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Annals of Sports Medicine and Research

Case Report

Two Voices: Recovery from Disordered Eating as Told by an Elite Male Athlete and his Sports Nutritionist

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Abstract

This case report is written from the dual perspective of an elite male track athlete and the registered dietitian sports nutritionist who helped him recover from an eating disorder. The athlete was an international student who came from Great Britain to the United States to compete in track and cross country at the Division 1 collegiate level. Early in his freshman year, he developed an eating disorder that persisted throughout his college career, affecting his health, emotional wellbeing, and physical abilities to train, compete and recover from sports injuries. The athlete and sports nutritionist had a working relationship that spanned a six year recovery journey. Working collaboratively with a sport psychologist, they restored the athlete's health, his relationship with food, and his ability to achieve success in his sport. During low points defined by self-starvation, he was underweight, anemic and injured. At peak wellness, he set a track record for running a sub-4 minute mile and earned All American honors in individual distances and with several relay teams. Currently, he is a healthy Olympic hopeful who trains and competes with the Great Britain national team. This case report is unique since most often those speaking publicly about eating disorders are women. The report shares the athlete's experience in his own words alongside the nutritionist's clinical insights and description of treatment strategies that facilitated recovery. This paper demonstrates the need for comprehensive and ongoing interventions provided by a multidisciplinary sports medicine team to treat college athletes who experience eating disorders.

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Submitted: 07 February 2015

Accepted: 25 February 2015

Published: 27 February 2015

Keywords

- Sports nutrition
- Eating disorders
- Sport psychology
- Collegiate athletics
- Male
- Athlete

ABBREVIATIONS

BMI: Body Mass Index; ED: Eating Disorder; EDNOS: Eating Disorder Not Otherwise Specified; IOC: International Olympic Committee; NCAA: National Collegiate Athletic Association; ON: Orthorexia Nervosa; RD: Registered Dietitian; RED-S: Relative Energy Deficiency in Sport; UK: United Kingdom; US: United States

INTRODUCTION

Athletes are vulnerable to disordered eating and Eating Disorders (ED). While more prevalent in female athletes in "lean" sports, disordered eating and EDs are non-discriminatory; they occur in all sports [1]. In addition to the pervasive sociocultural idealization of thinness, perceived performance improvements and several other factors specific to the sport environment have been identified as contributors to increased risk in athletes versus the general population [2] and in certain sports tied strongly to aesthetics, appearance or weight-based competition criteria [3-5]. Personality characteristics including perfectionism and competitiveness, body dissatisfaction, interpersonal stress and anxiety, direct advice or perceived pressure to lose weight, frequent dieting and weight cycling, injuries, and influences of coaches and teammates have all been noted to add to the athlete's ED risk portfolio [1-6]. Collegiate athletes face particular challenges with the added demands of rigorous academics, scholarship commitments, and performance pressure at a young age and in an environment that is often far from home and without substantial support systems in place [6]. While female athletes are disproportionately affected by eating disorders compared to male athletes, ED rates in males are on the rise [1].

Disordered eating spans a continuum that ranges from dieting and restrictive eating, includes abnormal, rigid and often ritualistic eating behaviors, and may progress to clinical eating disorders [3]. More recently, a condition termed Orthorexia Nervosa (ON) emerged, labeled a psychopathological condition characterized by an obsession with high quality or righteous

food [7]. ON has been documented among athletes, shares many features with eating disorders, and because of its propensity for highly restrictive eating could compromise the health and nutritional status of an athlete [8]. The combined prevalence of disordered eating and eating disorders varies widely from 0-19% in male athletes and 6-45% in female athletes [9]. A recent study involving 156 Brazilian male athletes in weight-class sports, sports where leanness improves performance and sports with aesthetic ideals used validated assessments and found that more than one-quarter of athletes showed disordered eating behaviors which were associated with body image dissatisfaction [10]. As symptoms are frequently underreported by athletes [11] and it is likely that those with more substantial symptomatology may choose not to participate in studies, this estimate could easily be considered a conservative underestimate. Across the board, estimates of ED prevalence are typically considered underestimates given that so many individuals suffer in silence and experience disorders that go undetected, remain untreated, or fall below clinical diagnostic thresholds.

Given the high demands of athletic training and peak performance in sport, maladaptive eating behaviors place athletes at risk for RED-S, relative energy deficiency in sport. An interdisciplinary International Olympic Committee (IOC) consensus committee defined the syndrome of RED-S as "impaired physiological function including, but not limited to, metabolic rate, menstrual function (in females), bone health, immunity, protein synthesis, and cardiovascular health caused by relative energy deficiency" where an imbalance occurs between dietary energy intake and energy expenditure required to sustain homeostasis, health and activities of daily living, growth and supporting activities [12]. The resulting package of low energy availability, disordered eating behavior, and pathologic weight control measures that may include starvation, excessive exercising, purging or laxative abuse often driven by body image dysmorphia results in hormonal and metabolic imbalances, serious medical complications, and impaired athletic performance. Female athletes are traditionally considered most vulnerable to RED-S; in fact the term is an updated and more comprehensive definition of what was formerly called the Female Athlete Triad [13]. In its broader definition, the IOC recognizes that the syndrome also affects men; however there are only a handful of studies on low energy availability in male athletes. Clearly, more research is needed.

Protecting the mental and physical health of the athlete, and ensuring peak athletic performance are priorities in the face of these well documented risks. To do so requires specialized and focused attention, availability of resources, and partnerships involving coaches, athletes and sports medicine professionals across several disciplines. This case report shares the story of an elite male athlete who developed and recovered from an eating disorder during his collegiate track career. From the perspective of the athlete himself and the sports nutritionist who managed his care, a multidisciplinary team-treatment approach is described, interspersed with the athlete's description of his experiences and both the motivators and the obstacles that impacted his recovery journey.

CASE PRESENTATION

David was a 19 year old college freshman when he self-referred to the sports nutritionist after meeting in person at a team-based nutrition lecture that was hosted in mid-December by the Department of Athletics for the men's track and cross country teams.

Appearing pale and quite thin, he approached the nutritionist after the talk asking for an individual consultation stating, *"I really need your help. I need to lose weight."* On his initial intake form, he reported that he hoped to achieve the following three goals from nutrition consultation: *information and help on weight loss; information on replacing fat with muscle; and how to survive Christmas*. The personal strengths he said he would draw on to achieve his goals were, *"determination to achieve; and willpower to drive towards a goal."* When asked what challenges he thought might limit his abilities to achieve his goals, his responses were, *"temptations; and worries about my health (is my weight safe?)."*

Social History

An international student from the United Kingdom (UK), David had moved to Boston in August to begin training with his new team as an NCAA Division 1 scholarship athlete. His major support network consisted of his mother and brother, both of whom were back in England. He had solid relationships with his teammates and was particularly close with several female distance runners on the women's team. Here is David's description of coming to America:

"Moving to Boston from the UK was, in itself, a very stressful event for me. Despite the excitement of starting a new chapter in my life, beginning my college degree, and embarking on my NCAA career, I was very aware of the fact that I was moving to a foreign country, alone, 3,000 miles from any sort of familiarity. At the age of 18, this was to be my first time ever away from home for any significant period of time; a home where I had a loving mother who literally did everything for me. Suddenly, here I was in a foreign country where, despite speaking the same language, people were speaking differently to me and [it was] a very different culture than the one I was used to.

The pressures of being brought to the university on a full scholarship were immediately apparent to me upon joining the team. Perhaps that pressure was entirely self-placed, but the thought of someone believing I was worth $50,000 a year made me feel strongly pressured to ensure I earned it and proved that I was indeed worth it. I daren't fail to live up to expectation. I had to make sure I was doing the right things every day so that I was working towards being the success the coaches wanted me to be."

Weight History

At a height of 5'11" (180 cm), David presented at a weight of 149 pounds (67.7 kg) and a body mass index (BMI) of 20.8. His usual and *"comfortable competing weight"* was 146 pounds (66.4 kg). Upon moving from the UK to the US, experiencing a much more diverse, abundant and varied food supply, and increasing his training intensity, he had gained weight in the first few months at school. By November, his weight was up to 159 pounds (72.3 kg). At that time, his coach told him that he had gained weight and needed to lose it. In response, David began restricting his energy intake significantly, dropping 10 pounds (4.5 kg, or 6.3% of his body weight) in about 2 weeks. His weight had stabilized at 149

pounds and he was seeking nutrition counseling to overcome what he perceived as a weight plateau, stating that his goal weight was 143-146 pounds. He was weighing himself multiple times daily and both his mood and his self-evaluation were heavily influenced by the numbers that the scale displayed. At only 3-5 pounds above his reported goal weight, he was displaying a level of dietary restraint and concern over his body image that seemed out of proportion for the discrepancy.

"When my coach approached me about 2 months into my first semester and jokingly patted me on the belly, remarking that I was obviously enjoying American food a little too much, I was instantly horrified. In that second, I felt like I was a failure – that I was letting myself and my team down by doing something that was jeopardizing my ability as a runner. I had indeed gained weight during those first two months, but acknowledgement of this, so publicly, with direct intention by my coach to say that it was adversely affecting me, left me desperate to correct the "problem." As a person, I very much live my life by the "all or nothing" rule, and if I turn my attention to something, I will either give it 100%, or I won't bother at all. Desperate to lose the weight and show my coach I was serious about my training, I readily focused 100% on getting my weight as low as I possibly could."

Diet History

In high school, David reportedly never worried about what he ate or about his weight. When he presented to nutrition, he brought a food diary that showed highly regimented and highly restrictive eating behavior with little daily variation in food choices, relying on a narrow range of low-calorie foods like fruits, cereal, skim milk, lean deli meats, and some cooked vegetables. His fat intake was quite restricted and he was vigilant about keeping that source of concentrated calories out of his diet. His intake ranged from 500 to 1,200 calories per day and up to about 40 grams of protein per day, well below his needs, placing him in a situation of Relative Energy Deficiency given his training (RED-S).

He was taking an athlete's formula vitamin/mineral supplement and a fat metabolizer. His meal patterns were erratic and he rarely ate lunch. He often made food decisions based on the calorie-burning requirement to *"get rid of it"* through exercise.

"I believed I was just being the most dedicated athlete I could be – making necessary sacrifices for my passion. When I went home that first Christmas, my family supported my nutrition decisions since I was a collegiate athlete now, and I obviously had to make some sacrifices in order to be the best I could be. Little did they (or I, at the time) realize that their supportive behavior was actually adding fuel to the fire, providing me with positive feedback for the poor choices I was making. I had always been of slim build, so people didn't really notice or comment on my weight as it was nothing new."

Athletic Performance

David reported that he was not performing well athletically when he was at 159 pounds. He reported noticing a clear improvement since achieving his current weight. He did not have any injuries at initial presentation. The intensity of his training was described as quite high. He frequently blamed bad performances on what he had eaten or allowed himself to indulge in.

"Logic, at the time, told me that lighter equals faster, so the lighter I could be, and the faster I could be! It was only when I started to realize that actually losing weight really does take a toll on the body, and that the way I was doing things was affecting other aspects of my life too that I realized I may have been in a little bit of trouble. Trying to balance schoolwork with heavy training, and trying to live my day-to-day life would have been tough enough on its own without the added stress of trying to do it all on an empty stomach and low energy levels. However, I just saw these negatives as "necessary evils" – things that I had to go through if I truly wanted to be a champion."

Psychology

David met the diagnostic criteria for EDNOS, eating disorder not otherwise specified [14] characterized by the occurrence of significant weight loss in a short time, fear of weight gain, disturbance in body perception, preoccupation with weight and eating, avoidance of eating and certain eating situations, and highly restrictive intake substantially below his needs, particularly given his intense sport and training regimen. Concerning his evaluation of self, he was harshly self-critical and used a lot of negative self-talk, reflecting a negative mood state and wavering self-confidence. Quite consistently, he expressed dissatisfaction with his body and his weight. He talked about chasing perfection on the track and on the scale, demonstrating a strong drive for perfectionism and achievement in sport. He constantly compared himself to his teammates and complained, *"Everyone else is smaller than me. I'd be faster if I were smaller."* Yet he would contradict himself by admitting, *"I'm the fastest on the team."* He was not receptive to a referral to sport psychology.

Entry Point

David's entry point into sports medicine was through nutrition. He came on his own, seeking guidance to achieve weight loss, to improve his athletic performance, and seeking validation that what he was doing was rational, justified, necessary and safe.

"The interesting thing about this process was that I never saw it as a disorder in the early stages. Instead, I believed that my inability to lose weight beyond a certain point was something I was doing wrong – either still eating too much or having too little willpower to follow through on what I had planned. I noticed that I was able to get to a certain weight and then it suddenly became very difficult to maintain, but because I had set myself a target of being lighter than I was, I again felt like I was failing to perform because I couldn't get my weight to where I thought it needed to be. My end-goal was to lose weight. I had to. I had no choice. In my mind, my scholarship depended on it.

The real eye-opener came a few days after that first Christmas when I decided I would "make up" for the amount I had eaten on Christmas Day by eating absolutely nothing for two days, and then setting off for a 20-mile run on the third day. As anyone would expect, I did not feel well during this run and I ended up passing out at the side of the road, collapsing onto the pavement. It was when I finally had an honest conversation with myself about whether or not this was normal behavior that I realized I was struggling to do

this alone and that I should look for help. Even then, it still didn't feel like an eating disorder – just something I needed to do that I couldn't do on my own anymore.

Treatment Plan

David committed to a weekly schedule of nutrition counseling with the sports nutritionist. While he was extremely lean and had lost weight rapidly, he was not at an unsafe BMI. The focus of the nutrition intervention was therefore not specifically focused on weight restoration but rather to build a trusting provider relationship to address the disordered eating behaviors; to provide nutrition education, address myths, and correct misinformation about food, nutrition, nutritional supplements, health and performance; to reintroduce foods with the goals of improving nutritional quality and achieving protein/calorie adequacy; to normalize his eating patterns by focusing on adding lunch to his daily plan; and establish a support system of peers. He got rid of the scale and replaced it with a mini-fridge in his dorm room. He set goals and worked on becoming a flexible eater. We worked weekly to identify objective evidence linking self-care and proper nutrition to positive athletic and health outcomes. For example, to distract his focus from the scale and to quiet the internal voices telling him he was fat, we had the strength coach measure his body fat to prove that he was lean, regardless of the pounds displayed on the scale. His body fat percentage was 3.1%, well beyond lean, at the lower limit of the range for essential body fat for a male [15].

He refused referrals to sport psychology, but that recommendation remained consistently on the table. Five months into the working relationship, a referral to sport psychology was raised again by the nutritionist. When he refused to go, the response was,

"Would you go if I went with you?" To that, he agreed. Together, we had weekly joint sessions where the sport psychologist and sports nutritionist worked with David over the next 3 months providing cognitive behavioral therapy and nutritional counseling to reshape his belief systems, restructure his thoughts, build coping and communication skills, uncover the root causes of the disorder, learn to deal with negative emotions, explore motivations to recover, and gradually extinguish the eating disordered behaviors. In that time, he regained 10 pounds and both his athletic performance and his self-confidence improved.

"The biggest thing that helped me overcome my issues was learning to focus on the positive feedback that came out of my running. I eventually learned that when I ate more, I felt better when I ran. When I ate more, my running clothes fit a little bit better. When I ate more, I felt happier and had more energy to do the training I wanted to do. The flip-side of this was when I may have had a bad run on a day when I had eaten something I felt I shouldn't have, or I had eaten an amount that may have felt like "too much." That was negative feedback on food vs running; but learning to ignore the negativity and attribute those experiences to being "just one of those days" was a healthier state of mind for me. Up until that point, bad runs or poor races were always blamed on food or my weight, but never the other way around. Good races had always just been "lucky," and I had never attributed them to good nutrition or fueling my body correctly."

Progress, Relapses and Extended Follow Up

David's recovery journey spanned his entire undergraduate career and extended into his time as a graduate student. He had several substantial relapses and suffered the physical, emotional and athletic consequences of his low body weight and low energy availability. He was treated by sports medicine for anemia and foot injuries during his sophomore year. His sub-par performance on the track was blamed on his weight, causing him to restrict his diet again. His weight fluctuated as did his emotional state. His self-confidence faltered and his disordered behaviors reemerged under stress. He continued his work with sports nutrition and by junior year, he was at his peak. He was eating healthy, had many positive experiences both on and off the track, and his self-confidence was high. As a junior, at a weight of 154 pounds (about 10 pounds above his original "goal weight"), he broke a 25-year old school record by running the mile in under 4 minutes (3:59.14, to be exact). He earned several honors, records, and accolades that year for a consistent set of outstanding performances at several distances and as a member of several relay teams. In spite of such success, he experienced another relapse during his senior year when, for the third time, his coach told him to lose weight. By now, he knew how to recognize the return of disordered thoughts and behaviors and he quickly reconnected to nutrition counseling to work through the relapse.

David's running career continued as a post-grad because of lost seasons of eligibility from when he was undernourished and injured as an undergraduate, thereby extending his collegiate track career. During graduate school, he fluctuated between feeling "*invincible*" and being in relapse. It was during this time that his weight dipped as low at 137 pounds (62.3 kg; BMI 19.2) and he developed signs of ON. Working with the sports nutritionist, David got himself restored to a healthy weight and a healthy eating plan. This depiction indicates the fragility of David's status, the entrenchment of the eating disorder, and the dynamic process of his recovery journey that spanned more than 5 years' time. With professional help, David achieved wellness and reclaimed his running career. Today, he is a healthy professional living and working in England. He is an Olympic hopeful, training with the Great Britain national team to earn a chance to compete for his country. He is committed to telling his story so that other athletes, coaches, and sports medicine professionals can learn and benefit from his experiences and insights.

"The main piece of advice I have for anyone dealing with these issues, either as an affected athlete or an advisor to an affected athlete, is figure out what the motivation is for their actions. Why does the athlete engage in these behaviors? Until you know why an athlete wants to eat restrictively, you will never be able to change that behavior.

For me, it was entirely about performance. I wanted to be the very best athlete I could be, and I would do anything to be the best. In my head, my motivation for eating restrictively was to lose weight so that I could be lighter and therefore run faster. Until I realized that my motivation was actually to perform, and not just to lose weight (which had become my focus because of the disorder), I could not make changes. I finally realized that improved nutrition was actually the thing that would enable me to compete better, and therefore, I moved slowly towards that.

It is foolish to think that men are immune to these issues. Eating disorders are associated so strongly with female athletes that men can almost go unnoticed and, speaking from experience, careers could potentially be ruined without anyone really understanding why. I felt as though my body could tolerate the restrictive eating better than many women's bodies, so I could almost get away with it. Anyone can go through this mental battle, and anyone who does is going to have their own reasons and motivations for doing so.

This experience has actually taught me a lot about who I am as an athlete and as a person. With regards to running, I know much more about my body, what it needs and how to help it perform at its best. The process of educating myself about the nutritional needs of an athlete has actually allowed me to develop very healthy eating habits that I will carry with me for life. I've had the liberating experience of learning that even if I do make poor nutrition decisions from time to time, my body is always going to find a way to cope with it and keep me in a place where I can perform at my best. I believe that I had to go through this tough journey in order to improve myself and make changes for the better. I am born to run, and when I take care of myself, there is no way I can fail. I am invincible."

DISCUSSION

David's case illustrates concepts that have been described in the published literature by identifying factors that contributed to the onset of his eating disorder, factors that sustained his disordered behaviors, factors that allowed him to enter into treatment, factors that motivated and assisted his recovery, and factors that were either obstacles to recovery or triggers for relapse. David experienced both internal traits (negative mood, feelings of social isolation in a foreign country far from home, body dissatisfaction, and drive for perfectionism/achievement) and external factors (negative influences of hurtful comments, sports performance issues, and pressures unique to the sport environment, such as scholarship commitments and coaches' expectations) that contributed to the onset of his eating disorder, many of which have been previously described [2]. When faced with the possibility that he was a *"failure,"* his self-esteem, self-confidence and athletic identity were threatened, contributing to the root cause of his eating disorder.

As in this case, most eating disturbances in male collegiate athletes go undetected, occur at the subclinical level [4], or are not taken seriously. David's eating disorder went largely unnoticed by his coach, teammates, family and friends. No one questioned his restrictive eating behaviors or his weight loss, yet a coach felt justified to comment when he perceived him as overweight. The coach's public criticism of David's weight was both a factor in the onset of his eating disorder and a trigger for relapse. Research shows that important persons in adolescents' lives (family members and peers) can influence the development of body image concerns through teasing behaviors and social comparisons [16]. These observations could certainly be extended to coaches and teammates who quickly become a "family" for collegiate athletes. Social norms within a team, competitiveness, negative talk, and role modeling of dysfunctional behaviors are all factors that exist within teams that can contribute to or sustain disordered eating behaviors [1]. Finally, new research provides evidence that an athlete's eating psychopathology is predicted by perceived levels of interpersonal conflict with the coach [17], suggesting that conflict resolution in the athlete-coach relationship is a potential target for awareness and remediation through therapeutic intervention. Coping and communication skills learned in psychotherapy can help athletes work effectively towards conflict resolution.

Nutrition was David's entry point for treatment as he was most comfortable asking for help around food and weight concerns. This is not uncommon for an athlete as food and nutrients, even in controlled and limited amounts, are considered essential to performance at some level. It has been shown that nutrition knowledge of athletes is generally low to moderate at best, but that higher levels of nutrition knowledge are associated with outcomes desired by athletes, specifically higher fat-free body mass and higher muscle power [18]. In addition to nutrition counseling to normalize the ED behaviors, nutrition education to improve nutrition knowledge is an integral treatment strategy to help the athlete achieve a more adequate and higher quality eating plan that would enhance lean muscle mass and facilitate healthy weight management, removing the temptation to diet.

In contrast to his valuation of nutrition, at 19 years of age David stigmatized therapy, didn't think the severity of his condition warranted it, and simply *"didn't want anyone inside my head."* Nonetheless, once a trusting relationship was built with the nutritionist, he was more willing to engage in therapy. He said, *"I really didn't like [the sport psychologist] at first. But I went because I trusted you. You told me it would help me and I believed you."* The ability to work in joint professional counseling sessions was a luxury afforded by the university infrastructure and resources. In the real world managed by a system of third-party payers and reimbursements for services, that would rarely if ever happen. Yet clearly, this powerful interaction was a turning point for David that solidified his recovery journey, allowed him to explore his motivation to recover and identify and address the root causes of his disorder, and taught him the necessary skills to drawn on when relapses occurred. It has been suggested that athletes need specialized treatment, and research into treatment strategies and motivation for recovery among athletes with eating disorders is warranted [1]. The feasibility and efficacy of the joint counseling model used here deserves consideration and formal evaluation, particularly in settings where logistics allow closer physical and perhaps more collaborative interactions among sports medicine professionals, as in collegiate athletics.

The factor most clearly identified as an initiator of recovery in this case was opening up to a trusted other. For David, it was the sports nutritionist. This factor was reported as essential by 38% of female athletes in a recent qualitative study of ED recovery experiences [19]. Eventually, David also experienced some of the other key factors described previously in the literature [19,20] including experiencing negative consequences of the disorder (both physically and emotionally), confrontation and intervention (by the addition of sport psychology), and improvements in mood and self-esteem allowing him to recognize and prioritize self-care and nourishment. Significant factors that assisted David's recovery efforts that were similarly described by female athletes [19,20] were cognitive changes, important relationships (with female runners who were also struggling with EDs), professional

care, behavioral changes, and the motivators in the sport environment that drove him to succeed. Factors that hindered David's recovery included stigma concerning psychotherapy, negative cognitions and faulty belief systems, pressures and persons in the sport environment, praise received in response to restrictive eating and intense training that was perceived as commitment to sport, and body checking, some of which have been described previously [19]. Research specifically describing male athletes ED recovery experiences is lacking in the literature and is needed to better inform both clinical practice and risk assessment.

In summary, this case report depicts the length of the recovery effort, demonstrating that recovery from eating disorders does not happen in a short time, is characterized by progress mixed with relapse before sustained recovery occurs, and is difficult to achieve without professional help. A multidisciplinary team of sports medicine professionals including sports nutrition, sport psychology, athletic trainers, and sports physicians is needed to most effectively provide a comprehensive treatment plan [11,21]. Athletics administration plays a key role related to financing support services, providing educational programs for coaches and athletes, fostering a culture that is free from stigma and promotes healthy norms, and forming close partnerships with student health services and strong referral networks with professionals in the local community. Collegiate settings that lack these services, or key components of them, will have less success in identifying, treating or preventing eating disorders among student-athletes. In contrast, a supportive infrastructure and a comprehensive model for delivering confidential, accessible services provided by licensed professionals with eating disorder and sports expertise will break down barriers to treatment, connect athletes to providers, and enhance the potential for full recovery. This case study makes the clear case that brief interventions or guest speakers brought occasionally into college athletics programs will not be sufficient to prevent or to treat disordered eating in the absence of multidisciplinary, ongoing services provided by sports medicine, nutrition and psychology professionals.

There is no doubt that student-athletes need special services to help them manage the demands of recovery therapy on top of their heavily burdened school, sport and travel schedules. An important goal is to keep them enrolled in college and healthy enough to be eligible to train with their teammates and experience success athletically and academically while experiencing success overcoming the eating disorder. Certainly this is not possible if the athlete is medically unstable, a safety concern, or if the sport/college environment is too toxic for the athlete to remain in. Early detection and timely, effective interventions are essential to prevent athletes with disordered eating from progressing to the point where inpatient, residential or intensive outpatient levels of care are required to treat the disorder; situations in which athletes stand to lose their athletic-identity, support systems, and unique motivators in the sport environment that can actually assist recovery. Therapy that helps the athlete identify and deal with the root causes of the disorder while nutritional status and eating habits are restored is essential but all too often not achieved. The words David used to sum up his experience demonstrate the transformation he underwent through therapy by standing in stark contrast to his college-age belief system, *"Restrictive eating caused my underperformance and injuries. I learned about the small things that help my body achieve its goals: hydration, nutrition and psychology."*

Scientific Implications

This case report provides insight for clinicians, athletic administrators, coaches and athletes about onset and recovery from disordered eating. A strong rationale for eating disorder treatment teams and services in college athletics is depicted by this case where onset was experienced in freshman year and recovery efforts spanned an entire undergraduate and graduate career. This report is timely as the NCAA identified student-athletes' mental health and wellness as a priority area in 2014 with a specific goal of making mental health services for student athletes as available and as normative as services treating and preventing physical injuries in sport [22]. New tools are needed for identifying ED risk, particularly among male athletes and athletes in sports traditionally considered to be at lesser risk whose disorders often go undetected and untreated. The ED field will advance with more research into the recovery experiences of college athletes, and male athletes specifically, giving voice to the recovery journey itself. In the literature and in biographies in the popular press, far more is written about prevalence, risk, onset, burden, and consequences of eating disorders than is written about recovery journeys and treatment strategies. Clinical reports that show evidence of successful ED treatment models and client outcomes help to justify the creation of services and positions for professional providers within university athletic departments. Finally, research and clinical practice that experiment with and evaluate novel intervention models, like the joint counseling technique used in this case, will help to advance the field of ED recovery by breaking down barriers to treatment and defining effective treatment strategies.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the Department of Athletics at Boston University for their support in providing resources and sports medicine services including sports nutrition and sport psychology to student athletes including the one featured in this case report.

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Cite this article

Proctor DS, Quatromoni PA (2015) Two Voices: Recovery from Disordered Eating as Told by an Elite Male Athlete and his Sports Nutritionist. Ann Sports Med Res 2(2): 1016.