Group therapy for bulimics: Implications for school counselors

Kelly Ann Clark

University of Northern Iowa

Copyright ©1994 Kelly Ann Clark

Follow this and additional works at: https://scholarworks.uni.edu/grp

Part of the Education Commons

Recommended Citation

https://scholarworks.uni.edu/grp/2232
Abstract

Although our society has become increasingly preoccupied with eating and weight, it is only relatively recently that publicity has been given to eating disorders such as anorexia nervosa and bulimia" (Hendrick, 1985, p. 275). For purposes of this paper, the author is only going to deal with bulimia. Bulimia has primarily been a concern among college-age women, but over the past decade the prevalence of the disorder has increased dramatically among adolescent females (Omizo & Omizo, 1992). The increasing incidence of bulimia warrants concern for those professionals working with adolescents, such as school counselors and therapists in private practice or agencies. Since bulimia is a "serious disorder that can have a drastic impact on the quality and direction of an individual's life" (Butterfield, McKay, Peters, & Swassing, 1984, p. 183), it is important to learn what can be done to prevent this disorder and which treatment modes are most effective with this population.
Group Therapy for Bulimics:
Implications for School Counselors

A Research Paper
Presented to
The Department of Educational Administration
and Counseling
University of Northern Iowa

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts in Education

by
Kelly Ann Clark
August 1994
This Research Paper by: Kelly Ann Clark

Entitled: Group Therapy for Bulimics: Implications for School Counselors

has been approved as meeting the research paper requirements for the Degree of Master of Arts in Education.

June 30, 1994
Date Approved

Terry Kottman
Adviser/Director of Research Paper

6/30/94
Date Approved
Ann Vernon
Second Reader of Research Paper

6-30-94
Date Received
Robert H. Decker
Head, Department of Educational Administration and Counseling
"Although our society has become increasingly preoccupied with eating and weight, it is only relatively recently that publicity has been given to eating disorders such as anorexia nervosa and bulimia" (Hendrick, 1985, p. 275). For purposes of this paper, the author is only going to deal with bulimia. Bulimia has primarily been a concern among college-age women, but over the past decade the prevalence of the disorder has increased dramatically among adolescent females (Omizo & Omizo, 1992). The increasing incidence of bulimia warrants concern for those professionals working with adolescents, such as school counselors and therapists in private practice or agencies. Since bulimia is a "serious disorder that can have a drastic impact on the quality and direction of an individual's life" (Butterfield, McKay, Peters, & Swassing, 1984, p. 183), it is important to learn what can be done to prevent this disorder and which treatment modes are most effective with this population.

Bulimia in women without histories of associated weight disorders was first described in the literature in 1978 and officially recognized as a diagnostic entity in 1980 (American Psychiatric Association, 1980). Bulimia is an eating disorder previously seen as a subtype of another disorder, anorexia nervosa, but bulimia possesses its own distinct characteristics (Zimpfer, 1990). Bulimia is recognized by recurrent episodes of binge eating. A binge typically involves rapid consumption of large quantities of foods, which then may be followed by purging, using self-induced vomiting, laxatives, or diuretics (Zimpfer, 1990).
According to the newest criteria of the American Psychiatric Association (cited in Hendrick, 1985, p. 275), bulimia can be diagnosed when the following characteristics are present:

1. Recurrent episodes of binge eating in a discrete time period, usually less than two hours.

2. At least three of the following: (a) consumption of high caloric, easily digested food during a binge; (b) inconspicuous eating during a binge; (c) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting; (d) repeated attempts to lose weight by severely restricting diets, self-induced vomiting, or use of cathartics or diuretics; and (e) frequent weight fluctuations greater than ten pounds due to alternating binges and fasts.

3. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.

4. Depressed moods and self-deprecating thoughts following binges.

5. The bulimic episodes diagnosed as not due to anorexia nervosa or any known physical disorder.

In the last ten years, bulimia has emerged as a widespread clinical problem, particularly affecting women in their teens and twenties (Gould, McKenna, & Oesterheld, 1987). Despite the medical and psychological consequences of bulimia, high prevalence rates have been reported, with between 5% and 19% of female high school or college students reporting all the essential symptoms of bulimia (Conners, Johnson, & Stuckey, 1984). Although most bulimics are women, studies of bulimia which have
included men have reported that 5% to 13% of their bulimic subjects were males (Cauwels, 1983; Mitchell & Pyle, 1982).

Despite the fact that bulimic symptoms typically begin during adolescence, only recently have studies of bulimic behavior in teenage students appeared (Butterfield et al., 1984; Carter & Duncan, 1984; Crowther & Post, 1985; Crowther, Post, & Zaynor, 1985; Maceyko & Nagelberg, 1985; VanThorre & Vogel, 1985). For purposes of this paper, the author will explore certain physical, psychological, and behavioral characteristics typically displayed by adolescents with bulimia. After these issues are addressed, the author will discuss the effectiveness of group therapy with this population, as well as the role and responsibility the school counselor has towards the bulimic adolescent.

Physical Characteristics

In contrast to the obvious thinness of anorexics, the physical signs of bulimics are not as apparent because many bulimics maintain near normal weight (Lacey, 1982). Physical complications for bulimics include dehydration, light headedness, heart arrhythmias, hypokalemia (low levels of potassium), and/or kidney damage (Frey, 1984). Chronic vomiting may cause stomach cramps or ulcers, irritation of the esophagus, swelling of the salivary glands, and dental decay (Butterfield et al., 1984; Frey, 1984). VanThorre and Vogel (1985) found that symptoms of bulimia were more likely to appear in persons who at some time had been overweight or tended to have been heavy within the normal range.
Psychological Characteristics

A variety of psychological characteristics appear to be associated with bulimia, including depression and anxiety, alienation and isolation, poor self-concept, sex-role confusion, and compulsive behaviors related to food and eating (Maceyko & Nagelberg, 1985). Maceyko and Nagelberg (1985) studied 1,268 female high school students aged 13-18 and discovered 8% met the DSM-III criteria for bulimia. Compared to normal eaters, adolescent bulimics were less prone to minimize their worries and complaints and more likely to doubt themselves. The bulimic adolescents in this study were described as impatient, deceitful, inattentive and forgetful.

Vincent (1984) studied 2,210 female high school students and discovered 12.8% met the DSM-III criteria for bulimia. Vincent (1984) described the typical female bulimic high school student as noticeably insecure, self-denying, and prone to self-abasement. Also, she usually manifested depression, anxiety, family problems, and mood fluctuations.

Similar to the findings by Maceyko and Nagelberg (1985), Crowther and Post (1985) found that bulimic adolescents were significantly more depressed, had lower self-esteem, and perceived themselves as significantly overweight. Other findings suggested that bulimic adolescents possessed disturbed eating attitudes and behaviors, had a significantly greater discrepancy between current and ideal weight, and felt it was more important to achieve this ideal weight. Carter and Duncan (1984) also found high school bulimics to have disturbed attitudes toward
Behavioral Characteristics

Bulimic individuals have a desperate fear of becoming fat and are believed to show more harmful impulsive behavior such as stealing, drug and alcohol abuse, self-mutilation, and suicide attempts (Carter & Duncan, 1984; Crago, Neal, Shisslak, & Swain, 1987; Harrel & Rutherford, 1983). There seems to be a relationship between alcoholism and bulimia (Van Thorre & Vogel, 1985), which suggests that bulimics have a propensity for addictive and impulsive behaviors. Bulimic adolescents tended to consume more alcohol than nonbulimic adolescents, which suggested the susceptibility of addictive behaviors with these individuals. Crowther and Post (1985) reported high school bulimic girls behaved quite differently from their peers, in regards to alcohol consumption. Compared to nonbulimic girls, bulimic adolescents reported significantly more frequent consumption of alcohol (Crowther & Post, 1985). Crowther and Post (1985) suggested that the bulimic adolescents were acting out in a somewhat deviant or impulsive way, not just conforming to peer pressure.

Behaviorally, these individuals in schools frequently make trips to the restroom as a result of laxative abuse or a desire to vomit (Frey, 1984). They may avoid the school cafeteria in an attempt to fast or binge secretively. Bulimics sometimes steal food from the cafeteria or binge on food from school vending machines. Also, students with bulimia often times sleep through their classes due to lack of energy from their abnormal eating patterns (Frey, 1984).
Group Therapy

The extent and severity of the bulimia problem has impelled professionals in the helping services to develop treatment strategies for interventions. Various forms of treatment have been proposed, such as individual psychotherapy, family counseling, psychoeducational programs, behavioral interventions, pharmacological, and groups. The most effective and efficient approach with bulimic victims has been found to be group therapy (Lenihan & Sanders, 1984).

For the purpose of this paper, the author reviewed the outcomes of research studies that explored the effects of group work with bulimic individuals. The author explored the advantages and disadvantages found in the literature in regard to the use of groups.

Group psychotherapy has been widely adopted in the treatment of bulimia during the past five years, reflecting both the pressure to provide cost-effective, high volume treatment and the impression that group treatment may offer unique benefits to this population (Gould, McKenna, & Oesterheld, 1987). The group modality, regardless of theoretical bias, is strongly recommended because it provides the ingredients that are considered crucial to successful intervention: social support, the presence of knowledgeable peers, the breaking of secrecy, the sharing of shame, reality testing with the peers by examining unrealistic beliefs and expectations, and learning, in an interpersonal context, to express affect (Gould, McKenna, & Oesterheld, 1987).

A growing number of studies have been published (Abramowitz & Berry, 1989; Davis, Fairburn, & Garner, 1987; Davis, Olmsted, & Rockert,
1990; Fairburn, 1981; Franko, 1987; Katzman, Lee & Rush, 1986; Weiss & Wolchik, 1986) which reflect a wide range of group treatment models and orientations. For this reason, the author chose to organize the studies according to their group type, either cognitive-behavioral, self-help, psychoeducational, psychodynamic orientations or intensive therapy.

Cognitive-Behavioral

Lee and Rush (1986) assessed the effectiveness of cognitive-behavioral group therapy in the treatment of bulimia in comparison with a randomized waiting list control. Subjects were taught relaxation techniques to control the anxious and dysphoric feeling that often precipitated their eating binges. Maladaptive attitudes towards eating and food were challenged during group sessions through rational restructuring, while homework was simultaneously used to shape normal eating patterns.

Data from this study indicated that group cognitive-behavioral therapy resulted in significant reductions in both binging and purging compared with subjects on the waiting list. These lower binge and purge frequencies were largely maintained at 3-4 months posttreatment. Also, significant reductions in depressive symptoms occurred with therapy. Although group-treated subjects did better than wait-listed subjects, only 26% of treated subjects stopped binging completely, and only 6% showed full remission of both binging and purging (Lee & Rush, 1986).

In contrast to these findings, Fairburn (1981) reported complete remission of binging and purging in 9 of 11 subjects with cognitive-behavioral techniques in treatment. In addition to cognitive-behavioral
techniques, Fairburn (1981) applied contingency contracting to the treatment process. Due to the absence of a waiting list or control group in this study, one cannot attribute therapeutic success to the treatment alone.

Agras, Bachman, Kirkley, and Schneider (1985) examined the efficacy of two group treatments for bulimia. The members of the cognitive-behavioral group were instructed to make specific changes in their eating and vomiting behavior, whereas the members of the nondirective group were given no instructions. Results from this study indicated the cognitive-behavioral treatment group tended to have fewer dropouts and greater, more consistent decreases in binging and purging behaviors. At 3-month follow-up, 38% of the cognitive-behavioral and 11% of the nondirective group participants continued to abstain from binging and vomiting (Agras et al., 1985).

These results are in accord with Lacey (1983) who followed his patients for two years after cognitive-behavioral group treatment and reported stability of outcome over that amount of time. Sixty-nine percent of his patients stopped vomiting and reported less depression, a lower Eating Attitudes Test (EAT) score, and an increase in ideal weight (Lacey, 1983). These studies suggest that cognitive-behavioral treatment produces lasting effects in bulimic women.

Two other studies examined the short term effects of group treatment using a combined cognitive-behavioral and psychodynamic approach. Ames, Davis, Frommer and Gibson (1987) formed groups, either mild, moderate, or severe, based on the frequency of binging and vomiting prior to group treatment. Ninety-two subjects were randomly assigned to a 12-
week group treatment program. This group treatment was typically psychodynamically oriented. It used a supportive-interactional model focusing on individual dynamics, group dynamics, and specific cognitive-behavioral interventions. Although the group format was not prestructured, nutritional information was offered and strategies for behavior change were provided to the group members. Results of this study indicated there was, for the entire sample, a significant reduction in both binging and vomiting from pre- to posttest, corroborating other studies that have found short term group treatment for bulimia effective (i.e. Lacey, 1983; Agras et al., 1985).

An interesting finding was noted in this particular study. Ames et al. (1987) found group members whose symptomatology was most severe at the beginning of the group showed the greatest reduction in bulimic symptomatology at the conclusion of group treatment (i.e. a reduction of nearly seven binging episodes per week and more than four vomiting episodes per week). On the other hand, group members with mild symptomatology at the beginning of the group tended to significantly increase their symptom behavior at the end of the group (i.e. an increase of greater than three binging episodes per week and greater than two vomiting episodes per week). The authors proposed that being exposed to more severe bulimics may induce greater symptomatology in some mild bingers, due to increased anxiety from the group experience. The homogeneity of group members in symptom severity at pretreatment may need to be considered when forming a group. The study done by Ames et al. (1987) does not answer this question, but suggests further research is
necessary to examine patterns of symptom severity and symptom change through group treatment.

Stevens and Salisbury (1984) found the use of a combined behavioral and psychodynamic treatment approach effective in enabling five out of eight group members to obtain a dramatic reduction in binge/purge episodes and remain symptom free at a ten-month follow-up. The group leaders helped members develop psychological connections between feelings and actions in order to maintain symptom control. Common psychological characteristics, such as lack of awareness of hunger, absence of pride or self-confidence, low self-esteem, and distrust of their own judgement, were revealed among bulimic members through this group experience (Stevens & Salisbury, 1984).

In agreement with the studies that concentrated on strictly cognitive-behavioral interventions, cognitive-behavioral methods with psychodynamic understanding in a group setting seems to yield effective results in bulimic women with maintenance over an extended period of time.

Self-Help

Self-help groups have been defined as voluntary associations of individuals who share a common need or problem (Franko, 1987). Some of the “active ingredients” that make a self-help group effective are behavioral processes, such as social reinforcement, training in adaptive behaviors, and modeling of coping strategies (Levy, 1976).

Franko (1987) conducted a study to evaluate the benefits of a self-help group for women with eating disorders. A total of seventeen members
participated in the group and were diagnosed with either anorexia nervosa or bulimia. The group was open to members with either disorder. Franko (1987) identified the following benefits of this self-help group: (a) 78% of the group members reported that they found the group helpful to them (i.e. members gave support and understanding, decreased feelings of uniqueness, and offered new strategies for coping with eating difficulties); (b) 78% reported increased interpersonal relationship with other group members; (c) 83% of group members said that the group was the first place where they felt others understood what they were going through and felt they could openly discuss their feelings; (d) 56% of group members would have preferred a therapeutic group to a self-help group; and (e) 84% of group members felt there should have been more structure in the group.

From the results of this study, it appeared that the self-help group was beneficial in the treatment of anorexia nervosa and bulimia. Some reasons that may explain this are: (a) eating disorders are typically shrouded in secrecy and denial, and the group diminishes the problem by facing it; (b) social isolation which is often felt by this population can be alleviated by the involvement with others; and (c) being with “one’s own kind” offers a truly empathetic experience (Franko, 1987).

Because the majority of group members expressed the need for more structure and professional guidance in the group, it might be that a formal type of group structure would be more effective with some individuals. Although this group was open to women with either eating disorder, recent research has suggested that a separate group for each would be more
appropriate due to the differences in eating behaviors and psychological issues (Anderson, 1981; Garfinkel et al., 1980; Stevens & Salisbury, 1984).

Psychoeducational

Psychoeducation is defined as "the process of disseminating information about the nature of a disorder for the purposes of fostering attitudinal and behavioral change in the recipient" (Davis, Olmsted, & Rockert, 1990, p. 882). Psychoeducational interventions are frequently used as an initial component in the cognitive-behavioral treatment of bulimia nervosa because they provide the conceptual rationale for the cognitive and behavioral strategies that make up the multifaceted treatment package (Davis, Fairburn, & Garner, 1987).

Katzman, Weiss, and Wolchik (1986) examined the effectiveness of a psychoeducational group treatment program for bulimics. The effectiveness of the seven-week program was evaluated relative to no treatment controls. The treatment program focused on decreasing depression, enhancing self-esteem, increasing assertion, and improving body image (Katzman et al., 1986). Compared to the no-treatment group, the women who participated in treatment showed significant improvements in binges per month, depression, and self-esteem. Also, the number of purges per month decreased for the women in the treatment group. In contrast, this behavior increased for women in the no-treatment group.

These results are similar to those of Conners, Johnson, and Stuckey (1984) which showed significant improvements in psychological functioning, including self-esteem, depression, assertiveness, and pathological attitudes about eating. An overall reduction of 70% in binge/
purge episodes occurred in bulimic women who participated in a fifteen-week group treatment.

Both Katzman et al. (1986) and Conners et al. (1984) used an eclectic approach incorporating education, self-monitoring of behavior, goal setting, assertion training, relaxation, and cognitive restructuring in group treatment. These authors, as well as Boskind-Lodahl (1976), argued that bulimia is not just an eating disorder, that it coexists with behavioral and personality deficits that maintain the maladaptive behavior.

Results from these studies demonstrate group treatment that focuses on deficits wider than just the maladaptive eating pattern (Katzman et al., 1986) and aim at interrupting the symptomatic behavior and the accompanying feelings of hopelessness and helplessness (Conners et al., 1984) are effective strategies for treating bulimic individuals. Short-term, structured group treatment with bulimics can lead to attitudinal and behavioral change.

Davis, Olmsted, and Rockert (1990) evaluated the effects of seven psychoeducational groups offered over an eighteen-month period. Information and self-care strategies were presented to the group members in a highly structured lecture format. Each group meeting focused on a different theme and included a topic relevant to bulimics, such as psychological or physiological consequences of bulimia. The psychoeducational groups assisted members in normalizing their eating behavior through the presentation of relevant information and providing self-care strategies, such as meal planning, problem solving, cognitive restructuring, or self-monitoring.
Results indicated changes in eating symptoms, overall binge eating reduced 82% and vomiting reduced 65%. Thirty-two percent of the sample stopped binge eating, and 24% ceased vomiting. Twenty-one percent of the sample were completely free of eating symptoms in the month after treatment, and 76% of the sample maintained reductions 3-5 months after treatment (Davis, Olmsted, & Rockert, 1990). Between 29% and 56% of subjects evidenced a significant change on instruments measuring drive for thinness, dietary restraint and body dissatisfaction, although only 6% to 19% reported significant change on measures of personality dysfunction and associated psychopathology following their group participation (Davis, Olmsted, & Rockert, 1990). These results suggest remission of eating symptoms may be temporary, with relapse likely to occur.

Psychodynamic Orientations

Self-psychological. Barth and Wurman (1986) described a long-term, psychodynamic, group therapy approach which utilized concepts from self-psychology to explain some of the dynamics of bulimia. The authors suggested that “Bulimic women utilize the group to complete a structural gap in their psychological makeup. While they use the group for external support and structure, they also use it to build important internal structure” (Barth & Wurman, 1986, p. 736).

Barth and Wurman (1986) observed extremely helpful effects of long-term group psychotherapy with women from their clinic. The significance of the group was apparent with women who were not able to make successful use of other forms of treatment. Many of their clients fled from individual therapy when they began to feel too close or dependent on the
therapist or when the therapist was unable to meet all of their needs. The group offered these clients a place where they could share their experiences and symptoms without embarrassment, which enhanced their self-esteem throughout the group.

Statistical changes in attitudes or behavior were not calculated in this study, although benefits of the group viewed by the members were discussed. A marked decrease in binge/purge episodes were experienced by many members, and they started to use the group as a support system whenever they felt the urge to begin the binge/purge cycle. Many members telephoned one another in the need of support or to offer suggestions. This is an important aspect of group therapy with this population. It provides a support system for people who have never been able to utilize other people for support in the past (Barth & Wurman, 1986). Other benefits of this particular psychodynamic group therapy were: decreased sense of shame and guilt; increased sense of strength, self-confidence, and self-esteem; and less distorted, negative feelings towards one's self-image.

**Educative/Support.** Abramowitz and Berry (1989) examined the effects of short-term educative/support groups and subliminal psychodynamic activation on the binging behavior and psychological functioning in twenty-seven females. Four groups were formed: two educative/support groups with either experimental or neutral stimulus; and two attention/placebo (telephone contact vs. social contact) with either experimental or neutral stimulus. The subliminal message "Mommy and I are two" was an experimental stimulus to be used as an alternative to binge eating by
"activating a fantasy of reunion with one's mother" (Abramowitz & Berry, 1989, p. 76).

The findings generally indicated that participants in the group conditions improved more than the participants in the attention/placebo conditions. The following were specific improvements in only group participants: lowered scores on the Eating Disorders Inventory on drive for thinness, interpersonal distrust, and psychological tendencies toward bulimia; decreased amount of vomiting episodes and in loss of control during binge episodes; decreased amount of binge episodes; and decreased amount of depression and anxiety (Abramowitz & Berry, 1989).

A finding in this study worth mentioning was subjects who participated in an educative/support group but received no subliminal psychodynamic activation message, showed lower signs of improvement compared with participants in the educative/support group with subliminal activation. This should be considered when using psychodynamic approaches in group therapy with bulimic women.

**Intensive therapy.** Goff, Harper, Hatsukami, Mitchell, and Pyle (1989) conducted a 2-5 year follow-up study of one-hundred bulimic women, who had participated in their outpatient intensive group psychotherapy program. Eighty-seven percent of the subjects had completed the 10-weeks of group treatment. The outpatient intensive program was a structured group psychotherapy approach which emphasized cognitive-behavioral techniques and nutritional counseling. At an average 42-month follow-up, results indicated 75% of subjects continued improvement in their eating behavior, and 66% were free of bulimic behavior (i.e. binge/
purge episodes), although a portion of these achieved this remission through additional treatment or through attendance at self-help groups.

In contrast, 25% of subjects were viewed as treatment failures. These patients continued to have significant bulimic behaviors at follow-up and had relapsed to their baseline level of bulimic symptoms recorded at pre-treatment (Goff et al., 1989). Hypotheses were formed about treatment failures and were typically confirmed from the group results. Individuals with the worst treatment outcome tended to be those individuals with the worst eating behaviors at baseline. For example, 70% of group failures were vomiting several times a day at baseline, compared to 32% of the best outcome group (Goff et al., 1989).

This study contradicted findings in the study by Ames et al. (1987). Ames et al. (1987) found group members with the most severe symptomatology at the beginning of treatment showed the greatest reduction in bulimic symptomatology after treatment. Members with mild symptomatology tended to increase bulimic behavior. Goff et al. (1989) found individuals with less severe symptomatology showed the greatest reduction in bulimic behavior. Even though these two studies have contrasting results, this suggests that if a group is not homogeneous in symptom severity at pretreatment, adverse effects could occur in group members. Perhaps symptom severity should be a component in screening procedures for bulimic groups, despite theoretical basis.

Overall, research studies indicate that group therapy with bulimics is effective. Various types of groups have been used with this population and have shown positive results. Cognitive-behavioral groups have
resulted in reductions of binging and purging (i.e. Agras et al., 1985; Ames et al., 1987; Fairburn, 1981; Lacey, 1983; Lee & Rush, 1986; Stevens & Salisbury, 1984); less depression (Lee & Rush 1986; Lacey, 1983); fewer dropouts (Agras et al., 1985); lower EAT score and an increase in ideal weight (Lacey, 1983). Franko (1987) showed that a self-help group had benefits with bulimics, such as increased interpersonal relationships or decreased feelings of uniqueness. Psychoeducational groups resulted in improvements in psychological functioning (Conners et al., 1984; Davis et al., 1990); and changes in eating patterns (Davis et al., 1990; Katzman et al., 1986). Group therapy with psychodynamic orientations (i.e. self-psychological, educative/support, intensive therapy) also yielded positive changes. All studies indicated common results, such as a decrease in binge/purge episodes (Abramowitz & Berry, 1989; Barth & Wurman, 1986; Goff et al., 1989). Two studies indicated a decrease in depression or sense of shame (Abramowitz & Berry, 1989; Barth & Wurman, 1986).

Implications for School Counselors

Over the past few decades, bulimia has been on the rise, primarily affecting the female adolescent population. The etiology of bulimia is not agreed upon in the literature, but sociocultural factors seem to play an important role. Some researchers suggest that the sociocultural value of thinness being the ideal for women in the Western society may play an essential part in the development of bulimia (e.g., Boskind-Lodahl & White, 1978; Copeland & Herzog, 1985). Many youngsters have unrealistic attitudes about eating and weight, which may make them susceptible to bulimia. With this in mind, school counselors can play a
central role in the prevention, identification, and treatment of bulimia through their traditional roles of coordinating, collaborating, and counseling.

Prevention

The school counselor's most vital role may well be that of preventionist. The school counselor should devote time and energy to setting up an educational program aimed at the prevention of eating disorders (Omizo & Omizo, 1992). The school counselor is in an ideal position to provide education to parents, students, and teachers, which may be the key to diminishing this prevalent eating disorder.

Omizo and Omizo (1992) suggested that children close to puberty should be the primary targets of a prevention education program because pubertal changes often result in eating fluctuations. For some youngsters, the "physical and emotional changes accompanying puberty may represent a loss of control significant enough to precipitate anorexic or bulimic behavior" (Butterfield et al., 1984, p. 189). School counselors should include various topics on pubertal changes in their prevention program.

Information about bulimia could be integrated into existing classes such as health education, home economics, physical education, or classroom guidance. School counselors or teachers can educate students about proper nutrition and diet. They can also lead class discussions about the connection between food and emotions, specific health consequences of eating disorders, the role of women in today's society, and the media's portrayal of women (Crago et al., 1987). Parents, teachers, and school
personnel can be educated on the etiology and effects of bulimia through inservices, workshops, or parent groups. Brochures describing the etiology, dynamics, effects, and treatment of bulimia are another possible reference for students, teachers, and parents (Frey, 1984). Prevention in the schools is necessary to alleviate this increasing problem among school age children. Efforts toward prevention should also extend to the family and community through pamphlets at fitness centers or grocery stores, PTA meetings, or yearly parental seminars at schools.

Identification

One of the school counselor's responsibilities is to recognize the symptoms of bulimia, most of which are observable in the school setting. Common psychological characteristics (e.g., low self-esteem, depression), behavioral signs (e.g., frequent bathroom trips, avoidance of food), and physical manifestations (e.g., teeth discoloration, extreme weight loss) displayed by typical bulimics should alarm a school counselor. Frey (1984) noted that a change in personality or behavior is often the first indicator to teachers or counselors that an eating disorder may be present. Maceyko and Nagelberg (1985) reported that only a small proportion of bulimics actually seek help for this problem, so a school counselor must be alert to possible warning signs. Some students may not identify their eating behavior as the presenting problem in a counseling session. Omizo and Omizo (1992) explained that a school counselor who suspects that a student is bulimic should visit with the student in an effort to determine whether or not there is reason for concern. Kubistant (1982) believed that bulimics are both willing and relieved to discuss their
problem when a sensitive, open, and understanding person is available. The school counselor is in an excellent position to be this person and can make an assessment of the student's current status, which can provide useful information to additional professionals involved in the student's diagnosis and treatment.

**Treatment**

Before the school counselor takes on the task of counseling a bulimic student, he or she must decide which problems can be handled in the school setting and which cannot. The school counselor must also consider the amount of time he or she has available for a suffering bulimic. VanThorre and Vogel (1985) noted that one of the best resources for dealing with students who may be or are bulimic is the referral process. School counselors should not treat clients with bulimia unless well-trained in the area and under specific supervision of a qualified clinician (Frey, 1984). For this reason, a vital function of the school counselor is to coordinate their efforts with physicians, psychologists, and other appropriate referral sources in his or her community.

With youngsters who report less severe bulimic behavior, the school counselor can implement individual or group counseling. As indicated previously, group therapy has been found to be the most effective approach with bulimics (Lenihan & Sanders, 1984). Research supports that the advantages of treatment of bulimics in groups far outweigh the disadvantages.

A general approach within the school setting could be to start a group for students who have “problems with food” (Hendrick, 1985). Although
the group is not specific to bulimics, it could provide a positive atmosphere for students to discuss eating behaviors. This type of group could prove to be educational, preventative, or therapeutic for various members.

Specific issues for bulimics which could be explored, in the school setting, through group counseling include: (a) raising self-esteem; (b) teaching assertiveness skills with special focus on the family setting; (c) teaching relaxation skills to be used in eating and noneating situations; (d) monitoring anxiety about food by daily record keeping and emotional journals; and (d) educating about nutrition as well as the negative effects of bulimia (Hendrick, 1985). These group approaches could help challenge bulimic behaviors in students, while offering support during their recovery process.

School counselors are in ideal position to help the target population affected by bulimia. Through preventative techniques, such as setting up an educational program, educating other persons who have contact with students about bulimia, discussing pubertal changes and societal pressures, and providing information about bulimia to students in classes, the school counselor can try to stop this problem before it starts. The school counselor has to be able to identify possible victims of bulimia and refer them to outside professionals whenever necessary. Most of the time, a referral will be needed with severe bulimics, but the school counselor can play a role in the treatment process with less severe bulimics. The school is a supportive setting where groups can be conducted to help these students deal with their eating problems.
Conclusion

Bulimia constitutes a current, major health concern in Western society. Because of the increasing incidence of this disorder among adolescent females, professionals in the helping services are alarmed. The onset of bulimia is often during the adolescent years, which puts people who work with adolescents, particularly school counselors, in an ideal position to establish preventative programs, identify students who have the disorder, and assist in the treatment process.

In virtually every group study, regardless of specific type of treatment or orientation, the group intervention was successful on whatever criteria was used. Common to the majority of studies was the reduction or elimination of binge/purge behavior, as well as improvements in psychological functioning. Depression tended to reduce, while self-esteem improved.

The group setting seems to have the potential advantage for bulimics. Gould, McKenna, and Oesterheld (1987) summarized that the group framework offers three opportunities to bulimics unattainable through other treatment interventions: (a) an end to secrecy and isolation by sharing with peers; (b) reality-testing for distorted beliefs and self-perceptions with empathetic feedback, credible because it comes from others also affected; and (c) an interpersonal context where the links between food behavior and relationships may become clear through the evolving relationships among members. Research has suggested that groups help bulimics form a support system where they can turn in the event of a possible relapse. The maintenance of reduced bulimic behavior and prevention of relapse
are concerns of helping professionals. These concerns provide direction for further research.

Goals of treatment need to be taken into consideration when determining which particular group treatment a bulimic would respond to best. Also, research has suggested symptom severity at pretreatment as a characteristic producing different effects in bulimics. The research findings about the effectiveness of group treatment with bulimic women are encouraging, and the group setting provides a short-term, cost-effective intervention.

The school counselor must not take on the task of treating a bulimic alone. The individual needs of a student must be assessed to determine if group treatment in the school setting is an option. The longer the student has practiced this abnormal eating behavior, the more likely he or she will require a referral to an outside agency or possibly hospitalization. The school counselor must know his or her own limitations when faced with this difficult population.

Depending on the severity level, the bulimic individual can be reached through group counseling in the school setting. The school counselor must become knowledgeable about bulimia in order to use counseling approaches effectively with these individuals. The school counselor can be instrumental in the treatment of this dangerous practice, as well as in the implementation of prevention programs and identification.
References


*International Journal of Eating Disorders, 5*, 21-34.


*British Medical Journal, 286*, 1609-1613.


