Available online at www.sciencedirect.com
ScienceDirect
Appetite 48 (2007) 289–300
Appetite
www.elsevier.com/locate/appet

Research report

College students' mental models for recognizing anorexia and bulimia nervosa

Jennifer S. Hunt[a,*], Alexander J. Rothman[b]

[a]Department of Psychology, University of Nebraska-Lincoln, 238 Burnett Hall, Lincoln NE 68588-0308, USA
[b]Department of Psychology, University of Minnesota, 75 East River Road, Minneapolis MN 55455-0344, USA

Received 7 July 2005; received in revised form 1 May 2006; accepted 19 May 2006

Abstract

Knowledge about eating disorders influences lay people's ability to recognize individuals with anorexia nervosa (AN) and bulimia nervosa (BN) and refer them to professional treatment. We assessed mental models (stored knowledge) of AN and BN in 106 college students. Results indicated that most students have general, but not specific, information about AN and BN's symptoms, consequences, causes, duration, and cures. They also believe that people with eating disorders tend to be young, White women. These findings suggest that lay recognition of eating disorders may be based primarily on observations of dysfunctional eating behaviors and therefore facilitated by additional knowledge.
© 2006 Published by Elsevier Ltd.

Keywords: Anorexia nervosa; Bulimia nervosa; Mental models of illness; Health attitudes

Introduction

Consider the following scenario: Becky, a college sophomore, recently has noticed unusual behavior in her roommate, Molly, who has become more reserved and secretive. Although she sometimes goes to meals, she never seems to eat much. She also complains about being cold and tired. Becky is concerned that there is something wrong with Molly, but she is not sure exactly what the problem is or what to do about it.

Eating disorders such as anorexia nervosa (AN) and bulimia nervosa (BN) affect millions of individuals (Becker, Grinspoon, Klibanski, & Herzog, 1999). They can lead to serious physical and psychological outcomes, including bone damage, cardiac problems, infertility, malnutrition, depression, and death (Fairburn & Harrison, 2003; Sullivan, 1995; Treasure & Szmukler, 1995). It therefore is critical that individuals with AN and BN are appropriately diagnosed and treated.

Peers and family members may play an important role in recognizing disordered eating and suggesting that an individual needs professional care (Campbell & Roland, 1996; Price & Desmond, 1990; Pritts & Susman, 2003; Suls, Martin, & Leventhal, 1997; Tsogia, Copello, & Orford, 2001). However, the ability of lay people to recognize potential eating disorders depends on their knowledge of the behavioral, physical, and psychological characteristics associated with AN and BN. For example, how Becky responds to her roommate depends on whether she knows that minimal eating, coldness, and fatigue are potential indicators of AN. Thus, to understand, and ultimately improve, help-seeking for eating disorders, it is necessary to assess what lay people know about AN and BN.

In this paper, we provide detailed data about knowledge and beliefs about AN and BN in a group that is particularly likely to encounter it, college students. We first discuss the role of lay people in eating disorder referrals as well as previous research about lay people's knowledge of AN and BN. We then describe a study that

*Corresponding author. Tel.: +1 1402 472 4591; fax: +1 1402 472 4637.
E-mail addresses: jhunt@unlserve.unl.edu (J.S. Hunt), rothm001@umn.edu (A.J. Rothman).

0195-6663/$ - see front matter © 2006 Published by Elsevier Ltd.
doi:10.1016/j.appet.2006.05.013

comprehensively assesses college students' mental models of AN and BN. Finally, we discuss the implications of the research for understanding lay recognition of AN and BN and for increasing lay referrals.

The importance of lay referrals for AN and BN

Over the lifespan, AN is diagnosed in approximately 0.5–1% of the population and BN is diagnosed in approximately 1–4% of the population (American Psychiatric Association [APA], 2000; Fairburn, Hay, & Welch, 1993; Hsu, 1996; Wakeling, 1996). According to the DSM-IV-TR (APA, 2000), there are four diagnostic criteria for AN: (1) failure to sustain a minimally normal weight, (2) extreme fear of weight gain, (3) distorted body image or excessive emphasis on weight in self-evaluation, and (4) amenorrhea (i.e., absence of menstruation). BN has five criteria: (1) repeated occurrences of binge eating, (2) repeated instances of compensatory behaviors (e.g., purging, laxative abuse) to prevent weight gain, (3) episodes of binge eating and compensatory behaviors at least twice per week for 3 months, (4) excessive emphasis on weight in self-evaluation, and (5) disordered eating behaviors that occur separately from periods of AN.

Epidemiological research indicates that a much larger portion of the population regularly engages in disordered eating behaviors, such as intentional starvation and purging (French, Perry, Leon, & Fulkerson, 1995; Heatherton, Nichols, Mahamedi, & Keel, 1995; Serdula et al., 1993; Story, French, Resnick, & Blum, 1995). For example, approximately 12% of teenagers report chronic dieting or purging to lose weight (Ackard, Neumark-Sztainer, Hannan, French, & Story, 2001; Story et al., 1995). Although many individuals who report dysfunctional eating may not have full-blown eating disorders, they still may require medical and/or psychological intervention to restore healthy eating and bodily functioning (Pritts & Susman, 2003).

Notably, eating disorders often go undetected (Hay, Marley, & Lemar, 1998; King, 1989; Whitehouse, Cooper, Vize, Hill, & Vogel, 1992) due to factors such as lack of familiarity among physicians, the ambiguity of related symptoms (e.g., fatigue), and the presence of comorbid conditions (Blumenthal, Gokhale, Campbell, & Weissman, 2001; Pritts & Susman, 2003). A key factor may involve the unwillingness of many individuals with AN and BN to seek treatment (Becker et al., 1999; Pritts & Susman, 2003), thus requiring another lay person, such as a friend or family member, to intervene (Campbell & Roland, 1996; Suls et al., 1997; Tsogia et al., 2001). School counselors have reported that students with eating disorders often come to their attention through referrals by other students, teachers, or parents (Price & Desmond, 1990). Likewise, interviews with family members may constitute an important source of information for physicians to diagnose eating disorders (Pritts & Susman, 2003). However, for such lay referral to occur, people need to be well-informed about the physical, psychological, and behavioral indicators of eating disorders.

Lay knowledge about eating disorders

Research from different disciplines indicates that people form cognitive representations of their knowledge about specific health problems. One framework asserts that *mental models of illness* contain information about several dimensions of a condition, including its (1) *identity* or nature (i.e., symptoms), (2) *causes*, (3) short- and long-term *consequences*, (4) *duration*, and (5) *cure* (Lau & Hartman, 1983; Leventhal, Nerenz, & Steele, 1984). Another framework, *mental health literacy* (Jorm, 2000), posits that cognitive representations of illnesses include this information as well as the ability to recognize a condition, attitudes about seeking treatment, and knowledge about how to obtain additional information. Despite minor differences, both frameworks assert that illness representations serve several functions, including organizing information about health problems, helping individuals plan and implement treatment strategies, and serving as schemas to guide the recognition and interpretation of new information (Jorm, 2000; Leventhal et al., 1984). As a result, they may influence whether people notice health-relevant information (e.g., low body weight), interpret it as indicative of a health problem (e.g., connect it with AN), and respond to it in an appropriate manner (e.g., encourage a friend to see a doctor).[1]

To date, eight studies have assessed some aspect of lay people's mental models of eating disorders (Butler, Slade, & Newton, 1990; Chiodo, Stanley, & Harvey, 1984; Furnham & Hume-Wright, 1992; Huon, Brown, & Morris, 1988; Lee, 1997; Mond, Hay, Rodgers, Owen, & Beumont, 2004a–c; Murray, Touyz, & Beumont, 1990; Smith, Pruitt, Mann, & Thelen, 1986). Typically, these studies have measured people's ability to recognize accurate information about AN or BN, for example, by labeling statements as true or false. Results indicate that the majority of lay people believe that excessive dieting is the primary characteristic of AN, and binge eating and purging is the primary characteristic of BN (Huon et al., 1988; Murray et al., 1990; Smith et al., 1986). They also believe that psychological factors (e.g., emotional problems), and social factors (e.g., pressure to be slim) can lead to eating disorders (Chiodo et al., 1984; Furnham & Hume-Wright, 1992; Huon et al., 1988; Lee, 1997; Mond et al., 2004b, Smith et al., 1986). They think BN can be treated by counselors, general practitioners, self-help groups, and better nutrition. Finally, lay people appear to be more knowledgeable about AN than BN, but few report detailed

[1] Although mental health literacy is a somewhat broader concept than mental models of illness, the current article focuses on features shared by both frameworks (e.g., knowledge about the nature of an illness and its consequences and treatments). Thus, for sake of simplicity, from this point forward, we will use the term, mental models, to refer to research from both traditions.

دریافت فوری ← متن کامل مقاله

ISIArticles
مرجع مقالات تخصصی ایران

✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
✓ امکان دانلود نسخه ترجمه شده مقالات
✓ پذیرش سفارش ترجمه تخصصی
✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
✓ دانلود فوری مقاله پس از پرداخت آنلاین
✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات