The Effectiveness of Counseling Groups in Schools to

Help Students Cope with Eating Disorders.

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Abstract

This paper will address the effectiveness of using groups with different styles and techniques in a K-12 school setting to help students with a range of eating disorders. The groups may be effective based on one type of psychological theory versus another, or because of the short-term versus long-term nature of the groups, to name a few. The students differ in the particular eating disorder with which they are associated or in the severity of their diagnosis. The school settings range from elementary to high school as well. Overall, this paper will present the most effective group model for students with eating disorders at several of the grade levels within an educational system.
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The Effectiveness of Using Groups in School to Help Students Cope with Eating Disorders.

There are as many as 10 million people in the United States who have eating disorders according to the National Eating Disorders Association (2005). This number indicates the growing problem of eating disorders and an important reason why the issues around this should be addressed. Hurley (2001) finds that 1 to 4 percent of all young women are estimated to develop an eating disorder in their lifetimes, most being white and upper middle class with the onset of the disorder occurring anywhere from the early teens to mid-twenties. The fact that this disorder can occur at such an early age and that the percentages of people affected is higher than in the past shows that early action is necessary.

Many statistics have changed over time, such as certain categories into which a person with an eating disorder falls; like ethnic or socioeconomic backgrounds. Anorexia is very present in the United States today. Once a disease which was said to be had by white, affluent women; anorexia is now seen in all racial, socioeconomic, and gender groups. Carlton and Ashin (2007) estimate that one out of every two hundred 10- to 15- year-old girls suffers from anorexia, making it the third most common chronic condition among adolescent girls. Eating disorders are found in diverse populations today and not just the affluent. Different populations that have been found to have had this disorder include African American, Black, Asian, Asian-American, Hispanic, Native American, Cuban American, Mexican-American and lesbian/gay (National Eating Disorders Association, 2005). These statistics not only show how big a problem eating disorders are nationwide but how important it is to learn about and educate others about the importance of this disease.
The Importance of Interventions for Eating Disorders

It is important to recognize eating disorders early in the prevention and intervention stages rather than in the responsive stage, where people have often times suffered greatly or beyond repair. Eating disorders are a bigger problem than believed or understood. The National Eating Disorders Association (2005) says that between 0.5-1% of American women suffer from anorexia nervosa. It has one of the highest death rates of any mental health condition with 5-20% dead. It typically appears in early to mid-adolescence. Also, it is associated with symptoms of depression, similar to bulimia nervosa as well as bulimia affecting changes in social adjustments. Bulimia nervosa affects 1-2% of adolescent and young adult women. The prevalence of Binge Eating Disorder, another common eating disorder, is approximately 1-5% of the general population.

There are many reasons people have heard of causing teenage deaths, such as teen driving accidents and firearm accidents. But, suicide which is also a leading cause of death is not always recognized in the smaller, more subtle ways of harm such as eating disorders. According to Bardick, et al. (2004), anorexia nervosa affects approximately 2% of the North American population, and bulimia nervosa affects approximately 4%, of which 10% are males. (p. 2) Individuals with eating disorders, particularly females ages 15-24, have a higher mortality rate, 12 times higher, a significant amount more than any other cause of death. Early interventions are not available for students with eating disorders in schools or early prevention is not available for anyone who may develop one of these diseases. It may continue on without anyone realizing something is wrong until severe medical attention is needed. “In western cultures, more than every second girl and nearly every third boy in the USA have eating disorders, fluctuating around 50-60% continuing 1-2 years and around 10% persisting into
adulthood (Hautala, et al., 2008, p. 675). Students with eating disorder occurring multiple times or throughout a number of years usually suffered from multiple psychological problems and health complaints such as anxiety, depression and body dissatisfaction, some of which had arisen already earlier in adolescence.

Eating-disordered behaviors can seriously affect many aspects of a person’s life including but not limited to school performance, learning and behavior (Rhyne-Winkler & Hubbard, 1994). These social, academic and career concerns indicate another strong need to intervene early if warning signs are noticed by counselors or other educators in a school setting. They are important reasons for staff to educate themselves about the symptoms that could occur. Staff members can look for symptoms in the school setting for students with eating disorders, including; frequently making trips to the restroom, avoidance of the school cafeteria, sleeping in class, fainting, having undiagnosed learning disorders, and having change in personality (Frey, 1984). Not only can eating disorders affect a student’s health physically, but in many other ways including social, academic and career failure in school.

One way of intervening early in the school setting for students who have eating disorders is to develop groups that focus on the specific issues of eating disorders. According to Bauer, Sapp, & Johnson (2000), school is an ideal spot for establishing counseling groups for at-risk students in the schools. Using cognitive-behavior theory is important to breaking the cycle of failure that they often experience and school is a good place where these behaviors, cognitions, and emotions can be modified through instruction. The counseling group is viewed as an educational experience in which group members can learn and practice new behaviors and skills. Not only are groups a good intervention process for a group of students working through specific issues, but it educates them and allows them to help educate others in the group as well. It not
only allows them to be responsible for themselves but empowers them by helping each other. Group sessions can be good forums to educate clients on important topics that may not be addressed elsewhere. Group therapy can help clients feel supported and accepted and know that they are not alone. Clients who otherwise have a hard time forming relationships can eventually learn to share, get close, trust, love, and be loved. “Truth without judgment is a critical life lesson, and group therapy is a perfect place to practice it” (Costin, 2007, p. 177).

As educators, we are not only trying to help students succeed in school academically but socially and emotionally as well. By having these eating disorder groups, students learn that they are not alone with their problems and become more motivated to succeed in school and make plans for the future (Phillips & Phillip, 1992). Also, having students in groups promotes individual change but also changes the environment around them for their benefit as well as the benefit of others. In a study by Zinck & Littreell (2000), short-term group counseling correlated with significant improvement of achievement scores and interpersonal relationships. Group counseling is shown to be effective in assisting young people to adjust to changes in family structure and to manage aggression and stress. Disciplinary referrals dropped off and students had improved relationships after counseling groups. Group counseling appeared effective in promoting individual change and producing attitudinal and affective changes.

As the world and the children in it change, so do the problems they face. “With an increasing number of children ages 8 through 13 ending up in eating disorder treatment, the need for early education and prevention programs is crucial” (Costin, 2007, p. 295).

*The Types of Different Eating Disorders*

According to Volstadt (1999), a general eating disorder is defined as a person who works out their emotional problems by using food issues such as eating or dieting rather than dealing
with their feelings. They use issues surrounding food, weight, and dieting to avoid other problems and aspects of their life.

The following three definitions describe the main types of eating disorders which will be discussed in this paper along with a few less common disorders. The first eating disorder is Anorexia Nervosa which is a serious, potentially life-threatening eating disorder characterized by self-starvation and excessive weight loss. The second eating disorder is Bulimia Nervosa which is a serious, potentially life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviors such as self-inducing vomiting designed to undo or compensate for the effects of binge eating. The third eating disorder is Binge Eating Disorder (BED) which is a type of eating disorder not otherwise specified and is characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating (National Eating Disorders Association, 2005).

*The General Overview of Using Groups*

There are many different strategies that can be used for students with eating disorders, one being the use of group counseling within the school setting. According to Page & Chandler (2004), the at-risk student can be helped through small-group counseling through mental health counselors. Many people may be hesitant to be a part of group counseling, but that alone is a good reason to try it. Group therapy can help you feel that you are not alone. It allows you to meet others who are experiencing the same things. It may be the first time you have met someone who shares your thoughts, emotions, and behaviors, and can understand and not be judgmental (Kirkpatrick & Caldwell, 2001). People will learn to focus on others and not just themselves. “Group therapy is an opportunity for people to sit in a circle with others and be fully present, listen attentively, practice empathy and attunement, and tell the truth without judgment.
One of the main reasons group therapy works is that it serves as a microcosm for the world at large. It is practice for living life in relationship with others” (Costin, 2007, p. 167).

In a school setting, groups can be a great way to help students get to know each other and take comfort in the idea that they have others whom they can turn to that are going through the same thing. Gerrity & DeLucia-Waack (2007) discuss the many advantages to groups for adolescents including how they are a natural way for adolescents to relate to each other, how they emphasize the learning of life skills, how they focus on generalizing behaviors practiced in the group to real-life situations, and how they provide multiple feedback and increase self-esteem that comes about through helping others. Since many people that have problems with eating disorders feel out of control or are trying to take control in a negative way, being part of a group can help them be in control of something positive. Groups can provide a place for students to be able to belong and contribute to something. Peer groups can help girls build support systems for themselves by encouraging and facilitating the connections they have with each other. Group experience can provide many important things to a person with an eating disorder who feels alone and unworthy such as a sense of belonging, empowerment from the group experience, a bond with the group members, and a helpful, worthwhile, and fun experience (McVey, Lieberman, Voorberg, Wardrope, & Blackmore, 2003).

People who feel they are alone and cannot describe their problems to their friends and family can have people to talk to who are going through the same things and who can really understand where they are coming from. In group therapy, a therapist helps guide the discussion among people with the same problem. A group can help to get to the heart of a person’s problem and make them feel like they are able to open up and be empathized with. Being in a group of people with the same problems makes it harder for individuals to say, as they might to a
therapist, “You just don’t understand” (Volstadt, 1999). Many clients agree that the most important feature of the group is the personal contact with other people and the experience of sharing their fear and misery and their positive progress with others who “really know what it’s about” (Lenihan & Sanders, 1984, p. 254).

For people with eating disorders support groups are important because people with anorexia tend to withdraw from others. People with anorexia tend to withdraw more from people they are close with and social situations as they become more obsessed with food and exercise. Being in a support group helps the person with the eating disorder become in contact with others again and start talking (Volstadt, 1999). Since people are often anxious in public, being confident enough to be in a group can provide enough support to get back into a social atmosphere. Lenihan & Sanders (1984) recommend different reasons to be in group psychotherapy including the following: a) people with eating disorders have a strong social etiology and group therapy is a “social cure” for a socially determined dysfunction, b) these people typically report strong experiences of social isolation and the group provides minimal, and c) safe social/emotional contact that allows the student with the eating disorder to eventually risk contact in her outside world.

One thing to remember is that although small group counseling sessions are often times good interventions in the school setting, groups do not take the place of therapy. However, students feel that counseling groups are safe places to communicate concerns and that trusting relationships are developed among students involved in the program (Phillips & Phillips, 1992). A counselor is not a therapist, but an additional resource to outside help that the student and family should also receive. Group therapy with peers dealing with eating issues is often used in addition to individual or family therapy (Carlton & Ashin, 2007). Interpersonal therapy, group
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psychotherapy and psycho-education along with other types of therapy are additional tools therapists use to dislodge eating disorder behavior and replace it with healthy concepts. But although all of the different treatment methods can work, no single method works in all cases (Rocha, 1999).

Groups

There are many types of groups that can be created with a combination of different styles, theories, timelines and strategies. These different methods that can be used make up different types of groups and will be described in further detail below.

*Styles of Groups*

Different styles of groups deal with what the group is focusing on and what specific problems the clients are dealing with. There are many ideas of what kinds of groups are available according to different therapists who have studied and learned about these styles.

According to Corey & Corey (1987), there are six different types of groups, each focusing on different kinds of problems. The first style deals with group therapy problems which is meant to alleviate specific symptoms. The second style deals with group counseling which is meant to alleviating specific short-term issues. The third style deals with personal growth periods which help with personal issues during transition in life. The fourth style deals with T-groups which help with sensitivity training and human relations skills. The fifth style deals with structured groups which work with one theme, awareness, and coping skills. The sixth style deals with self-help groups which are support groups with a common identity (Phillips & Phillips, 1992).

According to Myrick (1987), there are three different types of group. The first type of group is crisis-centered which deals with an urgent problem. The second type of group is
problem-centered which deals with issues of concern to students. The third type of group is growth-centered which deals with personal and social development (Phillips & Phillips, 1992).

Sometimes more general support groups are described as a “drop-in” group where new people can come in at any time. This may not be the best idea for a group concerning eating disorders. There are concerns regarding participants in group therapy sharing negative ideas, becoming a complaint session, normalizing/glamorizing eating disorder behaviors, engaging in attention-seeking behaviors, and participants applying pressure (Costin, 2007). These are concerns to watch out for as a group leader and to be prepared to handle if they arise in group sessions.

Theories of Groups

There are several different theories that can be used in group, whether a counselor uses only one specific theory or a combination of a few theories. Each theory can have different ideas and techniques that might be helpful with the different types of clients in the group. Below some of the different theories will be described generally and suggestions of how to use the theories in support groups, especially eating disorders, will be discussed.

Adlerian Psychology. Adlerian therapy has many ideas that can be useful when working with groups. Using Adlerian psychology could be helpful since it understands the feeling of inferiority, which many people with eating disorders would have. True to what many victims of eating disorders think, feel and do, Adler says that “the inferiority may exist only in the imagination of the individual when he compares himself with others” (Dreikurs, 1989, p. 23).

Using encouragement is another very important aspect of Adlerian psychology. Encouragement is seen by many Adlerians as being the single most effective tool in changing behavior (Herring & Runion, 1994). The counselor should be encouraging to the students in
group to get better and to work on their individual goals and the group members should be encouraging to each other as well. Encouraging the activation of social interest is important especially to a person with an eating disorder who is isolating themselves from others.

Using the Adlerian theory of social interest in a group setting would be useful because according to Adler “social interest is expressed subjectively in the consciousness of having something in common with other people and of being one of them” (Dreikurs, 1989, p. 5). So, people in the group who might feel alone in other places could see that they have similarities with others in the group and feel a sense of belonging there. They could also participate in contributing to the group by helping others and contributing their knowledge, advice, and experiences.

Herring & Runion (1994) discuss the four basic phases of Adlerian counseling: 1) establishing the relationship, 2) performing analysis/assessment, 3) promoting insight, and 4) reorientation. In the last stage of counseling different techniques can be used such as spitting in the soup, pushbutton technique, catching oneself, acting as if, and task setting and commitment. This is teaching the patients to learn to catch themselves doing the unhealthy behaviors and calling them out when they find themselves back in the old habits, learning to stop when they know they should not be doing something.

Also, recognizing the four goals of misbehavior and realizing when they are acting in a way to get noticed. Understanding as a student what is wanted and recognizing a more positive way to get that attention and as an educator realizing feelings and understanding what the student is looking for. Finding a way for the student to belong and contribute, such as being in a group setting which was mentioned earlier, can be a positive way for the child to help and be helped.
Rational-Emotive Therapy. Rational-emotive therapy (RET) can help deal with issues of perfectionist and black and white thinking and can also deal with handling guilt patterns (Lenihan & Sanders, 1984). It can help to resolve both emotional and behavioral problems. This type of therapy can help turn irrational thoughts into rational thoughts and help them gain more self-constructive thoughts of themselves. The therapist helps the client to challenge their self-destructive thoughts and learn how to turn those thoughts to rational ones and learn how to spot these destructive ideas in everyday thinking. The therapist helps the client to learn how to change their fundamental thinking and learn to have unconditional self-acceptance.

Cognitive-Behavioral Therapy (CBT). Cognitive-behavioral therapy (CBT) can work in many different ways including working on the principle that a pattern of false thinking and belief about one’s body can be recognized objectively and altered, thereby changing the response and eliminating the unhealthy reaction to food (Lawton, 2005). Cognitive-behavioral therapy can also be used to address the behavioral, cognitive, and affective areas of an eating disorder as well as to examine contradictions in thought and behavior, purposes, advantages and disadvantages, and costs and benefits (Bardick, et al., 2004). CBT increases the strength and effectiveness of interventions with children who have problems with self-control, which many people with eating disorders have. Also, these interventions which help students increase positive self-statements also work to increase the self-esteem of the student (Bauer, Sapp, & Johnson, 2000).

Cognitive-Behavior Therapy can help deal with issues of perfectionist and black and white thinking (Lenihan & Sanders, 1984). CBT addressed symptom reduction by increasing participants’ awareness of personal thoughts and feelings related to eating patterns and introducing strategies for changing their behaviors and belief system (Gerrity & DeLucia, 2007).
Since many people with eating disorders have recurring symptoms it would be helpful for counselors to help students with maintenance plans to prepare for changes in the future.

**Guided Imagery.** Guided imagery can be used to imagine different outcomes for stressful situations and to develop relaxation techniques to diminish anxiety. This treatment is a nonintrusive intervention and is a healing way to shape reality (Bardick, et al., 2004). The therapist uses descriptive language to help the client imagine different scenarios using one or many of the client’s senses to help mentally alleviate their stress or anxiety.

**Narrative Therapy.** Narrative therapy is the retelling of personal narratives and opening up to see how their words do have an effect on others. Narrative therapy can help clients share their personal truth openly and begin the telling of their positive outcome and may lead to goal setting (Bardick, et al., 2004). The therapist acts as an investigative reporter questioning different problems throughout a client’s story to investigate how the problem has affected the person’s life.

**Interpersonal Therapy.** Interpersonal therapy deals with depression or anxiety that might underlie the eating disorders along with social factors that influence eating behavior (Lawton, 2005). The therapist works to find out the causes of the depression and what is maintaining it within the client’s personal relationships and social context. The therapist helps to address these problem areas and works to improve relationships to increase life satisfaction.

**Person-Centered Therapy.** The unconditional positive regard and acceptance among group members is more powerful than acceptance by the counselor and leads to deeper self-exploration, self-understanding, and growth. Different techniques can be used such as unconditional acceptance, active listening, reflection of feelings and meaning, clarification, and summarization (Bauer, Sapp, & Johnson, 2000).
Mixed group/individual treatments. One study showed mixed group/individual treatments being the most effective interventions and cognitive behavioral interventions more effective. Studies have shown that groups combined with other treatments including medication, individual or family therapy, etcetera, were better than group treatment alone (Gerrity & DeLucia-Waack, 2007). So, a counselor may use one theory or a combination of theories, none of which are just right or wrong, because they all seem to have advantages to them if used in the right way.

Short term vs. Long term Groups

Different groups run for different amounts of time according to settings and the type of group that is being held. Time-limited therapy groups are considered 12-14 weeks (Lenihan & Sanders, 1984). Short term therapy groups are said to have interventions lasting less than 6 months (Gerrity & DeLucia-Waack, 2007). Groups in school are typically shorter than groups outside of school such as a rehabilitation center or hospital. This is because school groups are not the same as therapy but an extra support group. A student could attend groups in both places at the same time or do a more therapeutic group first then come to the school’s support group. A short-term group in a school setting would be considered about eight weeks and a long-term group in school would be considered about 24 weeks.

It is important to keep up group attendance, if a group gets too long, members can tend to drop out due to a number of different reasons. However, having groups in school leaves less room for students to not attend unless there are scheduling conflicts with class or something important a member cannot miss. A good strategy a counselor in school can use is to schedule groups so that they are spread out but in a consistent manner. For example, having group on the same day each week but switching the period the student misses class.
In a school setting, groups usually start and stop once or twice a year: once at the beginning of the year in the fall and once after winter break when the new semester starts. A group usually meets between 8-10 times a semester, 40-60 minutes a session depending on class length. Students usually decide themselves whether they want to be in the group for one semester or both, although some may be required or recommended to be in the group for a certain amount of time depending on their specific issues. If a client wants to be in a different, less specific type of group when they have accomplished their goals in one group that could be arranged too. That way the student is kept involved in a structured place of belonging but one that is less intense.

**Strategies**

There are different strategies counselors leading support groups can use, whether they are mixing certain types of clients together or the atmosphere they want to have when group is in session. People can experiment with different strategies until they find the set-up that works the best for the group and which helps the people in the group the most, keeping in mind that different therapies and techniques are created or advanced as time changes.

An atmosphere of warmth, support, and genuine human contact is encouraged at all times. The counselor and group members should support each other and listen with respect to fellow members, giving advice as needed. A feeling of unconditional positive regard and empathetic understanding should be sensed within the group. In group settings, students can learn to give others positive feedback, pointing out the strengths and value of each individual (Jensen-Scott & DeLucia-Waack, 1993).

Sometimes minimal structure is encouraged, although this does not work with all types of groups (Lenihan & Sanders, 1984). Some groups need more structure so they do not get too off
track depending on which type of problems the group is dealing with. There should be consistency in a group’s structure such as rules, check-in, and goals at least to create a feeling of safety within the group. Also, groups may not always operate in a certain way and the counselor needs to be able to be flexible if something comes up which changes the way the group needs to operate for the day or in the future.

Another strategy to consider is single-sex groups. This would be considered a homogeneous group, a group in which all members were of the same gender, all in a single category. In one study, the girls stated that girls-only groups would provide a “safe” context where expression was not limited by the presence of male peers (Zinck & Littrell, 2000). Keeping males and females separate for most groups seems to be the safest and most comfortable atmosphere, although this is based on only one study, so recognizing to not make it a basis on how to form groups.

People with anorexia and bulimia are more similar than dissimilar, so mixing them is not seen as a problem. This would be considered a heterogeneous group, a group in which all members did not have the exact same eating disorder, but were similar enough to be in the same support group. A mixed group helps clients see that it’s what’s underneath that counts. Mixed groups provide experiences that break through distorted thinking in a way that the therapist or a client with a similar illness cannot. Mixed groups are more successful when there are a fairly balanced number of diagnoses (Costin, 2007).

Counselors will learn through experience and research which groups are most effective for eating disorders whether they should have all girls with anorexia nervosa in a group or if they can include girls with bulimia nervosa. Either way, a counselor should adjust with the students
in the group and learn that even though there may not be a 100% correct or incorrect way to form a group, there are better fits than others.

Eating Disorders

There are many types of eating disorders, some of which are more well-known than others. Each one of them is important, but they all are different. It is important to be able to know the signs to watch for before things get serious and to know which consequences come from which disorders. Certain disorders may be more similar to others and could work in a group together where as others may not work quite as well together. Below both a few eating disorders which have already been somewhat discussed will be further looked into as well as a few others which have not been mentioned yet.

Types of Eating Disorders


The American Psychiatric Association has established four very specific criteria that must be met to “officially” diagnose someone with anorexia: 1) Refusal to maintain body weight above minimally normal ranges for age and height, 2) intense fear of becoming fat, 3) disturbance in the way in which one’s body weight or shape is experienced, and 4) absence of at least three consecutive menstrual periods in females who have achieved menarche. Types: 1) Restricting type and 2) Binge-purge type (Carlton & Ashin, 2007, p. 7-9).

There are many consequences that can come from being anorexic. One consequence is that a female’s menstrual cycle can stop, which can lead to osteoporosis and severe fractures.
Another consequence is that anorexia can be taxing on the heart. It can also cause damage to the circulatory system and possible severe thyroid malfunction could occur. Brain size can decrease from anorexia and there can be stomach and digestion problem. Lastly, anorexia can cause depression which could lead to suicide (Hurley, 2001).

Some form of dieting to lose weight always occurs at the beginning of anorexia nervosa. Signs of someone being anorexic could be marked weight loss, abnormal attitude to weight and abnormal perception of the body, and other physical changes (Kirkpatrick & Caldwell, 2001). People suffering from anorexia today exhibit rigid control of their “out of controlness,” making an effort to deny or to purge not just food but yearnings, ambitions, and sensual pleasures. Emotions are feared and translated into somatic (body) experiences and eating disorder behaviors, which serve to eliminate the feeling and needing aspect of self. “Rather than losing their desire to eat, those suffering from anorexia report spending 70 to 85 percent of each day thinking about food but denying their bodies even when driven by hunger pangs” (Costin, 2007, p. 8). Self-induced starvation goes against normal bodily instincts and can rarely be maintained.

**Bulimia Nervosa.** The National Eating Disorders Association (2005) defines bulimia nervosa as “a serious, potentially life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviors such as self-inducing vomiting designed to undo or compensate for the effects of binge eating”.

(According to the American Psychiatric Association, someone must satisfy four specific criteria to be diagnosed with bulimia: 1) Recurrent episodes of binge eating, characterized by eating an excessive amount of food within a discrete period of time and by a sense of lack of control over eating during the episode, 2) Recurrent inappropriate compensatory behavior in...
order to prevent weight gain—such as self-induced vomiting or abuse of laxatives, diuretics, enemas, or other medications (purging); fasting; or excessive exercising—occurs, on average, at least twice a week for three months, 3) Self-evaluation is unduly influenced by body shape and weight, and 4) The disturbance does not occur exclusively during episodes of anorexia nervosa.

Types: 1) Purging type and 2) Non-purging type (Carlton & Ashin, 2007, p. 11-13).

There are many consequences that can come from being bulimic. One consequence is developing other addictions aside from being bulimic. A second is developing teeth erosion and decay. Lastly, having muscle weakness and spasms as well as heart attacks, stomach ulcers and heart problems (Hurley, 2001).

An episode of binge eating is medically defined “as eating within a specific period of time an amount of food larger than most people would eat, and having a sense of lack of control; the bulimic feels she cannot stop eating or control what or how much she is eating. Purging behaviors are used to eliminate the unwanted food eaten during a binge, and to prevent weight gain. Purging behaviors include vomiting, laxatives, diuretics (water pills), suppositories, and enemas” (Kirkpatrick & Caldwell, 2001).

The act of purging becomes powerfully addictive not just because it controls weight, but because it is calming, serves as a way of expressing anger, or helps the individual cope in some way (albeit destructively). Eventually the binge/purge behavior becomes an addiction in the sense that the person does not need to be triggered to do it; but rather the behaviors become a normal part of daily life (Costin, 2007).

*Binge Eating Disorder.* The National Eating Disorders Association (2005) defines binge eating disorder (BED) as “a type of eating disorder not otherwise specified and is characterized by recurrent binge eating without the regular use of compensatory measures to
counter the binge eating”.  

Binge-eating disorder consists of a pattern of recurring binges without compensating behaviors (such as vomiting) to try to lose the weight that may be gained during the binges. Binge eaters eat large amounts of food when they do not feel physically hungry, and they eat alone due to feelings of embarrassment. They commonly feel guilt, disgust with themselves, and depression (Kirkpatrick & Caldwell, 2001).

The binge eating patterns in BED are longer than those found in bulimia; binges can last entire days as opposed to hours and the bingeing needs to have existed for six months or more instead of the three months required for bulimia. Many of these people suffer from debilitating eating patterns often cued by the need for self-soothing rather than by physiological cues (Costin, 2007).

_Eating Disorder Not Otherwise Specified_. Eating Disorder Not Otherwise Specified is one that does not meet the strict diagnostic criteria for either anorexia or bulimia (Carlton & Ashin, 2007). Eating disorders not otherwise specified are similar to anorexia nervosa in that they fulfill all of the criteria except one. Eating Disorders Not Otherwise Specified related to bulimia are described as people who have compensatory behaviors such as binging and purging but have those behaviors less than twice a week (Kirkpatrick & Caldwell, 2001).

According to Costin (2007), roughly one-third of those who present for treatment of an eating disorder fall into the Eating Disorder Not Otherwise Specified category.

_The Female Athletic Triad_. This “triad” consists of amenorrhea (loss of menses), bone loss, and disordered eating (Carlton & Ashin, 2007). This can occur in females who are in
competitive sports starting at a young age including but not limited to gymnastics, swimming and track.

**Muscle Dysmorphia.** Muscle Dysmorphia also known as “bigorexia nervosa” or “reverse anorexia” is when someone has an excessive preoccupation with body size and muscularity. This disorder is usually seen in males who see the ideal man being a bodybuilder and thinks that he has to be buff and uses anabolic steroids, supplements, or overeating as a way to achieve this (Stout, 2004).

**Seriousness**

People with eating disorders can have a wide range of severity depending on which disorder they have and how long they have been having symptoms. One student may just have low self-esteem about their weight and feel bad, whereas another student may not be eating at all or binging and purging. Also, whether the student has just started getting these feelings or whether they have been having eating problems for months or years makes a difference in their severity and the strategies that need to be used with the individual.

A thorough assessment is required to determine the severity of the disorder and to provide a framework for treatment. School counselors may find self-report questionnaires and/or structured interviews useful in identifying the presence and severity of eating-related symptomatology in individuals at risk for an eating disorder. Individuals with eating disorders are notoriously unreliable when initially reporting the severity of their symptoms. Individuals with anorexia tend to falsify information for self-protective reasons and individuals with bulimia may omit information because of an overwhelming sense of shame (Bardick, et al., 2004).

It is advisable for overweight and normal-weight students to participate in separate groups (Rhyne-Winkler & Hubbard, 1994), such as binge-eating disordered students and
Groups and Eating Disorders

anorexic students, for example, if weight and even further comparisons within the group are
going to be negative rather than helpful. Putting clients with different disorders such as anorexia
and bulimia, however, may be helpful since many of the reasons behind the disorders are similar.

Age/Onset

People develop eating disorders at many different times in their lives. However as the
world is becoming more modern, the age of onset is decreasing and concerns about weight are
reaching way down into the elementary levels. Some people will have an eating disorder for a
certain amount of time while others will relapse and continue their habits for many years.
Although anorexia can occur at any age, for most its onset will take place during puberty or
young adulthood according to Flynn (2008). In general, eating disorders occur in adolescents
and young adults, although one study reported that 5% of cases occurred in children under 12
years old (Lawton, 2005). Flynn (2008) states that eating disorders may begin as early as age
eight and Bardick. et al. (2004) says that girls as young as 9 years of age are concerned about
their weight. Fifty-two percent of females have dieted by the age of 14 and 78% of a female 12-
14 year old sample preferred to weigh less, even though only 19% were actually overweight
(Jensen-Scott & DeLucia-Waack, 1993). First through third graders, ages 9-11, and ages 15-19
are three age groups that the National Eating Disorders Association finds eating disorders within
(2005).

There are many different factors that can cause eating disorders. There are psychological
factors such as low self-esteem, feelings of inadequacy, and depression. Students may use eating
disorders as a way to deal with their psychological problems and feel that they can at least
control that aspect of their life. There are interpersonal factors such as troubled relationships and
history of abuse. Students may use eating disorders as a way to forget about their relationships
or try gain attention from someone in the wrong way. There are social factors such as cultural pressures and norms that are associated with being thin which equals beautiful. Students may use eating disorders as a way to try to fit in and be what the media is portraying women to be, thin. There are biological factors such as chemical in the brain and family influence. Students may use eating disorders as a way to live because it is what their body is used to or from what they have seen their family do. All of these factors can influence students today and have a big impact on how they see themselves as individuals in the world.

Anorexia usually first occurs in adolescence with peaks at 13 to 14 years of age and at 17 to 18 years of age (Lawton, 2005). The onset of the illness [anorexia] often follows a stressful life event. Low self-esteem is often at the heart of these stresses. The average age of onset in the illness is 17 years old, although it can occur in girls of 6 or 7 and in post-menopausal women (Kirkpatrick & Caldwell, 2001).

A European study detected bulimic behavior in 14.4% of adolescents 14 to 16 years old, with full-blown bulimia observed in 1.8% of girls and .3% of boys (Lawton, 2005). Bulimia nervosa most commonly begins during or after puberty, very rarely before puberty, but also can be seen at any age. In one study, the mean age of onset of bulimia nervosa was 13.9 years old, with a range of 11 to 15 years as the age when the disorder first appeared (Kirkpatrick & Caldwell, 2001). According to the National Institute of Mental Health, over half of individuals diagnosed with anorexia will eventually develop bulimia (Flynn, 2008). About 40-50 percent of anorexics become bulimic, but not all people with bulimia have anorexia (Volstadt, 1999).

Since the vast majority of people who suffer from these disorders report the onset of their illness by age 20, prevention programs should focus on children, young people, and their parents to maximize prevention efforts (Costin, 2007). According to one study, there were differences in
effectiveness based on age, with interventions for elementary students almost twice as
efficacious as those for middle and high school students, although interventions were effective
for all ages (Gerrity & DeLucia-Waack, 1993). These statistics are proof of how young students
are when they start to concern themselves with issues about weight and body-image. They are
telling of how early counselors in the schools need to start to incorporate lessons about positive
body image and self-esteem when working with all students as a preventative manner and how a
universal system needs to be set up to handle these issues as they come up developmentally.

Delivery Systems in Schools

The American School Counselor Association (ASCA, 2005) Model’s purpose is to have a
framework for school counseling programs to create one vision and one voice for school
counseling programs. A school counseling program should be comprehensive in scope,
preventative in design and developmental in nature. The program is delivered through different
methods including the Guidance Curriculum, Individual Student Planning, Responsive Services,
and System Support. The delivery methods include many different things, a general idea
includes the following: Guidance Curriculum includes providing lesson plans, Individual Student
Planning includes advising and appraisal, Responsive Services include counseling and referrals,
and System Support includes collaboration. Below these different delivery methods will be
discussed with more detail, especially in regards to how groups are incorporated into the system.
Also, the way in which curriculum around eating disorder can be used both as a preventative
method and as an intervention will be described. The program should be developmentally
appropriate and fit the needs of all students. The comprehensive system described below focuses
on what all students should know, understand, and be able to do in the domain of the
personal/social area regarding eating disorders.
Group Counseling

According to the ASCA Model, groups like this fit into the section called Guidance Curriculum. They also fit under Responsive Services to crisis in which the counselor needs to intervene and prevent further problems into the future. The ASCA National Model also suggests that, as a counselor works with groups, they are delivering the guidance curriculum through group activities to meet specific needs of the students, individual and small group advisement, and individual and small group counseling as Responsive Services. These different delivery methods will be further discussed in specific sections below, both in general terms and in regards to groups for students with eating disorders.

There are many types of students that could be placed in certain groups for students with eating disorders, but each student would be screened first and interviewed to see if they were an appropriate fit. Some things that students would be selected on are the type of eating disorder they had, the seriousness of their eating disorder, and their age. These types of things could really connect or separate a group depending on the right or wrong placement of a student.

School Guidance Curriculum

The school guidance curriculum consists of developmental lessons which can be presented to students through both classroom and group activities and which will provide them with the knowledge appropriate for their developmental level. When working on issues such as eating disorders, the content area of personal/social growth is the focus (ASCA, 2005).

One of the most effective approaches available to the school counselor in dealing with children’s eating-disordered behaviors involves incorporating information about eating disorders into the guidance program. Developmental guidance programs have four goals that are directly relevant to eating disorders and weight management programming: 1) understanding self and others, 2) understanding attitudes and behaviors, 3) improving decision making and problem
solving, and 4) improving interpersonal and communication skills (Jensen-Scott & DeLucia-Waack, 1993). The counselor can present a classroom guidance unit focusing on issues related to nutrition. Lesson topics include body-image and self-esteem, locus of control, approval-seeking behavior, body-image and nutrition, excessive exercise, and perfectionism (Rhyne-Winkler & Hubbard, 1994).

School counseling curriculum can also be delivered through group activities such as small groups outside of the classroom that respond to students’ specific needs. Group counseling is a direct service offered to students as part of a comprehensive school counseling program (Ripley & Goodhough, 2001). Zinck & Littrell (2000) found group counseling to be an effective use of school counselors’ time and resources, suggesting that it is an appropriate approach to school-based intervention. They also found time-limited small group counseling to be a cost-and time-efficient practice that is developmentally appropriate.

In the school setting, it is a good idea to implement a universal primary prevention program. The program could use life-skills promotion aimed at teaching effective ways to cope with the normative stressors that are associated with the onset of body image concerns and dieting (Mcvey, Lieberman, Voorberg, Wardrope, & Blackmore, 2003). Primary prevention refers to systematic efforts to reduce the number of new cases of eating disorders. The “selective” form of primary prevention focuses on groups such as middle-school girls and boys who are at high risk because this period coincides with the physical, psychological, and social changes of puberty. Secondary prevention refers to identifying and rehabilitating people who are showing the early signs and symptoms of what could become a severe and chronic eating disorder (Costin, 2007).

*Individual Student Planning*
Individual student planning deals with the counselor working with students one on one to plan personal goals and develop future plans. Individual planning can be delivered through individual or small-group appraisal, such as a counselor evaluating a student’s skills and achievement. Also, through individual or small-group advisement, counselors can help students plan personal/social goals (ASCA, 2005).

A counselor would meet with a student individually before adding the student to a group to assess what problems the student had and what resources would be most helpful to the student. If a student was advised to become part of a group, the counselor would continue to meet one on one throughout the time the student was in the group and afterwards as necessary. The counselor would also meet with the student in a group as long as the student wanted or as long as the counselor and others deemed necessary.

**Responsive Services**

The responsive services component of the ASCA Model meets students’ immediate needs whether it requires counseling, consultation, referral, peer mediation or information. Services can range from early intervention to crisis response in an attempt to meet students’ needs. Other people in the school building and families are consulted throughout these stages to help in all areas of the students’ lives (ASCA, 2005).

School counselors can work with individuals to help with difficulties regarding developmental tasks. Working with individuals in school prevention efforts is a first step to making these changes through teaching critical thinking skills necessary to reject broad societal messages, such as the need to be thin, and encouraging young people to adopt healthy diet and nutrition habits (Shaw, Ng, & Stice, 2007). School counselors can also work with small-groups to help with personal concerns. They can help identify problems and actions to help with the
problem. Although counselors can provide this counseling to individuals and groups, it is important to remember that they are not providing therapy which should be provided through outside sources. Counselors should have referral sources to deal with crises and be able to give out this information as necessary to families.

When counselors work as student advocates and consult with others on behalf of the student, they are demonstrating another delivery strategy of responsive services. Counselors collaborating, educating and training, creating curriculum, conducting ecological analyses, and identifying and referring are all preventative methods that can be used. This can also be facilitated by attention to the four Cs: Consciousness-raising, Connection between people, Competence-building, collaborative action for constructive Change (Costin, 2007).

If counselors are preventive along with the help of others in the schools, families, and communities starting at an early age and use effective tools and skills to teach students about healthy habits, body image and self-esteem, there will be less of a need for responsive services when students are older.

Conclusion

In conclusion, using groups to help students cope with eating disorders has been found to be a positive and helpful experience for the students in the groups. These groups are responsive in nature, but also incorporate preventative lessons on healthy lifestyles and body-image. Ideally, making these groups available before problems become too severe would also be helpful in the schools, starting at a young age.

This study demonstrated that implementing group counseling in a high school was contingent upon supportive school policies and personnel, thorough planning, and advocating for programmatic initiatives (Ripley & Goodhough, 2001). Results demonstrated that school-based
health education programs, when properly planned and evaluated, can have a positive and lasting impact on body image, eating behaviors, attitudes, and self-image of adolescents (Hurley, 2001). Zinck & Littrell (2000) found that group counseling for female at-risk students fosters effective and lasting change.

All adolescents (including those who show some or no symptoms) may benefit from the adoption of a healthier life-style. School programming can be used to promote the adoption of healthier lifestyles. Various formats can be used, such as classroom, small group, and individual (Jensen-Scott & DeLucia-Waack, 1993).

The counselor should be consistently working to find the best group formations based on concepts discussed in this paper, such as the types of theories and styles that can be used as well as which combination of students to put together. Through experience, a counselor will find the best group format that works most effectively and makes sure the students are being helped when in the group, as well as taking away methods and techniques to use for the future.

The earlier a counselor intervenes in a student’s life surrounding body image and self-esteem topics such as using guidance lessons starting in elementary school, the better concepts a student will have about them self. Even with early guidance, however, a counselor still needs to be prepared for responsive counseling. After the initial incident is resolved with the student, providing group sessions would be a great next step for the student. By preparing support groups starting every semester, a counselor is able to positively support the students in their school and provide them with the services they need to survive their adolescent years.
References


one district’s program. *School Counselor, 39*(5), 390-393.


