The Dormouse: Recollections of a lightweight rower with overtraining syndrome

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I am a sport psychologist, academic, and athlete who is currently conducting empirical research in the field of overtraining syndrome. My passion for furthering our knowledge of overtraining syndrome has been inspired by my personal experience of the condition, when I was competing as a lightweight rower. My story tells a raw, emotive account of my experience of the condition within the context of contemporary research. I hope it will provide a wider awareness of the symptoms, aetiology, and risk factors of overtraining syndrome amongst the athletic and sport science community and allow a greater level of care for athletes.

Successful high-performance lightweight rowers require exceptional physical attributes, along with high levels of dedication and resilience. However, when faced with frustrating setbacks such as injury and illness, like many athletes, the qualities that elevated me to the top of my sport became my own worst enemy. It is well documented that vigorous, specifically-targeted training, followed by a sufficient period of recovery, is essential for improving athletic performance. This is a difficult balance to strike in many sports, but when you layer on the added constraints associated with a weight contingent sport such as lightweight rowing, training becomes more complex. Lightweight rowing places an upper limit on the body weight of competitors – 57kg for women and 70k for men. Making weight was a real challenge for me at 5'7", so I maximized every opportunity to burn calories, and that often meant choosing an active recovery session over a rest day in my already challenging training schedule. The extreme and absurd weight loss strategies I employed in the days leading up to major competitions seem incomprehensible now; for example, it was not uncommon for me to frequently severely restrict my food and drink intake, to the point of dehydration.

These strategies proved effective, as I won a bronze medal at the Nationals, and later a coveted place on the England lightweight women's rowing squad for the 2002 Commonwealth Games. Everything was going to plan, when one morning at 5.30 a.m., as I reached over to turn my alarm off, I felt my head begin to spin, my heart was pounding, and I felt violently sick. I threw up to ease the nausea, sipped some water, put on my kit and drove to the rowing club. I managed to complete the training session, but my legs felt like lead and my heart was racing. This was the start of a progressive decline in performance. One of the most debilitating symptoms I experienced was the need to sleep. I became affectionally known as "The Dormouse," because I slept over 10 hours a night and during the day. When I stood up my heart rate would go through the roof and my blood pressure would drop, I felt constantly dizzy and sick. I caught cold after cold and I felt like I had a pair of golf balls permanently lodged in my throat. Despite these debilitating physiological symptoms, I was more motivated than ever to represent my country.

At this time in my career, I was not a lottery (government) funded athlete and I didn't have access to the sport science team at British Rowing. I therefore had to rely on my general physician for support. All tests came back negative: no glandular fever, anaemia, normal thyroid function. There was no other explanation, so I was diagnosed with depression and prescribed antidepressants. In hindsight, I wasn't depressed. I was in a state of helplessness and hopelessness because I couldn't find an answer to my problem. I was underperforming at an unprecedented level and I did not know why. As time went on, my symptoms didn't improve. I was struggling to hold down my part-time job, I had withdrawn from my rowing friends. I felt utterly alone. As I reached my lowest point, my coach found the details of a doctor who specialized in sports medicine and I paid for a private consultation. It confirmed I was experiencing persistent fatigue, elevated resting heart rate, recurrent infections, and mood disturbances, and he diagnosed me with overtraining syndrome (Budgett, 1998). I was

advised to continue resting and, when my heart rate had returned to a normal rate when I first woke up in the morning and remained stable throughout the day I could begin a phased return to training. This, however, was like a form of torture to me.

My recovery from overtraining syndrome was a challenging process and I had various relapses along the way, but none as severe as the first one. I had gone from training 3-4 hours a day for six days of the week, to 5 minutes a day on three days of the week at best. I felt totally lost and alone - I missed the structure my training gave to my life, the camaraderie of my team mates, the buzz of racing and the identity of being a rower. The rehabilitation process was a gradual one, but after two years I was able to do a full training session in my boat with the rest of the squad.

By the time I was fit enough to trial for the national team again I was completely burnt out. I had gone full circle, my mindset had changed from balancing my continued drive to train with my physical inability to do so, to losing all motivation for rowing despite my body's readiness to return to training. The sport that I loved more than anything else in the world became something I absolutely despised. I quit rowing soon after I had made a full recovery and I never got in a boat again.

Overtraining syndrome can be a devastating condition, as the root cause of the characteristic fatigue is often not recognized until months of poor performance have passed. Accurate diagnosis is difficult as there are often numerous other medical and psychological conditions that present with similar symptoms. Overtraining syndrome can only be diagnosed once all other causes have been excluded. Until a definitive diagnostic tool for overtraining syndrome is developed, regular monitoring of a combination of performance, physiological, biochemical, immunological, and psychological variables seem to be the best strategy to help identify athletes who are failing to cope with the stress of training (Schwellnus M, Soligard T, Alonso J-M, et al. 2016).

There are various warning signs that an athlete may be susceptible to overtraining syndrome such as a decrease in performance that lasts weeks or months, persistent fatigue, muscle fatigue, increased sense of effort in training, loss of competitive drive, sleep disturbances, elevated resting heart rate, mood disturbances, loss of appetite, weight loss, loss of libido, excessive sweating, recurrent infections, sore throat and increased fall in blood pressure and increased heart rate on standing. If an athlete is diagnosed with overtraining syndrome, the recommended treatment is rest. In some cases, 'relative rest' is advised, with the athlete building up their training volume prior to intensity, starting from 5-10 minutes daily until they reach 1 hour (Budgett, 1998). Given the psychological implications of overtraining syndrome, athletes should consider seeking support from a sport psychologist. This might help ameliorate some of the mental health concerns that are often associated with overtraining syndrome. Due to the complexities surrounding the diagnosis and treatment of overtraining syndrome, early identification and prevention is of the utmost importance.

Take Home Points:

1. Learn to listen to your body – treat the early signs of overtraining with rest and a phased return to training.
2. Individualize training programs - not all athletes are the same.
3. Seek support from a sport psychologist during the rehabilitation period.

References

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