

Sidebar text: Therapeutics: Anorexia & obesity - Dawson

Childhood Anorexia & Obesity: A Growing Issue

Dee Dawson

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This well-attended talk was given by Dr Dee Dawson of Rhodes Farm Clinic. The clinic, which pioneers the system of taking anorexic children out of hospitals into a more homely setting, was set up by Dr Dawson in 1991. Dr Dawson is especially interested in the physical and nutritional aspects of eating disorders and oversees the re-feeding programme at Rhodes Farm. The audience were eager to hear Dr Dawson's views on the recent epidemic of eating disorders, with both obesity and anorexia on the increase.

Anorexia

Firstly, the presentation looked at anorexia. The diagnosis for anorexia nervosa is as follows:

- Deliberate weight loss, due to a morbid fear of fatness
- Distorted body image; believing they are fat when it is very clear they're not
- Patient at least 20% below normal weight (for height and age)
- Girls have no periods
- Usually with excessive exercising

The incidence of anorexia nervosa in schoolchildren has risen in the past few years, and studies from various countries suggest that 1 in 100 girls and 1 in 1000 boys are suffering from the illness at any one time. Many people don't realise that anorexia nervosa kills more people than all other mental illnesses put together and it is estimated that one in five of all sufferers go on to die as a consequence. Thirty years ago anorexia was solely a middle class illness, and even though it mainly affects the middle class, we are now seeing it move through the classes and it is not unusual to see working class children in the clinic now. Anorexia occurs primarily in white children, as the black population does not value thinness in the same way that the white population does. Also, in Asian families, food is much more family-orientated and families tend to eat together far more, so it is easier and quicker to spot. Mostly, it is high achievers that develop anorexia, whether in the field of academic, sport, or music: they need to be the best and will do whatever it takes to achieve that.

Dr Dawson proposes a four-pronged approach to treating anorexia nervosa which consists of the following:

- Re-feeding
- Family therapy
- Family counselling
- Individual therapy

Re-feeding

Dr Dawson stressed the importance of re-feeding and explained how vital it is that this is given top priority when treating patients with anorexia nervosa. It is difficult for anyone who is cold, blue, malnourished and hungry to engage in therapy, and usually these children are so ill there is no time to wait for therapy to start having an effect. Furthermore, it is not in their power to make a child use therapy to think rationally about why they are not eating but is in their power to make sure the child eats, puts on weight and restores their physical health, even if they remain anorexic in their thinking. If they succeed in this, it buys them more time: if they can get the child functioning normally at a normal weight they won't be left with a legacy of ill health when they eventually feel the need to get better.

When re-feeding a child, there are several aspects the clinic are interested in:

- What they eat; the clinic try and get patients to return to a normal teenage diet, which includes making sure they eat fat in their diet too.
- How much they eat; the children are weighed twice a week and their calories are adjusted depending on their weight gain, allowing them to gain 1kg per week very accurately. If the child still does not reach their target, then the clinic does not allow them to do normal physical activities until they get their weight back to above their target.
- How they eat; anorexics usually have a very ritualistic way of eating, for example, eating baked beans one at a time. The clinic highlights that this is an anorexic way to eat and instead children are encouraged to eat normally.

Family therapy

Following the activation of the re-feeding programme, the clinic asks the child and family to engage in family therapy. It is extremely rare to see a family that doesn't have identifiable reasons why a child might become anorexic, so it is vital that these problems are openly discussed and changes made.

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Such issues that come up in family therapy include marital problems, rivalry and health problems. Rivalry for achievement and affection can result from the child feeling they are not doing as well in comparison to their siblings. Health problems can include deaths within the family, alcoholism and any mental or physical illnesses that either parent may be suffering from.

It is important that these issues are openly discussed, as parents often try to keep these from children and are unaware that they know about them. Other issues that may surface in family therapy sessions are any family history that might flag a genetic pre-disposition, any sexual, physical or emotional abuse, or any issues at school, such as bullying or self-imposed pressure to succeed.

It takes very skilled family therapists to help them confront their problems. Families tend to avoid conflict and children often try to protect their parents, so it's important that they are reassured to speak out about anything that is worrying them.

Family counselling

These sessions include the whole family and work through ways of dealing with anorexia. Whereas family therapy concentrates on emotional and relational problems within the family, counselling looks at practical ways of dealing with anorexia once the child returns home. Families would much rather talk about the pros and cons of eating full cream milk instead of difficult emotional issues, so its important to have separate sessions focusing on each. Firstly, they work on putting the parents back in charge; when an anorexic child first enters the clinic, their parents have often lost control, with the child stipulating how much and, in some cases, what the family should eat.

Another focus is getting the parents to agree to work together and with the clinic. Children can try what's known as 'splitting', where they will try and drive a wedge between their parents, or more commonly between the staff at the clinic and the child's parents. Children can tell their parents 'horror stories' about the clinic leading parents to worry, so the clinic pre-empt this by highlighting this as common behaviour in the parents' guide. Communication is vital; the child needs to see that their parents and the clinic are working together.

Finally, these sessions look at the management of anorexic behaviour, including the child's food intake, exercise and how the family can keep control of this when the child returns home. Some of these decisions can be very difficult for the parents to make, for example telling their child they have to reduce the number of hours they exercise or even cut out some athletic pursuits altogether.

Individual therapy

In theory, every child should have access to individual therapy. Most children have psychodynamic psychotherapy, which enables these often damaged children to talk about their experiences in a safe environment. Some children do build a trusting relationship with their therapist, but many remain totally silent or speak on a very superficial level. For these children, family therapy is even more important. The clinic is also starting to use cognitive behavioural therapy (CBT) more frequently as this is particularly useful with obsessive-compulsive problems.

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Role of schools

Schools have an increasingly important role to play in the detection and care of children with eating disorders. They should be among the first at spotting the problems, seeing children losing weight and becoming obsessive about their schoolwork and exercise. Dr Dawson also thinks schools could do more to educate children about the horrors of eating disorders and should be much quicker at insisting an obviously sick child should be excluded from school. Curbing exercise is something that schools should do but are reluctant to do so.

Schools also play a crucial role in liaising with the inpatient unit. Once the child is admitted, the unit co-operates with teachers to see that the child keeps up with schoolwork. Many of

the children who attend the clinic have been bullied so this needs to be dealt with before the child returns. It is not unusual to suggest to the parent that the child should move schools, especially if the experience has been particularly traumatic.

Media influence

Dr Dawson then went on to discuss the role of the media in eating disorders. Children from normal, stable families who have no problems or anxieties are unlikely to develop anorexia nervosa as a result of seeing pictures of skinny models. However, children with low self-esteem and who feel they could improve this if they lose weight, react very differently. These children are born with obsessive compulsive personality and a perfectionist streak; for them dieting is easy and as 'perfection' is often portrayed today as size 8 or even a size zero, it is easy to see why they choose to starve as a way of dealing with their problems.

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Images such as the ones we see on the catwalk or in magazines make women and children, particularly those that are vulnerable, feel inadequate and insecure about their appearance. We can do nothing to control the sorts of people who are role models from our children; we can only address these body issues at school and discuss the damage these low weight people are doing to their bodies.

Our obsession with so-called healthy eating and exercise is affecting children at a younger age. Our children are constantly exposed to talk about evil foods and hear their parents and friends talking about workouts and gyms. Dr Dawson doesn't think that certain high-profile chefs are helping the situation, by constantly reminding our children about what is healthy and what is not, and particularly does not think this should be discussed with children of primary school age.

Obesity

School meals in the 1950s were very different to how they are today and yet obesity was not a problem, but why? Because people walked to school, did physical exercise and games at school every day and played in the street after school on bikes and scooters. All this has changed.

With regards to putting on weight, we need to over-eat by 7,000 calories in order to put on 1 kg. This equates to over-eating by just 20 calories a day: less than one Malteser! If a child does this every year from the age of 4, they will be 10kg overweight by the time they are 14. For a child, that is a lot.

However, an overweight child can shed 10kg a year by expending 200 calories a day in exercise. This can easily be achieved by cycling or playing netball for half an hour. Rather than vilifying chips, we should start organising more activities for our children. The government should be encouraging more exercise when in fact, we are seeing the opposite.

Obesity in 6-11 year olds has trebled since 1976-1980, and has increased by even more in 12-17 year olds.

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Dr Dawson believes that our children should be taught about healthy nutrition in their teens, in schools by professionals trained in nutrition. A healthy diet consists of 50% carbohydrate, 20% protein and 30% fat. Of these three food groups, fat is the most confusing. There are ‘good’ fats, such as olive oil, nuts and oily fish and ‘not so good’ fats, such as butter and fat from meat. However, even though butter contains saturated fats, these are less harmful than the varying levels of hydrogenated fats in spreads made from vegetable oil, and which are promoted as being much healthier than butter. This lack of understanding also causes people to cut fat out of their diet completely, which can have grave consequences. Some fats help boost metabolism to burn fat and are necessary for healthy skin, fertility and to enhance memory, mood and concentration.

“Despite being a nation of ‘fat phobics’, obesity is rising.”

Despite being a nation of ‘fat phobics’, obesity is rising. There is no magic method to lose weight: the simple reality is to just eat fewer calories, ensuring it is enough to keep warm and move around throughout the day. Problems arise in people who consistently eat more than they can burn, with the extra calories being stored as fat. Parents seeing their child put on excess weight should be able to restrict calories by monitoring their intake of food. In young children, this can be done without realising they are on a diet; if you can hold their weight stable then as they grow they will lose their fat.

It’s too simplistic to blame fast food chains for our obesity problem. A cheese or egg mayonnaise sandwich made at home contains more calories than a hamburger and chips, which are cited as the epitome of fattening fast food. Conversely, the ‘healthy’ alternatives that fast food places provide can also easily contain more calories. From an obesity point of view, only calories are important, but from a fat point of view both the salad and the cheese sandwich contain more total fat and saturated fat than the hamburger and chips. Despite this we are constantly being told not to buy fast food and if we do, to choose the salad option.

This session was a truly eye-opening insight into eating disorders and Dr Dawson and all at Rhodes Farm should be highly commended for the work they do. It was clear that many of the issues struck a chord with the audience, particularly those with children, so it is felt Dr Dawson should continue lecturing and educating to make us all more aware of these horrific illnesses affecting our children.

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