Intuition: The BYU Undergraduate Journal in Psychology

Volume 12 | Issue 1 Article 4

2017

The Influence of Group Dynamics on Eating Disorders

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Abstract:
Eating disorders can have a devastating effect on individuals both physically and psychologically. For this reason, it is important to understand diverse factors, including group dynamics, that affect the development of eating disorders. I examined the influence of group dynamics on whether eating disorders are viewed as acceptable. Further understanding of social influence may enhance the prevention of eating disorders.
Keywords: eating disorders, anorexia nervosa, bulimia, binging, binge eating, group dynamics, groupthink, in-groups, out-groups

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GROUP DYNAMICS AND EATING DISORDERS

Formation

At a time when obesity is more common than ever before, the simultaneous preoccupation with pencil-thin bodies may be understandable (Ogden, Carroll, Kit, & Flegel, 2012). Eating disorders are associated with physical, such as anemia, constipation, and osteoporosis, and are often accompanied by mental disorders, such as depression, anxiety disorders, and substance abuse (American Psychological Association, 2011). Eating disorders develop from several factors ("Eating Disorders," 2011). In particular, group interactions may be a key factor in the reinforcement of destructive eating patterns (Day & Keys, 2008).

Consequently, changing negative group dynamics might prevent the development of eating disorders. For example, Marcos, Sebastian, Aubalat, Ausina, and Treasure (2013) argued that harmful role models may promote the development of such disorders, and Kao, Rogers, Spitzmueller, Lin, & Lin (2014) urged that educational efforts led by positive mentors could reduce the prevalence of eating disorders.

Factors in the Development of Eating Disorders

Environmental and biological factors influence the

development of eating disorders. Easter (2011) focused on the influence of genes, emphasizing the genetic predisposition to mental disorders, including addictions, as part of a "complex causal eating model" (p. 23). Other factors in the model included culture, gender, family, and personality.

Similarly, Fay and Lerner (2013) found that individuals with a higher likelihood of eating pathology and body dissatisfaction tended to be female, perceived themselves as overweight, had higher-than-average actual body weights, and experienced lower self-esteem. They authors reported that long-term participation in sports in general had no effect on the likelihood of eating disorders. Anderson, Petrie, Reel, and SooHoo (2013) studied body-weight pressures in female athletes and found that sports, such as gymnastics, presented a "greater risk due to a heightened focus on appearance as it relates to performance success" (p. 138).

Group Dynamics as a Factor in the Etiology of Eating Disorders

According to Cruwys et al. (2012) the groups a person interacts with play a critical role in her or his eating habits, for example, menu choices (see Ellisoin, 2014). Cruwys et al. found that

the degree to which a person identified as a member of a group corresponded directly to t group's influence on menu preferences determine eating habits. Similarly, Howland, Hunger, and Mann (2012) found that, as Friend A in a dyad changed or restricted her or his eating habits, Friend B changed her or his as well and not only when around Friend A but also in private.

Marcos, Sebastián, Aubalat, Ausina, and Treasure (2013) reported that f peers and family members influenced an individual's body image and body-image satisfaction. Crandall (1988) found that binge eating was a social norm among college women who belonged to sororities and that popularity increased with more frequent binging.

An Example of Media Influence

To illustrate the powerful influence of media, I will describe an extreme case of eating disorders as lifestyle. The online group Ana and Mia support anorexia nervosa and bulimia as personal lifestyle choices (Day & Key, 2008). This virtual group initially challenged the image that a person with an eating disorder is passive and helpless. Instead, they sought to empower women diagnosed with such orders by providing dangerous "tips

and tricks." They also reinforced the thin-female body image (Harshbarger, Ahlers-Schmidt, Mayans, Mayans, & Hawkins, 2009).

Family Group Therapy for Eating Disorders

Brauhardt, Zwaan, and Hilbert (2014) reported on the treatment of eating disorders occurs within a treatment framework that may include admission to a hospital or specialized center in order to gain weight to a predetermined point; individual, group, and family psychotherapy or counseling; multidisciplinary social and occupational therapy; and prolonged outpatient follow-up after discharge (see also Ben-Tovim, 2003).

Family counseling and family therapy are often part of the treatment. For example, , a therapist might work not only the individual who has been diagnosed but with her or his family as well (Bean, Louks, Kay, Cornella-Carlson, & Weltzin, 2010).

The Maudsley method (McCullough, 2013).is a form of family therapy based on the idea that parents play an important role in a child's recovery from an eating disorder and is aimed to empower the family to find solutions to problems associated

with the disorder. (Rather than blaming the family for the disorder, they are viewed as a force for good (Bean et al. , 2010). The eating-disorder patient's parents have an essential role in reaching three treatment goals: restoring the patient's body weight to normal levels based on height and age, placing the responsibility for eating choices on the patient, and helping the patient work through emotional and physical developmental issues that may be restricting recovery (Bean et al., 2010). This method takes these aims and divides them into three phases. The first goal is to restore a healthy body in order to prevent common secondary health issues, such as malnutrition, primary hypothermia, cardiac dysfunction, psychological and cognitive deficits, and growth and hormonal changes. To achieve the second goal, the therapeutic process might include conversations about other settings, such as school or specific social events, and how the patient can maintain a healthy body weight within them. Throughout the course of family therapy, the therapist may help the patient and other family members to establish appropriate relational boundaries with the family (McCullough, 2013).

Initially, parents of children with eating disorders may feel powerless and guilty. In one family's experience (Parent

& Parent, 2007), the parents observed their daughter Ann'.s g failed attempts at treatment. They began to educate themselves about treatment options and discovered the Maudsley method. After consulting with the family's Maudsley treatment team, which consisted of a child psychiatrist, his staff, and Ann's pediatrician, Ann began the process of refeeding. Her parents were encouraged to find ways to help Ann manage her eating. According to the parents, "We learn[ed]…her destructive behaviors and her insistence that she 'didn't want to get better' were all just symptoms of an illness over which she had no meaningful control" (p. 72). They reported that, as they were consistent in helping her eat and expressing their love for her, her body weight increased. Conflicts about weight gain were not as extensive as they were previously (McCullough, 2013). The last of her symptoms to remit were fear of eating and displeasure in eating. Four months after reaching her healthy body weight, Ann was able to return to school.

Other Approaches

As members of a group interact, one or more members of the group may model eating habits for other group members (Cruwys et al., 2012). Positive group dynamics, such as those

in the case study described above, may lead to lasting recovery from eating disorders. Current methods for eating-disorder prevention include two strategies: "inoculation" and early-adolescence intervention. Inoculation refers to the effort to educate people about the negative effects of eating disorders (Brauhardt, de Zwaan, & Hilbert, 2014). It assumes that, if the devastating effects that permeate the media are understood, a person's resistance to them will increase. Early intervention requires the detection of likely symptoms, such as body-image dissatisfaction and repetitive dieting, during adolescence and providing intervention promptly.

Mentoring can also be effective (Kao et al., 2014). Schools may be an ideal setting for the implementation of such programs (Smith & Hollman, 2013). Older students could be selected to serve as mentors to younger students regarding exercise and wellness, healthy eating, and other factors related to the development of eating disorders.

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