Table S3	Prevalence and assessment of disordered eating (DE) in adolescent male elite athletes			
Reference	**Sample characteristics**	**Assessment of DE**	**Prevalence of DE**	**Additional findings**
Rosendahl[16] 2009	• 576 athletes (366 male, 210 female) • 291 controls (122 male, 171 female) • 26 different sports • 218 athletes (136 male, 82 female) competing in weight-sensitive sports • Age: 14-18 years; athletes 15.7 (±1.25) years; controls 15.9 (±0.9) years	Self-reported EAT	15.6% of male elite athletes (compared with 9.0% non-elite athletes and 12.3% controls) and 34.0% of female elite athletes (compared with 24.4% non-elite athletes and 36.1% controls) scored ≥10 in the EAT indicating DE behaviour.	• DE prevalence was predicted by gender and dietary experience, but not by athlete status (athletes vs. non athletes). The frequency of DE was five times higher among boys and eight times higher among girls with a thinner body ideal compared with a thicker or equal body ideal. • An ED risk ratio of 1.73 for male elite athletes vs. non-athletes; 1.27 for male elite athletes vs. non-elite athletes and 0.73 for non-elite athletes vs. non-athletes was found. • A significantly higher DE prevalence was found among male athletes competing in weight-sensitive sports; no significant difference among female athletes.
Martinsen[13] 2010	• 606 athletes (389 male, 217 female) • 355 controls (197 male, 158 female) • 50 different sports • 159 athletes competed in weight-sensitive sports • Age: all 15-16 years	Self-reported questionnaire including EDI subscales (BD, DT), various DE symptoms and BMI	13.1% of male and 44.7% of female athletes showed DE symptoms compared with 30.5% of male and 70.9% of female controls.	No association among symptoms of DE and athletes competing in leanness sports, non-leanness sports, physically active controls or non-physically active controls.
Francisco[48] 2013	• 131 elite athletes (30 male, 101 female) competing in aesthetic sports • 112 (15 male, 99 female) non-elite controls; 480 (227 male, 253 female) controls competing in non-aesthetic sports • two different sports (gymnastics, dancing) • 133 athletes competing in weight-sensitive sports • Age: all 15.3 (±2.1) years	Self-reported EDE-Q and MRFS-IV	6.7% of male elite athletes showed DE at clinical level compared with 6.2% of controls and 0% of male non-elite athletes.	• No significant body dissatisfaction differences among male elite athletes vs. male non-elite and control. • No significant DE prevalence differences among male elite athletes, non-elite athletes and controls.
Francisco[61] 2013	• 85 athletes (25 male, 60 female) • 142 controls • two different sports (gymnastics, dancing) • 85 athletes competing in weight-sensitive sports	Self-reported EDE-Q and MRFS-IV	20% of athletes (mixed gender group) scored above the clinical cut-off for ED in the EDE-Q compared with 14.1% of controls (mixed gender group).	• Significantly higher EDE-Q scores, more shape concerns, higher BMI and significantly lower body dissatisfaction were found among the male athlete group compared with the non-athlete controls.

	• Age: athletes 15.35 (±2.73) years; controls 14.58 (±1.81) years			
Martinsen[8] 2013	• 611 athletes • 355 controls • 50 different sports • 163 athletes competed in weight-sensitive sports • Age: Athletes with 16.5 (±0.3) years; controls 16.9 (±0.3) years; athletes significantly younger (p=0.003).	•Self-reported questionnaire including EDI subscales to identify "at risk" individuals •Followed by standardised clinical interview of all "at-risk" individuals using DSM-IV criteria	7.0% of athletes (vs. 2.3% control) had an ED with 3.2% (vs. 0% control) for male compared with 14.0% (vs. 5.1% control) for female athletes.	• With 73.5% (F:M=20:5), EDNOS was the most frequent ED in athletes, followed by BN with 23.5% (F:M=7:1) and AN with 2.9% (F=100%). • No difference among the proportion of athletes classified as being ‘‘at risk’’ for ED between weight-sensitive and less weight-sensitive sports in female athletes. Subgroup comparison in male athletes was not possible because of the few ED cases.
Martinsen[22] 2014	• 611 athletes (390 male, 193 female) screened • 231 athletes clinically interviewed • 50 different sports • Age: all 16-17 years	•Screening by self-reported questionnaire including EDI subscales (BD, DT), various DE symptoms and BMI. •Clinical interview (EDE) using DSM-IV criteria.	5.6% of the athletes were excluded after pre-test screening due to a present ED. 11.7% of the clinically interviewed athletes were diagnosed with an ED.	
Giel[14] 2016	• 1138 athletes (638 male, 500 female) • 51 sport disciplines • Age: all 16.3 (±1.1) years	Self-reported SCOFF, body acceptance subscale of the FKKS, reported weight control behaviour	21.5% of athletes with 14.4% of male compared with 30.7% of female athletes answered ≥2 questions of the SCOFF positively. 32.5% of athletes showed an eating disorder pathology.	

EAT, Eating Attitudes Test; ED, eating disorder; EDI, Eating Disorder Inventory; BD, body dissatisfaction; DT, drive for thinness; BMI, body mass index; EDE-Q, Eating Disorder Examination Questionnaire; MRFS-IV, McKnight Risk Factor Survey IV; DSM-IV, 4th edition of the Diagnostic and Statistical Manual of Mental Disorders; EDNOS, Eating Disorder Not Otherwise Specified; BN, bulimia nervosa; AN, anorexia nervosa; SCOFF, SCOFF questionnaire; FKKS, Frankfurter Körperkonzeptskalen.