

SCHOOL COUNSELOR'S ROLE IN RECOGNIZING AND ADDRESSING EATING DISORDERS IN  
THE FAIRBANKS NORTHSTAR BOROUGH SCHOOL DISTRICT

By

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### **Abstract**

Eating disorders are recognized as the deadliest mental-health illness. Eating disorder symptoms frequently appear in adolescents in middle school and high school, which is a time when school counselors are part of a teenager's life. School counseling offers a solid platform to educate and collaborate with stakeholders such as parents, other school staff, and coaches. Fairbanks, Alaska, like other small communities, lacks resources for the treatment of eating disorders. However, there are dietitians, counselors, and doctors in the local community who are able and willing to work together on behalf of a student struggling with an eating disorder or eating disorder symptoms. They can help with treatment for mild cases and with locating an appropriate venue for in treatment care. Based on an examination of current literature on eating disorders and the roles that school counselors can play in recognition of and treatment for young people with eating disorders, a website and booklet have been developed specifically for school counselors in the Fairbanks North Star Borough School District.

*Keywords:* eating disorders, school counselor, collaboration, education

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## School Counselor Role in Recognizing and Addressing Eating Disorders in the Fairbanks North Star Borough School District

The media in the United States provides an onslaught of information about food and the human body. This information promotes ideas about the best or worst foods, food that will extend one's life expectancy or shorten it and increase cognitive abilities or result in Alzheimer's. The media discusses the obesity epidemic and various ramifications for health in individuals who are overweight. However, there are those whose relationship to food and their body lead them to other types of health concerns. Their behaviors fall under the large heading of eating disorders (ED). Eating disorders include anorexia nervosa (AN), binge-eating disorder (BED) and bulimia nervosa (BN), among others (American Psychiatric Association, 2013).

School counselors, particularly those working in middle and high schools, are in a position to educate and collaborate with stakeholders to develop resources for students who are at risk for eating disorders at a clinical level (ASCA, 2017). Adolescents of both sexes are at an increased risk for eating behaviors that are precursors for clinical levels of eating disorders (Neumark-Sztainer, Wall, Larson, Eisenberg, & Loth, 2011; Vo, Lau, & Rubinstein, 2016). According to Neumark-Sztainer et al. (2011), these behaviors are not just a phase but can carry through to adulthood with various physical and psychological consequences. The purpose of this project is to investigate the following research question using the literature:

What roles can school counselors in the Fairbanks North Star Borough School District (FNSBSD) play in the screening, prevention, and referral to treatment of students with ED in middle and high school settings?

Once this question is answered, an online resource guide and handout will be developed for use in the FNSBSD to assist in addressing the problem of ED in Fairbanks schools.

### **Overview of Eating Disorders**

The causes of ED and the way they present themselves are complex (Fursland et al., 2012). The appearance of an individual is not a basis for an eating disorder diagnosis. A thin person could have an illness, have a high metabolism, or not have adequate sources of food (Thomas & Schaefer, 2013). Someone who is normal weight or even obese could be suffering from BN or BED. In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), ED are “characterized by a persistent disturbance of eating or eating related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning” (American Psychiatric Association, 2013, p. 329). There are several types of ED; some will be considered here.

#### **Anorexia Nervosa**

According to the DMS-5 (American Psychiatric Association, 2013), anorexia nervosa (AN) has three major criteria. The first is that an individual has less food intake than a healthy person requires, resulting in a lower than expected body weight for a person's age and size. Second, there needs to be a powerful aversion to gaining weight. Third, a person suffering from AN assesses himself or herself almost entirely on their perceptions of how their body is shaped, how much they weigh, or what size clothes they wear. A person with AN has hunger cues and even fantasies about eating but chooses not to eat enough to maintain a healthy weight (Buser, 2012).

**Bulimia Nervosa**

Bulimia nervosa (BN) has several characteristics according to the DSM-5 (American Psychiatric Association, 2013). One is repeating incidents of binge eating. Binge eating is defined as consuming a large amount of food in a short amount of time that would be unusual for most individuals. This behavior is accompanied by feeling a loss of control. In addition to bingeing, periodic purging of various types must also occur. The most common form of purging is self-induced vomiting but can also be an incorrect use of laxatives, exercising to an extreme or going without eating for periods of time. The DSM-5 indicates that clinical BN has an occurrence of bingeing and purging at least once a week for a minimum duration of 3 months. Beyond the physical criteria, there is also an emotional component, which involves how a person sees himself or herself. In the case of those suffering with BN, their self-evaluation is primarily determined by how they see their bodies' size and dimensions (American Psychiatric Association, 2013).

**Binge-Eating Disorder**

Binge-eating disorder (BED) has the binge component of BN without the purging (American Psychiatric Association, 2013). A person experiencing this disorder will consume large amounts of food in a shorter period than most people and experience shame and remorse afterward. They do not eat as a result of hunger; rather they will often eat compulsively until they are physically distressed. Eating is often done out of sight of others due, in part, to embarrassment over the amount of food they are consuming. The DSM-5 again gives frequency of bingeing events to indicate when there is a clinical level of the disorder. In the case of BED, it must cover a 3-month time span and occur at least one time each month.

### **Other Specified Feeding or Eating Disorder**

“Other Specified Feeding or Eating Disorder” (OSFED) is new to the DSM-5. It replaces “Eating Disorder not Otherwise Specified” (EDNOS) in the previous edition. According to Campbell and Peebles (2014), both categories recognize that ED do not always fit the specific definitions given in the DSM-5 but can still cause high levels of distress. The DSM-5 clarifies this category by giving some examples. The idea behind this approach is that a person may fit most of the criteria for a disorder, such as AN, but lack one aspect such as having their weight in the normal range rather than subnormal. Another example would be bingeing or purging less than the designated criteria for BN but still experiencing significant distress. There is no simple explanation for any eating disorder. As a result, one way to conceptualize the root causes of ED is through examining the ecological systems surrounding an individual.

### **Understanding Risks for ED through Bronfenbrenner's Systems**

Bronfenbrenner developed his ecology of human development to understand how individuals are affected by and, in turn, affect the different settings around them (Brendtro, 2006). He envisioned a nested set of systems with the individual at the center (Bronfenbrenner, 1977). Immediately surrounding the individual is the microsystem that includes those things that directly affect a person such as family, school, neighborhood, and peers. Next is the mesosystem, which is the interaction between different parts of the microsystem such as a teacher talking to a parent. The next level is the exosystem that includes those entities that do not come in direct contact with an individual, but which still influence them. This would include such things as mass media, legal services, and friends of the family. At the outer rim is the macrosystem that incorporates the overarching culture that impacts an individual. As his model developed, Bronfenbrenner later included biological and genetic factors in his bio-ecological model (Bronfenbrenner & Ceci,

1994). Bronfenbrenner's theories provide a way to consider risk factors that inform the development of ED in an individual (Piran, 2015).

### **Biopsychosocial**

Bronfenbrenner recognized that along with various systems each person has their own characteristics including sex, age, health, and genetics (Bronfenbrenner & Ceci, 1994). Other important influences to consider are resiliency and developmental stages. Through the use of adoption and twin studies, it has become apparent that there is a strong genetic component to ED (Culbert, Racine, & Klump, 2015; Fursland et al., 2012; Le, Barendregt, Hay, & Mihalopoulos, 2017). These genetic elements are frequently seen together in people suffering from ED combined with personality traits such as perfectionism, negative emotionality, impulsivity, and negative urgency (Culbert et al., 2015). These traits are seen to predate the onset of ED according to Culbert et al. (2015) and contribute to eating disorder development.

Simply being female is a risk for the development of an eating disorder (Culbert et al., 2015). This may be in part to hormonal influences. Culbert et al. (2015) state that more research is needed to see if results could be duplicated regarding ovarian hormones and their impact on the development of ED. This is not to say that males do not experience ED, but that they do not experience them to the degree that females do (Dryer, Farr, Hiramatsu, & Quinton, 2016). In some of his later writing, Bronfenbrenner examined the passage of time through the chronosystem (Bronfenbrenner, 1986). There are certain points in the passage of person's life where an individual may be more likely to develop an eating disorder. These include the beginning of puberty (particularly if it is early onset according to the DSM-5), the first years at a university and pregnancy (Le et al., 2017). The age of the individual is also a risk factor. The age for eating disorder onset is somewhat up for debate, but it is safe to say that mid to late

adolescence is a significant period for the development of ED (Culbert et al., 2015; Le et al., 2017; Stice, Rohde, & Shaw, 2013).

### **Microsystems**

The microsystem is composed of settings that directly interact with an individual such as family, peers, school, church, and the neighborhood (Bronfenbrenner, 1977). This is the level where school counselors are. Their closeness to the center of the systems indicates the significance that a school counselor can play in the life of a student. There are several ways that families can contribute to the development of an eating disorder as part of the microsystem. If there is obesity in a family, there is an increased chance that a child will eventually develop BN or BED (Le et al., 2017). Being female and seen as weighing too much by parents is a risk factor for ED (Allen, Byrne, Forbes, & Oddy, 2009). Men who have had a poor relationship with their parents face greater odds of developing an eating disorder. In addition, an added risk for men is a want of social interaction and trouble articulating feelings (Gueguen et al., 2012). Adverse life experiences such as sexual or physical abuse and the death of someone close are also risk factors for ED (American Psychiatric Association, 2013; Fursland et al., 2012; Le et al., 2017) at the microsystem level.

The interactions and resulting emotions between an individual, their peers, and close family members exist at the microsystem level. In Bronfenbrenner's systems, influence goes both ways between the individual and various components. One of the ways this can be seen in individuals affected by ED is in the emotions of guilt and shame (Oluyori, 2013). Guilt and shame are emotions that are self-focused in a way that incorporates an individual's negative perception of how others may see them (Oluyori, 2013). Zerbe (2016) suggests that this shame can be from negative intergenerational views toward body weight. In their research, Matos,

Ferreira, Duarte, and Pinto-Gouveia (2015) found that individuals afflicted by an eating disorder frequently had negative peer input as children which then became associated with body shame. Peers also exert influence regarding the current trends in body image and what is socially acceptable (Piran, 2015; Rohde, Stice, & Marti, 2015). For some, this leads to control of their food and their body in order to find their place socially among peers. Failure to achieve control or achieving control in a socially unacceptable manner can lead to a shame cycle, which is difficult to break (Oluyori, 2013).

Along with trying to fit in socially with peers, adolescents who are involved with certain types of sports in school and outside of school are at increased risk for ED (Kong & Harris, 2015). Sports that are aesthetically based, such as gymnastics and dance, create a culture that increases risk for ED. Also, people involved with sports where a thinner build is associated with increased performance, such as running and swimming have an increased risk for ED (Kong & Harris, 2015). Individuals participating in wrestling, boxing, and body building with its specific weight categories, are also at a higher risk for ED (Jones & Morgan, 2010). The higher the level of competition, the higher the risk. Pressure to obtain and maintain a sleek figure can come at an athlete from coaches, peers, and family. Students transitioning to college sports are especially vulnerable (Quatromoni, 2017).

### **Exosystems**

Moving out from the microsystem is the exosystem. The exosystem includes areas that indirectly affect an individual such as friends of the family, neighbors, cultural influences, and mass media (Bronfenbrenner, 1977). A thin-body ideal has been promoted for decades in Western society and the media (Fursland et al., 2012; Le et al., 2017; Stice, Rohde, Butryn, Menke, & Marti, 2014). As this ideal has increased in Western culture, the incidences of ED

have also risen (Fursland et al., 2012). When the thin ideal becomes internalized, body dissatisfaction frequently follows often leading to disordered eating (Juarascio et al., 2011). These are areas that a school counselor can address with students who are struggling with eating disorder issues by promoting positive body image within a school culture. Promotion within a school culture can be accomplished by educating staff, students and coaches. Small groups can also be used as a tool to both educate and challenge students to think critically about messages that society promotes regarding our bodies. This will be discussed in depth in the school counselor roles section of this paper.

Existing in the school culture in the FNSBSD is a sub-group of students who have a unique ecological system of their own. These are students who are part of a family in the military. A person involved in the military, directly or as a dependent, experiences ecological systems unique to the branch they are associated with (Bagby, Barnard-Brak, Thompson, & Sulak, 2015). Military culture can be considered as the macrosystem level, the particular branch of the military as the exosystem, and the military unit as the microsystem in almost a familial way. In their small study, Schvey et al. (2015) found that military dependents were at elevated risk for disordered eating and depression. They suggest that this could, in part, be due to increased levels of ED found in those in the military, meaning the possibility of both a genetic component and learned behaviors from parents (Schvey et al., 2015). For school counselors in Fairbanks, taking military culture into account and its impact on youth is important considering the two military installations located in the FNSBSD.

### **Mesosystems**

Perhaps the most important of Bronfenbrenner's systems in understanding ED is the mesosystem, which is the interaction between the other systems. It is through the interaction of



multiple layers of risk factors ranging from genetics to cultural pressure that an individual develops an eating disorder or its symptoms (Culbert et al., 2015). A prime example is body image disorder (BID), which is considered one of the leading risk factors for ED (Le et al., 2017). It begins in the exosystem where the media promotes an unrealistic body image for both males and females (Brown & Keel, 2015). This can result in an internalization of the thin ideal in an individual, which combined with genetic predisposition can lead to ED (Culbert et al., 2015). The messages about the thin ideal espoused by Western society trickle down to families and peers who can add pressure to an individual who may be genetically and emotionally predisposed to acquire an eating disorder, resulting in a perfect storm of risk factors for developing an eating disorder (Linville, Stice, Gau, & O'Neil, 2011; Piran, 2015). Messages in health and sports magazines promoting ultra-thinness as a goal combined with “thin focused sports” (Kong & Harris, 2015) combined with an adolescent who has internalized the thin ideal can lead to body dissatisfaction, which has been shown to lead to ED and the accompanying extreme behaviors used to try to reach an unattainably perfect body (Stice et al., 2014). Determining how wide-spread ED are can be challenging. Part of the difficulty is deciding the parameters of eating disorder behaviors to be counted.

### **Looking at the Numbers**

Although it is useful to sort ED into categories in order to understand their presentation, causes, and treatments, it may also be useful to consider ED to be on a continuum (American Psychiatric Association, 2013). This continuum provides a way to recognize that not all distressing behaviors associated with eating fit neatly into a category. There is a category for “Unspecified Feeding or Eating Disorder” in the DMS-5. This condition has some symptoms of clinical ED, but does not meet all the criteria. The one requirement is that a person has

“clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association, 2013, p. 354). Along with definitions of ED, there are statistics that help understand how widespread ED are in the general population and in various subgroups.

There is more than one way that statistics relating to ED are presented and understood. Swanson, Crow, Le Grange, Swendsen, and Merikangas (2011) acknowledge that it is difficult to compare data from different sources due to the variations in research parameters. The size of the sample as well as the ethnicity, gender, age, and location of the subjects all vary and, consequently, affect the results (Locke, Silverman, & Spirduso, 1998). The length of studies varies, from onetime interviews to multiyear periodic assessments. Settings can be clinical, in treatment, or in the community (Swanson et al., 2011).

For an initial examination of the statistics surrounding ED, three resources will be used. The first is the DSM-5. The DSM-5 obtains its data from a clinical setting. Because lower percentages of people who consider themselves a minority will seek clinical help at the same rate as Caucasian sufferers for ED (Marques et al., 2011) this will affect the data obtained from clinical settings. However, because research into ED is frequently based on DSM-5 definitions (Culbert et al., 2015; Rohde et al., 2015; Stice, Marti, Shaw, & Jaconis, 2009; Suokas et al., 2013), it is important to include its results when coming to an understanding of ED. One of the leading researchers into ED is Dr. Eric Stice. He and his colleagues performed a study in 2009 examining 496 females over an 8-year period beginning at age 12. They used a community-based sample to examine clinical, and subclinical AN, BN, and BED as well as purging disorder (PD). Lastly, Swanson et al. (2011) used results from the National Comorbidity Survey—Adolescent Supplement (NCS-AS) to find statistics for ED in teens. The NCS-AS is a

population-based survey using interviews from 10,123 male and female adolescents from ages 13–18. Both the Stice' and Swanson' surveys examined ED that did not meet the full criteria for AN, BN, and/or BED. They recognized that those suffering from subclinical expressions of ED still suffer functional impairment, especially socially (Stice et al., 2009; Swanson et al., 2011).

In order to compare the statistics from these studies, the following table has been created.

Table I

*Eating Disorder Statistics Comparing Three Studies*

	AN	ANSUB	BN	BNSUB	BED	BEDSUB	PD
DMS-5 12-month prevalence	0.4%		1%– 1.5%		1.6F/.8%M		
Swanson et al. (2011) Lifetime prevalence	0.3%	0.8%	0.9%		1.6%	2.5%	
Stice et al. (2009) Lifetime prevalence Female only	0.6%	0.6%	1.6%	6.1%	1%	4.6%	4.4%

It is easy to see right away that it is difficult to compare simply because of differences in what is included in each study. The DMS-5 has the OSFED category but only includes data for clinical AN, BN, and BED. Both Stice and Swanson were concerned with broadening the scope of their research beyond the clinical levels for ED because of evidence that the subthreshold levels have physical, psychological, and emotional impairment associated with them (Stice et al., 2009; Swanson et al., 2011). As a result, both Stice et al. (2009) and Swanson et al. (2011) included data for subclinical symptoms for ED. Stice et al. (2009) included only girls in their

sample over an 8-year time period. Adding the percentages of all the categories included by Stice et al. (2009) indicates that 18% of females experience some level of distress due to disordered eating patterns at some point in their life. Swanson et al. (2011) included both sexes and a more ethnically diverse population than Stice et al. (2009). While the end totals differ due to research parameters, one important takeaway from Swanson et al. (2011) is that ED at both the clinical and subclinical levels affect more than White, upper-class females.

### **Not Just a White Female Problem**

The DMS-5 suggests that AN and BN are seen mostly in post industrialized, high-income countries with White people having the highest rates of AN compared to people who identify as Latino, African American or Asian. The DMS-5 suggests that their statistics may be somewhat skewed because groups other than White people are less likely to seek treatment for mental-health concerns. However, Najjar, Jacob, and Evangelista (2018) found that multiethnic low-income adolescents had a “high prevalence of disordered eating” and “high rates (28%) of nonclinical bingeing” (p. 84), which indicates that behaviors that can lead to ED are not just a White, high-income phenomenon.

Both Swanson et al. (2011) and Marques et al. (2011) used large data sets that included a broad spectrum of the U.S. general population. The difference was that Swanson et al. (2011) focused on culling data from youth who are 13–18 year old, and Marques et al. (2011) looked at adults. Below is an examination of the lifetime prevalence that Marques et al. (2011) and Swanson et al. (2011) were able to gather regarding different ethnicities and clinical levels of ED.

Table II

*Comparing Results of Lifetime Prevalence in Two Studies Relating to ED and Ethnicity*

	Non-Latino White	Latino	African American	Asian	Other
AN Marques	0.39	.08	0.15	0.1	
AN Swanson	0.4	0.2	0.09		0.1
BN Marques	0.51	2.03	1.31	1.5	
BN Swanson	0.7	1.6	1.0		1.3
BED Marques	1.14	2.11	1.48	1.24	
BED Swanson	1.4	2.4	1.5		1.4

Although many studies, particularly older ones, have focused on young White females, it is seen from the above table that ED affect a much wider population with those experiencing BN having higher rates in African American and Latin populations (Kwan, Gordon, & Minnich, 2018). Gordon, Castro, Sitnikov, and Holm-Denoma (2010) suggest that there is a protective factor for people identifying as Latin and African American, since some have a positive view of larger body sizes. Those identifying as Asian were opposite in that they had greater body dissatisfaction at a lower body mass index (BMI) than any other group (Latner, Knight, & Illingworth, 2011). Latner et al. (2011) also noted that those identifying as Asian based their self-worth on not only their appearance but also on how healthy they considered themselves. The combination of appearance, health, and desire for a lower BMI resulted in a narrower model for body image than other ethnicities and cultures in the study. Gordon, Brattole, Wingate, and

Joiner (2006) stated that in all the studies they had seen there was always some indication of ED in people from minority groups.

### **Alaska Natives /Pacific Islanders**

For school counselors in Fairbanks, Alaska, it is important to understand the effects of ED on Alaska Natives (AKN), and Pacific Islanders. People who identify with these groups are represented in the FNSBSD by around 13% of the school body (FNSBSD, 2017). There are few studies on either of these ethnicities in connection with ED, and much of the research on AKN is outdated (Naegele & Cook, 2017).

In studies concerning ED in Pacific Island nations, it was found that there is a difference in what is considered an ideal body for those from island groups and the Western thin-ideal (Latner et al., 2011). Latner et al. (2011) examined body image with a total of 173 undergrad students from the University of Australia and the University of Hawaii comprised of Pacific Islanders, Asians, and Whites. They found that individuals from the Pacific Islands like Samoa tended to have a more positive view of their bodies despite a higher BMI than others in the study. Being content with a higher BMI does not mean that people from the Pacific Islands are totally immune to ED. McCabe, Ricciardelli, Waqa, Goundar, and Fotu (2009) note that in the Fiji Islands there was a rise of eating disorder behaviors when TV programming became accessible in 1995.

In regard to ED, those who identified as American Indian and AKN were one of the least examined groups (Striegel-Moore et al., 2011). In some research articles, those identifying as AKN were grouped with those identifying as American Indians, despite differences in cultures (Garrett & Herring, 2001). Naegele (2013) conducted a small, qualitative study dedicated solely to those identifying as AKN. The focus of the research was body image dissatisfaction (BID) in

AKN women at the University of Alaska in Fairbanks. BID is typically seen as stemming from the cultural pressure to fit the thin ideal (Polivy & Herman, 2002). Naegele and Cook (2017) state that BID leads to “low self-esteem, suicidal ideation, depression, and risky behaviors” (p. 142). Polivy and Herman (2002) assert that BID frequently, if not always, precedes ED. The women interviewed by Polivy and Herman (2002), who had identified with all ethnic groups including White, developed BID in middle school and high school. Factors such as bullying due to physical differences or media images contributed to insecurities and low self-esteem. One theme Naegele and Cook (2017) discovered was that food associated with traditional AKN culture was considered by the women interviewed as healthier than the processed foods linked to Western society. This struggle to balance input from more than one culture can be seen in people identifying with minority ethnicities and can contribute to the development of ED (Kwan et al., 2018).

### **Acculturative Stress and Discrimination**

Eating disorder symptoms and eating psychopathologies in people identifying with ethnic minorities are acculturative and are often associated with stress and discrimination, perceived or otherwise (Kroon Van Diest, Tartakovsky, Stachon, Pettit, & Perez, 2014; Kwan et al., 2018). According to Kwan et al. (2018), “acculturation is the process of assimilating to a different culture, which may include the adoption of the beliefs, attitudes, and behaviors of the dominant culture to minimize the differences” (p. 25). Stress increases as an individual attempts to balance behaviors between two cultures (Kroon Van Diest et al., 2014). The acculturation process can include internalizing the thin-body ideal, rampant in U. S. society, which in itself can lead to eating disorder behaviors. The thin-body ideal is compounded by acculturative stress caused in

part by the discrepancy between Western body ideals and the culture of origin ideals with which an individual identifies (Kwan et al., 2018).

Kwan et al. (2018) also address discrimination as a factor contributing to ED in ethnic-minority people. Kwan et al. (2018) describe discrimination as “unfair treatment that is demeaning or degrading in response to an essential characteristic of a person” (p. 25). ED can give a sense of being in charge in situations that feel out of control. ED may also arise through lowered self-esteem and depression resulting from discriminatory actions (Kwan et al., 2018). Both acculturative stress and discrimination were connected with several types of ED and eating disorder behaviors including drive for thinness, bulimic symptoms, eating restraint, and shape concern (Kwan et al., 2018).

The deficiency of research for members of ethnic minorities could be one of the reasons that there are even more barriers to treatment of ED than for Caucasians. Kazdin, Fitzsimmons-Craft, and Wilfley (2016) recognize that members of minority groups are much less likely to be asked by a doctor about eating disorder warning signs. Gordon et al. (2006) conducted a study where clinicians were given scenarios about a person with eating disorder symptoms. The only variable that was changed was the ethnicity of the client. The results showed that members of ethnic minorities, especially African Americans were less frequently asked about eating disorder behaviors or the eating disorder behaviors were not attributed to an actual eating disorder. This omission can lead to a lack of diagnosis and treatment (Gordon et al., 2006). Currently, there is an increasing awareness that ED affect people from various cultures, ethnicities, and genders (Buser, 2010; Strother, Lemberg, Stanford, & Turberville, 2012).



### **Non-Female Gender**

A group in which ED are often overlooked and underdiagnosed is men (Strother et al., 2012). Jones and Morgan (2010) state that men have been discounted due to stereotypes and being “theorized out of existence” (p. 23). While still not studied as extensively as females, recent research indicates that 10–20% of people suffering from AN and BN are male, and as many as 40% of diagnosed cases of BED are in men. In their study of children, ranging in age from 5 to 13, Madden, Morris, Zurynski, Kohn, and Elliot (2009) found that one out of four with evidence of early onset ED were boys. Women have had an unrealistically thin ideal foisted upon them for many years. Now men, and women, are increasingly fed images of semi-nude men with sculpted muscles (Strother et al., 2012). Action figures present impossible physiques for men in much the same way that the Barbie doll portrays an unattainable figure for women (Jones & Morgan, 2010).

ED present themselves somewhat differently in men. Whereas women may only think they are fat, men with ED will often have a history of actually being overweight at some point in their lives (Strother et al., 2012). Excessive exercise is a common way of purging for men as they attempt to attain the current idealized image of muscular thinness in Western culture. Men and boys may also turn to substance abuse by using steroids and growth hormones in order to achieve a sculpted physique (Strother et al., 2012). Much of this behavior stems from muscle dysmorphia. Muscle dysmorphia is listed with body dysmorphia in the DSM-5. Muscle dysmorphia is a fixation on the lean muscularity prized by men in combination with a despairing, possibly inaccurate view of one's own body (Dryer et al., 2016). Perfectionist tendencies often occur with muscle dysmorphia as men, both gay and straight, attempt to meet an unrealistic standard of body perfection (Dryer et al., 2016).

When the LGBT community is considered separately, Feldman and Meyer (2010) state that gay and bisexual men appear to have more elevated rates of body image disorder (BID), eating disorder symptoms, and clinical ED than heterosexual men. In fact, they assert that lesbian women and gay men have almost indistinguishable rates of ED compared to heterosexual women. In a larger study, Guss, Williams, Reisner, Austin, and Katz-Wise (2017) examined ED specifically among transgender high school students. This more recent study agreed with Feldman and Meyer (2010) in recognizing that transgender youth have a greater chance of suffering from an eating disorder than cisgender males. Feldman and Meyer (2010) conjecture that puberty, which is a risk factor for heterosexual youth to develop ED, is even more stressful for young people who have gender dysphoria. Pre-adolescents with AN will sometimes stay prepubescent, thereby, allowing a delay in dealing with gender issues on an internal and external level (Deshane, 2015-2016). Deshane (2015-2016) describes gender dysphoria in an individual viewing their assigned gender as something difficult to bear. For those born female who view themselves as male, the act of food restriction causes similar physical change to going through hormone therapy (Deshane, 2015-2016). The goal is not to be thin but to be themselves. Because the underlying issues are different, the treatment between a cisgender anorexic female and a person born female who wants to be male must be different as well (Deshane, 2015-2016). ED are not simple, and they are not one size fits all.

A person with disordered eating, can be severely underweight, obese, or normal in appearance. Ethnic minorities can experience stress or trauma from discrimination that can lead to ED or eating disorder behaviors. With this in mind, a school counselor must approach each individual as unique. In addition, school counselors need to be aware of the potentially severe

consequences of ED and eating disorder symptoms. No matter who they affect, ED negatively impact the quality of life for those experiencing them (Fursland et al., 2012).

### **Consequences of ED**

#### **Physical**

Understanding the potentially severe outcomes from ED is important for school counselors if they are going to be willing to give the issue of ED the attention needed (Buser, 2012). In their review of adolescent health, Campbell and Peebles (2014) state that physically—ED can impact “every organ system, and complications can occur at any weight” (p. 585). As much as one third of those hospitalized for AN have serious cardiac complications (Campbell & Peebles, 2014). Those individuals with purging behaviors and some with BN can also experience issues relating to the heart (Campbell & Peebles, 2014). Gastrointestinal issues are associated with malnutrition, vomiting, or binge eating (Campbell & Peebles, 2014). Vomiting, laxative abuse, or abuse of diuretics can upset electrolytes (Campbell & Peebles, 2014). When the endocrine system is thrown off kilter, there are several potential consequences, especially for maturing adolescents. These include “decelerated linear growth, pubertal delay, or pubertal regression, and menstrual dysfunction in females” (Campbell & Peebles, 2014, p. 586). Neurologically, adolescents are particularly at risk, since their brains are still developing (Campbell & Peebles, 2014). This developmental consequence is especially true for severe AN, which can lead to “reduced brain tissue volume and impaired neuropsychological functioning” (p. 586).

#### **Comorbidity**

Comorbidity is common in ED (Strother et al., 2012). Most people with ED have “as many as two to four additional separate psychiatric diagnosis” (Jones & Morgan, 2010, p. 28).

These diagnoses can be evident before an eating disorder develops, occur at the same time or become apparent after the eating disorder has taken hold (Campbell & Peebles, 2014).

According to the DSM-5, those individuals struggling with AN, BN, and BED could also be dealing with depression, anxiety, mood disorders, or being bipolar. Persons with AN, in particular, may also have issues with alcohol and/or drug disorders (American Psychiatric Association, 2013). The most devastating physical consequence is death.

### **Morbidity**

AN has the highest mortality rate among mental disorders with death resulting from physical decline and suicide (American Psychiatric Association, 2013; Kazdin et al., 2016). Although AN has the highest mortality rate, other ED have elevated rates compared to the general population. In their extensive study conducted in Finland, Suokas et al. (2013) examined 2,450 adult patients in tertiary care, mostly at the outpatient level. They examined a wide range of individuals with ED and symptoms. In the DSM-5, clinical AN had a high mortality rate at 13 times the controls. In contrast, Suokas et al. (2013) found an eighteenfold increased risk of death for those with BN compared to the controls. The main cause for death for those with BN was suicide (Suokas et al., 2013).

In their section on suicidality, Swanson et al. (2011) highlighted two phenomena. One was that suicide ideation was similar between those with clinical levels of AN and those who were subclinical. Secondly, as seen in other studies, those with BN had a higher level of suicidality compared to those with other ED with more than half reporting suicidal ideation and more than one third actually attempting suicide (Suokas et al., 2013). Another finding from Suokas et al. (2013) was that, unlike AN, mortality increased after the second year post-treatment for BN. The severity of potential repercussions from ED, physically and emotionally,

makes it important that school counselors continue to monitor individuals over time (Buser, 2012) as well as assist students and their families to find treatment as needed.

### **Barriers for Treatment**

It can be difficult for an individual and their family to recognize and then find treatment for an eating disorder. Once an individual and their family have recognized that a student has symptoms for an eating disorder, it can take as long as 15 months before help is sought and treatment begins (Kazdin et al., 2016). In addition, Weissman and Rosselli (2016) stated that only one in four persons who have an eating disorder will seek, and actually obtain, treatment that is explicitly for ED. Kazdin et al. (2016) listed several steps needed to get high-quality treatment for ED: experiencing symptoms, identifying symptoms as something that needs addressing, deciding if action is needed, identifying options for treatment, finding treatment, beginning treatment, and staying in treatment.

At any point along the way, barriers can prevent completion of treatment. With ED, one of the initial barriers is denial by the individual that there is a problem (Buser, 2012; Kazdin et al., 2016). Another initial barrier is that primary care physicians often misdiagnose an existing eating disorder (Kazdin et al., 2016). Even if physicians and individuals recognize the need for treatment, the individual may believe that they would be stigmatized if they sought treatment. Those suffering with AN often struggle with shame that could prevent them from seeking treatment. Despite extreme thinness, they can feel shame about being “fat” (Rance, Clarke, & Moller, 2017). They can also feel shame that they are not sick enough to need treatment when they see someone thinner than they see themselves. The cost of mental health services can be prohibitive, especially if there is a lack of insurance coverage. Treatment for AN can be

exceptionally expensive reaching up to over \$40,000 a year when inpatient care is needed (Kazdin et al., 2016).

If individuals and their family decide treatment for an eating disorder is necessary and have insurance or finances to cover it, barriers may still be experienced as attempts are made to find a well-trained therapist for ED (Kazdin et al., 2016). Cities with universities and well-to-do urban centers tend to be focal points for mental health specialists. Small towns and rural areas tend to be underserved. Kazdin et al. (2016) suggest that if a one-on-one approach were used, there would simply not be enough mental health professionals to go around. Despite the challenges, school counselors can play a vital role in helping families overcome barriers in order to obtain help for students struggling with an eating disorder.

In addition, school counselors are in a position to work at different systemic levels to reduce risk for ED among the students in a school (Buser, 2010). Schools are considered part of the microsystem for an individual in that they, and the people in them, directly affect a student (Bronfenbrenner, 1977). School counselors are also part of a student's mesosystem, since they interact with the parents of a student as well as other staff at the school. School counselors also can help connect students to the exosystem through education about cultural influences. Also, in the exosystem are resources that school counselors can help connect students to such as clinical counselors and dietitians. Because of their ability to connect to various ecological systems of a student, school counselors are in a position to address ED effectively in several ways.

### **School Counselor Roles**

School counselors in secondary schools can be effective in addressing ED simply because of the place they work. Secondary schools are where there are young people at an age when ED and the risk factors leading up to them are becoming evident (Breithaupt, Eickman, Byrne, &

Fischer, 2017). Although the onset of full-blown ED occurs most often between the ages of 17 and 22, risk factors can become apparent much younger (Rohde et al., 2015). Rohde et al. (2015) discovered that children as young as 10 experienced low body-esteem. By the age of 11, children could be seen who had body dissatisfaction and distorted perceptions of their own size. By the age of 12, children were buying into the thinner body type as idyllic. Rohde et al. (2015) conducted research that indicated it was body dissatisfaction that “significantly predicted future ED” (p. 192). Early intervention and identification have been shown to be important in preventing the development of an eating disorder and the consequences associated with it (Campbell & Peebles, 2014).

The repercussions of ED on students affect them in areas that a school counselor is called upon to address. School counselors are to help meet the needs of students socially, emotionally and academically (ASCA, 2017). ED can cause negative consequences in all these areas for those suffering from some level of an eating disorder. There is often a preoccupation with and rumination on eating and the body (Livingston & Sammons, 2006). This takes away from the student's ability to concentrate on scholastic endeavors. In addition, ED affects students through physical fatigue caused by inappropriate eating patterns and purging associated with AN and/or BN. Recognizing the effects of ED on students is part of the school counselor role to address students' academic and social emotional needs (Livingston & Sammons, 2006). School counselors, as part of the mesosystem of students, can interact with multiple stakeholders in a youth's life such as parents, teachers, and coaches to prevent and screen for ED in students. These interactions can take the form of education, collaboration, preventative measures, and help with finding long-term treatment when needed.

### **Education and Collaboration**

The stakeholders that a school counselor can connect with are teachers, administrators, nurses, coaches, and parents (Currin & Schmidt, 2005). Yager and O'Dea (2005) found that there was a deficiency in knowledge and understanding of ED among people working in schools. Even school counselors did not feel knowledgeable in this area. Finding reliable resources is the start of the education process. Once the school counselor has gained an understanding of ED, they can reach out and educate other members of the school staff and parents (Yager & O'Dea, 2005). There are resources available to help with informing coworkers and parents, some of which are listed in the application (Appendix C).

Parents are an important part of helping an adolescent negotiate eating disorder symptoms. A school counselor can be a person who can either help educate parents directly or point them to useful online or in-person resources (Buser, 2012). The education of both parents and the school staff needs to include not only facts about ED but also ways to encourage a positive environment for students by setting a good example of a healthy relationship to food. This modeling can be particularly difficult, since some staff and parents may be struggling with their own dysfunctional eating behaviors (Buser, 2012). School counselors need to be aware of their own issues surrounding food and body image in order to interact with students in a way that presents a healthy, non-triggering interface (Carney & Scott, 2012).

Once the education element has been put in place, a school counselor can begin to advocate for collaboration between school staff, including school psychologists, social workers, and nurses, to best meet the needs of students (Carney & Scott, 2012). When considering the overlap between the physical and emotional inherent in ED, it is evident that Nurses can make effective collaborators when addressing ED in schools (Najjar et al., 2018). Tuttle, Yordy,



Appling, and Hanley (2018) describe four steps for collaboration between school counselors and school nurses, which could be applicable to others in the school setting as well. The first step they suggest is to meet to discuss the parameters of each job to establish a base for collaboration. The second step is to cover the important area of ethics for each profession, especially in the area of confidentiality (ASCA, 2016; NASN, 2018). The third step to establish ways that school counselors and nurses can collaborate for the benefit of the students in their care—this collaboration can also include recognizing and using community resources. In the last step, the process is continued through “ongoing communication and consultation” (Tuttle et al., 2018, p. 18).

Collaboration in a school setting requires care in the area of confidentiality. School counselors understand the need to respect students’ rights to confidentiality. (ASCA, 2016). However, there are times when disclosure is needed to prevent harm to the student or others. In the case of ED that can have serious mental and physical health consequences (Suokas et al., 2013), consultation with staff may be in order. Section A.2 also refers to the need to recognize the importance of parents’ rights to be a “guiding voice in their children’s lives” (ASCA, 2016). Broaching the possible need to confide in parents needs to be done with the utmost respect for the student and, when appropriate, with the student’s knowledge and cooperation.

Working together can assist the students and their advocates in problem solving and in creating an environment in the school that will lead to positive interactions on many levels. Discussions can lead to finding and implementing programs aiding in the prevention of ED in a particular school. Group efforts can be used to help in working out details of budgets, schedules, and gaining support from the administration. In-service training can be developed in cooperation with other staff members. By educating and collaborating with parents, teachers, and coaches, a

school counselor increases the likelihood that a student will be recognized as struggling with an eating disorder and, as a result, get the help they need (Carney & Scott, 2012).

### **Prevention Groups**

Along with working collaboratively with stakeholders, a school counselor can work through the use of small groups to aid in the prevention of ED (Buser, 2012). Small groups are one way that school counselors are encouraged to reach students in a school setting (Paolini, 2016). There have been several programs for eating disorder prevention that have been developed and tested (Mora et al., 2015; Sanchez-Carracedo et al., 2015; Wilksch, Paxton, Austin, O'Shea, & Wade, 2017). Although they may show some promise, few have been developed for dispersion. Some programs, like the REbel program, have been developed to have websites, training, and curriculum (Breithaupt et al., 2017). The REbel program, however, has not had extensive research conducted (one pilot trial is readily available). This limits the reliability of this program. When a program has been validated through extensive, properly conducted research, there is a greater likelihood that results can be replicated (Roberts & Priest, 2006). If a school counselor is going to use a program in their school, the program should be reliable, accessible and affordable (Buser, 2012).

*The Body Project* (Stice et al., 2013) has had numerous studies conducted, which show its reliability. *The Body Project* relies on the use of cognitive dissonance (CD) which has been shown to reduce the onset of ED during a three-year follow-up (Le et al., 2017). CD has also been shown to be effective for treatment of those who have developed an eating disorder (Stice et al., 2014). The goal of CD is to create tension between how a person behaves and their thoughts about the behavior (Stice et al., 2013). This discomfort can ultimately bring about a change in a person's behavior. The dissonance in the case of ED is created, in part, through

media literacy and the process of verbalizing a viewpoint that contradicts behavior (Stice et al., 2013). The program is easily assessable both in book form and online.

*The Body Project* was developed to target young women mostly in high school and college settings who experience body dissatisfaction and who have internalized the thin ideal (Stice et al., 2013). These issues have both been shown to be precursors and risk factors for developing ED. This program has been through eight independent labs and has shown to be effective in reducing eating disorder symptoms. The evidence base includes studies that have shown the intervention was effective when school counselors and others with different amounts of clinical experience were the ones who conducted the program (Stice et al., 2013). This makes it an attractive resource for school counselors. When used in a real-world situation, the results were encouraging with a 73% risk reduction in eating disorder onset (Stice et al., 2013).

*The Body Project* was designed to be used as a manual for school counselors, nurses, teachers and psychologists (Stice et al., 2013). The authors even suggest that peers can be part of the leadership team. While extensive training is not needed, there are certain qualities that Stice et al. (2013) has viewed as essential for leaders to have if groups are to be successful. An effective leader should be engaging, have zest, and a sense of humor. At a minimum, they should have a basic understanding of the relationship between body dissatisfaction, internalized thin ideal, and ED. It would also be beneficial for leaders to spend time increasing their understanding of ED and the cultural factors underlying them. In addition, Stice et al. (2013) believed that it would be helpful for leaders to have some experience in leading groups.

*The Body Project* has been well studied and developed to be easily used. However, there is little mention regarding reaching out to members of ethnic minority groups. Rodriguez, Marchand, Ng, and Stice (2008) did conduct a study showing that a dissonance-based eating

disorder program provided positive results for people who identified as Asian American and Hispanic. This leaves a gap in addressing whether a dissonance-based program would work well with those identifying with other ethnic minorities. As a result, a school counselor using *The Body Project* in a diverse setting would need to be sensitive to the potential for misunderstanding due to cultural differences between the counselor and the students (Sue & Sue, 2016). As it exists, *The Body Project* has minimal cultural tailoring. However, a motivated school counselor could contrive deeper adaptation through integrating cultural perspectives and concepts familiar to ethnic minorities in their school, which would make the group experience more effective (Antonio & Chung-Do, 2015).

Stice et al. (2013) make it clear that *The Body Project* is aimed very specifically at young females, since they are the most likely to experience ED or eating disorder symptoms. In an email from Dr. Stice, he indicated that there is ongoing work being conducted by Dr. Tiffany Brown and her associates for programs based on *The Body Project* for both cisgender and gay men (E. Stice, personal communication, October 28, 2018). The initial work done by Brown, Forney, Pinner, and Keel (2017) included cognitive dissonance, which is used in *The Body Project* with results showing a lowering of “symptoms across time” (p. 8). In an email, Dr. Brown indicated that there are also continuing studies being conducted for a program aimed at gay men (T. Brown, personal communication, October 31, 2018) that she developed with Dr. Keel (Brown & Keel, 2015). Currently, this program is not available for general use but is undergoing trials, which should be completed by 2022. Dr. Brown believes that *The Body Project* could also be used with adolescent boys effectively (T. Brown, personal communication, October 31, 2018). While it is discouraging to not have ready resources for young men, *The Body Project* is a highly respected program (Buser, 2012), which can positively impact students

in a school setting. Whatever group program is used, a school counselor in the FNSBSD needs to be able to recognize signs that a student may be on a continuum that can range from BID to a full-blown clinical eating disorder (Carney & Scott, 2012).

### **Warning Signs**

Some of the initial signs for disordered eating could be any type of abnormal eating behaviors such as dieting (especially fad diets), eating for reasons other than hunger, such as soothing emotions, and meal skipping (Carney & Scott, 2012). Having a BID is one of the most solid predictors of ED (Le et al., 2017). A school counselor can be aware of discussions surrounding food and eating behaviors. Peers are influential and can create hazards for those who may have more risk factors that can lead to clinical levels of an eating disorder. As a young person moves on the continuum toward developing an eating disorder, behaviors such as food rituals, avoidance of whole food groups, excessive exercise, and constant talk about food and calories may become evident (Carney & Scott, 2012). Understanding the DSM-5 breakdown of various ED is important for a school counselor. Also important for the school counselor to understand is that it is not just thin, upper-class White girls who can display unhealthy behaviors surrounding food.

At some point, a school counselor may have a conversation with a student whom they suspect may be dealing with some level of disordered eating behaviors (Carney & Scott, 2012). Two characteristics of ED are denial and defensiveness. As a result, a student needs to be approached with sensitivity, honesty, and a caring attitude that conveys support for them as a person. It would be profitable to begin with a general discussion of the students' well-being or lack of it before addressing the concerns a school counselor may have about possible disordered

eating behaviors (Carney & Scott, 2012). At this point, having an easy to use screening tool is desirable (Buser, 2012).

### **Screening for ED**

In order to help with the difficult task of evaluating ED, there are many assessments. Tury, Gulec, and Kohls (2009) gave brief descriptions of several measurements for eating and body image disorders. The assessments vary in length, focus, and cost. Engelsen and Laberg (2000) described The Eating Disorder Examination (EDE) as the “golden standard” of assessments for ED. This particular evaluation is ideally administered by an interviewer who has been trained to use proper procedures to gain a detailed picture of an individual’s relationship to ED (Fairburn, 2008). Although an interview-style assessment may be the gold standard for ED, it may not be the best solution in all situations. In a school setting, where time and money are at a premium, a short, inexpensive screening that can be administered by a non-expert would be beneficial.

With the previous criteria in mind, the SCOFF screening tool was developed in the late 1990s in London (Morgan, Reid, & Lacey, 1999) for non-specialists. It was never intended to be a full diagnostic tool but rather a way to alert the screener that the person they are screening may be suffering from an eating disorder (Tury et al., 2009). It has only five questions. The following are the questions as adapted for the U.S.:

1. Do you make yourself **S**ick because you feel uncomfortably full?
2. Do you worry you have lost **C**ontrol over how much you eat?
3. Do you believe yourself to be fat when **O**thers say you are too thin?
4. Have you recently lost more than **F**ourteen pounds in a 3-month period?
5. Would you say that **F**ood dominates your life? (Parker, Lyons, & Bonner, 2005)

A Finnish study by (Hautala et al., 2009) used the SCOFF screening tool and compared it to the health exam given by school nurses for seventh and eighth graders. The nurses were asked if they felt a student was at risk for an eating disorder after giving the standard health exam. In addition, students were given the SCOFF questionnaire by the school nurse. The student would fill out the questionnaire and return it to the nurse as part of the health exam. The result was that only 11% of the students who self-reported as having eating disorder symptoms were assessed by the nurses as being at risk for an eating disorder. Unlike most who use the SCOFF scale, the Finnish study used one positive response to the prompts listed above, rather than two, to determine the cutoff. The SCOFF scale is not perfect in that it has been noted for not always recognizing people who could be at risk (Parker et al., 2005; Tury et al., 2009). Despite that, it is still recognized as a solid tool for screening purposes (Hautala et al., 2009; Tury et al., 2009).

After using a screening tool, if a school counselor suspects that a student is heading toward or already at a clinical level for an eating disorder, they need to be able to work with a student and their family to find what will be most helpful in supporting a student's recovery. The school counselor may need to encourage a medical evaluation along with an evaluation by a qualified counselor who has experience in the area of ED. The American Psychiatric Association has developed a guideline for determining level of care, which can be found in Appendix A. Helping a family make these connections, can go a long way to overcoming the many barriers to receiving treatment. Understanding the types of counseling that are considered the most effective for ED is a critical part of establishing valid referrals.

### **Validated Treatments for Eating Disorder Referrals**

There are three treatments for ED that have validity which will be briefly looked at here. These are family-based treatment (FBT), enhanced cognitive-behavior therapy (CBT-E) and

dialectical behavior therapy (DBT). FBT has been recognized as a solid, verified treatment for adolescents, especially for those with AN (Grange, Lock, Agras, & Bryson, 2015; Lock, 2015; Rienecke, 2017). With some adaptation, it has also been recognized as effective in treating BN (Grange et al., 2015). This treatment is intensive and relies on parents to take responsibility for establishing proper eating patterns in the initial stages. Gradually, responsibility is handed to the adolescent at a point that is right for the age of the teen. Recognizing that there will be challenges in the future, the family is assisted in identifying what these ordeals could be and in developing various coping strategies (Rienecke, 2017).

While agreeing with the effectiveness of FBT, Grave, Calugi, Doll, and Fairburn (2013) suggested that a treatment that is less “labor intensive” would reduce expenses and make help more accessible (p. 9). Fursland et al. (2012) had previously shown that CBT-E was effective in treating a wide range of ED but did not include adolescents in their study. In their small study which used CBT-E, (n=46), Grave et al. (2013) were able to show a good outcome for adolescent patients that was well-maintained over 60 weeks. CBT-E has four stages. The first is a psychoeducational piece that is used to help understand the need for behavioral change. Contemplating the presenting behaviors helps the client to begin to understand their own behaviors (Fursland et al., 2012). The counselor and client work together to determine goals. This stage covers the first seven sessions. The second stage around the eighth session, reviews, in a systemic way, the progress the client is making with the treatment.

The next eight sessions cover the third stage. In this stage, clients examine the factors that keep their eating disorder in place. Once these factors are examined in detail, strategies are developed to eradicate the negative factors. The fourth stage is a transition for the end of treatment and includes looking at potential triggers and what was helpful during treatment to deal



with them. Grave et al. (2013) found that CBT-E was effective with adolescence. The addition of parental involvement was the differing element from the original treatment.

DBT addresses the regulation of emotions and has been shown to help adults with binge-ED (Safer, Lock, & Couturier, 2007). Safer et al. (2007) modified this approach for adolescents and discussed the results from their case study. They indicated that it was effective but too limited to be able to generalize to other girls. A study that Mazzeo et al. (2016) performed indicated that both Black- and White-adolescent girls with BED could benefit from DBT.

Whichever therapy is used for clinical-level ED, a three-pronged approach is essential (Cook-Cottone, 2015). This approach includes a medical evaluation to ascertain if there are physical problems that need to be addressed. The physician also monitors the physical well-being of a young person during and after the therapy process. It is important to have the support of a knowledgeable dietician to ensure a proper diet is tailored to the individual and the specific eating disorder. Last, a therapist or counselor who has training specific to ED needs to help the client work through underlying issues. Each member of the team needs to be in communication with the others to have the best outcome (Buser, 2012). An investigation was conducted to discover if any options are available to people living in Fairbanks, Alaska for the treatment of ED.

### **Resources in Fairbanks, Alaska**

In order to understand the culture of Fairbanks and Anchorage areas, regarding ED, phone calls were made, and emails were sent to counselors, dieticians, school nurses, athletic directors, doctors, and behavioral health units. Some responded; some did not. Enough of a responded to obtain some understanding of the situation in Fairbanks. To start, the school climate will be examined.

School counselors from the FNSBSD that I spoke to indicated that there is no specific training for school counselors in the FNSBSD regarding students exhibiting eating disorder behaviors. The head of the department for nursing services for the FNSBSD, Laurie Schneider, indicated in a phone conversation that the same was true for school nurses. She felt, however, that nurses play a key role in working with students who have an eating disorder, and that it would be important for school counselors and school nurses to work more collaboratively. This would mean dealing ethically with privacy issues in such a way that the best interests of the students are served. Ms. Schneider shared an incident where she was working with a student who had suicidal ideation. She was unaware of the issue due to concerns over confidentiality that the school counselor had. She felt that this was detrimental for the student (L. Schneider, personal communication, October 29, 2018.)

In addition, coaches can play a role in recognition of students who may be dealing with an eating disorder, especially since athletes can be more at risk for ED. The athletic director at West Valley High School, Wayne Sawchuck, stated in a conversation that there is no specific training for coaches in the FNSBSD regarding ED. After looking through the trainings offered to coaches, he found an optional training about nutrition with a subsection on ED. He was given the coaches' toolkit from the National ED Association (NEDA) and was appreciative of the information (W. Sawchuck, personal communication, January, 31, 2019.)

Since there is no specific training for school counselors in the FNSBSD regarding ED, a counselor wanting more information needs to self-educate. There are websites that give a great deal of information. Two websites are NEDA and F.E.A.S.T. The NEDA website offers an educator toolkit that is very useful for understanding ED. In addition, it offers screenings, definitions, resources, and ways to share information about ED. F.E.A.S.T is a website that is

specifically for families with children who suffer with an eating disorder. Like NEDA, F.E.A.S.T offers information in a variety of forms. In addition, it offers ways for families to connect on a global scale to share information and encouragement. Once a school counselor has taken the time to gain valuable information for himself or herself, they can begin to make other school professionals aware of the issue. There are many tools available for doing this, especially on the NEDA and F. E. A.S.T. websites. These websites are important resources that school counselors can share with parents of students with ED. However, when it comes to finding local resources, there are limited options.

The gap for finding expert help for those suffering from ED and its symptoms in the state of Alaska is large. If you go on any site dealing with ED and try to use their search for resources in your area, you will most likely come up with nothing. What does this mean for a school counselor who is trying to assist students and their families to find help? Although there may not be resources specifically for treating ED in Fairbanks, there are people in the area who have an understanding about ED and can give some assistance to students and families. Several local counselors were contacted in the Fairbanks area. Some did not respond; some did not work with people with ED, but there were two that I contacted who had experience and an understanding of what is needed to assist adolescents to overcome ED. Holly Sanborn, who works at Turning Point Counseling Services in Fairbanks, has had experience during her training working in an inpatient unit for those with ED. Although she has not had extensive training for ED, she indicated in a phone conversation that she does understand the importance of working with families and with a team, which includes a physician and dietician (H. Sanborn, personal communication, December 2, 2018.) In a phone conversation, Angela Brown, with Lotus Family Counseling, shared that she has similar attitudes toward working collaboratively with families,

dietitians, and physicians (A. Brown, personal communication, December 2018.) Both counselors use cognitive-behavioral therapy as part of their treatment plan, which has been shown to be an effective treatment for ED. Not all counselors in the Fairbanks area were contacted, so this is not an exhaustive list. The ones selected originated from a google search, followed by phone calls and emails. Those who responded to phone calls and emails were interviewed. Even when they did not work with clients experiencing ED, they were asked for information regarding anyone in the Fairbanks area who does. Section A.6.b. of the ASCA codes advise school counselors to give a list for referrals whenever possible and encourage parents to interview a prospective counselor in order to make an informed personal decision for their children (ASCA, 2016). On its website, NEDA provides a list of questions that parents can use when choosing a counselor (see Appendix B.)

There are dietitians at the Fairbanks Memorial Hospital and the Tanana Valley clinic who are very knowledgeable and can offer help to adolescents with eating disorder symptoms. Dieticians have at least a bachelor's degree and must pass a national examination. Ideally, a dietician with a specialty in eating disorders would be part of a team working with a patient experiencing distress associated with ED. Someone who is a nutritionist does not usually have the same level of training as a dietician and does need to have passed a qualifying exam ("What is the difference between a nutritionist and dietitian?," 2018). However, in the Fairbanks area, there is no one to my knowledge who has a specialty in eating disorders. Katie Garrity works at Fairbanks Memorial hospital (FMH). In an email responding to questions, Ms. Garrity indicated that she has worked with a "handful" of teens in the outpatient clinic who have had ED or eating disorder symptoms. She incorporates families as well as physicians. She reported that it can be a challenge to coordinate care with counselors even when the teen is already working with one

(K. Garrity, personal communication, January 5, 2019.) Shelby Braun works at the Tanana Valley Clinic (TVC). In a conversation with Ms. Braun, she related the extensive research she has done independently on ED. She also indicated that she had hoped to help develop a network of doctors, dietitian and counselors to work specifically with clients dealing with ED at TVC. This did not come about and unfortunately, Ms. Braun will be leaving the Fairbanks area when her military husband is transferred (S. Braun, personal communication, October 31, 2018). Both Ms. Braun and Ms. Garrity are accessible upon referral from a doctor or counselor. With any dietitian, it is always best to also have a physician and counselor working together with them for the benefit of the client (Cook-Cottone, 2015).

There are pediatricians who are aware of eating disorder issues. In a phone interview with Dr. Mishelle Nace, a Fairbanks pediatrician, she strongly asserted that the pediatrician should be on the front lines when it comes to eating-disorder treatment. According to Dr. Nace, any young person who is displaying eating disorder symptoms needs to have a physical exam to eliminate any underlying physical issues. An example she gave was that a student who has undiagnosed cancer may eat little and be losing weight. When it comes to a patient who does have an eating disorder, Dr. Nace believes in coordinating care with a dietitian and counselor. She was asked if there are any counselors in Fairbanks that she would recommend. Her response was that many of the patients who she works with who have an eating disorder are already seeing a counselor. She also mentioned that for both outpatient and inpatient care, insurance is often the driving factor determining where help will be sought (M. Nace, personal communication, February 10, 2019.)

When it comes to anything beyond outpatient care, however, going out of state is the only option. The Fairbanks Memorial Hospital does not provide behavioral health services for

minors. The behavioral health unit at the Tanana Valley Clinic did not respond to emails or phone calls inquiring if they provide services for adolescents who have ED. The hospitals in Anchorage do not provide services for those struggling with ED and will send teens out of state for treatment (personal communication February 26, 2019.) The comment from Providence Mental Health Unit and North Star Behavioral Health was that they did not specialize in eating-disorder treatment and as a result would refer patients out of state (personal communication, February 26, 2019.) Finding an inpatient treatment option takes a coordinated effort between the counselor, physician, and dietitian, as well as the insurance company, according to Dr. Nace (M. Nace, personal communication, February 10, 2019.) If a student does need to have inpatient care, they will need help when they return to integrate back into the school, which may have many triggering elements related to the eating disorder. According to Shelby Braun and Dr. Nace, the school counselor can play a vital role in this process by monitoring the student and allowing them to eat in the counselor's office to reduce the stress associated with eating around a lot of people.

E-therapy (over the Internet) can be a cost-effective way to overcome barriers to receiving treatment in a rural community (Casey, Joy, & Clough, 2013). Prabhakar (2012) even suggests that for some clients, e-therapy allows them to open up in a deeper fashion than face-to-face therapy. School counselors should be aware, however, of possible issues with e-therapy including proper verification of online therapists, proper following of ethical protocols, and possible issues with multistate interactions. Bright Heart Health (Bright Heart Health, 2019) does provide online help through e-therapy and online group interactions. Because finding help for ED is challenging, a web-site and brochure have been developed to assist school counselors in the FNSBSD.

### **Application**

Through research of peer reviewed literature and research regarding resources for the treatment of ED in Fairbanks and the state of Alaska, it is evident that there is a gap in the availability of information for the prevention and treatment of ED in the FNSBSD. In order to assist Fairbanks' school counselors, a website (see appendix C) has been developed for their use in understanding ED and how to help students struggling with them. The address for the website is: <https://jawidman01.wixsite.com/website>. There are three purposes for the website:

1. To provide general information regarding ED,
2. To highlight ways that school counselors can assist students struggling with ED, and
3. To provide links for in-depth exploration of topics relating to ED.

This application is not meant to be exhaustive, nor is it intended to relieve a school counselor's responsibility to verify suggested resources as an appropriate intervention for a student and their family. The school counselor needs to consider the health of the student, family history, and specific areas of diversity including cultural/ethnic identity. Throughout this application, screenshots from the website are provided along with descriptions of them. In addition, an explanation of the purpose of the information on the screenshot is provided.

An additional resource is a handout (see appendix C) for FNSBSD school counselors. It includes basic information regarding ED as well as local and distant resources that can be used by a school counselor. There are links provided, which allow the school counselor to access additional information on ED and their treatment. These resources can be shared through local school counselor meetings, the Alaska School Counseling Association website and yearly meeting, and through reaching out to various districts around the state.

### **Conclusion**

School counselors in the FNSBSD can play a vital role in interacting with students under their care who may be struggling with an eating disorder. They can help prevent clinical-level ED through educational groups and early screening, collaborate and educate stakeholders, and work with parents to find care for students who need additional help. While Fairbanks is limited in in-depth, inpatient care for adolescents with an eating disorder, there are professionals, dietitians, counselors, and doctors who have educated themselves about ED and can offer elementary care for them. School counselors can make use of the resources available to assist students in their schools who have clinical ED or are suffering from eating disorder symptoms.



### References

- Allen, K., Byrne, S., Forbes, D., & Oddy, W. (2009). Risk factors for full- and partial-syndrome early adolescent ED: A population-based pregnancy cohort study. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(8), 800-809.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D. C.: American Psychiatric Association.
- Antonio, C. K., & Chung-Do, J. (2015). Systematic review of interventions focusing on indigenous adolescent mental health and substance use. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center, 22*(3), 36-56.
- ASCA. (2016). ASCA ethical standards for school counselor. Retrieved from <https://www.schoolcounselor.org/asca/media/asca/Ethics/EthicalStandards2016.pdf>
- ASCA. (2017). ASCA National Model. Retrieved from <https://www.schoolcounselor.org/school-counselors/asca-national-model>
- Bagby, J., Barnard-Brak, L., Thompson, L., & Sulak, T. (2015). Is anyone listening? An ecological systems perspective on veterans transitioning from the military to academia. *Military Behavioral Health, 3*(4), 219-229.
- Breithaupt, L., Eickman, L., Byrne, C., & Fischer, S. (2017). REbeL peer education: A model of a voluntary, after-school program for eating disorder prevention. *Eating Behaviors, 25*, 32-37.
- Brendtro, L. (2006). The vision of Urie Bronfenbrenner: Adults who are crazy about kids. *Reclaiming Children and Youth, 15*(3), 162-166.
- Bright Heart Health. (2019). Bright heart health: Expert care online. Retrieved from <https://www.brighthealth.com/>

- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32, 513-531. doi:10.1037/0003-066X.32.7.513
- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22(6), 723-742.
- Bronfenbrenner, U., & Ceci, S. (1994). Nature-nuture reconceptualized in developmental perspective: A bioecological model. *Psychological Review*, 101(4), 568-586.
- Brown, T., Forney, K., Pinner, D., & Keel, P. (2017). A randomized controlled trial of *The Body Project*: More than muscles for men with body dissatisfaction. *International Journal of ED*, 1-11.
- Brown, T., & Keel, P. (2015). A randomized controlled trial of a peer co-led dissonance-based eating disorder prevention program for gay men. *Behaviour Research and Therapy*, 74, 1-10.
- Buser, J. K. (2010). American Indian adolescents and disordered eating. *Professional School Counseling*, 14(2), 1-18.
- Buser, J. K. (2012). The school counselor's role in addressing eating disorder symptomatology among adolescents. *Ideas and Research You Can Use: VISTAS 2012*.
- Campbell, K., & Peebles, R. (2014). ED in children and adolescents: State of the art review. *Pediatrics*, 134(3), 582-592.
- Carney, J. M., & Scott, H. L. (2012). Eating issues in schools: Detection, management, and consultation with allied professionals. *Journal of Counseling & Development*, 90, 290-297.

- Casey, L. M., Joy, A., & Clough, B. A. (2013). The impact of information on attitudes toward e-mental health services. *Cyberpsychology, Behavior, and Social Networking, 16*(8), 593-598. doi:10.1089/cyber.2012.0515
- Cook-Cottone, C. (2015). Incorporating positive body image into the treatment of ED: A model for attunement and mindful self-care. *Body Image, 14*, 158-167.
- Culbert, K., Racine, S., & Klump, K. (2015). Research review: What we have learned about the causes of ED - a synthesis of sociocultural, psychological, and biological research. *Journal of Child Psychology and Psychiatry, 56*(11), 1141-1164.
- Currin, L., & Schmidt, U. (2005). A critical analysis of the utility of an early intervention approach in the ED. *Journal of Mental Health, 14*(6), 611-624.
- Deshane, E. (2015-2016). The other side of the mirror: Eating disorder treatment and gender identity. *LGBTQ Policy Journal at the Harvard Kennedy School, VI*, 89-101.
- Dryer, R., Farr, M., Hiramatsu, I., & Quinton, S. (2016). The role of sociocultural influences on symptoms of muscle dysmorphia and ED in men, and the mediating effects of perfectionism. *Behavioral Medicine, 42*, 174-182.
- Engelsen, B. K., & Laberg, J. C. (2000). A comparison of three questionnaires (EAT-12, EDI, and EDE-Q) for assessment of eating problems in healthy female adolescents. *Nord J Psychiatry, 55*(2), 129-135.
- Fairburn, C. G. (2008). *Cognitive behavior therapy and ED*. New York, NY: Guilford Press.
- Feldman, M., & Meyer, I. (2010). Comorbidity and age of onset of ED in gay men, lesbians, and bisexuals. *Psychiatry Research, 180*, 126-131.
- FNSBSD. (2017). *Fairbanks North Star Borough School District report card for 2016-2017 school year*. Retrieved from Fairbanks, AK:

<https://www.k12northstar.org/cms/lib/AK01901510/Centricity/Domain/1125/Fairbanks-District-Report-Card-2016-2017-Final.pdf>

- Fursland, A., Byrne, S., Watson, H., La Puma, M., Allen, K., & Byrne, S. (2012). Enhanced cognitive behavior therapy: A single treatment for all ED. *Journal of Counseling & Development, 90*, 319-329.
- Garrett, M., & Herring, R. (2001). Honoring the power of relation: Counseling native adults. *Journal of Humanistic Counseling, Education and Development, 40*, 139-160.
- Gordon, K., Brattole, M., Wingate, L., & Joiner, T. (2006). The impact of client race on clinician detection of ED. *Behavior Therapy, 37*, 319-325.
- Gordon, K., Castro, Y., Sitnikov, L., & Holm-Denoma, J. (2010). Cultural body shape ideals and eating disorder symptoms among White, Latina, and Black college women. *Cultural Diversity and Ethnic Minority Psychology, 16*(2), 135-143.
- Grange, D., Lock, J., Agras, S., & Bryson, S. (2015). Randomized clinical trial of family-based treatment and cognitive-behavioral therapy for adolescent bulimia nervosa. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(11), 886-894.
- Grave, R. D., Calugi, S., Doll, H., & Fairburn, C. G. (2013). Enhanced cognitive behaviour therapy for adolescents with anorexia nervosa: An alternative to family therapy? *Behaviour Research and Therapy, 51*, 9-12.
- Gueguen, J., Godart, N., Chambry, J., Brun-Eberentz, A., Foulon, C., Divac, S., . . . Huas, C. (2012). Severe anorexia nervosa in men: Comparison with severe AN in women and analysis of mortality. *International Journal of ED, 45*, 537-545.

- Guss, C., Williams, D., Reisner, S., Austin, S., & Katz-Wise, S. (2017). Disordered weight management behaviors, nonprescription steroid use, and weight perception in transgender youth. *Journal of Adolescent Health, 60*, 17-22.
- Hautala, L., Junnila, J., Alin, J., Gronroos, M., Maunula, A., Karukivi, M., . . . Saarijarvi, S. (2009). Uncovering hidden ED using the SCOFF questionnaire: Cross-sectional survey of adolescents and comparison with nurse assessments. *International Journal of Nursing Studies, 46*, 1439-1447.
- Jones, W., & Morgan, J. F. (2010). ED in men: a review of the literature. *Journal of Public Mental Health, 9*(2), 23-30.
- Juarascio, A., Forman, E., Timko, C., Herbert, J., Butryn, M., & Lowe, M. (2011). Implicit internalization of the thin ideal as a predictor of increases in weight, body dissatisfaction, and disordered eating. *Eating Behaviors, 12*, 207-213.
- Kazdin, A. E., Fitzsimmons-Craft, E. E., & Wilfley, D. E. (2016). Addressing critical gaps in the treatment of ED. *International Journal of ED, 50*, 170-189.
- Kong, P., & Harris, L. (2015). The sporting body: Body image and eating disorder symptomatology among female athletes from leanness focused and nonleanness focused sports.
- Kroon Van Diest, A., Tartakovsky, M., Stachon, C., Pettit, J., & Perez, M. (2014). The relationship between acculturative stress and eating disorder symptoms: Is it unique from general life stress? *Journal of Behavioral Medicine, 37*, 445-457.
- Kwan, M., Gordon, K., & Minnich, A. (2018). An examination of the relationships between acculturative stress, perceived discrimination, and eating disorder symptoms among ethnic minority college students. *Eating Behaviors, 28*, 25-31.

- Latner, J., Knight, T., & Illingworth, K. (2011). Body image and self-esteem among Asian, Pacific Islander, and White college students in Hawaii and Australia. *ED, 19*, 355-368.
- Le, L., Barendregt, J., Hay, P., & Mihalopoulos, C. (2017). Prevention of ED: A systematic review and meta-analysis. *Clinical Psychology Review, 53*, 46-58.
- Linville, D., Stice, E., Gau, J., & O'Neil, M. (2011). Predictive effects of mother and peer influences on increases in adolescent eating disorder risk factors and symptoms: A 3-year longitudinal study. *International Journal of ED, 44*, 745-751.
- Lock, J. (2015). An update on evidence-based psychosocial treatments for ED in children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 44*(5), 707-721.
- Locke, L., Silverman, S., & Spirduso, W. (1998). *Reading and understanding research*. Thousand Oaks, CA: SAGE Publications, Inc.
- Madden, S., Morris, A., Zurynski, Y., Kohn, M., & Elliot, E. J. (2009). Burden of ED in 5-13-year-old children in Australia. *PubMed, 190*(8), 410-414.
- Marques, L., Alegria, M., Becker, A., Chen, C., Fang, A., Chosak, A., & Diniz, J. (2011). Comparative prevalence, correlates of impairment, and service utilization for ED across US ethnic groups: Implications for reducing ethnic disparities in health care access for ED. *International Journal of ED, 44*, 412-420.
- Matos, M., Ferreira, C., Duarte, C., & Pinto-Gouveia, J. (2015). ED: When social rank perceptions are shaped by early shame experiences. *Psychology and Psychotherapy: Theory, Research & Practice, 88*, 38-53.
- Mazzeo, S., Lydecker, J., Harney, M., Palmberg, A., Kelly, N., Gow, R., . . . Stern, M. (2016). Development and preliminary effectiveness of an innovative treatment for binge eating in racially diverse adolescent girls. *Eating Behaviors, 22*, 199-205.

- McCabe, M., Ricciardelli, L., Waqa, G., Goundar, R., & Fotu, K. (2009). Body image and body change strategies among adolescent males and females from Fiji, Tonga and Australia. *Body Image, 6*(299-303).
- Mora, M., Penelo, E., Gutierrez, T., Espinoza, P., Gonzalez, M., & Raich, R. (2015). Assessment of two school-based programs to prevent universal ED: Media literacy and theatre-based methodology in Spanish adolescent boys and girls. *The Scientific World Journal, 2015*. doi:<https://doi.org/10.1155/2015/328753>
- Morgan, J., Reid, F., & Lacey, J. (1999). The SCOFF questionnaire: Assessment of a new screening tool for ED. *BMJ, 319*, 1467-1468.
- Naegele, K. (2013). *Alaska native females: Understanding body image dissatisfaction in a culturally diverse country*. (Master), University of Alaska Fairbanks, Fairbanks, Alaska.
- Naegele, K., & Cook, C. (2017). Body image dissatisfaction (BID) from an Indigenous Alaska native female perspective. *The Northern Review, 45*, 141-160.
- Najjar, R., Jacob, E., & Evangelista, L. (2018). Eating behaviors, weight bias, and psychological functioning in multi-ethnic low-income adolescents. *Journal of Pediatric Nursing, 38*, 81-87.
- NASN. (2018). National association of school nurses code of ethics. Retrieved from <https://www.nasn.org/nasn/nasn-resources/professional-topics/codeofethics>
- NEDA. (2018). National ED association. Retrieved from <https://www.nationaleatingdisorders.org/>
- Neumark-Sztainer, D., Wall, M., Larson, N., Eisenberg, M., & Loth, K. (2011). Dieting and disordered eating behaviors from adolescence to young adulthood: Findings from a 10-

- year longitudinal study. *Journal of the American Dietetic Association*, 111(7), 1004-1011.
- Oluyori, T. (2013). A systematic review of qualitative studies on shame, guilt and ED. *Counselling Psychology Review*, 28(4), 47-59.
- Paolini, A. (2016). School counsellors: Promoting healthy body image amongst adolescents. *International Journal of School and Cognitive Psychology*, 3(1), 1-2.
- Parker, S. C., Lyons, J., & Bonner, J. (2005). ED in graduate students: Exploring the SCOFF questionnaire as a simple screening tool. *Journal of American College Health*, 54(2), 103-107.
- Piran, N. (2015). New possibilities in the prevention of ED: The introduction of positive body image measures. *Body Image*, 14, 146-157.
- Polivy, J., & Herman, C. (2002). Causes of ED. *Annual Review of Psychology*, 53, 187-213.
- Prabhakar, E. (2012). E-therapy: Ethical considerations of a changing healthcare communication environment. *Pastoral Psychology*, 62, 211-218.
- Quatromoni, P. A. (2017). A tale of two runners: A case report of athletes' experiences with ED in college. *Journal of the Academy of Nutrition and Dietetics*, 117(1), 21-31.
- Rance, N., Clarke, V., & Moller, N. (2017). The anorexia nervosa experience: Shame, solitude and salvation. *Counselling & Psychotherapy Research*, 17(2), 127-136.  
doi:10.1002/capr.12097
- Rienecke, R. (2017). Family-based treatment of ED in adolescents: Current insights. *Adolescent Health, Medicine and Therapeutics*, 8, 69-79.
- Roberts, P., & Priest, H. (2006). Reliability and validity in research. *Nursing Standard*(44), 41-47.



- Rodriguez, R., Marchand, E., Ng, J., & Stice, E. (2008). Effects of a cognitive dissonance-based eating disorder prevention program are similar for Asian American, Hispanic, and White participants. *International Journal of ED, 41*(7), 618-625.
- Rohde, P., Stice, E., & Marti, C. N. (2015). Development and predictive effects of eating disorder risk factors during adolescence: Implications for prevention efforts. *International Journal of ED, 48*(2), 187-198.
- Safer, D., Lock, J., & Couturier, J. (2007). Dialectical behavior therapy modified for adolescent binge eating disorder: A case report. *Cognitive and Behavioral Practice, 14*, 157-167.
- Sanchez-Carracedo, D., Fauquet, J., Lopex-Guimera, G., Leiva, D., Punti, J., Trepal, E., . . . Palao, D. (2015). The MABIC project: An effectiveness trial for reducing risk factors for ED. *Behaviour Research and Therapy, 77*, 23-33.
- Schvey, N., Sbrocco, T., Stephends, M., Bryant, E., Ress, R., Spieker, E., . . . Tanofsky-Kraff, M. (2015). Comparison of overweight and obese military-dependent and civilian adolescent girls with loss-of-control eating. *International Journal of ED, 48*(6), 790-794.
- Stice, E., Marti, C. N., Shaw, H., & Jaconis, M. (2009). An 8-year longitudinal study of the natural history of threshold, subthreshold, and partial ED from a community sample of adolescents. *Journal of Abnormal Psychology, 118*(3), 587-597.
- Stice, E., Rohde, P., Butryn, M., Menke, K., & Marti, C. N. (2014). Randomized controlled pilot trial of a novel dissonance-based group treatment for ED. *Behaviour Research and Therapy, 65*, 67-75.
- Stice, E., Rohde, P., & Shaw, H. (2013). *The body project*. New York, NY: Oxford University Press.

- Striegel-Moore, R., Rosselli, F., Holtzman, N., Dierker, L., Becker, A., & Swaney, G. (2011). Behavioral symptoms of ED in Native Americans: Results from the add health survey wave III. *International Journal of ED, 44*(6), 561-566.
- Strother, E., Lemberg, R., Stanford, S., & Turberville, D. (2012). ED in men: Underdiagnosed, undertreated, and misunderstood. *ED, 20*, 346-355.
- Sue, D., & Sue, D. (2016). *Counseling the culturally diverse theory and practice* (7 ed.). Hoboken, N.J.: John Wiley & Sons.
- Suokas, J., Suvisaari, J., Gissler, M., Lofman, R., Linna, M., Raevuori, A., & Haukka, J. (2013). Mortality in ED: A follow-up study of adult eating disorder patients treated in tertiary care, 1995-2010. *Psychiatry Research, 210*, 1101-1106.
- Swanson, S., Crow, S., Le Grange, D., Swendsen, J., & Merikangas, K. (2011). Prevalence and correlates of ED in adolescents: Results from the national comorbidity survey replication adolescent supplement. *Archives of general psychiatry, 68*(7), 714-723.
- Thomas, J., & Schaefer, J. (2013). *Almost anorexic: Is my (or my loved one's) relationship with food a problem?* Hazelden Center City, MN: Harvard University.
- Tury, F., Gulec, H., & Kohls, E. (2009). Assessment methods for ED and body image disorders. *Journal of Psychosomatic Research, 69*, 601-611.
- Tuttle, M., Yordy, M., Appling, B., & Hanley, E. (2018). School counselor and school nurse collaboration: Partnering for K-12 student success. *Journal of School Counseling, 16*(4).
- Vo, M., Lau, J., & Rubinstein, M. (2016). ED in adolescent and young adult males: Presenting characteristics. *Journal of Adolescent Health, 59*, 397-400.

- Weissman, R., & Rosselli, F. (2016). Reducing the burden of suffering from ED: Unmet treatment needs, cost of illness, and the quest for cost-effectiveness. *Behaviour Research and Therapy, 88*, 49-64.
- Widman, J. (2018). School counselor eating disorder toolkit. Retrieved from <https://jawidman01.wixsite.com/website>
- Wilksch, S., Paxton, S., Austin, S., O'Shea, A., & Wade, T. (2017). Outcomes of three universal eating disorder risk reduction programs by participants with higher and lower baseline shape and weight concern. *International Journal of ED, 50*, 66-75.
- Yager, Z., & O'Dea, J. (2005). The role of teachers and other educators in the prevention of ED and child obesity: What are the issues? *ED, 13*, 261-278.
- Zerbe, K. (2016). Psychodynamic issues in the treatment of binge eating: Working with shame, secrets, no-entry, and false body defenses. *Clinical Social Work Journal, 44*, 8-17.

## Appendix A

	<b>Level One: Outpatient</b>	<b>Level Two: Intensive Outpatient</b>	<b>Level Three: Partial Hospitalization (Full-day Outpatient Care)</b>	<b>Level Four: Residential Treatment</b>	<b>Level Five: Inpatient Treatment</b>
<b>Medical Status</b>	Medically stable to the extent that more extensive medical monitoring, as defined in levels 4 and 5, is not required			Medically stable to the extent that intravenous fluids, nasogastric tube feedings, or multiple daily laboratory tests are not needed	<p><b>For adults:</b> Heart rate &lt;40 bpm; blood pressure &lt;90/60 mmHg; glucose &lt;60 mg/dl; potassium &lt;3 mEq/L; electrolyte imbalance; temperature &lt;97.0°F; dehydration; liver, kidney, or cardiac compromise requiring acute treatment; poorly controlled diabetes</p> <p><b>For children and adolescents:</b> Heart rate near 40 bpm; orthostatic blood pressure changes (&gt;20 bpm increase in heart rate or &gt;10 mmHg to 20 mmHg drop); blood pressure &lt;80/50 mmHg; low potassium, phosphate, or magnesium levels</p>
<b>Suicidality</b>	If suicidality is present, inpatient monitoring and treatment may be needed depending on the estimated level of risk				Specific plan with high lethality or intent; admission may also be indicated in patient with suicidal ideas or after a suicide attempt or aborted attempt, depending on the presence of other factors modulating suicide risk
<b>Weight as percentage of healthy body weight</b>	Generally >85%	Generally >80%	Generally >80%	Generally <85%	Generally <85%; acute weight decline with food refusal even if not <85% of healthy body weight
<b>Motivation to recover, including cooperativeness, insight, and ability to control obsessive thoughts</b>	Fair-to good motivation	Fair motivation	Partial motivation; cooperative; patient preoccupied with intrusive, repetitive thoughts >3 hours per day	Poor-to-fair motivation; patient preoccupied with intrusive repetitive thought 4-6 hours a day; patient cooperative with highly structured treatment	Very poor to poor motivation; patient preoccupied with intrusive repetitive thoughts; patient uncooperative with treatment or cooperative only in highly structured environment

**AMERICAN PSYCHIATRIC ASSOCIATION LEVEL OF CARE GUIDELINES FOR PATIENTS WITH EATING DISORDERS**

	<b>Level One: Outpatient</b>	<b>Level Two: Intensive Outpatient</b>	<b>Level Three: Partial Hospitalization (Full-day Outpatient Care)</b>	<b>Level Four: Residential Treatment</b>	<b>Level Five: Inpatient Treatment</b>
<b>Co-occurring disorders substance use, depression, anxiety)</b>	Presence of comorbid condition may influence choice of level of care				Any existing psychiatric disorder that would require hospitalization (i.e., severe depression, addiction, self-harm)
<b>Structure needed for eating/gaining weight</b>	Self-sufficient	Self-sufficient	Needs some structure to gain weight	Needs supervision at all meals or will restrict eating	Needs supervision during and after all meals or nasogastric/special feeding modality
<b>Ability to control compulsive exercising</b>	Can manage compulsive exercising through self-control	Some degree of external structure beyond self-control required to prevent patient from compulsive exercising; rarely a sole indication for increasing the level of care			
<b>Purging behavior (laxatives and diuretics)</b>	Can greatly reduce incidents of purging in an unstructured setting; no significant medical complications, such as cardiac or other abnormalities, suggesting the need for hospitalization			Can ask for and use support from others or use cognitive and behavioral skills to inhibit purging	Needs supervision during and after all meals and in bathrooms; unable to control multiple daily episodes of purging that are severe, persistent, and disabling, despite trials of outpatient care, even if routine laboratory test results reveal no obvious abnormalities
<b>Environmental stress</b>	Others able to provide adequate emotional and practical support and structure		Others able to provide at least limited support and structure	Severe family conflict or problems or absence of family so patient is unable to receive structured treatment in home; patient lives alone without adequate support system	
<b>Geographic availability of treatment program</b>	Patient lives near treatment setting			Treatment program is too distant for patient to participate from home	

(NEDA, 2018)

## Appendix B

Questions to Ask When Interviewing A Therapist from [www.NationalEatingDisorders.org](http://www.NationalEatingDisorders.org)

1. What is your experience and how long have you been treating eating disorder?
2. How are you licensed? What are your training credentials? Do you belong to the Academy for Eating Disorder (AED)? AED is a professional group that offers its members educational trainings every year. This doesn't prove that individuals are up-to-date, but it does increase the chances.
3. How would you describe your treatment style? Many different treatment styles exist. Different approaches may be more or less appropriate for your child and family depending on your child's situation and needs.
4. What kind of evaluation process do you use to recommend a treatment plan? Who all is involved in that planning?
5. What are the measurable criteria you use to assess how well treatment is working? Can you give me a few examples?
6. Do you use published clinical practice guidelines to guide your treatment planning for eating disorder? How?
7. What psychotherapeutic approaches and tools do you use?
8. How do you treat coexisting mental health conditions such as depression or anxiety?
9. How do you decide which approach is best for the patient? Do you ever use more than one approach? When?
10. What kind of medical information do you need? Will a medical evaluation be needed before my child begins treatment?

11. How will you work with my child's other doctors, such as medical doctors, who may need to provide care?
12. How often will you communicate with them?
13. Will you work with my child's school and teachers? How often do you communicate with them?
14. Will medication play a role in my child's treatment?
15. Do you work with a psychopharmacologist if medication seems indicated, or do I find one on my own?
16. What is your availability in an emergency? If you are not available, what are my alternatives?
17. What are your criteria for determining whether a patient needs to be hospitalized?
18. What is your appointment availability? Do you offer after-work or early morning appointments?
19. What happens in counseling sessions? If a particular session is upsetting for my child, will you advise me on how best to support my child?
20. How long does each counseling session last? How many will there be and how often?
21. How often will you meet with me/us as parents?
22. How do you involve key family members or friends?
23. What specific goals will be set for treatment and how will they be communicated?
24. How and when will progress be assessed?
25. How long will the treatment process take? How do you know when recovery is happening and therapy can stop?

26. Do you charge for phone calls or emails from patients or family between sessions? If so, what do you charge, and how, and to whom (insurance company or patient) is that billed?
27. Will you send me written information, a treatment plan, treatment price, etc.? The more information the therapist or facility is able to send in writing, the better informed you will be.
28. Do you deal directly with the insurer or do I need to do that?
29. When is payment due?
30. Are you reimbursable by insurance? What if I don't have insurance or mental health benefits under my health care plan? It is important for you to research your insurance coverage policy, and what treatment alternatives are available in order for you and your treatment provider to design a treatment plan that suits your coverage.

With a careful search, the provider you select will be helpful. If the first time you meet is awkward, don't be discouraged. The first few appointments with any treatment provider can be challenging. It takes time to build trust when you are sharing highly personal information. If you continue feeling that a different therapeutic environment is needed, consider other providers.

(NEDA, 2018)



**Appendix C**

Website and Handout for School Counselors in the Fairbanks North Star Borough School  
District to Provide Information for the Prevention, Recognition and Treatment of ED

By

Joyce Widman

University of Alaska Fairbanks

The website *School Counselor Eating Disorder Toolkit* has been developed to assist school counselors to understand eating disorders, and the importance of addressing the needs of students who may be at risk for developing one. The website can be accessed at <https://jawidman01.wixsite.com/website>. Screenshot 1 for the *School Counselor Eating Disorder Toolkit* (Widman, 2018) shows the title page along with the menu options. Areas covered in this website are: prevention of ED, collaboration with stakeholders and resources for education and treatment for ED. In addition, there is a page with links to other websites and local Fairbanks resources for school counselors to further explore the topic of ED and their treatment.

School Counselor Eating Disorder Toolkit

Home Prevention Collaboration Resources for Treatment Links

Screenshot 1 by author (Widman, 2018)



Fairbanks School Counselor  
Eating Disorder Toolkit

The purpose of the following page (Screenshot 2) on the website is to alert school counselors to the seriousness of ED and the importance of understanding them. ED are the deadliest mental-health disorder with morbidity stemming from both physical damage and emotional trauma leading to suicide (Kazdin, Fitzsimmons-Craft, & Wilfley, 2016; Castillo & Weiselberg, 2017). There is a link to the NEDA home page. The NEDA website has extensive information regarding many aspects of ED (NEDA, 2018).



Screenshot 2 by author (Widman, 2018)

## Educate Yourself, It's Important!

Eating disorders have  
the highest mortality rate  
of any mental illness!

[Get Started!](#)

Screenshot 3 gives a general overview of eating disorder facts. The focus is primarily on additional reasons that a school counselor should be informed about ED due to the prevalence of disordered eating and the age, approximately 14, at which people often develop clinical levels of ED. Screenshots 4-6 give more detailed information about the major categories of ED as defined by the DSM-5 (American Psychiatric Association, 2013). A person with anorexia nervosa avoids an adequate intake of calories for their size and activity level. They are obsessively focused on their body and relate lower body weight to success. Bulimia Nervosa (BN) sufferers have periodic episodes of binge eating which are defined as eating a large amount of food in a short period of time. This is accompanied by a feeling of loss of control and some method of purging. The purging can take the form of, among other things, vomiting, inappropriate use of laxatives and excessive exercise. Since some with nonclinical levels of ED can still experience high levels of stress, the DSM-5 has created a category called "Other Specified Feeding or Eating Disorder" (American Psychiatric Association, 2013). Each of these pages is linked to the NEDA website for further information on the individual disorder.

Screenshot 3 by author (Widman, 2018)

## Understanding Eating Disorders

- You can't tell if someone has an eating disorder by looking at them
- Up to **20%** of adolescents struggle with eating disorders or disordered eating symptoms
- Eating disorders cause physical and emotional harm if left untreated including **higher risk of suicide**
- Most eating disorders begin in early to mid adolescence
- School counselors can help by preventative programs, screening, collaboration and helping parents find resources.



(Gordon, Brattole, Wingate, & Joiner, 2006; Rohde, Stice, & Marti, 2015; Suokas et al., 2013; Castillo & Weiselberg, 2017; Buser, 2012)

## Eating Disorders Defined

Screenshot 4 by author (Widman, 2018)

Eating disorders involve behaviors relating to food consumption that negatively impact an individuals' physical, emotional and/or social life.



### Anorexia Nervosa

A person may be suffering from anorexia nervosa if they:

- have less intake of food than a healthy person requires
- have a powerful aversion to gaining weight
- base their self-worth on their perception of their body

(American Psychiatric Association, 2013)



Screenshot 5 by author (Widman, 2018)

Bulimia Nervosa

A person may have bulimia nervosa if they:

- have repeated incidents of binge eating
- feel a loss of control when eating
- purge through various methods

(American Psychiatric Association, 2013)





Screenshot 6 by author (Widman, 2018)

Other Specified Feeding or Eating Disorder

A person who may have other specified feeding or eating disorder if they:

- suffer physically, emotionally or socially from eating related behaviors that do not fit neatly into a clinical category

(American Psychiatric Association, 2013)

The purpose of Screenshot 7 is to alert the school counselor to the fact that it is impossible to know if a person has an eating disorder simply by looking at them. Individuals experiencing ED are often assumed to be White upper-class, skinny girls. However, Gordon, Brattole, Wingate, and Joiner (2006) state that there has not been a study showing that any ethnic minority group is insusceptible to having an eating disorder. In addition, males can also have ED (Fursland et al. 2012).

Screenshot 7 by author (Widman, 2018)

**Appearance**

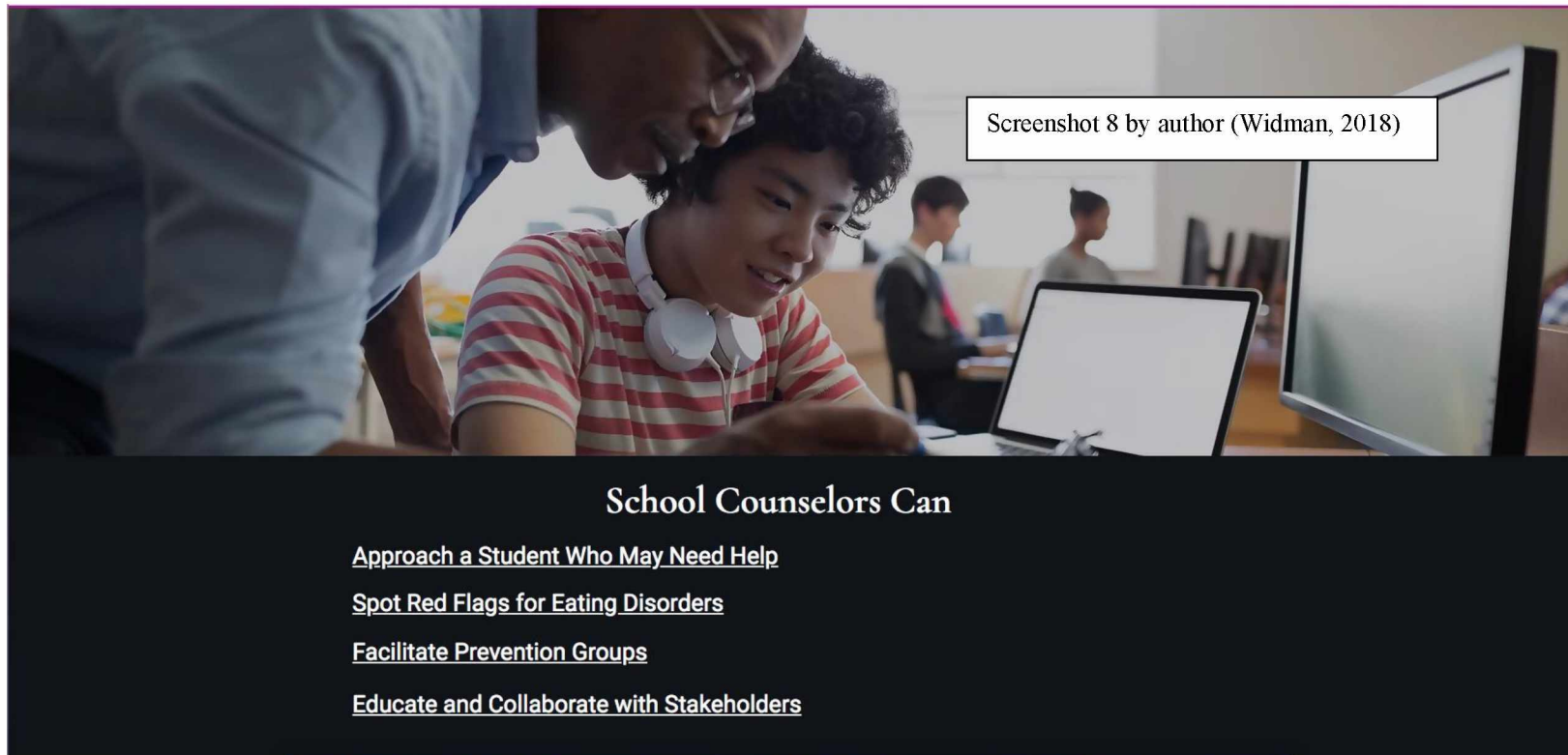
How a person looks, their gender, their socioeconomic level or their race does not determine if a person has or is susceptible to an eating disorder.

[Go to NEDA for more information](#)

(Gordon, Brattole, Wingate, & Joiner, 2006)



There are many ways that a school counselor can help in the prevention and treatment of students with disorder eating symptoms and ED. Screenshot 8 is an overview with details in following screenshots. Each line links to further information on the topic.





The first three links on Screenshot 8 take the browser to the prevention section, which is shown in Screenshots 9–12.

Approaching a student who is suspected of having problems with eating disorder symptoms should be done with a great deal of sensitivity. One of the characteristics for an eating disorder is denial, so approaching a student from a perspective of caring for their general well-being can open a door for further conversation regarding the student's relationship to eating and food (Carney & Scott, 2012).

## Prevention

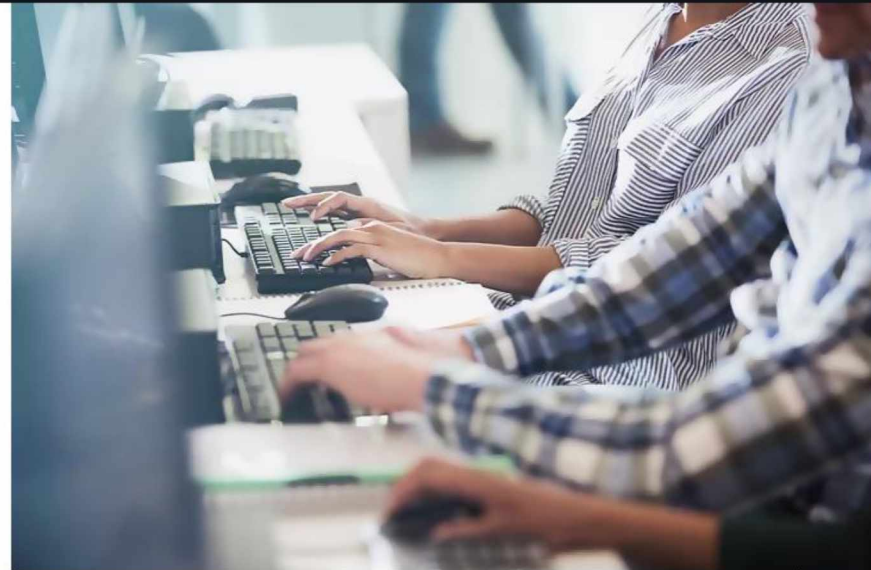
Screenshot 9 by author (Widman, 2018)

Early Screening and Intervention are Imperative

### Approaching a Student

Two characteristics of ED are denial and defensiveness. As a result, a student needs to be approached with sensitivity, honesty and a caring attitude that conveys support for them as a person. It would be profitable to begin with a general discussion of the students' well being or lack of it before addressing the concerns a school counselor may have about the student having an eating disorder. At this point, having an easy to use screening tool is desirable.

(Carney & Scott, 2012)



Screenshot 10 covers the topics of red flags that can signal the presence of an eating disorder and a simple screening that can be done if a school counselor has concerns for a student. There is a link, “Red Flags,” that takes the browser to an extensive list of indicators for ED on the NEDA page. Some of the warning signs are eating for reasons other than hunger, having body-image dissatisfaction, cutting out entire food groups and excessive exercise. The “SCOFF” link takes the browser to the simple SCOFF screening tool, which can indicate the need for further evaluation. This is shown in Screenshot 11.



#### Red Flags and Screening

The earlier an eating disorder is recognized, the easier it is to help a student overcome it. There are several RED FLAGS that can indicate a student may be grappling with an eating disorder and other issues associated with it.

**In a school setting, along with observation, a simple, inexpensive tool is helpful in evaluating the likelihood that a student is struggling at some level with disordered eating or even a clinical level eating disorder. SCOFF is a screening tool that has been in use for many years and has been recognized as valid for initial evaluation.**

(Parker, Lyons, & Bonner, 2005)

# Spot Red Flags

Screenshot 11 by author (Widman, 2018)



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As school counselor's it is important to have tools that are validated, easy to use and cost effective. For initially screening students for an eating disorder, the SCOFF assessment meets all these criteria according to several research articles.

## SCOFF

1. Do you make yourself **S**ick because you feel uncomfortably full?
2. Do you worry you have lost **C**ontrol over how much you eat?
3. Do you believe yourself to be fat when **O**thers say you are too thin?
4. Have you recently lost more than **F**ourteen pounds in a 3-month period?
5. Would you say that **F**ood dominates your life? (Parker, Lyons, & Bonner, 2005)

If a student answers yes to 2 or more questions, further assessment by a counselor or psychologist is warranted.

Screenshot 12 addresses the use of small groups in the school setting. Use of small groups by school counselors has been shown to be effective (Paolini, 2016) and is encouraged by the American School Counselor Association (ASCA, 2016). One of the best-developed group programs for the prevention of ED is *The Body Project* (Stice, Rohde, & Shaw, 2013). It uses dissonance to alert young people to the dishonesty of the media as it presents overly thin, airbrushed models as a positive goal for young people. The program is designed to allow for discussion. It is not intended to be a therapy but rather a preventative measure. Currently, the program is designed for young women. Dr. Tiffany Brown is working toward development of a program that would address young men (T. Brown, personal communication, October 31, 2018).



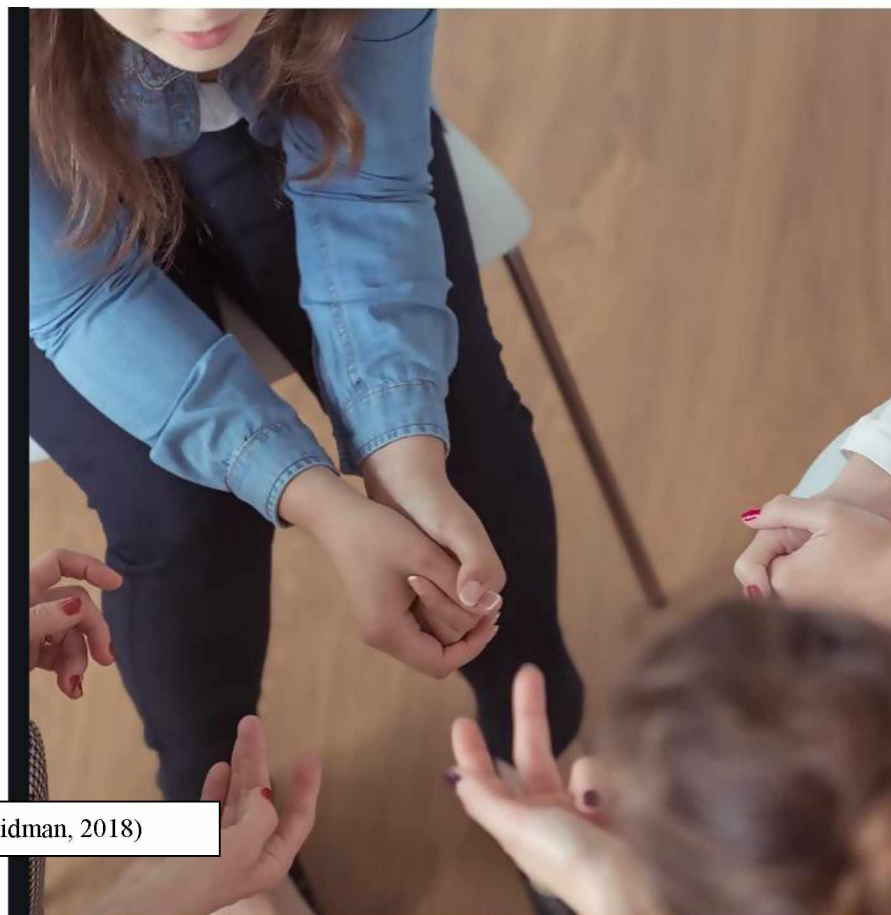
### Prevention through Small Groups

Small groups have been shown to an effective way to work with several students in a school setting. The Body Project is a well validated prevention tool for use with small groups of adolescent girls. According to the NEDA website, the Body Project "provides a forum for women and girls to confront unrealistic beauty ideals and engages them in the development of healthy body image through verbal, written, and behavioral exercises."

(Stice, Rohde, & Shaw, 2013)

Currently, there are groups being developed for young men both LGBTQ and heterosexual. However, they are still in the research and testing stage. If you are interested in participating in the research contact Dr. Tiffany Brown at UCSD: [tiffanybrown@ucsd.edu](mailto:tiffanybrown@ucsd.edu).

Screenshot 12 by author (Widman, 2018)



The fourth link on Screenshot 8, “What School Counselors Can Do,” takes the browser to Screenshots 13–16. These screenshots address four different groups of stakeholders that school counselors can educate and collaborate with in order to address the needs of students who are at risk for developing an eating disorder or who have already developed one. Screenshot 13 addresses interactions with parents. Rienecke (2017) believes that parents are the best resource for recovery for students who have an eating disorder. The ASCA ethical codes acknowledge the importance of parents and guardians in a student's life (ASCA, 2016). As a result, collaborating with parents and guardians as much as possible for the benefit of a student struggling with an eating disorder is vital. Finding solid resources for families is challenging with many barriers that need to be overcome to find adequate help. These barriers include denial that there is an eating disorder by both the student and the family, misdiagnoses by a physician or counselor, fear of misunderstanding and judgment, the high cost of counseling and inpatient services, and the difficulty in finding resources in a small community (Buser, 2012; Kazdin et al., 2016). There are two links on Screenshot 13. The “Find Resources” link takes the browser to the “Links” page on the website which provides connections to the NEDA website and F.E.A.S.T., which is a website developed by and for families dealing with ED. The second link, “Questions,” takes the browser to the NEDA website and offers a list of questions to ask a potential counselor.

## Education and Collaboration

Screenshot 13 by author (Widman, 2018)

### Toolkits for Stakeholders



#### Parents

Parents play a key role in helping a young person overcome an eating disorder. Finding information and help for treatment can be daunting. School counselors can come alongside to help parents overcome barriers and [find resources](#). They can also help families know the [questions](#) to ask potential helpers.

(Buser, 2012; Kazdin et al., 2016)

Screenshot 14 recognizes the importance of educating and collaborating with others on the school staff. Having multiple connections with students raises the chance that someone at risk for developing an eating disorder will be noticed (Currin & Schmidt, 2005). Yager and O'Dea (2005) recognize that most educators do not have a good understanding of ED and the negative impact they can have on students. The link, "Educator Toolkit," takes the browser to the NEDA website and offers a toolkit developed specifically for educators. It includes definitions and ways that educators can be involved with helping students struggling with disordered eating.

Screenshot 14 by author (Widman, 2018)

### Educate School Staff

Having a positive relationship to a student struggling with an eating disorder is important. The more a school staff is educated, the more chance that someone can connect in a meaningful way with a student in need.

(Currin & Schmidt, 2005)

[Educator Toolkit](#)



Screenshot 15 addresses the importance for school counselors to educate and collaborate with coaches in the schools. Students involved with certain types of sports are at increased risk for developing an eating disorder (Kong & Harris, 2015). Participation in sports where appearance is important like dance and gymnastics increases risk for ED. In addition, sports where a thin build is perceived as enhancing performance such as running and swimming increase risk. Sports that have specific weight categories such as wrestling, boxing, and body building, create cultures where the misuse of food is common (Jones & Morgan, 2010). Lastly, athletes who are at a higher level of competition with a goal to participate in college athletics are at a greater risk than other athletes for developing an eating disorder (Quatromoni, 2017). The link, “Coach Toolkit,” takes the browser to the NEDA site with tools for coaches to use in the recognizing athletes who may be in trouble with disordered eating.



Screenshot 15 by author (Widman, 2018)

### Educate Coaches

Athletes can be at an increased risk for eating disorders—coaches need information to create a body positive atmosphere. When educated, coaches can help spot students who may be struggling with an eating disorder.

(Kong & Harris, 2015)

Coach Tool Kit



School nurses can be key people for a school counselor to collaborate with since they can observe and address physical concerns with and for students (Tuttle, Yordy, Appling, & Hanley, 2018). Confidentiality is a concern, however, the ASCA ethical code A.6.a. addresses the need for collaboration to recognize early on when a student is showing evidence of troubling symptoms (ASCA, 2016). Currently, there is no training for nurses in the FNSBSD regarding recognition and treatment of ED (L. Schneider, personal communication, October 29, 2018). The button, "School Counselor/Nurse Collaboration Article," takes the browser to the Tuttle et al. 2018 article on collaboration with nurses.

Screenshot 16 by author (Widman, 2018)

### Collaborate School Nurses

The School Nurse provides another pair of eyes and perspective for evaluating a student who may be at risk for an eating disorder.

[School Counselor/Nurse Collaboration Article](#)

(Tuttle, Yordy, Appling, & Hanley, 2018)



Screenshot 17 lists some local resources a school counselor can share with families in the Fairbanks community who are concerned about a student they suspect may need help with treatment for an eating disorder. The list was developed after many phone calls to various medical options in the Fairbanks community. Some, like the Behavioral Health Unit at Fairbanks Memorial Hospital, do not treat adolescents. Many counselors do not work with people who are dealing with ED. These options in the website are current as of June, 2019. None of the resources specialize in ED, but they have had experience and know approaches for treatment that have been shown to be effective. These would include family therapy, cognitive-behavioral therapy, and dialectical-behavior therapy (Rienecke, 2017; Grave, Calugi, Doll, & Fairburn, 2013; Safer, Lock, & Couturier, 2007). There is a link, "Questions to ask a Possible Counselor," which takes the browser to a NEDA page that lists questions to ask a potential counselor before beginning any kind of treatment.



## Resources for Eating Disorder Treatment

Treatment for eating disorders needs to be approached with a cohort of three professionals: a physician, a counselor and a dietitian who have a good understanding of eating disorders.

Screenshot 17 by author (Widman, 2018)

### Primary Care Physician:

Start with students' personal doctor

### Fairbanks Counselors:

Holly Sanborn at  
[Turning Point Counseling](#)

Angela Brown at  
Lotus Family Counseling  
907-251-1053

### Fairbanks Dietitians:

Shelby Braun at  
Tanana Valley Clinic  
907-459-3500

Katie Garrity at  
Fairbanks Memorial Hospital  
katiekgarrity@gmail.com

[Questions to ask a possible counselor](#)



Screenshot 18 gives some options for online resources. Bright Heart Health is a telemedicine option that includes treatment options for those with ED. They also provide follow-up care for post in-treatment care. Renfrew Center is one example of an inpatient-care option. There are centers around the country but none in the state of Alaska for ED that have reached a level where inpatient care is needed. According to a local pediatrician, what often dictates where a person goes for treatment is the center that is covered by the families' insurance due to the high cost of treatment (M. Nance, personal communication, February 10, 2019).

Following are the links listed on the website:

Bright Heart Health: <https://www.brighthearthealth.com/>

Renfrew Center: <http://renfrewcenter.com/>

NEDA: <https://www.nationaleatingdisorders.org/>

F.E.A.S.T.: <https://www.feast-ed.org/>



Screenshot 18 by author (Widman, 2018)

**Distance Resources**

[Bright Heart Health](#): Provider for telemedicine

[The Renfrew Center](#): In treatment care

[NEDA](#): National Eating Disorders Association

[F.E.A.S.T.](#): Support for Parents

Screenshots 19 and 20 give links to further information and resources regarding ED for school counselors and other stakeholders. NEDA, the National ED Association, is a nonprofit organizations that provides information for individuals, families and professionals. They have a help line, an online screening tool and handouts for various stakeholders. They also provide PowerPoints that can be used to educate people about ED. F.E.A.S.T. is an online community for families with a member suffering from an eating disorder. It is a way to for families connect and offer encouragement to each other. Both NEDA and F.E.A.S.T. offer toolkits and booklets on various topics directed toward different groups of people involved in students' lives. There is also a link to the Body Project website which is the small group-program discussed earlier. In addition, there are links to several articles which have good information for school counselors who would like to learn more. Following are the links in the website.

### **Information on ED**

Neda: <https://www.nationaleatingdisorders.org/learn>

NEDA Tool Kits

Educators: <https://www.nationaleatingdisorders.org/school-community>

Coaches: <https://www.nationaleatingdisorders.org/learn/help/coaches-trainers>

Parents: <https://www.nationaleatingdisorders.org/parent-toolkit>

F.E.A.S.T. - <https://www.feast-ed.org/>

F.E.A.S.T. Tool Kits

Guide to Treatment: <https://simplebooklet.com/treatmentguide#page=0>

Coming to Terms with ED: <https://simplebooklet.com/diagnosisguide#page=0>

Nutrition: <https://simplebooklet.com/nutritionguide2015>

Neurobiology of ED - <https://simplebooklet.com/neuroguide#page=0>

Body Project: <http://www.bodyprojectsupport.org/background>

### **Articles**

Addressing Critical Gaps in the Treatment of Eating Disorders DOI: 10.1002/eat.22670

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

[https://www.counseling.org/Resources/Library/VISTAS/2012\\_Vol\\_1\\_67-104/2\\_2012-ACA-PDFs/Article\\_97.pdf](https://www.counseling.org/Resources/Library/VISTAS/2012_Vol_1_67-104/2_2012-ACA-PDFs/Article_97.pdf)

Eating Issues in Schools: Detection, Management, and Consultation with Allied Professionals DOI: 10.1002/j.1556-6676.2012.00037.x

Screenshot 19 by author (Widman, 2018)

## Tool Kits



[Educators](#)

[Coaches](#)

[Parents](#)

## Parent Resources



### NEDA - National Eating Disorder Association

[Parent Tool Kit](#)

F.E.A.S.T. - The Global Support and Education Community of and for Parents of Those with Eating Disorders

[Guide to Treatment](#)

[Coming to Terms with Eating Disorders](#)

[Nutrition](#)

[Neurobiology of Eating Disorders](#)

Links

Screenshot 20 by author (Widman, 2018)



## National Eating Disorders Association

[NEDA](#)

### Articles

[Addressing Critical Gaps in the Treatment of Eating Disorders](#)

[The School Counselor's Role in Addressing Eating Disorder Symptomatology Among Adolescents](#)

[Eating Issues in Schools: Detection, Management, and Consultation With Allied Professionals](#)

### Small Group Program

[Body Project](#)

Screenshot 21 is a picture of the author and contact information, followed by Screenshot 22, which has the list of references for the website. This website has been developed to fill the gap for school counselors in the FNSBSD. At this time, March 2020, there are no specific trainings or materials developed for working with students experiencing an eating disorder or disordered eating. Online resources and tools to use when addressing ED in the school setting have been compiled. In addition, local resources have been listed, which are current as of this writing.

ED and eating disorder symptoms can have devastating consequences. School counselors, when equipped, are in a position to address students who are at an age when ED are commonly developed. They have contact with important stakeholders in students' lives and can be a part of educating and collaborating with these stakeholders including, parents, guardians, teachers, administrator, nurses and coaches. As individuals who have developed contacts in the local community, school counselors can help in finding treatment options when a student has developed an eating disorder beyond the abilities of the school counselor to treat.





Screenshot 21 by author (Widman, 2018)

### Contact Me - Joyce Widman

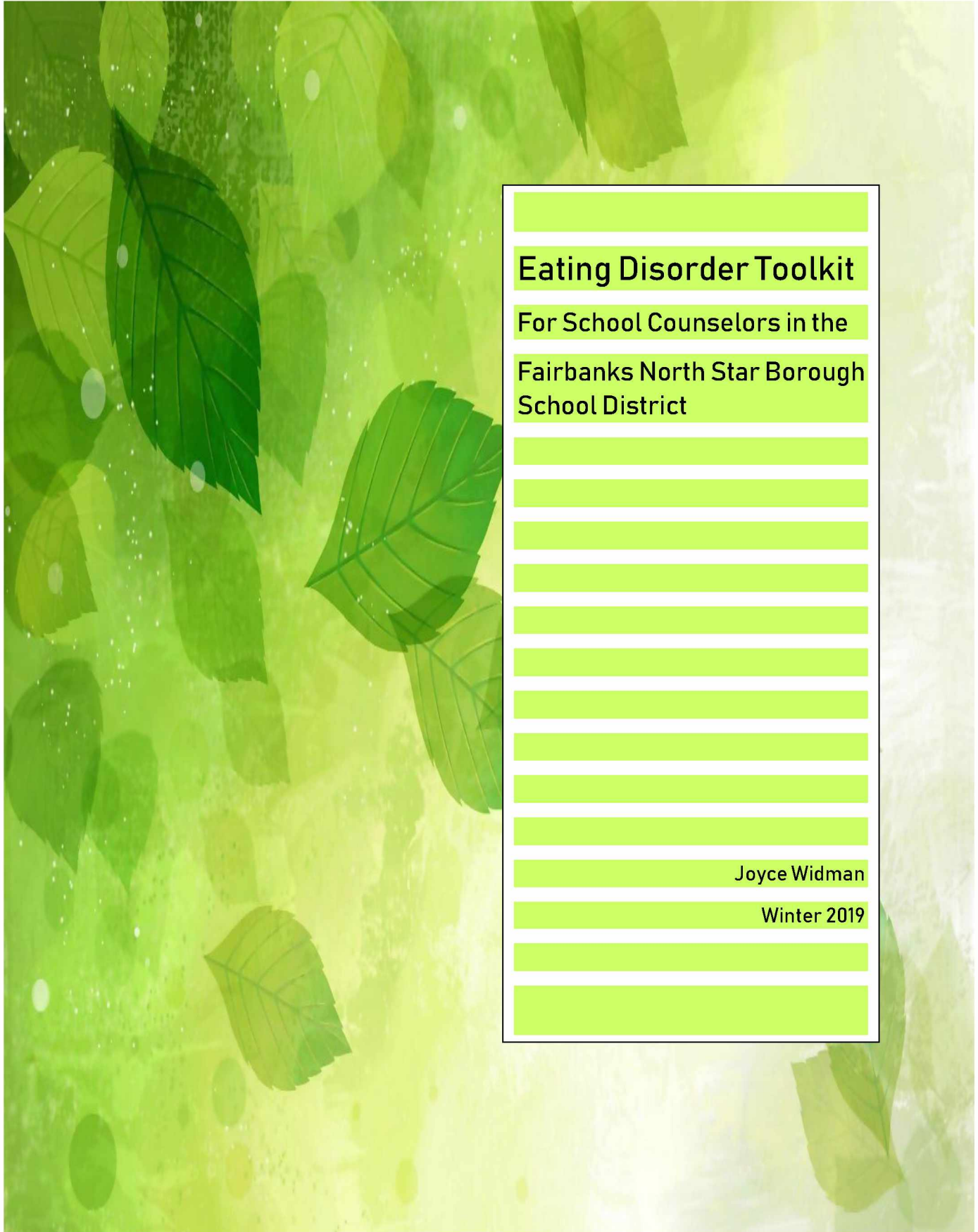
Share ideas and resources that you have found valuable for working with students who are struggling with eating disorders.  
[jawidman01@alaska.edu](mailto:jawidman01@alaska.edu)

## References

Screenshot 22 by author (Widman, 2018)

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D. C.: American Psychiatric Association.
- Buser, J. K. (2012). The school counselor's role in addressing eating disorder symptomatology among adolescents. *Ideas and Research You Can Use: VISTAS 2012*.
- Carney, J. M., & Scott, H. L. (2012). Eating issues in schools: Detection, management, and consultation with allied professionals. *Journal of Counseling & Development, 90*, 290-297.
- Castillo, M., & Weiselberg, E. (2017). *Bulimia nervosa/Purging disorder*. *Current Problems in Pediatric and Adolescent Health Care, 47*, 85-94.
- Currin, L., & Schmidt, U. (2005). A critical analysis of the utility of an early intervention approach in the eating disorders. *Journal of Mental Health, 14*(6), 611-624.
- Gordon, K., Castro, Y., Sitnikov, L., & Holm-Denoma, J. (2010). Cultural body shape ideals and eating disorder symptoms among White, Latina, and Black college women. *Cultural Diversity and Ethnic Minority Psychology, 16*(2), 135-143.
- Kazdin, A. E., Fitzsimmons-Craft, E. E., & Wilfley, D. E. (2016). Addressing critical gaps in the treatment of eating disorders. *International Journal of Eating Disorders, 50*, 170-189.
- Kong, P., & Harris, L. (2015). The sporting body: Body image and eating disorder symptomatology among female athletes from leanness focused and nonleanness focused sports.
- Parker, S. C., Lyons, J., & Bonner, J. (2005). Eating disorders in graduate students: Exploring the SCOFF questionnaire as a simple screening tool. *Journal of American College Health, 54*(2), 103-107.
- Rohde, P., Stice, E., & Marti, C. N. (2015). Development and predictive effects of eating disorder risk factors during adolescence: Implications for prevention efforts. *International Journal of Eating Disorders, 48*(2), 187-198.
- Stice, E., Rohde, P., & Shaw, H. (2013). *The body project*. New York, NY: Oxford University Press.
- Suokas, J., Suvisaari, J., Gissler, M., Lofman, R., Linna, M., Raevuori, A., & Haukka, J. (2013). Mortality in eating disorders: A follow-up study of adult eating disorder patients treated in tertiary care, 1995-2010. *Psychiatry Research, 210*, 1101-1106.
- Tuttle, M., Yordy, M., Appling, B., & Hanley, E. (2018). School counselor and school nurse collaboration: Partnering for K-12 student success. *Journal of School Counseling, 16*(4).

In addition to a website, a handout has been developed to give to school counselors. It has general information about ED plus links to further resources similar to the website.



**Eating Disorder Toolkit**

**For School Counselors in the  
Fairbanks North Star Borough  
School District**

Joyce Widman

Winter 2019



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## Introduction

It is easy to marginalize the need to address ED as a school counselor. School counselors already have many demands on their time, and there are many other issues to address that apply to larger populations. Anorexia nervosa (AN) is probably the eating disorder that most people have heard about. It affects about 0.5% of the population (Suokas et al., 2013). But when other forms of ED are included along with eating disorder symptoms, up to 10% of the population will experience some form of an eating disorder in their lifetime (Kazdin, Fitzsimmons-Craft, & Wilfley, 2016). In addition, the median age for any person to develop an eating disorder is approximately 10–14 years of age, putting high school and middle school counselors in a prime position to recognize young people who may be at risk for developing an eating disorder (Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). Ultrathin, White, adolescent girls are the ones most often associated with ED, but the truth is that ED affect persons of any weight, gender, and ethnicity (Gordon, Brattole, Wingate, & Joiner, 2006). ED have the highest mortality of any mental health disorder due to physical effects and suicide (Campbell & Peebles, 2014; Castillo & Weiselberg, 2017). In addition, those with ED or eating disorder symptoms suffer emotional pain, which can interfere with social interactions, academics, and, of course, physical well-being (Kazdin et al., 2016). It is worthwhile for a school counselor to have an understanding of what ED are, and how they can be addressed in the school setting.



## Eating Disorder Overview

### Consequences of ED are Serious

Individuals who struggle with ED can experience negative effects physically, mentally, and emotionally. Some of the physical effects can be impaired heart function, gastrointestinal issues, a compromised endocrine system, and decreased brain functionality (Castillo & Weiselberg, 2017). Most importantly, those dealing with an eating disorder have higher rates of suicidality. These rates can be as much as 18 times higher than the non-compromised population (Suokas et al., 2013). There are three major categories of ED.

**Anorexia Nervosa** is defined as having food intake insufficient for health requirements and a severe aversion to weight gain. In addition, there is an obsessive preoccupation with the body and perceived imperfections (American Psychiatric Association, 2013).

**Bulimia Nervosa** is a disorder with repeated episodes of binge eating accompanied by feeling like they have lost control. This is then followed by some sort of purging like vomiting, inappropriate use of laxatives or obsessive exercise. In order to be considered a clinical level according to the DSM-5, the binge/purge cycle should occur at least once a week for a duration of a minimum of 3 months (American Psychiatric Association, 2013).

**Binge-Eating Disorder** is the third major category of ED. This is similar to bulimia nervosa (BN) without the purge component. Binging is defined as eating a large amount of food in a short period of time accompanied by significant distress, shame, and guilt. Due to shame this most often occurs in solitude and is not done to satisfy hunger (American Psychiatric Association, 2013).

In addition to these categories, the DSM-5 recognizes that many suffer from ED that do not quite meet the clinical criteria for specific disorders and yet experience life-disrupting distress. Hence the “Other Specified Feeding or Eating Disorder” (OSFED) category was developed (American Psychiatric Association, 2013).

## **What Can a School Counselor Do?**

### **Educate and Collaborate**

In the ASCA Ethical Standards, school counselors are encouraged to collaborate with whatever stakeholders are needed to optimize services to students (ASCA, 2016, §§ A.6.b; B.2.q.). It is impossible for one school counselor to have close connections with all students in a school, so working with all staff members increases the likelihood that someone will have a relationship with each of the students in a school (Currin & Schmidt, 2005). A school counselor can educate staff regarding ED, how to recognize them, and what to do if a student may need further help. Since athletes are more at risk for developing an eating disorder, educating coaches is critical (Kong & Harris, 2015). Nurses are also important staff personal to educate and collaborate with (Tuttle, Yordy, Appling, & Hanley, 2018). Currently, there is no mandated education for either nurses or coaches in the FNSBSD in the area of ED. In addition, educating teachers is important, since they often have connections with students that allow them to see potential problems, especially if they are aware of red flags and the seriousness of ED (Buser, 2012; Currin & Schmidt, 2005). There are several tools already developed by NEDA, including tool kits for educators, coaches, and a PowerPoint presentation. For more information, see the links page.



## Develop Prevention Groups

School counselors are encouraged to use group work to speak to the social/emotional needs of the student body (ASCA, 2016, §A.7.a.). Students in middle and high school are at a developmental point in their lives when they are more susceptible to the development of ED due to physical and emotional changes, peer pressure, and media input (Rohde, Stice, & Marti, 2015). Stopping a clinical level of an eating disorder before it starts by using small groups can prevent the severe consequences of an eating disorder. One of, if not the best, preventative group program for ED is *The Body Project*. This program uses the dissonance between media messages and personal viewpoints to create a space for students to accept their own bodies. This highly interactive program is easily accessible and was created to be used by those with counseling experience (Stice, Rohde, & Shaw, 2013). For more information, see the links page.

## Recognize Signs

While a person with an eating disorder cannot be recognized by body weight, gender, or ethnicity (Gordon, Brattole, Wingate, & Joiner, 2006), there are some warning signs that warrant further investigation.

- ❖ Fad dieting
- ❖ Eating for reasons other than hunger
- ❖ Dissatisfaction with body image
- ❖ Food rituals
- ❖ Avoiding food groups
- ❖ Excessive exercise
- ❖ Obsessive focus on food (Campbell & Peebles, 2014)

## Screen

If a school counselor or another school staff member suspects a student may have issues with disordered eating, a simple screening can be administered. Denial is characteristic of those with ED or eating disorder symptoms, so simply asking a student if they have an eating disorder will most likely be met with defensiveness. Approaching the student with a caring attitude and seeking to ascertain how they are doing in general is a good way to start (Carney & Scott, 2012). A brief, validated, screening called SCOFF can be used to evaluate a student. It can be given directly or in writing and consists of the following questions:

- ❖ Do you make yourself **Sick** because you feel uncomfortably full?
- ❖ Do you worry you have lost **Control** over how much you eat?
- ❖ Do you believe yourself to be fat when **Others** say you are too thin?
- ❖ Have you recently lost more than **Fourteen** pounds in a 3-month period?
- ❖ Would you say that **Food** dominates your life? (Parker, Lyons, & Bonner, 2005)

Two or more yes answers indicate that a student needs further evaluation and is likely to have an eating disorder.

## Working with Families

When a school counselor determines that a student may be experiencing a clinical level of an eating disorder, it is time to support the student and their family in obtaining long-term treatment (ASCA, 2016, §A.1.b). Parents and guardians are key components in developing a plan for treatment. Family-based treatment has been shown to be effective, especially for younger adolescents (Grange, Lock, Agras, & Bryson, 2015; Lock, 2015; Rienecke, 2017). It takes a large time commitment on the family's part for this treatment to be successful. Enhanced

cognitive-behavior therapy (CBT-E) has been shown to be effective for all types of ED and in use with adolescence (Fursland et al., 2012; Grave, Calugi, Doll, & Fairburn, 2013). NEDA has developed a list of questions that are useful for parents when searching for appropriate counseling options (see links page). A three-pronged approach including a physician, counselor, and dietitian has been shown to be necessary for progress with an eating disorder (Cook-Cottone, 2015). With this in mind, it is important for families and students to work with the primary-care physician to rule out the possibility of an underlying physical ailment and to monitor possible physical manifestations of the eating disorder.

## Barriers to Treatment

Once an eating disorder has been diagnosed, there are many barriers to obtaining treatment. It can take as long as 15 months from recognition that help is needed to treatment start. These barriers can include:

- ❖ Denial
- ❖ Misdiagnoses
- ❖ Fear of stigmatization
- ❖ The high cost of treatment, especially inpatient care
- ❖ Finding well-trained counselors, therapists, and programs (Buser, 2012; Kazdin et al., 2016)

## Local Resources

As with most small communities, Fairbanks has limited recourses for mental health disorders, especially ED (Kazdin et al., 2016). While there are no counselors trained extensively to treat ED, there are some who do have valuable experience in this area. As of June 2019, the following are resources in the Fairbanks community that help get a student and their family started in their journey to finding help with an eating disorder:

- ❖ Turning Point Counseling 907-347-7776
  - Holly Sanborn
- ❖ Lotus Family Counseling 907-251-1053
  - Angela Brown
- ❖ Tanana Valley Clinic – Diabetes & Nutrition Education Center 907-459-3500
  - Shelby Braun
- ❖ Fairbanks Memorial Hospital
  - Katie Garrity – [katiegarrity@gmail.com](mailto:katiegarrity@gmail.com)

When it is determined by a physician and/or counselor that a young person needs inpatient treatment, there are no options in the state of Alaska. Finding a treatment center is most often determined in coordination with the counselor, physician, and location. Because of the high cost of treatment, the insurance company often has the final say in choice of treatment center.

### Distance Resources

- ❖ Fairbanks School Counselor Eating Disorder Toolkit [jawidman01.wixsite.com/website](http://jawidman01.wixsite.com/website)
- ❖ Bright Heart Health <https://www.brighthearthealth.com/>
  - This is a telemedicine service which has counselors experienced in treating ED.
- ❖ Renfrew Center <http://renfrewcenter.com/>

- This is an example of an inpatient treatment center for ED. Often the choice of an inpatient facility is determined by insurance parameters along with location.
- ❖ School Counselor Eating Disorder Toolkit <https://jawidman01.wixsite.com/website>

## Links to Information for School Counselors and Families

**Neda:** <https://www.nationaleatingdisorders.org/learn>

### **NEDA Tool Kits:**

Educators: <https://www.nationaleatingdisorders.org/school-community>

Coaches: <https://www.nationaleatingdisorders.org/learn/help/coaches-trainers>

Parents: <https://www.nationaleatingdisorders.org/parent-toolkit>

**F.E.A.S.T.** - <https://www.feast-ed.org/>

### **F.E.A.S.T. Tool Kits:**

Guide to Treatment - <https://simplebooklet.com/treatmentguide#page=0>

Coming to Terms with ED - <https://simplebooklet.com/diagnosisguide#page=0>

Nutrition - <https://simplebooklet.com/nutritionguide2015>

Neurobiology of ED - <https://simplebooklet.com/neuroguide#page=0>

## Articles



Addressing critical gaps in the treatment of ED

DOI: 10.1002/eat.22670

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

[https://www.counseling.org/Resources/Library/VISTAS/2012\\_Vol\\_1\\_67-104/2\\_2012-ACA-PDFs/Article\\_97.pdf](https://www.counseling.org/Resources/Library/VISTAS/2012_Vol_1_67-104/2_2012-ACA-PDFs/Article_97.pdf)

Eating Issues in Schools: Detection, Management, and Consultation With Allied Professionals

DOI: 10.1002/j.1556-6676.2012.00037.x

### Body Project

<http://www.bodyprojectsupport.org/background>

### Conclusion

The website and handout have been developed to give school counselors tools to understand ED and their impact on adolescents. In addition, resources have been given for further investigation into ED. The resources are also useful for educating teachers, coaches and parents. Along with educating, the website and handout encourage collaboration with the school community, parents, and local resources to support and get help for adolescents in the Fairbanks area who suffer from ED and eating disorder symptoms.

### References

Allen, K., Byrne, S., Forbes, D., & Oddy, W. (2009). Risk factors for full-and partial-syndrome early adolescent eating disorders: A population-based pregnancy cohort study. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(8), 800-809.

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D. C.: American Psychiatric Association.
- Antonio, C. K., & Chung-Do, J. (2015). Systematic review of interventions focusing on indigenous adolescent mental health and substance use. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center*, 22(3), 36-56.
- ASCA. (2016). ASCA ethical standards for school counselor. Retrieved from <https://www.schoolcounselor.org/asca/media/asca/Ethics/EthicalStandards2016.pdf>
- ASCA. (2017). ASCA National Model. Retrieved from <https://www.schoolcounselor.org/school-counselors/asca-national-model>
- Bagby, J., Barnard-Brak, L., Thompson, L., & Sulak, T. (2015). Is anyone listening? An ecological systems perspective on veterans transitioning from the military to academia. *Military Behavioral Health*, 3(4), 219-229.
- Breithaupt, L., Eickman, L., Byrne, C., & Fischer, S. (2017). REBEL peer education: A model of a voluntary, after-school program for eating disorder prevention. *Eating Behaviors*, 25, 32-37.
- Brendtro, L. (2006). The vision of Urie Bronfenbrenner: Adults who are crazy about kids. *Reclaiming Children and Youth*, 15(3), 162-166.
- Bright Heart Health. (2019). Bright heart health: Expert care online. Retrieved from <https://www.brighthearthealth.com/>
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32, 513-531. doi:10.1037/0003-066X.32.7.513
- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22(6), 723-742.
- Bronfenbrenner, U., & Ceci, S. (1994). Nature-nuture reconceptualized in developmental perspective: A bioecological model. *Psychological Review*, 101(4), 568-586.
- Brown, T., Forney, K., Pinner, D., & Keel, P. (2017). A randomized controlled trial of *The Body Project*: More than muscles for men with body dissatisfaction. *International Journal of Eating Disorders*, 1-11.
- Brown, T., & Keel, P. (2015). A randomized controlled trial of a peer co-led dissonance-based eating disorder prevention program for gay men. *Behaviour Research and Therapy*, 74, 1-10.
- Buser, J. K. (2010). American Indian adolescents and disordered eating. *Professional School Counseling*, 14(2), 1-18.
- Buser, J. K. (2012). The school counselor's role in addressing eating disorder symptomatology among adolescents. *Ideas and Research You Can Use: VISTAS 2012*.
- Campbell, K., & Peebles, R. (2014). Eating disorders in children and adolescents: State of the art review. *Pediatrics*, 134(3), 582-592.
- Carney, J. M., & Scott, H. L. (2012). Eating issues in schools: Detection, management, and consultation with allied professionals. *Journal of Counseling & Development*, 90, 290-297.
- Casey, L. M., Joy, A., & Clough, B. A. (2013). The impact of information on attitudes toward e-mental health services. *Cyberpsychology, Behavior, and Social Networking*, 16(8), 593-598. doi:10.1089/cyber.2012.0515
- Cook-Cottone, C. (2015). Incorporating positive body image into the treatment of eating disorders: A model for attunement and mindful self-care. *Body Image*, 14, 158-167.
- Culbert, K., Racine, S., & Klump, K. (2015). Research review: What we have learned about the causes of eating disorders - a synthesis of sociocultural, psychological, and biological research. *Journal of Child Psychology and Psychiatry*, 56(11), 1141-1164.
- Currin, L., & Schmidt, U. (2005). A critical analysis of the utility of an early intervention approach in the eating disorders. *Journal of Mental Health*, 14(6), 611-624.

- Deshane, E. (2015-2016). The other side of the mirror: Eating disorder treatment and gender identity. *LGBTQ Policy Journal at the Harvard Kennedy School*, VI, 89-101.
- Dryer, R., Farr, M., Hiramatsu, I., & Quinton, S. (2016). The role of sociocultural influences on symptoms of muscle dysmorphia and eating disorders in men, and the mediating effects of perfectionism. *Behavioral Medicine*, 42, 174-182.
- Engelsen, B. K., & Laberg, J. C. (2000). A comparison of three questionnaires (EAT-12, EDI, and EDE-Q) for assessment of eating problems in healthy female adolescents. *Nord J Psychiatry*, 55(2), 129-135.
- Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. New York, NY: Guilford Press.
- Feldman, M., & Meyer, I. (2010). Comorbidity and age of onset of eating disorders in gay men, lesbians, and bisexuals. *Psychiatry Research*, 180, 126-131.
- FNSBSD. (2017). *Fairbanks North Star Borough School District report card for 2016-2017 school year*. Retrieved from Fairbanks, AK: <https://www.k12northstar.org/cms/lib/AK01901510/Centricity/Domain/1125/Fairbanks-District-Report-Card-2016-2017-Final.pdf>
- Fursland, A., Byrne, S., Watson, H., La Puma, M., Allen, K., & Byrne, S. (2012). Enhanced cognitive behavior therapy: A single treatment for all eating disorders. *Journal of Counseling & Development*, 90, 319-329.
- Garrett, M., & Herring, R. (2001). Honoring the power of relation: Counseling native adults. *Journal of Humanistic Counseling, Education and Development*, 40, 139-160.
- Gordon, K., Brattole, M., Wingate, L., & Joiner, T. (2006). The impact of client race on clinician detection of eating disorders. *Behavior Therapy*, 37, 319-325.
- Gordon, K., Castro, Y., Sitnikov, L., & Holm-Denoma, J. (2010). Cultural body shape ideals and eating disorder symptoms among White, Latina, and Black college women. *Cultural Diversity and Ethnic Minority Psychology*, 16(2), 135-143.
- Grange, D., Lock, J., Agras, S., & Bryson, S. (2015). Randomized clinical trial of family-based treatment and cognitive-behavioral therapy for adolescent bulimia nervosa. *Journal of the American Academy of Child & Adolescent Psychiatry*, 54(11), 886-894.
- Grave, R. D., Calugi, S., Doll, H., & Fairburn, C. G. (2013). Enhanced cognitive behaviour therapy for adolescents with anorexia nervosa: An alternative to family therapy? *Behaviour Research and Therapy*, 51, 9-12.
- Gueguen, J., Godart, N., Chambry, J., Brun-Eberentz, A., Foulon, C., Divac, S., . . . Huas, C. (2012). Severe anorexia nervosa in men: Comparison with severe AN in women and analysis of mortality. *International Journal of Eating Disorders*, 45, 537-545.
- Guss, C., Williams, D., Reisner, S., Austin, S., & Katz-Wise, S. (2017). Disordered weight management behaviors, nonprescription steroid use, and weight perception in transgender youth. *Journal of Adolescent Health*, 60, 17-22.
- Hautala, L., Junnila, J., Alin, J., Gronroos, M., Maunula, A., Karukivi, M., . . . Saarijarvi, S. (2009). Uncovering hidden eating disorders using the SCOFF questionnaire: Cross-sectional survey of adolescents and comparison with nurse assessments. *International Journal of Nursing Studies*, 46, 1439-1447.
- Jones, W., & Morgan, J. F. (2010). Eating disorders in men: a review of the literature. *Journal of Public Mental Health*, 9(2), 23-30.
- Juarascio, A., Forman, E., Timko, C., Herbert, J., Butryn, M., & Lowe, M. (2011). Implicit internalization of the thin ideal as a predictor of increases in weight, body dissatisfaction, and disordered eating. *Eating Behaviors*, 12, 207-213.
- Kazdin, A. E., Fitzsimmons-Craft, E. E., & Wilfley, D. E. (2016). Addressing critical gaps in the treatment of eating disorders. *International Journal of Eating Disorders*, 50, 170-189.



- Kong, P., & Harris, L. (2015). The sporting body: Body image and eating disorder symptomatology among female athletes from leanness focused and nonleanness focused sports.
- Kroon Van Diest, A., Tartakovsky, M., Stachon, C., Pettit, J., & Perez, M. (2014). The relationship between acculturative stress and eating disorder symptoms: Is it unique from general life stress? *Journal of Behavioral Medicine, 37*, 445-457.
- Kwan, M., Gordon, K., & Minnich, A. (2018). An examination of the relationships between acculturative stress, perceived discrimination, and eating disorder symptoms among ethnic minority college students. *Eating Behaviors, 28*, 25-31.
- Latner, J., Knight, T., & Illingworth, K. (2011). Body image and self-esteem among Asian, Pacific Islander, and White college students in Hawaii and Australia. *Eating Disorders, 19*, 355-368.
- Le, L., Barendregt, J., Hay, P., & Mihalopoulos, C. (2017). Prevention of eating disorders: A systematic review and meta-analysis. *Clinical Psychology Review, 53*, 46-58.
- Linville, D., Stice, E., Gau, J., & O'Neil, M. (2011). Predictive effects of mother and peer influences on increases in adolescent eating disorder risk factors and symptoms: A 3-year longitudinal study. *International Journal of Eating Disorders, 44*, 745-751.
- Livingston, D., & Sammons, L. (2006). The effects of eating disorders on student academic achievement and the school counselor's role. *Perspectives in Learning, 7*(1), 35-37.
- Lock, J. (2015). An update on evidence-based psychosocial treatments for eating disorders in children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 44*(5), 707-721.
- Locke, L., Silverman, S., & Spirduso, W. (1998). *Reading and understanding research*. Thousand Oaks, CA: SAGE Publications, Inc.
- Madden, S., Morris, A., Zurynski, Y., Kohn, M., & Elliot, E. J. (2009). Burden of eating disorders in 5-13-year-old children in Australia. *PubMed, 190*(8), 410-414.
- Marques, L., Alegria, M., Becker, A., Chen, C., Fang, A., Chosak, A., & Diniz, J. (2011). Comparative prevalence, correlates of impairment, and service utilization for eating disorders across US ethnic groups: Implications for reducing ethnic disparities in health care access for eating disorders. *International Journal of Eating Disorders, 44*, 412-420.
- Matos, M., Ferreira, C., Duarte, C., & Pinto-Gouveia, J. (2015). Eating disorders: When social rank perceptions are shaped by early shame experiences. *Psychology and Psychotherapy: Theory, Research & Practice, 88*, 38-53.
- Mazzeo, S., Lydecker, J., Harney, M., Palmberg, A., Kelly, N., Gow, R., . . . Stern, M. (2016). Development and preliminary effectiveness of an innovative treatment for binge eating in racially diverse adolescent girls. *Eating Behaviors, 22*, 199-205.
- McCabe, M., Ricciardelli, L., Waqa, G., Goundar, R., & Fotu, K. (2009). Body image and body change strategies among adolescent males and females from Fiji, Tonga and Australia. *Body Image, 6*(299-303).
- Mora, M., Penelo, E., Gutierrez, T., Espinoza, P., Gonzalez, M., & Raich, R. (2015). Assessment of two school-based programs to prevent universal eating disorders: Media literacy and theatre-based methodology in Spanish adolescent boys and girls. *The Scientific World Journal, 2015*. doi:<https://doi.org/10.1155/2015/328753>
- Morgan, J., Reid, F., & Lacey, J. (1999). The SCOFF questionnaire: Assessment of a new screening tool for eating disorders. *BMJ, 319*, 1467-1468.
- Naegele, K. (2013). *Alaska native females: Understanding body image dissatisfaction in a culturally diverse country*. (Master), University of Alaska Fairbanks, Fairbanks, Alaska.
- Naegele, K., & Cook, C. (2017). Body image dissatisfaction (BID) from an Indigenous Alaska native female perspective. *The Northern Review, 45*, 141-160.
- Najjar, R., Jacob, E., & Evangelista, L. (2018). Eating behaviors, weight bias, and psychological functioning in multi-ethnic low-income adolescents. *Journal of Pediatric Nursing, 38*, 81-87.

- NASN. (2018). National association of school nurses code of ethics. Retrieved from <https://www.nasn.org/nasn/nasn-resources/professional-topics/codeofethics>
- NEDA. (2018). National eating disorders association. Retrieved from <https://www.nationaleatingdisorders.org/>
- Neumark-Sztainer, D., Wall, M., Larson, N., Eisenberg, M., & Loth, K. (2011). Dieting and disordered eating behaviors from adolescence to young adulthood: Findings from a 10-year longitudinal study. *Journal of the American Dietetic Association, 111*(7), 1004-1011.
- Oluoyi, T. (2013). A systematic review of qualitative studies on shame, guilt and eating disorders. *Counselling Psychology Review, 28*(4), 47-59.
- Paolini, A. (2016). School counsellors: Promoting healthy body image amongst adolescents. *International Journal of School and Cognitive Psychology, 3*(1), 1-2.
- Parker, S. C., Lyons, J., & Bonner, J. (2005). Eating disorders in graduate students: Exploring the SCOFF questionnaire as a simple screening tool. *Journal of American College Health, 54*(2), 103-107.
- Piran, N. (2015). New possibilities in the prevention of eating disorders: The introduction of positive body image measures. *Body Image, 14*, 146-157.
- Polivy, J., & Herman, C. (2002). Causes of eating disorders. *Annual Review of Psychology, 53*, 187-213.
- Prabhakar, E. (2012). E-therapy: Ethical considerations of a changing healthcare communication environment. *Pastoral Psychology, 62*, 211-218.
- Quatromoni, P. A. (2017). A tale of two runners: A case report of athletes' experiences with eating disorders in college. *Journal of the Academy of Nutrition and Dietetics, 117*(1), 21-31.
- Rance, N., Clarke, V., & Moller, N. (2017). The anorexia nervosa experience: Shame, solitude and salvation. *Counselling & Psychotherapy Research, 17*(2), 127-136. doi:10.1002/capr.12097
- Rienecke, R. (2017). Family-based treatment of eating disorders in adolescents: Current insights. *Adolescent Health, Medicine and Therapeutics, 8*, 69-79.
- Roberts, P., & Priest, H. (2006). Reliability and validity in research. *Nursing Standard, 44*, 41-47.
- Rodriguez, R., Marchand, E., Ng, J., & Stice, E. (2008). Effects of a cognitive dissonance-based eating disorder prevention program are similar for Asian American, Hispanic, and White participants. *International Journal of Eating Disorders, 41*(7), 618-625.
- Rohde, P., Stice, E., & Marti, C. N. (2015). Development and predictive effects of eating disorder risk factors during adolescence: Implications for prevention efforts. *International Journal of Eating Disorders, 48*(2), 187-198.
- Safer, D., Lock, J., & Couturier, J. (2007). Dialectical behavior therapy modified for adolescent binge eating disorder: A case report. *Cognitive and Behavioral Practice, 14*, 157-167.
- Sanchez-Carracedo, D., Fauquet, J., Lopex-Guimera, G., Leiva, D., Punti, J., Trepal, E., . . . Palao, D. (2015). The MABIC project: An effectiveness trial for reducing risk factors for eating disorders. *Behaviour Research and Therapy, 77*, 23-33.
- Schvey, N., Sbrocco, T., Stephends, M., Bryant, E., Ress, R., Spieker, E., . . . Tanofsky-Kraff, M. (2015). Comparison of overweight and obese military-dependent and civilian adolescent girls with loss-of-control eating. *International Journal of Eating Disorders, 48*(6), 790-794.
- Stice, E., Marti, C. N., Shaw, H., & Jaconis, M. (2009). An 8-year longitudinal study of the natural history of threshold, subthreshold, and partial eating disorders from a community sample of adolescents. *Journal of Abnormal Psychology, 118*(3), 587-597.
- Stice, E., Rohde, P., Butryn, M., Menke, K., & Marti, C. N. (2014). Randomized controlled pilot trial of a novel dissonance-based group treatment for eating disorders. *Behaviour Research and Therapy, 65*, 67-75.
- Stice, E., Rohde, P., & Shaw, H. (2013). *The body project*. New York, NY: Oxford University Press.

- Striegel-Moore, R., Rosselli, F., Holtzman, N., Dierker, L., Becker, A., & Swaney, G. (2011). Behavioral symptoms of eating disorders in Native Americans: Results from the add health survey wave III. *International Journal of Eating Disorders, 44*(6), 561-566.
- Strother, E., Lemberg, R., Stanford, S., & Turberville, D. (2012). Eating disorders in men: Underdiagnosed, undertreated, and misunderstood. *Eating Disorders, 20*, 346-355.
- Sue, D., & Sue, D. (2016). *Counseling the culturally diverse theory and practice* (7 ed.). Hoboken, N.J.: John Wiley & Sons.
- Suokas, J., Suvisaari, J., Gissler, M., Lofman, R., Linna, M., Raevuori, A., & Haukka, J. (2013). Mortality in eating disorders: A follow-up study of adult eating disorder patients treated in tertiary care, 1995-2010. *Psychiatry Research, 210*, 1101-1106.
- Swanson, S., Crow, S., Le Grange, D., Swendsen, J., & Merikangas, K. (2011). Prevalence and correlates of eating disorders in adolescents: Results from the national comorbidity survey replication adolescent supplement. *Archives of general psychiatry, 68*(7), 714-723.
- Thomas, J., & Schaefer, J. (2013). *Almost anorexic: Is my (or my loved one's) relationship with food a problem?* Hazelden Center City, MN: Harvard University.
- Tury, F., Gulec, H., & Kohls, E. (2009). Assessment methods for eating disorders and body image disorders. *Journal of Psychosomatic Research, 69*, 601-611.
- Tuttle, M., Yordy, M., Appling, B., & Hanley, E. (2018). School counselor and school nurse collaboration: Partnering for K-12 student success. *Journal of School Counseling, 16*(4).
- Vo, M., Lau, J., & Rubinstein, M. (2016). Eating disorders in adolescent and young adult males: Presenting characteristics. *Journal of Adolescent Health, 59*, 397-400.
- Weissman, R., & Rosselli, F. (2016). Reducing the burden of suffering from eating disorders: Unmet treatment needs, cost of illness, and the quest for cost-effectiveness. *Behaviour Research and Therapy, 88*, 49-64.
- What is the difference between a nutritionist and dietitian? (2018). Retrieved from <https://nutritionsciencedegree.org/what-is-the-difference-between-a-nutritionist-and-a-dietician/>
- Widman, J. (2018). School counselor eating disorder toolkit. Retrieved from <https://jawidman01.wixsite.com/website>
- Wilksch, S., Paxton, S., Austin, S., O'Shea, A., & Wade, T. (2017). Outcomes of three universal eating disorder risk reduction programs by participants with higher and lower baseline shape and weight concern. *International Journal of Eating Disorders, 50*, 66-75.
- Yager, Z., & O'Dea, J. (2005). The role of teachers and other educators in the prevention of eating disorders and child obesity: What are the issues? *Eating Disorders, 13*, 261-278.
- Zerbe, K. (2016). Psychodynamic issues in the treatment of binge eating: Working with shame, secrets, no-entry, and false body defenses. *Clinical Social Work Journal, 44*, 8-17.