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Article 97

The School Counselor's Role in Addressing Eating Disorder Symptomatology Among Adolescents

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Adolescents who struggle with eating disorders are immersed in a complex, multifaceted mental health concern. For many caught in the spiral of eating disorder symptomatology, denial is a prevalent phenomenon (Couturier & Lock, 2006). Adolescents will engage in a secret struggle with problematic behaviors such as dieting, binging, and purging; often, they are hiding the truth of their sickness even from themselves (Vandereycken, 2006b; Vandereycken & Humbeck, 2008). The secrecy of eating disorders can be an impediment in the identification of symptoms (Carney & Scott, 2012). Secrecy may also hinder the treatment of these disorders; unaware of their own serious illness, adolescents may not seek out treatment (Vandereycken, 2006a). Moreover, their problematic behaviors will often go undetected; peers, family members, teachers, and other adults in the adolescent's life may not recognize the subtle signs of a dangerous disorder.

School counselors are in a position to combat the secrecy and denial of eating disorders. Authors have noted that, when compared to seeking medical attention for eating disorder concerns, "school-based identification and early intervention may be more promising and more acceptable to young people who are at a risk of developing an eating disorder" (Currin & Schmidt, 2005, p. 620). School counselors can be a vital resource in addressing eating disorders among students (Carney & Scott, 2012; Currin & Schmidt, 2005).

School counselors can be attuned to the populations most at risk for developing these physically and emotionally taxing disorders and can gear prevention programs to these targeted groups (Stice & Shaw, 2004). Furthermore, school counselors can be trained to recognize the warning signs of eating disorders—paying attention to small, yet revealing symptoms which may indicate a critical health concern (Bardick et al., 2004; Carney & Scott, 2012). Currin and Schmidt (2005) underscored the reality that school staff can be critical observers of student behavior change and/or weight alteration, thus identifying eating disorder symptoms at an early stage. These authors asserted that school

professionals are thus in a “unique position” in terms of early identification, as this ability to observe students—on a daily basis, over several years—is found in few other settings (p. 620). School counselors are also likely see students in a range of settings in the school, such as during lunch, in the halls between classes, and going to after school activities (e.g., athletics); these various settings can provide school counselors with an array of opportunities for observations of students’ behaviors and beliefs around eating and weight. For example, school counselors can be attuned to students who tend to not eat lunch (Carney & Scott, 2012). School counselors may also be in a position to gain the trust of adolescents and, consequently, an adolescent may share his or her struggle with binge eating, obsessive exercise, or constant worry about weight (Bardick et al., 2004; Currin & Schmidt, 2005).

School counseling professionals can bring a voice to the often silent and shrouded symptoms of eating disorders. Authors have noted that intervention early in the progression of an eating disorder may be related to more successful treatment outcomes (Currin & Schmidt, 2005). As more school counselors are able to provide informed prevention programs, identify adolescents struggling with eating disorders, and offer early intervention strategies, adolescents will benefit. Those at risk for developing an eating disorder may be assisted before symptoms manifest. Those already in the throes of eating disorder symptoms may be more likely to recover and less likely to progress to more entrenched eating disorder behaviors and attitudes.

Definitions and Symptoms of Eating Disorders

Eating disorders can be complicated in terms of accurate identification, as they can be categorized as fitting into one of several clinical diagnoses. Moreover, some problematic behaviors and attitudes may not reach a diagnosable level, yet may still be concerning (Grigg, Bowman, & Redman, 1996; Tylka & Subich, 2002). Researchers have documented that some individuals who display subclinical forms of disordered eating (i.e., behaviors such as binge eating, purging, and severe dieting which do not meet thresholds for a diagnosis) may later develop a diagnosable eating disorder (Herzog, Hopkins, & Burns, 1993; Shisslak, Crago, & Estes, 1995; Stice, Marti, Shaw, & Jaconis, 2009). This section will review the major clinical diagnoses of eating disorders and will also attend to the subclinical forms of eating disorders. The terms *eating disorder symptomatology*, *disordered eating*, and *disordered eating behaviors and attitudes* will be used to signify clinical and subclinical anorexia, bulimia, and/or binge eating.

Anorexia Nervosa

Authors have noted that the term *anorexia* is a misnomer (Lask & Frampton, 2009). Anorexia means a lack of appetite, but an absence of hunger is not an accurate descriptor of those who struggle with this disorder; rather, anorexia sufferers engage in starvation behaviors (Vandereycken & Van Deth, 1994). Far from losing their appetite, those immersed in symptoms of anorexia are usually extremely hungry; in fact, authors have noted that they often evidence fixations with food that are similar those of individuals who are starving for reasons such as famine (Bruch, 1973). Bruch (1978) termed the defining feature of anorexia to be the “*relentless pursuit of excessive thinness*” (p. *xxi*).

Anorexia nervosa (AN) is an eating disorder which is diagnosed through the use of four major criteria. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000), outlines the primary indicators of anorexia nervosa, focusing chiefly on the physical symptomatology. In order to provide readers with the most current information on the diagnosis of eating disorders, the proposed *DSM-5* revisions to the AN diagnosis (and other eating disorder diagnoses in subsequent sections) will also be discussed (APA, 2012a; 2012b; 2012c; 2012d). These proposed *DSM-5* diagnostic categories have not been finalized as of the writing of this article and may be altered in the final *DSM-5* version. The first main criterion is a body weight 85% of the normal weight for a person's age and height; extreme weight loss may cause this criterion to be met, as well as failure to gain weight as the body grows (*DSM-IV-TR*; APA, 2000). The proposed *DSM-5* revisions remove the specific reference to a weight percentage and replace it with the criterion of a "significantly low body weight" (APA, 2012a, Criterion A). The second diagnostic marker is fear of weight gain despite the reality of being underweight (*DSM-IV-TR*; APA, 2000). In the *DSM-5* revisions, fear of weight gain would not be a necessary symptom of AN; rather, an individual could exhibit actions which prohibit gaining weight, despite being underweight (APA, 2012a). The third diagnostic criterion is distortion in perceiving body weight and shape, with an excessive link between body shape and self-concept, and an unwillingness to recognize this exceedingly low weight (*DSM-IV-TR*; APA, 2000). This criterion is not proposed for revision in the *DSM-5* (APA, 2012a). Finally, the fourth marker of anorexia is amenorrhea, which is considered a missing of three consecutive periods, a diagnosis category which is met if the client is menstruating only with the help of hormones (*DSM-IV-TR*; APA, 2000). Amenorrhea would no longer be an indicator of AN in the proposed *DSM-5* revision (APA, 2012a). The *DSM-IV-TR* also demarcates two specific types of anorexia nervosa (*DSM-IV-TR*; APA, 2000). One is the *restricting type* wherein the anorexia sufferer restricts food and does not binge or purge. In the *binge-eating/purging type*, however, the anorexia sufferer does binge and purge through such means as vomiting and use of laxatives, diuretics, and enemas (*DSM-IV-TR*; APA, 2000). In the proposed *DSM-5* revision, these subtypes would apply to the prior 3 months of an individual's symptomatology (APA, 2012a).

Bulimia Nervosa

Unlike AN, which was first documented in the 19th century (Gull, 1888; Laseque, 1873/1964) bulimia nervosa (BN) as it is characterized today was not discovered until the 1980s (Striegel-Moore & Cachelin, 2001). The etymology of the term bulimia is rooted in the Greek words for ox and hunger (Tillmann, 2009). Authors have noted that bulimia is indicative of much more than a physical hunger; this disorder signifies a "hunger for meaning, expression, and connection" (Tillmann, 2009, p. 100).

According to the *DSM-IV-TR*, there are four major criteria for a clinical diagnosis of BN (APA, 2000). The first main diagnostic criterion for BN is an engagement in binge eating, which is defined as consuming an obviously large amount of food within a specific time frame and concurrently experiencing a lack of control regarding this eating behavior (APA, 2000). The second criterion involves actions in which an individual engages to counteract this binge eating in the hopes of avoiding weight gain (APA, 2000). These compensatory behaviors can include obsessive and intense exercise, misuse

of laxatives, diuretics, and/or enemas, skipping meals/fasting, and self-induced vomiting (APA, 2000). These two diagnostic criteria are not proposed for change in the *DSM-5* (APA, 2012c). The third diagnostic marker defines the frequency of binge eating and compensatory behaviors: these behaviors need to occur twice weekly and need to have been occurring this often for 3 months (APA, 2000). The proposed *DSM-5* revision changes the frequency of this diagnostic marker; binge eating and compensatory behaviors would need to take place once a week for 3 months for a BN diagnosis (APA, 2010b). Finally, a clinical diagnosis of BN includes an over-concern with one's body weight and shape such that an individual's view of the self (e.g., self-esteem, self-concept) is excessively determined by these factors (APA, 2000), a marker not altered in the *DSM-5* (APA, 2012c). Two types of BN are also delineated by the *DSM-IV-TR* (APA, 2000), but these subtypes will be removed in the *DSM-5* revision (APA, 2012c). As a final note, a diagnosis of BN necessitates that these behaviors and attitudes are not part of an AN diagnosis (APA, 2000; APA, 2012c).

Binge Eating Disorder

In the *DSM-IV-TR*, binge eating disorder was not a separate diagnostic category, but was included under the Eating Disorder Not Otherwise Specified (EDNOS) category discussed below (APA, 2000). In the proposed *DSM-5* revision, however, Binge Eating Disorder (BED) is a separate diagnosis (APA, 2012b). Diagnostic criteria include regular binge eating (once weekly for a duration of three months) without actions to curb weight gain (APA, 2012b). Binge eating is defined by consuming abnormally large quantities of food in a specific time period and a sense of loss of control during these binge eating behaviors (APA, 2012b). In addition, individuals must feel displeasure and concern about their binge eating (APA, 2012b). Other defining traits of binge eating incidents include several additional symptoms (at least three of the following must be present): abnormally rapid eating; a sensation of fullness that is not pleasant; consuming many calories despite a lack of hunger; eating in solitude due to shame; and emotions of guilt, disgust, or depression after binge eating (APA, 2012b). Moreover, a clinician must determine that the client feels significant distress about binge eating, that a client is not continually engaging in compensatory actions such as purging, and that a client's binge eating is not part of a BN or AN diagnostic picture (APA, 2012b).

Other Eating Problems

The *DSM-IV-TR* also makes provision in its diagnostic categories for Eating Disorder Not Otherwise Specified (EDNOS; APA, 2000). This diagnosis can be applied to individuals who do not meet the exact requirements for a diagnoses of BN or AN. For example, the EDNOS diagnosis may be applicable to those who, despite evincing symptoms consistent with most criteria for BN, do not fit the specific duration or frequency of binge eating and compensatory behaviors. In the *DSM-5* proposed revision, the EDNOS category will be changed to a category titled Feeding and Eating Conditions Not Elsewhere Classified (APA, 2012d). Clients who binge eat at a lower frequency than needed for a BED diagnosis, clients who binge and purge at a lower frequency than required for a BN diagnosis, and AN symptoms in a client who is a normal weight would all fit in this new diagnostic category (APA, 2012d). The *DSM-5* proposal terms these symptoms presentations as *subthreshold* or *atypical* eating disorders (APA 2012d).

Another presentation of disturbed eating delineated in the *DSM-5* proposal includes clients who purge, but do not binge eat, in addition to other symptomatology outlined in the *DSM-5* proposal (APA, 2012d).

As this final diagnostic category reveals, not all eating problems fit neatly into a diagnosis of AN, BN, or BED. Individuals with subclinical eating disorders may engage in problematic behaviors such as fasting, skipping meals, using diuretics and laxatives, binge eating, self-induced vomiting, and obsessive exercising, but may not exemplify a symptom pattern that fits full criteria for a clinical diagnosis (Grigg et al., 1996; Tylka & Subich, 2002). These behaviors are concerning in and of themselves and, as noted previously, there is evidence that subclinical levels of disordered eating may progress to full-scale eating disorders (Stice et al., 2009).

Adolescents in a school setting may struggle with clinical levels of an eating disorder and may also exhibit a range of subclinical behaviors which warrant intervention. Accurate identification of symptomatology is vital, so that school counselors can determine the necessary level of care. Some students—specifically those in the throes of a diagnosable eating disorder—will likely need referral for a higher level of care where issues such as weight re-stabilization, medical treatment, regular therapy, and nutrition consultation can take place (APA, 2006). School counselors may be able to engage in some intervention efforts with adolescents who are struggling with behaviors such as consistent dieting—but who do not meet clinical diagnostic criteria—provided that other professionals are also involved (APA, 2006; Carney & Scott, 2012; Ray, 2004). More information on the collaboration among professionals in treating clients who struggle with clinical and subclinical eating disorders will be discussed in a later section. Finally, school counselors may encounter adolescents who do not yet exhibit symptoms of disordered eating, but who show signs of the precursors to disordered eating, such as an adolescent who voices consistent displeasure with his or her appearance. School counselors can intervene on a preventive level with these students, offering programs which work to combat the influence of risk factors such as body dissatisfaction and thin-ideal internalization (Bardick et al., 2004; Stice, 2002).

Prevalence Rates and Demographics

School counselors will be aided in their identification of disordered eating concerns if they are aware of the prevalence rates for a range of disordered eating behaviors. These statistics reveal the scope of the problem among male and female adolescents. Furthermore, school counselors will benefit from demographic data on groups most at risk for disordered eating.

A National Comorbidity Survey, carried out from 2001 to 2003, provided population-based prevalence rates for AN, BN, and binge eating disorder (Hudson, Hiripi, Pope, & Kessler, 2007). Among females, the lifetime prevalence rate for AN was reported to be 0.9% and the lifetime prevalence rate for BN was reported to be 1.5%. Among males, lifetime prevalence rates for AN and BN were reported as 0.3% and 0.5%, respectively. Prevalence rates BED were reported to be 3.5% among women and 2% among men. In a study specific to adolescents, tracking lifetime eating disorder prevalence among females at age 20, Stice et al. (2009) reported the following prevalence rates: 0.6% for AN; 1.6% for BN; and 1% for BED.

As these statistics reveal, the incidence of clinical eating disorders meeting all of the *DSM-IV-TR* diagnostic categories is relatively low (APA, 2000). Data on subclinical eating disorder symptoms, however, reveal a much different picture. In one study, 22% of adolescent females reported crash dieting and 21% reported fasting during the past month (Grigg et al., 1996). In a study involving older adolescent males, 17% reported a lifetime history of binge eating behaviors (Striegel-Moore, Silberstein, Frensch, & Rodin, 1989). Stice et al. (2009) also reported prevalence rates for subclinical eating disorders: 0.6% for subclinical AN; 6.1% for subclinical BN; and 4.6% for subclinical BED.

The literature on the demographic correlates of clinical and subclinical eating disorders has revealed that many groups of individuals are susceptible to these dangerous disorders and distressing symptoms. However, adolescents are an age group at specific risk for developing eating disorders; in reviews of the research evidence on age of onset, authors have reported that eating disorder symptomatology often begins during adolescence (Bulik, Reba, Siega-Riz, & Reichborn-Kjennerud, 2005; Fairburn & Harrison, 2003). The transitions associated with adolescence—including physical maturity, social acceptance, and school transition—may function to trigger eating disorder symptomatology (Andersen, 2004).

The literature has revealed that females are consistently at higher risk for eating disorder symptomatology (*DSM-IV-TR*; APA, 2000). In one study of 739 adolescents, the authors reported that, for every one male adolescent who reported eating problems, there were 10 female adolescents who reported eating problems (Aime, Craig, Pepler, Jiang, & Connolly, 2008). However, eating disorder symptomatology among males is nonetheless a concerning issue; authors have discussed symptoms to which males may be especially prone, such as an obsession with the gym and gaining muscle mass (Pope, Phillips, & Olivardia, 2000; Stout & Frame, 2004).

Research in the eating disorder field has long been guided by the main assertion that eating disorder symptomatology is primarily a White concern (Smolak & Striegel-Moore, 2001). Opposing this claim, researchers have revealed that individuals of many diverse racial and ethnic groups struggle with eating disorder symptomatology; some male and female adolescents of color report higher rates of disordered eating compared to White adolescents (e.g., Neumark-Sztainer et al., 2002; Ricciardelli, McCabe, Williams, & Thompson, 2007; Smith & Krejci, 1991; Striegel-Moore et al., 2000). These findings do not, however, reduce the need for additional investigation; authors have called for increased research on eating disorder symptomatology among individuals of color (e.g., Root, 2001; Smolak & Striegel-Moore, 2001).

Risk Factors for Eating Disorders

In addition to becoming cognizant of the diagnoses, symptoms, prevalence rates, and demographic characteristics associated with eating disorder symptomatology, school counselors also would benefit from awareness of specific factors which researchers have linked with disordered eating among adolescents. In this way, school counselors can identify those students who may be most at risk for developing disordered patterns and can design prevention programs which target these risk variables (Bardick et al., 2004; Ray, 2004; Stice & Shaw, 2004). Authors have noted that a range of models have been proposed to explain the genesis of eating disorders, as numerous factors have been linked

to eating disorder symptomatology (Ricciardelli & McCabe, 2004; Striegel-Moore & Cachelin, 2001). The following section will discuss only some of the variables which have been linked with disordered eating. Moreover, authors have discussed the need for more research to establish the casual factors associated with eating disorder symptoms (Striegel-Moore & Cachelin, 2001).

One model of eating disorder etiology and maintenance is termed the dual pathway model (e.g., Stice, 2002). In this model, certain factors have been hypothesized to work together in fostering bulimic symptomatology. More specifically, this model suggests that bulimic symptomatology is a result of perceived pressure to be thin, which leads to an internalization of an unrealistic thin body ideal, which results in body dissatisfaction, which leads to negative affect and dieting; both negative affect and dieting are posited to ultimately engender bulimic symptomatology (Stice, 1994; Stice, 2002; Stice & Shaw, 2002). Several empirical studies have established the validity of this mediational model, including studies with longitudinal research designs (for a review, see Stice & Shaw, 2002). In addition to working in combination, these variables have also been directly linked to disordered eating (for a review, see Stice, 2002). Researchers have often focused their investigations on female samples; less empirical research on risk factors for disordered eating—particularly longitudinal research—has been carried out with male adolescents (e.g., Stice, 2002).

Perceived pressure to be thin can come from numerous channels, including family, peers, and the media (Thompson & Stice, 2001). Pressure for thinness is embedded in the sociocultural model of eating pathology, which posits that individuals in Western society experience pressure to strive for and eventually reach a thin body ideal (Thompson & Stice, 2001). According to this model, pressure can be either overt messages from family or peers (e.g., “You look like you gained some weight over the summer—you should be careful what you eat.”) or may be communicated more subtly (e.g., a plethora of thin models in popular magazines; Thompson & Stice, 2001). Researchers have found that perceived pressure for thinness is associated with disordered eating among male and female adolescents (Halliwell & Harvey, 2006; Stice, Presnell, & Spangler, 2002).

As a result of this intense pressure for a certain body shape, authors have posited that individuals internalize a thin body ideal (Thompson & Stice, 2001). Researchers have documented a relationship between thin ideal internalization and eating disorder symptomatology among male and female adolescents (Halliwell & Harvey, 2006; Stice & Agras, 1998). Moreover, authors have reviewed research indicating that thin ideal internalization predicts body dissatisfaction (Stice & Shaw, 2002).

Body dissatisfaction has been called one of the most “robust” risk factors for disordered eating attitudes and behaviors (Stice, 2002, p. 833) and researchers have documented a link between body dissatisfaction and eating disorder symptomatology among male and female adolescents (Halliwell & Harvey, 2006; Stice, 2001; Stice & Bearman, 2001; Wertheim, Koerner, & Paxton, 2001). Body dissatisfaction is also posited to lead to negative affect and dieting (Stice & Shaw, 2002).

Longitudinal studies have documented that negative affect predicts disordered eating among female adolescents (Stice et al., 2002) and researchers have found that depression intensifies as disordered eating symptoms increase among male adolescents (Aime et al., 2008). In order to manage this negative affect, adolescents may turn to

eating disorder symptomatology; authors have discussed that individuals may specifically rely on binge eating and bulimic symptoms to manage these negative emotions (Heatherton & Baumeister, 1991; Stice, Presnell & Spangler, 2002; Wertheim et al., 2001). Strikingly, disordered eating behaviors many times do, in fact, help individuals decrease negative emotions. For example, studies have shown that, after binge eating and purging, females reported an improved mood (Smyth et al., 2007; Tachi, Murakami, Murotsu, & Washizuka, 2001). While some negative emotions, such as shame, may increase after a binge eating and purging, other negative emotions, such as frustration, have been found to decrease (Tachi et al., 2001).

In addition to the pathway from negative affect to disordered eating, researchers have also documented that dieting behavior predicts disordered eating among female adolescents (Stice & Agras, 1998; Patton, Selzer, Coffey, Carlin, & Wolfe, 1999). Studies involving male adolescents have also suggested a relationship between dieting and disordered eating. For example, Rasmus, Anna-Lisa, Mauri, Rittakerttu, and Kaj (2010) studied male and female adolescents who reported dieting behaviors and found that adolescents who engaged in dieting due to depression or a subjective sense of being overweight were more likely to also report disordered eating, compared to adolescents who dieted for other reasons. Despite this support in the literature for the relationship between dieting and disordered eating, Stice (2002) concluded that experimental evidence has provided conflicting results, as some studies have found a relationship between calorie deprivation and decreased eating disorder symptomatology.

In his review of the research, Stice (2002) also discussed the role of perfectionism in increasing disordered eating behaviors for certain individuals, while also noting that not all empirical evidence has supported this conclusion. Researchers have documented an association between perfectionism and disordered eating among male and female adolescents (McCabe & Vincent, 2003; Wade & Lowes, 2002). In addition, literature abounds with the classification of the perfectionistic behavior of an individual struggling with eating disorder symptomatology—particularly an anorexia sufferer (e.g., Bruch, 1973, 1978, 1985; Gordon, 2000). However, this ambition to be perfect masks a fear of being less than perfect and an internal sense of incompetence (Bruch, 1978). As Bruch (1978) described, an anorexia sufferer may seem high-achieving and content, but this is not the whole story; rather, this representation is “replaced, on closer contact, by the picture of underlying ineffectiveness, inability to make decisions, and constant fear of not being respected or rated high enough. These youngsters appear to have no conviction of their own inner substance and value” (p. 43).

Adolescents of color may develop disordered attitudes and behaviors about eating due to factors which differ from the risk factors for White adolescents. For example, literature has suggested that some individuals of color may become vulnerable to developing eating disorder symptomatology due to the stressors associated with living in two different cultures and the tension between two value systems (Lake, Staiger, & Glowinski, 2000; Smolak & Striegel-Moore, 2001). Buser (2010) discussed the application of this cultural clash hypothesis in relation to disordered eating among American Indian male and female adolescents. While the relationship between disordered eating and an adolescents’ sense of cultural clash lacks strong empirical evidence, authors have posited that eating disorder symptomatology may arise due to an adolescent feeling uncertain and conflicted about identity issues (Mumford, Whitehouse, & Platts, 1991).

Individuals may also develop problematic eating patterns as a way to gain a sense of control in an otherwise disorienting reality (Humphry & Ricciardelli, 2004; Katzman & Lee, 1997).

Prevention in Schools

School counselors can be highly involved in forming and delivering prevention programs which aim to reduce the incidence of eating disorder symptomatology (Bardick et al., 2004). Authors have noted, however, that prevention programs need to be designed carefully and intentionally, with caution not to glamorize eating disorder symptomatology and/or teach adolescents disordered strategies (Piran, 1998; Russell & Ryder, 2001). In general, the research has identified several key components of successful eating disorder prevention programs, which can be used as a guide. Stice and Shaw (2004) noted that programs which ask participants to actively engage with the material—rather than those which are predominantly educational—result in more successful outcomes. Plausibly, in an interactive format, participants are more likely to connect with the material and apply it personally—which then facilitates the learning of new skills and ultimately the changing of behavior and attitudes (Stice & Shaw, 2004). Additionally, authors have identified homework assignments as being vital in successful prevention programs (Stice, Shaw, Burton, & Wade, 2006). Dissonance-based prevention programs have been reported as being successful with adolescent participants (Stice, Marti, Spoor, Presnell, & Shaw, 2008; Stice, et al., 2006). These programs are highly interactive, using a format which encourages personal application and group sharing. In one example of a dissonance-based prevention program, adolescents initially engaged in group discussion about the thin-ideal; participants also completed homework assignments about this thin-ideal, such as writing an essay arguing against the thin-ideal (Stice et al., 2006). Later in the program, participants were asked to share, in the group, about a personal experience regarding feeling pressured to be thin; participants were also asked to personally challenge themselves to change thoughts and behaviors in their life which conformed to the thin-ideal standard (Stice et al., 2006).

School counselors can also provide programming to parents—individually or as a group—in order to help parents develop strategies which reduce the risk of eating disorder symptomatology among adolescents (Stout & Frame, 2004). Individuals receiving treatment for disordered eating have reported that specific family qualities may function to prevent eating disorder symptomatology from manifesting (Loth, Neumark-Sztainer, & Croll, 2009). In particular, these participants noted that creating a supportive and nurturing family environment—especially during adolescence—is critical to preventing onset of symptoms. One 19-year old male participant who was being treated for AN, said this, “Kids can’t have this idea that you are more lovable if you are thinner, because I know a lot of people who do it for that reason” (Loth et al., 2009, p. 149). Another important family quality highlighted by these authors involved the ways in which food, weight, and body image are talked about in the family. The importance of modeling positive body and food attitudes, avoiding negative comments about food and body, and creating a positive family mealtime were all factors noted to be vital to prevention (Loth et al., 2009).

Inclusion of teachers and other school staff in prevention programs is also important in the school setting (Russell & Ryder, 2001). Studies have shown that some teachers—specifically health education and physical education teachers—may themselves evince disordered eating behaviors and attitudes, such as engaging in over-exercising (Yager & O’Dea, 2009). Thus, teachers and other staff can be educated about healthy body and food attitudes and behaviors, in addition to helping them recognize the susceptibility of adolescents to disordered eating attitudes and behaviors (Piran, 2004; Stout & Frame, 2004). Modeling of disordered eating has been understood as a risk factor for disordered eating—specifically for bulimic symptomatology (Stice, 2002). Teachers can be given insight on how to create an affirming, supportive classroom environment and model healthy attitudes daily with their students; authors have suggested that having teachers reflect on their own body image and eating experiences—such as recalling experiences of being taunted about one’s body—may help teachers empathize with their students (Piran, 2004).

Authors have also discussed the importance of alerting school personnel, such as teachers, coaches, and administrators, to the potency of their words; even a casual remark about weight and food may negatively impact an adolescent (Bardick et al., 2004; Piran, 2004). One successful prevention program, which was carried out on both the middle and high school levels, infused disordered eating prevention activities into the school curriculum and involved classroom teachers (Phelps, Sapia, Nathanson, & Nelson, 2000). When teachers are given such a primary role, it will likely be necessary to provide teacher training on skills such as listening in an active and attuned manner and offering compassionate, tolerant feedback (Phelps et al., 2000).

Intervention in Schools

School counselors may also work with adolescents who are already exhibiting eating disorder symptomatology (Carney & Scott, 2012). As noted previously, when an adolescent is in the midst of a clinically diagnosable eating disorder, referral to outside professionals is likely indicated (Bardick et al., 2004). Some adolescents may need inpatient treatment, while others may benefit from regular, intensive outpatient therapy (APA, 2006). For adolescents who display subclinical eating disorder symptoms, school counselors may be able to provide some intervention (Carney & Scott, 2012; Ray, 2004). However, collaboration and consultation with outside professionals will be imperative, as it is considered best practice in the eating disorder field to have a multidisciplinary treatment approach (APA, 2006). These treatment teams often include a physician who can assess for the disorder’s impact on physical health—including such issues as osteoporosis and cardiovascular concerns; a nutritionist who can assist an adolescent in developing an eating plan; a psychiatrist who can determine potential psychotropic medication needs; and a counselor who can provide a range of therapeutic interventions (APA, 2006). Prominent therapy techniques that have been used with individuals struggling with eating disorder symptomatology include family therapy, group therapy, experiential therapy, cognitive behavioral therapy, and psychodynamic therapy (APA, 2006; Bruch, 1985, 1978, 1973; Dokter, 1995; Gordon, 2000). Cognitive behavioral therapy has received solid empirical backing as a treatment for disordered eating (e.g., Cooper & Shafran, 2008). As part of this team, school counselors may serve a vital

function in the therapeutic treatment of eating disorder symptomatology. A school counselor may be positioned especially well to address issues which arise in the school context and are pertinent to the adolescent's disordered eating behaviors and attitudes.

Eating disorder symptomatology can be a tenacious issue; authors have discussed the persistence of disordered eating symptoms (such as symptoms of BN) and various factors which have been found to contribute to these chronic symptoms (Fairburn et al., 2003). Yet, there are several counseling techniques which may benefit adolescents struggling with disordered eating patterns. Authors have underscored that individuals struggling with eating disorder symptomatology often have difficulty expressing their emotions (Bruch, 1973, 1978, 1985; Dokter, 1995; Gordon, 2000; Lubbers, 1991; Schaverien, 1994; Warriner, 1995). In fact, eating disorders have been conceptualized as a way in which to act out emotions which sufferers are unable to voice (Dokter, 1995; Schaverien, 1994). Consequently, expressive therapies may be especially beneficial for these adolescents, as a creative media—such as art, music, or drama—may provide a way to access and express emotions which have previously been expressed only through disordered eating behaviors (Dokter, 1995). These creative techniques provide a means for emotional expression without the use of words (Schaverien, 1994). One author (Warriner, 1995) related her own experience with AN and her engagement in art therapy, noting that “anorexia and illustration have at least one thing in common. They are both about expressing oneself without words, yet one is destructive and the other creative” (p. 24).

Conclusion

Eating disorder symptomatology is a struggle for many adolescents; statistics reveal that subclinical concerns are quite prevalent among this age group (e.g., Grigg et al., 1996; Striegel-Moore et al., 1989). Yet, disordered eating can be a complicated and difficult concern to address, as many adolescents may deny that they are engaging in extreme dieting, binge eating, over-exercising, and are consumed with thoughts about weight and food (Couturier & Lock, 2006). School counselors can play a role in addressing eating disorder symptomatology even when an adolescent is in the midst of denial. School counselors may be able to recognize early warning signs of disordered eating and may also be in a position to gain the trust of struggling students (Currin & Schmidt, 2005). Moreover, school counselors can facilitate referrals to outside care, collaborate with other professionals, provide intervention to students, and design prevention programs which seek to reduce the onset of eating disorder symptomatology (Bardick et al., 2004; Ray, 2004; Stout & Frame, 2004). Ultimately, dedicated, knowledgeable, and compassionate school counselors have the potential to bring voice to an often silent struggle. Through giving voice to the symptoms and, more importantly—through giving voice to the pain, exhaustion, and fear beneath the disordered eating symptoms—an adolescent can be moved to a place of healing and recovery.

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