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The Efficacy of Treatment Therapies for Pre-pubescent Children with Eating Disorders

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An eating disorder is defined as an abnormal eating habit involving either an over-excessive or insufficient intake of food that is detrimental to an individual's health (Comer, 2010). The diagnosis of an eating disorder in pre-pubescent children is rare, but increasingly common. There is little research on treatment for children with an eating disorder diagnosis. In this study, I propose to test three different types of therapy on sixty inpatient children (ages nine to eleven) diagnosed with an eating disorder to examine the effect each type of therapy has on a child.

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Anorexia nervosa and bulimia nervosa are two fast growing problems in the United States (Collins, 2012). Today there are a total of eight million people in the United States with an eating disorder; women make up about seven million, and men make up one million (Collins, 2012). Eating disorders are no longer only occurring in adolescents and adults, but are now increasingly diagnosed in children (Collins, 2012). About 42% of six to nine year old girls wish they were thinner, and 80% of 10 year olds are afraid of being fat (Collins, 2012).

As reviewed by Comer (2010), anorexia nervosa is an eating disorder in which weight loss becomes excessive to a point of where the individual is unhealthy. The individual may diet, or exercise excessively, such that they will burn more calories in a workout than they consume daily, or the individual will take part in purging. In order to be diagnosed with anorexia nervosa, symptoms include having a strong fear of gaining weight, having a distorted body image, and refusing to maintain a healthy weight (Clarke, Gordon, Hatch, Kohn, Madden, Touyz, & Williams, 2010). As a result of the restricted caloric intake, females often cease menstruation due to the lack of nutrition (Clarke et al., 2010).

Unlike anorexia nervosa, bulimia nervosa is defined as an eating disorder in which an individual will binge without self-control, and purge in order to prevent gaining weight. As reviewed by Comer (2010), most individuals with bulimia nervosa will binge in secrecy. The binges will result in the individual feeling disgusted with themselves, which lead them to purge. Through purging a feeling of self-relief is achieved. With bulimia nervosa, the individual will portray a normal weight, but have a distorted body image when viewing themselves. Having a distorted body image means that although the individual is at a healthy weight they cannot help but view themselves as overweight. Since most bulimic individuals are of a normal, healthy weight, an outsider will not know that the individual is in fact suffering from an eating disorder. The weight of bulimia patients usually stays within a normal range. However, in some severe cases an individual may

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become seriously underweight classifying them as an anorexic.

It is not an easy task to identify that someone has an eating disorder. With bulimia, a dental exam is a critical way to begin to diagnose. Due to frequent purging, the enamel of the teeth will wear away, because of the constant exposure to stomach acid from persistent vomiting. A physical exam will further reveal electrolyte imbalances through a blood test, broken blood vessels in the eyes from the constant vomiting, rashes and pimples (reviewed in Comer, 2010).

Although there are tests to confirm an eating disorder, when it comes to children it is even more difficult to diagnose an eating disorder, largely because doctors are not expecting there to be one. Bryant-Waugh, Fosson, and Lask (1992) tested whether doctors recognize eating disorders in children or not. Case studies of two 11 year olds were presented to pediatricians and primary care physicians in which they had to diagnose each individual. One third of pediatricians (31%) suggested an eating disorder, whereas only two percent of the primary care physicians did. The pediatricians were more likely to diagnose a child with an eating disorder when presented with eating problems and weight loss than a primary care physician. These data suggest that a physicians' knowledge of a child with anorexia is limited, which is problematic because the child should get help sooner than later (Bryant-Waugh, Fosson, and Lask, 1992). Bryant-Waugh, Fosson, and Lask (1992) found that in families that had a child with an eating disorder, it took months before being referred to a psychiatric clinic for help because doctors failed to diagnose an eating disorder in a child. The failure to identify an eating disorder also often delays their treatment. Families are too focused on the medical issue related to anorexia nervosa that they fail to treat the underlying behavioral or emotional issues. By ignoring the underlying behavioral or emotional issues, the individual will continue to have a disorder because their treatment is not aimed at these underlying causes (Bryant-Waugh, Fosson,& Lask, 1992).

Co-morbidities are another problematic issue with diagnoses. Co-morbidity can be defined as the presence of one or more disorders in addition to a primary disorder or disease (Comer, 2010). For example, adolescents were often found to suffer from an eating disorder in addition to mental problems such as: self-mutilation or suicidal tendencies (Leichner & Manley, 2003). In this study, some adolescents experienced feelings of self-worthlessness or undeservingness resulting in suicidal thoughts. Individuals with these feelings are powerless over their eating disorder. Leichner and Manley (2003) focused on select treatments to improve the individual's condition in addition to their co-existing cognitive issues.

There have been advancements in therapy treatments for eating disorders over the past years. Cognitive therapy is one helpful therapy used for an individual with an eating disorder to try. It is a way for the individual to express their personal feelings in an environment in which they can be encouraged not to give up hope (Leichner & Manley, 2003). The individual can tackle the mental issues at hand by using this psycho-education to overcome their feelings of self-worthlessness (Leichner & Manley, 2003). According to Grilo, Vitousek & Wilson (2007), cognitive behavioral therapy is a treatment designed to promote an individual's drive to change. This therapy is used to change a person suffering from bulimia's eating habits, while preventing relapse, and enhancing their body image (Grilo, Vitousek & Wilson 2007). The therapy lasted anywhere from four to six months, and was made up of 16 to 20 sessions. Statistics show that in 30% to 50% of all cases the binging and purging of bulimia was eliminated entirely (Grilo, Vitousek & Wilson 2007).

Currently, family therapy is the primary choice for patients diagnosed with anorexia nervosa, and cognitive behavioral therapy for those diagnosed with bulimia nervosa (Grilo, Vitousek & Wilson 2007). 50% of anorexia patients will make a full recovery (Grilo, Vitousek & Wilson 2007). A specific family therapy treatment study involved a 6 to 12 month period with about 10 to 20 family sessions. In the early stages, the parents were told to take full control over the anorexic, and were taught effective ways to handle the situation. The results were that 90% of the patients were symptom free five years after therapy. This was true of the individuals who were younger at the age of onset. For those individuals older at the age of onset, treatment was ineffective (Grilo, Vitousek & Wilson 2007). The use of family therapy has been shown to be an effective part of treatment for adolescents with eating disorders in another study as well (Leichner & Manley, 2003). Leichner and Manley (2003) stated that parental involvement during the treatment of adolescents can be important especially when there is positive communication within the family. By having positive communication the risk for suicide diminishes (Leichner & Manley, 2003). Parental involvement was shown to be highly effective for children and adolescents undergoing inpatient and outpatient

treatment (Liebman, Sit, Weaver, 2012). When the patient's family was involved in therapy, the condition improved. Having a family support system is particularly important for outpatients, in contrast to inpatients, where medical professionals are not always available. The goal of outpatient treatment relies heavily on the patient. Once in outpatient, the family members were an important variable in ensuring the patient ate, and gained weight (Liebman, Sit, & Weaver, 2012). Liebman, Sit, and Weaver (2012) examined patients who transitioned from inpatient to outpatient and found that although, there are required family office sessions, a majority of the recovery was done in the home setting away from medical professionals. The patients keep a log book of their emotions, eating habits, and any arguments had with their family. Behavioral change was the primary focus of the individual, in addition to adequate caloric intake for proper weight gain. Having family support does lower the chance of relapse. Once weight gain has successfully occurred, then any other underlying issue presented can be addressed (Liebman, Sit & Weaver, 2012).

Another treatment used on patients with bulimia nervosa is interpersonal psychotherapy (Grilo, Vitousek & Wilson 2007). This treatment was designed to help an individual identify and change any interpersonal problem they feel is caused by the eating disorder. Interpersonal psychotherapy does not directly focus on the symptoms of the eating disorder (Grilo, Vitousek & Wilson 2007). However, since cognitive behavioral therapy is proven to be more effective in treatment, the interpersonal psychotherapy is used as an alternative (Grilo, Vitousek & Wilson 2007).

In Bryant-Waugh, Fosson, and Knibbs' study (1987) children admitted to hospitals for treatment were studied. These children portrayed a significant improvement, not only by weight gain but mood, social skills and communication skills as well.

The cause of anorexia nervosa and bulimia nervosa are unknown. Today however, researchers use a multidimensional risk perspective. A multidimensional risk perspective places individuals at risk for eating disorders based on identifiable factors. Among the identifiable factors are: ego, cognitive, and mood disturbances, as well as societal, family, and multicultural pressures (Reviewed in Comer, 2010). In one study, Bryant-Waugh, Fosson, and Knibbs (1987) studied the clinical manifestations, family patterns and hospital treatments for children under the age of 15 who self-starved. These children had food avoidance which resulted in their weight loss. Psychiatric and psychological background records were reviewed and the children were found to have a distorted body image, fear of becoming fat, depression, food avoidance, excessive exercise, and a history of binging; which classified them as having an eating disorder (Bryant-Waugh et al., 1987). Bryant-Waugh et al., (1987) assessed family patterns to see if any contributed to children with eating disorders. In many cases, a lack of privacy in the home was found, children had over protective parents, and family communication problems. A history of anorexia was found in some families, as well as a history of a mental illness, alcoholism, and anxiety (Bryant-Waugh et al., 1987).

When it comes to eating disorders, females are more likely to be diagnosed than males (Comer, 2010). Attie and Brooks (1989) studied the emergence of eating disorders in girls. The physical changes brought on by puberty, personality development, and family relationships were taken into account to determine if they contributed to the development of eating disorders (Attie & Brooks, 1989). The findings showed that eating disorders emerged in response to the physical changes occurring during puberty. Girls who felt more negatively about their bodies were found likely to develop an eating disorder (Attie & Brooks, 1989). Findings also suggest that body image becomes a main focus, and that making an effort to control weight heightened during middle-school years, during which the adolescent is completing their pubertal growth (Attie & Brooks, 1989). There was no link found between the girls' family relationships and eating disorders once other factors such as pubertal development were taken into account (Attie & Brooks, 1989). Personality variables do not have much of an effect until middle to late adolescent years in which they will account for more than the physical changes (Attie & Brooks, 1989).

Vitousek and Manke (1994) researched personality as a direct predictor of eating disorders. Women who were anorexic tended to have personality traits such as: being tense, hyperactive, alert and/or rigid. These women were found to walk, talk, and think extremely rapidly. An anorexic individual will often be extremely driven and ambitious yet feels insecure, and is an introvert (Vitousek & Manke, 1994). The women with bulimia nervosa were found to have great levels of impulsivity, as well as qualities of restraint and disinhibition which accounted for the reason these individuals engage in binging and purging (Vitousek & Make, 1994). They are able to restrain from eating in certain situations, but then in others lose total control to a point where they are overindulging.

Eating disorders are increasingly common in pre-pubescent children. However, there is very little research

on treatment for children. I propose a study to test the efficacy of three different types on therapy on pre-pubescent children. I predict individuals will advance and do much better in cognitive therapy sessions because they are one-on-one and it gives the individual a better insight to their disorder at present.

Research Question

What are the effects of different types of therapy sessions on pre-pubescent children with either anorexia nervosa or bulimia nervosa?

PROPOSED METHOD

Study Design

This is an experimental study, designed to test different treatment therapies for pre-pubescent children with eating disorders.

Participants

Sixty children within the ages of nine years old to eleven years old with a confirmed diagnosis of either anorexia nervosa or bulimia nervosa will be recruited for this study referred by a pediatrician. Each child will be admitted voluntarily for clinical inpatient therapy. Children will be randomly assigned to one of three therapies: cognitive therapy, family therapy, and social-group therapy.

Procedure

Each child will attend their therapy session daily. For the cognitive therapy, the child will undergo a therapy session individually (one-on-one) with a therapist. This therapy session aims to have the individual acknowledge his/her feelings and emotions, and to have the individual recognize his/her eating disorder. The family therapy sessions will have the child undergo daily sessions with the parents present and a therapist. The social-group therapy will have a group of four children and one therapist meeting to talk about the eating disorders each child suffers from. The therapy sessions will continue for about six weeks, looking for improvement in the child's health, mental, and the behavioral and emotional status by the end. Each child will be given a Rosenberg Self-Esteem survey to fill out at the start of the six weeks. Each child will also receive a body image scale in which they will have to circle an image based on how they feel their body closely resembles. Following each therapy session, the individual will keep a log of how the session went, any accomplishments, and how they feel. The main focus of the three therapies is getting the child to feel secure in their own skin while overcoming their eating disorder, and any mental or behavioral issues in association. I will compare the way in which each child feels mentally and physically post-treatment. Post-treatment, the child will again receive a Rosenberg Self-Esteem survey, as well as a body-image scaled. The outcomes of the therapy sessions will be based off of the results of the daily logs, the Rosenberg Self-Esteem survey and the body image scale.

CONCLUDING REMARKS

Significance

It is expected that this study will provide new and insightful information on the subject of children with eating disorders. There has not been much research performed on children of ages six to eleven, but with this study the main focus is on these children. With the outcome of this study, it is expected that within a controlled environment, a therapy session that works for most will be concluded and therefore used on children diagnosed with an eating disorder in the future.

Limitations

There are limitations to this study. First, the study is restricted to providing treatment to children of the ages nine to eleven, inpatient only. So the results are limited to a select population. The children are already diagnosed so therefore, the parents are aware of the presenting problem. Children also of these ages are very reliant on their parents. However, this study is to focus on their independence in select therapy sessions. These children may not even been fully aware of their presenting problem, and may need their parents for guidance in many situations. By not having their parents always with them, invalid information may be obtained.

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