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Barbara Bickford

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THE LEGAL DUTY OF A COLLEGE ATHLETICS DEPARTMENT TO ATHLETES WITH EATING DISORDERS: A RISK MANAGEMENT PERSPECTIVE

BARBARA BICKFORD*

I. INTRODUCTION

In virtually every college athletics department across the United States, there is an athlete with an eating disorder engaged in intercollegiate competition. Progressively larger proportions of eating disordered women have been identified in the general population and in college student populations, and they clearly have an analogue in the athletic sphere.¹ Knowledge of eating disorders in athletics populations has existed for almost twenty years, yet many colleges and universities seem to be ignoring the problem.² Eating disorders are a serious health threat that require prompt medical attention.³

Colleges may owe some duty of care to their athletes, in fact a college that ignores eating disorders may be negligent. To prevent legal liability, colleges and universities must educate their employees to be aware of and recognize symptoms of eating disorders, create a plan for intervention and treatment or referral, and engage in preventative education. As a general policy, it is unacceptable for colleges to recruit student-athletes, promise to train them to achieve peak performance, and ignore them as they simultaneously destroy their health.

II. PREVALENCE: A PROBLEM EXISTS

Researchers and therapists have indicated for the past fifteen years that athletes are a high risk group for developing eating disorders.⁴ Prev-

* Assistant Professor, Sports Administration, Department of Exercise & Sport Science, University of North Carolina at Chapel Hill.

1. See Virginia G. Overdorf, *Eating Related Problems in Female Athletes*, in *EATING DISORDERS AMONG ATHLETES: THEORIES, ISSUES AND RESEARCH*, 67, 79 (David R. Black ed., 1991).

2. See, e.g., Randall W. Dick, *Eating Disorders in NCAA Athletic Programs*, 26 *ATHLETIC TRAINING* 136 (Summer 1991).

3. See AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 539-550 (4th ed. 1991)[hereinafter DSM4].

4. See e.g., Marlene Boskind-White & William C. White, *Bulimarexia: A Historical-Sociocultural Perspective*, in *HANDBOOK OF EATING DISORDERS*, 354, 366 (Kelly D. Brownell,

alence of disordered eating is significantly higher among athletes involved in sports in which light weight or small body size is deemed necessary to achieve performance success, weight classifications apply, and aesthetic ideals of beauty apply than compared to the general population.⁵ Although some sports seem to have a higher prevalence of athletes with eating disorders, the NCAA survey showed that eating disorders were reported in almost every sport, and that no activity should be considered exempt from the problem.⁶

The prevalence rates reported have varied according to the population sample and the tools utilized to collect the data. Borgen and Corbin reported that 20% of the athletes tested demonstrated eating disorder tendencies;⁷ Rosen, McKeag, Hough and Curley reported 32% of athletes used unhealthy weight control behavior;⁸ Worsnop reported that 10% of the female athletes at the University of Texas had eating disorders, and another 20 to 30% showed signs of eating disorders;⁹ and Overdorf found that an alarming rate of over 40% of the athletes tested were using pathogenic weight control methods, including exercise abuse.¹⁰

In a 1985 study of college athletes, Guthrie found that 7% of the athletes were identified as weight preoccupied according to the Eating Disorders Inventory,¹¹ "[8%] of the athletes were identified as bulimic according to strict criteria of the Diagnostic and Statistical Manual of

John P. Foreyt, eds., 1986); Sherry Buickel, *Anorexia Nervosa and Bulimia in Athletics*, 18 ATHLETIC TRAINING 137, 137-138 (Summer 1983).

5. See Andrew A. Skolnick, "Female Athlete Triad" Risk for Women, 270 JAMA 921 (1993); Sharon R. Guthrie, *Prevalence of Eating Disorders Among Intercollegiate Athletes*, in EATING DISORDERS AMONG ATHLETES, *supra* note 1, at 43, 66. See also James A. Blumenthal et. al., *Is Running an Analogue of Anorexia Nervosa?*, 232 JAMA 520, 523 (1984); Jack L. Katz, *Long Distance Running, Anorexia Nervosa and Bulimia*, 27 COMPREHENSIVE PSYCHIATRY 74, 78 (Jan./Feb. 1986); Suzanne Nelson Steen & Shortie McKinney, *Nutrition Assessment of College Wrestlers*, 14 PHYSICIAN AND SPORTSMED. 100, 116 (Nov. 1986); Lionel W. Rosen & David O. Hough, *Pathogenic Weight Control Behaviors of Female College Gymnasts*, 16 PHYSICIAN AND SPORTSMED. 141, 146 (Sept. 1988).

6. See Dick, *supra* note 2, at 138, 140.

7. See Jorumn Sundgot Borgen & Charles B. Corbin, *Eating Disorders Among Female Athletes*, 15 PHYSICIAN AND SPORTSMED. 89, 95 (Feb. 1987).

8. See Lionel W. Rosen et. al., *Pathogenic Weight Control Behaviors in Female Athletes*, 14 PHYSICIAN AND SPORTSMED. 79, 85 (Jan. 1986).

9. See Richard L. Worsnop, *Eating Disorders*, CONG. Q. RESEARCHER, Dec. 18, 1992, at 1097, 1102.

10. See Overdorf, *supra* note 1, at 76.

11. See Guthrie, *supra* note 5, at 49. (The Eating Disorder Inventory (EDI) was developed by Garner, Olmsted, and Polivy in 1983 to measure eight attitudinal and behavioral dimensions associated with anorexia nervosa. Research and clinical experience have shown the scale to have high utility as a prognostic screening instrument. *Id.* at 46).

Mental Disorders (DSM-III),¹² “[41%] of the athletes reported binge eating tendencies and 16% purged through the use of vomiting, laxatives and/or diuretics.”¹³ Twenty percent of athletes indicated on the Purging Mechanism Inventory¹⁴ that they engage in purging behaviors to control weight, with an additional 11% engaged in severely restrictive dieting or fasting, 47% using excessive exercise as part of athletic training, and 34% exercised additionally beyond the athletics setting.¹⁵ Perhaps the most alarming finding in Guthrie’s study was that 23% of the athletes reported that they had an eating disorder in the past, 14% admitted to currently having an eating disorder, and 73% of female gymnasts, 41% of synchronized swimmers, 39% of cross country runners, and 36% of swimmers and divers reported pathological eating behaviors.¹⁶

Whether athletics programs are a breeding ground for disordered eating behavior, or whether competitive sports attract compulsive over-achievers who are predisposed to eating disorders is not known.¹⁷ The athletic personality is almost a textbook definition of an eating-disorder personality: compulsive, driven, and self-motivated.¹⁸ The athlete who accepts the challenges of serious competition is rigidly self disciplined and a perfectionist, like the anorectic, but only in behaviors relating to athletics participation.¹⁹ Although athletes displayed less extreme behavior patterns, and are considered psychologically healthier than eating disordered patients, “the athletes’ self perceptions differ markedly from reality and their perceptions of how they think others see them.”²⁰ A little over half of athletes in the Overdorf study saw themselves as heavy, while in reality only 3% would be in a heavy category.²¹

12. *Id.* at 49. (The Diagnostic and Statistical Manual of Mental Disorders is acknowledged by the American Psychiatric Association as the recommended source for discrete, uniform, reliable identification of clinical entities.)

13. *Id.* at 52.

14. *See id.* at 46. (The Purging Mechanism Inventory (PMI) identifies methods of weight control as well as the frequency with which each method is used.)

15. *See id.* at 52. (Using the DSM IV 1994 criteria, which includes vigorous exercise, strict dieting and fasting as purging methods, this study would indicate that almost all athletes, male and female, are engaged in purging behaviors as a method of weight control.)

16. *See id.* at 53.

17. *See generally* Preston Zucker et. al., *Eating Disorders in Young Athletes*, 13 *PHYSICIAN AND SPORTSMED.* 88, 88-106 (Nov. 1985); Borgen & Corbin, *supra* note 7, at 89-95.

18. *See* James S. Thornton, *Feast or Famine: Eating Disorders in Athletes*, 18 *PHYSICIAN AND SPORTSMED.* 116, 119 (Apr. 1990).

19. *See* Skolnick, *supra* note 5, at 923.

20. Overdorf, *supra* note 1, at 71-72.

21. *See id.*

The awareness of the advantage of reducing body fat for optimal athletic performance coupled with the strong negative aesthetic and moral connotations of fatness in our society creates strong pressures on athletes to abhor and reduce body fat.²² As athletic performance improves and records become more impressive, athletes will go to extreme lengths to improve their techniques and enhance the physical state of their bodies.²³ The use of pathological weight control techniques is a quick way to reduce body fat to increase strength, speed and endurance. For these athletes, disordered eating is just one more sacrifice to gain a competitive advantage.²⁴

There may be a small percentage of eating disordered persons who participate in athletics because of their compulsive need to exercise.²⁵ "[T]he non-athletic anorectic exercises frantically for fear of gaining weight. In comparison, the anorectic athlete trains hard with the hope of improving performance."²⁶ What begins as a simple equation in the mind of many athletes, "Weight Loss = Improvement" may lead to an uncontrollable obsession with harmful and potentially fatal consequences.²⁷ Optimal competitive weight and superior performance become interrelated goals, although the athlete's idea of thinness usually represents a degree of emaciation unhealthy for a normal person.²⁸

Unfortunately, many athletics departments are choosing to look away from this serious problem.²⁹ "In March 1990, a one-page survey was sent to the senior women administrators (SWAs) of athletics programs at each of the 803 NCAA member institutions."³⁰ Only 491 of the member institutions responded to the survey, although each of these institutions had previously received eating disorders educational materials from the NCAA and should have perceived eating disorders to be a serious problem for athletic populations.³¹ "Of the responding institutions,

22. See Joanne S. Chopak & Mary Taylor-Nicholson, *Do Female College Athletes Develop Eating Disorders as a Result of the Athletic Environment?*, in *EATING DISORDERS AMONG ATHLETES*, *supra* note 1, at 87, 90-91 (factors in the athletic environment do contribute to eating disorders.)

23. See INTERNATIONAL ATHLETIC FEDERATION, *TOO THIN TO WIN* 5 (1988) [hereinafter, *Too Thin To Win*].

24. See *id.*

25. See *Eating Disorders in Athletes: The Dietician's Perspective*, 5 *SPORT SCI. EXCHANGE ROUNDTABLE* (1994) [hereinafter *Eating Disorders in Athletes*. . .].

26. *Id.*

27. See *Too Thin to Win*, *supra* note 23, at 5.

28. See Guthrie, *supra* note 5, at 44.

29. See Dick, *supra* note 2, at 136.

30. *Id.*

31. See *id.*

313 (64%) indicated that at least one eating disorder of a student athlete had occurred."³² "The remaining 178 institutions reported no persons with eating disorders in their athletics programs."³³ Given that a minimum of 6% of the general population has an eating disorder, and that athletic populations report even higher incidence of eating disorders, it is alarming that more than one-third of the intercollegiate athletics programs in this country do not recognize eating disorders or are ignoring this serious problem.³⁴

Eating disorders are easily the gravest health problem facing female athletes.³⁵ Inattention to these problems may be related to the fact that aberrant behaviors have still not been recognized by athletics personnel as serious, or because the problem is perceived as primarily a female issue and is therefore not serious.³⁶ What exactly are eating disorders? And why are athletes who engage in these behaviors at risk?

III. DEFINITIONS AND DESCRIPTIONS OF EATING DISORDERS PREVALENT IN ATHLETICS

There are three types of eating disorders — anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified — that are commonly known in athletics populations.³⁷

A. *Anorexia Nervosa*

The typical anorectic is a white adolescent female from a middle to upper class family.³⁸ She is unrealistically a perfectionist and consequently, highly motivated.³⁹ Anorectics are also described as obedient and over compliant, due to a lack of self esteem, which "is highly dependent on [her] body shape and weight."⁴⁰ Outwardly, she will give the appearance of being under control, while she may actually be very dependent upon others, such as parents, coaches, or advisors.⁴¹ She tends

32. *Id.* at 136, 138.

33. *Id.* at 138.

34. *See generally id.* at 138.

35. *See* Merrell Noden, *Dying to Win*, SPORTS ILLUSTRATED, Aug. 1994, at 52, 54.

36. *See* Overdorf, *supra* note 1, at 67-68.

37. *See* DSM4, *supra* note 3, at 539-550. (A subclinical eating disorder termed "anorexia athletica" has been proposed to classify athletes who show significant symptoms of eating disorders, but who do not meet the DSM4 criteria.)

38. *See* Craig Johnson & David L. Tobin, *The Diagnosis and Treatment of Anorexia Nervosa and Bulimia Among Athletes*, 26 ATHLETIC TRAINING 119, 120 (Summer 1991).

39. *See* Thornton, *supra* note 18, at 119.

40. DSM4, *supra* note 3, at 540.

41. *See* P. Perry, *Overview of Eating Disorders*, in WOMEN'S SPORTS FOUNDATION, EATING DISORDERS RESOURCE PACKET 1 (1990).

to be a loner, and despite expressed concern from friends and family about her emaciated appearance, she will insist that she is fine.⁴² It is rare for an individual with anorexia nervosa to acknowledge being thin, and she will "typically deny the serious medical implications of [her] malnourished state."⁴³ The clinical criteria for diagnosing anorexia nervosa is outlined in Table 1.

TABLE 1: CLINICAL DEFINITION OF ANOREXIA NERVOSA

- "[r]efusal to maintain body weight at or above minimal normal weight for age and height"⁴⁴
- "[I]ntense fear of gaining weight or becoming fat, even though underweight"⁴⁵
- a distorted body image or disturbance in the way one perceives one's body weight, size or shape⁴⁶
- "denial of the seriousness of the current low body weight"⁴⁷
- a weight loss of 35% of the original body weight or a body weight of less than 85% of expected normal weight⁴⁸
- "amenorrhea," defined as the "absence of at least three consecutive menstrual cycles"⁴⁹

The physical effects and serious medical complications resulting from disordered eating are a threat to the total health of the athlete, and will ultimately be a threat to her life.⁵⁰ Routine training and competition create additional stress on an already abused body, putting eating disordered athletes at greater medical risk than the average eating disordered population.⁵¹ Initially, the athlete's performance should improve with weight loss, particularly if the athlete was above an ideal competitive weight prior to training.⁵² As body fat decreases, the oxygen which was used to oxygenate the excess fat tissue, is now utilized more effectively

42. See Johnson & Tobin, *supra* note 38, at 120.

43. DSM4, *supra* note 3, at 540.

44. *Id.* at 544.

45. *Id.*

46. See *id.* at 540.

47. *Id.* at 545.

48. See *id.* at 540.

49. *Id.* at 545.

50. See John D. Stephenson, *Medical Consequences and Complications of Anorexia Nervosa and Bulimia Nervosa in Female Athletes*, 26 *ATHLETIC TRAINING* 130, 132 (Summer 1991).

51. See *id.*

52. See Worsnop, *supra* note 10, at 1097; *Eating Disorders in Athletes. . .*, *supra* note 25.

by the muscles.⁵³ However, after a certain degree of weight loss, the body becomes deprived of sufficient calories and nutrients to fuel, maintain, and regenerate the muscle tissue as required for ordinary training.⁵⁴ “Muscle power and endurance will also be affected by a diminution in protein synthesis and inadequate glycogen and fluid stores.”⁵⁵ Fatigue becomes constant and injuries repair slowly.⁵⁶ “In addition, an eating disordered athlete is likely to become ill more frequently, which negatively impacts her ability to train consistently.”⁵⁷ Ultimately, the loss of strength and concentration due to disordered eating will negatively affect performance.⁵⁸

Eating disorders are coupled with amenorrhea and osteoporosis in a medical grouping known as the female athlete triad.⁵⁹ Inadequate nutrient and energy intake effect hormone production resulting in amenorrhea.⁶⁰ The further consequence of amenorrhea is osteoporosis, which results from decreased estrogen levels in the amenorrheic women.⁶¹ “[L]ong term irreversible health effects are likely in the female who does not achieve peak bone density.⁶² Anorectics have suffered stress fractures just walking down the street.⁶³

Dizziness and loss of consciousness while participating in most sports may lead to serious injury.⁶⁴ Endocrine abnormalities are well documented, and “fluid and electrolyte disturbances can increase the risk of cardiac arrhythmia, renal damage, and impaired temperature regulation to the athlete who stresses her body to maximum levels.”⁶⁵ Unfortunately, by the time the athlete has driven herself to this level of depletion, she is already psychologically caught in an eating disordered

53. See *Eating Disorders in Athletes*. . . , *supra* note 25.

54. *See id.*

55. *Id.*

56. *See id.*

57. *Id.*

58. *See id.*

59. *See id.*

60. *See id.*

61. See Barbara L. Drinkwater et al., *Menstrual History as a Determinant of Current Bone Density in Young Athletes*, 263 JAMA 545, 548 (1990) (Osteoporosis is loss of protein matrix tissue from the bone, causing it to become brittle and easily fractured.); Noden, *supra* note 35, at 56.

62. *Eating Disorders in Athletes*. . . , *supra* note 25.

63. See Noden, *supra* note 35, at 56; Worsnop *supra* note 9, at 1102.

64. See *Eating Disorders in Athletes*. . . , *supra* note 25.

65. *Id.*

behavioral whirlpool.⁶⁶ She is not able to recognize her problem, and is likely to address her failing performance level by losing more weight.⁶⁷

Common medical conditions caused by anorexia nervosa include:

- dry skin and dehydration caused by reduced fluid intake and excessive fluid elimination
- constipation due to the failure to ingest or retain adequate amounts of food and/or fluid
- bloating and distention of the stomach and abdominal area due to malnutrition, long periods of starvation, frequent vomiting and/or excessive use of laxatives or diuretics
- impaired renal function, dulled intestinal nerves and general gastro-intestinal systems problems from laxative abuse
- cramps and muscle spasms from insufficient potassium and protein intake
- dizziness due to low blood pressure
- disruption of normal hormonal secretions including decreased estrogen leading to amenorrhea and osteoporosis
- cardiovascular problems, hypotension, decreased cardiac output, cardiac arrhythmia, and electrocardiogram abnormalities
- complications of self induced vomiting including dental erosion, esophagitis, esophageal laceration, internal hemorrhage, and parotid gland enlargement.
- mild anemia
- significant fluid and electrolyte disturbances.⁶⁸

B. Bulimia

Bulimia is often confused with anorexia because the term is used to describe both a symptom and a syndrome of disordered eating. The word "bulimia" means "gorging" or "insatiable appetite." Bulimia, the symptom, generally describes binge eating. Bulimia, the syndrome, is a serious disorder involving compulsive preoccupation with food and compulsive episodes of overeating followed by a purgative episode.⁶⁹

The clinical diagnostic criteria for bulimia is listed in Table 2.⁷⁰

66. See Thornton, *supra* note 18, at 118.

67. See *id.*

68. See Stephenson, *supra* note 50, at 132; *Eating Disorders in Athletes. . .*, *supra* note 25.

69. Barbara Bickford, *Definitions, Symptoms and Risk Factors for Eating Disorders*, in *EATING DISORDERS AND ATHLETES: A HANDBOOK FOR COACHES* 11, 13 (Susan Chappell Holliman ed., 1991).

70. See DSM4, *supra* note 3, at 549-550.

TABLE 2: CLINICAL DEFINITION OF BULIMIA

- recurrent episodes of binge eating characterized by both eating an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances, and a sense of lack of control over eating during the episode.
- repeated attempts to prevent weight gain by severely restrictive dieting or fasting, self induced vomiting, use of cathartics or diuretics, or vigorous exercise
- the binge eating and inappropriate compensatory behaviors both occur at least twice a week for three months on average
- self evaluation is unduly influenced by body shape and weight
- the binge/purge episodes are not due to anorexia or any other known physical disorder.

Like anorectics, the bulimic has poor self esteem and issues of achievement conflict.⁷¹ Additionally, bulimics suffer from feelings of rejection, and have difficulty expressing anger and frustration. The bulimic has a psychological feeling of inadequacy, and believes she is unable to face her problems or cope with the world directly; she may also suffer from anxiety, depression, or suicidal tendencies.⁷² Bulimics often feel that their life is dominated by conflicts about eating.⁷³ The binge is a direct end-product of this feeling of lack of control; the purge is relief.⁷⁴ Many bulimics have previously been anorectic.⁷⁵

“Bulimics may be overweight, at recommended weight or slightly underweight and their weight can fluctuate frequently due to the binge/purge episodes. Bulimics tend to have a less distorted body image than the anorectics and will focus on their self-diagnosed trouble spots such as the hips, thighs or waist.”⁷⁶ Bulimics are also impulsive as well as compulsive, and will often times abuse other substances such as drugs or alcohol.⁷⁷ They are ashamed of their behavior, and will be extremely secretive and protective of their habits.⁷⁸

71. *See id.* at 546.

72. *See Thornton, supra* note 18, at 118.

73. *See id.*

74. *See Johnson & Tobin, supra* note 38, at 120.

75. *See id.*

76. Bickford, *supra* note 69, at 14.

77. *See DSM4, supra* note 3, at 546.

78. *See id.*

If weight loss were the only consequence of bulimic behavior among female athletes, there would be little cause for concern.⁷⁹ However, research indicates that disordered eating, when combined with strenuous exercise, leads to physical damage that often is only partially reversible.⁸⁰ "Dehydration is common in individuals who restrict food intake, self-induce vomiting, and/or use large amounts of diuretics or laxatives. Attempting to train and compete in a chronically dehydrated state will decrease performance and may lead to acute complications such as heat exhaustion or heat stroke."⁸¹ Dental problems are often seen in athletes who vomit in an effort to lose weight.⁸² "The regurgitation of gastric acid causes enamel to erode, resulting in extensive carries and possibly periodontitis."⁸³ Bulimics may suffer from "menstrual irregularity or amenorrhea [due] to weight fluctuations, to nutritional deficiencies or to emotional stress."⁸⁴ Table 3 outlines some of the more common medical complications related to bulimia.⁸⁵

79. See Worsnop, *supra* note 9, at 1102.

80. *See id.*

81. *Eating Disorders in Athletes. . .*, *supra* note 25.

82. *See id.*

83. *Id.*

84. DSM4, *supra* note 3, at 548.

85. *See id.* at 542-548.

TABLE 3: MEDICAL COMPLICATIONS OF BULIMIA

Complications of binge eating

- severe abdominal pain
- acute stomach dilation
- post-binge pancreatitis

Complications of self-induced vomiting

- severe loss of potassium chloride
- dental erosion
- esophagitis
- parotid gland enlargement

Complications of laxative abuse

- severe depletion of potassium
- cardiac abnormalities secondary to hypokalemia
- cathartic colon
- dependency to stimulate bowel movements

Complications of diuretic abuse

- severe loss of potassium
- dehydration
- edema
- fluid and electrolyte disturbances

Complications of ipecac use

- arrhythmia
- cardiac myopathy.

C. Eating Disorders Not Otherwise Specified

Many athletes display symptoms of eating disorders, but do not meet the strict criteria to be medically diagnosed anorectic or bulimic.⁸⁶ However, athletes with less than clinically definable symptoms may be classified as within the realm of "eating disorder not otherwise specified" (ED-NOS).⁸⁷ "For athletes, even the relatively mild health effect of disordered eating can have a devastating impact" and should not be ignored.⁸⁸ Table 4 outlines the diagnostic criteria for an eating disorder not otherwise specified.⁸⁹

86. See Guthrie, *supra* note 5, at 52.

87. See DSM4, *supra* note 3, at 550.

88. *Eating Disorder in Athletes. . .*, *supra* note 25.

89. DSM4, *supra* note 3, at 550.

TABLE 4: CLINICAL DEFINITION OF EATING DISORDER
NOT OTHERWISE SPECIFIED

This category is for disorders of eating that do not meet the criteria for any specific eating disorder:

- all of the criteria for anorexia nervosa are met except that the individual has regular menses
- all of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range
- all of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months
- the regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food
- repeatedly chewing and spitting out, but not swallowing, large amounts of food
- binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa.

IV. DUTY OF THE COLLEGE OR UNIVERSITY ATHLETICS DEPARTMENT

To date, "[f]ew cases have arisen in which an injured player or his parents seek recovery from the school, . . . particularly in view of the presumed large number of injuries suffered in connection with school athletics."⁹⁰ Furthermore, no case history has been recorded of an athlete or her parents suing her coach, athletics department, or college or university for injuries suffered from eating disorders. Often athletes "may feel reluctant to sue the coach or the school,"⁹¹ or the assumption of risk or contributory negligence defense may inhibit their filing.⁹²

In general, to win a negligence suit a plaintiff must establish the following for factors:

1. a duty or obligation recognized by the law, requiring the actor to conform to a certain standard of conduct;

90. 57 AM. JUR. 2D *Municipal, County, and State Tort Liability* §606 (1988).

91. *Id.*

92. *See id.*

2. a failure to conform to the standard required;
3. a causal connection between the conduct and the resulting injury; and
4. actual loss or damage resulting to the interests of another.⁹³

Beginning with the first factor, the question of whether a defendant owes a duty of care to a plaintiff is a question of law, therefore, a court should determine whether the particular facts give rise to any legal duty on part of the defendant.⁹⁴ Without such evidence there can be no duty because a “negligence claim must fail if based on circumstances for which law imposes no duty of care on the defendant.”⁹⁵

As a general rule, a public high school “only owes a duty of reasonable care to protect student athletes involved in extra-curricular sports from unreasonable, concealed, or unreasonably increased risks, and a school is not liable to a plaintiff who is aware of an appreciates the risk inherent in the activity or where there does not exist a special relationship between the school and the plaintiff.”⁹⁶ Several cases dealing with intercollegiate athletes help define this duty at the college level.

One of the most important cases at the college level is the *Kleinknecht* case. In *Kleinknecht*, the Third Circuit Court of Appeals found that a college has a special relationship with its student-athletes due to its recruitment of the athletes, and therefore, a college owes a duty of care to its athletes.⁹⁷ The Court relied on cases developed in the realm of high school athletics, finding that the college’s active recruitment of the student-athlete balanced out the lack of custodial relationship between the student-athlete and the college.⁹⁸

The *Kleinknecht* case provides a benchmark for establishing when a coach, college or university acts with ordinary care. In this case, the school acted reasonably in requiring a student-athlete to have a medical examination prior to athletics participation.⁹⁹ The medical examination revealed no medical history of heart problems, or symptoms of heart disease.¹⁰⁰ For these reasons, the athletics department personnel had no

93. WILLIAM L. PROSSER, *HANDBOOK OF THE LAW OF TORTS*, § 30, at 143 (4th ed. 1971).

94. *See* RESTATEMENT (SECOND) OF TORTS §328(B) (1965).

95. *Kleinknecht v. Gettysburg College*, 989 F.2d 1360, 1366 (3rd Cir. 1993).

96. Caroline R. Krivacka & Paul Krivacka, *Tort Liability of Public Schools and Institutions of Higher Learning for Accidents Occurring During School Athletic Events*, 68 A.L.R.5th 663, §2[a] (1999).

97. *Kleinknecht*, 989 F.2d at 1366.

98. *Orr v. Brigham Young University*, 108 F.3d 1388, 1997 WL 143600, *2 n2 (10th Cir. 1997)

99. *See Kleinknecht*, 989 F.2d at 1366.

100. *See id.*

reason to know, and could not have known, that Kleinknecht was at risk for a fatal arrhythmia.¹⁰¹

Following *Kleinknecht*, two state Supreme Courts further delineated a college's duty to its student-athletes. In the first case, the Supreme Court of Appeals of West Virginia found that when a state university provides recreational activities to its students it does so in fulfillment of its educational mission, and in performing a public service.¹⁰² As a result, "the University owes a duty of due care to its students when it encourages them to participate in any sport."¹⁰³

The next case decided by the Supreme Judicial Court of Maine made clear that "a college has a legal duty to exercise reasonable care toward its students."¹⁰⁴ As such, "[t]hat duty encompasses the duty of college coaches and athletic trainers to exercise reasonable care for the health and safety of student athletes."¹⁰⁵

A thorough pre-participation medical examination is likely to indicate symptoms of disordered eating.¹⁰⁶ As symptoms of eating disorders are recognizable, this duty of reasonable care could attach and the coach would be expected to act as the reasonable prudent coach in the same or similar circumstance by seeking medical attention for the athlete and guarding against further damage. This would all be in exercising the coach's and school's duty of reasonable care toward the athlete due to the special relationship between the college and athlete and the fact that the school has either encouraged the athlete to participate or specifically recruited the athlete based upon athletic participation. In fulfilling this duty the coach and college must exercise reasonable care for the health and safety of its student-athletes.

In an earlier case, *Stineman v. Fontbonne College*, the Eighth Circuit Court of Appeals found that the college had a duty to provide medical assistance to a hearing impaired athlete who was struck in the eye by a softball.¹⁰⁷ In deciding the case the court noted a three-part test established by the Missouri Appellate Court in *Kersey v. Harbin*:

1. the defendant must have been able to appreciate the severity of the plaintiff's injury

101. *See id.*

102. *See Kyriazis v. University of West Virginia*, 450 S.E.2d 649, 655 (W. Va. 1994).

103. *Id.*

104. *See Searles v. Trustees of St. Joseph's College*, 695 A.2d 1206, 1209 (Me. 1997)

105. *Id.*

106. *See Johnson & Tobin, supra* note 38, at 122.

107. *See Stineman v. Fontbonne College*, 664 F.2d 1082, 1086 (8th Cir. 1981).

2. one or more of the defendants had the skill to provide adequate medical treatment
3. providing medical attention would have avoided the injury's ultimate harm.¹⁰⁸

Although the *Stineman* court decided that it did not need to follow this test it acknowledged that the *Kersey* elements could be met in the present case because (1) the coaches present knew that the ball had hit Stineman with a tremendous impact, (2) the school's medical clinic was across the street from the softball field and so the coaches could easily have transported Stineman to this location for treatment, and (3) if Stineman had received adequate and timely medical treatment there was a substantial likelihood that she would not have lost her vision.¹⁰⁹

This test could also be used to establish a college's duty to athletes with eating disorders. One need only look to the plethora of information available on eating disorders to establish that athletics department personnel are able to appreciate the severity of eating disorders, or that athletics department knew or should have known of the severity of eating disorders. It could be argued that athletics department personnel do not have the skills to provide adequate medical treatment for athletes with eating disorders, and therefore not satisfy the second part of the *Kersey* test. However, the only treatment required in the *Stineman* case was to get the injured person to the medical clinic itself.¹¹⁰ The only skill necessary in the case of an athlete with an eating disorder would be to refer the athlete to treatment.¹¹¹ The third part of the test would also be satisfied: early medical intervention is key to preventing the permanent medical complications and potential death for athletes with eating disorders.

A reasonable, prudent person must be able to foresee an injury or harm in order to conform to the duty a care recognized by law.¹¹² It is not necessary to prove that the very injury which occurred must have been foreseeable by the coach in order to establish that his conduct constituted negligence; negligence is established if a reasonably prudent

108. *Id.* (citing *Kersey v. Harbin*, 531 S.W.2d 76, 81 (Mo. Ct. App. 1975)).

109. *See Stineman*, 664 F.2d at 1086, 1087.

110. *See id.*

111. *See* Ann C. Grandjean, *Eating Disorders — The Role of the Athletic Trainer*, 26 ATHLETIC TRAINING 105, 108 (Summer 1991); Johnson & Tobin, *supra* note 39, at 134; Kathryn Zerbe, *Recognizing Eating Disorders by Athletic Coaches*, ANAD WORKING TOGETHER (Nat'l. Ass'n. of Anorexia Nervosa and Associated Disorders), Sept. 1993, at 1.

112. *See* PROSSER, *supra* note 93, at §31 at 145.

person would foresee that injury of the same general type would be likely to happen under the circumstances.¹¹³

No person can be expected to guard against harm from events which are not reasonably to be anticipated at all, or are so unlikely to occur that the risk, although recognizable, would commonly be disregarded.¹¹⁴ However, if the risk is an appreciable one, and the possible consequences are serious, the question is not one of mathematical probability alone.¹¹⁵ As the gravity of the possible harm increases, the apparent likelihood of its occurrence need be correspondingly less to generate a duty of precaution.¹¹⁶

Information easily available on eating disorders and athletes indicates that coaches should be able to foresee the harm of allowing athletes to participate without medical attention. Prevalence studies show that eating disorders are to be anticipated in athletics populations. The risk is an appreciable one and the possible consequences are serious — the most serious consequence being death.

For an athletics department to be negligent in not exercising its duty of ordinary care for athletes with eating disorders, there must be a causal connection between the conduct of the athletics department personnel and the resulting harm to the athlete. Eating disorders are complex problems with biological, psychological and sociological components. It is not the intent of this paper to show that colleges, universities, or athletics departments are the cause of eating disorders. However, "it is possible for an eating disorder to be triggered by a single event, or by comments from a person who is . . . important to the athlete."¹¹⁷ In following this analysis, coaches are the single most blamed source of eating disorders in athletics populations.¹¹⁸ Careless comments about fat, weight, or athlete's specific body parts may trigger pathological behaviors in athletes that can lead to serious problems with eating disorders.¹¹⁹ Although it may be inappropriate to label any single incident as "causing" an eating disorder, the coach still has a duty of care to his athletes, and breach of that duty is negligence.

113. See generally FOWLER V. HARPER & FLEMING JAMES, JR., THE LAW OF TORTS §§18.2 & 20.5 (1956).

114. See W. PAGE KEETON & WILLIAM L. PROSSER, PROSSER & KEETON ON THE LAW OF TORTS §31 (5th ed. 1984).

115. See *id.*

116. See *id.*

117. Grandjean, *supra* note 111, at 108.

118. See *id.*

119. See *id.*

Furthermore, under the doctrine of respondeat superior, an employer can be held to be responsible for the actions of its employees.¹²⁰ If the coach or any athletics department personnel is found to have acted inappropriately, he could be found to have been negligent, and the college or university could then be found to be vicariously liable for the negligence of the coach, its employee.

As eating disorders are a self-inflicted condition, the college or university faced with this problem may use "assumption of risk" as an affirmative defense. Assumption of risk is fundamentally based on consent, and applies regardless of the care used.¹²¹ In general, "participants properly may be held to have consented by their participation to those injury causing events which are known, apparent or reasonably foreseeable consequences of the participation."¹²² In order to establish the athlete's assumption of risk, "a college or university must show that the athlete was aware of the dangerous condition and the resultant risk, although it is not necessary to demonstrate that the plaintiff foresaw the exact manner in which his injury occurred."¹²³

The reasoning applied in these cases, which generally deal with the physical condition of facilities or equipment, should not be extended to waive the duty of an athletics department to its athletes with eating disorders. The athlete cannot voluntarily consent to participating in intercollegiate athletics with an eating disorder, and assume the risks inherent to that condition, because most victims of eating disorders are unable to realize they have a problem.

Although research indicates that eating disorders are more prevalent in athletics populations, no study indicates that eating disorders are inherent to athletics participation. The college or university would have to prove that the athlete should have been aware of the danger to herself, or that events had occurred which should have forewarned her about the dangers of eating disorders in order to show that the athlete assumed the risk because proper instruction was given.¹²⁴ Unless the college or university provided an eating disorders education program, the athlete

120. See *Bennett v. United States*, 102 F.3d 486, 489 (11th Cir. 1996).

121. See *Kovacs v. Sturgeon*, 79 Cal. Rptr. 426, 430 (Cal. Ct. App. 1969); *Hildebrand v. Minyard*, 494 P.2d 1328, 1330 (Ariz. Ct. App. 1972).

122. See *Schiffman v. Spring*, 202 A.D.2d 1007, 1008 (N.Y. App. Div. 1994) (citing *Turcotte v. Fell*, 502 N.E.2d 964 (N.Y. 1986)).

123. See *Schiffman*, 202 A.D.2d at 1008 (citing *Lamey v. Foley*, 188 A.D.2d 157 (N.Y. App. Div. 1993)).

124. This would seem appropriate in following cases similar to *Pirkle v. Oakdale Grammar Sch. Dist.*, 253 P.2d 1, 4 (Cal. 1953), wherein an athlete was found to have assumed the risk of athletic participation when proper instruction was given.

would not know or have reason to know of the danger to which she was subjecting herself.

Admittedly, some jurisdictions have abolished assumption of risk and treat it either as an aspect of whether the defendant owes the plaintiff a duty of care, or whether there is a question of the plaintiff's contributory negligence in undertaking the risk.¹²⁵ Contributory negligence arises when a plaintiff fails to exercise due care.¹²⁶ It is defined as conduct on the part of the plaintiff which falls below the standard to which she should conform for her own protection, and which is a legally contributing cause in addition to the negligence of the defendant in bringing about the plaintiff's harm.¹²⁷ At common law, any amount of contributory negligence would bar or proportionately limit recovery by the plaintiff.¹²⁸ Therefore, to be exempted by contributory negligence, the college or university would have the burden of proving that the athlete's behavior was a legally contributing cause of her damages. As eating disorders are a medical condition which the athlete cannot control, it is unlikely that a jury would bar the athlete from recovering from the school for breaching its duty of care merely for being sick.

Most states have overcome the harshness of the contributory negligence rule by adopting a comparative negligence rule. Comparative negligence allocates the responsibility for damages incurred between the plaintiff and the defendant based on the relative negligence of the two and reduces the amount of damages to be recovered by the plaintiff in proportion to her fault.¹²⁹ Assuming that a jury would find the athlete negligent for her illness, the seriousness of her injuries and permanent physical damage would likely weigh heavily against the college or university and their "deep pockets."

V. GUIDELINES FOR THE ATHLETICS DEPARTMENT TO MEET THE DUTY OF CARE

The college or university must take responsibility for eating disorders among athletes. To show that they have acted prudently to satisfy the duty of ordinary care under the circumstances, the college should have a comprehensive education, intervention, treatment, and prevention program which includes:

125. See KEETON & PROSSER, *supra* note 114, at 495.

126. See generally *id.* at §65, at 451-452.

127. See *id.* at 451.

128. See *id.*

129. See *id.* at §67, at 468-470.

- an education program for athletics department personnel to meet the duty to provide competent coaching, proper supervision and training.
- a pre-participation physical examination and/or screening program for student-athletes to meet the duty to prevent injured or unfit athletes from participating.
- an intervention protocol and treatment plan to meet the duty to provide medical assistance.
- an eating disorders prevention and nutrition education program directed toward athletes to meet the duty to exercise ordinary and reasonable care for the safety of student-athletes under their authority as well as to address assumption of risk and contributory negligence issues to determine what the athlete knew or should have known.

A. *Education for Athletics Department Personnel*

In order to meet this proposed legal duty athletics department personnel must be educated about the seriousness of eating disorders, understand their role in preventing athletes from striving for unrealistic weight and body shape goals, recognize the warning signs, and be prepared to manage problems that may arise. Because coaches are the single most blamed source of eating disorders in athletics populations, they must be trained to be sensitive to the weight concerns of athletes. The policy of the athletics department must mandate that coaches "put the health and well being of their athletes first, above all other concerns including win/loss records, championships and their own personal coaching reputations."¹³⁰ "[C]oaches should also realize the influence that they have and accordingly be careful of what recommendations concerning weight and body fat they make to their athletes, knowing that there is a possibility that [the recommendations] may be taken to an extreme."¹³¹ The coach should be educated and remain current on issues concerning nutrition, diet and weight control.¹³²

Because coaches have a duty to protect the athlete's overall health, they should never encourage an athlete to try crash weight loss programs.¹³³ Coaches' education about safe weight control and weight loss measures would include:

130. Jennifer Alkema, *Are College Athletes at Risk*, ANAD WORKING TOGETHER (NATIONAL ASSOC. OF ANOREXIA NERVOSA & ASSOCIATED DISORDERS), Fall 1994, at 4.

131. *Id.*

132. *See id.*

133. *See Grandjean, supra* note 111, at 110.

- defining optimum performance weight, but not overplaying the impact of weight on performance
- setting a reasonable time frame for weight reduction with a maximum goal of two pounds lost per week.
- increasing energy expenditure at a moderate rate, not more than 1,000 calories per week above the total caloric intake
- referring athletes to a reputable nutrition source or professional dietitian or nutritionist.¹³⁴

Treatment of eating disorders is much more effective when the disordered behavior is detected early, so athletics department personnel need to be educated to recognize the symptoms and warning signs.¹³⁵

“The most obvious physical symptom of anorexia is an emaciated appearance. The anorectic’s shoulder blades, backbone, and hip bones will protrude, and the muscle groups are clearly visible.”¹³⁶ However, “the athlete with anorexia will not be as thin or light as a non-athletics anorectic because training has increased her muscle mass,” and muscle tissue weighs more than other tissue.¹³⁷ She will have an irrational interpretation of her appearance, and will continue dieting without regard to her health.¹³⁸

Another obvious symptom is secondary amenorrhea due to the heightened physical activity and low body fat of the anorectic. A study comparing regularly menstruating runners with amenorrheic runners showed the 62%, almost two-thirds, of the amenorrheic runners had diagnosable eating disorders as defined by the DSM-III. Although common in athletics populations, amenorrhea should be considered a warning sign and not disregarded as a convenient by-product of training.

Anorectics may suffer from cold intolerance and complain of chills (hypothermia). Their skin may appear blue or gray at their extremities due to acrocyanosis. Anorectics will dress in many layers of baggy, oversized clothing to psychologically cover their perceived fat and to physically stay warm. A thin layer of downy “fur” (lanugo) may appear on the anorectic’s body as a physiological response to help maintain body temperature. Other physical changes include skin rashes and loss or thinning of hair.¹³⁹

134. *See id.*

135. *See* Stephenson, *supra* note 50, at 134

136. Bickford, *supra* note 69, at 13.

137. *Id.*

138. *See* Stephenson, *supra* note 50, at 134.

139. Bickford, *supra* note 69, at 13.

“The anorectic will usually not be able to display a normal range of emotion. The pursuit of thinness becomes a sign of mastery and control and is the [eating disordered athlete’s] way of dealing (or not dealing) with her feelings.”¹⁴⁰ “As a result of her starvation tactics, the anorectic usually suppresses her feelings and may no longer be able to recognize other normal bodily sensations such as hunger, thirst, or pain.”¹⁴¹ She may be moody, irritable and display increased anxiety or depression.¹⁴²

The anorectic may also be described as hyperactive and obsessed with exercise. She is constantly moving, and may workout several times each day. Anorectics are generally restless sleepers and early risers, this behavior has been compared to that of a hungry animal who prowls through the night in search of food.¹⁴³

Weight loss is generally “accomplished primarily through reduction in total food intake.”¹⁴⁴ The athlete may binge by excluding what she perceives to be highly caloric foods, such as carbohydrates, from her diet.¹⁴⁵ She will exhibit disorganized eating patterns, such as skipping meals, or claim adherence to strict diets (such as veganism) and unusual or extreme food preferences.¹⁴⁶ Most anorectics eventually end up with a very restricted diet that is sometimes limited to only a few foods, such as a banana for breakfast, an apple for lunch and lettuce for dinner.¹⁴⁷

Because bulimics usually stay in a normal weight range and are secretive about their binge/purge behavior, bulimia is much harder to physically or behaviorally detect than anorexia. The bulimic may have tremendous mood swings. She may be shy and withdrawn, and feign helplessness. Moments later, the bulimic may become aggressive, angry, anxious and outgoing. Many bulimics are good actresses who may appear carefree and extroverted when they are inwardly unhappy. They may also become so adept at lying (about eating, vomiting, money, weight, etc.) that they sometimes believe that their deceptions are really the truth.

....

Behavioral symptoms specific to bulimia include obsessive rumination, difficulty swallowing and retaining food, and food sensi-

140. *Id.* at 14.

141. *Id.*

142. *See* Stephenson, *supra* note 50, at 134.

143. *Id.* at 15.

144. DSM4, *supra* note 3, at 540.

145. *See* Stephenson, *supra* note 50, at 134.

146. *See id.*

147. *See id.*

tivities. Bulimics will chew their food well beyond what is necessary for digestion (to prepare for regurgitation). Bulimics will generally choose their foods very carefully, and may avoid spicy or textured foods that create discomfort during the purge.¹⁴⁸

Anyone involved with intercollegiate athletes — coaches, athletic trainers, administrators and advisors — should take notice when:

an athlete repeatedly comments about being or feeling fat, especially if the athlete is at normal or below normal weight. The athlete's "self-talk"- verbal expression of feelings and belief systems will provide a series of give-aways to diagnose disordered eating. References to death, killing, or dying, such as "I'll die if I eat another bite," or "I'd kill to be under 100 pounds," should immediately raise a red flag. Coaches should never reinforce or encourage this type of "think thin" behavior.

. . . .

Changes in eating behavior, frequent self weighing or intense fear of, or refusal to be weighed, wide fluctuations of weight over a short period of time, evidence of severe calorie restriction, alternating fasting and feasting, loss of appetite, rapid eating, obsession with dieting or with a particular food, and depression after eating are all easily identifiable behavioral symptoms of disordered eating.¹⁴⁹

An athlete that always excuses herself to the bathroom immediately after eating should be suspect, particularly if her eyes are watery or blood-shot when she returns.¹⁵⁰ Vomitus odor in the bathroom is a more obvious sign of bulimic behavior.¹⁵¹ Frequent complaints of constipation, and evidence of diet pills or laxatives are an indicator of pathological weight control behaviors if the athlete is otherwise healthy.¹⁵²

Eating disordered athletes generally become anti-social, separating themselves from their teammates.¹⁵³ "[They] may stay up alone at night to gain privacy for further bingeing." Disappearance of food from the cupboards and refrigerator, and unexplained cake or candy wrappings hidden under pillows, mattresses, or chairs can also provide clues of binge eating¹⁵⁴

148. Bickford, *supra* note 69, at 15.

149. *Id.* at 17.

150. *See id.* at 16.

151. *See id.*

152. *See id.*

153. *See id.*

154. *Id.*

There are several times during an athlete's career that she (or he) will be predisposed to developing disordered eating behaviors. Freshman or transfer years are extremely stressful as the athlete adapts to new living conditions, friends, routines, and responsibilities. An injured athlete can gain weight due to inactivity and may use pathogenic behavior to "crash diet." An athlete standing on a performance plateau will try almost anything to gain a competitive edge. Eating disorders also have an epidemic effect on a team — if one athlete has a problem, it is likely to spread to her teammates.¹⁵⁵

It is important that athletics department personnel are aware of the behaviors which suggest an athlete has an eating disorder, but they should not attempt to diagnose or treat the athlete.¹⁵⁶ The role of the coach, or other designated athletics department employee such as the athletic trainer, is to help the athlete acknowledge pathological behavior and to assist the athlete in contacting an eating disorders specialist for professional evaluation.¹⁵⁷ If the athlete denies the problem, but the symptoms observed appear conclusive, the athletics department should have access to a trained clinician who can review the situation and recommend further action.¹⁵⁸ This behavior would be considered prudent under the circumstances and most likely would satisfy the athletics department's duty to provide proper supervision and provide medical assistance.

B. Intervention

The athletics department should have a written protocol for athletics department personnel to confront the athlete once disordered eating behaviors are detected.¹⁵⁹ Just as in alcoholism and other self-abuse illnesses, the first and most difficult step toward recovery is for the athlete to acknowledge that there is a problem.¹⁶⁰ The designated representative from the athletics department, the coach, athletic trainer, or other staff member who is close to the athlete, "should initiate communication about the eating disorder."¹⁶¹ It is important for the meeting to be pri-

155. *Id.* at 11-12.

156. *See NCAA Concerned About Eating Disorders*, 7 MIRROR IMAGES (Anorexia/Bulimia Support, Inc.), Fall 1991, at 1.

157. *See id.*

158. *See id.*

159. *See NCAA Concerned About Eating Disorders*, *supra* note 156, at 10.

160. *See* Barbara Bickford et. al., *Strategies for Prevention/Intervention*, in *EATING DISORDERS AND ATHLETES: A HANDBOOK FOR COACHES*, *supra* note 69, at 23, 27.

161. *Id.*

vate, "to establish a confidential and mutually respectful relationship."¹⁶² The designee "should be direct by telling the athlete that [they are] aware of her problem and that [the university or athletics department] is available to help and support her recovery."¹⁶³ It is not helpful to ask the athlete if she has a problem, as most athletes do not recognize that they have a problem and the question only provides the opportunity for more denial.¹⁶⁴ "A direct approach such as, 'I've noticed . . . (these specific behaviors) . . . and would like to help you overcome your eating disorder,' is much more effective."¹⁶⁵ A full explanation of the behaviors or patterns that generated suspicion of the problem should be given.¹⁶⁶ "The typical anorectic will deny that a problem exists. She is likely to get very angry and defensive. She will lie about anything to keep the coach from helping her."¹⁶⁷ Athletics department personnel must not ignore the warning signs or allow the athlete to continue her pathological behaviors, but firmly insist that she receive help.¹⁶⁸ Again, if the athlete denies the problem, but the symptoms observed appear conclusive, the athletics department should have access to a trained clinician who can review the situation and recommend further action. The bulimic, on the other hand, generally harbors so much guilt that she may be more receptive toward intervention.¹⁶⁹ The athletics department should have a system of medical referral available for the athlete to obtain a comprehensive diagnostic evaluation.¹⁷⁰

A pre-participation examination is another way for the athletics department to identify disordered eating symptoms, and protect the college or university from liability for allowing an unfit athlete to participate in intercollegiate athletics.¹⁷¹ The physician screening for eating disorders "should obtain the woman's menstrual history, including age of menarche, frequency and duration of menstrual cycles, last period, and any hormonal therapy that she may be taking."¹⁷² If the college or university does not require pre-participation medical examinations, the athletic trainer may screen for symptoms of eating disorders. Standard tests such

162. *Id.*

163. *Id.*

164. *See id.*

165. *Id.*

166. *See id.*

167. *Id.*

168. *See id.*

169. *See id.*

170. *See Skolnick, supra note 5, at 922.*

171. *See id.*

172. *Id.*

as the Eating Disorder Inventory, as well as complete menstrual history, may be used to detect pathological behavior.¹⁷³ If the pre-participation screening is positive, the athlete should be referred to a specialist for a comprehensive diagnostic evaluation.¹⁷⁴

C. Treatment

Diagnosis should only be made by a physician or psychologist trained in eating disorders.¹⁷⁵ "Having these key individuals in place will help ensure that the athlete will receive the proper treatment," and that the athletics department meets its duty to provide medical assistance.¹⁷⁶ "Given the multi-determinant nature of eating disorders, clinicians have found that effective treatment requires a comprehensive initial assessment as well as a range of biopsychosocial treatment interventions."¹⁷⁷

The initial evaluation by an eating disorders specialist will "be comprehensive in covering relevant factors that have influenced the course of the disorder and that would affect the course of treatment."¹⁷⁸ A typical assessment may include evaluation of the following factors:

- **Weight history** — questions about the patient's current, highest, lowest and desired weight to provide a historical record of how weight preoccupation and fluctuations have affected the patient's self esteem and life adjustment.
- **Body image** — perception ranges from mild distortions to severe delusions and can reflect the patient's overall adjustment. Though patients have traditionally been preoccupied with being thin as a way of managing intrapersonal and interpersonal difficulties, athletes who train in the search of other forms of physical perfection may be just as pathological.
- **Dieting behavior** — what age a patient began dieting, the frequency of dieting attempts, the degree of restriction, the use of fad diets, and the general pattern of dieting behavior as well as the training demands of the athlete's sport
- **Binge eating** — assess the major life circumstances surrounding the onset of the behavior, the athlete's daily routine, and the specific pattern of the episodes.
- **Purging behavior** — the means an athlete uses to purge unwanted calories including vomiting, restrictive dieting, exces-

173. See Guthrie, *supra* note 5, at 46.

174. See Skolnick, *supra* note 5, at 922.

175. See Grandjean, *supra* note 111, at 108.

176. *Id.*

177. Johnson & Tobin, *supra* note 38, at 119.

178. *Id.*

sive exercise, use of laxatives, diuretics and diet pills and the context and pattern of the behavior to determine whether it is pathological.

- **Medical issues** — evaluation of the athlete's physical condition for medical complications.
- **Personality disorders** — the presence of a personality disorder forecasts a slow, difficult treatment. This may be even more critical for the athlete because eating disorders, binge eating, dieting, vomiting or using laxatives, or excessive exercise may be part of a normal training regimen. It must be determined whether eating or exercise constitutes excess or abuse by considering the extent to which the training regimen is serving a defensive or compensatory function. Evidence of stormy, chaotic interpersonal relationships may suggest that training and dysregulated patterns of eating are substitutes for close, interpersonal relationships. A history of self-injury or other self-destructive behavior is of great concern. A formal assessment battery of projective and objective testing instruments may be helpful.
- **Family characteristics** — family history, family dynamics, and the patient's current level of family involvement also play a crucial role in the onset and maintenance of eating disorder symptoms.
- **General level of adaptive function** — the extent to which the athlete is able to work, go to school, or engage in interpersonal relationships, as well as if the athlete is willing and motivated to change, and what intellectual, emotional and financial resources she can bring to treatment.¹⁷⁹

Once the athlete is diagnosed with an eating disorder, a team treatment approach seems to be the most successful.¹⁸⁰ Doctor, nutritionist, psychologist and athletics department need to work together to create an effective treatment program and to be sure that the messages sent to the athlete are consistent.¹⁸¹ Treatment will be "most successful when the athlete feels that the clinician understands the central role of athletic competition in supporting identity and self-esteem."¹⁸² It should be recognized that there is a therapeutic aspect of participation in sport, but that continued training could be dangerous for the athlete.¹⁸³

179. *Id.* at 122-25.

180. *See* Grandjean, *supra* note 111, at 110.

181. *See id.*

182. Johnson & Tobin, *supra* note 38, at 125.

183. *See id.*

Stabilizing any dangerous medical conditions is the initial goal of a treatment program; achieving a healthy target weight is next.¹⁸⁴ To stabilize dangerous medical conditions, it is imperative to stop any further weight loss.¹⁸⁵ A diet and workout program that addresses nutritional needs and caloric intake and expenditure must be established.¹⁸⁶ "For example, a runner who is fifteen pounds under the recommended weight range for her height and body type and is still losing must have an intake/expenditure program worked out that will allow her to maintain present weight."¹⁸⁷ After maintaining that weight for two weeks, efforts can then be made to slowly increase intake to achieve the target weight.¹⁸⁸ Weight gain should be approached very cautiously, as the athlete is likely to cheat if she thinks the eating disorders support team is trying to make her fat.¹⁸⁹ The athlete's progress should be carefully monitored.¹⁹⁰

Recovery is an educational process, and the athlete is more likely to cooperate the more she knows about the potential serious medical risks of her behavior. The consequences of continued weight loss [should be] clearly defined, with emphasis on the deterioration of her performance. An absolute bottom weight limit is set and if she sinks below that weight, she should be taken to the infirmary, doctor, or clinic.¹⁹¹

When the athlete's weight is stable, the eating disorders support team can create a plan to increase weight.¹⁹² It is generally recommended that only "100 calories per day be added to the present diet."¹⁹³ This small caloric increase will prevent a huge instant weight gain, which may psychologically reduce the athlete's willingness to continue treatment.¹⁹⁴ It will also enable the body to physically deal with added nutrients and calories.¹⁹⁵ The ultimate goal is a minimum level of body fat consistent with high energy availability, good performances and good health.¹⁹⁶

184. See Bickford et. al., *supra* note 160, at 29.

185. See *id.*

186. See *id.*

187. *Id.*

188. See *id.*

189. See *id.*

190. See *id.*

191. *Id.*

192. See *id.*

193. *Id.*

194. See *id.*

195. See *id.*

196. See *id.*

Athletics department personnel and others, such as teammates or family members, that interact with the athlete should be educated about the psychological and physiological changes that occur while the athlete is recovering.¹⁹⁷ "As hormone levels change to a normal range, there will be tremendous mood swings. The athlete may have trouble sleeping, and she may feel feverish due to an increase in body temperature."¹⁹⁸ The bulimic may experience a more traumatic recovery than the anorectic.¹⁹⁹ Many will be unable to keep food down, even if they want to, as the gag reflex is retrained.²⁰⁰ Nausea and other gastro-intestinal problems are common.²⁰¹ "An athlete who has chosen to compete as an outgrowth of her need for excessive exercise may psychologically need to give up that particular sport to recover. . . . Most athletes who are involved in eating disorders will return effectively to competition without the disorder."²⁰²

Every eating disorder treatment plan should be unique to the individual athlete. Treatment may include several of the following common interventions:

- **Time-limited Psychoeducational Group Therapy** — most useful for bulimics who are 18 - 30 years old, have high motivation for change, who are at or near normal weight, and who do not have a personality disorders. Psychoeducational groups help patients to understand the cognitive, emotional and interpersonal triggers of their symptoms and to develop normal eating patterns and alternative strategies for coping with negative influences or conflicts. Strategies include self-monitoring, goal setting, educating about nutrition and the consequences of restrictive dieting, and challenging irrational beliefs about thinness and dieting. These groups work best for athletes when there is at least one other athlete in the group.
- **Individual psychotherapy** — used to treat both the symptoms of eating disorders and the underlying psychological and emotional problems. Athletes who rapidly form a working alliance with the therapist can reduce and quickly eliminate bingeing and purging in one to four months. Eliminating restrictive eating in low weight bulimics and anorectics usually requires a longer course of individual therapy.

197. *See id.* at 28.

198. *Id.*

199. *See id.*

200. *See id.*

201. *See id.*

202. *Id.*

- **Nutritional counseling** — counseling by a nutritionist or a well-informed nurse or therapist is an important component in the overall confrontation of the patient's illogical assumptions about food and weight
- **Medical monitoring** — athletes with very low weight, those who binge and purge several times a day, those whose laxative abuse is severe or prolonged, and those who have other illnesses should be seen regularly by an internist familiar with eating disorders.
- **Psychopharmacological treatment** — those athletes prone to major depressive episodes or panic attacks and chronic anxiety may find anti-anxiety or anti-depressant medication useful.
- **Hospital care** — when an athlete suffers from medical complications that endanger her life, or is self-injurious or suicidal, hospitalization should be employed.²⁰³

Treatment is generally a long, slow process. "Literature indicates that at one to two year follow-up, approximately one third of [eating disordered] patients will be completely recovered, one third will be significantly improved, and one third will be unchanged."²⁰⁴ Once an athlete has been diagnosed with an eating disorder, it is important that the athletics department encourage and monitor the athlete's progress throughout their entire intercollegiate athletics career to satisfy the duty to provide medical assistance.

D. Prevention

With eating disorders, an ounce of prevention may literally be worth a pound of cure. Perhaps the most effective way of reducing the university's potential liability for athletes with eating disorders is to prevent eating disorders. An education program emphasizing diet, nutrition, weight loss, and athletics performance should be made available to all athletes, either en masse, as small groups or teams, or through individual counseling.²⁰⁵ The results of the Guthrie study indicate that "athletes have some awareness of eating pathology and would be receptive to nutritional education and guidance, training emphasizing total fitness and body composition rather than body weight or body fat alone, positive interactions between athletes and athletics personnel on weight control issues, and stress management counseling."²⁰⁶ The program should in-

203. See Johnson & Tobin, *supra* note 38, at 125-127.

204. *Id.*

205. See Grandjean, *supra* note 111, at 108.

206. Guthrie, *supra* note 5, at 56.

clude discussion about food myths, eating and dieting, psychological and sociological pressures about thinness, body fat and its relationship to athletic performance, myths about pathological weight control behavior, and the physical consequences of disordered eating.²⁰⁷

“The type of educational program can range from formal to informal; many local programs as well as national organizations provide educational programs at a minimal cost. There are a number of books, articles, and pamphlets written on eating disorders, and symposiums and workshops are frequently offered on the subject.”²⁰⁸ The NCAA also has a three-part video series, *Nutrition and Eating Disorders*, which is targeted to athletics department personnel.²⁰⁹ Educating student-athletes about the destructive effects of disorder eating behavior may prevent them from falling into the downward spiral, and it may also protect the athletics department by satisfying the duty to exercise reasonable care for the safety of student-athletes under their authority.

VI. CONCLUSION

The prevalence of eating disorders in athletics populations is alarming and cannot be ignored. Information about eating disorders is readily available. Colleges and universities must take responsibility and educate their employees to conduct their athletics programs in a manner that recognizes the athlete’s health and safety. Recognition of eating disorders, intervention and treatment plans should be established, as well as preventative education programs. The legal duty of the athletics department should be to exercise ordinary care as the reasonably prudent person in the same or similar circumstances. A reasonable person would not look the other way.

207. See Bickford et. al., *supra* note 160, at 23.

208. Grandjean, *supra* note 111, at 108.

209. See *id.*