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Prevalence and Treatment for Eating Disorders in Young Athletes

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Prevalence and Treatment for Eating Disorders in Young Athletes

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Abstract

Eating disorders can be tricky disorders to detect, discuss, and treat. Often based in insecurity, individuals struggling with these disorders may already be trying to disappear. Well-known and keenly felt pressures to look a certain way within society combined with expectations to perform at a certain level and to look as an athlete is *supposed* to look can result in a high-risk situation for many adolescents. With these pressures looming, eating disorders may be justified to reach misguided goals. This is obviously problematic because eating disorders have one of the highest morality rates among mental health issues. Research on the prevalence of young athletes exhibiting disordered eating and the steps for treatment has been reviewed in hopes of building knowledge to use while supporting individuals within the counseling field. The rate of disordered eating, risks, causes of such disorders, and potential treatment options are the main focus. Research on the prevalence of eating disorders among adolescent athletes and possible treatment options are reviewed. Additionally, limitations of the literature are discussed, including the oversaturation of research regarding young females with eating disorders and prevalence over treatment focused literature.

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Eating Disorders in Young Athletes

Introduction

Eating disorders can arise for many different reasons, each individual affected has their own story. One of the most known motivators for the development of eating disorders is societal pressure to look a certain way. These pressures to look lean and thin can overtake many. Beyond guidelines of what a body *should* look like, there are strong expectations of leanness and what society perceives as health in athletes. This pressure seeps into the self-esteem, behaviors, and attitudes of young athletes across society, gender, and sport.

Treatment of eating disorders can be intimidating for many. Often times those struggling with disordered eating are in denial themselves; and therefore, keep it hidden from others. They see negative weight management behaviors as necessary means that justifies the end result. This determination, denial, and lack of motivation to change hides the disorders and can make it difficult for loved ones to approach the topic. Even with these barriers it is important to remember that eating disorders have a high mortality rate and they must not be ignored. In high risk populations such as young athletes it is vital to gain the knowledge and confidence necessary to help those who develop disordered eating, to better understand the prevalence of disordered eating in young athletes, and know steps that can be taken to treat or create interventions for these young athletes.

Literature Review

Eating Disorders in Young Athletes

It is important to first define what disordered eating is. According to Sue, Sue, Sue, and Sue (2016) disordered eating is showing unhealthy strategies, behaviors, or attitudes towards

food intake or weight control that can lead to the development of symptoms of eating disorders. Sue et al. (2016) go on to explain the multiple types of eating disorders such as *anorexia nervosa*, *bulimia nervosa*, *binge-eating disorder*, and *eating disorder not otherwise specified*. These disorders present a range of symptoms, varying from restrictive calorie intake, body image distortion, intense fear of changes in weight or appearance, use of vomiting or excessive exercise to control weight, and more according to Sue et al. (2016). Unchecked and untreated disordered eating can lead to the official diagnosis of any one of the aforementioned eating disorders. Unchecked and untreated eating disorders have a high mortality rate (Insel, 2012). As is true with most disorders, these symptoms can present in any individual and young athletes are not immune. In fact, young athletes present as a high-risk population. According to Laramée, et al. (2017), up to 22% or about one in five female high school athletes have intention to use restrictive eating strategies. This number was found by Laramée, et al. (2017) using the Theory of Planned Behavior (TPB) framework. The pressures these athletes feel is a result from being a part of what the researchers refer to as aesthetic sports, or sports that emphasize appearance as well as performance, with examples in various research being gymnastics, swimming, cheerleading, running, among a few others (Laramée, et al., 2017). This combined expectation is what creates an environment conducive to relying on unhealthy weight control habits.

Often times, self-esteem levels can be correlated with disordered eating. In a study done by Ferrand, Magnan, and Philippe (2005) it was found that when comparing a group of elite female synchronized swimmers, a group of non-aesthetic sport athletes, described as sports that do not put an emphasis on leanness to enhance performance, and a group of non-athletes, the swimmers “reported greater negative feelings about their appearance” and “low perceptions of how others evaluate[d] their physical appearance” (p. 882). This phenomenon could easily add to

the pressures of being lean and result in disordered eating. Though there are multiple motivations behind the development of eating disorders, low self-esteem a common motivator (Ferrand et al., 2005). As suggested by Ferrand et al. (2005) the non-athletes and non-aesthetic sport athletes have less pressure to view themselves a certain way. This could result in a lower risk of low self-esteem. The combination of high athletic performance and appearing thin at the same time is a high-risk situation in terms of self-esteem and this in turn could result in a high-risk situation for developing disordered eating (Ferrand et al., 2005).

Although there is a focus on young women athletes in much of the athletic eating disorder research, it is not the only gender that can be affected. Young men athletes that also participate in high risk sports are not immune to disordered eating. As found by Wadas and DeBeliso (2014), "disordered eating among male athletes may be more of an issue than previously thought" (p. 1). Within their research of 68 male cross-country runners who all completed the EAT-26, EMI-2, and the ATHLETE questionnaires, three runners were at risk of having eating disorders with nine more meeting the cut off for at risk disordered eating behaviors (Wadas & DeBeliso, 2014). These two groups of participates combined made up 17.6% of the study's population (Wadas & DeBeliso, 2014). Wadas and DeBeliso (2014) are not the only researchers who have found signs of disordered eating in male athletes and running is not the only sport that harbors these unhealthy symptoms. Wrestling is well known for having a weight class structure that separates athletes and matches based on their weight (Rose, 2018). For instance, an athlete weighing 150 pounds would not be in the same weight class as an athlete weighing 250 pounds (Rose, 2018). It is also well known that this is a male dominated sport and therefore is another area that needs to be considered when looking for young male athletes developing disordered eating (Gough, 2019). According to a research review done by Know

(2017), wrestlers being evaluated on weekly weight fluctuations "lost on average 4kg or 8.8lbs a week" (p. 1) with the most popular weight control methods identified as "increase exercise, food restriction, gradual dieting, and heated wrestling rooms" (p. 1). These behaviors are unhealthy ways to control weight and promote athletic performance and participation in these techniques raise the concern that these young, male athletes could be at risk of developing eating disorders (Know, 2017).

An important thing to consider while discussing male disordered eating is the validity of eating disorder measures for this specific population. Often disordered eating in males presents itself differently than how it is typically seen in females (Martinsen & Sundgot-Borgen, 2013). This is because their motivations can sometimes be different. As found by Martinsen and Sundgot-Borgen (2013) current eating disordered measures may not be able to accurately "differentiate between male athletes who are dissatisfied with their body because they want to be more muscular, athletes who are dissatisfied because of the extra fat, or those with ED" (p. 1195). Disordering eating can have multiple motivations, not just being slim and lean as just stated by Martinsen and Sundgot-Borgen (2013) regarding possible male motivations. Regardless of if an individual has concerns over being slim or not being muscular enough, not properly taking care of physical health can obviously be dangerous. Both of these types of concerns are seen in at risk athletes and should be considered even when established eating disorder measures may overlook less traditional or known representations of disordered eating.

Treatments and Interventions for Eating Disorders in Young Athletes

One avenue that can be utilized when it comes to the identification and treatment of youth athletes with disordered eating is coaching staff. Coaches have the opportunity to closely track performance and often times biometrics of their athletes (Plateau, McDemermott, Arcelus,

& Meyer, 2014). This, along with the bond that often forms between coach and athlete, provides a unique opportunity (Plateau et al., 2014). Plateau et al. (2014) go as far to state that "[c]oaches have an important role in identifying disordered eating behaviors and attitudes among their athletes...which may be critical in preventing the onset of a clinical eating disorder" (p. 722). Plateau et al. (2014) continue on saying that coaches can intentionally look for physical indicators, eating attitudes and behaviors, social cues, and various performance indicators. Specific examples could include drastic changes in weight, avoiding situations where the student would have to eat in front of others or talk about eating habits, or a strong focus on biometric measurements such as body fat percentage, muscle mass, or body measurements (Plateau et al., 2014). Coaches have access to all of these factors as part of their job description (Plateau et al., 2014). Furthermore, it is vital that the identification of disordered eating is a high priority as it can prevent reaching an official eating disorder diagnosis or more quickly provide treatment options for those athletes who have already reached a more severe stage of development (Plateau et al., 2014). When discussing the coaches' role concerning athletes with disordered eating it is important to consider how their sport motivates the unhealthy mindset (Plateau et al., 2014). Pressures to perform, evaluation of appearance, and access to extreme strategies in terms of nutrition and physical activities all feed into the reasons behind developing disordered eating (Plateau et al., 2014). Having an ally, such as a coach, working on the inside so to speak can be a valuable asset (Plateau et al., 2014). Some pressures, even if it is an inaccurate perception, could come from fear of a coach's opinion (Plateau et al., 2014). If coaches commit to not only identifying possible disordered eating, but also was open about their support of healthy strategies over disorder strategies, a huge effect could be seen in this high-risk population (Plateau et al., 2014).

Another factor that could be extremely beneficial in terms of treating eating disorders is levels of motivation. Unfortunately, many individuals see their disordered eating as useful or necessary (Clausen, Lübeck, & Jones, 2013). Particularly in the case of athletes with eating disorders, their unhealthy, disordered eating strategies could be a part of their performance plan, meaning they may be unwilling to give them up or see no need (Clausen et al., 2013). This is why the motivation to change is a crucial step in treatment options (Clausen et al. 2013). conducted a systematic review looking into this concept. The researchers looked into pretreatment procedures involving levels of motivation to change and if they affected the posttreatment results (Clausen et al., 2013). Clausen et al. (2013) found that "when looking at categorical measures of level of recovery at posttreatment...the association with motivation to change seems to be more stable" (p. 756). Any individual with a type of mental disorder would be resistant to change if they saw the disorder as beneficial or an intentional strategy (Clausen et al., 2013). The reasons athletes are a higher risk population for disordered eating in particular (high levels of pressure to perform and look a certain way) add to this disordered thought process (Clausen et al., 2013). Therefore, looking into the motivation of a student or client to change before beginning treatment could prove largely helpful (Clausen et al., 2013).

Family therapy is another avenue for the treatment of eating disorders. According to Jewell, Blessitt, Stewart, Simic, and Eilsler (2016) family-based therapy has shown efficacy and higher levels of recovery from Anorexia Nervosa at six and twelve-month follow ups as compared to only individual therapy sessions. Research has begun showing similar results for the treatment of *bulimia nervosa* as well (Jewell et al., 2016). Jewell et al. (2016) state that the therapy's framework includes four phases, which combined to have the following emphasis and tasks:

> A clear focus on working with the family to help their child recover, coupled with a strong message that the family is not seen as the cause of the problem; expecting the parents to take a lead in managing their child's eating in the early stages of treatment; externalizing the eating disorder; and a shifting of focus on to adolescent and family developmental life cycle issues in the later stages of treatment. (pp. 578-579).

These tasks resulted in a full family therapy experience (Jewell et al., 2016). It was found to be the most successful in female clients with a shorter duration of disordered eating at the start time of the therapy (Jewell et al., 2016). However, it was still effective at various levels in other demographics (Jewell et al., 2016). When considering the best way to support young athletes struggling with these disorders, referring to a family therapist may provide a holistic approach with surrounding care (Jewell et al., 2016).

There has also been promising research to support the use of Dialectical Behavior Therapy (DBT) in the treatment of eating disorders in youth. DBT based interventions are usable by clinical mental health counselors and school counselors alike (Lenz, Taylor, Fleming & Serman, 2014). The focus falls on four main areas including "[s]kills training…of coping that develop a client's ability to tolerate subjective distress, regulate emotional responses, increase interpersonal social skills, and increase individual capacity to engage in mindfulness practices" (Lenz et al., 2014, p. 27). Adolescents are already in need of skills training to help them healthily transition into adulthood (Lenz et al., 2014). Developing strategies to handle perceived stressors, regulate emotions, develop appropriate social skills, and utilize mindfulness techniques are already typically a part of therapy or school counselor curriculum (Lenz et al., 2014). When distorted eating is involved, practicing these skills is even more important (Lenz et al., 2014).

When these common curriculum goals are used as a part of DBT, there are eight strategies that the counselor should keep in mind. According to Lenz et al. (2014), they are:

> "(a) accepting the primary dialectic of change within a context of the client's reality; (b) educating, modeling, and practicing effective problem solving; (c) having an irreverent attitude regarding the repeated use of maladaptive coping strategies; (d) fulfilling the role of consultant exclusively to clients; (e) actively validating through acceptance and empathic communication; (f) teaching behavioral coping skills; (g) facilitating a warm, growth-fostering relationship; and (h) providing contingency strategies that reduce risk of self-harm as needed" (p. 27).

According to the authors, with these strategies in mind, the DBT inspired skills training techniques has shown success particularly with women in treatment for distorted eating (Lenz et al., 2014).

Applications to School Counseling

School counselors may be another resource to utilize in the prevention and treatment of eating disorders in youth. As mentioned in the above paragraph regarding family therapy, there is more success in the treatment of eating disorders the quicker interventions begin (Jewell et al., 2016). This phenomenon is not solely seen in family therapy approaches. This is where a school counselor, who is in schools as a student support, could be of assistance (Buser, 2012). Often times, as Buser (2012) states "[s]chool counselors can be attuned to the populations most at risk for developing these physically and emotionally taxing disorders and can gear prevention programs to these targeted groups" (p.1). Youth developing disordered eating can be in denial about their eating habits and the seriousness of the potential disorder (Sue et al., 2016). This means that it can be well hidden from those who wish to help (Sue et al., 2016). School

counselors are a part of young adults' support services and are often a part of their daily educational experience. With proper training, school counselors can be utilized in the early detection of eating disorders in at risk populations, such as young athletes (Buser, 2012). Searching for students who avoid eating in front of others, trips to the bathroom quickly following mealtimes, consistent and often looks into reflection surfaces, and defensive or avoidant reactions to conversations about eating habits are all hints that a school counselor could be aware of (Sue, et al., 2016). Also mentioned by Sue et al. (2016), eating disorders can be difficult to detect, but these red flags combined with a drastic weight change or emphasis on weight in certain sporting environment is enough for school counselors to at least keep an eye out.

School counselors also could be helpful in preventative measures. Buser (2012) goes on to say that school counselors are equipped to target certain high-risk factors with tailored preventative interventions. For example, with young athletes being at a higher risk, school counselors can incorporate cognitive distortion psychoeducation, challenge *ideal* body types in the school community, or perhaps run small counseling groups aimed at boosting self-esteem (Buser, 2012). Providing tools for young adults to combat negative coping strategies could help prevent the development of disordered eating. If preventative measures do not succeed, the school counselor would be able to turn to skills building techniques (Buser, 2012). As mentioned, DBT has been found to be useful in the treatment of distorted eating (Lenz et al., 2014). School counselors have expertise in helping students develop socioemotional skills; the coping skills highlighted in DBT do not seem to be too far from these skills already highlighted by American School Counselor Association (ASCA) *Mindsets and Behaviors* (2014). However,

if these skills do not seem to be providing any change in the student, it is the school counselor's responsibility as stated by ASCA (2016) guidelines to refer to a more specialized treatment site.

Discussion

There has been research to support the prevalence of eating disorders, but less literature on step by step treatment options. Upon initial searches of eating disorders and sports induced disordered eating, pages of results appeared highlighting the existence of eating disorders and emphasizing the high-risk in adolescents and athletes. Of course, there is research on treatments available, it just took more time and refined searches to find solutions due to the saturation of prevalence-based literature. It could also be assumed that the lack of obvious, concrete steps for treatment of disordered eating may be due to the seriousness of the disorders and the need for specialized mental health providers to be involved. As mentioned, the ASCA (2016) guidelines state that school counselors must not give treatment outside of their competence. Serious developments of eating disorders must seek in-depth treatment. The bias of this research has been through a school counselor perspective. A more throughout search into clinical mental health treatment literature may have been useful to find specific eating disorder therapy options. However, even though these disorders should be handled with great care, future research could benefit from moving away from solely prevalence based inquires to treatment solutions tailors to various levels of training or specialization, such as but not limited to concrete and effective steps a school counselor could take to support the treatment process of eating disorders. Perhaps, additionally, research on how to bridge the gap between specialized mental health practitioners and adults, including school counselors and coaches to offer the most holistic treatment of eating disorders.

A large majority of the research found had young, female participants. Less research was found regarding male participants. Virtually no research was found with non-binary or transgender participants. The target area for this research was athletes in their adolescent years, but no parameters were set regarding gender identity. With gender well-known to be the means of societal bias and discrimination, research on all genders is vital. Questions regarding how body dysmorphia affects multiple genders and stages of transition and how different societal expectations based on gender identity influence disordered eating behaviors are important subsections of this research topic that are lacking in the literature. Research needs to be done on effective treatments as well as a more diverse array of participants. More should be done to address these questions.

Conclusion

Disordered eating can be identified by adults in the student athlete's life. Coaches and school counselors have both been identified as resources for this population. Coaches see the performance and often times the physical changes in student athletes that others may not see. From there, guidance could be given on nutritional needs along with physical exertion. Similarly, school counselors are trained to look for social, emotional, and mental aspects of each student's life, including student athletes. They may notice a change in self-esteem or social behaviors that could indicate the development of an eating disorder. From there school counselors have the means to provide supports, such as those suggested by DBT type interventions. Additionally, school counselors, or anyone in the student's life, can make outside referrals. Referrals specifically could be made to family-based therapy or other specialized treatment providers or in-patient facilities. Depending on the individual student, treatment ranging from school-based

prevention programs or skills training interventions to specialized clinical mental health therapy should be utilized.

While eating disorders can be complicated to identify and treat, there is hope for youth affected by these disorders. Adults in the lives of affected students, such as young athletes, need to be up to date on the research, warning signs, and treatment options available. Societal pressures and performance expectations increase the risk for teenage students, and the nature of the disorders to hide, have low confidence, and justify the unhealthy behaviors makes it difficult to identify and treat disordered eating. As research suggests, it may be difficult to identify and treat these disorders, but not impossible. Research supports the notion that motivation work, DBT based interventions, and family-based therapy can help with lasting treatment results. Young athletes are at a high risk for these disorders, but with the proper support and treatment, the disorders can be treated.

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