



USSA: EATING DISORDERS

Eating Disorders

A substantial section of the athletic population is not eating adequately. Why not?

- Some individuals are not putting enough time into food preparation, perhaps because they are too busy, too tired or lack sport nutrition skills and food preparation skills.
- Some athletes believe in the myth that 'thin means fast'. While excess body fat may hinder performance in many sports, excessive weight loss and radical methods of weight loss are also detrimental to performance.
- Some individuals are experimenting with abnormal dietary practices in the pursuit of weight loss and / or health. They are putting themselves at further risk of nutritional complications and ill health.
- Some athletes may be suffering from a clinical condition called an eating disorder.

Eating disorders affect a large number of Americans. The true prevalence within the American population is unknown due to the variety of definitions for eating disorders used by researchers and due to the tendency of affected individuals to hide their condition. The incidence of recognized eating disorders in the American population has been predicted to be 0.1%; in athletes overall, 13 - 20%; and in athletes in weight category / aesthetic sports, 15 - 60%.

To understand the topic of eating disorders one needs to understand the difference between normal and disordered eating. Many athletes can lose sight of what normal eating behavior is.

Normal Eating

Normal eating usually consists of the following behavior:

- Eat when you are hungry
- Eat until you are satisfied
- Demonstrate moderate constraint in food selection
- Over eat at times and also under eat at times
- Trust your body to make up for your inaccuracy in eating
- Leave food on your plate, knowing you can eat again later
- Be flexible about eating when you are hungry, when it fits your schedule, and when there is food around



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Disordered Eating

Certain athletes display compulsive and obsessive behavior and therefore are at high risk of disordered eating patterns. Disordered eating is especially seen in two groups: athletes whose sports have an emphasis on body weight / composition, and female teenagers who face the additional social emphasis placed on slimness.

Disordered eating is defined as a spectrum of sub-clinical abnormal eating behaviors. It is differentiated from an 'eating disorder' by the degree and frequency of the abnormal eating behavior.

Examples of disordered eating include:

- Repetitive fad dieting
- Inability to eat adequately in public
- Fat & sugar phobias
- Patterns of alternating starvation & overeating
- Excessive supplementation with vitamins, minerals and/or herbs
- Excessive exercise
- Laxative abuse

For many individuals disordered eating remains undiagnosed, as the intense physical and mental stresses people endure mask it. Prolonged disordered eating can lead to nutrient inadequacies and impaired psychological function, which consequently affects work capacity and health. As a consequence these individuals experience decreased exercise capabilities, gastrointestinal complications, low self-esteem, and in the case of females, amenorrhea (loss of the menstrual cycle or not obtaining it by 16 years of age) and osteopenia (bone mass reduction).

Eating Disorders

Eating disorders may be defined as gross disturbances in eating behavior. The five main types of eating disorders include:

- Anorexia nervosa
- Bulimia nervosa
- Obesity
- Pica
- Eating disorders not otherwise specified (EDNOS)

The focus of this education sheet is on anorexia nervosa and bulimia nervosa. Discussion will also occur on eating disorders that are not defined and are sub acute modifications of anorexia and bulimia nervosa. Examples include binge eating disorder and anorexia athletica.



Anorexia Nervosa

Anorexia nervosa (AN) is a psychological and physiological syndrome characterized by bizarre eating habits, distorted body image, self-imposed starvation, vigorous exercise, abuse of laxatives or diuretics, and/or voluntary vomiting. According to the American Psychiatric Association, the criteria for diagnosis are:

- Disturbance of view of body size or shape
- Refusal to maintain / gain the minimal body weight for age and height
- Intense fear of weight gain or becoming fat
- Absence of at least 3 menstrual cycles for females.

Warning signs are not diagnostic criteria, but if an individual is demonstrating these signs regularly then professional assistance should be sought:

- Dramatic loss of body weight (25% of body weight)
- Preoccupation with food, calories & weight
- Avoiding food-related social events
- Excessive and relentless exercise
- Mood swings
- Denial of illness
- Self-centeredness
- Classification of foods as good and bad
- Obsessive-compulsive behavior in lifestyle factors outside that of food

Bulimia Nervosa

Bulimia nervosa (BN) is an eating disorder involving episodes of binge eating (rapid consumption of a large amount of food in a short period of time) followed by a need to rid the body of excess calories such as: self-induced vomiting, laxative abuse, strict dieting/fasting and/or excessive exercise.

The American Psychiatric Association criteria for bulimia nervosa include:

- Recurrent episodes of binge eating, i.e. a minimum average of 2 binge eating episodes a week for at least 3 months
- Feeling a lack of control over eating behavior during the eating binges
- Regular use of self-induced vomiting, laxatives or diuretics, vigorous exercise, or strict dieting or fasting in order to prevent weight gain
- Persistent over concern with body shape and weight.

Warning signs are not diagnostic criteria, but if an individual is demonstrating these signs regularly then professional assistance should be sought:



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- Fluctuation of weight gain & loss (In general, the weight is within the 'normal' weight range.)
- Excessive concern about weight
- Cycle of strict dieting and binge eating
- Increased self-criticism of body shape and size
- Tooth erosion
- Depressive moods and/or self deprecating thoughts
- (May) visit toilets after meals

The warning signs for bulimia are far less visible than for anorexia due to the weight being near the normal range. Like anorexia, bulimia is strongly influenced by low self-esteem and poor body image. Often these conditions are triggered by 'life crises'. The distress of the binge-purge cycle adds to the feelings of guilt, worthlessness, and depression.

Eating disorders not otherwise specified (EDNOS) account for approximately 50% of eating disordered case. They are generally sub-acute cases of anorexia and bulimia nervosa. Examples include: binge eating disorder and anorexia athletica.

Binge Eating Disorder

Binge eating disorder is a newly defined condition. These individuals have a history of over eating but use no compensatory measures to lose the excess calories eaten. Consequently these individuals are either overweight or obese. Research is in the early stages with this condition.

Anorexia Athletica

Anorexia athletica is also a newly recognized condition. This condition affects sport people and it is a combination of anorexia and bulimia nervosa. An energy restriction diet and a high training load lifestyle are interspersed with binges. The binges are often not as extreme as those seen in BN, and may consist of 'healthy' foods. These individuals often abuse exercise and food and are often very lean in appearance.

Causes of Eating Disorders

There are a lot of theories about the origin of eating disorders and often the causes are multi-dimensional. The theories cover:

- Psychological factors e.g. low self-esteem
- Social influences e.g. peer influence
- Environmental conditions e.g. living away from home
- Traumatic event e.g. family separation
- Media e.g. female fashion magazines
- Competitive sport e.g. coaches, parental and/or self-induced pressure to succeed



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Athletes are potentially a high-risk group because of the following conditions:

- (Unrealistic) body composition requirements for their sport
- Intense pressure to succeed
- The sporting environment can breed eating disorders
- The compulsive and obsessive personality of athletes

Treatment:

Treatment involves a multi-disciplinary team. The team members consist of: psychologists, dietitians, and a physician. The doctor provides physical assessment, provides medication at times of need, and provides support in diagnosis. The dietician focuses on body composition, nutritional status, and meal plans. The psychologist treats with cognitive behavioral or family therapy.

Prognosis:

Eating disorders are often chronic in nature and therefore a long-term management and maintenance treatment program is required. Approximately two-thirds of patients have persistent food and weight preoccupations. Many will continue to have social phobias, obsessive-compulsive symptoms and/or substance abuse. For uncomplicated cases, symptomatic improvement is generally seen over a number of years.

The Role of The Coach

It is very important that coaches perform the following:

- Build trust and mutual respect
- Get the athlete to obtain appropriate treatment
- Assist with the exercise rehabilitation process
- Adopt procedures to improve self-esteem and worth
- Provide education to other athletes on the team
- Look after them, as it is very demanding having an athlete with an eating disorder on the team



Stories of Eating Disorders in Sport

Males generally reach their athletic peak after puberty when their bodies have grown and strengthened. However, for certain sports females rise to the highest echelon at a young age. This is commonly seen in sports such as: gymnastics, figure skating, tennis and swimming. For these elite athletes childhoods are lost in the pursuit of a shot at glory. These athletes are reported to be perfectionists and are at risk of burnout, lifetime injuries and potentially eating disorders. The young elite athlete can become caught in the American obsession with winning and the cultural fixation on beauty and weight. The sports national governing bodies, parents and coaches, who all should be looking after these athletes, can lose their way in ambition and politics. Below provides two examples of female athletes who experienced eating disorders.

Christy Henrick

Christy was once an elite American gymnast, who lost her life to anorexia nervosa. In reflection, she was a prime candidate for anorexia; she was a perfectionist and a person who gauged her worth on other people's judgments. When Christy retired from the sport of gymnastics her weight kept dropping. She went in and out of the hospital with a weight of less than 60 lbs. In her mind gymnastics was the blame for her eating disorder. After nearly five years of starving, Christy lost her life at 52 lbs to multiple organ failure.

(Reference: Little Girls in Pretty Boxes by Joan Ryan; 2000, Warner Books, U.S.A.)

Eli Best

At 14 years of age her parents separated and Eli threw herself into sport, as everything else in life seemed to be falling apart. Off the court she began to self-destruct. She began to smoke, drink and become disruptive in school. Basketball helped control her careless behavior. Eli was offered a position in the Australian national program and left home at 15 years of age feeling like this opportunity was a saving grace. Injury, puberty and consequent weight gain caused the coaching staff to inform Eli that she needed to lose weight. Her method of trying to lose the weight the coaching staff requested was Bulimia nervosa. Eli left the Institute depressed and confused and commenced life back at home less than a year later. At 16 years of age she continued to be sick and injured and was diagnosed with Chronic Fatigue Syndrome. A few years later she developed the life-threatening condition called anorexia nervosa. At 21 years of age, at the time of wanting her family to allow her to die, the recovery process began. She recognized she hated almost every aspect of herself and had for most of her life. How was she going to recover when she did not respect whom she was fighting for. Her journey began with learning to love and respect herself. She chose to live. Today the experience of anorexia has become a distant memory.

(Reference: Eli's Wings by Elizabeth Best; 2002, Penguin Books, Australia)