Activity Levels, Sports Involvement and Eating Disorder Recovery

There are few clear guidelines that provide direction for this fairly controversial and largely unstudied area. As a result, different approaches are followed depending on whether the individual concerned is a child, adolescent or adult, recreational or elite athlete, in stable or unstable medical condition. Some points for your consideration:

1. **Goal:** The goal is to promote a healthy approach to active living so that health benefits and not health costs can be derived. This includes the promotion of activities that develop optimal bone (some impact) and cardiac health, are social and not isolatory, are time limited and not inappropriately physically taxing and have a positive impact on emotional well being. Promoting this approach among compulsive, obsessive and excessive exercisers is exceptionally challenging, the goals however remain the same with safety being the most paramount.

2. **Medical Acuity:** No matter the age or athletic status, an individual in an acute and medically compromised state is not to be engaging in strenuous physical activity. Acute status might include but is not limited to: recent episode(s) of fainting; cardiac instability; electrolyte disturbances due to multiple daily binge-purge episodes, frequent daily laxative abuse; absence of adequate nutritional intake and/or chronic dehydration.

3. **Nutritional Rehabilitation:** This is the first treatment of choice and must be clearly defined. Health goals including body weight and medical status need to be established at the outset and can be linked to activities that are to be curtailed or resumed. It is best for everyone to know up front what the rules are.

4. **Excessive Exercisers (McGough, 2004; Shroff et al., 2006):**
   - choose to pursue activities in isolation
   - are motivated to be active, based on compensation for calories consumed
   - limit other age appropriate activities in order to exercise
   - exercise at inappropriate times and in inappropriate places
   - struggle to resist the urge to exercise
   - exercise despite injury or medical instability
   - may be in the latter stages of their illness if they have a chronic eating disorder history

5. **Athletes:** In the case of <u>some</u> athletes full cessation of participation in their chosen sport may not be required (Alleyne, 2006):
   - If the athlete is found to have disordered eating rather than an eating disorder i.e. may have eating patterns that do not match their caloric expenditures but are not demonstrating significant body image disturbance <u>and</u> are not acutely medically compromised
   - If they are willing to receive nutritional education to learn how to better match nutritional intake with athletic activities
   - If once they are provided with relevant education are willing to take active steps to improve their nutritional intake

- If they understand and are willing to modify activities until a more optimal health state is achieved
- If their participation in their sport is not significantly linked to body shape and weight issues i.e. they are inspired to make changes in their eating and activities for the benefit of their sport performance rather than reluctant to make changes for the potential impact this might have on their body shape and weight.

6. **Menses:** Refrain from early use of oral contraception to assist with loss of menses as this will mask a key determinant of physical health and nutritional rehabilitation. This is particularly critical in those in the midst of or close to puberty. Nutritional rehabilitation and weight gain remain the treatment of first choice for loss of menses as resumption of menses is a significant marker for improved health and therefore an indication that activity levels may cautiously be increased.

7. **Parents:** Those that model active living and not exercise for weight loss are in the best position to help their children establish a healthy relationship to sports and physical activity. Encouraging parents to examine their own relationship to exercise and active living is important.

8. **Have a Plan!:** Most active living best practice guidelines promote 30-60 minutes of activity 3-5 days per week. For recreational athletes, this then becomes the benchmark for those seeking to improve their relationship to exercise. Many treatment programs have adopted a graded activity schedule that reflects changes in medical stability for example moving from complete bedrest to weekly unescorted trips to a local gym (Thien et al., 2000). This same philosophy can be applied to working with children at home as long as their medical status is monitored and fine. Starting out with 15 minutes per day of physical activity and building to 30 minutes is not an uncommon strategy. An agreement with an adult patient could use a similar strategy.

9. **Anorexics:** Encourage a range of activities rather than pursuit of only a few that follows a rigid/ fixed schedule. Monitor medical status very carefully and adjust activity levels as health improves or declines. Promote exercise as a way to maintain overall health and not simply as a method for weightloss.

10. **Bulimics:** Encourage physical activity not as a method for caloric compensation but rather as a way to more effectively manage emotions (anxiety and depression) and derive overall health benefits. Promote physical activity as pleasure not pain, play not work using structured activities that help to promote a sense of consistency, predictability and routine.

11. **Education:** Excessive exercise may not be accomplishing what an individual believes it to be doing. For those who always engage in the same activities that do not include strength building, fitness might in fact be being compromised rather than built. This is particularly the case where someone is additionally nutritionally compromised.

12. **Children and School:** You may need to work with parents to support requests that a child be exempt from gym and /or temporarily removed from school teams while their health is being restored. Children in schools today face multiple stressors that can aggravate or trigger body image concerns and/or disordered eating. Parents can be encouraged to become aware of their child's school environment particularly around policies pertaining to weight based teasing, starve-a-thons, unwarranted use of fat callipers and BMI testing by individuals ill equipped to deal with individual responses to the testing, and promotion of physical activities that are inclusive of all sizes, shapes and skill levels.