The athlete's "nerves"

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TO write this article has been both a challenge and an enigma, for what constitutes 'nerves'? The word, as I understand it, was not found in several dictionaries, including *Britanica*. Nor could a satisfactory account be found in books on coaching, sport physiology and sport medicine. So there is little that the writer can refer to in scratching the surface of this nebulous, but real, subject of 'nerves' but to quote from personal experience and refer to several of his own articles where facets of this topic are touched upon.

People understand by 'nerves', 'getting the needle', varying degrees of irritability, loss of appetite and sleep and prior to a race, dry mouth, palpitations and so on. These symptoms are effects of the body's priming for an anticipated action and if excessive, are used against itself like a car driven with the brakes on, much energy is wasted getting nowhere.

One Olympic prospect told me her racing performances were consistently inferior to those in training, not an unusual story. Sport is the social equivalent of combat and produces the reactions that combat produced in man's ancestors. The primitive form of competition is combat, perhaps mortal combat. The fear engendered causes a regression in character, the recently acquired behaviour patterns fading, the athlete being stripped to a primitive form of his own personality and becoming almost child-like at times. It takes a mature mind to remain calm in a distressing situation, for the reaction to stress depends upon experience of stress. Simply, experience helps in overcoming 'nerves', but not wholly so because some experienced internationals show stress under competition, though the international has greater stress to face than his club-mate. A situtation where so much is expected with no moral escape frequently produces suppressed or evident panic, sometimes to such degree that the athlete may drop out before or during competition. It appears there are comparisons within the animal kingdom. Whether sport protects against personality problems is uncertain, but possibly the fit athelete through repeated stress learns to cope with daily problems more effectively than his brethren (*mens sane in mens corpore*).

'Nerves' are encountered in training, competition and following injury. They do not feature large in training though athletes training to extensive schedules may exhibit stress. Nerves might feature more in professional sport where livelihood depends on fitness and performance, though I have little experience of such sport. 'Nerves' occur hours, days (or even weeks) before the anticipated events. Initially, I recall, there are 'butterflies' in the stomach, listlessness and a mild fear reaction climaxing before the event, as accumulated or repressed energy awaits the crack of a gun. As stated, one can become child-like before competition with silly conversation, selfishness, irritability, bragging, excuse making and running off to micturate. I recall one athlete who wet himself before competition—how like a child!

To athletes under stress, complaining becomes frequent. From my experience, both at home and abroad, complaints which in normal circumstances would evoke little response, are now magnified. They concern accommodation, officials, washing facilities, training facilities, wrong time of arrival, lack of sleep, minor infections of the eyes, ears, nose, throat and skin, headaches, blisters, bruises, digestive upsets and personal problems. These are best handled with the co-operation of the team physician,

coach and senior team members. Concerning demands for pep-pills or food additives, I discourage and discuss these useless substances, to avoid dependence upon them, but where demand exceeds reason something innocuous is given together with reassuring words. Sometimes it is worth having a masseur or physiotherapist with the team, but it remains uncertain if the benefit of these treatments lie purely in the physical field; physiotherapists have told me how athletes talk and relax under treatment. Personal morale depends on such factors as team morale, successes, quality of officials, food and accommodation. All these problems and others, including home sickness, sexual problems, diets, drinking and smoking, concern over injuries, fears of heart strain, heat-stroke and more subtle reactions to stress from the bread and butter work of team physicians and, as readers of this journal will realise—how like general practice it is.

The responsibility of the team physician and coach is to understand the athlete and his attitude towards his problem, themselves remaining calm and objective. A number of occasions are recalled where the coach had shown pre-race stress and become a hindrance to his pupil. My aphorism is that 'just as anxious mothers have anxious children, so anxious coaches have anxious athletes' (and anxious doctors have anxious patients). The art is to listen—the lesson for the doctor being that 'silence is diagnostic and therapeutic and though golden costs little'. In verbalizing his fears, the athlete learns to cope with his problems, to stand (and run) on his own feet.

Elaborating on athletic injuries, I consider there are broadly two types, major and minor. Major injuries such as fractures, tendon and muscle ruptures are sent to hospital and so do not come my way. It is my opinion that minor injuries, which constitute the majority of injuries, get better irrespective of treatment and those who give treatment really support the athlete (and possibly themselves) until healing is completed. The most important aspect of such an injury is not so much the condition but the athletes attitude towards it; and if therapist instead of massaging, strapping or prescribing for the affected part, helped the athlete to gain insight and face up to the reality of his problem, not only would he help his charge but also he would improve his own art as a therapist. I suspect that when a minor injury does not get better in the time alloted by nature, then one has to look for a cause at an altitude of about six feet (excluding conditions of a long natural history, such as jumper's heel, achilles tendon and tennis elbow). Some such athletes have been labelled neurotic and then treatment terminated but this is where treatment should begin. The following cases illustrate the necessity to understand the athlete's attitude towards his injury, toward competition and toward life.

An international miler had symptoms from a knee injury persisting for several months, which impeded training in spite of vigorous treatment at a teaching hospital. It had not been appreciated that the athlete had equated his traumatic *arthritis* with his mother who was partially crippled with *spinal arthritis*. It took no more than a few minutes to elicit this fear and within six weeks he was running very close to four minute miles. (Attitude to injury).

A tennis player developed severe earache before an international contest. She was most offensive when I found nothing wrong physically. Her coach confided later that she usually produced such symptoms especially if expected to loose. She lost! (Attitude to competition).

Another athlete had been off-form for several months from a painful calf muscle injury not responding to therapy. His best mile was 4 minutes 17 seconds, yet now was unable to beat 4 minutes 45 seconds. Everyone realized that he couldn't run well because of his painful calf but nobody knew that his girl-friend was pregnant and this had upset his sleeping and eating but once he was made to verbalize his anxiety and discuss it with his girl-friend and prospective parents-in-law, his appetite and performance improved. (Attitude to life.)

A number of reports have appeared on the supposed value of hypnosis in training and competition, but I am not altogether convinced . . . yet. Where it does help is it more effective than the traditional pep-talk from a trusty coach? Even so, here are two suggestive, but not conclusive cases.

A junior international athlete sprained his ankle and had pain and limp months later. Consultations included physiotherapists, a doctor, an osteopath and finally an orthopaedic surgeon. The pain went but a limp persisted in races. By then this lad had lost enthusiasm and performed poorly. After discussion with the national coach, hyponsis was considered. He was a rapid deep subject and non specific suggestions of relaxation and improvement in attitude were given (specific suggestions are never made for the patient is quite aware of the reasons for hypnosis and the operator should not impose specific features on to the patient). Later both he and the coach wrote that there was a highly satisfactory improvement in training, performance and outlook; the nagging thoughts of injury went and incidentally he was no longer troubled in getting to sleep.

A pistol shot was very tense prior to competition. Hypnosis was attempted and non-specific suggestions of relaxation given. Although not considered as being hypnotized, he remained calm until winning his international event next day.

In the realm of injury, hypnosis can be of benefit, especially where the injury has a non-neurotic basis, for pain and limitation of movement, which are the principal features of muscle strains, can be eased by the hypnotic phenomena of analgesia and muscle relaxation. In the writer's series of 250 orthopaedic cases taken from 800 general cases in general practice, the following results were achieved:

Total	250	Hypnotised	190	Not hypnotized	60
Cures	104	Helped	38	Unsuccessful	108

There is about 40 per cent symptom removal from all subjects in my hands in selected cases. This rises to just over 50 per cent when hypnotized subjects only are considered, excluding those subjects who achieve some degree of relief. These results do not form part of a controlled trial and so loose some of their value; it must be borne in mind that some of the patients who were undergoing prolonged hospital treatment also showed an instantaneous symptom removal. These results contradict all my previous learning and experience for there is an apparent alteration in the natural history of disease.

If the symptoms have a neurotic basis then it is essential to reach the root of the problem rather than do a simple symptom removal (*Encyclopaedia of Sport Medicine*, in press, Pub., University of Wisconsin).

Fewer sexual problems are seen now than 20 years ago. The common questions on sex in sport concern masturbation, varioceles, jock-straps, the effect of sport on menstruation and vice-versa, on its supposedly masculinizing effect, on child-birth and training, on marriage and intercourse and on the taking of 'sex' tablets and hormones. The approach to all these matters depends on the doctor's experience of sport and his approach to life. Most general practitioners will have little trouble in disposing of such non-problems in sportsmen and women.

Sport is a redirection of energy, it is a civilized form of combat which satisfies the instinct of self-preservation. It is the social equivalent of a biological necessity. The reward of combat is physical security—the reward of sport is physical and social satisfaction, and, to some extent intellectual and spiritual satisfaction.

If this article causes cerebral conflagrations in clinicians and coaches it will have achieved its purpose, if it is inadequate or superficial then the writer would be interested to learn what improvements can be made.

REFERENCE

Ryde, D. H. (1956). *Practitioner*, **177**, 73.