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Fat is not a four-letter word : examining the factors that contribute to eating disorders in adolescent females and the role of school counselors in prevention and treatment

Megan B. Tressel
University of Northern Iowa

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Abstract

An eating disorder is an obsession with food, weight, and body image that can lead to both physical and emotional problems (Mickley, 2001). The rate of eating disorders among girls between the ages of 9-13 is steadily rising (Herzog & Delinsky, 2001). It is estimated that approximately eight million girls and women in America have symptoms of some type of eating disorder, and this is a conservative number because many girls go undiagnosed (Meehan, 1990). Recently Schur, Sanders, and Steiner (2000) showed that 41 % of girls ages 9-10 desired a thinner body shape, which indicates that children are developing concerns about their bodies at younger ages.

FAT IS NOT A FOUR-LETTER WORD: EXAMINING THE FACTORS THAT CONTRIBUTE TO EATING DISORDERS IN ADOLESCENT FEMALES AND THE ROLE OF SCHOOL COUNSELORS IN PREVENTION AND TREATMENT

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Michael D. Waggoner
Head, Department of Educational Leadership, Counseling, and Postsecondary Education

An eating disorder is an obsession with food, weight, and body image that can lead to both physical and emotional problems (Mickley, 2001). The rate of eating disorders among girls between the ages of 9-13 is steadily rising (Herzog & Delinsky, 2001). It is estimated that approximately eight million girls and women in America have symptoms of some type of eating disorder, and this is a conservative number because many girls go undiagnosed (Meehan, 1990). Recently Schur, Sanders, and Steiner (2000) showed that 41% of girls ages 9-10 desired a thinner body shape, which indicates that children are developing concerns about their bodies at younger ages.

Some of the factors responsible for the increased incidence of eating disorders include the power of the media and the thin ideal (Garner, Garfinkel, Schwartz, and Thompson, 1980). Young females are being exposed to messages about their bodies at younger ages and are formulating opinions about themselves without proper information. They take these messages at face value and as they look at girls and women in the media, they try to emulate how they look without understanding the negative behaviors that are associated with obtaining these images. Furthermore, girls are entering puberty and experiencing intense body changes at an earlier age. They do not have the cognitive capacity to understand what these changes mean and why they are occurring.

The purpose of this paper is to explore the numerous factors that contribute to eating disordered behaviors in adolescent females and to emphasize the severity of this disorder, including irrational perceptions about body image, depression,

poor eating habits, an immune system that is compromised, feelings of loneliness and isolation, and self-doubt (Matthews, 2001). In addition, the role of the school counselor in the prevention and treatment of eating disorders will be examined because they can play an active role if they understand the dynamics of this disease.

Characteristics of Anorexia Nervosa and Bulimia Nervosa

Anorexia nervosa has been described for over a century in the literature, but it was not included in the DSM until 1980(Herzog & Delinsky, 2001; American Psychiatric Association, 1980). The current criteria in the DSM-IV includes the following: (1) refusal to maintain body weight at or above a minimally normal weight for age and height, (2) intense fear of gaining weight or becoming fat, even though underweight, (3) disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight, and (4) in postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles (American Psychiatric Association, 2000, p. 544-545).

In contrast, the term bulimia nervosa was virtually unknown before 1980. One year after Russell (1979) wrote about bulimia, it appeared as a separate eating disorder with its own criteria in the DSM-III (American Psychiatric Association, 1980). The criteria for bulimia has not changed since that time. The DSM-IV criteria for bulimia nervosa includes the following: (1) recurrent episodes of binge eating, which is characterized by eating, in a discrete period of time (e.g., within

any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances, and a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control how much one is eating), (2) recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise, (3) the binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months, (4) self-evaluation is unduly influenced by body shape and weight, and (5) the disturbance does not occur exclusively during episodes of anorexia nervosa (American Psychiatric Association, 2000, p. 549-550).

Factors Contributing to Eating Disorders

Healthy Adolescent Development

The most significant event of adolescence is the onset of puberty. During puberty, the female body grows and changes more rapidly than any other time of life, with the exception of infancy (Wagner, 1996). Puberty is triggered by hormonal changes in the body, and these changes may take place as early as age 10 or as late as age 15 (Abraham & Llewellyn-Jones, 1997). Weight gain in adolescent females is linked to the onset of puberty (Killen et al., 1994). Girls increase their muscle bulk during this period and cease to gain height. Fat is deposited throughout their hips, upper legs, and breasts. Furthermore, adolescent eating behaviors are typically unhealthy during this time. The combination of these factors leads to an increase in weight. This increase in

weight often leads females to develop concerns about their body image (Striegel-Moore & Kearney-Cooke, 1994). In an attempt to combat weight gain during this time period and to increase body image satisfaction, many females acquire unhealthy eating patterns (Killen et al., 1994).

In conjunction with weight gain during puberty, females experience a tremendous decrease in their self-esteem. The body changes in size and shape, and adolescent females tend to focus on these changes. They spend a great deal of time in front of the mirror examining their bodies, and the smallest flaws become obsessions (Pipher, 1994). The way they view their bodies is directly connected to their self-esteem because the way they think about themselves is intertwined with their physical appearance.

The Role of the Media

Evidence of a clear but gradual shift in the cultural ideal for a woman's body shape has been supported in the research (Garner, Garfinkel, Schwartz, & Thompson, 1980). In the last two decades, our culture has developed an obsession with thinness, and what is considered beautiful has become slimmer and slimmer (Pipher, 1994). Happy, successful women are portrayed in magazines, movies, and on television by actresses and models who are young, toned, and thin. In contrast, unsuccessful and unhappy people are portrayed by people who are older, less attractive, and heavier (Matthews, 2001). The underlying message is that a person must be thin and attractive in order to achieve success.

The thin ideal is difficult for adolescents to achieve because of their increase in weight and change in body size during puberty. Although these changes are natural for girls this age, they are bombarded with images that tell them they need to be thin. Fueled by the desire to reverse these changes, they begin to engage in unhealthy dieting and exercise patterns by skipping meals, eating small portions, or refusing to eat in front of other people. Fatty foods that were once favorites, such as meats or sweets, are now considered unacceptable. Exercise behaviors become obsessive and take up large amounts of time, becoming a required activity rather than one that is enjoyable (Matthews, 2001).

Personality Traits

Perfectionism. Several personality traits have been linked to the development of an eating disorder (Vitousek & Manke, 1994). One such trait is perfectionism, which involves striving for unrealistic, unattainable goals Kalodner & Scarano, 1992). Brouwers and Wiggum (1993) identified two characteristics of perfectionism found in eating disordered patients: unrealistic expectations and dichotomous thinking. Perfectionists have overly high expectations for themselves and are frustrated by their inability to meet their goals. They conclude that they are weak and unable to succeed. Their mind-set is based on "should" thinking, and even when they are successful, they believe that they should have done it better. Adolescent girls think that they should be thinner although they are naturally gaining weight due to puberty. When they are unable to attain the body shape that they consider to be desirable, they blame themselves for not being successful and feel bad about themselves.

Dichotomous thinking refers to all-or-nothing thinking; there is no middle ground (Burns, 1980). Brouwers and Wiggum (1993) indicated that this type of thinking contributes to the maintenance of eating disorders because the patient thinks that either she has to continue the disordered behavior or she will be fat. In the eating disordered patient's mind, there is no other alternative.

Poor body image. According to Matthews (2001), individuals who have a poor body image are constantly trying to lose weight. They have extreme fears of gaining weight and becoming obese, wearing baggy clothes to hide their bodies and obsessing about clothing size. Females with poor body image complain that they are fat even after constant reassurances that this is not the case. They spend an inordinate amount of time in front of the mirror and usually find something to criticize.

Low self-concept. Nassar, Hodges, and Ollendick (1992) found that eating disordered females expressed little satisfaction with academic achievements, physical appearance, leadership ability, and their self-expression. Similar to females who have poor body image, females with an eating disorder have a hard time identifying any of their positive traits. They do not believe they are good at anything or contribute in a positive way.

Family Influences

Genetic predisposition. According to research conducted by Holland, Sicotte, & Treasure, 1988; Hsu, Chesler, & Santhouse, 1990; and Kendler et al., 1991, results of family and twin studies of eating disordered individuals suggest that there may be a genetic propensity for developing an eating disorder.

However, most genetic researchers do not believe that a gene for eating disordered behavior exists. They are more apt to believe that a number of risk factors are passed on, such as certain personality traits, proneness to affective disorder, and obesity (Vitousek & Manke, 1994).

Family cohesion. Studies conducted with eating disordered adolescent females found that they view their families as lower in cohesion and higher in conflict (Leon, Fulkerson, Perry, & Dube, 1994). During adolescence, there is typically an increase in parent-child conflict due to the changing nature of the adolescent. Since adolescence is a major risk period for developing an eating disorder, some researchers speculate that strong family cohesion may play a role in combating eating disordered behavior (Leon et al., 1994).

Parental attitudes about physical appearance. Parents are important role models for their children, and through modeling, feedback, and instruction, they can influence both their children's body image as well as their eating behavior (Striegel-Moore & Kearney-Cooke, 1994). Consistent with our culture's gender role stereotypes, mothers seem to have more involvement in controlling their children's eating behavior (Striegel-Moore & Kearney-Cooke, 1994). Since eating behavior is directly linked to physical appearance, parents, especially mothers, who place a great deal of importance on their own physical appearance may be more likely to place greater importance on the appearance of their children. This may put undue pressure on children to look a certain way and could possibly lead to some type of eating disorder.

According to the research by Striegel-Moore and Kearney-Cooke (1994), the majority of parents who were not satisfied with their own physical appearance were satisfied with their children's physical appearance. The areas where they tried to help improve appearance were related to acne and orthodontic treatment. In relation to the issue of weight and body image, most of the parents involved in the research attempted to promote healthy eating patterns and build a positive body image through positive role modeling.

Implications for School Counselors

Prevention

Adolescence is the time when females are at highest risk for developing an eating disorder. (Striegel-Moore & Kearney-Cooke, 1994; Killen et al., 1994). Because the negative ramifications of this disease are so severe, it is critical to implement prevention programs (Jensen-Scott & DeLucia-Waack, 1993). One of the best ways to implement a preventative focus is through a comprehensive developmental guidance program that specifically addresses issues that are relevant to healthy eating behaviors.

Implementing an eating disorder program has been a topic of some controversy, however. O'Dea and Abraham (2000) noted that prevention programs have repeatedly been ineffective. These researchers found that educational programs may be harmful because they increase the students' knowledge of eating disorders. They stressed the importance of developing a program that emphasizes student-centered approaches that foster self-esteem.

In their opinion, this approach is more beneficial than focusing on information that highlights the dangerous outcomes of dieting and purging.

On the other hand, Jensen-Scott and DeLucia-Waack (1993) supported the notion of a preventative program, noting that a developmental philosophy strives to build in all students both cognitive and behavioral skills that are needed to lead and maintain a healthy lifestyle. The techniques used to build these skills attempt to reach three goals: (1) to increase students' awareness of their behaviors and cognitions, (2) to help students to assess their eating and exercise behaviors and cognitions, and (3) to help students to identify alternatives when lifestyles are unhealthy. The program that they have proposed is not just for students identified with an eating disorder; rather it is an informational and student-centered program for all students, containing interventions that help them attain the aforementioned goals. If these goals are met, students will not only have a larger knowledge base in relation to healthy lifestyles, but they will also have interventions they can use to help improve their overall health. A discussion of appropriate interventions that match with each goal will be addressed.

Behavioral component. In relation to the first goal of increasing awareness of behaviors and cognitions, Jensen-Scott and DeLucia-Waack (1993) suggested the use of a food diary that is used to monitor eating habits. The students are responsible for writing down what was eaten, where it was eaten, whether or not the food was a meal or a snack, if the food was eaten alone or with other people, and what thoughts and feeling occurred while eating (Ferguson, 1975). The goal

of keeping a food record is to identify maladaptive eating patterns, such as eating when not hungry or eating out of anger. Furthermore, they highlight distortions regarding how much food was or should have been eaten. Wilson, Fairburn, & Agras (1997) also encouraged the use of food diaries, or what they refer to as self-monitoring. They emphasized discouraging the practice of calorie counting which may exacerbate anxiousness about weight issues. Once students have a written record of eating behaviors, they may discover that they eat at a certain time of the day out of boredom. With this pattern identified, certain techniques can be implemented, such as eating in a designated area, planning meals ahead of time, or avoiding certain activities while eating. Healthier eating habits, such as eating only at regularly scheduled meals or slowing down the pace of eating can also be implemented based on the eating pattern. Craighead, Kazdin, and Mahoney (1981) suggested positive consequences, or the use of a reward, to help maintain these new eating patterns.

Along with the food diary, an activity log of exercise can be kept to track daily exercise and activity levels. Relevant information such as time of day and amount of time spent on the activity can be recorded. The log is meant to be an informative tool for students so that they can see if their behavior is healthy or excessive (Jensen-Scott & DeLucia-Waack, 1993).

The final intervention for the behavioral component of this program is training in problem-solving skills, decision-making, and social skills. According to Mizes (1988), bulimics have reported feeling helpless and tend to avoid problems. Similarly, Andersen (1985) reported that anorexics tend to show dependent

behavior. This type of behavior can be changed through learning to identify problems, developing reasonable goals, and choosing methods to reach these goals (Urbain & Kendall, 1980). This process gives students a sense of control over their lives.

Decision-making is a crucial part of the problem-solving process. Students can be taught what their decision-making style is through different activities such as values clarification activities (Jensen-Scott & DeLucia-Waack, 1993). These types of activities help students define what is important to them and they can then use that information to make their decisions.

Students also need to be taught effective ways to communicate with others. Williamson (1985) discussed the importance of being able to express their thoughts and feelings, as well as ways to give and receive feedback. This process gives students a sense of ownership over their thoughts and feelings.

Cognitive component. The second goal of this prevention program focuses on the assessment of behaviors and cognitions. Ellis (1984) suggested examining irrational beliefs by having students make a list of their beliefs related to eating. The main focus would be on teaching students how to identify their awfulizing and demanding belief systems (Corey, 1996). The students would also focus on self-downing thinking patterns. The counselor would have students examine why they believe that they should be thinner and what their weight says about them as a person. The students might also explore their beliefs about what they think about others in relation to their weight. Once the irrational beliefs

have been examined, Ellis (1975) discussed how the thoughts can be modified, and eventually replaced, through cognitive restructuring.

Another intervention in the cognitive component is for students to examine their personal strengths and weaknesses aside from their body weight and shape. Jensen-Scott and DeLucia-Waack (1993) emphasized that students can learn to define themselves positively, based on factors over which they can exercise some control.

Nutritional component. Adolescence is an incredible time of physical change and also an important time for developing healthy eating habits (Striegel-Moore & Kearney-Cooke, 1994). Teenagers often lack education about what kinds of foods they should eat and how many calories they need to consume each day. Several computer programs help students take information from their food diaries and plug it in to the program. The program then gives them feedback on whether or not their eating patterns are healthy.

In connection with the computer programs, timely and accurate information about nutrition needs to be disseminated to the students. The teacher or a nutritionist can talk about the recommended daily allowance of vitamins and minerals, how the food pyramid works and what exactly it means, ways to decrease fats and increase carbohydrates, and how to find hidden calories (Jensen-Scott & DeLucia-Waack, 1993). Teaching students about appropriate nutrition will not only be helpful to them during adolescence, but it will help them establish a lifetime of healthy eating.

Individual Counseling

Many schools are not implementing a comprehensive developmental guidance program- the school counselor is the guidance program. Because this is the reality in so many schools, the counselor is in a crucial position to provide services to the eating disordered student. Although school counselors may not have extensive training in how to work with eating disordered clients, they are in a unique position because they see students on a daily basis. Daily access to students can lead to a strong relationship and create optimal conditions for therapeutic work. However, school counselors also need to be realistic in how much time they can devote to one student. A referral to a mental health agency may be necessary depending on the severity of the case. The school counselor can collaborate with the outside agency and serve as a resource for the student during school hours.

If school counselors provide counseling to eating disordered students, Omizo and Omizo (1992) stressed that they should acknowledge that the student's willingness to treat the eating disorder as unhealthy behavior is an important first step in the recovery process. With this in mind, they noted that the first objective of individual counseling is for the school counselor to help the student gain an understanding of the potentially dangerous outcome of her behavior. Education about the disorder, such as causes, risk factors, symptoms, and possible outcomes if no treatment is available need to be shared.

Once the student becomes more educated about her disorder, the reconstruction of an identity needs to be explored (Omizo & Omizo, 1992). The

student with an eating disorder has typically tried to please everyone in her life, with the exception of herself. She operates from an external locus of control (Hood, Moore, & Garner, 1982). It is important for the school counselor to help build self-esteem and self-confidence. Omizo and Omizo (1992) suggested reestablishing a personal identity by assessing the student's standards and expectations for herself and others, challenging these beliefs with more realistic standards, increasing self-awareness through beliefs and values clarification, and helping the student define herself by her strengths and weaknesses.

One final component of individual counseling is self-monitoring (Omizo & Omizo, 1992). This process helps to increase awareness on the part of the student. Many eating disordered students are unable to accurately identify their hunger cues, therefore causing them to eat at times when they are not actually hungry. By keeping record of what was eaten as well as feelings experienced at the time of eating, eating disordered students can begin to recognize and understand their hunger cues.

Group Counseling

The fact that eating disorders are becoming more and more common among adolescent females provides a strong argument for the use of group counseling techniques in the school setting (Daigneault, 2000). Omizo and Omizo (1992) noted that groups can decrease feelings of isolation, increase interpersonal learning, and provide support and feedback from peers who are struggling with the same disorder. They also highlighted the fact that the group setting

encourages students to not only accept responsibility for their own recovery, but to also commit to helping others in their recovery.

The group setting is designed to provide an opportunity for the students to discuss issues related to self-esteem, body image, poor eating habits, and faulty thinking. Daigneault (2000) suggested a narrative therapy approach to working on the above issues. The first technique she proposed was externalizing, a process where the girls try to separate themselves from their problem. They gave their eating disorder a name and talked about how it affected their lives. This process of separating themselves from their disorder allowed them to begin to develop a sense of perspective about the problem.

Another powerful technique of narrative therapy that can be employed in the group setting is the process of deconstructing the problem story and developing an alternative story. Parry and Doan (1994) suggested that the group facilitator listen to the story in an attempt to hear about the times when the client has not struggled with the eating disorder. These exceptions to the problem help provide a starting point for building an alternative story, a story in which students have control over their life and are not affected by the disorder.

Another useful narrative therapy approach that helps to deconstruct the problem story and to create an alternative one is the use of art activities, such as drawing a picture of the eating disorder, a picture of themselves with the disorder, and a picture of themselves without the disorder. According to Daigneault (2000), this activity helped the students look closer at their

relationship with their eating disorder and discuss what their lives might be like without the disorder.

A variety of group activities can be employed to help the eating disordered student think differently about their bodies and themselves. Other useful techniques include visualization exercises that help them to envision their futures (Myrick and Myrick, 1993) and the use of videotapes and film to examine the role of our media and how it influences our image of an ideal woman (Daigneault, 2000).

Effectiveness of Treatment

The treatment of eating disorders is a relatively new field, and good information on the long-term recovery process is not yet available. Researchers do know that the average length of tome to recover is about five years, which includes periods of both recovery and relapse (Matthews, 2001).

Although people with eating disorders tend to go undiagnosed , the research shows a fairly high rate of recovery for those who are diagnosed. Matthews (2001) reported that about 60% of people with eating disorders recover, meaning that they maintain a healthy weight and they eat a varied diet. Psychologically, many report that they feel stronger and more insightful due to having recovered from the disorder.

In spite of treatment, about 20% of people with eating disorders make only partial recoveries. They continue to focus too much on food and weight. The remaining 20% do not improve, even with treatment. Their lives revolve

completely around food and exercise, and they spend a great deal of their time in and out of emergency rooms and eating disorder clinics (Matthews, 2001).

Conclusion

As explored in this paper, the number of adolescent females engaging in unhealthy eating behaviors is on the rise. Our culture places a tremendous amount of pressure on females to be a certain size and weight. Now more than ever, it is crucial that we focus on the messages that we are sending to adolescent females about how their appearance shapes who they are as a whole person. School counselors are in an excellent position to help build self-esteem and confidence, which are powerful weapons for young females to possess as we encourage them to fight against cultural expectations, as well as their own beliefs, about the nature of the ideal woman.

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