


Olympic Park Sports Medicine Centre
Melbourne and East Melbourne Campuses

Addictive Behaviours at Sporting Clubs: Eating Disorders & Overtraining



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Possible presentation:

- Changes in weight, particularly a dramatic loss in weight over a short time
- Weight loss secondary to another illness eg. Flu, CFS then 'difficulty' returning to previous weight
- Desire to lose weight, despite being unnecessary, dangerous or misguided eg. for sport
- Dragged along by parent who has picked up symptoms

Eating / Food Related Features

- Preoccupation with food thoughts
- Decreased awareness of fullness and hunger signals
- Avoidance of eating (i.e. Extreme dietary restriction)
- Avoidance of foods judged as "forbidden"
- Avoidance of eating in social situations or when the content of food eaten cannot be controlled
- Binge eating (i.e. large amount of food and loss of control)
- Experiencing extreme amount of guilty after eating
- Slow eating (in anorexia)
- Fast eating (in bulimia)
- Rearranging or "playing" with food on the plate
- Hoarding food

Psychological Features

- Low self esteem
- Depression / irritability / moodiness
- Social Isolation / avoidance
- Interpersonal problems
- Lack of Assertiveness
- An unhealthy need for approval
- Impaired performance at work / school / etc.
- Anxiety problems
- Suicidal thoughts or behaviours
- Hypersensitivity to criticism
- Perfectionism characterised by unrealistically high expectations of self (and sometimes others)
- Fear of being more independent or taking responsibility for self
- Drug misuse

Interventions – AN vs BN

The most appropriate intervention used in anorexia nervosa & bulimia nervosa are very different.....

AN

- High hospitalisation, recidivism & fatality rate
- Requires a high level of medical involvement
- Weight gain is almost always necessary
- Clients often present in a state of denial
- Often requires medication – depression (75%), anxiety (100%) therefore need to be closely monitored

BN

- Often present at a "normal" weight, therefore the severity can be underestimated
- Requires a strong psychological approach
- Often centred around body image, sense of self, self esteem
- Nutrition focussed on "normalising" eating patterns and addressing negative eating behaviours eg. EIP
- Can continue for many years if left untreated

Intervention – Nutrition....

First priority = nourishment
Second priority = weight restoration to weight agreed upon by practitioner & client

Issues to address:

1. Client has extreme fear of gaining weight, fuelled by irrational thoughts around food & eating

Examples:

- Any food with more than 1g of fat will make me fat
- If I start eating I will lose control and won't be able to stop
- If anyone sees me eating they will think "why is she eating that?"

2. Client has usually lost touch with "normality" re. weight, body image, food variety, feelings of fullness etc. This requires lots & lots of counselling using objective examples and generating challenges for the client to get their own evidence eg. if I eat a little more my weight will not get out of control

- Requires strong degree of trust & rapport
- Do not usually disclose weight to client

Practical Suggestions for Practitioners....

These suggestions are to be used by a variety of practitioners in communication with one another

1. Detection and Early Intervention is essential
2. Medical Screening and Assessment
 - eating disorder history (from patient & parent/carer)
 - family dynamics / social support
 - medical history
 - physical examination
 - special tests (full blood / ESR / urea & electrolytes / bone density / ECG)
3. Ascertain patient's motivation for recovery & assist to motivate the patient
4. Negotiate weight gain with anorexic patients
 - Accept chronic nature of anorexia nervosa
 - Develop rapport, trust & collaborative relationship
 - Educate about the effects of starvation
 - Negotiate target weight at minimum safe medical weight (note: this will NOT usually be as a BMI of 20)
 - Encourage periodic weighing by ONE trusted practitioner eg. Dietitian OR Doctor. Would advise no disclosure as this serves to distress patient.
 - Encourage patient & family responsibility
5. Bulimia / Other Eating disorders
 - Control eating behaviour and delay weight loss attempts, link in with with Dietitian & Psychologist for practical behaviour change strategies for patient
 - Encourage periodic weighing to reassure patient
 - Encourage self-acceptance and living current full life
6. Discourage Dieting and Normalise Eating Behaviour

Practical Suggestions for practitioners....

7. Binge Eating and Oversetting management Strategies
 - Self monitoring re. moods, feelings
 - Identification and use of alternative behaviours
 - Problem Solving and dealing with underlying issues
8. Managing Self-Induced Vomiting and Laxative Abuse
 - Identifying sources of support
9. Contraception Issues
 - Self induced vomiting and laxative use that result in diarrhoea counter the effectiveness of oral contraceptives.
10. Use of Medication in treating Eating Disorders
 - Anorexia: medication not often used except when depression is also an issue for the patient. Dietary supplements are more commonly used.
 - Bulimia and Binge Eating: antidepressants have been shown to reduce the frequency of bingeing episodes (Prozac has the strongest support for this). If there is no psychological support for these patients the rates of relapse are very high when medication is withdrawn.
11. Dental implications for Anorexia & Bulimia
 - Enamel erosion
 - Salivary gland enlargement
 - Xerostomia (dry mouth) / decreased salivary flow
 - Oral mucosa irritation
 - Cheilosis (cracking lips / fissures at angles of lips)

Practical Suggestions for Practitioners....

Other notes:

Be aware of language & behaviour – we are aiming for a relationship of trust & rapport, not one of judgement & blame

Ensure that the client is very involved in the treatment

Honesty is essential at all times

If in doubt, refer! There are practitioners who can assist you in the treatment of you client. Don't take on more than you can handle!

When is a referral appropriate?

- Sudden reduction or increase in weight, particularly if accompanied by a level of distress and/or an unidentified cause.
- Anyone who presents at either a "normal" weight or who is underweight but describes themselves as "fat" or "overweight."
- Anyone who is diagnosed with an eating disorder according to the DSM IV criteria.
- When a parent, carer or coach has noticed changes in physical and emotional state of the patient, regardless of whether the patient agrees.
- * Many patients may present in a state of denial, therefore it is imperative to seek counselling and an integrated level of care as soon as possible.

Practical suggestions – steps to take.....

See patient, suspect an eating disorder or disordered eating
Conduct medical review as previously discussed

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Recommend to see a Psychologist & Dietitian for assessment – explain that this is PART of the intervention and that we work as a TEAM.

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If refuses, continue to monitor medical status on a weekly basis, particularly if at very low weight

If accepts, contact practitioners for handover and continue to liaise.

Overtraining

Personal characteristics that may place individuals at-risk for experiencing excessive stress include:

- Low self-performance expectations
- Low self-esteem
- Frequent worries about failure
- Frequent worries about adult expectations
- Less perceived fun
- Less satisfaction with winning, regardless if competition was won
- Perceived importance of sport to parents

Physiological / Psychological Changes

Caused by constant competition and excessive training. General signs and symptoms of overtraining include (Fry, Morton, & Keast, 1991):

- Difficulty concentrating during training
- Tension during training
- "I don't care" attitude
- Lowered self-esteem
- Feelings of depression
- Fear of competition
- Mild leg soreness, general achiness
- Pain in muscles & joints
- Washed-out feeling, tired, drained, lack of energy
- Sudden drop in ability to run 'normal' distance or times
- Insomnia
- Headaches
- Inability to relax, twitchy, fidgety
- Insatiable thirst, dehydration
- Lowered resistance to common illnesses; colds, sore throat, etc.

Signs and Symptoms

Feelings	Thoughts	Behaviours	Physical
Anxiety	Limited attention span	Pacing	Tight Muscles
Fear	Self-criticism	Nail-biting	Sweaty palms
Moodiness	Poor decision-making	Nervous laughter	Heart Pound
Irritability	Fear of failure	Crying	Trembling
Worry	Making mental errors	Restlessness	Headaches

Other factors that are related to burnout in individuals and youth include (Weinberg & Gould, 1995):

- Overtraining
- Differing coaching styles
- Perfectionism
- Parental pressure
- Performance expectations by self and others

Overtraining Syndrome

Up to 90 signs and symptoms of OTS have been identified, of which the most common are:

- Decreased physical performance
- General fatigue, malaise and loss of vigour
- Insomnia
- Change in appetite
- Irritability, restlessness, excitability, anxiety
- Loss of body weight
- Loss of motivation
- Lack of mental concentration
- Feelings of depression.

Advice to Coaches

- Maintain accurate records of performance during training and competition and be prepared to adjust training intensity/volume when performance declines;
- Encourage and reinforce optimal nutrition, hydration and sleep;
- Be aware that multiple life stressors – including, work, home and family pressures – may add to the stress of physical training;
- Treat OTS with rest – but try to find ways to make it appealing to athletes. 'Active recreation' may aid recovery and help deter monotony;
- Encourage athletes to communicate with you about their physical, mental and emotional concerns;
- Consider questionnaires or interviews – after consulting a psychologist – to determine changes in mood states.