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Adolescent eating disorders : causes, implications, and treatment

Margaret P. Messenger
University of Northern Iowa

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Abstract

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ADOLESCENT EATING DISORDERS: CAUSES, IMPLICATIONS, AND TREATMENT

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Margaret P. Messenger

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John K. Smith
Head, Department of Educational Leadership, Counseling, and Postsecondary Education

Abstract

The purpose of this research is to better understand eating disorders. Possible causes such as social and cultural factors, family environment, and personal characteristics are stressed. Health complications for both adolescent males and females are discussed. Therapy approaches such as treatment and prevention for adolescents are also described.

"I wasn't eating much, I exercised constantly, I isolated myself in my room, looking at myself in the mirror, crying and punching my stomach because I hated the way I looked." This quote is an example of the distorted thoughts and actions adolescents suffering from an eating disorder experience. These experiences stem from distorted views they have about themselves, as well as how they think others perceive them. Costin (1999) found that females represent 90 to 95 percent of eating disorder cases. In fact, Menassa (2004) stated that "eating disorders has been ranked the third most common chronic illness among adolescent females in the United States" (p.24). However, although eating disorders are basically a female problem, there has been an increase of male cases within the past few years, according to Costin. Due to suicide, starvation, and cardiac arrest, there is a 10 percent mortality rate with eating disorders according to Menassa. Consequently, there is a dire need for increased knowledge about causes, implications, and treatment by both school personnel and parents so that eating disorders can be effectively prevented or treated.

Anorexia nervosa and bulimia nervosa are two eating disorders commonly found among adolescents (Menassa, 2004). Although both are eating disorders, they involve different aspects. According to Menassa, anorexia nervosa is characterized by an unrealistic view of body image, including excessive weight loss and denial of the danger of being too thin. Due to this denial, anorexics will

be afraid of gaining weight, when in reality they are already underweight. On the other hand, Bulimia nervosa consists of binge eating. The individual eats large amounts of food within a short time followed by self-induced vomiting, laxative use, or excessive exercise to prevent weight gain (Menassa, 2004).

One of the most effective ways to increase the knowledge about eating disorders is through school counselors. Counselors have an opportunity to act as role models and give important information regarding healthy eating behaviors to students (Ray, 2004). According to Manley (as cited in Ray, 2004), having direct contact with parents, teachers, coaches and community members allows school counselors to educate students about the characteristics and symptoms of eating disorders, prevalence rates in adolescents, risk factors and prevention. More importantly, school counselors have the advantage of identifying students with eating disorders at an early stage. They are able recognize students' attitude changes around food, weight, and body shape (Ray). If characteristics of eating disorders should arise, the school counselor has resources such as referral agencies and doctors that are specialized in working with these concerns (Ray).

The purpose of this paper is to provide essential knowledge regarding eating disorders, beginning with the history of eating disorders. Social cultural factors such as the media, sexual orientation, and activity involvement will be discussed. The impact of communication patterns, emotional connection, and sexual abuse

within the family environment will be addressed. Information regarding health complications, treatment and prevention is also provided.

History of Eating Disorders

It is frightening to think about how eating disorders have become so predominant. The occurrence of eating disorders has greatly increased the past 50 years for females 10-24 years old (Hoek, Hoeken, & Seidell, 2003). When referencing historical records, Hoek, Hoeken and Seidell found eating disorders greatly increased from 7.4 per 100,000 people in 1980 to 51.7 per 100,000 people in 1993.

The term eating disorders has been around since the late 1800's. In fact, during the middle ages, self-starvation was a regular religious practice until it was eventually recognized as a disorder (Menassa, 2004). Menassa noted that the first documented case for the physical symptoms of anorexia nervosa was in the early 1800's by Sir William Gull in England and the first emotional disturbance of anorexia was recorded by Charles Laseque in France (Menassa). The first symptom of bulima was noted many years later in 1959 (Menassa). According to Costin (1999), the first case study that contained descriptive detail was in 1933 in a diary kept by Ellen West which revealed that she no longer wanted to deal with her obsession with thinness and food and committed suicide.

Although eating disorders have been around for over two hundred years, the concern about eating disorders has surfaced only within the past fifteen to twenty

years (Costin, 1999). Originating from Greek, anorexia means lack of appetite or avoidance and dislike of food (Blinder & Chao, 1994). "Bulimia, derived from the Greek, means ravenous hunger"..."The patient practices binge eating that consists of self-induced vomiting, ruminatory regurgitation, and laxative abuse" (p.16).

Prior to the 1980's, it was difficult to identify a person with a true diagnosis of an eating disorder (Costin, 1999). Furthermore, very few mental health professionals or dietitians made it a priority to identify eating disorders (Seid, 1994). Because eating disorders represent a life threatening disease, every professional in the counseling field should have some understanding of these disorders. Therefore, professionals should have a heightened awareness of the need to not only provide counseling for adolescents with a diagnosed eating disorder, but for anyone struggling with problems of eating and weight (Seid).

Social and Cultural Factors

Eating disorders are often a result of social and cultural factors surrounding young people. The media, sexual orientation, and athletic involvement are the three social factors that will be discussed.

Media

The media regularly sends out the message that being thin is better, resulting in some individuals feeling this pressure and developing eating disorders. Messages such as, "Loose weight now, ask me how," "Lose 20 pounds in 20 days," "Get the

body that gets the guys," "Flatten your stomach," and "Reduce those thighs" are all messages found in magazines and newspapers, on billboards, in television commercials, and bumper on stickers (Costin, 1999). Costin found a connection between diet commercials and a decrease in body size among playboy models and Miss America contestants. Rothblum (1994) found that sales pitches are not as effective if they include unattractive women. For example, television programs such as the Charlie's Angels characters portrayed three extremely attractive women portraying values of attractiveness. Rothblum suggested that television shows such as this one, which are watched by male college students, increase the standards of attractiveness of women. As a result of only seeing very attractive females in the media, "90-95% of American women feel they don't measure up and they are strange" (p. 8).

Sexual Orientation

Thomson (1996) stated that heterosexual women and gay men had lower ideal weights and were more anxious with their weight than heterosexual men and lesbians. Although males with all variations of sexual orientations develop eating disorders, there has been an increased correlation between sexual orientation and the onset of eating disorders (Costin, 1999). Costin found that cultural pressures within the homosexual community to be thin has increased the risk of eating disorders among homosexual men. In addition, the conflict between gender

identity and sexual orientation also causes eating disorders, but according to Costin, the conflict is resolved by decreasing their sexual drive through starvation.

Involvement in Athletics

Both males and females involved in athletics are at higher risk for developing eating disorders and body image concerns (Thompson, 1996). Specifically, Beals (2004) noted that the prevalence of eating disorders among female athletes ranges from 1% to 62% and between 0% to 57% in male athletes. Athletes at greatest risk are those participating in sports that stress leanness at low competition levels (Shelby, 2000). Thompson found that athletes such as gymnasts, runners, body builders, rowers, and wrestlers are among the highest in body image dissatisfaction. Beals stressed that these athletes are expected to be thin so they can achieve their peak athletic performance. On a related note, athletes receive a big part of their self-concept from their performance, resulting in their sense of self-worth and self-esteem (Beals). Therefore, the combination of maintaining a low body weight and athletic success makes it hard for the athlete to separate his or her anorexic identity from athletic identity, thus complicating treatment (Beals).

Despite the fact that it is common for 3.4% to 66% of female athletes to experience menstrual dysfunction as a result from their leanness and high training volume, the reality is that athletes who suffer from an eating disorder will want to hide this by claiming that it is a result of their intense training (Beals, 2004).

Moreover, Beals revealed that athletes with eating disorders avoid "high-risk" situations such as eating with the team due to the fear that other teammates will notice their capability of eating a lot of food but staying so thin, or avoiding eating altogether. Eventually, hiding becomes difficult when the team is on a road trip, causing tremendous anxiety which hinders competition and performance (Beals).

Family Environment

Conflict and communication patterns, emotional connections or lack thereof, and sexual abuse within the family are factors that have been shown to relate to eating disorders (Botta & Dumlao, 2002).

Conflict and Communication Patterns

According to Botta and Dumlao (2002), communication patterns within a father/daughter relationship as well as a mother/daughter relationship are important in an adolescent's life. The father/daughter communication pattern becomes especially important when conflict occurs. Specifically, if conflict is not resolved, eating disorders and other forms of psychopathology can develop (Botta and Dumlao). Therefore, Botta and Dumlao stated that the outcome of adolescent psychological development is directly related to how conflict resolution is addressed within family relationships.

There is also link between low self-esteem and eating disorders. Botta and Dumlao (2002) found that low self-esteem can be the result of the weak

father/daughter relationship and eventually eating disorders are used as a substitute. There seem to be two extremes of a father/daughter relationship that may be the cause of eating disorders. On one hand, the father may be over controlling and excessively restrictive, and on the other hand, the father may fail to support the open communication of ideas and feelings (Botta and Dumlao). Although these are different extremes, they both lead to low self-esteem and eventually can result in eating disorders (Botta & Dumlao). A comparison study was conducted between fathers who had a daughter with an eating disorder and without an eating disorder. Botta and Dumlao found that the eating disordered daughters had fathers who used an increased amount of negative communication that included a high amount of belittling and blaming.

Emotional Connection

Motley (1997) described how children connect eating with physical and emotional fulfillment or deprivation from birth. Specifically, there is an emotional connection between a baby and its mother, who is the first to provide it with food (Motley). It is important for mothers to set a good example for their children because a weak relationship or bond between mother and daughter can put the child on the wrong track. Setting a good example may prevent their children from receiving stereotypical views of body shape and dieting from society as well as from mothers themselves (Motley). Therefore, a positive emotional connection between mother and child will result in positive self-esteem

and a healthy relationship with food. Unfortunately poor body image and negative beliefs about dieting and food are occuring more frequently due to weak emotional connections between mother and daughter (Motley). In addition, Motley stated that eating disorders also are influenced by insecurity or anxiety attachment which stems from low self-esteem, bad relationships, and unrealistic character development.

Motley (1997) noted that "females within a family system tend to develop unhealthy behaviors and attitudes as a result of a genetic propensity to gain weight, familial food preferences, family economics, family attitudes about dieting, and the family's negative attitude toward fitness" (p.5). Although the media, magazines, movies, and books readily influence young females, it is important for mothers to develop healthy attitudes toward food and their body. This responsibility falls on the mother because she is seen as the meal-planner and therefore passes on ideas about food and self-image (Motley). Motley also found when treating a client who possesses a weak relationship with food that the family as a whole plays a significant role in creating a positive attitude toward food. Therefore family counseling becomes a necessity to change the environments that influenced the advancement of eating disorder.

Sexual Abuse

The past decade has increasingly brought attention to childhood sexual abuse (Piran, Sheridan, & Stermac,1996). According to Piran, Sheridan and Stermac,

survivors of childhood sexual abuse develop symptoms such as depression, suicide attempts, self-mutilation, substance abuse, dissociative phenomenon, multiple identities, and eating disorders. Of all the symptoms, the development of eating disorders is most common among children who have suffered from sexual abuse (Schwartz & Cohn, 1996). Although an eating disorder is just one result from sexual abuse, it is used to substitute for the loss of control of their bodies that occured during the abuse (Piran ,Sheridan, & Stermac). In addition, an unclear survival approach stems from the belief that adults can be trusted, thus sexually abused children develop an embarrassment about their body, resulting in the body becoming a source of shame (Schwartz & Cohn). Schwartz and Cohn suggested this loss of control and shame is compensated by over controlling other elements such as habitually throwing up and taking laxatives.

Health Complications

"Although there is clearly a continuum in the spectrum of physical illnesses encountered in anorexia and bulimia, with much overlap, the discussions of anorexia and bulimia and their unique health complications are also useful" (Costin, 1999, p.229). Both male and female health complications are of serious concern and need to be recognized before the body begins to shut down (Costin).

Male and Female

Not only is the disease of eating disorders harmful in itself, but a variety of health complications add to the problematic disease even more (Costin, 1999).

The most common seem to include testicular abnormality, metabolic abnormalities, gastrointestinal symptoms, cardiac complications, reproduction, and osteoporosis (Costin). Costin stated that eating disorders within males results in a decrease in testosterone and testicular abnormality becomes a permanent condition in 10 to 20 percent of male cases (Costin). Bulimia sufferers commonly experience metabolic abnormalities due to several purging behaviors (Schulte & Mehler, 1999). Waldholtaz (1999) discussed gastrointestinal symptoms that are created from food restriction, bingeing, and/or purging behaviors, noting the following:

> Specifically, anorexia nervosa can create gastroparesis, gastroesophageal refulx, constipation, abdominal pain, and abnormal liver levels, whereas bulimia nervosa leads to a different set of GI symptoms. In fact, eventually bulimia causes heartburn, odynophagia, dysphagia, hoarseness, sore throat, diarrhea and abdominal cramping (p.86-99).

Anorexia nervosa has the highest mortality rate from among all other psychiatric disorders (Costin, 1999). Sadly, women fifteen to twenty-four years old are twelve times more likely to die from anorexia nervosa than from anything else (Costin). Cardiac complications are the cause of these deaths and are the main reason for the high mortality rate (Powers, 1999). The risk of death can occur during the lowest weights as well as weight gain because the heart is more vulnerable to dysfunction (Powers). Additionally, Hofeldt (1999) noted that

reproduction complications such as premature birth, miscarriages, and low birth weight infants are not uncommon as a result of an eating disorder. Another complication of anorexia is osteoporosis, which causes bone fractures resulting in the inability to restore bone mass (Hofeldt).

Treatment

Treatment is vitally important when it comes to treating eating disorders. Individual and family therapy are two popular options in treating eating disorders.

Individual Therapy

Using Cognitive Behavioral Therapy (CBT) to treat eating disorders was developed in the early 1980s by Christopher Fairburn of the University of Oxford (Palmer, 2000) and is considered to be the most effective therapy for individuals with this disorder (Arnow, 1996) because it allows clients to be active in therapy by monitoring themselves and stabilizing their eating habits. This self-monitoring helps patients recognize the large amount of time and energy the eating disorder is consumming, therefore keeping them from valued activities and relationships (Netemeyer & Williamson, 2000). Although CBT is short term, Kennerley and Waller (2003) noted that the recovery rate is between 40-50% of cases. In addition, this approach is most effective because of the patients' opinion toward weight and shape as well as restrained eating (Arnow). In treating eating disorders, the prescriptive process and interactional pattern of CBT have been found to be most appropriate (Arnow). The prescriptive process of CBT help

initiate the steps to recovery by discussing the growth and maintenance of eating disorders (Arnow). When using the prescriptive process, it is important to note both the patient's in-session behavior and the patient's opinion about how therapy will help his or her recovery (Arnow). The second option using CBT includes the interactional pattern. Accroding to Arnow, the interactional pattern focuses on early interventions that are dependant upon the patient's behavior between therapy sessions.

Family Therapy

Family therapy includes various techniques to treat eating disorders (Atkins & Warner, 2000). The Milian technique includes questioning family members about their personal as well as others' thoughts, beliefs, relationships and behaviors in the past, present and future (Atkins & Warner). The hope is that these questions will trigger and create new thinking and behavior (Atkins & Warner). The Transgenerational model can be useful by sharing family history, culture and beliefs from past generations to the present (Atkins & Warner). Relaying this information allows children to gain a sense of themselves and their place in the family, according to Atkins and Warner, so exploring the family dynamics through the transgenerational model gives the patient and family an opportunity to establish new pathways for the future.

Atkins & Warner (2000) cited a variety of therapeutic techniques that include ritual planning, family sculpting, and role- playing. These techniques help the

families make changes both in and outside of therapy sessions (Atkins, & Warner). Atkins and Warner also found that it is helpful to open up the family dynamics as well as specific relationships.

Family therapy involves working with the whole family, parts of the family, couples and the individual (Atkins & Warner, 2000). Eventually, the therapist works at finding ways to involve the family system by using relational patterns, behavior and stimulated communication between family members, thus allowing each family member to have a space and voice within the family (Atkins & Warner).

Although these techniques have a different approach used in treating eating disorders, they all seem to be an important piece of the recovery process. Overall, these methods allow the family to see themselves through the eyes of others. It also gives the family an opportunity to emotionally fulfill the needs that were previously ignored due to parents dealing with their own personal issues. The family as well as the therapist participate in "elicitating and respecting the patients' feelings and centring, cultivating and nurturing the self" (Atkins & Warner, 2000, p.139).

Prevention

Prevention is important to incorporate within the school environment. Through a variety of strategies, effective prevention can help educate adolescents about the development and dangers of eating disorders.

Classroom-based Instruction

Snow (2000) identified successful prevention programs, including classroom based instruction. This training allows teachers to integrate the prevention within their classroom instruction as well as other self-awareness activities. Training faculty and staff to recognize students at risk for eating disorders is a good start to prevention (Challey, 1998). Although classroom instruction helps students become aware of warning signs in their peers and differences in healthy and unhealthy body images, it can conflict with what they have otherwise learned about stereotyping appearances. Snow noted that one way of avoiding this confusion is for teachers and school counselors to educate children about nutritional awareness and the benefits of eating. Moreover, speakers and/or counselors can talk to students about proper nutrition and hygiene, and what kinds of food their body needs (Snow). And, since students come from families with different kinds of involvement by parents, speakers must build self-esteem and confidence by discussing proper self-care. It is difficult for educators to determine or even control the amount of positive influence and support children receive at home, so teachers, school nurses, counselors, psychologists, and athletic coaches who spend legitimate time with students need to meet the challenges of preventing the onset of eating disorders in children and adolescents (Challey, 1998).

Unrealistic Strategies

Prevention can be introduced through various strategies, some of which are more realistic than others. Strategies at the individual level and societal level are two methods of prevention, but they are unrealistic, according to Steiner-Adair and Striegel-Moore, 1998. Steiner-Adair and Striegel-Moore noted that the individual level concentrates on keeping the child sheltered from television and fashion magazines to help prevent eating disorders. The societal level implies removing television and fashion magazines from the entire society. Steiner-Adair and Striegel-Moore suggested that this strategy is impractical because it would be difficult to detect all contributing factors in television and magazines.

Realistic Strategies

Two realistic methods of prevention have been found to decrease eating disorders. One is to reduce causes of the disorder and the second is to strengthen adolescents against the pressures to be thin (Steiner-Adair & Striegel-Moore, 1998). These methods are very popular within a school-based environment and are shown to be most effective (Steiner-Adair & Striegel-Moore). In addition, Striegel-Moore and Steiner-Adair discussed six approaches to prevention: One, display an understanding of eating disorders as well as the awareness of cultural influences that create eating disorders. Two, recognize the differences of eating disorder development among genders. Three, give adolescents the opportunity to refuse influences as well as speak about the influences of eating disorders. Four,

relay the history of respected female beauty led to a variety of medical complications in women. Five, emphasize that eating disorders are an unhealthy way to deal with other negative factors going on in their life as well as offering healthier ways to cope with the unhappiness. Six, change the way adolescents receive information about their health at home as well as school. When implementing these six approaches, it is important to recognize that the level of prevention should be determined by the adolescents' psychological development and way of learning (Striegel-Moore & Steiner-Adair). For example, Striegel-Moore and Steiner-Adair suggested that in order for girls to have healthy development they need close relationships, preferably with a female who will listen and demonstrate a healthy life style. If presented correctly, prevention approaches allow adolescents to receive the tools they need in making healthy decisions (Menassa, 2004).

Conclusion

With the increasing awareness about eating disorders, it appears that the actual real causes of eating disorders stem from social and cultural factors and family environment. Knowing these causes can help counselors implement age-appropriate prevention programs. If prevention should fail, there are a variety of treatments that should begin as soon as possible to prevent or minimize health complications, allowing patients to live a healthy, productive life.

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