group (medical staff) is responsible for its review. I spoke with others in the department who felt as if their input would be valuable to the process, and had concerns with the state of the current policy and how communication occurs. According to the nutritionist,

“I feel like the pieces are in place somewhat but there is no perfect program only because each athlete’s needs are so different. And my own personal philosophy is just to communicate that to the entire team. And we have the opportunity. We meet once a month just to talk about it – it is kind of like a women’s case meeting but it is primarily about athletes with eating disorders that the counselor, physicians or myself are working with. We can all sit in the same room and see where people are.”

She also notes that the decentralization of the organization often results in delayed communication within the department. Here she talks about how the nutritional area worked with NCAA to develop information on supplements, and then was notified by the compliance officer that they needed to develop supplement guidelines.

“It is interesting that we got a memo from Compliance about supplements where we had already developed the materials about the NCAA policy on supplements that we hand out at pre-participation physicals to each student athlete. We don’t just make this stuff up.”

Although formal mechanisms for communication are in place, neither formal nor informal communication occurs in a manner that has facilitated much deviation from the last revision of the policy three years ago. On the committee structure, an athletic trainer commented:

“The Medical Advisory Committee. We have one here. You know, we didn’t even meet the entire year, so I don’t know if that committee is still – I mean, it is a BS committee to me personally. Our staff here just cringes when we have to meet ... I am not really sure [what the purpose of the committee is]. I have been a member of the committee for about three years. We did not meet once this school year. I think we are probably defunct, which we should be. Because there are a couple of administrators and a couple of outside physicians, a couple of inside physicians, two athletic trainers, counselors, I mean, the committee kept getting bigger and bigger because everybody wants to get on this committee that does nothing.”

The decentralization of the organization allows for autonomy in decision making, which is valued in both the academic and athletic cultures. It also allows “experts” at the local level to make and enact decisions without much institutional oversight. This loose level of authority by the institution can allow decisions to be made with little conflict, because decisions are often made by a separate entity and not communicated with others who are not directly involved.

This autonomy can also lead decision makers to have a false sense of expertise about their own decision-making ability. The lack of variation in the policy from year to year indicates that these individuals are making repeated decisions (reviewing the eating

disorder policy every year) and thereby feel a false sense of authority, expertise, and control over the situation.

Theme at institution with realized policy: Organizational structure supports a champion. The realized policy institution is a large public institution in a small town, and is one of two major institutions in the state. It is in the Big 12 Athletic Conference and is a Doctoral/Research University–Extensive under the Carnegie classification. The institution comprises just over 30,000 students, primarily from within the state, but the student athletes are a much more diverse subgroup of the student body.

The structure also plays a key role at this institution, but in a very different way from the partially realized policy institution. Although there are separate practice facilities and a training room, the medical staff, counseling staff, and nutritional staff are part of the regular university offices on campus. Student athletes make appointments with them just as any other student on campus would. I spent two consecutive days at this institution, and three evenings in the town itself. Here, student athletes are intentionally integrated into the student body, as noted by several of the health care professionals I interviewed. This integration is a result of a value held at this institution, which guides how they view the *student athlete*, in that order.

Uniquely, this institution created a position within medicine and athletics dedicated to the medical needs of female student athletes. This position is important because eating disorders are still viewed primarily as a women's medical issue. It is also important because policy at this institution has become realized through the efforts of a *champion*. The fact that the organizational structure supports both a medical expert and a champion is the key to the advancement of the policy at this institution. Her importance

was noted by nearly everyone I interviewed, including the student athletes. At one point, as I went from interview to interview, I felt like part of an infomercial about this champion. Excerpts from these interviews are given below from various constituencies.

From the physician, on who he relies on for information and support:

“Especially (name), because it is one of her areas of interest.”

The Associate Athletic Director:

“The number one actor (in policy formation) has been (name).”

The counselor

“We are so fortunate to have (name). She is our gateway for the eating disorders work that happens and the communication. She does a great job in working with the upper and lower administration and is kind of the go between.”

From the coach:

“... what can we do to be more proactive rather than constant reactive kind of thing. So what can we do when we have something in place right away ...the discussions with (name) got the ball rolling. This discussion, the main discussions, are with (name)”

Although the organizational structure supports and allows her to fulfill this role, this process also depends on the individual in the position. The structure supports her dedication to all female student-athlete medical issues, not just eating disorders. It is her own passion for and commitment to eating disorders that has continued the forward momentum of eating disorder policy within the department. She has been at the institution for 13 years, so it is not clear if the same decision-making process would occur if another individual were appointed to the position.

Cross Case Themes

This section presents themes identified across the three case-study institutions. In large part, the themes address a majority of the research questions asked, but go beyond answering them individually. Decision making in organizations is complex, and much of what I found could not simply be linked directly to one stage or model of decision making. These themes are presented as an attempt to amalgamate the individual parts of the decision-making process for developing policy on student athletes with eating disorders within the context of three institutions, recognizing that these themes may not necessarily be evident in institutions outside this investigation.

Theme 1: Policy decisions are reactive. One of the underlying questions I wanted to answer was whether policy decisions occurred as a reaction to a critical incident or event. This reaction would lead to a choice: to consider creating a policy as a means for dealing with an evident problem among student athletes. The evidence overwhelmingly supports the conclusion that discussions about student athletes and eating disorders, and policy discussion and creation, are formulated in a reactive manner, but not necessarily in reaction to a critical incident. At all of the institutions, the reactions ranged from an overall awareness of an ongoing problem to response to a critical incident, including the death of one's own student athlete or the death of another student athlete somewhere else. In fact, at the institution with the unrealized policy, the athletic trainer commented,

"I think at times policies can be created in two ways. One, somebody says, 'what's your policy on X?' and then you have that knee jerk reaction of, oh, we need a policy on this ... this is one of those things that if a month ago somebody said, 'what's your policy?' it would have been very simple. We don't have one.

Should we, now that you have got me thinking about it? Yeah, that is something we should probably do. And so, yes, after you being here, should we? That is something that we will discuss.”

An athletic trainer at the institution with the realized policy talked about how a policy in another area of athletic medicine was prompted:

“The other one policy that was developed before this was a pregnancy policy, which is actually very needed, and it came out of a need of someone being treated poorly after being pregnant on a team and somebody treated them basically, ‘you’re off the team.’”

What I found most surprising was that incidents of hospitalization, serious illness, or death as a result of an eating disorder did not prompt a reaction. These incidents occurred prior to and after the formulation of policy at two of the institutions. Although the incidents were enough to cause concern and discussions, not one member of either institution referred to these incidents as having major impact on developing or revising policy. A response by one physician indicated almost a detached view of the medical care, policy application and the student athlete at the institution. I was not able to discern whether this seemingly indifferent attitude came out of the medical culture, the institutional culture, or just this individual’s own background and experiences, but in any case, it affirms the reactive nature of decisions.

“When these things really get heated, is usually when there is a poor outcome. Someone dies or something like that. I think it is mostly reactionary to things that are happening ... you are seeing a lot of poor outcomes or bad issues happening so you start to think that ‘we need to be on board with this [having a policy]’”.

Theme 2: Eating disorders are a female medical issue. Eating disorders are still primarily regarded as an issue related to females, regardless of the presence of eating disorders in men, the most visible being in men's wrestling. Eating disorders also fall under the umbrella of medical care in athletics. This status is evident from the committee structure of the NCAA, the organizational structure of athletics departments, and the duties of individual athletic trainers and physicians. The theme is evidenced in the premise that athletic training and medical staff are responsible for all medical issues and are the key policy formers. It is evident in discussions between medical staff and administrative staff in the consideration of alternatives during the decision-making process. Everyone looked to other health care experts for information about eating disorders in general, other institutional policies, and health care industry best practices for identifying, managing, and treating eating disorders.

A dominant, often assumed, underlying value held by institutions and athletics departments, and by Western culture, is a concern for the health, safety, and welfare of all people. This understood and often unstated premise is essentially that medical and health issues in the United States are important—they are a value. Entire professional fields are dedicated to health and medicine. In athletics, we have specialists (athletic trainers). There are governmental mandates from numerous agencies that research and regulate our health care system. The NCAA issues regulations to institutions as to the standard of care they must provide. At the institutional level, staff are hired to deal with student-athlete medical issues, resources are allocated to support them, and alternatives are considered (including policy).

Policies are developed by the medical and athletic training staff, indicating that eating disorder policy decisions are formulated by a committee of athletics staff, led by primarily medical staff. One physician noted that

“As far as the medical stuff it comes from myself and the trainers. Our trainers usually do the writing and then I review ... we kind of go back and forth that way.

Very little input from the ADs. They accept our role as being experts in the field.”

An athletic administrator at the same institution confirmed this finding:

“I feel very comfortable with the staff that we have in place, (name) is one of the best and is outstanding. I feel very comfortable with the staff in place and the issues that need to be raised will be raised.”

The medical and athletic training staff also say they rely on their peers for other models that have worked before, especially when considering what the policy should look like and how to implement it.

Change results when the policy is enacted. Eating disorder policies are created and located in the medical offices, training rooms and medical-related handbooks of the athletics departments. They are listed in a medical section in a coach’s handbook. Posters, fliers, informational leaflets, and booklets are located in the medical offices. The medical staff are responsible for implementing the policy and for communicating the policy to others. The medical staff monitors eating disorders on the campus and conducts student-athlete research to measure the policy’s effectiveness and gather information for future decision making regarding changes to the policy. The medical staff makes future recommendations to others on any alterations or continued use of current policy based on the results.

Theme 3: Loyalty to the athletics family is important. This theme confirms that the culture and values of athletics are prominent in the decision-making process. The rationale for adopting policy mentioned by student athletes, faculty, athletics staff, and administrators reflects the paternalistic relationship that exists within the culture of athletics, and to some extent, within higher education. In considering policy, the most important reason given by all three institutions centered on student athlete health and welfare, physical, emotional, social, and educational. Embodied in both the passion and text of the comments was the custodial responsibility of the athletic department for taking care of athletes.

Evidence of this familial culture in intercollegiate athletics is noted by Adler and Adler (1998). Organizations that most often evoke strong feelings of loyalty tend to come from relationships that are more paternalistic in nature, which have five critical components: domination, identification, commitment, integration, and goal alignment. Athletics provides an excellent example of each of these areas. College athletic teams generate a loyalty that surpasses the blander forms of organizational commitment found in ordinary organizations, and are akin to combat units or religious cults (Adler & Adler). One administrator describes the organizational environment as like that of a family-run business.

“We kind of have a unique situation in the athletic department. So your athletic director is more of a CEO type person. But then you have got like in a factory you have the coaches, the managers ... you have got the athletes who are the labor, and then you have got all of the people like us that are like the custodians”

This theme of family and loyalty is evidenced also in the rationale used to justify or explain why the policy is important. In his explanation of why the athletic department had a policy, one athletic administrator commented,

“We recruit student athletes to (unnamed college or university), and we firmly believe that we do so with the student’s welfare absolutely number one ... and their parents believe in us and trust in us that we are going to take good care of their children for the four or five years that they are at our institution.”

A faculty member confirmed this and noted that,

“When we bring students to this campus to participate for us in athletics, we have a strong custodial responsibility to protect their health.”

An athletic trainer explained it in terms of how the policy is carried out:

“There is some protective mechanism in here too in case someone has an eating disorder and they have to get treatment; they are treated as any other medical condition. They are still a member of the family and they still have their scholarship. There are still safety things in place that they have to be treated appropriately.”

Athletes also comment about the obligation to be taken care of by the athletic department in a family sense. One said,

“I think it is important to have a policy. And I think every school should have a policy of some sort ... these people are taking care of in every way, athletics and everything. We are under their supervision. So they should take care of us in all ways.”

Another athlete commented,

“It is supposed to be like a family. You need help you stay in it. That is the big thing they preach here is families. Family values of the school. They take care of you and they educate you.”

More evidence of this familial culture is evidenced in the responses of the athletes to the question about what they would do if they knew or suspected that a teammate had an eating disorder. Eight of the nine student-athletes interviewed responded that they would approach the person if he or she was a teammate, but would not necessarily do so if the person were just another athlete on a different team. In addition, teams tend to handle the problems “within the family” and do not talk to other teams or other members of the athletic department about problems.

Theme 4: A champion with expertise is needed. The importance of an expert champion in the development of eating disorder policies was evident in each source of information. At the unrealized policy institution, the notion of a champion with expertise is especially evident because of the lack of expert knowledge on their campus or within the athletic department. There is no commitment or passion by any one person on the staff to address the issue, especially among the medical personnel, where a program would need to be based. The athletic trainer, the one medical expert in the department, is not confident of his ability to deal with this issue and he does not have or make the time to pursue such ventures. There is no full-time physician on campus for student athletes, nor are there nutritionists or sport psychologists on staff. The student athletes commented directly on this need for expertise:

“The one nutritionist they brought in for us talked with us like we were normal students and telling us things like, ‘oh, just watch your carbs’ and it is like, no

don't tell us that. And I don't think that they have brought in qualified nutritionists to deal with the specific kinds of athletes we have here. And I think too many times they come in and talk to us basically about nutrition. You know, you aren't talking about a bunch of third-ranked horses about how to eat. You need to tell us more specifically about how to do it in more detail instead of just, 'oh, you know, these are how calories work.'"

Thus, underlying the decision not to have a policy here is the fact that there is no expert champion to make an informed decision about eating disorder policy.

There is an edge of frustration among the staff and students at the unrealized policy institution about the lack of policy, as well as at the partially realized policy institution about lagging policy steps. The nutritionist at the latter institution commented directly on the importance of this expertise in mentioning her own resource reference, a physician who is connected with the institution, and also in her own practice.

"He is such a guru. As a physician, he went off to school and got his MPH. And he has developed for himself this specialty – because you will meet a lot of physicians who are specialists in what they do, but may not be specialists in eating disorders. And if your specialty is in eating disorders, you still may not understand all of the issues related to eating disorders in athletes. So when I have a young person ... who I suspected was at risk for disordered eating, I am not going to make that diagnosis. But I want to find for them a physician and a therapist or a counselor who is not just a physician or isn't just a therapist or a counselor, but they need to have some expertise not only in eating disorders but also in working with athletes..."

A number of things are different at this institution that has allowed initial policy formation. First, the culture of the institution supports health and medical concerns because there is a medical school. Second, within the organizational structure in athletics are physicians, a counselor, and a nutritionist, each with some expertise in their fields. What is missing here, however, is a champion to keep the conversations fresh. This institution is highly decentralized, with athletics personnel scattered across campus and between buildings. Even the medical and health professional staff members are not all in one area, which often leads to a lack of formal or informal communication. In addition, the senior woman administrator, who could have been the champion and used to be responsible for dealing closely with women's athletics, no longer has this oversight; it has been divided up among many other professionals.

A large amount of evidence from numerous sources at the realized policy institution indicates that the champion with expertise was crucial to policy formation. As mentioned earlier, the organizational structure supports this champion, who is a medical professional working with athletes. In addition, this champion has been with the institution for 13 years, so she has the historical knowledge that enables the translation of the policy to newcomers. Such longevity also lends credibility to her role as the expert champion. Of the nine individuals I interviewed, all mentioned her importance in some way and knew about her efforts in this area.

This individual was also entirely responsible for coordinating my visit to the institution, arranging interviews with all of the important actors and students, and escorting me around campus for the two days I was there. I had the opportunity for many informal conversations with her, and noted, most of all, her humility about her level of

importance in the decision-making and policy formation loop. She commented on feeling fortunate to be able to be in the position she is in within the institution because it is a rarity across the country. I gained the sense that she may not fully realize her importance, but others do. As one athletic trainer commented “Had it not been for (name), there still probably wouldn’t be anything here for us.”

Research Questions

To explore, describe, and explain the decision-making process, I have selected research questions to examine the choice, process, and change elements of organizational decision making, as well as looking for evidence of the background issues of ambiguity, longitudinal/historical context, incentives, repeated decisions, and conflict, against which decisions are made. The unit of analysis here is at a macro level, departmental or institutional, rather than the micro level of individual persons or players. However, it is important to note that although the answers to these questions are drawn from many sources---documents, field notes, surveys, interviews, and focus groups--- much of what I found about the institutions and departments is directly drawn from the individuals within them. Documents, focus groups, and field notes have been used primarily as a triangulation method to confirm what I found in the individual interviews. The responses to the questions are meant to further clarify and highlight how themes presented in the previous section address these questions, and to illustrate how the evidence and findings answer the questions. Although some of this analysis is discussed in the preceding section, this section is meant to bring the information together in a succinct manner.

Research Question 1: Do the culture and values of athletics play a greater role than the culture of the institution in the policy decision-making process? There was no

evidence to support the premise that athletics culture was more prominent than institutional culture in decision making. This finding is not surprising, considering that the current cultural values and practices in college athletics have their foundation in the unique history of higher education in this country (Beyer & Hannah, 2000). This history includes the importance of athletics as part of the institutional goal to “better the human condition” (Beyer & Hannah, p. 106). As described earlier in the *Loyalty to the athletics family* theme, the references to taking care of student athletes are very similar to what higher education has traditionally called *in loco parentis*, affirming that the role of the institution and those within it is to take care of its students in place of their parents. It follows that congruency in culture and values is expressed in the decision-making process.

More interesting is that athletics and institutional cultures were not the only two cultures expressed in the decision-making process. Because eating disorders are considered a medical issue, the culture of medicine, and in particular, athletic medicine, becomes apparent in the decision-making process. The stated purpose of sports medicine professionals is to take responsibility for optimizing health for athletes (Arnheim & Prentice, 2000). It follows then, that the medical culture is exhibited in the choice phase, including alternatives and premises (do no harm), and in the change phase to determine what the policy looks like in implementation.

At the two institutions with some formal policy, the medical and athletic training staff are the primary policy writers. In answering questions about what information was used in making decisions about the policy, these individuals relied heavily on

professional medical journals, other health care professionals, and medical conferences.

One physician noted:

“I like going to meetings. And it is not just the presentations at the meetings, it is the networking I do at meetings. I have been dealing with this now and I have been going to ACSM (the American College of Sports Medicine) ... and I have relationships with these people. It is the formal scientific presentation but it is also the informal networking.”

The medical culture was also illustrated in the verbiage used in the answers to interview questions and in the language of the policy documents themselves. The following response from a physician illustrated how the phraseology and content of the policy goes from medical research to policy and practice as he notes how the treatment protocol was developed and followed:

“Last year we started talking about luteal phases function and now there is good evidence that estrogen is not good for them. But it is going to get them only from point A to point A-1, not up to point C. And we are going to incorporate that into how we do things again this year .. we still think that the birth control pill is a good way to do it.”

This use of medical jargon in responses from medical personnel was common. A section of one policy about the plan for preparticipation examinations states it will use studies “to determine if there is iron deficiency. . . . hemoglobin, ferritin and transferritin will be tested.” Someone not familiar with this type of scientific terminology may not understand the connection between this test and eating disorders, and why it is labeled in such a detailed manner in a policy document. However, because the policy and decision-

making framework is also born out of the medical culture, these types of references are commonly reflected here.

A final key finding about the culture—institutional, athletics, or medical—is that it directly impacts the process of decision making. The culture has a much more pervasive influence on decision making than just being funneled through the choice phase, as suggested by Chaffee (1983). The culture directly impacts the process phase of the model, as evidenced by how medical personnel gathered information to make decisions, how judgments were made concerning what to include in the policy, and how and where athletics departments housed policy documents. At this point in decision making, the choice was already made, yet the culture independently directed the process. A reconfiguration of the original model is illustrated in Figure 4.3, highlighting this finding.

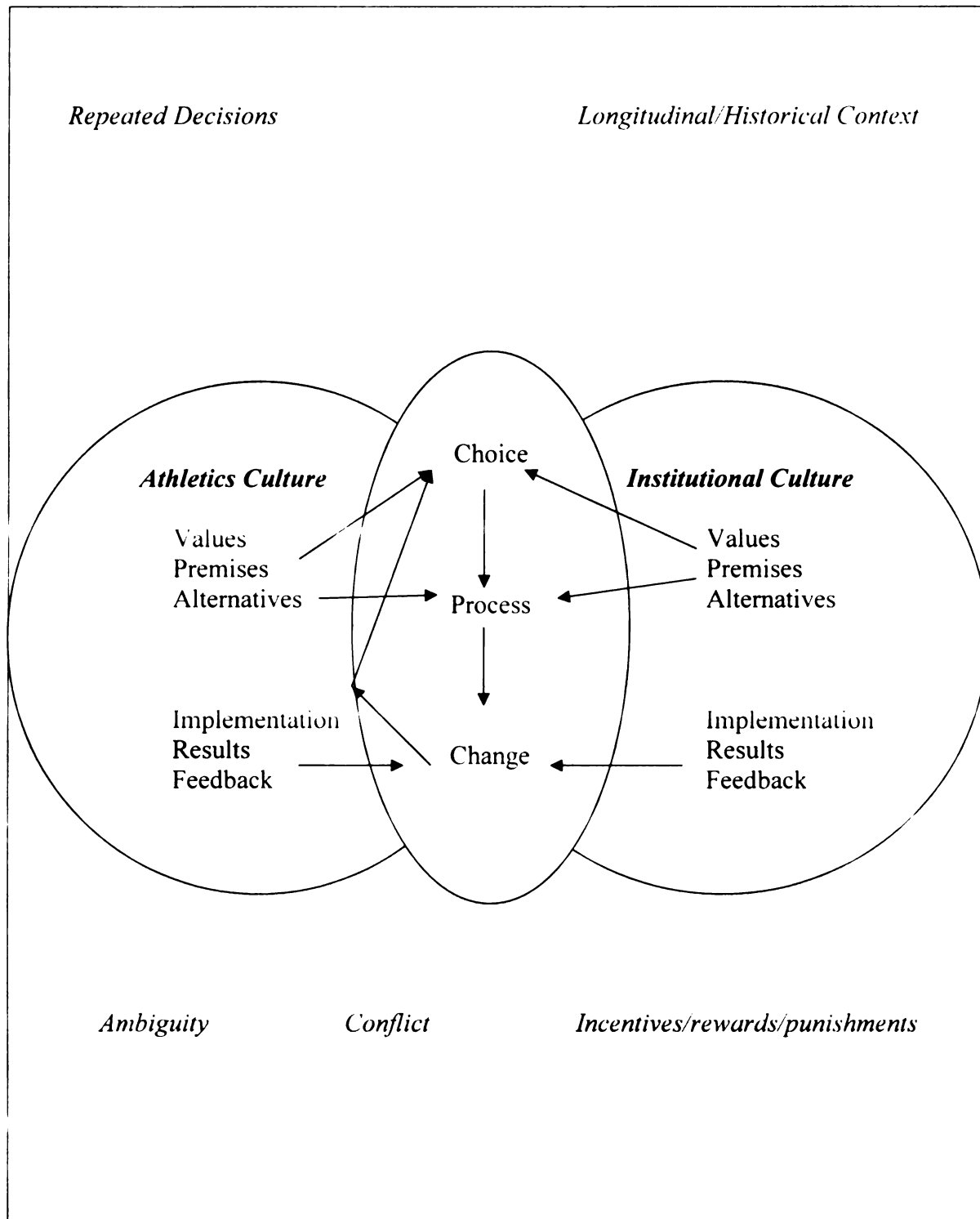


Figure 4.3 The decision-making theoretical framework as adapted from Chaffee (1983) and Shapira (1997), including findings from this investigation.

Research Question 2: Does the level of understanding and knowledge of eating disorders affect the decision-making process? At the unrealized policy institution, the lack of understanding and knowledge was primarily evidenced by a lack of policy. It is necessary to reiterate that the lack of knowledge or understanding did not preclude policy formation at the two other institutions studied, or even in the larger sample of the seven institutions that sent back policies identified in the policy document analysis. However, evidence that the level of understanding is important was prevalent across all institutions, as revealed in the alternatives considered for measuring, identifying, preventing and treating eating disorders.

This investigation confirms what many others have concluded: identification is perhaps the single largest barrier in addressing eating disorders in athletes (Ryan, 1992). Signs and symptoms for one individual may or not help in identifying others. Even the *DSM-IV* criteria do not cover every case, especially those who present as disordered eating, as noted by numerous researchers (Brownell, Rodin, & Wilmore, 1992; Guthrie, 1991; Leon, 1991; Sundgot-Borgen, 1993). In the present study, one physician commented about problems of identifying student athletes with eating disorders: "It is not like a rash where it is sticking out on their forehead and you can see it covered with make up."

The lack of understanding is further revealed through the results of the questionnaire indicating that 66.66% of the responding institutions offered educational programs for athletics personnel or student athletes, and only 28.57% made attending educational programming mandatory. This supports Beals' (2003) finding that eating

disorder education was not receiving the priority necessary to effectively prevent eating disorders among student athletes in Division I institutions.

Further exacerbating the problem of lack of knowledge is that eating disorders are often intentionally hidden by those affected so as not to be identified, and are then more difficult to treat once identified. In the early stages of an eating disorder, an athlete has a strong sense of denial of the problem and an intense fear of fat that overrides his or her ability to receive feedback and monitoring from others (Berning & Steen, 1991). Instead of accepting assistance or treatment, the athlete becomes more clever in disguising the evidence of the eating disorder (Hornak & Hornak, 1997).

The few individuals who had substantial knowledge about eating disorders noted that the individualization of the problem makes both treatment and policy formation difficult. Along with the difficulty of identifying those with eating disorders comes the question of what to do with them in the management and treatment stage. One nutritionist noted:

“... the issue of eating disorders are so different depending on the individual. The diagnosis can vary depending on the person. The intervention and the treatment is going to vary depending on the person...eating disorders is a continuum, it is not a black and white box. So because it is such a continuum, how do you establish a policy that is going to encompass all of those different realms that you are going to see along the spectrum?”.

Even Sherman and Thompson (2001) note that the lack of systematic training opportunities for professional psychologists in the area of eating disorders and student athletes is a problem. Increasing the knowledge about and understanding the causes and

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correlates of eating disorders can and should continue to be a research and interest area across many fields, especially with the aim of providing additional educational programming for athletes, coaches, athletic trainers, and administrative and support staff (Beals, 2003; Rockwell et al., 2001; Vaughan et al., 2004).

Research Question 3: What has prompted discussions about developing and/or implementing policy on eating disorders? As discussed in the *Policy decisions are reactive* theme, the findings in this investigation suggest that discussions were most often prompted by the realization that one or more student athletes were suspected or identified as having an eating disorder. Some persons interviewed had direct knowledge of this reason because of their involvement in the treatment of individuals. Many others simply suspected this was why a policy was in place.

At one institution, the fact that a star athlete had hidden her disorder was alarming to many. The physician at this institution noted,

“We had three big cases that really jump up and a lot of small ones in the middle. One of them was one of our starting basketball players and she had some back problems ... this was years ago. The athletic trainer was watching her, and she was doing things, and kids on the road noticed how she was eating on the road. And her teammates came up to us ... we looked and said this is one of our star athletes and we didn’t see it was this bad.”

The physician illustrates the next point about reactive responses— that information about problems often comes from another student athlete, who mentions a concern to the athletic trainer or medical professional. Teammates are like family members, in that they have a history and future together and they behave in organized

ways with one another (Zimmerman, 1999). They spend much of their time together at meals, practices, competitions, and on road trips. Thus, the fact that teammates commonly report a concern is not surprising. This also confirms the premise that a student athlete with a problem does not self-identify, rather, the initiation of the reaction chain often begins with a concern by others. One athletic trainer in this study illustrated a common finding across the cases through this comment:

“Since that time we have had a soccer player come in, and it was really the teammates that said something to us . It was more than one saying ‘hey, when we are on the road and she doesn’t eat.’”

Interestingly, while decisions were reactive in nature, they were not necessarily in reaction to one critical incident. At the unrealized policy institution, incidents with student athletes with visible eating disorder problems did not result in a policy. Indeed, policy decisions were made in a reaction to *something*—a concern about a lack of attention to female athlete medical issues, a pattern of increasing prevalence of disorders, maybe a case or individual. In the case of the unrealized policy institution, a policy may develop as a result of this investigation bringing it to the attention of the department. The senior woman administrator, an academic counselor, and athletic trainer mentioned that my coming to their institution could serve as a wake-up call for them to develop something.

In addition, all sites seemed interested in understanding eating disorders. I received many informal questions about what other schools were doing, what would I share back with them, what models did I know about, and so forth. Individuals were hungry for more information about what to do. How long this interest remains

heightened, or whether it serves as an impetus for further discussion or even action, is unknown and beyond the scope of this investigation.

Research Question 4: Who are the important decision makers in athletic policy on eating disorders? At what level in the organization do they reside? Policy decision making on eating disorders is led primarily by the medical and athletic training staff. This confirms the importance of medical care providers, as discussed in the cross case theme of *Eating disorders are a female medical issue*. It also reiterates the importance of the medical culture in decision making. According to Perriello (2001), the role of the physician is to monitor the health and nutrition of all patients, especially in light of sport participation, and physicians need to take a more active role in discussing nutrition with patients. Deals (2003) asserts that sports medicine professionals have the responsibility to become skilled in recognizing, preventing, and treating disorders. A college trainer's responsibility is to assist athletes in maintaining optimal health (Arnheim & Prentice, 2000), including identifying athletes at risk for and those with eating disorders, as well as taking steps toward preventing eating disorders in student athletes. An important step in prevention is policy formation (Vaughan et al., 2004). At one institution, discussion and subsequent policy creation was led by a physician, and at the other, an athletic trainer, suggesting support for the premise of a very local level or ground-up policy development approach.

A formalized committee may or may not be a part of the process. Although decision making by committee has been suggested as a best practice by practitioners in athletics policy formation (Conn & Malloy, 1990), the policies in this study were primarily developed locally by members of the athletic medicine staff within the athletic

department. Consistent with the practice suggested by Conn and Malloy, the athletic director or his or her designee does serve in a role of final approval, but he or she does not get involved at the development levels. In addition, the Athletics Advisory Council set up at institutions generally has no knowledge of this localized process, as evidenced by the lack of awareness of the faculty representative at the realized policy institution. When asked about this council in particular, the faculty representative notes that “we have an athletics council .. I would not say they have been very strong in terms of policy formation.” The president of the institution, though the voting member at NCAA, has no involvement in policy formation at this level, nor any general knowledge of decisions made at this level. There also was no evidence indicating that overall institutional approval or faculty senate consideration was necessary for policy formation or implementation. The faculty representative goes on to say,

“I think we have fairly good institutional control when it comes to things like admissions, continued eligibility, those sorts of issues, particularly those that are compliance oriented. The softer issues, people where eating disorder policies would come into play, are handled more by the athletics department. I don’t think the faculty senate has ever contemplated an eating disorder policy.”

It is clear that this type of policy is viewed as a local or departmental policy within the larger institutional organizational structures of these three institutions.

Research Question 5: What affects the alternatives considered when making policy decisions about student athletes with eating disorders? This investigation supports the assertion that organizational culture has an impact on decision making, as described in the response to Question 1 above. The values and premises of medicine, athletics, and

higher education all impact the alternatives considered by the individuals responsible for making decisions about policy and the process and manner by which the policy is formed, adopted, and implemented.

In addition, because the decisions in this investigation are made primarily by a select group of individuals from medicine or athletic medicine, many of the alternatives considered are a result of the ability of such individuals to generate or have knowledge about the topic area of eating disorders in student athletes. The professional connections with other health care providers that the decision makers had, in addition to access to journals, research, and eating disorders information in general directly impacts the knowledge base of the decision makers.

Contextual issues unique to the athletic departments also affect the alternatives considered. The incidence, prevalence, and type of eating disorders seen within the student athlete population at an institution shapes the “truth” about eating disorders and athletes at an institution. For example, if no student athlete had ever been known to have an eating disorder, it is highly unlikely that an institution would have a policy. As evidenced by interview comments at the unrealized policy institution, only a small number of individuals had any direct knowledge of any student athletes with eating disorders. In both institutions with a policy, research was conducted at the outset of policy development in order to demonstrate its need. At the realized policy institution, a graduate student did her master’s thesis on the topic. The findings generated from this thesis supported the verbal assertion made by the athletic trainer to the administrative staff concerning evidence of a problem with student athletes and eating disorders. At the partially realized policy institution, a similar needs assessment or prevalence study was

mentioned by three individuals. All three wanted to show me the evidence that illustrated the need for assistance for student athletes with eating disorders, but could not because the student athletes could be identified from the documents they collected.

Most of the occurrences and references about eating disorders prevalent in these departments were focused on female student athletes who were not eating. This may be attributed to the fact that females make up 90% of those with eating disorders (*DSM-IV*). In addition, most of the current research on eating disorders in general, and within the student athlete population, focuses on women, though some authors are beginning to include men in the discussion (Petrie & Rogers, 2001). This helps to explain why very little mention was made about males with eating disorders.

In addition, throughout the interviews little mention was made of athletes who were bulimic, and this finding also was evidenced in a document issued by a Student Athlete Nutrition and Performance Task Force at one institution. This document, designed to “ensure that student athletes receive the nutritional assessment and educational services appropriate to their needs to help them achieve peak performance,” included a section on screening for eating disorders that addressed issues of menstrual history, body composition, and iron deficiency, all of which are signs of anorexia nervosa rather than bulimia nervosa (*DSM-IV*).

This study affirms the importance of determining prevalence and incidence rates, established by needs assessments or anecdotal evidence relative to the populations affected, and their direct effect on alternatives considered in decision making on policy formation.

Research Question 6: Is there evidence of a rationale to justify adoption of or abandonment of eating disorder policy? The primary rationale for developing an eating disorder policy was a genuine concern for the overall physical and psychological health and well-being of student athletes. This confirms the importance of culture and values across medicine, education and athletics, as indicated by the paternalistic culture of higher education and athletics in the *Loyalty to the athletics family* theme, as well as the culture of medicine to provide the best possible care and do no harm, as presented in the *Eating disorders are a female medical issue* theme. It also confirms the stated purpose of sports medicine professionals to be responsible for ensuring optimal health for athletes (Arnheim & Prentice, 2000). This rationale of concern for health presented itself across all three institutions, and even members of the unrealized policy institution submitted it as a reason to adopt a policy should they decide to implement one.

Initially I thought that the unrealized policy institution made a decision not to have a policy because it was smaller and less financially able. Evidence did not indicate that the unrealized policy institution abandoned a policy. Instead, the level of discussions necessary to lead to formal consideration of a policy had not taken place. Of paramount concern to this institution, as well as to the others, were resources, including time, money and staff. Interestingly, individuals across institutions recognized that resources were limited everywhere, although some felt more passionately about it than others.

A different way of looking at the resource issue was brought forward by the nutritionist at the partially realized policy institution. This institution is by far the wealthiest of the three studied here in terms of endowments, research dollars, and other revenue, including revenue generated from athletics.

“I think people get wary when the things that would be best to do for the student athlete might be too expensive. So I think there is a dollar figure there. But, you can have all of the policies in the world, but getting a person into treatment and having them accept help ... you can have a policy that says multidisciplinary care, but it is all very expensive if they don't want to change, the fear, the denial, all of those problems go on. What good is a policy?”

Thus, even though resources are available at this institution, the complex nature of eating disorders makes resources alone insufficient to provide a solution.

Research Question 7: Does communication of the policy or measurement of its effect on eating disorders in student athletes (if adopted) occur? Policy and health researchers alike indicate the importance of communication and measurement of any implemented policy, and specifically for eating disorder policy, to coaches, administrators, athletic trainers, health and medical personnel, and student athletes (Bickford, 1999; Conn & Malloy, 1990; Vaughan et al., 2004). Evidence in this study supports both communication of the policy and outcomes measurements of its effect on student athletes. At both the partially realized and the realized policy institutions, the policy is made known to various members of the athletic staff, most notably coaches, nutritionists, counselors, and athletic trainers, through e-mails, verbal communication, and handbooks published or housed in the medical or athletic training offices.

An important finding is that neither institution with a policy took measures to communicate the policy to the student athletes. Neither department included it in the student-athlete handbook, the primary written communication piece to all student athletes. This lack of communication was further confirmed by focus group interviews

with the student athletes, who had no knowledge about eating disorder policy, although they did have knowledge of the results of policy implementation. When asked if they were aware of the eating disorder policy at their institution and what they knew about it, students commented:

“Not much, I guess.”, “No.”, “Do we have one?”, and “I didn’t know that we have one.”

However, when asked what they saw being done about eating disorders for student athletes, the same students commented:

“I know we have a sports nutritionist and I know we have athlete orientation where they talk about it.”

“I know we had a speaker and she spoke about eating disorders because I believe she had one—the problem is not everyone was able to go to that.”

“We get these little handouts like healthy eating.”

“During preseason we have a lot of nutrition meetings and then for people that are actually having a problem they have counseling sessions and stuff like that.”

“I think (name) did a lot of reaching out. And team members can go to (name) and have meetings and stuff like that. I mean, she’s pretty good about putting out pamphlets and stuff out on disorders. Early in the season (name) will go around to each of the teams and she gives a brief talk about it.”

Although the student athletes really have no direct knowledge of the policy per se, or its formation, they do see evidence of its enactment through the educational programs, literature and personnel.

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In addition, at both institutions the policy is reviewed annually, individual cases of eating disorders are tracked, and evidence is gathered about trends among teams through the athletic training staff. However, when pressed, no one had direct evidence that the policy or subsequent measures had affected prevalence rates, either positively or negatively, or that there had been any analysis of data. Most of the evidence was anecdotal or just a good “feeling” that they had something in place. Time, expertise, and confidentiality are three possible factors. It is important to note that research into eating disorder policies continues to be part of the process for the realized policy institution, and is part of the activities of the Student Athlete Nutrition and Performance Task Force. This continuing research measures various psychological and physiological indicators of all incoming female athletes to try to identify those at risk for eating disorders early on, and has been an ongoing project for the past 3 years.

Chapter 5: Discussion

This chapter discusses the research problem; the methodology used to examine the research questions; the findings as they relate to the decision making conceptual framework and previous research; an interpretation and possible explanation of the findings; possible implications and applications of this investigation; and recommendations and suggestions for additional research.

The Research Problem

The purpose of this investigation was to explore, describe, and explain the decision-making processes undertaken by institutions in the development and implementation of student-athlete eating disorder policy within the context of intercollegiate athletics and the higher education environment. Specifically, this study identified the policies and practices of athletic departments at select NCAA Division I institutions; compared the policies and practices across the institutions; and examined the decision-making process through the lens of Chaffee's (1985) general choice, process, and change model of decision making, using as a backdrop Shapira's (1997) concepts of ambiguity, historical context, incentives and penalties, repeated decisions, and conflict in the decision-making process.

Methodology

The study was conducted in two phases. First, a questionnaire was sent to 31 Division I institutions offering both women's gymnastics and men's wrestling, requesting responses from the senior woman administrator and team physician or head athletic trainer on the current state of eating disorder policy and procedure at each institution.

Seven institutions returned policy documents in response to this questionnaire. These documents were analyzed and compared in terms of content themes. Next, I used an ethnographic case study approach with three selected institutions of varying policy implementation levels to explore, explain, and describe the decision-making process. This approach involved individual interviews with faculty and staff at each institution, focus group interviews with student athletes, the collection of documents, and field notes gathered through observations and informal conversations.

Findings

Examining decision making through the theoretical framework of choice, process, and change (Chaffee, 1983) in combination with the background issues of ambiguity, historical context, repeated decisions, incentives and rewards, and conflict (Shapira, 1997) proved useful in understanding and explaining the decision-making processes for policy on eating disorders. Four major themes underlying the decision-making processes were identified across all institutions: policy decisions are reactive; eating disorders are a female medical issue; loyalty to the athletics family is important; and a champion with expertise is needed. These four themes are intertwined with one another in the decision-making process. Generally, two themes are linked with the choice process and underlying cultural values: eating disorders are a female medical issue and loyalty to the athletics family is important. That policy decisions are reactive in nature relates to the policy process. The need for an expert champion is a component of change.

This study confirmed that decision making is a disorderly process. Actual decisions reflect aspects of various traditional decision-making models (Chaffee, 1983; Shapira, 1997). While no one model fully explains decision making in this study, there

was evidence to support the importance of the major concepts of choice, process, and change (Chaffee). Some evidence of particular concepts from the various models of decision making was also present, further advancing the premise that decisions occur in a variety of ways and for reasons which do not always appear rational or move through a methodical, mechanical process (Chaffee).

The premise of decision making as a value-laden process conducted within a complex cultural context (Chaffee, 1983; Shapira, 1997) was strongly supported in this investigation. Evidence from the interviews, as well as the policy documents, illustrated the importance of the values of student athlete health and safety, custodial responsibility and care, and autonomy. The complexity of the organization as a combination of higher education, athletics, and medical cultures further demonstrated the importance of culture. The values within the culture are highlighted in the decision-making process. In this investigation, one culture was not found to be more dominant than the others, but the culture of medicine was found to play a key role, including influencing the values considered throughout the decision-making process.

In addition to culture and values, decisions were guided by premises. Although different at each institution, the premises influencing the alternatives considered in the decision-making process were related to knowledge. The first was eating disorder knowledge and expertise of decision makers, especially the health care providers. This finding was most clearly exhibited in the unrealized policy institution, as ambiguity within the choice phase (Shapira, 1997) served as a barrier to making a decision or to having discussions about developing an eating disorder policy. The second issue is the knowledge of eating disorder prevalence, which would demonstrate the need for a policy.

This knowledge, once attained, spurred discussions, decisions, and development of a policy.

As a part of understanding the process element of decision making, gaining the knowledge about the need to make a decision is an important step. The discussion began once there was knowledge of a problem, affirming the premise that policy decisions are reactive in nature. Thus, as Chaffee (1983) contends, the choice, based on values, premises, and alternatives, guides the process, which in this case is reactive and leads to change (policy development). One additional element to this process component is that decisions are made in a historical or longitudinal context (Shapira, 1997). Participants in organizational decision making are part of ongoing processes, and commitment may be more important in such processes than judgmental accuracy, as evidenced in the importance of having a champion with expertise as a part of the process. This champion is able to keep discussions moving forward over a period of time by retaining knowledge about what has happened in the past and remaining committed to advancing the effort in the future.

The change concept (Chaffee, 1983) was primarily evidenced at the two institutions with a policy, in the actual adoption of the policy document, communication to others about the policy, the hiring of selected staff members, and the continued measurement of eating disorder cases and patterns. Processes of formal and informal communication were identified, an expert champion was recognized as important to keep the process moving forward. The individuals affiliated with the process of formulating and communicating the policy were at the local level, primarily athletic training and medical care providers within the athletic departments. It is not known whether, at the

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unrealized policy institution, a choice was made to reexamine the eating disorder policy as an alternative to the current student-athlete case-by-case approach or whether they will consider any alternatives at all. Regardless, the results of the change feed back into future decision choices.

One important discovery concerned the lack of influence by student athletes. Duderstadt (2000) asserts that student athletes are the least represented group in discussions and decisions about issues that directly impact them. Although a formalized organization, the Student Athlete Advisory Committee, has been created to give them a voice, this investigation confirmed that student athletes are not part of the discussion, decision, or communication about the actual adoption of a policy. The student athletes were affected by the organizational change that resulted from the decision, such as hiring counselors and nutritionists or hosting educational programs, but had no visible influence in the choice or process aspects of the policy decision. It is not clear why the students on the Student Athlete Advisory Committee were so unaware. This lack of awareness indicates that the formalized communication structure is not truly utilized. Perhaps because the NCAA requires the formation of such a group, athletics departments comply because they have to, not because they truly value student athlete input. This issue of forced compliance to NCAA regulations may play an important role in understanding decision making within athletics departments and institutions, and could be explored further.

Although the general model of choice, process, and change (Chaffee, 1983) is adequate for understanding and explaining decision making about student-athlete eating disorder policy, there were some concepts of decision making noted by Shapira (1997)

that had either minimal or no support. This result may be a function of the limited number of cases, the unique cultures of the institutions selected, or the bias or lack of knowledge in the respondents' understanding of how the decision-making process occurred. It also could reflect the lack of importance of a particular concept within the organization.

The first concept that lacked support was the influence of making repeated decisions. Shapira asserts that many individuals in decision-making roles make repeated decisions on similar issues. I did not find evidence that making repeated decisions on health, welfare, or medical issues was important in the decision-making process for policy formation. This finding may be a function of the level at which these policies are created and discussed; the local athletic medical personnel are primarily responsible for policy formation. Although institutions have policies on a variety of health- and safety-related topics, the process through which these policies were formed did not appear to affect eating disorder policy formation significantly.

Shapira (1997) continues with the concept of repeated decisions, noting that individuals develop a sense of using their skills (which may be faulty) and a sense of having control of the situation (which may also be faulty), stating that such beliefs are pervasive in thinking about risk taking. There was some evidence of this concept at the unrealized policy institution in the way its actors chose to handle student athletes with eating disorders on a case-by-case basis. The comment by several members at this institution about "handling it case by case works for us" supports the idea that they are willing to take a risk because past practice has worked before.

A second characteristic of organizational decision making presented by Shapira (1997) is the importance of incentives and penalties. Incentives and penalties in the organizational context are real and have long lasting effects, primarily because of the longitudinal nature of decision making in organizational settings. In addition, because survival is a basic aspect of life in organizations, incentives and penalties play a key role. One could assert that the incentive to the organization to adopt a policy would be saving the lives of their student athletes or reducing the penalty of institutional and departmental legal liability and medical costs. At one institution, there was a small piece of evidence that pointed to the avoidance of a penalty. At the partially realized policy institution, the initial discussions about student athletes with eating disorders stemmed from a concern about negative publicity from the lack of attention the department was paying to female medical issues in comparison to those of male athletes. However, the decision in response to this concern was to conduct a needs assessment of this population, not to adopt a policy. Later, the interpretation of the needs assessment results led to the decision to continue discussion and develop a policy. As evidenced throughout the interviews and in the text of the policy documents, what Shapira describes as incentives and penalties are seen in this context as a duty or obligation by the decision makers.

Finally, the notion of conflict is notably absent in decision making about eating disorder policy. No one I interviewed across all three institutions had a reason for not having a policy. There appeared to be no heated debates about its development, no individual or group mentioned being ignored in the decision (although clearly the student athletes were ignored), and there was no evidence that the hierarchical nature of organizational structure or sources of authority were important in this decision. I was

surprised by this finding at first, especially considering the political nature of sport organizations (Miller, 2002) and the issues of power and control that have been pervasive within them (Sperber, 1990, 2000; Duderstadt, 2000).

However, upon further consideration of the context in the three institutions, the finding that conflict was not a large part of the decision-making process fits. This result can be attributed to the fact that eating disorders still remain relatively hidden. They are hidden by the athletes. Often, even if an athlete is identified, issues of confidentiality keep individual cases hidden from others in the organization. It is not a topic of discussion that occurs often in the organization. A coach and a physician at two separate institutions noted, “the issue usually becomes heated when we have a poor outcome or something bad happens to an athlete.” An example would be serious hospitalization or the death of a student athlete due to an eating disorder. However, there was no direct evidence, other than casual references to past instances, that led me to believe that a bad outcome had happened recently at any of these institutions. Even taking into account the reactive nature of decision making, the absence of any recent crisis and the fact that the decisions had not been in reaction to a critical incident indicate that conflict may not have been present at the time of the decision to develop a policy.

Interpretation and Explanation of Findings

These findings do not stand alone, nor can they be explained simply as an athletic phenomenon or a higher education phenomenon. The values, alternatives, premises guiding the choices, processes, and changes are affected primarily by the concepts of ambiguity and a longitudinal or historical context in this study. There was less evidence

to support the importance of repeated decisions, incentives, or conflict in the decision-making process.

These findings may be explained by looking at how issues of health policy development, organizational decision making, intercollegiate athletics, and women's medicine historically influence how we have come to know and understand eating disorders in student athletes. These are the threads that make up the fabric of our Western culture, and subsequently are part of the assumptions upon which we have based our decisions. Examining these issues helps explain the current state of policy development with regard to eating disorders and student athletes.

Eating Disorders as a Woman's Issue

This investigation found that eating disorders are still primarily understood to be a female student-athlete issue. The realized policy institution, for example, focused its policy language on women. This focus is not unexpected; nearly 90% of cases of eating disorders appear in women (*DSM-IV*). Moreover, even publications aimed at educating higher education professionals on counseling student athletes with eating disorders place the discussion in the context of female student athlete issues (Etzel et al., 1996).

There are also different societal expectations for men and women with regard to appearance and attractiveness. Messages in our current culture focus on the notion that beauty, success, personal worth, and happiness relate to being thin, and these messages are aimed primarily at women (Thompson & Sherman, 1993a). Billie Jean King described this phenomenon when she referred to her own experience as a female athlete in a 2000 commentary:

Women, especially female athletes, have always been judged by their appearance. I'll never forget the time I was told by a good friend and supporter, "You'll be good because you're ugly, Billie Jean." I was 16 at the time, and this comment was devastating. It is the kind of comment, stated in a friendly, offhanded way, that can shatter the confidence of a young woman. It's similar to, "If you just lost a few pounds, you'd be a better runner, swimmer, jumper, tennis player ... take your pick." It's the kind of comment that can kick off a frenzied attempt to please, to lose a few pounds, to do something to make yourself more attractive, faster, or better. We women will bend over backwards to please our critics, despite their thoughtless, inconsiderate, and totally unfounded comments (Otis & Goldingay, 2000, p. vii).

The medical professionals in this study, and the student athletes, understand that male athletes also have eating disorders. Identifying males with eating disorders is difficult for a variety of reasons. Most notably, male participants in sports such as wrestling are the least likely to seek medical or psychological treatment specific to eating disorders; they do not want to admit to having a "woman's problem" (Anderson, 1990).

In the late 1980s and early 1990s, collegiate wrestlers, noted for their extreme weight loss measures, were in the spotlight nationally. In 1997, representatives from the Amateur Athletic Union, the NCAA, the National Federation of State High School Associations (NFHS), the National Wrestling Coaches Association, and USA Wrestling formed the Joint Task Force to Protect Wrestling. The task force acknowledged the weight loss problem, dedicated itself to maximizing the health and safety of athletes, and

proposed safe and responsible weight control practices (Perriello, Almquist, & Johnson, 2002).

The ultimate complication of rapid weight loss occurred in 1998 with the death of three college wrestlers in the United States. Their deaths were directly attributable to dehydration in attempts to lose too much weight too rapidly. In response, the sports medicine community, along with the NCAA, redesigned the weight criteria for wrestlers (Perriello, 2001). The NCAA mandated that all wrestling programs at the college level follow a weight management program, which they title the *NCAA Rules and Interpretation*.

This step was meant to stop the pathogenic weight loss behaviors of purging, over exercising, and other methods which led to dehydration, and ultimately death in the case of a few wrestlers. This measure has proven successful - NCAA data shows that a significant improvement in weight loss practices and a decrease in harmful effects on health have occurred as a result of the program (Bubb, 2001). Most notable about this example is that the deaths of a few *men* in a single sport were enough to cause the NCAA and medical community to take action to change policy.

Women's Medicine

A key factor in viewing eating disorders as a women's health issue lies in the medical community. In our society, Western medicine still lags behind on women's health and medical issues. This lack of sophistication in women's medicine is likely one of the reasons that eating disorders have not been fully address in the medical community. Only after the feminist movement of the 1960s were women's health and

medicine addressed separately from those of men, primarily through grassroots efforts (Council on Graduate Medical Education [COGME], 1998).

Thankfully, the political forces behind the current women's health movement differ markedly from those of the 1960s. In 1983, the Assistant Secretary for Health commissioned the United States Public Health Service to form a task force to assess the status of women's health in the U.S. and to identify the most important factors that influence health and disease (COGME, 1998). The task force presented recommendations in 1985, including recognizing the effect of social and demographic changes on women's health issues, stressing the importance of preventative health services, and identifying biases in both research and clinical practice that has resulted in inadequate health care for women.

In 1987, the National Institutes of Health (NIH) budget was examined to determine how research funds were allocated according to gender. The study found that only 13.5% of the NIH budget supported research for women's health issues. Women were not adequately represented in many of the research studies affecting both genders. In response to an outcry from the Congressional Caucus for Women's Issues, the NIH created the Office of Research on Women's Health (ORWH) in 1990. The charge of this office is to enhance research on women's health, ensure that women's health issues are adequately addressed in NIH research, ensure that women are represented in all NIH studies, and increase the number of women in biomedical careers (COGME, 1998).

These initiatives have led to a call for change in the way health and medical practitioners are trained (COGME, 1998). Health care needs of women are still not being met by the current health care delivery and medical education systems. The basic

precepts guiding the conduct of medical research, education, and practice, as well as the societal biases that influence the health of women today, remain a concern. Broadening the knowledge base and expanding training for health professionals entails an appreciation for not only the biological differences between the genders, but also the demographic, psychosocial, economic, and environmental factors affecting women's health.

Women's health issues have been addressed historically in relation to the differences in the reproductive system. The medical community has addressed eating disorders in this fashion, noting consequences of what is known as the female athlete triad—amenorrhea, osteoporosis and eating disorders (Otis and Goldingay, 2000; Rust, 2002). Continued education for and research within the medical community is a positive step toward recognizing and developing an understanding of the disease and making decisions to adequately prevent, manage, and treat it (Pearson, Goldklang, & Striegel-Moore, 2001; Rust, 2002).

Title IX and Women in Sport

The enactment of Title IX in 1972, which prohibited sex discrimination in educational institutions receiving federal funds, has markedly changed the face of the athletic environment. In the 1970s, women participated on varsity teams without scholarship assistance and with little institutional backing for coaches, uniforms, travel, medical assistance, or athletic training (Carpenter & Acosta, 2004). Their accomplishments generally went unrecognized. The Association for Intercollegiate Athletics for Women (AIAW) was formulated in 1971 to create a voice for women's athletics. The AIAW was still trying to formulate its policies when Congress passed Title

IX. In the 1980s, the NCAA took over women's athletics and the AIAW became defunct. Numerous lawsuits occurred during this decade. For a short period, Title IX lost its jurisdiction over college athletics. The 1990s saw more lawsuits concerning enforcement. In 1992, the U.S. Supreme Court determined that punitive and compensatory damages are available to the successful plaintiff in a case involving intentional violations of Title IX. Current cases in the courts focus more on the jurisdiction of Title IX as it applies to conferences, associations, and the NCAA. Much of the concern focuses on the loss of men's minor sports because of administrative decisions to sacrifice these sports rather than restructure the status of the budgets that favor premier sports, generally football, to meet the mandate to provide access to athletic benefits to both men and women.

Nationwide, college women have the ability to participate in more athletic teams than ever before (Carpenter & Acosta, 2004). This growth in participation is highlighted by comparing the number of female *athletes* to the number of athletic *teams* offered. In 1968, three years before the passage of Title IX, 16,000 college female *athletes* participated on varsity teams. In 2004, there are over 8,400 varsity women's intercollegiate NCAA *teams*. In 1970, the average number of female varsity sports per school was 2.5; in 2004, it is 8.32 (Carpenter & Acosta). More women involved in sport than ever means more women's medical issues to address. The feminist movement seemed to affect both women's health issues and women in athletics in the same way, first through grass roots efforts, then through federal legislation.

The National Health Agenda and Weight

Women's health and medicine are part of our overall national approach to health and weight control. For decades, recommendations about weight provided by federal

agencies have focused on the dangers of obesity and the need for weight loss. This focus has provided the public with an incomplete, often inaccurate picture, making it difficult to increase our understanding of health (Cogan, 1999b). To adequately address current issues of health and weight, including eating disorders, it is important to understand the historical development of the field and the culture in which policy decisions take place.

The national focus on eliminating or preventing obesity has led to increases in dieting and other weight loss behaviors. At any one time, as many as 70% of Americans are trying to lose weight. Young women are the most likely to be struggling with their weight (Centers for Disease Control and Prevention [CDC], 1991). More than \$33 billion is spent annually on weight loss products, programs, and aids in the U.S., not including costs of medical and psychological interventions such as drugs and surgery (Wolf, 1991). For half a century, psychologists, physicians, nutritionists, other health professionals, and commercial weight loss organizations have directed the weight loss efforts of the obese and overweight (Cogan, 1999a, 1999b). The federal government has spent millions of dollars on public health campaigns, directed its agencies to set specific guidelines for weight, and pushed weight loss for those not fitting the guidelines. Even with so much of the population dieting and vast resources and federal agencies addressing obesity, the incidence of obesity has not declined. Rather, obesity continues to rise.

Equating weight loss with good health has not stemmed the problem of obesity. As a society we focus on weight loss rather than health. Further, these efforts take place in a culture with a *thinness bias* (Cogan, 1999c). Thinness bias is the introduction of systematic error into the testing of phenomena, focusing on results that favor thinness or paying selective attention to information that promotes thinness (Cogan, 1999c).

Thinness bias is pervasive in the US. It manifests itself in our everyday interactions, including magazines, television, and research journals and in health and policy recommendations (Cogan, 1999b). Although bias cannot be entirely eliminated, it is difficult to recognize and change when it arises in the form of public health policy.

Although the consequences of a weight-centered approach to health are substantial, they are often overshadowed by overvaluing obesity prevention and treatment. An unintended outcome of thinness bias and the focus on weight loss is that people are literally dying to be thin. Although the rates of obesity have not gone down, the rates of eating disorders have risen, with millions of people suffering from anorexia, bulimia, and binge eating disorder (Thompson & Sherman, 1999). The time is right for a new national health agenda, but whether action will be taken in the form of new policy is yet to be determined.

Recent initiatives from the National Institutes of Health include promoting and supporting eating disorder research, creating task forces to address the understanding of eating disorders, hosting workshops, and publishing reports. There has been very little legislative activity on eating disorders in Congress. The first bill addressing eating disorders was not introduced until 1987. This bill offered a resolution designating a National Eating Disorders Awareness Week. Although there have been 17 freestanding bills introduced, only one bill was ever passed into public law. In 1989, the week of October 23–29, 1989, was designated as Eating Disorders Awareness Week (Eating Disorders Coalition [EDC], 2003). Since 1997, Congress has occasionally mandated agencies to address the problem of eating disorders through appropriations report language. The agencies targeted have been the National Institute of Mental Health

(NIMH), the National Institute of Child Health and Human Development (NICHD) and the Secretary's Office. Most of the agencies addressing eating disorders offer a fact sheet or information on their Web site. The Eating Disorders Coalition, a not-for-profit agency dedicated to research, policy, and action, has charged Congress and federal agencies to increase their activity concerning eating disorders and to use their authority to direct both its agencies and its report language to further address eating disorders (EDC).

Looking at eating disorders of student athletes in the historical context of women's health and medicine, women's participation and inclusion in the athletic environment, and the national focus on weight loss rather than on general health, helps to explain why the state of the art of policy formation on eating disorders in intercollegiate athletic departments is at a seemingly infantile stage of development, especially as compared to policies that deal with men's health and athletics. It takes time to incorporate change, and both women's health and women's athletics are fairly new to the landscape of the medical and athletics cultures.

Implications

This investigation highlights the importance of the four major themes evident in the decision-making process for student-athlete eating disorder policy. This section addresses implications for practice based on these four themes.

Theme 1: Policy Decisions Are Reactive

The reactive nature of policy decision making in this investigation is not surprising, since policy decisions often occur in response to a perceived threat or need (Shapira, 1997). This finding does not preclude the possibility that decision making could be proactive. By recognizing the general reactive nature of decision making, it is possible

to be more proactive by reviewing implemented policies and practices on a timely schedule within the department. This step will keep the policies up to date. It may also encourage continued discussion on topics that inform future policy decisions.

In the case of eating disorders, the reactive nature of decision making is exacerbated by the lack of knowledge or expertise about the topic. This finding was most evident at the unrealized policy institution, where ambiguity about eating disorders and prevalence rates stifled any discussion about forming policy. One solution may be to find a way for eating disorders research and information to become a more integral part of the athletics environment.

Finally, further exploration is needed into the concept of repeated decision making within organizations. Although there was little support for Shapira's (1997) concept of repeated decisions as meaning that organizations make the same decision repeatedly, there may be value in examining the way decisions are made. Birnbaum (1988) presents repeated decision making in the sense that an organization makes decisions in the same way, time and again. This type of repeated decision making within an organization may help to explain why decisions are reactionary. Unless something happens to intercede, the organization will keep arriving at the same conclusions, whether the issue is eating disorders, other health and safety issues, academic issues, or even eligibility issues. Thus, looking at how other decisions are made within the organization—for example, who is influencing the decision, and are decisions made by the same important actors each time and in the same manner—may further advance the understanding of decision making.

Theme 2: Eating Disorders Are a Female Medical Issue

Evidence in this investigation confirms other research that generally links eating disorders with women's health and medicine (*DSM-IV*). This finding highlights the importance for the health and medical fields of continuing to pay close attention to women's medical issues, including eating disorders. Continued research from various groups of health professionals, educators, and sport personnel are important if we are to develop policy and implement practice that adequately addresses the prevention, treatment, and management of eating disorders within intercollegiate athletics.

The perception of eating disorders as a female medical issue highlights the premise that two worlds are at work with this issue. There is the world of the health care professional, whose primary concern is the physical and psychological well being of student athletes. There is also the sport world, which focuses on improving athletic performance (Thompson & Sherman, 1999). In this investigation, it was apparent that the decisions, policy writing, and where the policy is housed primarily represented those in athletic medicine. Even the text and language within the policies represented the medical culture and spoke in medical jargon. To continue to make changes in the athletic environment, such as the adoption of a policy on eating disorders, health and medical professionals must work collaboratively with those in the sport world (Thompson & Sherman, 1999).

This finding may mean inclusion of sports administrators in the decision-making process at the organizational level. It also may indicate the need for adapting the policy language or location so it is easily understandable and accessible to those in the sport world. On a broader research scale, it means publishing research and practice

implications in outlets read by members of the athletic management and coaching communities.

Theme 3: Loyalty to the Athletics Family Is Important

This theme confirmed the importance of loyalty in the athletics culture in shaping decisions and actions within the athletic department, and how this culture guides other interactions with the larger institutional organization. The intense loyalty inherent in the familial culture of athletics has serious implications, and can lead to dangerous consequences in the context of student athletes and eating disorders. Eating disorders tend to remain hidden, not only by the athlete with a problem but by fellow athletes who are not willing to address a problem they see within their own team or on other teams. Student athletes expressed a concern over “blowing something out of proportion” or “getting a teammate in trouble.” This attitude can become deadly if an athlete with a suspected problem continues to go unreported.

Although much of the success of athletic teams is based upon a notion of trust and a bond built between athletes, coaches, and other athletic staff members, this bond can create an environment that reinforces eating disorders. It is important for coaches and athletics staff to foster an athletic environment that encourages communication and openly acknowledges the potential problems and issues student athletes may face. This finding has direct implication for communication practices among student athletes, coaches, and athletics staff.

One possibility would be to include eating disorders information in the student-athlete and coaching handbooks in addition to the medical manuals for the athletics departments. For example, the student-athlete handbooks collected in this investigation

include information for athletes on how to respond in the event someone offers them a gift or what to do if a reporter calls. It may also be appropriate to include information on eating disorders.

Another implication of this finding is a need for educational programming that reaches athletics administrators, coaches and student athletes. This study confirms earlier research findings that coaches, trainers, administrators, and student athletes all lack good information on identifying, preventing, and treating eating disorders. Although some institutions offered educational programs or materials, very few made attendance mandatory. The implementation of mandatory education programs for student athletes, coaches, administrators, and other athletics staff is the next logical step (Bickford, 1999).

Theme 4: A Champion With Expertise Is Needed

Peter Drucker once commented that “whenever anything is being accomplished, it is being done, I have learned, by a monomaniac with a mission (Clemmer, 2004, p. 1).” This person within the organization is a champion. A look back at women’s medicine and women’s athletics, as well as at our national health agenda, indicates that many changes began with a grassroots approach and a passionate, credible champion to push the issues forward even in the face of ambiguity or conflict. It also takes this champion to bring others on board in support and to influence those in positions of power and authority to make a decision that creates a change.

The organization with a realized policy had such a champion, supporting what others in the business world have found - that the presence of a champion is needed for organizational change to occur (Clemmer, 2004). The organizational structure of the athletics department supported the emergence of this champion through the creation of a

position dedicated to female student-athlete health and medicine. The organizational support for such a champion was not present at the other two institutions. I advocate for a reexamination of the organizational structure of athletic departments, including athletic medicine, at least at the institutional level, in an effort to address this need for a champion.

From a national perspective, athletic departments are mandated by NCAA to have a senior woman administrator. Perhaps some recognition of the importance of a champion for female student-athlete health and medicine on a larger scale, supported through a governing organization like the NCAA, would provide further support for the champion and subsequent policy development.

Recommendations for Future Policy Work

The push by both NCAA and institutions of higher education to integrate academics with athletics is a positive first step in creating an environment for more informed decision-making processes. However, in the case of eating disorders, and student athlete health and welfare in general, this integration leaves out the responsible parties: the athletic trainers and medical professionals. These professionals are key players in policy formation and in the maintenance of student athlete health, yet there is no one place within the organization where they reside. In some cases, team physicians have their own separate practices outside of the institution and are on contract time with the athletics department. In other cases, the team physician is also the campus physician. Athletic trainers often work with teams, but also teach in sports medicine curriculums within an academic department. The alignment of health and medical personnel in athletics is not dealt with in a uniform way, as other athletics personnel are at the

institutional and departmental level. Understanding and addressing this lack of consistency within the organizational structure at institutions is a key element for future exploration on decision making about eating disorders and other student athlete health and welfare issues.

Medical and health professionals are important in the decision making process, but it is apparent that reliance on the medical and health professions to create eating disorder policy is not enough. Eating disorders are a complex combination of social, emotional, psychological, and physiological factors. Reliance on higher education, athletics, or the NCAA to create policy is not enough either, as our values of autonomy and self-regulation often impede progress in areas where we lack understanding. If the notion of a champion works on an institutional level, then perhaps investigation is warranted into how a champion at a larger organizational level could promote policy for student-athlete eating disorders on a broader scale.

Where this champion would come from is not well defined. To find a knowledgeable, credible expert with the sustained passion plus evidence of connection to the power and authority necessary to exact such change is difficult. Indeed, others have tried and failed. The Knight Foundation Commission on Intercollegiate Athletics has been marginally successful in creating change within the NCAA. It is an influential entity, made up primarily of university presidents, which may be able to stimulate conversations about change. The NCAA historically has fought outside intervention. Congress has attempted to enact change. Indeed, the NCAA recognizes the influence and power of Congress, as illustrated by the opening of an NCAA satellite office and the retention of local legal counsel in Washington, D.C. (Katz & Hilliard, 1995). However, it

is a slow-moving, political body that cannot enact change itself, though it may serve as a catalyst for NCAA action.

Academic researchers have called for change in health and weight policy. Legal experts have championed change on the basis of protection from liability. The medical community has tried to form a united front, some joining with the American Academy of Eating Disorders to push for further research. The Eating Disorders Coalition has formulated recommendations for Congress. Even individual student athletes have told their countless tragic stories to the nation in a variety of media, and have won lawsuits against schools because of their eating disorders (Fleming & Wong, 2004). The NCAA outwardly supports measures to prevent, identify, and treat eating disorders, and even allows for payments for such services (NCAA, 2002b). Yet we still have not gotten to the point where this activity has been enough to enact change at more than a local departmental or institutional level.

Western culture invokes a “pull ourselves up by our bootstraps” mentality, fighting for individual rights and freedom to make individual decisions. This autonomy is an ingrained value. It manifests itself in the health care system; we do not have a national health care system. It manifests itself in athletics, with people competing in demanding environments to achieve individual recognition. Autonomy is regaled in higher education and research, where success is largely measured by individual achievements or comparing achievements against others. We are a democratic society, strongly believing in the importance of each person’s vote in our electoral process. We live in a culture where the “I” is generally more important than the “we”. Perhaps this is why grassroots

efforts in and of themselves only get beyond being a movement or a phase when someone, an expert champion, encourages a larger perspective.

Who will have the capacity to become the expert champion for eating disorder policy? The answer may ultimately have to come from the NCAA. The current president of the organization, Myles Brand, stated in his 2003 State of the Association speech, The “NCAA is a membership organization. It is the members, represented ultimately by university and college presidents, who decide on our future courses of action.” (Brand, 2003, p. 3) He recognizes the importance of college and university presidents, but also notes that it is the individual members of the NCAA whose responsibility it is to provide solid information to assist presidents in making decisions.

Information about eating disorders and student athletes has an important place in the organizational structure of the NCAA, through the Committee on Competitive Safeguards and Medical Aspects of Sports. Its stated mission is to “provide expertise and leadership to the Association in order to promote a healthy and safe environment for student athletes through research, education, collaboration and policy development.” (NCAA, 2003a) The committee is comprised of the experts in several areas—medical, athletic administration, academic research, legal, coaching, and student athletes, and it is charged with creating policy. The committee has representation of two of the three important factors as illustrated in the realized policy institution—organizational support, and expertise—but the third, the passionate champion, may not be fully realized within this committee. If members on this committee made eating disorder policy their passion, thereby turning the committee into the champion, it might be possible to affect change within the NCAA and on a broader scale.

Summary

The current investigation contributes to the existing literature by providing a baseline for determining eating disorder policy levels in Division I athletics, outlining the key components of several policies, and offering some possible explanations of the organizational decision-making process related to eating disorder policy. Overall, the decision-making framework of choice, process, and change (Chaffee, 1983) was supported. and clear evidence of the impact of cultural, historical and longitudinal factors and ambiguity was presented (Shapira, 1997). The four major themes—policy decisions are reactive, eating disorders are a female medical issue, loyalty to the athletics family is important, and a champion with expertise is needed—recognize the importance of values, culture, knowledge, organizational structure, and individual member participation in the decision-making process toward enacting policy change.

This study's findings clearly point to a need for further attention to eating disorder policy at a national level. The ambiguity about definitions and prevalence rates of eating disorders surely calls for continued research into the psychological, sociological, and medical causes and implications of eating disorders and disordered eating. This step needs to address audiences in the athletics realm, including the lay journals or magazines read by the individuals who interact with student athletes: coaches, administrators, and medical personnel.

The perpetuation of the belief that eating disorders are a female medical issue requires investigation. Work that addresses eating disorders in men and male athletes is needed. Further study of the culture of Western medicine and the ramifications it has on treatment of women's health also needs further exploration. Again, this work needs to be

addressed to specific, targeted audiences in order for it to become pervasive in our general population.

Looking at the ways in which athletics promotes a culture of family and the paternalistic nature of this environment may also be valuable in understanding the developmental needs of student athletes in particular. It is a critical step in recognizing the unique stressors and needs of student athletes. It may lead to a better understanding of the roles athletics personnel play in the lives of student athletes that reach far beyond the four or five years they interact together as a team.

More work exploring the role of an expert champion in the decision-making processes of institutions and athletics department is needed to confirm the importance of this figure. This investigation looked at a limited number of institutions in depth: expanding this line of inquiry either at a different subset of institutions or at a less detailed level across more institutions, may provide information that better represents the decision-making processes across other types of institutions beyond Division I.

Finally, examining the NCAA in depth, including its organization and decision-making processes, is a logical next step in the process. This is an area where future research could provide insight into affecting permanent change and a cultural shift in athletics, not simply local institutional change. To be sure, the NCAA does not support the idea of other organizations, commissions, or even Congress coming in to try to make sweeping reforms, and the effects of these attempts have been marginal. It is when the NCAA itself recognizes and supports its own decisions that change occurs within the organization and down to the individual institutions.

Appendix A: *DSM-IV* Diagnostic Criteria

Table A1 *DSM-IV* DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA

- A. 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% than expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
- B. Intense fear of gaining weight or becoming fat, even though under weight.
- C. 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 low body weight.
- D. In postmenarcheal 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 hormone, e.g., estrogen, administration.)

Specify type:

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington DC: Author. (pp. 544–545). *Note.* Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Copyright 2000. American Psychiatric Association.

Table A2 DSM-IV DIAGNOSTIC CRITERIA FOR BULIMIA NERVOSA

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 - (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
 - (2) 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)
- B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify Type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington DC: Author. (pp. 549–550). *Note.* Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Copyright 2000. American Psychiatric Association.

Table A3 DSM-IV EXAMPLES OF EATING DISORDER NOT OTHERWISE SPECIFIED (EDNOS)

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa.

From American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington DC: Author. (p. 550). *Note.* Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Copyright 2000. American Psychiatric Association.

Table A4 DISORDERED EATING BEHAVIORS

1. **Food restriction:** Limiting overall food intake, not eating many foods because they are "bad" and will make a person fat.
2. **Rigid food patterns:** Eating exactly the same thing every day. For example, eating a bagel every morning, yogurt and salad each day for lunch and meatless pasta at dinnertime, creating severe nutrient gaps.
3. **Inadequate protein diet:** Only occasionally eating meat, poultry, fish, dairy products or other protein sources like beans, legumes, nuts or soy products.
4. **Thought patterns:** Excessive negative thoughts or preoccupation with food, dissatisfaction with one's body, excessive fear of becoming fat and a distorted body image.
5. **Prolonged fasting:** Going several days without eating anything or only drinking water.
6. **Bingeing and purging:** Out-of-control eating followed by use of diet pills, diuretics, laxatives, or vomiting to control weight because of guilt.
7. **Excessive exercise:** Engaging in inordinate amounts of exercise at the expense of one's physical and psychological well-being, while denying any adverse effects.

From Veale, D. M. W. (1985). Does primary exercise dependence really exist? In J. Annett, B. Cripps, & H. Steinberg (Eds.), *Exercise Addiction – Motivation for participation in sport and exercise*. Leicester, UK: British Psychological Society.

Appendix B: Initial Questionnaire—Letters, Consent Forms, and Instrument

Appendix B1. Letter to Senior Woman Administrators (SWA), Head Athletic Trainers and Team Physician to accompany questionnaire

Dear (insert name of SWA, team physician or head trainer)

The purpose of this letter is to introduce myself and ask you to please take a moment to consider allowing me to collect research data at your institution. I am a Doctoral student in the Department of Higher, Adult and Lifelong Education at Michigan State University. I have chosen to pursue policy decisions with regard to athletes and eating disorders in the college setting as my dissertation topic.

My study is trying to determine the state of policy formation in athletics and how decisions are made to implement or not implement such policies. I am hoping to learn how institutions make decisions to implement athletic policy, who the key decision makers are, and ultimately the impact the policy has on its intended recipients. I have chosen (insert either SWA's, team physicians or athletic trainers) as an initial point of contact for this investigation. Enclosed is a short questionnaire which I will use to determine the state of eating disorder policy formation in athletics. All individuals and sites surveyed will remain confidential. I will be conducting a secondary portion of this study later which will include interviews and data collection at select Division I institutions.

Enclosed is a consent form, the questionnaire and a self addressed stamped envelope. Although I will know what institution participants are from so that I can combine results, I am trying to get a sense of what is happening in Division I so I will not be commenting about specific schools in the study. Participation in this study is voluntary, and you may choose not to answer any question for any reason, withdraw from the study at any time, or not participate in the study. Privacy of all participants will be protected to the maximum extent allowable by law.

I hope you will choose to participate in this research. I believe there is much to be gained by understanding policy formation and decision making in the athletic environment. I am happy to discuss this study with you further if you have questions and can be reached at 989-773-1538 or mille896@pilot.msu.edu. Thank you for your time and consideration.

Sincerely,

Anne Monroe
Ph.D. Student
Michigan State University

Appendix B2. An Examination of Eating Disorder Policy Formation in Intercollegiate Athletics

Consent Form for Questionnaire

I am conducting a study to determine the state of eating disorder policy formation in intercollegiate athletics. All participants will be asked to complete a written questionnaire. This should take no longer than one hour.

Participation in this study is voluntary, and you may choose not to answer any question for any reason, withdraw from the study at any time, or choose not to participate at all. Survey instruments will be identified by institution and not by individual respondent. Survey instruments will be sent to individuals known to the investigator and no one else, therefore, your responses will be kept confidential. Your privacy will be protected to the maximum extent allowable by law.

If you have any questions about this study, please contact the investigator (Anne Monroe, Ph.D. Student, at (989) 773-1538 or mille896@msu.edu). If you have questions or concerns regarding your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact – anonymously if you wish – Peter Vasilenko, Ph.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) by phone: (517) 355-2180, fax: (517) 432-4503, e-mail: ucrihs@msu.edu, or regular mail: 2020 Olds Hall, East Lansing, MI 48824.

To protect your confidentiality, you indicate your voluntary agreement to participate by completing and returning this questionnaire.

Appendix B3. Disordered-Eating Policy Questionnaire

1. Is there a written policy at your institution for athletes and eating disordered behaviors?

a. Yes _____

If yes, please attach a copy of the policy and return it with the survey.

If yes, is it published in the student-athlete handbook? _____

b. No _____

If no, is there a process for identification/management/treatment that is routinely followed but not written into policy?

1. Yes _____

Please describe the process:

Who is made aware of this process and how:

2. No _____

c. We are in the process of developing a written policy and/or protocol for athletes with eating disordered behaviors _____

2. Please indicate which of the following practices your institution participates in/utilizes (check all that apply)

a. Group Weigh-ins _____

e. Psychologist/counselor on staff _____

b. Individual Weigh-ins _____

f. NCAA Life Skills nutrition programming _____

c. Eating disorder screening _____

g. Education for coaching and other staff _____

If yes, which one: _____

If yes, is it mandatory? _____

d. Nutritionist on staff _____

h. Eating disorders treatment team _____

If yes, who is on the team? _____

Appendix C: Individual Institution Study—Letters and Protocols

Appendix C1. Letter to University Administration and Athletic Staff for Individual Interview

Dear (Insert name of President, Athletic Director, Athletics Staff, Coach, Trainer, or Other Staff)

The purpose of this letter is to introduce myself and to ask you to please consider the possibility of allowing me to collect research data within your institution. I am presently a Doctoral student in the Department of Higher, Adult and Lifelong Education at Michigan State University. I have chosen to pursue policy decisions with regard to athletes and eating disorders in the college setting as my dissertation topic.

This is an ethnographic research project in which I will visit the institution to collect documents and interview administrators, faculty and students. I am conducting a research project with Division I institutions. Briefly, the focus of this study is to explore the decision-making process of institutions that have considered a policy for eating disorders and student-athletes. With your permission, I would like to conduct this research in the Fall Semester 2003/Spring Semester 2004. Enclosed you will find a copy of the research proposal, which I think you will find interesting.

Although I will know who the participants are and the institution they are from so that I can combine results, I am trying to get a sense of what is happening in Division I so I will not be commenting about specific schools or mention individual names in the study. All individuals and sites involved in this study will remain confidential. The interview will be audio-taped and will take about 60 minutes. Participation in this study is voluntary, and you may choose not to answer any question for any reason, withdraw from the study at any time, or not participate in the study. Privacy of all participants will be protected to the maximum extent allowable by law.

I would enjoy discussing this project with you on the telephone. I will contact your secretary during the week of October 8, 2003, to arrange a phone conversation with you at your convenience. Thank you for your time and consideration in this matter.

Sincerely,

Anne Monroe
Ph.D. Student
Michigan State University

Appendix C2. Consent Form

An Examination of Eating Disorder Policy Formation in Intercollegiate Athletics

2003-2004

The interview you have been asked to participate in is designed to better understand the decision-making process behind policy formation in the university environment. Specifically, this investigation will examine the process of forming an eating disorder policy for student-athletes.

This interview will be audio-taped and will take about 60 minutes. Your participation is completely voluntary and you may refuse to answer any question or discontinue your participation at any time. If you choose to withdraw from the study, the audio-tape of your interview will be destroyed, along with any reports or notes. Your name and the name of your institution will be kept confidential and will not be utilized in publication format. This signed consent form will be maintained in a securely locked file, separate from the data files, reports, notes, transcriptions and tapes. Your privacy will be protected to the maximum extent allowable by law.

If you have any questions about this study, please contact the investigator (Anne Monroe, Ph.D. Student, at (989) 773-1538 or mille896@msu.edu). If you have questions or concerns regarding your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact – anonymously if you wish – Peter Vasilenko, Ph.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) by phone: (517) 355-2180, fax: (517) 432-4503, e-mail: ucrihs@msu.edu, or regular mail: 2020 Olds Hall, East Lansing, MI 48824.

I voluntarily agree to participate in this study.

Name:

Date:

Appendix C3. Interview Protocol

Adapted from Frost, Hearn, and Marine, 1997.

Introduction to be read to respondents: I am studying the ways Division I institutions deal with the issue of policy and eating disorders in athletes. I am interested in learning your perceptions of this issue, the central actors/decision makers on student-athlete policy, arguments emerging from discussion of policy and its effects on the campus, the athletic department and student-athletes. With that in mind, I have a series of questions I would like to pose for you. I encourage you however, to express any thoughts you might have on the topic, going beyond the particular question at hand. I have no interest in limiting what you might be able to tell me on this issue. The interview need not take more than 60 minutes of your time. I can certainly stay longer, though, if you have more you wish to tell me. After the interview, I will send a summary of our meeting to you to make sure I have captured your comments accurately.

1. How would you characterize the general history of eating disorders and student-athletes at your institution?
2. How would you describe the history of policy decisions in athletics?
3. Who are the central actors in policy formation in athletics?
4. Can you identify any strikingly singular events in athletics with regard to eating disorders? For example, do you recall any particular moments in which the issue became more visible or discussion more heated?
5. Could you tell me the two or three arguments most frequently made for adopting an eating disorder policy in athletics?
6. Could you tell me the two or three arguments most frequently made for not adopting such a policy?
7. What role has information, particularly research-based information from institutional researchers and policy analysts, played thus far in the discussions or development of a policy?
8. What factors have been considered in discussions or development of an eating disorder policy in athletics? What was the single most important factor in your mind?
9. What has been the influence thus far of: a) athletes? b) coaches? c) faculty? d) alumni? e) legal counsel? f) the senior woman administrator? g) the athletic director? h) the president? i) the NCAA or conference?

10. From your own perspective, what is the relationship between athletics at your institution and a) the quality of the undergraduate experience at the university? b) other aspects of the quality of the university? c) the reputation of the university in the state? d) the reputation of the university of nationally and/or internationally?
11. As you have followed the discussion, what have been the most important sources of information for you?
12. Please suggest any documents, or sources of documents, which you feel would help me in examining this issue.
13. Please give the name of anyone else who you believe would be helpful to me in examining this issue.
14. How sensitive are you to the prospect of your name, or that of the institution or system, being identified in any publications stemming from this study?
15. Is there anything else you would like to add regarding this issue or the study?

Appendix C4. Focus Group Consent Form

An Examination of Eating Disorder Policy Formation in Intercollegiate Athletics

Focus Group Consent Form

2003 -2004

The focus group interview you have been asked to participate in is designed to better understand the decision-making process behind policy formation in the university environment. Specifically, this investigation will examine the process of forming an eating disorder policy for student-athletes.

This focus-group interview will be audio-taped and will take about 60 minutes. Your participation is completely voluntary and you may refuse to answer any question or discontinue your participation at any time. If you choose to withdraw from the study, your responses will be excluded from the study. Your name and the name of your institution will be kept confidential and will not be used in any publications. This signed consent form will be maintained in a securely locked file, separate from the data files, reports, notes, transcriptions and tapes. Your privacy will be protected to the maximum extent allowable by law.

If you have any questions about this study, please contact the investigator (Anne Monroe, Ph.D. Student, at (989) 773-1538 or mille896@msu.edu). If you have questions or concerns regarding your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact – anonymously if you wish – Peter Vasilenko, Ph.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) by phone: (517) 355-2180, fax: (517) 432-4503, e-mail: ucrihs@msu.edu, or regular mail: 2020 Olds Hall, East Lansing, MI 48824.

I voluntarily agree to participate in this study.

Name:

Date:

Appendix C5. Focus Group Interview Questions – Student Athlete Advisory Committee

1. What are your thoughts about the issue of eating disorders and student-athletes?
2. What do you see being done at your institution (if anything) about it?
3. Are you aware of the policy at (____) school – Tell me about this policy.
4. Why (do you think) this policy was implemented?
5. What is or was your role in the development, implementation or communication of this policy? With other policies impacting student-athletes?
6. If you knew of a student-athlete with an eating disturbance, what would you do?
Would it matter if the person was not your teammate?

Appendix D: Policy Document Analysis Category and Coding Scheme

Philosophy/Mission	PM
PM: Departmental	PM - D
PM: Institution	PM - I
PM: NCAA	PM - NCAA
Education	ED
ED: Signs and Symptoms listing	ED - S
ED: Educational Plan for Department	ED - P
ED: Education Mandatory	ED - M
For Student-athlete	ED - M/SA
For Coaches	ED - M/CCH
For Others	ED - M/O
Identification	ID
ID: Process Outline	ID - P
Suspect	ID - P/S
Rules for Approaching	ID - P/R
Identified	ID - P/I
Confidentiality	ID - P/C
ID: Persons Involved	ID - I
Physician/Medical Staff	ID - I/MED
Psychologist	ID - I/PSC
Nutritionist/Dietician	ID - I/NRD
Coach	ID - I/CCH
Athletic Trainer	ID - I/ATC
Administrator	ID - I/AA
Senior Woman Administrator	ID - I/SWA
Family	ID - I/FAM
Management	MT
MT: Process Outline	MT - P
Assessment	MT - P/A
Treatment	MT - P/TX
Participation Call	MT - P/PC
MT: Persons Involved	MT - I
Physician/Medical Staff	MT - I/MED
Psychologist	MT - I/PSC
Nutritionist/Dietician	MT - I/NRD
Coach	MT - I/CCH
Athletic Trainer	MT - I/ATC

Administrator	MT - I/AA
Senior Woman Administrator	MT - I/SWA
Family	MT - I/FAM
Treatment	TX
TX: In House	TX - I
TX: Referral	TX - R
TX: Combination	TX - C
TX: Costs Incurred	TX - \$
Patient	TX - \$ P
Institution	TX - \$ I
Both	TX - \$ B
Policy Review Guide	PR
PR: Timing	PR - T
PR: Participants	PR - P
Institution General	GN
GN: Academic	GN - A
GN: Food Services	GN - F
Campus Resources	CR
CR: Counseling	CR - C
CR: Student Life	CR - SL
Liability Issues	LI
LI: Athletics Department	LI - A
LI: Institution	LI - I
LI: Other	LI - O
Physicals	PH
PH: Screening	PH - S
PH: Weigh-Ins	PH - WI
Group	PH - W/G
Individual	PH - W/I
Not Allowed	PH - W/N
General Formatting	FM
FM: Referral Process Flow Chart	FM - FC
FM: Departmental Forms	FM - F

Appendix E: Coding Schematic

Information Resource	IR
IR: Professional Peer Group	IR - PPG
IR: Other Health Care Professionals	IR - HCP
IR: National Collegiate Athletic Assn.	IR - NCAA
IR: Internal Research	IR - IR
IR: External Research	IR - ER
Communication Methods	CM
CM: Formal Institutional Committees	CM - FIC
CM: Localized Athletics Committees	CM - LAC
CM: Individual Informal Communication Across Mixed Departments	CM – IIC/MD
CM: Individual Informal Communication Within Athletic department	CM – IIC/AD
Important Actors	IA
IA: Coach	IA – CCH
IA: Medical Staff	IA – MED
IA: Athletic Trainers	IA – ATC
IA: Senior Woman Administrator	IA – SWA
IA: Faculty	IA – FAC
IA: Athletics administrators	IA - AA
Associate Athletic Director	IA- AAD
Athletic Director	IA – AD
Other	IA – OTH
IA: Nutritionist/Registered Dietitian	IA – NRD
IA: Psychologist/Counselor	IA – PSC
IA: Alumni	IA – ALM
IA: Legal Staff	IA – LEG
IA: President	IA – PRD
IA: President's Staff	
Provost	IA – PRD/P
Associate Provost	IA – PRD/AP
Other	IA – PRD/O
IA: Student Athletes - General	IA – SA/G
IA: Student Athletes – SAAC	IA – SA/SAAC
IA: Students - General	IA – STD/G
IA: Students – other student groups	IA – STD/SG
IA: Athletic Conference Members	IA - ACM
IA: National Collegiate Athletic Assn.	IA – NCAA
Organizational Structure	OS

OS: Athletic department Decentralized	OS – ADD
OS: Athletic department Centralized	OS – ASC
OS: Athletics Administration - >5 members	OS – AAB
OS: Athletics Administration - <5 members	OS – AAS
OS: Senior Woman Administrator	OS - SWA
Oversight of Teams	OS – SWA/OT
Men's	OS – SWA - OT/M
Women's	OS – SWA - OT/F
No Oversight of Teams	OS – SWA/NT
Oversight of Other Staff	OS – SWA/OS
OS: Athletic Training Staffing	OS - AT
Male Head ATC	OS – AT/M
Female Head ATC	OS – AT/F
Separate Head Female ATC	OS – AT/S
OS: Physician	OS - PHY
Institutional Medicine	OS – PHY/I
Athletics Medicine	OS – PHY/A
Shared	OS – PHY/S

Eating Disorder Contextual Issues	ED
ED: Prevalence Rates – General	ED – PR/G
ED: Prevalence Rates – Athletes	ED – PR/A
ED: Prevalence Rates – Their Athletes	ED – PR/TA
Aware of Some	ED – PR/TA - S
Aware of Many	ED – PR/TA - M
Aware of None	ED – PR/TA - N
None Here	ED – PR/TA - O
ED: Signs and Symptoms	ED – SS
ED: How to Identify	ED – ID
ED: Female Issue	ED - FEM
ED: Male Issue	ED - MAI/F
ED: Gender Neutral Issue	ED - GDN
ED: Medical Concern	ED - MED
ED: Non-medical Concern	ED - NMED
ED: Stigma	ED - SGA
ED: Fear	ED - FEAR

Policy/Discussion Impetus	PI
PI: Not Reactionary – proactive	PI - NR
PI: Reactionary	PI - R
Reaction to a Critical Incident	PI – R/CI
Death of Own Athlete	PI – R/CI - DO
Death of Another Athlete	PI – R/CI – DA
Other	PI – R/CI - O

Policy/Discussion Impetus – ctd.	PI
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Reaction to Recognized Pattern	PI – R/RP
Reaction to Stated Concerns	PI – R/SC
Medical Staff	PI – R/SC – MFD
Athletics Staff	PI – R/SC – AS
Athletic Director	PI – R/SC – AD
Coaches	PI – R/SC – CCH
Reaction to Stated Concerns	PI – R/SC
Institutional Faculty/Staff	PI – R/SC – IFS
President	PI – R/SC – PRD
Legal Staff	PI – R/CS – LG
Student Athletes	PI – R/CS – SA
Parent	PI – R/CS – PT
Other	PI – R/CA – OT
Reaction to NCAA Concern	PI – R/NCAA

Policy Rationale	PR
PR: Student Athlete Welfare	PR: SAW
Health – physical	PR: SAW - HP
Health – emotional	PR: SAW - HE
Personal Growth	PR: SAW - PG
Educational Growth	PR: SAW - EG
Custodial Responsibility	PR: SAW - CR
PR: Consistent Protocol	PR: CP
PR: Legal Liability	PR: LL
Protect Athletic department	PR: LL -PAD
Protect Institution	PR: LL - PI
Protect Athlete	PR: LL - PA
PR: Ethical Obligation	PR: EO

Policy Implementation	PP
PP: Resource Allocation – Athletics	PP: RA/A
Time	PP: RA/A - T
Staffing	PP: RA/A - S
Budget	PP: RA/A - B
Other Resource	PP: RA/A - O
PP: Resource Allocation – Institutional	PP: RA/I
Time	PP: RA/I - T
Staffing	PP: RA/I - S
Budget	PP: RA/I - B
Other Resource	PP: RA/I - O

PP: Policy Adoption	PP: PA
Approved by Athletic Director	PP: PA/AD
Approved by Senior Woman Admin.	PP: PA/SWA
Approved by Legal Staff	PP: PA/LG
Approved by President	PP: PA/PRD

Approved by Medical Staff	PP: PA/MED
Approved by Athletics Committee	PP: PA/AC
Approved by Institutional Committee	PP: PA/IC
Other Approval	PP: PA/O
PP: Communication	PP: COM
Published Policy Document	PP: COM/PUB
Yes	PP: COM/PUB - Y
No	PP: COM/PUB - N
Formal Communication	PP: COM/FC
Meetings with Athletics Staff	PP: COM/FC/MTG - AS
Meetings with Other Staff	PP: COM/FC/MTG - OS
Meetings with Student Athletes	PP: COM/FC/MTG - SA
Published in SA Handbook	PP: COM/FC/PUB - SA
Published in Coaches Handbook	PP: COM/FC/PUB - CCH
Published in Medical Staff Manual	PP: COM/FC/PUB - MED
Informal Communication	PP: COM/INF
E-mail	PP: COM/INF - EM
Phone	PP: COM/INF - TPH
Person to person	PP: COM/INF - PTP
PP: Knowledge of Policy's Existence	PP: KNW/PE
Yes	PP: KNW/PE - Y
No	PP: KNW/PE - N
PP: Policy Addresses Identification Protocol	PP: IDP
PP: Policy Addresses Referral Protocol	PP: RFP
PP: Policy Addresses Treatment Plan	PP: TXP
PP: Policy Addresses Confidentiality	PP: CF
PP: Policy Addresses Payment	PP: PAY
PP: Knowledge of Policy's Impact	PP: KNW/PI
Staffing	PP: KNW/PI - STF
Resource Allocation	PP: KNW/PI - RA
Educational Programs	PP: KNW/PI - EDP
Referral Process	PP: KNW/PI - RFP
Treatment Process	PP: KNW/PI - TXP
Other	PP: KNW/PI - O
PP: Policy Review	PP: PRVW
PP: Policy Measurement	PP: PMMT

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