

Analysis of eating disorders in fit kid aesthetic sport

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Abstract:

Eating disorders encompass a range of mental health conditions characterized by disrupted eating behaviors, often accompanied by attitudes or practices focused on weight management. Certain sports, particularly aesthetic sports, pose a higher risk for these disorders, being more prevalent among elite athletes compared to recreational or non-competitive participants. Objective: This research aims to analyze the potential attitudes and risk behaviors associated with the development of eating disorders among athletes in the Fit Kid discipline, considering factors such as age range and competition level. Additionally, the study aims to identify any correlation between higher weight and BMI and the increased prevalence of eating disorders. Materials & methods: 66 Fit Kid athletes between 11 and 19 years of age participated in this descriptive study. The instrument used to collect the information was the Eating Attitudes Test (EAT-26) and the data were analysed with the SPSS 28.0 statistical package. Results: The main results reveal a higher level of risky eating attitudes in the highest level of competition and in athletes with a higher BMI and weight.

Key Words: Body dissatisfaction, thinness, eating habits, competition level, BMI, gymnastics disciplines

Introduction

Eating disorders are a group of mental disorders characterized by abnormal eating behaviors, often accompanied by behaviors or attitudes focused on weight control (Sadock et al., 2015). The preoccupation with weight gain and obsession with eating is also connected to a key factor in these disorders: dissatisfaction with one's own body image (Torres et al., 2017). Body image is highly valued in various spheres of society, projecting standards of beauty that not everyone can achieve. This constant impact on physical appearance could be fostering feelings of dissatisfaction with body image, which together with its relationship with the risk of eating disorders can lead to problems associated with mental and physical health, especially in the younger population. Thus, the form of discomfort has been associated with psychological distress, low self-esteem or susceptibility to eating disorders.

Eating disorders can occur in both sexes but are more prevalent in females. Compared to males, females generally exhibit lower self-esteem, greater self-image instability, and higher levels of body dissatisfaction (Gutiérrez et al., 2015; Palacios & Sánchez, 2016). Similarly, eating disorders are less common among the sedentary population than among athletes, with the majority of cases occurring in females (Byrne & McLean, 2001; Sundgot-Borgen & Torstveit, 2004; Palacios & Sánchez, 2016). The most common stages of onset of these possible disorders are early and middle adolescence, however, their development can begin as early as age six (Swanson et al., 2011), since, for example, in 5- and 7-year-old girls who play aesthetic sports, a greater concern for weight is observable, compared to girls who play non-aesthetic sports or who do not play sports (Davison et al., 2002). In this context, adolescent gymnasts may exhibit greater risk factors associated with eating disorders and a higher likelihood of developing anorexia compared to adolescent non-gymnasts (Valles et al., 2020).

The most common eating disorders in Europe are anorexia nervosa and bulimia nervosa (Arija et al., 2022). The average age of onset is between 12 and 13 years for anorexia nervosa and between 14 and 15 years for bulimia nervosa (Keski-Rahkonen et al., 2007).

One of the risk factors for the development of eating disorders is the participation in certain sports, particularly aesthetic sports, where eating disorder symptoms occur more frequently (Krentz and Warschburger, 2011). Thus, sports with a strong emphasis on thinness have higher incidences of disordered eating behaviors among competitors, being more common among high-level or elite athletes than at recreational or non-competitive participants (Kong and Harris, 2014). Moreover, among athletes in aesthetic sports, the risk of experiencing these issues increases when they view weight regulation as a potential method for improving their performance (Krentz and Warschburger, 2011).

Also, a relationship can be established between aesthetic sports and body image dissatisfaction, being a risk factor in the development of risky eating behaviors in female athletes in these disciplines (Fortes et al., 2013). For example, among dancers and gymnasts, risky methods of achieving a particular body type, such as pressure to be thin and dietary restriction, are observed (Francisco et al., 2012). Similarly, more symptoms of eating disorders are found in sports that focus on thinness, with higher rates also found among elite athletes, even when they do not play aesthetic sports (Kong and Harris, 2014). Even among children involved in aesthetic sports, there is a quest to become even thinner, despite the fact that their levels of thinness are higher than in children involved in other sports (Lombardo et al., 2012).

Therefore, it appears that the risk of presenting and suffering from eating disorders is much higher among aesthetic sports, putting the spotlight on some of the gymnastic disciplines due to a possible attitude and preoccupation with weight and shape, which can become an obsession (Bloodworth et al., 2017). In this case, adolescent gymnasts may become even more vulnerable to developing such problems, as concerns and insecurities about their own body image, common at their age, are reinforced as they feel pressure to achieve or maintain a certain body shape and weight to compete at the highest level of sport (Tan et al., 2012). In this line, we can mention some gymnastic modalities where these associations have been studied.

For example, in artistic gymnastics, gymnasts seem to be at a higher risk of developing eating disorders than athletes in other sports (Papacharalampous et al., 2022). Gymnasts typically exhibit a high degree of body image dissatisfaction, which tends to increase during the competition season (Neves et al., 2016).

In the case of rhythmic gymnastics, it can be considered as the gymnastic discipline with the highest risk, compared to others, due to the possible pressure of the sport itself to show off a slim body (Nordin et al., 2003) and the need for gymnasts to have a certain body composition which, together with specific physical abilities, result in the biomechanical attributes that determine sporting success (Márquez, 2008; Palacios and Sánchez, 2016). This could increase the risk of seeking greater sporting performance through weight control and the pursuit of slimness (Palacios and Sánchez, 2016). The situation is accentuated among rhythmic gymnasts at a higher level, such as the international level, with respect to gymnasts at non-competitive levels (Donti et al., 2021; Kontele et al., 2022).

Fit Kid, on the other hand, is an emerging sport modality created in Europe in 1990, and which is part of the Spanish Federation of Dance Sport. This discipline has both individual and group participation. The categories of group participation can be duos, small groups of 3 or 4 athletes, large groups made up of 5 or 6 participants and large free groups where up to 15 members can participate together. In competition, there are three age groups from 7 years old to 16 years old and upwards. The participants must perform a floor choreography accompanied by music where they must include compulsory elements included in a scoring code (Fit Kid scoring code, 2023). This sport unites gymnastic elements with dance, which creates a remarkable artistic component, and requires certain physical qualities for its development such as flexibility, strength and endurance, as well as rhythmic and artistic qualities such as coordination or body expression (Paredes, n. d.). The nature of the Fit Kid has similarities with dance and with some gymnastic disciplines; therefore, the practice of this discipline could develop in athletes some alteration in eating behaviors.

Under these premises, the aim of this research was, on the one hand, to analyse the current state of behaviors or thoughts linked to eating disorders among Fit Kid athletes, according to age range and level of competition, and, on the other hand, to identify the type of association between a higher weight and BMI, with signs of more pronounced eating disorders.

Materials & methods

This descriptive study has been developed using a quantitative approach where the sample is by convenience. The sample was selected based on the following inclusion criteria: Fit Kid athletes from clubs in a municipality in the province of Alicante (Spain), with a valid federation licence, of first-class or second-class levels and with an age range of 11 to 24 years. Once these criteria had been applied, the total population with these characteristics was 80 athletes, of which a total of 14 were not included in the study because they did not obtain the corresponding informed consent

Participants

Finally, 66 sportsmen and women (62 girls; 4 boys) aged between 11 and 19 years (mean age 13.42 ± 1.84 years), belonging to 5 Fit Kid clubs in the municipality in question, participated voluntarily. The sample obtained represents 82.5% of the total population studied. Of the 66 participants, 19 are from the first-class level (95% of the population with these characteristics) and 47 from the second-class level (78.3% of the population with these characteristics). In addition, three age ranges were established to divide the sample, based on the three stages of adolescence (Güemes-Hidalgo et al., 2017): the first from 11 to 13 years (12.28 ± 0.78), the second from 14 to 16 years (14.52 ± 0.68) and the third from 17 years and older (18 ± 1).

Instrument

Basic anthropometric techniques and tools were used to determine the height and weight in kilograms and to calculate the BMI of the participants. The Eating Attitudes Questionnaire or EAT-26 (Gandarillas et al., 2003) was also administered. This questionnaire consists of 26 questions on attitudes and concerns about food, body weight and shape, with a Likert measurement scale, self-administered and with 6 response options

(1=never, 2=rarely, 3=sometimes, 4=often, 5=very often and 6=always). The score range of the EAT-26 can vary from 0 to 78 points, which results from the sum of all the points obtained in each of the items. According to Gandarillas et al. (2003), the cut-off score should be set at 10 points to distinguish cases at risk of developing an eating disorder from the general population. Thus, the 26 items that make up this tool are grouped into three factors:

- Factor 1: diet (items 6, 7, 16, 17, 22 and 24).
- Factor 2: bulimia and preoccupation with food (items 1, 2, 3, 4, 9, 10, 11, 12, 14, 18, 21, 23 and 26).
- Factor 3: oral control (items 5, 8, 13, 15 and 20).

Procedure

Initially, the research team contacted via telephone the coaches responsible for the Fit Kid clubs in the municipality involved. To arrange the visits, the objective of the study was explained, the description of the questionnaire and the measurements to be taken, the characteristics and criteria to be met by the athletes and the process to be followed. Subsequently, the athletes were informed of the aims of the research, their participation being voluntary and anonymous. After agreement with the above, informed consent was obtained from the legal representatives and athletes of legal age. At the same time, respect for the law on data protection regulations in accordance with the Declaration of Helsinki was ensured.

The data collection was carried out during the competitive period (March 2023), when there is greater pressure to perform well in training and to achieve a good result in competition. Once at the day and club indicated on each occasion, the athletes were grouped together, and the questionnaire was completed either online or on paper. In both cases, a series of descriptive data were included at the beginning (age, sex and level of competition), followed by the EAT-26 questionnaire. Athletes spent between 10-15 minutes completing the EAT-26 and, subsequently, body mass (Renpho digital scale, accurate to 0.05 kg) and height (Alfa measuring rod, accurate to 1 mm) were measured to obtain the calculation of BMI (kg/m²). The measurements were taken in front of the coaches and a researcher. For weight, the athletes were barefoot and in their training attire. For height, the athletes had to stand with their feet parallel, heels together and barefoot. The head, shoulders and buttocks were in contact with a vertical plane (wall).

Statistical analysis

The data were analysed using descriptive statistics, means, medians, standard deviations and cross-tabulations and the specialised software "Statistical Product and Service Solutions (SPSS)", version 28.0.0.0 (190) of IBM SPSS Statistics was used. Correlations between EAT-26 scores and age, weight, BMI and competition level were analysed using Spearman's correlation, and the comparison between the two competition level groups using the Mann-Whitney U test, with the level of significance being: $p \leq 0.05$. Finally, the internal consistency of the instrument through Cronbach's Alpha was 0.7.

Results

Regarding the descriptive data of the sample analysed (Table 1), the mean weight was 48.31 kg, the mean height 1.55 m and the mean BMI 19.9 kg/m². In this sense, the highest weight, height and BMI averages were found in the third age range, 17 years and older, and in the second-class level, for all three cases (with significant differences between levels for the height variable). Likewise, the lowest means for weight, height and BMI were found in the first age range, from 11 to 13 years, and at the first-class level. Thus, the growth trend was observed, where the higher the age, the higher the weight, height and BMI values.

Regarding the sample score on the Eating Attitudes Questionnaire (EAT-26), the mean score was 7.52 points, which was below a score of concern, indicating an absence of relevant eating disorder behaviours and attitudes (Table 1). However, scores with respect to age showed that the range of 17 years and older had the highest mean scores, bordering on the cut-off score. In terms of comparison between levels of competition, a slightly higher score was observed at the first-class level, but without significant differences (Table 1).

Table 1

Weight, height, BMI and EAT-26 of Fit Kid athletes according to age range and competition level

	Total	11-13	14-16	+17	First-class	Second-class	U-test
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	p
Weight (kg)	48.31(8.00)	45.01(7.26)	51.81(7.70)	56.04(3.12)	45.61(6.64)	49.40(8.30)	0.095
Height (m)	1.55(0.07)	1.54(0.07)	1.57(0.07)	1.60(0.05)	1.53(0.05)	1.56(0.08)	0.027
BMI (kg/m ²)	19.90(2.27)	19.10(2.10)	20.95(2.15)	21.95(0.59)	19.45(1.88)	20.08(2.40)	0.492
EAT-26	7.52(5.84)	6.58(5.79)	8.57(5.96)	10.60(4.72)	7.84(5.84)	7.38(5.89)	0.782

Note. M: mean; SD: standard deviation; p: significant differences between levels.

On the other hand, the correlation between weight and BMI with the Eating Attitudes (EAT-26) scores was analysed (Table 2), showing a low association with BMI and moderate with weight, as well as positive and direct associations with the EAT-26, the correlation being statistically significant only for weight.

Table 2
Correlations of EAT-26 scores

	EAT-26	Age	Age range	Weight	BMI	Level
EAT-26	1	0.279*	0.282*	0.308*	0.228	0.034

Note. ** $p < 0.01$; * $p < 0.05$

Results Associated with Eating Attitudes-26 According to the Analysis Factors

Regarding Factor 1, Diet, the highest concern was generally observed in the second age range and slightly above at the first-class level of competition. However, differences between levels were generally not statistically significant (Table 3).

Table 3
Factor 1: Diet according to age range and competition level

	Total		11-13		14-16		+17		First-class		Second-class		Levels test	U-
	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	p	
6	0	0.17 (0.48)	0	0.13 (0.40)	0	0.29 (0.64)	0	0 (0)	0	0.21 (0.54)	0	0.15 (0.47)	0.574	
7	0	0.20 (0.50)	0	0.08 (0.35)	0	0.43 (0.68)	0	0.20 (0.45)	0	0.32 (0.58)	0	0.15 (0.47)	0.125	
16	0	0.23 (0.49)	0	0.18 (0.50)	0	0.33 (0.48)	0	0.20 (0.45)	0	0.21 (0.42)	0	0.23 (0.52)	0.927	
17	0	0.23 (0.63)	0	0.33 (0.76)	0	0.10 (0.30)	0	0 (0)	0	0.26 (0.65)	0	0.21 (0.62)	0.739	
22	0	0.13 (0.63)	0	0.28 (0.64)	0	0.33 (0.66)	0	0.20 (0.45)	0	0.26 (0.73)	0	0.30 (0.59)	0.531	
24	0	0.45 (0.92)	0	0.40 (0.96)	0	0.48 (0.87)	1	0.80 (0.84)	0	0.37 (0.83)	0	0.49 (0.95)	0.671	
M Factor		0.24		0.23		0.33		0.23		0.27		0.26		

Note. Me: median; M: mean; SD: standard deviation; p : significant differences between levels.

Regarding Factor 2, Bulimia and preoccupation with food, the highest preoccupation was observed in the third age range and was the same for both levels of competition (Table 4).

Table 4
Factor 2: Bulimia and concern about food by age range and competition level

	Total		11-13		14-16		+17		First-class		Second-class		Levels test	U-
	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	p	
1	0	0.39 (0.78)	0	0.33 (0.83)	0	0.33 (0.58)	1	1.20 (0.84)	0	0.47 (0.91)	0	0.36 (0.74)	0.817	
2	0	0.12 (0.37)	0	0.05 (0.22)	0	0.14 (0.36)	0	0.60 (0.89)	0	0.21 (0.54)	0	0.09 (0.28)	0.360	
3	0	0.18 (0.55)	0	0.05 (0.32)	0	0.33 (0.80)	1	0.60 (0.55)	0	0.26 (0.56)	0	0.15 (0.55)	0.181	
4	0	0.26 (0.51)	0	0.20 (0.46)	0	0.29 (0.56)	1	0.60 (0.55)	0	0.26 (0.45)	0	0.26 (0.53)	0.734	
9	0	0 (0)	0	0 (0)	0	0 (0)	0	0 (0)	0	0 (0)	0	0 (0)	1	
10	0	0.14 (0.46)	0	0.10 (0.50)	0	0.14 (0.36)	0	0.40 (0.55)	0	0.05 (0.23)	0	0.17 (0.52)	0.367	
11	0	0.33 (0.71)	0	0.28 (0.75)	0	0.38 (0.67)	1	1.43 (0.55)	0	0.32 (0.58)	0	0.34 (0.76)	0.749	
12	0	0.32 (0.68)	0	0.28 (0.68)	0	0.29 (0.72)	1	0.80 (0.45)	0	0.32 (0.48)	0	0.32 (0.76)	0.399	
14	0	0.32 (0.68)	0	0.20 (0.56)	0	0.43 (0.81)	1	0.80 (0.84)	0	0.26 (0.65)	0	0.34 (0.70)	0.551	
18	0	0.12 (0.33)	0	0.10 (0.30)	0	0.19 (0.40)	0	0 (0)	0	0.05 (0.23)	0	0.15 (0.36)	0.281	
21	0	0.18 (0.49)	0	0.08 (0.27)	0	0.43 (0.75)	0	0 (0)	0	0.11 (0.46)	0	0.21 (0.51)	0.239	
23	0	0.35 (0.77)	0	0.30 (0.76)	0	0.24 (0.54)	1	1.20 (1.30)	0	0.47 (1.02)	0	0.30 (0.66)	0.850	
26	0	0 (0)	0	0 (0)	0	0 (0)	0	0 (0)	0	0 (0)	0	0 (0)	1	
M Factor		0.18		0.15		0.25		0.59		0.21		0.21		

Note. Me: median; M: mean; SD: standard deviation; p : significant differences between levels.

Finally, in Factor 3, Oral control, the highest scores were found in the first age range and at the second-class level of competition, with significant differences between levels only for item 13 "Others think I am too

thin" and item 15 "I take longer than others to eat". Moreover, this factor was the one with the highest mean score in the total sample. Among the three factors, the athletes felt the most external pressure about what they eat and their body shape (Table 5).

Table 5

Factor 3: Oral Control according to age range and competition level

	Total		11-13		14-16		+17		First-class		Second-class		Levels test	U-
	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	Me	M (SD)	p	
5	0	0.30 (0.78)	0	0.45 (0.93)	0	0.10 (0.44)	0	0 (0)	0	0.42 (0.90)	0	0.26 (0.74)	0.401	
8	0	0.18 (0.52)	0	0.18 (0.55)	0	0.24 (0.54)	0	0 (0)	0	0.16 (0.50)	0	0.19 (0.54)	0.677	
13	0	0.29 (0.63)	0	0.18 (0.45)	0	0.57 (0.87)	0	0 (0)	0	0.58 (0.90)	0	0.17 (0.43)	0.036	
15	0	0.47 (0.92)	0	0.57 (1.04)	0	0.33 (0.73)	0	0.20 (0.45)	0	0.05 (0.23)	0	0.64 (1.03)	0.010	
20	0	0.35 (0.73)	0	0.35 (0.77)	0	0.43 (0.75)	0	0 (0)	0	0.21 (0.63)	0	0.40 (0.77)	0.218	
M Factor		0.32		0.35		0.33		0.04		0.28		0.33		

Note. Me: median; M: mean; SD: standard deviation; *p*: significant differences between levels.

Discussion

The main objective of the study was to analyse the current state of behaviors or thoughts linked to eating disorders in Fit Kid athletes, according to age ranges and level of competition. As well as identifying the type of association between higher weight and BMI, with signs of more pronounced eating disorders.

Firstly, regarding the relationship between weight and BMI and a higher score in eating attitudes, it can be said that there was a moderate association between weight and behaviors or attitudes typical of certain eating disorders, and a low association with BMI. In this sense, regarding the relationship between BMI and the total assessment in EAT-26, Kontele et al. (2022) showed that in competitive athletes there was a negative correlation between these two variables, whereas one of the two variables increased, the other decreased, this being a low and generalised association. This indicated that the higher the BMI, the lower the EAT-26 score and vice versa. Thus, a lower BMI, which may be associated with an eating disorder, was associated with a higher score on the eating disorder screening test, but for non-competitive athletes there was no correlation between EAT-26 score and BMI value (Kontele et al., 2022).

Also, in relation to age, the highest mean scores in the present study were found in athletes aged 17 years and older, showing and approaching the first levels of concern in relation to the presentation of signs of eating disorders. In the other age ranges, and in general, no significant risk of developing risky eating behaviours was observed. However, the association between age and questionnaire scores was relevant, according to correlational studies. In this line, Escolar-Llamazares et al. (2017) identified in their research that women aged 18-25 years were the population group with the highest vulnerability to the possible development of eating disorders.

When analysing eating attitudes in relation to levels of competition according to the level of demand, the highest scores were observed at the first-class level, indicating higher risk behaviours regarding eating, although the differences between the two levels were not significant. Furthermore, in the case of the association between scores and level of competition, it was trivial for the EAT-26.

In the same vein, Kong and Harris (2014) found that at elite levels female, athletes more commonly presented symptoms typical of eating disorders, as well as a higher rate of worry and low self-image satisfaction, compared to lower levels or where athletes did not compete. However, in contrast to the present study, Kong and Harris (2014) did find significant differences between levels in EAT-26 scores, with the elite level showing more symptoms. This difference could be due to factors such as increasing levels of competition and increasing environmental pressure in relation to weight, as argued by Teixidor-Batlle et al. (2021).

Kontele et al. (2022) and Donti et al. (2021) also found that in Greek adolescent gymnasts, a higher percentage of competitive gymnasts had problems with food intake and in turn obtained higher scores on the EAT-26 than non-competitive gymnasts. This tendency can be related to the pressure to have the figure associated in a standardised way to the ideal body shape, according to the sport practiced (Nordin et al., 2003). Similarly, it can be linked to the need to achieve specific biomechanical attributes, which may be subject to a specific body composition that helps sports performance (Márquez, 2008; Palacios and Sánchez, 2016).

Regarding the Fit Kid athletes' eating attitudes, the most prominent factor was "oral control". The risk most present in the Fit Kid athletes for developing a dangerous eating attitude was the perception of an existing pressure on what they ate, their food intake and their body image, pressure apparently exerted by external agents or persons. Moreover, in contrast to other data collected, this pressure was observed more in the first age range and at the second-class level, including significant differences between levels for the items referring to "Others

think I am too thin" and "I take longer than others to eat", respectively. The development of this factor in athletes, who due to their age and training loads may be quite thin, may be related to the perception of their weight and body shape by outsiders, who may believe that the athletes are underweight or extremely thin.

This external pressure can sometimes be triggered by coaches themselves, directing comments that may negatively affect the perception of body image, comments about intake, suggesting dietary restrictions, as well as weight monitoring (Francisco et al., 2012). Likewise, these external pressures may come from comparisons between athletes by coaches, the idea that athletes present about what body shape and size they should have to be more competitive, among others (Teixidor-Batlle et al., 2019). This fact is present in different types of sport where a large percentage of high-level athletes claim to feel pressure regarding their body from their coaches (Kong & Harris, 2014). Positive correlations have even been observed between EAT-26 total scores and coaches' weight pressures, as evidenced in the study by Kontele et al. (2022). But it is not only the level of competition and pressure from coaches that can have an influence, but there are also other factors such as social pressure for a body type and peer pressure in the sporting world (Teixidor-Batlle et al., 2019).

In the presence of this problem, there is the possibility of applying eating disorder prevention programmes focused on reducing risk factors and improving athletes' self-image and body satisfaction, as evidenced by the project developed by Sundgot-Borgen et al. (2024), where athletes experienced benefits such as the attenuation of the expected worsening of body esteem and symptoms over time. As well as programmes aimed at calming eating disorder symptoms such as depression and anxiety, such as the one applied by Haynos et al. (2023) through positive affect treatment, a neuroscience-based behavioural treatment developed for affective disorders, adapting it to the treatment of anorexia nervosa.

In addition, it is essential to train parents on how to deal with their children's possible eating disorders and to give due importance to the understanding of distress and the emotional and cognitive representations that parents present about this problem, such as fear, anxiety or guilt, for example (Marchetti & Sawrikar, 2023).

In terms of limitations and future lines of research, the possibility of carrying out an analysis of the behaviors associated with eating behavior including other moments of the sports season is mentioned, to identify the moments of greatest vulnerability of the athletes. As well as the possibility of carrying out a gender comparison to study the factors, ages and risk levels in each case.

Conclusions

The main conclusions drawn from the study are the positive association of BMI with EAT-26 scores, which indicated that the higher the BMI and weight, the higher the risky eating attitudes. Overall, higher levels of evidence of eating disorders were observed at the first-class level of competition, which is the most demanding competitive level, so we need to be aware of nutritional status and prevent the development of eating disorders in Fit Kid athletes and intervene if necessary. Finally, the factor that caused most concern among the participants was "oral control" in the EAT-26, which was slightly more present in the first age range and in the second-class level of competition, with some significant differences between levels for certain items.

These results can be very useful for coaches of aesthetic sports, in general, and Fit Kid coaches, in particular, since identifying worrying eating attitudes in athletes could detect possible risk situations in the development of eating disorders. Likewise, being aware of the situation would allow them to take decisions in this regard, such as training on nutrition and sport or focusing on psychological work aimed, for example, at self-concept and self-esteem.

Our findings therefore reinforce the importance of having a team of specialists (sports psychologists, nutritionists, etc.) who can monitor athletes to ensure their health, performance and emotional stability, considering the level of competition and age of the athletes.

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