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The information contained herein includes both psychological and non psychological interventions. The delivery of psychological services requires a medical referral whilst non psychological services do not.

Each person is an individual and has a unique psychological profile, biochemistry, developmental and social history. As such, advice will not be given over the internet and recommendations and interventions within this website cannot be taken as a substitute for a thorough medical or allied health professional assessment or diagnosis.

Eating Disorders

Article QUICK LINKS :

INTRODUCTION TO EATING AND WEIGHT DISORDERS

Abnormal eating behaviours are typically caused by a combination of factors, including social norms promoting thinness (media and advertising), personality vulnerabilities, distortions of perceived appearance, overvaluing the benefits of weight or shape change, and dieting itself, - especially at critical stages of development. Together, these factors can lead to self-sustaining eating disorders, most commonly anorexia nervosa and bulimia nervosa.

Abnormal eating behaviours that begin as a response to calorie restriction gradually become coping mechanisms for problems in self-esteem, interpersonal relationships, and mood regulation. These behaviours are continued in a determined pursuit of thinness and an irrational fear of fatness as well as distortion of perception of body image.

Health care practitioners need to recognise eating disorders and understand their potential complications, which can include death from severe malnutrition, electrolyte abnormalities and suicide in depressed patients. It has been found that the earlier an eating disorder is recognised, and suitable individualised programmes implemented, the better the person will do. The first clues to the existence of anorexia or bulimia nervosa may be subtle (See Table 1).
For example, women may present to their health care practitioner with amenorrhea caused by weight loss; with fractures from estrogen deficiency-related osteoporosis; or with esophagitis or loss of tooth enamel from repeated vomiting.

When persons with eating disorders present with weight loss, the practitioner must consider other disorders such as hyperthyroidism, diabetes mellitus, malabsorption, and malignancy. However, the excessive and unrealistic fear of fatness in patients with anorexia nervosa differentiates it from other psychological and medical conditions causing weight loss.

Being overweight is a risk factor for many important disorders, including hypertension, hypercholesterolemia, diabetes mellitus, and, in women, endometrial carcinoma. Morbid obesity, (a weight greater than twice what is deemed normal) can lead to potentially fatal cardiopulmonary disease. Obesity is typically multi-factorial. In addition to excessive eating, common contributing factors are genetic predisposition, social class norms, nutrient availability and density, basal and exercise-dependent energy expenditure, and, occasionally,

underlying medical, neurologic, or psychiatric disorders. Many times, the psychological factor will be present. In general, the more severe the weight abnormality and the earlier it manifests, the more likely genetic or medical factors are involved. Binge-eating disorder is present in approximately 25% of obese individuals.

TABLE 1 POSSIBLE PRESENTATIONS OF EATING DISORDERS

CLINICAL FEATURE CAUSE

- Weight loss from self-starvation, purging, or compulsive exercise
- Amenorrhes or decreased sexual drive and function
- Abdominal pain or distension, Malnutrition and electrolyte imbalance
- Loss of tooth enamel from repeated vomiting
- Esophagitis or esophageal tearing
- Lanugo hair (fine downy hair of childhood)
- Fracture from minimal trauma due to loss of bone density
- Presence of laxatives, diuretics or signs of vomiting

LABORATORY AND RADIOLOGIC FINDINGS

- Metabolic alkalosis from repeated vomiting
- Hypocalemia from vomiting, diuretic or laxative abuse
- Anemia, malnutrition
- Low serum estrogen levels, suppression of GnRH and Gonadotropins, low testosterone
- Hyperprolactinemia
- Osteopenia

NOTE: People may die with normal laboratory values - as each person's metabolism is unique, laboratory values must be regarded as a guide only.

EATING AND WEIGHT REGULATION

The search for freedom from starvation has characterised much of human history; paradoxically, the availability of plentiful food in modern industrialised cultures can provoke extreme reactions. Especially since the 1950's, western industrialised nations have increasingly defined attractiveness in terms of artificial norms for thinness. Cases of anorexia and bulimia have increased several fold in recent decades, through both actual higher incidences and more accurate diagnosis. An estimated 0.51% to 1% of young women in Western societies suffer from the full syndrome of anorexia nervosa and six times as many women as men are affected. A much larger percentage of the Western world (more than 50%) are restrained eaters, that is, they will interrupt eating behavior before normal comfortable satiety terminates a meal - in other words, their foot is always on the brake while eating - they tend to be chronic dieters, either consciously or unconsciously.

The body normally regulates nutrient intake with exquisite sensitivity around a "set point" that maintains weight within a narrow range which remains stable and / or changes slowly over time. People who are not afflicted by medical or psychological disorders or by coercive socio cultural norms, as reflected through media and advertising, and who choose to primarily eat foods low in fats and concentrated sugars, exercise regularly, and who deal reasonably with everyday stresses, tend to stay within a narrow margin of weight deviation, an within their normal weight range.

A role for genetic factors in defining this weight range is supported by twin and adoption studies. However, these built in stable patterns of "motivated behaviour" are subject to many aberrations in Western society, through learned socio cultural norms quite apart from medical or psychological problems.

Eating disorders can be differentiated by relatively specific symptoms and signs. Although the fundamental causes of eating disorders are unknown, these conditions can be more accurately identified than many medical disorders for which laboratory tests exist.

TABLE 2 CRITERIA OF MAJOR EATING DISORDERS

ANOREXIA NERVOSA (RESTRICTING SUBTYPE)

- Self-induced starvation to less than or equal to 85% of normal weight
- Irrational fear of becoming fat
- Hypoganadism
- In women: amenorrhea for 3 months
- In men: decreased libido; decreased sexual drive
- Distortion of body image

ANOREXIA NERVOSA (BULIMIC SUBTYPE)

- All criteria for the restricting subtype, as above
- Binge eating twice/week for 3 months, on average
- Or, purging (vomiting, laxative or diuretic abuse) or other compensation (fasting, over-exercise) to avoid weight gain

BULIMIA NERVOSA

- Binge eating twice / week for 3 months
- Purging (vomiting, laxative or diuretic abuse) to avoid weight gain*
- Irrational fear of becoming fat
- Weight normal or high
- Distortion of body image
- Note 20% do not purge but follow binges with self-starvation or compulsive exercise.

ANOREXIA NERVOSA

The term "anorexia nervosa' was first coined in 1988 when it was used in the British medical journal The Lancet to describe a subset of people who, although thin and weak, insisted that they needed to lose weight and refused to eat a sufficient amount to remain alive. The diagnostic criteria for anorexia nervosa (Table 2) are:

1. Self-induced starvation to a weight at least 15% below normal;
2. An intense, irrational fear of becoming fat; and
3. Hypogonadism, manifested in women by missing three consecutive menstrual periods, and in men by a decrease in sexual function and interest.

Although the disorder is termed "anorexia," patients lose their appetite only after losing considerable weight. Another feature seen in many people with the disorder, though not a recognised criteria for diagnosis, is a distortion of perception in which patients believe that they are fatter than they really are. There is some suspicion amongst researchers that low levels of serotonin, a neurotransmitter, may contribute to the psychological problems linked with both anorexia and bulimia nervosa.

In more than 95% of people with anorexia nervosa, the disorder usually begins with a conscious wish to lose weight through dieting, often combined with exercise, and occasionally augmented by self-induced vomiting and abuse of laxatives, diuretics, or diet pills. The disorder then takes hold after months or years of self-critical scrutiny of body size and shape. Sometimes people will begin dieting because their friends or family members are dieting or are making comments about their appearance. The peak onset of primary anorexia nervosa is the early and late teens, (14 and 18 years of age) although, onset is possible as early as the age of seven, and may occur as late as the 70's. Persons especially predisposed to the disorder are young women with sensitive, self-critical, and sometimes compulsive aspects to their personality. Generally, they come from families with a history of depressive disorder as well as an "enmeshed" (living in each other's pockets without freedom to grow separately; having excessive reactivity to each other's moods and behaviours) style of family functioning. Participation in sports, ballet, modelling, wrestling, and other activities that promote thinness accentuates the drive to lose weight is usually a related factor.

Anorexic individuals usually come to medical attention because of concern by family, friends, teachers, etc., rather than because the patients themselves are worried. Those suffering anorexia nervosa, will often attempt to conceal their emaciation with layers of clothing, yet it is a relatively public disorder. Driving their weight loss is the excessive and unrealistic fear of fatness, a symptom clearly differentiating anorexia nervosa from other psychological and medical causes of weight loss.

Of patients with anorexia nervosa, two distinct subtypes have been identified: those who solely restrict their food intake (restricting subtype), and those who binge while at low weight, and then induce vomiting or abuse laxatives or diuretics (binge/purge subtype). Patients with both subtypes organise their behaviours, social lives, thinking, and ultimately their identity around promoting and maintaining weight loss and resisting weight gain. Families are distressed by the anorexic behaviour, which stubbornly resists both entreaties and threats. This usually makes families feel helpless, angry, or defeated, and on occasion, may provoke abuse.

The final, chronic stage of the disorder has two features. The illness becomes autonomous, resisting change, and the patient develops an identity based on the anorexia nervosa, a "sick role" that derails normal social and psychological development. The chronically low weight may also be sustained by the pathophysiologic effects of malnutrition, such as slowed gastric emptying and severe abdominal distress.

The emaciated state has characteristic systemic physiological signs, including hypotension, bradycardia, decreased core temperature, and loss of both intra-abdominal and subcutaneous body fat as well as decreased muscle mass. Radiographic and laboratory studies may reveal osteoporosis, brain shrinking, and variable degrees of anaemia and endocrine dysfunction. Gonadotropins and sex steroid concentrations are low, as can be the serum T3 but thyroxine is usually normal. Circulating cortisol and growth hormone concentrations are often highly irregular.

MANAGEMENT OF ANOREXIA NERVOSA

Most persons meeting the full criteria for anorexia nervosa will need to be treated as inpatients for several weeks to months. They are usually stabilised medically first, and then started on nutritional rehabilitation. The approach to feeding is usually by persuading the person to accept healthy amounts of food, prescribed as medicine, with the solemn promise that they will not be allowed to become fat. Education and support help programmes should be designed to assist the person understand their condition and the need for treatment. Much patience and compassion will be needed.

Nutritional rehabilitation is only the prelude to definitive management.
The central challenge is in persuading the person to think differently about their body size and nutritional needs, and to appreciate the role that their illness has come to serve in their life. Management is also directed toward identifying and treating coexisting mood, anxiety, and personality disorders, as well as alcohol or other substance abuse. After the person's weight has been restored to a healthy range, intensive practice in patterns of healthy daily living consolidates the interventional gains. Interventions for individuals under the age of 18 years seldom succeed unless it includes the whole family. Aftercare usually requires two to three years, and may involve individual, group, or family interventional programmes.

The death rate from anorexia nervosa is as high as 18%, primarily from medical complications and suicide. Most patients who survive eventually improve, but improvement occurs over a broadly disparate time frame from years to decades later. Coexisting psychiatric conditions, especially mood disorders, personality disorders, and substance abuse, often prove to be the most difficult aspects of long-term success. Mortality can be reduced by prompt medical stabilisation of low weight and hypokalemia, and by recognition and treatment of co-occurring depressive illness (30-50% of cases). The good news is that with effective intervention (acute plus relapse prevention), the disorder is rectifiable, not merely subject to improvement. Yet damage to the body will have already been done, effectively cutting short the life span in some instances.

BULIMIA NERVOSA

"Bulimia," is derived from the Greek words for "ox" and "hunger," and is a syndrome that includes two primary elements: 1) binge eating and 2) self-induced vomiting, laxative abuse, or other measures to avoid weight gain (See Table 2). A specific criterion for bulimia is repeated episodes of binge eating (an average of twice a week for 3 months), during which patients feel that they cannot control their eating. Purging is not essential to the diagnosis, but occurs in 80% of cases. The term "nervosa" was recently added to "bulimia" to emphasize the features that it shares with anorexia nervosa, primarily the relentless pursuit of lower weight and the morbid fear of fatness. Patients with bulimia may be over, under, or at ideal body weight, with normal weight range being most common. A diagnosis of anorexia nervosa takes precedence over bulimia if weight is below 85% of normal.

Bulimia nervosa, like anorexia nervosa, usually has its beginnings in dieting. Dieters tend toward bulimia rather than anorexia when their hunger overcomes their attempt to restrict food and they begin binge eating, which is not in itself abnormal in food deprivation when faced with abundant nutrition. The clinical disorder emerges when a morbid fear of fatness entrenches itself, and patients suffer psychological distress or medical complications after binge eating and subsequent purging and especially when binges are provoked by emotional distress rather than hunger.

Bingeing is exacerbated by restricting food early in the day (no breakfast, salad for lunch), so an appetite builds that may not express itself fully until late afternoon or evening, the most common times for bingeing. In extreme cases, sufferers consume 10,000 to 30,000 calories a day and binge throughout the day. The person's social life becomes organised around secret binge and purge episodes, requiring carefully timed entrances and exits. In a subset of bulimic people, the behaviour is part of a broader pattern of abnormally impulsive behaviour, including alcohol or other drug abuse, sexual promiscuity, and stealing.

Bulimia can develop at any age from the preteens to the 50's with the peak onset of few years later than anorexia nervosa, 18-20 year old. Half of documented cases have a history of anorexia nervosa or an anorexia-like episodes. Bulimia may alternate with anorexia nervosa in an irregular sequence over several decades.

Nonspecific abnormalities of gastric emptying and bowel function can cause abdominal distension that may worsen the person's distorted perception of their body size and increase their desire to purge. Repeated regurgitation of gastric secretions erodes the enamel on the lingual surfaces of teeth. Serious complications include systemic hypokalemic alkalosis, leading to cardiac arrhythmias, renal damage, and seizures. Most deaths among patients with bulimia are caused by arrhythmias or suicide.

Even after psychological intervention has succeeded in stopping their binge / purge behaviour, people may have persistent esophageal reflux that provokes unwanted vomiting for years.

Management of Bulimia Nervosa

After diagnosis and initial medical assessment, many people with bulimia nervosa are treated as outpatients, with a goal of gradually decreasing the frequency and severity of their bingeing and purging. But some people may need to have their behavior interrupted abruptly by hospitalisation, especially if severe and intractable or accompanied by suicide plans or medical complications. Bulimia sufferers are usually surprised and relieved to find that eating moderate quantities of food three times a day does not make them fat, as they had feared.

After bingeing and purging has ceased and any medical complications are treated, the focus of management turns to long-term inhibition of binge / purge behavior with cognitive-behavioral therapy. As in management of anorexia nervosa, the health care professional must recognise the commonly coexisting psychological conditions. Regular moderate exercise is helpful in both managing stress and promoting a healthy body shape and composition. Both cognitive behavioral psychotherapy, and interpersonal psychotherapy, have been shown to produce significant enduring improvements. The disorder has a good outcome if intervention is vigorous.

OTHER EATING DISORDERS AND APPETITE

Eating disorders sometimes do not fulfil all the criteria for anorexia nervosa or bulimia. For example, a person may have lost less than 15% of body weight or have fewer than two binge-purge episodes per week for 3 months, but have other typical, albeit milder, features of the disorders. These are called atypical eating disorders. Binge eating disorders (binges with no compensation) is a common "atypical" eating disorder.

Eating disorders can be manifestations or secondary complications of other medical and psychological conditions. For example, major depressive illness frequently causes substantial weight loss. Schizophrenia may lead to weight loss in individuals deluded by suspicions of poisoned food. Patients with dementia syndromes such as Alzheimer's disease have progressive cognitive incapacity that may prevent them from eating enough. Patients with panic disorder who develop social phobias about eating or vomiting in public may avoid food.

A number of medical conditions cause weight loss, including a few in which patients actually increase their caloric intake, e.g., hyperthyroidism, insulin-dependent (Type 1) diabetes mellitus, malabsorption, tuberculosis, and intestinal parasites. Tumours of the hypothalamus can cause appetite to decrease or increase. Decreased consciousness, cocaine or amphetamine abuse, and many drugs can all cause people to lose weight. But in contrast to patients with anorexia nervosa, people with weight disorders caused by these other medical conditions usually understand that they are too thin and manifest no phobic fear of fatness.

OBESITY

In some people, obesity appears to be a genetic trait. In such circumstances, the individual typically become progressively and severely overweight before adolescence, and will ordinarily have a family history of extreme obesity. When both parents are obese, a child has a 90% chance of being overweight; when one parent is obese, a 40% chance; and when neither parent is obese, this reduces to 10%. A few syndromes of congenital hypothalamic hyperphagia have been described, e.g. the Prader Willi syndrome, in which young children develop severe obesity, hypogonadism, and some degree of mental retardation.

Most often, mild to moderate obesity is acquired later in life. In addition to a genetic predisposition, this common form of overweight is attributable principally to a "good life" of ample, dense calories, with infrequent exercise and poor stress management.

The essential intervention for people with routine mild to moderate adult-onset obesity is to approach it non-judgmentally, appreciate its multifaceted pathogenesis, and consider critically whether the individual really needs to lose any weight, exercise more and consume fewer fats. Unless the extra weight is causing or exacerbating diabetes mellitus, hyperlipidemia, or hypertension, it is not clear that mildly to moderately obese people need to lose weight. Some authorities have demonstrated that repeated cycles of weight loss and gain may promote cardiovascular illness as much as or even more than simply remaining at a mildly elevated but stable weight.

The only ways proven to treat mild to moderate obesity effectively and safely over the long term are those in which the person changes their eating habits by lowering the caloric density of their food, and get more exercise. Nearly all of the appetite-suppressing drugs, whether prescribed or over-the-counter (which mostly contain phenylpropanolamine or caffeine), *are followed by a weight rebound*. Furthermore, many of these compounds can cause significant medical and/or psychological complications.

People with morbid obesity (more than twice 'normal' weight) can suffer life-threatening consequences such as cardiopulmonary failure. For such persons, more aggressive approaches can sometimes be justified, as behavioural techniques alone are seldom successful. Modern medical practices have on occassion intervened utilising gastric surgery with stapling to reduce stomach size, which has supplanted previous intestinal bypass procedures, (these led to frequent complications in as many as 50% of patients). Gastric stapling has been quoted as being successful for morbid obesity, a serious procedure but with fewer complications.

ABNORMALITIES OF BODY COMPOSITION AND RATIO

Prudent clinicians will not push overweight people to lose weight unless they have clear evidence of health risks. Percent of body fat, which can be estimated based on skinfold thickness and distribution of fat rather than weight, may be more critical factors in determining medical risk than weight alone. Risks to health and outcomes may increase when body fat exceeds 26-28% in women and men.

Distribution of body fat is also important. Higher concentration of fat in the abdomen in men, and in the upper torso especially around the shoulders in women, has been linked to earlier onset of coronary artery disease and noninsulin-dependent (type II) diabetes mellitus. Risk for cardiovascular disease increases when the ratio of waist circumference to hip circumference exceeds 0.95 in men and 0.80 in women. However, little is known about what hormonal, genetic and other factors determine body fat distribution, how to alter it, and how much the associated cardiovascular risks can be reversed. Recently, enthusiasm for using growth hormone or testosterone in men in their 50's - 70's to decrease fat, and to increase muscle mass, has been espoused but conclusive studies of the enduring risks and benefits are far from completed. Although women may not like a gynoid ("pear") distribution of weight, it appears safer than the android ("apple") distribution. Exercise has been demonstrated in convincing studies to be an independent health promoting factor, especially in formally sedentary people who now regularly maintain about 4-6 hours of moderate exercise per week. For those people with a BMI of 26-30 (19-25 is normal), becoming fitter (↑ lean muscle mass and exercise capacity) appears to be as important as losing weight.

CONCLUSION

Body weight is normally determined by poorly understood genetic factors, calories consumed, basal energy expenditure and with exercise.

The key feature of the major eating disorders, anorexia and bulimia nervosa, is a phobic fear of fatness that leads to self-induced starvation or bingeing and purging. Typically begun as dieting spurred by social norms and personal vulnerabilities, the conditions can become self-sustaining and life-threatening.

Eating disorders can cause such diverse problems as amenorrhea, esophagitis, irritable bowel syndrome, and osteopenia.

Weight loss secondary to other conditions can be distinguished from primary eating disorders by the person's recognition that they are too thin.

Morbid obesity increases cardiopulmonary mortality, which may justify aggressive behavioural modification programmes and in some instances, surgical intervention. Mildly to moderately overweight persons may require intervention only if their weight is causing or worsening other medical conditions, and generally benefit by increasing physical activity and decreasing fat consumption without the chronic hunger of dieting. Generally, dieting proves ineffective, costly, burdensome, and is often undertaken in an unhealthy manner.

Good nutrition is important - see the article on “The Paleolithic Diet” for an up to date view of eating like a caveman in the 21st century for more information

FURTHER READING SUGGESTIONS

- The Paleolithic Diet
- Food Allergies, Coeliac Disease, Milk Intolerance & Nutritional Issues

CHILDREN'S EATING DISORDERS / DISLIKES

SOME USEFUL TIPS IF YOUR CHILD REFUSES VEGETABLES

Parents often find it upsetting when a child refuses to eat their vegetables. Sometimes it becomes a real battle. But it's best not to force a child to finish his vegetables. Forcing may only strengthen the dislike. Since a variety of vegetables supply needed vitamins and minerals in a child's diet, don't give up. A different approach may do the trick.

Serve and eat a variety of vegetables. Realize that as a parent your eating habits will influence your child's habits.

Prepare vegetables to retain their taste, texture, eye appeal, and vitamin content, and avoid overcooking them. Many children actually prefer raw vegetables that are crunchy and brightly coloured. Children also enjoy raw vegetables served with a dip (nut spreads - apart from peanut butter, yogurt, or bean dip).

- Vegetables are best prepared by lightly stir-frying or steaming.
- Have your child help prepare vegetables for a snack, salad, or dinner.
- If it's garden season, have your child help you plant vegetable seeds and watch them grow into something good to eat.
- If you have some time, cut the vegetables into fun shapes and call them catchy names - carrot "coins", pepper "pinwheels", broccoli "flowers", and "vegetable pick up sticks."
- Don't give up on vegetables. Try again. From time to time reintroduce vegetables in your child's diet. A child who refuses a vegetable the first time may enjoy it the second or third time around.
- Add vegetables into other foods you prepare if all else fails. Make gluten free breads or muffins with pumpkin, squash, or carrots, chop a variety of vegetables and add to tomato sauce, meatloaf, omelettes, or casseroles, make soups using pureed vegetables (cream of broccoli, carrot, spinach).
- Extra fruit and fruit juice (especially citrus types) can help supply some of the nutrients your child is missing during those times when he refuses to eat vegetables.

WHAT TO DO IF YOU'RE CHILD REFUSES TO EAT

Preschool children will often go on "hunger strikes." To find a solution to the problem, you must first try and find the reason. Your child may be less hungry because he is in a slow growth stage or he may be practicing newly discovered independence. Refusing meals is a novel way to assert themselves.

However, more often than not, certain eating patterns may be interfere with mealtime. The following situations may be the reasons behind your child's hunger strike or difficult feeding times.

Ask yourself:

- Does your child refuse to eat at meals because he is filling up with snacks or drinks throughout the day?
- Does your child refuse to eat at meals because he knows that you allow him to get his own way when he does eat?
- Are mealtimes relaxed and pleasant times for the family?
- Do you expect your child to eat more than he can? Remember, a child needs fewer calories than an adult.
- Does your child get so excited from play that he becomes too tired to eat at mealtimes?
- Do you serve foods in forms young children can manage easily such as bite-sized pieces and foods they can pick up with their fingers?
- Are the foods you serve appetizing? Is there variety in the size and shape of food (round, sticks, cubes), texture of food (crisp, soft), flavour of food (strong, mild, sweet and sour), form of food (cooked and raw) and colour of food (contrasting colours of green, red, and orange in combination with foods of little colour)?

HERE ARE A FEW TIPS TO MAKE LIFE EASIER DURING THESE STAGES:

- Accept the "hunger strike" calmly. Try not to visibly show your disapproval or concern when your child refuses to eat. Your child's refusal to eat is probably not your fault.
- Give your child the extra attention he may be looking for between meals not during meals.
- Plan a quiet activity for your child before a meal such as reading a story or singing a song.
- Avoid becoming a short-order cook. Don't feed your child until the next scheduled snack or meal.
- Make mealtime pleasant. This is not the time to bring up family gripes or to lecture on good nutrition.
- Many children go on food strikes for a day or two. It is a perfectly normal pattern and unlikely to cause any ill effects. Before you know it, your child will be eating again.
- If the "strike" continues longer than a few days, talk to a doctor to be sure your child is not ill.

WHAT TO DO IF YOUR CHILD SNACKS

First, you will need to recognise that there is nothing wrong with snacking per se. Children have small stomachs and cannot always eat enough food in three meals to meet their energy needs or to satisfy their appetites longer than three to four hours. Snacks can be an important part of your child's diet provided they are nutritious and used at proper times during the day.

As a parent, you will need to take a firm stand on what snacks are and are not allowed between meals at home. Offer them midway between meals. Set a time for snacks so that your child will not get into the habit of refusing meals because he knows a snack is soon to follow. Having a set time in mind also avoids the pattern of your child eating on demand all day.

Plan ahead so you can offer the most nutritious snack to your child. A satisfying nutritious snack usually contains some protein, fat, and carbohydrate. Therefore, emphasize combinations of food such as fresh fruits and vegetables, nuts (almonds, walnuts, macadamias- no peanuts however), gluten free bread and cereal products, calcium enriched rice milk, lean meats, fish and poultry and meat substitutes like dry beans etc.. Use snack time as a good time to introduce new foods to your child.

Avoid advertised snack foods like chips, snack cakes, cookies, fruit drinks, soda, and candy. These foods are high in calories, gluten (especially wheat), refined sugar or artificial sweeteners (aspartame, saccharin), trans fats, and / or salt , and contain few nutrients. There are an increasing number of gluten-free, dairy-free alternatives in supermarkets these days and it is worth the effort to investigate them since healthy eating patterns are set in childhood.

WHAT TO DO IF YOUR CHILD WON'T DRINK MILK

There is no good reason for a human being to drink milk despite all the advertising hype. For example, there are no studies that prove that drinking milk prevents osteoporosis. In fact it has been found that drinking milk the way it has been processed, does not prevent osteoporosis at all and that it is actually dangerous to your health and exacerbates allergies (e.g. Asthma and eczema) See the Food Allergies that includes a section on Milk Intolerance article.

All the essential nutrients: calcium, vitamin D, riboflavin, and protein found in milk can be obtained from other food sources So, if your child refuses to drink milk, don't panic. Find alternatives that will supply him with the better sources of these vitamins and minerals and if a desire for a smoothie overwhelms then use calcium fortified rice milk and a protein powder as a base. Vitamin D is most available from vitamin D fortified milk and from exposure to sunlight. If you are concerned that your child may not be meeting his dietary needs, consult your paediatrician or nutritionist about a supplement.

IF YOUR CHILD IS OVERWEIGHT

Common reasons for obesity during childhood are overeating and lack of daily exercise. Preventing obesity in children will require vigilance on the part of parents because of the plethora of junk foods available at school canteens and from fast food chain outlets. Limiting the amount of snack food, daily exercise and eating whole organic foods which are nutrient dense are some suggestions which can help prevent obesity during the growing years. Apart from the expected variations in growth (during growth spurts), most children tend to grow at a consistent rate. However, occasionally a parent, teacher or health care professional will notice a sizable increase in an infant's or child's rate of weight gain. Should this weight gain continue, it is prudent to find out why.
Regular visits to your health care professional are recommended if you have concerns in this area.

Managing your child's weight is best accomplished if healthy eating and lifestyle patterns are modelled by the whole family as family dynamics play a major role

For more information or to make an appointment please contact us on (02) 9637 9998 during business hours.

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