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The role of school counselors in the identification and treatment of students with eating disorders

Abstract

Due to their severity and prevalence, eating disorders are currently a significant public health issue in the United States particularly among preadolescent females (Mitchell & Eckert, 1987; Lenihan & Sanders, 1984; Eisele, Herstgard, & Light, 1986). In each decade between 1950 and 1980, the number of pre-adolescent children diagnosed with anorexia nervosa has doubled (Rickards, 1982 as cited in Rhyne-Winkler, 1994; Peters, Butterfield, Swassing, & McKay, 1984). The increase in eating-disordered behaviors and attitudes exhibited among young females may be caused by or exacerbated by life-style changes within the family as well as by society's focus on thinness and beauty (Rourke, Smith, & Nolte, 1984 as cited in Rhyne-Winkler & Hubbard, 1994). Eating-disordered behavior can seriously affect children's school performance and learning (Pearson & Long, 1979 as cited in Rhyne-Winkler & Vacc, 1989; Pearson & Long, 1982 as cited in Rhyne-Winkler & Hubbard, 1994).

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THE ROLE OF SCHOOL COUNSELORS IN THE IDENTIFICATION AND TREATMENT OF STUDENTS WITH EATING DISORDERS

A Research Paper

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In Partial Fulfillment

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Dianne Dickinson Moran

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Introduction

Due to their severity and prevalence, eating disorders are currently a significant public health issue in the United States particularly among preadolescent females (Mitchell & Eckert, 1987; Lenihan & Sanders, 1984; Eisele, Herstgard, & Light, 1986). In each decade between 1950 and 1980, the number of pre-adolescent children diagnosed with anorexia nervosa has doubled (Rickards, 1982 as cited in Rhyne-Winkler, 1994; Peters, Butterfield, Swassing, & McKay, 1984). The increase in eating-disordered behaviors and attitudes exhibited among young females may be caused by or exacerbated by life-style changes within the family as well as by society's focus on thinness and beauty (Rourke, Smith, & Nolte, 1984 as cited in Rhyne-Winkler & Hubbard, 1994). Eating-disordered behavior can seriously affect children's school performance and learning (Pearson & Long, 1979 as cited in Rhyne-Winkler & Vacc, 1989; Pearson & Long, 1982 as cited in Rhyne-Winkler & Hubbard, 1994).

Adolescent eating disorders constitute a natural area of concern for elementary, middle school, and high school counselors in our society today. Both

Hendrick (1984), and Rhyne-Winkler and Vacc (1989), stated that one of the most effective roles a school counselor can take is that of preventionist and early interventionist. The school counselor is in a good position to identify individuals with eating disorders, provide relevant education and information for all students, and facilitate group treatment plans within the school setting. The counselor's role also includes contacting parents and making referrals to community agencies as necessary.

In this paper the role of the school counselor as preventionist and interventionist in the treatment of eating disorders will be examined. Also included are characteristics of anorexia nervosa and bulimia nervosa.

Characteristics and Symptoms

Although there are differences between anorexia nervosa and bulimia nervosa (often referred to as anorexia and bulimia), most professionals prefer to think of them as facets of a broader eating disorder.

Bulimia

Bulimia involves episodic but rapid ingestion of large quantities of food followed by purging behaviors such as vomiting or elimination.

Mizes (1985) stated that bulimia is characterized by marked binging and purging as well as associated guilt and depression. Bulimia often begins during a time of significant personal stress. Binges seem to be precipitated by negative emotional states such as anxiety or depression which are frequently associated with interpersonal difficulties or pressure from school. Individuals with bulimia often focus on how overwhelmed and fearful they feel about body fat, lack of self-control, burdensome responsibilities and loneliness.

Bulimic individuals' desire for thinness, control, and approval often becomes unrealistic (Rhyne-Winkler & Hubbard, 1994). They may attempt to reduce fears and tensions by self-selecting a concrete target in the form of food intake and elimination and may then focus on fighting this self-selected target (LeVine, 1993). For intervention and prevention to be most effective, it is important to identify individuals at risk for eating disorders as early as possible (Eisele, Herstgard, & Light, 1986; Hendrick, 1984; Peters, Butterfield, Swassing, & McKay, 1984).

Bulimia is associated with several medical complications including dehydration, electrolyte

imbalance, dental decay, gastrointestinal problems (Kaplan & Woodside, 1987 as cited in Jensen-Scott & DeLucia-Waack, 1993), and even cardiac arrhythmia which can result in death (Anderson, 1985 as cited in Jensen-Scott & DeLucia-Waack, 1993; American Psychiatric Association, 1994).

Anorexia

Anorexia is a self-imposed starvation for which there is no known medical cause (Marks, 1984 as cited in Rhyne-Winkler & Vacc, 1989). Like bulimia, anorexia is also associated with dehydration, electrolyte imbalance, dental decay, gastrointestinal problems, (Kaplan & Woodside, 1987 as cited in Jensen-Scott & Delucia-Waack, 1993), and cardiac arrhythmia (Anderson, 1985 as cited in Jensen-Scott & DeLucia-Waack, 1993). In addition, hypoglycemia, rectal problems, hematological abnormalities, amenorrhea, endocrine complications and other problems often occur in anorexic patients (Mitchell, 1986 as cited in Jensen-Scott & DeLucia-Waack, 1993; American Psychiatric Association, 1994). The incidence of anorexia has been estimated at between .24 and 1.6 per 100,000 population (Bemis, 1978 as cited in Hendrick, 1984). Some estimate that 1 out of every 250

adolescent females is a victim of anorexia (Levenkron, 1982 as cited in Hendrick, 1984). Approximately 5-15% of anorexics are male (Bemis, 1978 as cited in Hendrick, 1984; Mitchell & Pyle, 1982 as cited in Bauer, 1984). Anorexia appears only in western and highly westernized cultures such as Japan (Nassar, Hodges, & Ollendick, 1992). It seems to be related to issues of ethnicity, class, and gender, and occurs almost exclusively among whites in middle and upper classes (Nassar et al., 1992; Hendrick, 1984). This syndrome is often described as a relentless pursuit of thinness which begins with an individual's attempt to lose weight, and develops into a powerful drive for thinness that overrides all other physical and psychological concerns (Garfinkel & Garner, 1982; Nassar et al, 1992).

Commonalities

Fosson, Knibbs, Bryan-Waugh, and Lask (as cited in Nassar et al., 1992) reported that the first signs of an eating disorder occur at an average age of 11.7 years, with some patients evincing problems as early as 8 years of age. Death has been reported to occur in up to 18% of cases of eating disorders (Theander, 1985 as cited in Nassar et al., 1992). Although the

most frequently cited age for the onset of severe eating disorders is early adolescence (Bruch, 1978; Hendrick, 1984; Peters et al., 1984; Minuchin, Rosman, & Baker, 1978; Steele, 1981 as cited in Eisele et al, 1986), most of the current literature on eating disorders focuses on older teenagers and adults. Much of the research in the field has been conducted by Martha C. Rhyne Winkler and various associates, D. M. Garner, and P. E. Garfinkel.

History and Prevalence of Eating Disorders

Cases of eating disorders have been traced as far back as the 1600s and 1700s when anorexia nervosa was recognized in the medical literature. At that time, descriptions were provided by Morton in 1694, Gull in 1874 and Leseague in 1873 (as cited in Peters et al., 1984).

Historically, anorexia nervosa has been considered to be a rare disorder, but in the past two decades the number of individuals diagnosed with anorexia has increased dramatically (Neuman & Halvorson, 1983 as cited in Peters et al, 1984; Szmukler, 1985 as cited in Nassar et al., 1992). The prevalence for anorexia nervosa is estimated at up to 1% for female youth between ages 12 and 18 (American

Psychiatric Association, 1987). While the syndrome may be relatively rare in the population as a whole, it has been estimated that between 5% and 10% of today's young American women and teenage girls are anorexic (Nassar et al., 1992).

The subject of bulimia is also currently attracting great interest in scientific circles and among the general public (Mizes, 1985). Findings strongly suggest that bulimia is a much more serious and widespread problem than previously thought (Halmi, Falk, & Schwartz, 1981 as cited in Mizes, 1985). Moreover, most authors caution that their findings may underestimate prevalence due to patients' reluctance to report their eating disorder (Halmi, Falk, & Schwartz, 1981 and Strangler & Printz, 1980 as cited in Mizes, 1985). Estimates of the prevalence of bulimia range from 1% to 5% for females and up to 1% for males (Pyle, Neuman, Halvorson & Mitchell, 1991 as cited in Jensen-Scott & DeLucia-Waack, 1993).

In addition to individuals with clinically diagnosed eating disorders, larger numbers of individuals engage in some behaviors or possess some weight-related cognitions characteristic of persons having an eating disorder (Jensen-Scott &

DeLucia-Waack, 1993). For example, a survey of high school aged female students found that 21% binged on a weekly or more frequent basis, and 4% engaged in self-induced vomiting as least once a week (Johnson, Lewis, Love, & Stuckey, 1984). In addition, these researchers found that 52% of the female students had dieted by the age of 14, and 9% had dieted chronically. Eisele et al. (1986) noted that while 81% of the 12-, 13-, and 14-year-old females included in their study were assessed to be within the range for ideal weight or were underweight, 78% preferred to weigh less, and only 14% were satisfied with their current weight. Eisele et al. (1986) stated that because these students will probably try to lose weight, it is critical that eating-disordered students understand the benefits of losing weight in healthy ways and recognize realistic weights for their body structure and height.

Strategies for Counselors

Rhyne-Winkler and Vacc (1989) suggested that focus on prevention and early intervention should include staff and parent involvement, identification and assessment, classroom guidance, and small-group sessions. These researchers also suggested that goals

for all program components include developing healthy habits and attitudes toward eating, encouraging the development of self-control about eating, developing a healthy exercise routine, and improving self-esteem and autonomy. Nassar et al. (1992) concluded that implementing activities to promote better self-image at all grade levels in classrooms, group settings, or with individuals can contribute to positive growth in many areas.

Staff and Parent Involvement

In order to provide education to parents and school personnel, counselors may meet and consult with the entire faculty including physical education teachers, health teachers, school nurses, and the guidance steering committee if appropriate. Rhyne-Winkler (1994) stated that counselors may assist faculty in exploring ways in which classroom teachers can reinforce learning and then provide teachers with criteria useful in identifying and referring students suspected of having eating-disordered attitudes.

Parents can be educated about eating disorders through workshops and parents' groups. Counselors might schedule a meeting to present the planned program to parents and to address any concerns raised.

Materials on nutrition and health might be suggested (Gunn & Stevenson, 1985 as cited in Rhyne-Winkler & Hubbard, 1994; Rhyne-Winkler, 1994). A presentation to the Parent-Teacher Association and written correspondence sent home with students could provide additional contacts (Rhyne-Winkler & Hubbard, 1994).

If the eating disorder is entrenched or the student is in a critical physical state, the student and family need to be referred for treatment of the eating disorder (Hendrick, 1984; Nassar et al., 1992; Rhyne-Winkler & Vacc, 1989). This can be done by calling the local mental health association or community mental health center which will be able to identify the appropriate practitioner or clinic in the area. The counselor can make the contacts or assist the parents in doing so. Severe eating disorders and related problems need to be evaluated by someone who has special training, because many of the typically used general therapeutic strategies do not work in these cases. Some communities have also begun self-help groups for adolescents with anorexia, bulimia, and other eating disorders (Hendrick, 1984). Networking between school counselors and qualified professionals whenever appropriate can provide a

proactive thrust to diminish the ever-growing problem of eating disorders in young female adolescents.

Identification and Assessment

It is important that school counselors as well as parents learn to determine early clues that can be used to identify eating-disordered children. The following may be indications of anorexia or bulimia: (a) a marked change in eating behavior including amount and variety of food eaten, fasting and feasting, or loss of appetite (Steiner, 1982 as cited in Rhyne-Winkler & Vacc, 1989); (b) a change in overt behavior such as frequency of trips to the bathroom, not wanting to eat with a group, increase in amount of exercise, impulsive behaviors, or obsessive weighing (Harding, 1985 as cited in Rhyne-Winkler & Vacc, 1989); (c) changes in psychosocial behavior such as frequency of comments concerning body size and the need to diet, perfectionistic goals, sudden withdrawal, or extreme concern with achievement (Harding, 1985 as cited in Rhyne-Winkler & Vacc, 1989); and (d) physical change in loss of weight (Rhyne-Winkler & Vacc, 1989).

Based on results of her study of 379 fourth-, sixth-, and eighth-grade girls ranging from 9 to 15

years of age, Rhyne-Winkler (1994) found several factors which could indicate an eating disorder. These factors may include low body weight, a history of dieting, or self-reported dissatisfaction with weight or appearance. Academic disturbances or intense concern over general academic achievement, changes in behaviors such as eating habits, impulsivity, obsessive weighing or exercise, or social isolation could also be viewed as indicators of possible eating disorders. In a study composed of 159 girls ages 12 to 14, Nassar et al. (1992) suggested that a low self-concept is also one of the predisposing factors toward the development of an eating disorder.

In a 1989 study composed of 144 fourth-, sixth-, and eighth-grade females, Rhyne-Winkler & Vacc found that eating-disordered individuals are more likely to be high achievers and compliant. Silverman (1983, as cited in Peters et al., 1984) agreed with Rhyne-Winkler and Vacc and noted that most anorectics were of average intelligence and maintained good grades through compulsive study. Adolescent overachievers may, therefore, be at greater risk for developing an eating disorder than their peers.

Jensen-Scott and Delucia-Waack (1993) suggested that rather than concentrating solely on diagnostic criteria, school personnel could act more in line with the developmental guidance philosophy, that is, to foster in all adolescents the behavioral and cognitive skills needed to assume healthier lifestyles. They further suggested that such a shift in orientation might assist in crisis and remedial interventions and preventative objectives.

Classroom Guidance

Hendrick (1984) suggested that one of the most effective approaches available to school counselors in dealing with children's eating-disordered behaviors involves incorporating information about eating disorders into the guidance program. Myrick (1987, as cited in Jensen-Scott & DeLucia Waack, 1993) suggested that nearly all developmental guidance programs advance eight goals. Of these, four are directly relevant to eating disorders and weight management programming and are supported by several authors:
(a) understanding self and others (Levine, 1993),
(b) understanding attitudes and behaviors,
(c) improving decision-making and problem-solving, and
(d) improving interpersonal and communication skills

Jensen Scott & DeLucia-Waack, 1993; Hendrick, 1984; Rhyne-Winkler & Hubbard, 1994). The objectives of classroom guidance units on the subject of eating disorders are (a) to assist students in examining their knowledge and attitudes toward food and eating, (b) to assist students in developing a positive and realistic attitude toward body size, and (c) to provide students with accurate information concerning healthy dieting and exercise behaviors (Rhyne-Winkler & Hubbard, 1994).

Classroom guidance lessons can be developed that address healthy diet and exercise behaviors (Rhyne-Winkler, 1994), body esteem and self-esteem (Streigal-Moore, Silberstein & Rodin, 1986 as cited in Rhyne-Winkler & Hubbard, 1994; Rhyne-Winkler & Hubbard, in press as cited in Rhyne-Winkler, 1994; Nassar et al., 1992), lack of internal locus of control (Steiner, 1982 as cited in Rhyne-Winkler & Hubbard, 1994; Rhyne-Winkler & Hubbard, in press as cited in Rhyne-Winkler, 1994), approval-seeking behavior (Stroeber, 1980 as cited in Rhyne-Winkler & Hubbard, 1994), and perfectionism (Lenihan & Sanders, 1984; Rhyne-Winkler & Hubbard, in press as cited in Rhyne-Winkler, 1994).

LeVine (1993) was more definitive in listing four goals directly relevant to eating disorders and weight management programming: (a) understanding self and others, (b) understanding attitudes and behaviors, (c) improving decision-making and problem-solving skills, and (d) improving interpersonal and communication skills. More specifically related to eating disorders, the objectives might involve the cognitive, behavioral, and nutritional aspects. Levine further stressed that counselors may: (a) help students to increase their awareness of their current cognitions and behaviors, (b) help them to assess their behaviors on a continuum from healthy to unhealthy, and (c) help them to identify more appropriate alternatives to any unhealthy behaviors or cognitions.

Levine (1993) suggested a variety of ways by which school counselors may incorporate eating-disorder education into guidance programs. She recommended classroom guidance units on self-acceptance, realistic body size, stress management, decision making, healthy nutrition, and appropriate dieting might be incorporated into the curriculum.

Small Group Counseling Sessions

Since elementary and intermediate school counselors today are being faced with increasing numbers of bulimic and anorexic students, it is important to identify useful and feasible treatment goals and methods. In addition to providing information and strengthening awareness of eating disorders through classroom guidance sessions, the school counselor may form small groups (Hornak, 1983; Peters et al., 1984). Topics such as body esteem, dieting behaviors, and weight issues might be the focus of small group counseling sessions (Rhyne-Winkler & Hubbard, in press as cited in Rhyne-Winkler, 1994).

Rhyne-Winkler & Hubbard (1994) stressed that while it is advisable for overweight and normal-weight students to participate in separate group sessions, topics for both groups are similar. According to Rhyne-Winkler & Hubbard the group for normal-weight students with a preoccupation with weight, body size, dieting or exercise does not stress weight loss, but rather concentrates on realistic goal-setting, dealing with anger, healthy body image, assertiveness and perfectionism.

A typical group plan for any students with a concern over their weight, whether they be of normal weight or overweight, might include several sessions covering many topics. Rhyne-Winkler and Hubbard (1994) proposed the following plan. The first session would establish ground rules, provide educational information on diet and nutrition, explain food logs where each participant records daily eating along with accompanying moods, and administer an Adapted Eating Attitudes Test (AEAT) to each group member (Vacc & Rhyne, 1987 as cited in Rhyne-Winkler & Hubbard, 1994). The second session would deal with diet and nutrition, and a dietician might be invited to speak. Members would also discuss family eating patterns.

During session three a speaker such as the physical education teacher might discuss the importance of exercise and assist students in planning an exercise contract to be monitored by the counselor or the physical education teacher. During session four members would discuss specific eating behaviors such as eating only certain foods, eating too fast, or skipping meals (Rhyne-Winkler & Hubbard, 1994).

Session five's topic would be emotions associated with eating. A counselor might suggest bibliotherapy

to stimulate discussion of characters with whom they identify. Body image and goal-setting might be the topics of the sixth session when members might list and discuss personal goals related to body size. During session seven's self-esteem and autonomy theme, members would discuss people they admire focusing on characteristics unrelated to weight and appearance. The counselor could help students define themselves as a part of their family system and as a separate, unique component within the system (Rhyne-Winkler & Hubbard, 1994).

Rhyne-Winkler and Hubbard (1994) suggested an additional eighth session to deal with perfectionism, using Albert Ellis' (Ellis & Harper, 1975) "shoulds" and "oughts" be incorporated into the normal weight group. Rhyne-Winkler and Hubbard's final session for both the overweight and normal weight groups would be a review, evaluation, and reinforcement time. Members would complete another AEAT and an evaluation form that stresses areas of growth. It was suggested that counselors reinforce continued use of food logs, exercise plans, and peer support and set a date for a follow-up meeting in one month. In addition, they believed counselors need to make any necessary

referrals and facilitate a meeting for parents of group members to process what has been accomplished and to provide parenting suggestions.

Because of the information-sharing emphasis of group therapy, Conner-Greene (1987) believed groups should function more as a class than as a traditional support group. She suggested group sessions should provide factual information about the possible risks, using a symptom checklist to help members identify their own frequency, intensity, and duration of symptoms related to eating disorders. In Conner-Greene's (1987) proposed plan for group counseling, students could be taught to monitor their eating habits and moods which could help them identify patterns of binges and purges, as well as situations in which they are likely to binge.

Conner-Greene (1987) also stated that the purpose of a group program for bulimic students is (a) to address the broader issues relative to the development and continuation of eating disorders; (b) to provide factual information about the possible risks of the binge-purge cycle and the effects of caloric deprivation on behavior; and (c) to facilitate recovery from anorexic and bulimic behavior by helping

members identify for themselves any current problems they may be having that might be linked to bulimic behavior.

Conner-Greene (1987) believed group counseling is intended as a supplement to individual counseling. Conner-Greene (1987) also stressed the importance of an atmosphere of warmth, support, and genuine human contact in group sessions with students having eating disorders. Personal honesty and sharing of authentic concerns between members is as important as acceptance and support of each other. She emphasized an orientation toward personal behavior change. Members may choose a target behavior and, with the group's help, design their own change program. She cautioned that in working with eating disordered students a minimum amount of consistent structure is important.

In another approach to group counseling for students with eating disorders, Schneider and Agras (1985) believed that at least one session should encourage group members to become aware of their current behaviors and focus on identifying and developing alternative adaptive behaviors. Members should also be made aware of enjoyable and healthy activities in which they can take part and should be

encouraged to do these things whenever they get the urge to binge (Conner-Greene, 1987).

Hendrick (1984) and Nassar et al. (1992) proposed that another important part of the group activities should include providing members with information about basic nutrition, basal metabolic rate, caloric intake, and set point-the idea that each individual has a natural physiologically programed weight which the body maintains without effort. In addition to positions taken by Hendrick (1984) and Nassar et al. (1992), Schneider and Agras (1985) proposed incorporation of a relaxation program to reduce stress and anxiety and to enhance self-control. They suggested that initial practice take place in the group. It was also suggested that maintenance of a lending library of self-help materials for students and informational brochures for parents and staff would reinforce any program (Schneider & Agras, 1985; Nassar et al, 1882).

In contrast to the previously mentioned approaches, Lenihan and Sanders (1984) suggested methods which could include a brag time at the beginning of each session, pledges and contracts at the end of each session, and daily record keeping and

emotional journals. Beyond this minimal structure, Lenihan & Sanders believed groups should be allowed to evolve from week to week in response to the members' needs. However, they included several structured activities which could be included at some point in each group's life: (a) practice in relaxation techniques and the use of guided imagery, (b) self-hypnosis, (c) assertiveness training, and (d) social skills training. Whatever method is used, the advantages of treatment in groups far outweigh the limitations.

Because one of the most effective roles a school counselor can take is that of preventionist and early interventionist (Hendrick, 1984; Rhyne-Winkler & Vacc, 1989), a counselor might begin by simply conducting a short-term weight problems group in the school, in which students are educated about the range of weight disorders, from anorexia to obesity. A group format that provides both a lecture presentation and later discussion and sharing seems to be less threatening to many students who desire some therapeutic interaction, but do not want to call it therapy (Hendrick, 1984).

Instituting groups of this type will not only offer a forum in which students may begin to discuss

their problems before they become acute, but it may also cause a counselor to become an "understanding expert on weight disorders" (Hendrick, 1984, p. 432). Students who do not attend the group may seek out the counselor to obtain individual help. Just knowing that someone else really understands their plight is a relief to many eating-disordered students and may be their first step toward recovery.

In addition to facilitating groups which provide information and strengthen awareness of eating disorders, the school counselor may want to consider forming a support group. This type of group could help students discover they do have a problem, they are not alone, and help is available (Peters et al., 1984).

Summary

Eating disorders, which are found most frequently in middle-class female adolescents, have been increasing in prevalence over the past few years in the United States (Szmukler, 1985 as cited in Nassar et al., 1992). This problem is receiving increasing attention from those dealing with young adolescents. Since eating-disordered behaviors affect children's school performance and achievements, school counselors

are frequently called upon to assist with these students. There is a shortage of material specifically dealing with elementary and junior high school students. This paper reviewed literature regarding characteristics and symptoms of bulimia and anorexia, the history and prevalence of eating disorders, strategies for counselors including identification and assessment, staff and parent involvement, classroom guidance, and small group counseling. The literature noted that school counselors can make an important contribution to the identification process and can take an active role in primary and secondary prevention and intervention efforts within the schools to help reduce the incidence of this serious health problem.

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