

2008

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Recommended Citation

Giles, M., & Hass, M. (2008). Fostering a Healthy Body Image: Prevention and Intervention with Adolescent Eating Disorders. *Journal of School Counseling, 6*(13). Retrieved from <http://www.jsc.montana.edu/articles/v6n13.pdf>

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Comments

This article was originally published in *Journal of School Counseling*, volume 6, number 13, in 2008.

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Fostering a Healthy Body Image: Prevention and Intervention With

Adolescent Eating Disorders

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Abstract

Eating disorders are among the most frequently seen chronic illnesses found in adolescent females. In this paper, we discuss school-based prevention and intervention efforts that seek to reduce the impact of this serious illness. School counselors play a key role in the prevention of eating disorders and can provide support even when not directly involved in psychological or medical treatment. Because of their ability to play a leadership role in school-based prevention of eating disorders, school counselors are essential in facilitating a collaborative approach to the prevention of and intervention in eating disorders and their associated risk factors.

According to the National Eating Disorder Association (NEDA; 2006), 10 million females suffer from eating disorders, and among adolescent girls, eating disorders are the third most common chronic illness (Massey-Stokes, 2000). Unfortunately, because many young women are secretive about the thoughts and behaviors associated with these disorders, many cases go unreported and the official figures may be underestimated. Given these statistics and the impact of eating disorders on the social, emotional, and academic well being of young women, school-based prevention and intervention of eating disorders is critically needed. Although most school-based mental health professionals cannot diagnose or provide intensive treatment for disorders they can play a vital role in collaborating with the community specialists that provide treatment and by providing important needed support to students in the school environment.

Adelman and Taylor (2006) have proposed a three-tiered model as a way of conceptualizing the continuum of mental health services in the schools. These tiers or systems of service include promoting healthy development and preventing problems, responding to problems as soon after onset as possible, and providing intensive care. Due to limited training and time constraints, providing intensive treatment to those suffering from an eating disorder is often not possible for school-based mental health professionals such as school counselors. For this reason, this paper will focus on effective preventive and early-onset support services that can be provided in school settings.

Research has suggested that many factors play a role in the development of eating disorders, including certain demographic characteristics, personality

characteristics, family dynamics, genetics, socio-cultural influences, and dieting (Shisslak, Crago, Neal, & Swain, 1987). Most importantly, research has identified body dissatisfaction as the strongest precursor to eating disorders (Phelps, Sapia, Nathanson, & Nelson, 2000; Massey-Stokes, 2000).

Body dissatisfaction is not just a psychological phenomenon but also a social issue that arises out of cultural standards for body image. Western society considers the ideal body for women to be extremely thin. This image is reinforced in the media through the ubiquitous use of images of thin women in television, movies, and advertisement. The gap between the ideal promoted by society and the reality of women's bodies leads to body image dissatisfaction [BID] (Gabel & Kearney, 1998). Body image is defined as the perception that one has of his or her body, while BID is dissatisfaction with this perception, making it a subjective experience rather than one based on weight or actual body size (Choate, 2007; Phelps et al., 2000). BID is often accompanied by feelings of distress, depression, poor self-esteem, and an obsession with body shape or weight (Choate, 2007; Spearing, 2001).

Phelps et al. (2000) investigated the relationships between variables that are related to BID and found that risk factors included low physical self-esteem, lack of confidence in self, and acceptance of the current ideal of extreme thinness. Therefore, effective prevention programs should aim to reduce or prevent these beliefs and perceptions, along with increasing protective factors such as self-esteem, self-concept, and reduction of acceptance of the thin ideal (Phelps et al., 2000).

According to Gabel and Kearney (1998), BID is likely to lead to disordered eating, which consists of "behaviors that reflect any unhealthy modification of food

intake” (p. 32), such as eating to relieve undesirable emotions or dieting to lose weight when one is actually at a normal weight. One study of high school students in Minnesota found “disordered eating in 30% of 9th and 12th grade males . . . and 55% of females” (Croll, Neumark-Sztainer, Story, & Ireland, as cited in Bauman, 2008, p. 65). Disordered eating, which is not clinically defined, is thought of as a precursor to eating disorders, which are more extreme in their behaviors. In fact, Marchi and Cohen (as cited in Gabel & Kearney, 1998) found that “dieting in early adolescence was strongly associated with the development of bulimia nervosa symptoms” (p. 34).

Children and adolescents, especially females, are highly susceptible to BID and are therefore the group at highest risk of developing an eating disorder. School counselors are in frequent and regular contact with this age group. For this reason, it is critical that they become involved in prevention and intervention efforts (Bardick et al., 2004). School counselors are not trained in the psychological treatment of eating disorders. Nevertheless, they can educate themselves to recognize the behavioral precursors to eating disorders and intervene by connecting students who have the signs and symptoms of an eating disorder with the appropriate community resources. In addition, they can be part of the support system needed when a student recovering from an eating disorder returns to school (Bardick et al., 2004).

There are three primary eating disorders found in adolescents: anorexia nervosa, bulimia nervosa, and binge eating disorder (Spearing, 2001). Anorexia and bulimia are both formally recognized as psychiatric disorders in the Diagnostic and Statistical Manual-IV-TR (DSM-IV-TR; American Psychiatric Association [APA], 2000), whereas

binge eating is not. Nevertheless, all three disorders have serious implications for an individual's mental and physical health.

Eating disorders occur when there is a disturbance in a person's normal eating behavior, such as an excessive reduction of food intake or severe overeating (Spearing, 2001). Eating disorders can cause complications in physical, emotional, and behavioral growth and can be life threatening (Bardick et al., 2004). They often co-occur with psychiatric disorders such as depression, substance abuse, and anxiety. This means that preventive and treatment efforts must address the eating disorder along with these comorbid conditions through collaborative and systematic (family, school, community) interventions (Bauman, 2008).

Some of the medical complications associated with anorexia, bulimia, and binge eating are an irregular heart beat and associated problems, kidney and liver damage, loss of muscle mass, permanent loss of bone mass, destruction of teeth and gums, throat and mouth problems, damage to the lining of the stomach, cessation of the menstrual cycle, stunted growth, weakened immune system, dry or yellow- or gray-appearing skin, hair growth, and fainting spells. At the extreme, these symptoms can lead to death (Anorexia Nervosa and Related Eating Disorders, Inc. [ANRED], 2006).

Eating Disorders

Anorexia Nervosa

On average .5-3.7% of females are estimated to suffer from anorexia nervosa at some point in their life. Adolescents are most prone to the disorder, although girls as young as seven have been diagnosed (Massey-Stokes, 2000). According to the DSM-IV-TR (APA, 2000) symptoms include refusal to maintain body weight at or above a

normal range, an extreme fear of gaining weight or being fat, even though underweight, distress surrounding the way body weight or shape is experienced and, in females, amenorrhea, the absence of at least three consecutive menstrual cycles, can occur.

Because of the intense fear of becoming fat or the misperception of being overweight, food and eating becomes an obsession with individuals who have this disorder, and strange eating habits often develop. These behaviors include eating small quantities of select foods, while avoiding others. A person with anorexia also continuously checks his or her body weight and uses other ways, in addition to food restriction, to control his or her weight, such as intense exercise, purging, and the use of laxatives (Spearing, 2001).

Bulimia Nervosa

According to Spearing (2001), approximately 1.1-4.2% of females will have bulimia nervosa in their lifetime. The DSM-IV-TR (APA, 2000) defines bulimia as repeated episodes of binge eating, which involves eating an amount of food that a person would not normally eat in a given period of time, along with the feeling that bingeing cannot be controlled. Also present are behaviors that counter the bingeing to avoid weight gain, including fasting, induced vomiting, misuse of laxatives, diuretics, and enemas, and excessive exercise. These symptoms all must occur at least twice a week for three months to be diagnosed as bulimia nervosa.

Similar to anorexia, individuals with bulimia will value themselves based on their perceptions of their body weight and shape. They have a similar fear of being or becoming obese. However, unlike those with anorexia, persons with bulimia typically weigh within their normal weight ranges. Additionally, bulimia is most prevalent in

adolescence and early adulthood, but almost completely absent during pre-adolescence (Spearing, 2001).

Binge Eating Disorder

Although it is not recognized as a formal psychiatric disorder, binge eating affects 2-5% of Americans in any given six-month period (Spearing, 2001). One symptom of this disorder is recurrent episodes of binge eating, similar to those found in bulimia nervosa. These episodes often occur with behaviors such as eating faster than normal, eating in private, and eating until uncomfortably full and are followed by feelings of guilt or shame (Spearing, 2001). Unlike bulimia, binge eating is not associated with a means to compensate for the caloric intake, such as vomiting, laxatives, or exercise. As a result, many people with this disorder are overweight (Thompson, 2004). If a person with binge eating disorder becomes obese, additional complications may arise. These include the risk of cardiovascular disease, bowel, breast and reproductive cancers, diabetes, and arthritis (ANRED, 2006).

In addition to physical risks, binge eating can also be accompanied by anxiety, depression, low-self esteem, and thoughts of suicide (Thompson, 2004). Binge eating is usually a way of coping with emotions and is used to numb unwanted feelings, including those related to the stressors of normal daily life. Other symptoms include loss of sexual desire, feelings of disgust, avoidance of social activities for which food might be involved, and feeling that life will be better if weight is lost (Thompson, 2004).

Behavioral and Psychological Warning Signs

Behaviors associated with eating disorders, such as bingeing and purging, are often looked for as signs of an eating disorder. However, these behaviors are often very

private and can go undetected for long periods of time. Thus, it is important to note additional behaviors that arise in at-risk individuals that can be noticed in daily activities. In addition to symptoms that may go unnoticed, there are many behavioral and psychological signs that a person may have an eating disorder. An awareness of these signs can help school counselors identify and intervene in early onset and clinical cases. More subtle signs of eating disorders may include changes in general behaviors, social interactions, and psychological functioning. According to Bardick et al. (2004), individuals with an eating disorder will often appear as “enthusiastic, perfectionistic, and intelligent individuals involved in a wide range of activities” (p. 169).

Behavioral warning signs include wearing baggy, oversized clothes, exercising excessively, involvement in competitive sports for which appearance is important, reading fitness and health magazines, weighing oneself excessively, spending an excessive amount of time in front of the mirror, and constantly checking the fat on one’s stomach, arms, or under one’s chin. In addition to these personal behaviors, there are social warning signs as well, such as avoidance or isolation from friends and family, avoidance of social activities due to rigid eating and exercise schedules that must be maintained, and a desire to hide these behaviors from others (Bardick et al., 2004).

Other behaviors that suggest the presence of an eating disorder include dieting, an excessive intake of low-fat or “healthy” foods, counting calories, fasting, vegetarianism, skipping meals, avoiding social situations involving food, complaining of food allergies or hypoglycemia, and becoming a family cook without eating what he or she has made (Bardick et al., 2004). Many of these behaviors may be hard to detect by school personnel unless they are present during meal times. This is why education and

collaboration with parents and the community is so important in the detection of disordered eating. In addition, if a comprehensive prevention program is in place, most students will be aware of the behavioral warning signs, and peers can help notify school personnel if they feel that someone is exhibiting risky behaviors.

In addition, those involved in the lives of adolescents should watch for psychological warning signs. These signs include “perfectionism, competitiveness, a sense of over-responsibility, emotional distress, criticism of self and others, conformity, external locus of control and low self-esteem, mood swings, complaining of ‘feeling fat’, an inability to express emotions, and demonstration of ‘black and white’ thinking” (Bardick et al., 2004, p. 169).

Tier 1-Prevention

Early adolescence is a time when girls go through many developmental changes including, but not limited to, “physical changes . . . the emergence of dating relationships, school transitions and contradictory gender role expectations” (Choate, 2007, p. 317). Adolescent girls begin to focus on their appearance and body shape as a strong determinant of their self-worth. At the same time there are many societal pressures to conform to the thin-ideal. This pressure seems to increase at the same time that young women’s bodies are growing in ways that contradict that ideal. This can lead to BID, which is the leading precursor of eating disorders (Choate, 2007). Eating disorders can cause very serious health problems and even death. It is therefore imperative that school counselors become educated and involved in school-wide primary prevention.

The goal of primary prevention is to keep students from developing eating disorders by reducing risk factors and increasing protective factors. Ultimately, education is the first step in this effort (Wade, Davidson, & O'Dea., 2002; Bardick et al., 2004). According to Chido and Latimer, as well as Fairburn and Cooper (both as cited in Shisslak et al., 1987), many individuals with eating disorders learned their unhealthy behaviors from friends, family or the media. Therefore, prevention education might be more effective if it focused on the development of critical thinking skills in order to better enable adolescents to examine media messages and unhealthy behaviors rather than solely on the signs and symptoms of eating disorders themselves (Bardick et al., 2004). For instance, adolescents can be taught to resist the blind acceptance of an ideal of extreme thinness. Further, preventive education efforts should also focus on other risk factors, including low self-esteem and self-worth (Bardick et al., 2004; Phelps et al., 2000; Shisslak et al., 1987). Thus, education in critical thinking, self-awareness, and self-esteem are central in preventive efforts (Wade, Davidson, & O'Dea, 2002).

School-Wide Education

Education that addresses the risk factors for eating disorders should begin prior to junior high in order to provide children with the necessary tools to build self-esteem and, hopefully, avoid dissatisfaction with their body when they reach adolescence. This recommendation is based on Kater, Rohwer, and Londre's (2002) analysis of previous research that showed that preventive measures used at junior high and high schools were provided too late to have an effect. By the time children become teenagers and enter junior high school, body dissatisfaction and dieting are already common behaviors. Once established, these attitudes and behaviors are difficult to reverse.

Therefore, primary prevention strategies for BID and eating disorders seem best suited in the upper elementary levels. However, even younger elementary level students can benefit from education in good nutrition and the importance of regular exercise, thus laying a positive groundwork for later more focused preventive efforts.

The goal of a preventive education program is to develop positive self-esteem, self-efficacy, and a healthy body image, in addition to the personal and social skills needed in adolescence to counter the risk factors for developing BID and subsequent disordered eating. A study by Kater et al. (2002) demonstrated that children, prior to middle school years, can acquire knowledge about the intrinsic nature of body shape and weight, body image, healthy choices, and sociocultural life skills when presented with a curriculum that addresses these issues. Such a curriculum has the potential for helping adolescents counter unhealthy body images and negative cultural influences, such as the preponderance of messages about dieting found in on television and in the print media and images that equate feminine desirability with extreme thinness. Information also should be provided about body changes that occur in adolescence, how to remain healthy and active, and how detrimental it can be to lose weight and diet during this time (Kater et al., 2002; Massey-Stokes, 2000).

School counselors would benefit from working closely with classroom teachers in the development of a prevention program. Teachers are in constant contact with students and should be encouraged to help promote a healthy body image by incorporating education about proper nutrition, exercise, and self acceptance in their lesson plans (Gabel & Kearney, 1998). For instance, prevention efforts could be incorporated in a health education class, with lessons on nutrition and health and skill

development to reduce peer influence. An English class could have lessons on media literacy and persuasive advertising, while a Science class could have lessons on the human body and body composition (O'Dea & Maloney, 2000). Such a curriculum has the potential to make prevention a school-wide effort.

According to Akos and Levitt (2002), it is imperative that those who promote a healthy body image consider their own biases and behaviors. Not only do children model their peers, but also teachers, parents, counselors, and other adults in their lives. Some teachers may hold negative biases and attitudes that could have a harmful effect on students. The Health Promoting Schools Framework attempts to address this by promoting not only the health of the students, but the health of the school personnel as well (O'Dea & Maloney, 2000). It is a holistic approach that fosters collaboration within the school environment and between the school and the community. This approach focuses on three areas of prevention: school curriculum, school environment, and school-community partnerships.

The first area of focus is the development of a sequential health education curriculum at the school level. The curriculum requires that the messages remain consistent across all age groups and subject areas. In addition, the framework encourages teachers to be trained in the specific curriculum areas such as skills to reduce negative peer influence, normal body compositions and the impact of persuasive media messages. Additionally, staff should receive training to better understand eating disorders, effective preventive strategies and how to access counseling and referral services. To further their ability to be good role models, staff members should also be

given the opportunity to reflect on their own values and beliefs. This will help create a more healthful school environment (O'Dea & Maloney, 2000).

The second area is the school environment. The framework requires the school to create a healthy environment for students and staff. To do so, the school structures, policies, and practices must all be considered. For example, researchers have found that teasing by peers and significant adult figures can play a strong role in the development of eating disorders (Bauman, 2008). Therefore, examining meal policies, bullying and teasing policies, as well as the type and variety of sports programs, especially for overweight students, is necessary in preventive efforts (O'Dea & Maloney, 2000).

The third area is collaboration with community members, including families, community health workers, youth and educational services, and nongovernmental agencies (O'Dea & Maloney, 2000). This collaborative effort will help further promote the healthy attitudes being taught in the schools by providing educational programs and health services for students, teachers, school nurses, parents, and other members of the school and community. Collaboration with community members also can include asking individuals such as parents and health care workers to act as advocates to change the slim ideal within the community, which can, in turn, initiate the implementation of policies, procedures, and activities that promote a healthy lifestyle for children, parents, teachers, and all community members.

Establishing a school-based resource person for eating disorders can help facilitate community collaboration (Bardick et al., 2004). Although school based mental health professionals do not diagnose eating disorders, a school counselor can be an

important source of support for someone struggling with ED. In order to play this role, school counselors should have (a) some professional training related to the knowledge of diagnostic criteria and the warning signs of eating disorders, and (b) an understanding of how to work with at-risk individuals and their parents and make referrals to appropriate community agencies (Bardick et al., 2004). In addition, collaboration with local resources and clinical services can help facilitate access for students in need of outside services. This gives schools the opportunity to work collaboratively with the community to address BID and eating disorders (O'Dea & Maloney, 2000).

In addition to this holistic approach, giving adolescents the opportunity to challenge societal norms about body image and gender role expectations is essential. It is important not to stop with a discussion of these challenges, but also to provide youth with the opportunity to influence and change the norms presented in the media and their community (Massey-Stokes, 2000).

Media Literacy

As noted by Choate (2007), the Center for Media Literacy and Media Education Foundation has activities that directly address the messages portrayed in the media. Through these activities, girls are taught to think critically about what the media is attempting to portray and to deconstruct its negative messages. Education about the historical evolution of the ideal body type should be included to give girls the opportunity to see that the ideal is always changing. Finally, adolescents can be taught to challenge the social ideal and to help promote healthier cultural norms. Ultimately, the goal of

media literacy is to foster “the ability to identify, evaluate, and resist media messages” (Choate, 2007, p. 322).

Wade et al. (2002) compared a media literacy program and a self-esteem program. They found that the media literacy program decreased weight concern in adolescents, while increasing their self-concept. At post-intervention, the media literacy intervention had a medium effect size (.19), which, according to the authors, has the potential for clinical significance.

In contrast, the self-esteem program did not result in a reduction in the risk factors for eating disorders. One possible explanation for this discrepancy could lie in the teaching method and degree of collaboration in the program development. The teaching style of the media literacy program was more student-centered, while the self-esteem program was more didactic. In addition, the teachers involved in the media literacy program worked collaboratively to develop the program content, while the self-esteem program was, according to the teachers, an “imposition” (Wade et al., 2002, p. 380). In this regard, it is important to note that collaboration is a powerful aspect of preventive efforts.

Tier 2-Early Onset Interventions

Due to the obsessive, addictive nature of eating disorders, early intervention is essential. As noted by Akos and Levitt (2002), using interview tools such as Cooper and Fairburn’s Eating Disorder Examination (EDE) can help the counselor assess the importance that students place on body shape, as well as other concerns that can be addressed in individual counseling sessions. According to Guest (2000), the EDE is the “gold standard” in the identification of individuals at risk for eating disorders and can be

used to identify students in need of interventions. Individual counseling with a student who has not yet developed the clinical manifestations of BID and disordered eating can help the student to develop alternate ways to deal with problems and to practice new behaviors (Akos & Levitt, 2002).

School counselors can provide the student with activities that focus on resisting and critiquing the think-ideal and help them feel strong and value their bodies. This focus on developing cognitive dissonance and voluntary attitude shifts has been found to be effective in groups and can be adapted to individual work with students (Stice & Presnell, 2007). School counselors can encourage activities such as bicycle riding or rollerblading for students to derive satisfaction from their body. In addition, school counselors can use relaxation techniques such as guided imagery to help students desensitize themselves to outside events that cause negative feelings about their body and help them to “envision themselves as strong regardless of body shape” (Akos & Levitt, 2002, p. 140).

Relaxation, through guided imagery, is used to aid the student in imagining better outcomes for the stressful situations that they encounter. Bardick et al. (2004) provide specific examples of guided imagery, including: “imagining enjoying a relaxing meal with friends, allowing one’s body to become nourished and healthy, and viewing a problem from multiple perspectives” (p. 173). Guided imagery is thought to be a non-intrusive intervention that is useful in working with students “who lack a solid sense of self” (Bardick et al., 2004, p. 173).

Because adolescent girls are highly susceptible to pressure from their peers, group counseling can help promote a healthy body image through using the positive

influence of peers. Peer counseling allows students to build a support group, which is important because most girls with BID and disordered eating habits feel isolated and ashamed. For some girls with eating disorders, secrecy maintains the disorder. Having the opportunity for disclosure to a supportive group can be an important step in breaking the pattern of secrecy (Bauman, 2008). In addition, a group setting has the potential to provide a number of positive role models. It is important, however, that the counselor address any issues of countertransference as a means to be the best role model possible in terms of positive body image (Akos & Levitt, 2002).

A body image enhancement group gives girls the opportunity to improve their own body image and to help others in the group feel good about their body. Discussions of specific eating disorder behaviors should be limited, if not banned from the discussion, to prevent teaching new behaviors to other group members (Bauman, 2008). The group should provide accurate information and encourage helpful actions. In the end, the emotions that surround eating, self-esteem, and body image become the central theme of the group. The goal is to help individuals feel good about themselves while they, in turn, help others feel good as well (Akos & Levitt, 2002).

Tier 3-Intervention

If prevention and early-onset interventions fail to prevent the development of a full-blown eating disorder, more intensive treatment will be needed. Such treatment often involves collaborating with agencies outside the school system. School counselors should be knowledgeable enough about eating disorders to recognize the signs and symptoms and how to work with students and their parents to provide needed support at school and to make appropriate referrals.

Referrals for and the treatment of eating disorders will often include a medical doctor, a nutritionist, a mental health professional, and possibly a family therapist. After an assessment has been performed and the severity of the disorder is known, a treatment plan will be developed. There are typically three phases of treatment: (1) restoration of a healthy weight and healthy eating habits, (2) changes in thought and behavior, and (3) implementation of strategies to prevent relapse (Bardick et al., 2004). School counselors can play an important role in the recovery effort. While working closely with specialists, school counselors can carry out interventions that help support the student's recovery.

Summary

O'Dea and Maloney (2000) suggest that prevention of eating disorders should be school-wide and collaborative with the community. The Health Promoting School Framework is one model that provides this structure. It is comprised of education and improvement of self-esteem, which research finds to be effective in the prevention of risk factors for eating disorders. Additionally, the framework is flexible, so it can be replicated in different schools, based on the needs of each school.

Research also has found that a media literacy program can be effective in the prevention of eating disorders. The goal is slightly different from that of the above-noted framework and, ideally, should be incorporated into a school wide prevention effort. Media literacy aims to address the effects that the media have on the body image and self-worth of females. School counselors are in a good position to begin the process of education and implementation of these programs.

Interventions at the school level are important for those who are not reached through preventive efforts. As such, a school-based resource person for eating disorders should be established (Bardick et al., 2004). This person could be the school counselor or any school personnel who has knowledge of risk factors, symptomatology, prevention and treatment of eating disorders. Ultimately, his or her role is to have resources available to help identify at-risk students and to be able to refer them to outside resources.

School counselors are an important source of support for at-risk students or students recovering from an eating disorder. Individual and group counseling has proven to be useful in this effort. In addition, if a student is being treated for an eating disorder, it is important that the school counselor collaborate closely with the specialists who provide this treatment.

Limitations and Future Research

The focus of this article was prevention and intervention with eating disorders in females, especially children and adolescents. Therefore, many of the studies presented were primarily focused on females. The exclusion of males in a study of eating disorders, however, limits its generalizability. Studying males has the potential to generate additional findings that can be used in more inclusive prevention and intervention efforts. This is especially important because it has been found that up to 50% of boys have BID (Wade et al., 2002). In addition, research has also failed to provide useful information about the nature of ED among different cultural and ethnic groups. Increasing research done in this area would help identify interventions that reach all students.

Another weakness in the literature is that preventive research has mostly focused on adolescents. Although this is the age at which BID and eating disorders are most common, by the time children reach adolescence, their bodies images and eating habits may already may be engrained and, thus, difficult to reverse. It would be highly beneficial to study preventive programs used in upper elementary levels that focus on preempting negative thoughts about body image (Kater et al., 2002). Overall, better designed, comprehensive research on prevention of eating disorders is needed (Wade et al., 2002).

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