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Eating Disorders in School-Aged Children
Terri Darden and Kelly Hedrick

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR) lists criteria for anorexia nervosa that include refusing to maintain a normal body weight, weighing 85% below normal. Postmenarcheal females can be amenorrheic, having the absence of at least three consecutive menstrual cycles. Individuals diagnosed with this disorder have a fear of gaining weight or becoming fat. The DSM-IV-TR reports that 90% of anorexia nervosa cases occur in females (DSM-IV-TR, 2005).

Research shows that at some time during their adolescence around half of high school and college age girls and 10% of boys will develop an eating related disorder. While only 20% of girls may develop a diagnosed eating disorder like anorexia or bulimia, thirty percent have problems with eating and body image perceptions. The rate of eating disorders among adolescent girls has increased 300% since 1960. The percentage of eating disorders diagnosed among boys and younger children (ages 8–11) is also on the rise (Cumella, 2004).

The criterion for bulimia nervosa includes features of both binge eating and inappropriate compensation. Different forms of inappropriate compensation include purging, laxatives, diuretics, and excessive exercise. Binging and purging must occur an average at least twice a week for at least three months. Individuals suffering from bulimia nervosa, unlike anoxia nervosa, are able to maintain their normal body weight. Individuals often report a lack of control in their lives and feel that eating is the only thing they can control. Ninety percent of all bulimia cases are found in girls (DSM-IV TR, 2005).

Where does the foundation for eating disorders start? One study called the Teen Lifestyle Project looked at adolescent females’ body image, dieting patterns, and smoking habits. The study looked at the statement, “I’m so fat,” that is too often used by young girls. The study followed the girls over a three year period with a survey size of 300. The sample consisted of adolescent girls from lower to upper middle class families ranging in race. The girls were periodically interviewed on the above three topics. The girls regularly stated that they were fat, and that all of their friends also thought of themselves as being fat. “I’m so fat” was reported by the girls as something said many times a day. “I’m so fat” was said often when they felt they had no control over a situation.

Other reasons young girls used the saying “I’m so fat” were to show the group of their peers that they were not holding anything back about themselves, to show peers that they knew they were fat and already knew they should be on a diet, this way others would not tell them that they are fat, and to fit into a peer group by saying the same type things as the others. It is important to know that no matter what social group the girls were in, being thin was always a goal. They felt that being thin makes them popular and boys only like thin girls (Nichter & Vuckovic, 1994).

Another factor influencing the development of an eating disorder may be the issue of control. As bodies change and mature, many adolescents feel a loss of control over their bodies. In addition to body changes, adolescents typically deal with the issues of determining who they are, peer pressure, academic pressure, and stress.

Some adolescents may use eating habits as an attempt to feel a little control over their lives. By carefully regulating what they eat, either by eating too little or too much, they may feel more in control of themselves. Initially, eating disorder sufferers believe that this feeling of control helps reduce stress and anxiety. Marya’s story illustrates this point (Body Wise Handbook, 2004).

“My clothes weren’t right. My parents were weird, I didn’t fit in...I raised my hand too often at school....Then, at age 10, it seemed I woke up to a body that filled the room. Men were staring at me, and the sixth-grade boys snapped the one bra in the class. Home after school, I’d watch TV and pace. Munching chips. Talking to the dog. Staring out the window. Eating macaroni. Eating soup. Eating...” (Body Wise Handbook, 2004, p. 4).

The media has a large impact on young and old women’s self image. Hundreds of unrealistic female body images are constantly displayed on television shows, television commercials, movies, and magazines. The Teen Lifestyle Project survey also reported that one cause of young girls thinking that they are fat was their mothers. The survey indicted that mothers dieting habits have an impact on girls dieting. The girls in the study reported that 30% of their mothers told them that they needed to lose weight, however only 5% were considered clinically overweight. After all of this “fat talk” 44% were trying to lose weight dieting during the time of the survey and 51% were not (Nichter & Vuckovic, 1994). But it’s the fifty one
percent that do all of the talking that encourage the 44% to lose weight, sometimes at all costs. Sometimes it takes on the form of an eating disorder. There are a number of signs one can look for when one suspects that an individual is suffering from an eating disorder. The more common signs are significant weight loss, eating little amounts of food, and many bathroom breaks after meals. Other warning signs to look for include taking up smoking, empty laxative packages, skin discoloration, hair loss, wearing baggy clothing, broken blood vessels in the eyes, and social withdrawal with signs of depression and/or irritability (Jahraus, 2003).

Girls with anorexia may exhibit the following symptoms: loss of menstrual period, dieting with zeal when not overweight, claiming to feel “fat” when overweight is not a reality, preoccupation with food, calories, nutrition and/or cooking, denial of hunger, excessive exercising, frequent weighing, complaints of feeling bloated or nauseated when eating normal amounts of food, intermittent episodes of “binge-eating” and strange food-related behaviors. Girls with bulimia may exhibit the following symptoms: excessive concern about weight, strict dieting followed by eating binges, frequent overeating-especially when distressed, binging on high calorie, sweet food, expressing guilt or shame about eating, use of laxatives and/or vomiting to control weight, leaving for the bathroom after meals (secretive vomiting), being secretive about binges and vomiting, planning binges or opportunities to binge, feeling out of control, disappearing after a meal and depressive moods (Remuda Ranch brochure).

Sufferers of eating disorders may also engage in heavy caffeine use in the form of diet sodas or coffee without sugar. They may show intolerance of cold by shivering, having bluish skin or fingers and by wearing multiple layers of clothes. Girls with eating disorders may have skin and hair problems manifested in sallow, dry skin, and/or thin, dry hair, hair loss, and fine hair growth on the face and arms. Their faces may appear swollen, their cheeks like “chipmunk cheeks” due to swollen salivary glands. Friends, family, and others may notice mood changes such as anxiety, depression, irritability, increased obsessions and compulsions. Eating disorder victims may withdraw socially, isolating themselves from peers and family. (Cumella, 2004).

When individuals suffer from an eating disorder, there are many medical complications that can occur as a direct result of these disorders. Primary care providers on multidisciplinary teams address the issues of malnutrition, purging, and refeeding of individuals diagnosed with eating disorders. Though individuals suffering from anorexia nervosa often show more outward signs of malnutrition, individuals diagnosed with bulimia also can have many medical complications. Malnutrition occurs over time in individuals who are suffering from an eating disorder. Some complications can include a diminished brain, uterus, and kidneys, 25% loss of normal muscle mass in the heart, and bone deterioration often resulting in osteoporosis. However, if the individual returns to a normal body weight some of the organs usually return to normal size and functioning. Bone mass does not return to normal and the research is still not definite on if the brain can regenerate lost tissue (Jahraus, 2003).

Purging is often not noticed by family and friends when the individual is still in a normal body weight range. There are many forms of purging including vomiting, diuretics, and also laxatives. The medical complications of all forms of purging range from tears in the stomach and esophagus, teeth deterioration, salivary glands swelling, muscle cramping, heart rate disturbance, and constipation. Beginning to refeed individuals suffering from an eating disorder can also cause medical complications. The most severe being congestive heart failure and kidney failure. Other complications include electrolyte imbalance and refeeding hepatitis. All of these are direct complications due to the long malnutrition state their bodies have been in (Jahraus, 2003). Experts note that eating disorders have the highest mortality rate of any psychiatric disease, yet they can be treated and cured (Winik, 2004). If someone is suspected of having an eating disorder, what are their options for treatment and what steps should they take to get treatment? Initially, parents may think that they can handle it. In People Magazine, parents of a teenager with an eating disorder stated, “At first we thought we could tell her, ‘Stop it’, and she would. We thought this was self-indulgent behavior. It was only after counseling that we understood that you can’t just say, ‘Cut it out’” (Eating Disorders Information Sheet, 2004, pN. PAG).

The first step to take in the case of a possible eating disorder is to have the person have a complete assessment. This would include a medical examination to rule out any other physical causes for symptoms of eating disorders. Examinations may include laboratory tests such as complete blood counts, complete metabolic profiles, and an electrocardiogram. In severe cases where the person is more than 15% below ideal body weight, examinations may include a chest x-ray and a uric acid screening. Even more tests may be administered for patients severely underweight. A mental health assessment, preferably done by an eating disorder expert, is also very important to provide an accurate diagnosis. After these assessments are completed, the patient should pursue the
recommended level of care which may be an inpatient
treatment center, a residential center, a partial hospital, or intensive outpatient treatment (Maine, 2002).

Inpatient care is necessary when the individual’s vital signs are unstable or depressed, laboratory findings presenting acute risk, complications due to coexisting medical problems. Inpatient care is also recommended for the psychiatrically unstable whose symptoms are getting worse at a fast pace or are suicidal. Residential treatment is recommended for the medically stable who do not need intensive medical treatment or the psychiatrically ill who are unable to be helped by partial hospital or outpatient treatment (Maine, 2002).

Partial hospital care is suitable for the medically stable whose eating disorder impairs normal functioning but does not present immediate medical risk and for those who need daily assessments of physiological and mental status. Partial hospital care is also able to treat the psychiatrically stable who are unable to function in normal situations such as social situations and who are employing daily bingeing, purging or severely restricting their calorie intake. Intensive outpatient treatment is available for the medically stable who no longer need constant monitoring or the psychiatrically stable who are gaining control of their symptoms (Maine, 2002).

Once in treatment, patients may go through resistance, motivation, and change in their eating disorder. Initially those working with patients may experience resistance to changing eating patterns and must learn how to respond to resistance. Patients undergoing change will go through the change model that all individuals seeking help go through. They will begin with the pre-contemplation stage (I don’t need to change because nothing is wrong), followed by the contemplation (I know I need to change, but I …), preparation (I’m going to change), action (I am doing what is necessary in order to change), maintenance (I am committed to my recovery and prepared for a possible relapse), and relapse (I need to think about what I need for change to occur) stages (Eberly & Wall, 2004).

Remuda Ranch, an inpatient treatment center, is a Biblical-based program located in Wickenburg, Arizona. Remuda Ranch houses a team of highly skilled professionals including primary care providers, psychiatric care providers, psychologist, masters level therapist, registered dietitians, and a large staff of registered nurses, licensed practical nurses, and mental health technicians whose therapy model is based around the idea that the human body is composed of bio-psycho-social-spiritual elements. All of these elements must be balanced and working together to have a healthy individual. The average length of stay at the Remuda Ranch is 45 to 60 days. A high level of family involvement is used as part of the patient’s treatment (Remuda Ranch brochure).

Cognitive Behavioral Therapy is the approach that Remuda Ranch uses to treat their eating disorder patients. Within this model, patients are taught new skills to overcome negative thought patterns. Remuda Ranch empowers patients with skills that they can apply to their emotions and create new and positive behavior in their lives. Often eating disorders are used by individuals as a method of control over what they see as an uncontrollable life. Cognitive Behavioral Therapy gives individuals back their control over issues in their lives by helping them to control their emotions and behaviors and in turn taking the emphasis off of what they eat (Eberly & Wall, 2004). “In our view, after nutritional restoration, attending to these skills deficits is the single most important ingredient in the provision of clinical treatment for those with eating disorders” (Eberly & Wall, 2004, p.1).

Cognitive Behavioral Therapy works by using acceptance and change. The treatment team at Remuda Ranch realizes that there is a delicate balance that must be achieved with every individual suffering from an eating disorder. In order to reach a person, one must first understand the need that she has for someone to acknowledge her problems in her life that has lead her to the eating disorder. Only by using this approach can treatment start to change the behavior patterns within the individual. After this criterion has been met, the treatment team at Remuda Ranch uses four approaches to CBT skills training. First, the individual learns through observation and description how to participate with more effectiveness in their life. Second, interpersonal effectiveness, teaches the patients that all people have problems, but it is the attitude towards the problem that determines the outcome. Next, emotion regulation, teaches the patients how to own their emotions and how to better understand and decrease the suffering that their emotions bring to them. The last stage is learning to tolerate distress. Patients must learn how to handle their distress in a healthy manner. All of these stages combined aid in the recovery of patients suffering from an eating disorder (Eberly & Wall, 2003).

Another treatment method that is becoming common in the United States to treat eating disorders is called the Maudsley method. This method is the opposite of the model that Remuda Ranch uses. Instead of addressing issues of control that the individual suffering from an eating disorder such as Anorexia Nervosa might be experiencing, the Maudsley Method teaches the child’s parent ways to get their child to gain weight. The Maudsley Method encourages parents to cook their child’s favorite food and to monitor the
child for 24 hours to discourage and watch for any signs of purging. A 1997 study on 21 adolescent patients that used this method reported 90% full recovery from the eating disorder within five years (Schindehette, Sandler, Nelson, & Seaman, 2003). However, interviews with two mothers conducted by the researchers of this paper stated that the Maudsley Method did not work with their children. One mother stated that her husband forced liquids down their daughter’s throat, and this did nothing to improve the child’s condition. Another mother reported that she had the school counselor watch to make sure her daughter ate at lunch, and this only made her daughter angrier and her disorder worse because she found new ways to hide her food (personal communication, November 2004).

Psychiatric providers play yet another role in the multidisciplinary team when treating eating disorders. They determine if symptoms are part of the eating disorder or comorbid with another disorder and if an individual will respond to medication. Medication is often used in treating eating disorders, however it is never a sole means to curing an eating disorder. Medication at many facilities, including Remuda Ranch, are used to lessen the symptoms such as anxiety and depression that often accompany eating disorders. Prozac and Benadryl are used to treat anoxia and forms of medication that contain selective serotonin reuptake inhibitors (SSRI) are often used to treat bulimia. Often substance abuse, mood, and anxiety disorders are diagnosed along with an eating disorder and may need to be managed by other forms of medication (Wandler, 2003).

The school counselor can take a leadership role in developing a protocol that provides guidelines on talking with students and family members. School counselors can make referrals to health care providers with a working knowledge of eating disorders. The counselor may also want to be designated as the resource person who will become acquainted with local resources for referral (Body Wise Handbook, 2004). As the resource person, the counselor may answer questions and provide information to faculty members, arrange faculty workshops that provide continuing education credits for certification, help teachers learn how to identify signs of eating disorders, increase teachers’ awareness which may unknowingly promote disordered eating, muscle building obsessions, negative image, and size bias. School counselors can help to identify local and national experts who are qualified to diagnose eating disorders, and organize parent and community education programs that promote healthy body images (Eating Disorder Information Sheet, 2004). Counselors also need to become knowledge-able, become an advocate, be familiar with signs and symptoms of eating disorders, and take immediate action when there is a concern about a student (Body Wise Handbook, 2004).

References


Guideline for School Counselors: What Every School Counselor Should Know About Eating Disorders

Eating Disorder Criteria:

**Anorexia Nervosa**—The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR) criteria for anorexia nervosa includes a person refusing to maintain a normal body weight, weighing 85% below normal. Postmenarcheal females can be amenorrheic, having the absence of at least three consecutive menstrual cycles. Individuals diagnosed with this disorder have a fear of gaining weight or becoming fat. The DSM-IV-TR reports that 90% of anorexia nervosa cases occur in females.

**Bulimia Nervosa**—The criterion for bulimia nervosa includes features of both binge eating and inappropriate compensation. Different forms of inappropriate compensation include purging, laxatives, diuretics, and excessive exercise. Binging and purging must occur on average at least twice a week for at least three months. Individuals suffering from bulimia nervosa, unlike anorexia nervosa, are able to maintain their normal body weight. Individuals often report a lack of control in their lives and feel that eating is the only thing they can control. Ninety percent of all bulimia cases are found in girls.

Where it may start – issues of control, media images, peer pressure, academic pressure, and stress.

**Warning signs to look out for**—significant weight loss, eating little amounts of food, and many bathroom breaks after meals, include taking up smoking, empty laxative packages, skin discoloration, hair loss, wearing baggy clothing, broken blood vessels in the eyes, and social withdrawal with signs of depression and/or irritability. Girls with anorexia may exhibit the following symptoms: loss of menstrual period, dieting with zeal when not overweight, claiming to feel “fat” when overweight is not a reality, preoccupation with food, calories nutrition and/or cooking, denial of hunger, excessive exercising, frequent weighing, complaints of feeling bloated or nauseated when eating normal amounts of food, intermittent episodes of “binge-eating” and strange food related behaviors. Girls with bulimia may exhibit the following symptoms: excessive concern about weight, strict dieting followed by eating binges, frequent overeating—especially when distressed, binging on high calorie, sweet food, expressing guilt or shame about eating, use of laxatives and/or vomiting to control weight, leaving for the bathroom after meals (secretive vomiting), being secretive about binges and vomiting, planning binges or opportunities to binge, feeling out of control, disappearing after a meal and depressive moods.

**Talk to the student's parents, be familiar with the warning signs, and know referral services to give to parents.**

Kelly Hedrick is in the Masters of Education School Counseling Program at Columbus State University. She just completed her first year of academic work and will begin her Practicum at a middle school in Columbus. Kelly has a background in Domestic Violence and has worked for a year and a half at a mental health clinic before starting the masters’ program. Upon graduation, she hopes to work as a middle school counselor and eventually become licensed as a therapist.

Terri Darden is in the Masters program in School Counseling. She is a teacher/guidance counselor at a private school for K-12. She enjoys working with children and has a family of her own.