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The effects of movement, relaxation, and education on the stress levels of women with subclinical levels of bulimia

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Abstract

The purpose of this study was to assess the impact of a multidisciplinary intervention program on the attitudes and symptoms associated with bulimia nervosa (BN). The Bulimia Test (BULIT) and subscales from the Eating Disorder Inventory-2 (EDI-2) associated with BN were administered to 373 females to determine eligibility for participation in the study. In order to qualify for the study, participants had to be female, not be anorexic, and meet one of four criteria indicating that they had some of the symptoms of BN. Following the screening, 12 females were randomly assigned to a control group (C, n = 6) or an intervention group (I, n = 6). The I group then participated in an 8-week multidisciplinary intervention program consisting of small group discussions, movement improvisation, and relaxation techniques. Dependent variables consisted of scores from standardized instruments for anxiety, self-esteem, and BN. A multivariate analysis of variance (MANOVA) on the difference score from post- to pretest was calculated for state and trait anxiety. That analysis indicated that compared to the C group, which showed no reduction in anxiety, the I group had a significant reduction in anxiety following the intervention program. No significant differences were found between groups for self-esteem or symptoms of BN. Conclusions were that anxiety levels were lowered in the I group; however, attitudes or behaviors associated with BN were not affected by the intervention.

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Keywords: Bulimia; Movement therapy; Relaxation; Education; State-Trait Anxiety Inventory; Self-esteem

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1. Introduction

Research has shown that women with bulimia nervosa (BN) report higher levels of distress than a nondisordered-eating group (Soukup, Beiler, & Terrell, 1990). According to the interpersonal stress theory, a stressful antecedent triggers binge eating, and this overeating becomes a learned response to external and internal stress stimuli (Laessle et al., 1991). Hetherington, Altemus, Nelson, Bernat, and Gold (1994) found that anxiety levels were higher before eating a meal intended for purging relative to a nonpurged meal, both before and after the binge. However, one hour after the meal, anxiety increased in those who binged and did not purge. Furthermore, increased guilt, shame, and anger have been found after binge eating and purging (Kaye et al., 1992). A vicious cycle ensues—distress, binge, purge, guilt, and increased distress.

The relationship between the distress caused by stressful life events and eating disorder symptoms is bidirectional and complex (Shatford & Evans, 1986). Distress predicts eating disorder symptoms, and eating disorder symptoms predict increased distress (Rosen, Compas, & Tacy, 1993). Researchers have found that women with increased stressinduced cortisol reactivity consumed more calories than women who had low stressinduced cortisol reactivity when exposed to a laboratory stressor (Epel, Lapidus, McEwen, & Brownell, 2001). Even preference for food intake was affected by stress reactivity, as high cortisol reactors also ate significantly more sweet food. However, other studies have demonstrated that eating disorders in and of themselves create substantial stress in patients' lives (Hetherington et al., 1994; Rosen et al., 1993). For example, one study found that adolescents with eating disorders reported a greater number of stressful life events than non-eating-disordered adolescents only when eating disorder-related events were included in the analysis (Sharpe, Ryst, Hinshaw, & Steiner, 1997). According to Fryer, Waller, and Kroese (1997) stress should be considered both as a risk factor for eating disorders and a target for intervention. Many researchers have advocated the use of stress management strategies in preventative interventions for populations at high risk for developing eating disorders (Epel et al., 2001; Hetherington et al., 1994; Laessle et al., 1991; Soukup et al., 1990).

Group interventions targeting eating disorders have typically provided psychoeducational information about the symptoms of ED, the consequences of these behaviors, and healthy weight control techniques. While some of these psychoeducational group interventions have met with success (Jones & Stone, 1992), many of these interventions resulted in no positive changes (Carter, Stewart, Dunn, & Fairburn, 1997; Mann et al., 1997). Stice, Mazotti, Weibel, and Argras (2000) experimented with a covert prevention program that did not explicitly present information on eating disorder symptoms but used cognitive dissonance theory, and preliminary results were positive. Based on comparative studies, cognitive—behavioral therapy used alone or in combination with other techniques has resulted in the most significant reductions of binge eating and/or purging (McGillery & Pryor, 1998). While cognitive—behavioral interventions have met with partial success for some (Smolak, Levine, & Schermer, 1998), a small number of individuals with BN may not benefit at all (Wilson, 1996). Researchers have cited the need for creative and innovative intervention approaches

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