

A Tale of Two Runners: A Case Report of Athletes' Experiences with Eating Disorders in College

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ABSTRACT

Athletes are at higher risk than the general population for eating disorders, and risk is heightened for athletes in thin-build sports, including track. Collegiate athletes are particularly vulnerable to disordered eating when the transition from home to the college environment adds to the stress of performance pressures and the high demands of the sport environment. Male and female athletes who develop eating disorders share some common characteristics, yet their experiences can be quite different, in part as a consequence of their sex and how eating disorders develop, and are recognized, acknowledged, and treated, within the culture of sports. This case report describes the experiences of two track athletes, one male and one female, who were recruited to the same Division 1 collegiate track program. Both were elite athletes, freshmen in the same year, experiencing the same urban college environment, and experiencing an eating disorder characterized by restrictive eating, significant weight loss, injury, and compromised performance in sport. Both received treatment from a multidisciplinary team of professionals. Both athletes achieved weight restoration, recovery from the disorder, and success in their sport. In spite of the similarities, striking differences were apparent in clinical presentation, predisposing features, onset of symptoms, entry points to treatment, interventions received, and clinical courses through treatment that depict sex differences in how eating disorders present in athletes and are addressed in the sport environment. Findings endorse the need for research and inform prevention strategies, risk assessment, and intervention approaches for nutrition and sports medicine professionals and collegiate athletic departments.

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EATING DISORDERS ARE LIFE-THREATENING PSYCHIATRIC conditions with conspicuously high mortality rates.^{1,2} Estimates of up to 11 million Americans suffering from clinically significant eating disorders in their lifetime grossly underrepresent the total disease burden in the population³ and do not accurately represent the emotional turmoil that accompanies subclinical eating disorders. According to recent statistics, the epidemiology of eating disorders is shifting worldwide.³ Rates are increasing in the general population, particularly among teens between the ages of 15 and 19 years.¹ Notably, this at-risk population includes high school and college-age students in whom the prevalence of eating disordered behaviors is higher, even in the absence of a formal eating disorder diagnosis.⁴ Because athletes are at greater risk than nonathletes,^{5,6} collegiate athletes are particularly vulnerable to eating disorders and disordered eating behaviors given their life stage combined with sport-specific risks.⁷⁻⁹

Collegiate athletes are particularly vulnerable to disordered eating when the transition from home to the college environment adds to the stress of performance pressures and the high demands of the sport environment.¹⁰ Young adults who

have underlying psychosocial or genetic vulnerabilities and limited coping skills are perhaps most at risk. Yet identification, assessment, and treatment of eating disorders in the college athlete population is challenged by several realities. First, estimating the true prevalence of eating disorders among athletes is obscured by the secretive nature of the disorders and the inherent denial of the problem.^{3,11} Second, most studies on eating disorders in athletes involve female athletes, whereas male athletes have been largely understudied yet recognized as similarly vulnerable.^{3,12,13} Third, even among female athletes, rates of eating disorders vary by sport and by position. Aesthetic sports and sports in which a low body mass is perceived as offering a competitive advantage are associated with comparably higher rates.^{3,5} Finally, factors in both the collegiate environment and the sport environment introduce barriers to treatment or barriers to athletes coming forward for treatment^{7,10} that may be particularly salient for males, introducing a sex bias.^{11,13,14} Best practices in the care of athletes with eating disorders call for screening of all athletes, with evaluation and treatment delivered by an experienced multidisciplinary team whose providers have expertise and specialized training in

sports and eating disorders.^{3,7} The use of clinical assessment tools to inform decisions about treatment contracts, participation in sport, and return-to-play guidelines is also recommended.^{3,15-18} Yet across universities, the attention, concern, intervention activity, and resources devoted to assembling qualified treatment teams and addressing eating disorders within college athletic departments are highly variable. If lack of a coordinated system for appropriately identifying and addressing eating disorders on campus precludes timely intervention, medical and psychological complications of these disorders can have devastating effects on student-athletes' health and performance in sport.⁷

Male and female athletes who develop eating disorders share some common characteristics.^{3,11,19} At the same time, their experiences can be quite different,^{20,21} in part as a consequence of their sex and how eating disorders develop and are recognized, acknowledged, and treated in society at large and within the culture of sport.^{11,13,14} To elucidate some of the practical issues surrounding identification and treatment of eating disorders in sports, this case report provides a side-by-side detailed account of a male and a female collegiate athlete who gave permission for their cases to be published. Both were Division 1 (D1) track athletes who attended the same university. Both were exposed to the same collegiate sports environment, the same set of coaches and teammates, and access to the same sports medicine resources on campus. This paper chronicles similarities and differences in their clinical presentations, entry to treatment, and experiences in eating disorder recovery alongside the challenges and successes in their collegiate athletic careers.

CASE PRESENTATIONS

Both athletes were track athletes recruited to the same large, urban university in the same incoming freshman class in 2004. A multidisciplinary sports medicine program was newly formed on campus that September. This initiative added a part-time registered dietitian (RD) to the sports medicine team and prioritized assessment and intervention for student athletes at risk for eating disorders. The program consisted of an internal referral service in which sports medicine, sports psychology, and sports nutrition professionals provided confidential on-campus treatment services to student athletes.¹⁰ Both of these athletes received eating disorder treatment services from multiple members of the interdisciplinary sports medicine team, including an RD (the author). They each worked with the sports dietitian for approximately 5 years' duration, starting in their freshman fall semester through their postgraduate year, ending in 2009.

The course of each athlete's clinical assessment, eating disorder diagnosis, treatment, and recovery experience was detailed in clinical records maintained by the RD per standard clinical care guidelines. Nutrition diagnoses were made based on anthropometric, clinical, and dietary assessment data. Biochemical evidence of malnutrition is not considered here, because laboratory data were not available to the RD in this setting. Weight restoration was based on measured weights, using the scale in the athletic training room, in accordance with recommended procedures that evaluated weight in relation to ideal body weight (IBW) and body mass index (BMI) criteria.^{3,15,22,23} Both athletes gave signed

permission for their case reports to be shared in this publication. This report constitutes clinical care and did not involve human subject research; it was determined exempt from review by the university's Institutional Review Board.

The Female Athlete

The female athlete (FA) was a long-distance runner referred to the sports dietitian by the athletic trainer, endorsed by the sports medicine physician, because she was identified as being at-risk for an eating disorder. She was already working with the sports psychologist and came to nutrition "because my coach wanted me to see a nutritionist." She reported on her initial assessment form that she wanted "advice on athletic nutrition" and wondered if she should change what she ate, perhaps "eat more or eat less?" She stated that she was "open to ideas to improve performance." FA presented weighing 45.9 kg (101 lb) at a height of 1.68 meters (5'6"), representing 78% of IBW²³ and a BMI of 16.4. She had been amenorrheic for more than a year and weighed as little as 43.2 kg (95 lb; 74% IBW) in high school. She had a hospitalization and a diagnosis of anorexia nervosa (AN) during her senior year, before coming to college. FA's score on the Female Athlete Screening Tool²⁴ was 81, placing her in the range of a subclinical eating disorder; however, she denied any disordered eating concerns and likely underreported her behaviors on the assessment, as is common among elite athletes.¹¹

According to diagnostic criteria,²⁵ FA met the criteria for AN and the female athlete triad²⁶ on presentation. She was training intensely, with two training sessions per day. In addition to training for her sport, she was working out regularly in the campus fitness center. She was not well connected socially, even with her teammates, and she was hours away from her family. She was training solo, and before long, she was living alone off campus. FA was struggling academically. She would not take a rest day, even when she experienced injury. People inside and external to the sports environment expressed concern over FA's low-weight status and observed eating behaviors. Based on dietary recall data, she had a highly restrictive diet that was inadequate in protein and calorie intake, consisting primarily of small portions of fruits and vegetables with no added fats.

FA's nutrition diagnosis was malnutrition related to AN as evidenced by significant underweight and inadequate macronutrient and micronutrient intake in the setting of high-energy expenditure due to sport, creating low energy availability and a relative energy deficiency.^{15,16} The diagnosis of malnutrition was made based on anthropometry (weight, weight history, magnitude of recent weight loss, % IBW, and BMI criteria); clinical assessment (emaciated appearance with extremely low body fat that was visibly observable, amenorrhea, and other clinically reported pieces of information, including constipation, inadequate hydration, hair loss, anemia, cold intolerance, and the presence of stress fractures, indicating compromised bone health); and dietary assessment based on 24-hour dietary recalls, food records, and a diet history interview revealing inadequate protein/calorie intake, low dietary quality causing concern for essential fatty acid and micronutrient adequacy, and deeply entrenched disordered eating behaviors, restrictive eating, and disordered thoughts preventing adequate fueling for

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