

Research at the Institute of Child Health, University College London, shows that on average, three in every 100,000 British and Irish children under 13 have an eating disorder. Such figures highlight an urgent need to consider these children and the services available for them. Dasha Nicholls, a consultant child and adolescent psychiatrist and the lead researcher, speaks to CCYP

This was the first study of early-onset eating disorders among British and Irish children. Can you tell us something of the background to your study?

Well, part of the reason I did the study was that everybody was telling me anecdotally that they were seeing more childhood eating disorders these days, and I was saying to them, well how reliable is what you think you're seeing? Because the service at Great Ormond Street has been around for 25 years and seeing children with anorexia and other eating disorders isn't new to us. Also, people would often tell me about things that aren't eating disorders in the strict sense of the term. For instance, after my research was published, people in the media mentioned figures that were probably not reflective of true eating disorders – because people use the term very loosely to mean a whole range of eating and feeding difficulties, so it's quite difficult to know what's really happening. People would ask me if childhood (as opposed to adolescent) eating disorders were becoming more common and I had to say I didn't know. That's what prompted the study.

OK, so just to clarify – how are we defining eating disorders among children and young people?

As defined in the current classification systems, eating disorders are characterised by weight and shape concerns. So any type of disordered eating behaviour that is driven by feelings about one's body weight and shape is classified as an eating disorder. This might be about being underweight or overweight: 'I've eaten too much and I feel disgusted with myself because of how fat it will make me' or, 'I can't eat that because it will make me fat' It can be at either end of the weight spectrum and it's all driven by *feelings* about the self. But some of the children in my study group were those who determinedly avoid food but don't articulate fears about weight and shape. They often can't give a reason for it. It's a group of children we've seen in clinic for some time and different people give it different names, but whether it should be classified as an eating disorder or as something else is a matter for debate at the moment.

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Do you think GPs sometimes fail to pick up on eating disorders in children? Do they, perhaps, only consider them in relation to adolescents?

I think GP awareness of eating disorders has probably increased along with everyone else's, due to media coverage and the possible rise in cases presenting. But certainly, 10-15 years ago, GPs didn't expect to see children with eating disorders. Now, I think they know they might. I did some focus groups with GPs recently and they said that as soon as they do see someone with an eating disorder, they send them to the appropriate service, but it's quite rare for any individual GP to see many – and that's once they diagnose it as an eating disorder. I think there's a process that happens here that results in delay in the problem

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being treated, and it's not about lengthy waiting lists. There's a time when the child starts behaving strangely in relation to food, and parents/carers do notice but minimise it as a phase, or say, 'I don't need to get worried about this!' So there's a lag between onset and those around them finally recognising the problem. And then they look up information and realise it's serious, so they go to see their GP, and the doctor does the same thing and thinks it's probably a phase. And it takes the GP a while to recognise it's serious too. So by the time parents go to the GP, it's usually serious but professionals don't always respond as if it is. So those factors – parental denial and then professional denial – are what contribute to the delay in diagnosis and referral.

What kind of a prognosis is there for children who develop an eating disorder at a young age?
I've often used the comparison to leukaemia, because if you say 'leukaemia' to people, they don't fail to take it seriously. They'd drop everything to prioritise treatment. Yet treatment of leukaemia has improved radically over the last 10–15 years by making sure people get early good treatment by specialists, and so the prognosis for leukaemia is actually very good. And some sorts of leukaemia have a prognosis of 90 per cent recovery. And I think the same is true of anorexia – but *only* if you have access to specialist treatment, delivered by an appropriate service, staffed by people who know what they're doing. So the key issue here around prognosis is the time

lag we have at present and the organisation of services that will allow them to deliver the appropriate evidence-based treatment by a skilled team. Leukaemia outcomes improved by just such a restructuring and reorganising of services.

And that's not happening with all eating disorders at the minute?

No. People get haphazard, geographically disparate responses. It's improving and things are changing, but the jury's still out on what the best model of service is and whether children should be included with adolescents or treated separately. So there isn't yet an evidence-based service model – although there *is* evidence-based treatment. There are some studies not yet published that look at outcome in relation to service organisation, so it's definitely on people's research agendas, but for the moment, the bottom line is that if you do suspect a true eating disorder in a young person, then it's not something you have a go at. By the time it's fully fledged, I wouldn't recommend that lone practitioners work with an eating disorder, whether you're a counsellor, a dietician or a psychiatrist. You need to be working in a multidisciplinary team because you need somebody to think about the child, somebody to think about the family – and you may need to think about those separately because of confidentiality boundaries – and then you need somebody to think about the medical, dietetic and risk issues. And it's quite difficult for that all to be the same person.

I think most of us would refer on at some point. But where that point comes might vary!

Well, that brings me to the boundary between the young person being worried about their eating and actually having an eating disorder. Clearly there's a huge spectrum and probably about 10 per cent of young people do disordered eating of some kind, such as skipping breakfast or vomiting after a meal. Those behaviours are very common, as are anxieties about whether they're eating right, and about weight and body shape. It's when you get the two together – those behaviours and those anxieties – and an increase in intensity and frequency, that it starts to impact on their emotional wellbeing, in terms of levels of distress, and on their level of functioning. They can start to lose significant weight or reach a point of medical compromise. By that, we mean a girl's periods stopping, hair falling out, dry skin and nails, heart skipping a beat, feeling faint on standing – that sort of thing. Or they're unable to do things because of their eating behaviour – for instance, not being able to eat with their friends *because* of how they eat. That's when it's become serious and they need treatment.

Why do you think it's important to consider the needs of children in treatment separately from those of adolescents? Is it simply to do with,

for instance, the mode of treatment employed, or something else?

There are a number of things. One is to do with the degree of appropriate dependence on family. An adolescent may want to be in charge of their eating but that would be inappropriate for a child. So the focus of treatment and the level of authority of the parent would be different. That's one issue. The second is that the nutritional needs of children are different. So you need skilled monitoring of growth and development appropriate for their age. And third is recognising where children are at with their psychological and cognitive development, so the sorts of treatment that you might direct at adolescents would look very different with children, even if you were doing cognitive work.

Thirteen is the average age of menarche, and there's a huge change in brain function during adolescence, so a proportion of adolescents have an adult brain by the age of 14/15, although obviously some don't and those with eating disorders are less likely to. Even allowing for that, there's this big difference between the adolescent and the younger child. It's not just the capacity to weigh things up and balance things but also the ability to process emotions, identifying and putting into words how you're feeling about things. So if you're going to do any kind of groupwork, which is not uncommon in intensive treatment, putting a 12-year-old with a 16-year-old is not going to work! I think a lot of the principles of treatment are the same, but there are key elements of it, particularly at the severe end, that do need to be thought about differently for children.

And the issue of *where* they're treated is about what?

Well, a common dilemma is if you get a child of 11-12 who's got severe anorexia and they need to go for inpatient treatment – are they better off in a children's unit that is developmentally appropriate, or in an eating disorders unit, which may be more attuned to the specific issues of eating disorders? One of the purposes of this study was to do with my long-held view that the role of paediatric units in the care of eating disorders in this country needs to be improved. It's very haphazard. Some wards are absolutely fantastic and others would hold their hands up and say we don't know how to do this stuff and we're not even sure if it's our job. And that's quite different from in the USA and in Australia where the first port of call for most children with eating disorders is a paediatric ward, where the staff are organised and skilled to deal with this patient group. So one thing I was trying to map out was what the involvement of paediatricians was. Not least because of our reluctance to admit children to a psychiatric inpatient unit, but also because young children get sicker more quickly and a paediatric setting might be more appropriate.



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A direct result of some of my research is that, subsequently, I and some paediatric colleagues got together to write some guidelines for improving the care of young eating-disordered people on paediatric wards. Of course, if there is an intensive outpatient specialist service, the likelihood is they won't need to go to hospital at all.

I read that you called for 'urgent action' to improve the availability of services for younger children. What kind of carefully planned things would you like to see happen to improve this situation?

We need some serious consideration about service planning and the way services are commissioned at local, regional and national levels. I think it's a bit unclear within eating disorders what should be dealt with where. That kind of overall strategic planning is needed, but people want numbers to do that, which was part of the purpose of my study, and on the basis of the numbers we identified, there simply isn't justification for local services for *children* as opposed to adolescents – because the majority are certain to be 15 plus, the average age of onset for eating disorders. Yet the needs of an eight-year-old are clearly different, and one of the tensions is about taking children away from home if you do things at a national level.

Moving back to the disorders themselves, how far do you think it inevitable that young people with a family history of mental health problems, or their own early feeding problems, will present with some kind of eating disorder eventually? Or is it simply down to our media and culture?

Good question. *Inevitable*, no. The way to think about this is the same as when you know you're high risk for any disorder. There are some things you can do to look after yourself. And I think that's where we're at – it's helpful to know that some young people are more high risk than others and therefore to take that risk more seriously. But I don't think it's inevitable. What we're getting better at is mapping who's at risk and who's not. And then we're in the whole arena of how you maximise psychological wellbeing, because it's only if certain things happen that you'll be triggered into illness. And we're getting better at mapping not only the predisposing risk factors but what the triggers are for the onset of an eating disorder.

For example, we know that there's a very high association with puberty, when you get this massive gender differential, and your body shape alters, and there are rapid changes in social awareness and psychological and emotional development. And if you go into puberty early, which you're more likely to do if you're over- rather than underweight, that increases the risk. In this particular age group, school transition can be another precipitant because it requires all sorts of adaptation and new social skills at what can be a vulnerable time for some

children. More controversial triggers do include media images, social pressures around weight and dieting, and also discussion around the whole healthy eating agenda. Children suddenly come into a lot more information. If you happen to be a very black-and-white thinker and you're presented with a good food/bad food analogy, you haven't got the emotional and psychological capacity to process that information. It can get internalised in an unhelpful way.

So if there really is an obesity epidemic among children, how do you think this problem can be addressed, if dieting is bad advice and extra information about food is not necessarily helpful? Dieting and proper diet are very easily confused anyway.

Prevention isn't my specialist area at the moment so I'm going to be very cautious here, but there are a number of movements around. For example, acceptance of size of various kinds, and it not being about food but about behaviours. Often, talks about the importance of healthy eating and so on don't include enough about unhealthy and unhelpful *behaviours*, such as skipping meals and purging etc. But there's also the question of whether children can process nutritional information in a useful way at a young age. The idea that giving more information about nutrition is the answer... well, I don't personally believe it is. And anyway, children are not responsible for managing their own nutrition at nine or 10 or 11 years old – and shouldn't be, in my view. It's the parents' responsibility.

I agree. Finally, is there anything you would specifically say to counsellors working with children?

Basically, the advice is to not forget that, with any mental health problems, there may be other associated things going on – they may be living with parents who have significant mental health issues, or be in an abusive environment, or struggling with other co-morbidities such as depression or OCD, so I think to use their counselling skills to see what is going on relevant to the eating disorder for any individual child, but to remember that if, say, it's bullying, addressing the bullying won't necessarily address the eating disorder. And to refer on to a multidisciplinary team for the eating disorder at an early stage. ■

Interview by Eleanor Patrick

Dasha Nicholls is Consultant Child and Adolescent Psychiatrist at the Feeding and Eating Disorders service, Great Ormond Street Hospital. Primarily a clinician, she has also written book chapters, articles and national guidelines on eating disorders. Her research covers epidemiology, childhood risk factors, and clinical trials. She is President Elect of the Academy for Eating Disorders.

