

EATING DISORDERS REVIEW®



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One Year Later

Eating Disorders Awareness and Prevention Act: Still Not a Reality

Mary K. Stein, Managing Editor

House Bill 3928, introduced in Congress last spring, would have enabled states and local agencies to use federal funds to develop their own eating disorders awareness and prevention programs (see *EDR*, May/June 2000). The bill also

calls for a national public awareness campaign. The information campaign, specifically targeted at teens and young adults, would warn of the dangers presented by eating disorders.

This January, Representative Judy Biggert (R-IL), who wrote and introduced the original bill, reintroduced the amended bill as H.R. 46, "The Eating Disorders Awareness and Prevention Act of 2001," in the 107th Congress. The bill was referred to the Committee on Education and the Workforce, where it languishes on hold, at least for the time being.

Chris Close, Rep. Biggert's press secretary, reports that most of the House of Representatives' attention is currently focused on President Bush's Education Program, a fact that has delayed hearings on H.R. 46. Close added that one positive change that might help the amended bill move forward came when Rep. Biggert became a

Why the Delay?

member of the Education Committee. The bill has been slightly amended, but it is still designed to amend title VI of the Elementary and Secondary Education Act of 1965, to raise awareness of eating disorders and to create educational programs concerning eating disorders and for other purposes. The bill specifically mentions increasing awareness of eating disorders among parents and students and developing programs to train educators (such as teachers, school nurses, school social workers, coaches, school counselors and administrators). States and local municipalities would be allowed to use federal funds to develop and design their own eating disorders awareness and prevention programs. These programs could include teacher training programs, programs to develop role modeling, and mentoring programs. Funding would come from expansion of the

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own eating disorders awareness and prevention programs. These programs could include teacher training programs, programs to develop role modeling, and mentoring programs. Funding would come from expansion of the

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A program to provide a national education and awareness program rests in committee.

Update

Anorexia Nervosa: Clues to Weight Regain

Are there clinical clues that might predict which patients with anorexia nervosa (AN) will regain weight while attending a day treatment program? Dr. Marion P. Olmsted reported that those who achieved complete weight restoration with day hospital treatment were more attuned to their affective experience, and to feelings of hunger and satiety. They were less self-critical when coping with stressful situations, and also less likely to report stealing in the past. The study included 64 AN patients who attended a 4-day-per-week day hospital program. The patients had a mean BMI on admission of 16.9, and had been ill a mean of 8.3 years. Compared to the other patients, those who regained their weight had lower pretreatment scores on the Interoceptive Awareness subscale of the Eating Disorders Inventory, and lower scores on the Self-Criticism subscale of the Coping Strategies Inventory. The study was reported at the Eating Disorders Research Society meeting in November.

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allowable uses of the Innovative Education Strategic Block Grant program.

As the bill states, "The purposes of the act are (1) to provide states, local school districts and parents with the means and flexibility to improve awareness of, identify, and help students with eating disorders" and (2) to help ensure that such individuals receive a quality education and secure their chance for a bright future."

Public Service Announcements

Another portion of the bill calls for public service announcements, directing the Secretary of Education and the Secretary of Health and Human Services and the National Institutes of health "to carry out a program to develop, distribute, and promote the broadcasting of public service announcements to improve public awareness and to promote

the identification and prevention of eating disorders.

The bill also requests that a study be conducted by the National Center for Education Statistics and the National Center for Health Statistics no more than 18 months after the bill is enacted. The goal would be to evaluate the impact of eating disorders on educational advancement and achievement. The hope is to evaluate the extent to which students with eating disorders are more likely to miss school have delayed rates of development, or state and local programs to educate youth about the dangers of eating disorders as well as to evaluate the value of such programs. Finally, the study will make recommendations on measures that Congress, and the Department of Education, states, and local educational agencies can undertake to strengthen eating disorder prevention and awareness programs.

Olanzapine and Weight Gain in Anorexia Nervosa

Patients treated with olanzapine (Zyprexa), an atypical antipsychotic agent, often complain about excessive weight gain. Thus, it has been hypothesized that the drug could be useful in the treatment of anorexia nervosa. Indeed, in one study of two patients with chronic anorexia nervosa, use of olanzapine resulted in improved weight gain and maintenance of weight, as well as decreased anxiety and agitation in both (*Int J Eat Disord* 2000;27:363).

A more recent study of 41 female inpatients diagnosed with either restricting (26) or purging (15) anorexia nervosa showed very different results. Jill A. Gaskill, MSN, CRNP and colleagues at Western Psychiatric Institute and Clinic, Pittsburgh, reported that use of olanzapine was *not* associated with a greater weight gain among the 41 inpatients with AN. The study results were presented at a poster session at the Academy for Eating Disorders Meeting in May in Vancouver.

Higher doses did not make a difference

Twenty-one of the patients received a daily dose of 1.25 mg of olanzapine,

unless they were on a higher dosage at admission. The dosage was increased by 1.25 mg every 2-4 days, to reach a target dose of 5.9 mg/day unless patients complained of excessive sedation or orthostasis. At discharge, the average dose was 5.77 mg/day. The patients gained an average of 1.21 kg/week and the percent ideal body weight increased significantly over the course of treatment, from nearly 73% at admission to 84% at discharge.

Just as in the earlier study, patients receiving olanzapine were less anxious and agitated than the other patients during refeeding. Higher doses of olanzapine, such as more than 5 mg/day, did not lead to greater weight gain than lower doses, such as those below 5 mg/day.

The authors note that the result is not surprising in an inpatient setting, where caloric intake is maximized and fully monitored. They would like to see another study, one designed to see if use of olanzapine is associated with greater weight gain among AN patients in an outpatient setting, when caloric intake is less tightly controlled and restoring optimal body weight is an ongoing challenge.

Searching for Effective Outpatient Therapy for Adults with Anorexia Nervosa

Adult patients with relatively intractable anorexia nervosa may benefit significantly from outpatient psychological treatments, often without the need for hospital admission, according to British researchers. The group found that family therapy and psychoanalytic psychotherapy were effective outpatient approaches (*Br J Psychiatry* 2001;178).

Dr. Chris Dare and colleagues at the Maudsley Hospital, London, designed a randomized controlled study of 3 types of therapy, family therapy, focal psychoanalytic psychotherapy, and cognitive analytic therapy, among 84 consecutive patients referred to their hospital. These patients (average age: 26) were randomly assigned to one of four types of treatment: family therapy, focal psychoanalytic psychotherapy, cognitive analytic therapy, or low-contact routine therapy (control group) for 1 year.

Most of the patients were severely underweight (average BMI:15.4); 2 were male. Binge-eating and purging were common and frequent: 19 patients binge-ate at least weekly or daily and 30 vomited weekly or daily. The group had been ill for a mean of more than 6 years. Seventy-nine percent had been previously treated for their eating disorders. Thus, the patients had a fairly poor prognosis (late age of onset, long duration of illness, and a history of unsuccessful treatment).

Two approaches

In focal psychoanalytic psychotherapy, a short-term approach, the therapist takes a nondirective stance, giving no advice about eating behavior or other problems or symptoms. Instead, the focus is on addressing the conscious and unconscious meanings of the symptoms in terms of the patient's history and experiences with their family. The 50-minute therapy sessions were scheduled for once a week for 1 year.

Cognitive analytic therapy includes elements for cognitive therapy and brief, focused psychodynamic psychotherapy. The therapist helps the patient develop a formal "map" of the structure and place of anorexia nervosa in their lives and experience. In the CAT sessions, some contact with parents and/or the partner of the patient took place and their relationship to the patient was a topic during therapy. CAT sessions were scheduled for 90 minutes weekly during the first 20 weeks, then monthly for 3 months.

The family therapy sessions lasted 60 to 75 minutes and were scheduled by negotiation for a time between once per week and once every 3 weeks. The therapists saw the patient with his or her partner or spouse or parents for most of the sessions. A "dose" of individual patient-therapist contact was used at least once every 3 sessions.

"Routine" treatment was designed to be low-contact outpatient management, in which patients attended 30-minute sessions with a psychiatrist in the second or third year of training. Specific information about the nature and outcome of anorexia nervosa was given and the therapist encouraged the patients to develop a more regular and sustainable diet; regular monitoring of physical activity was also included. A senior clinician supervised the psychiatrists once a week. (The authors note that a serious disadvantage of this approach was the inexperience of the psychiatric trainees and turnover when trainees left the unit after 6 months to continue their training elsewhere.)

Weight gain better in specialized treatment groups

Overall, more than two-thirds of the patients remained abnormally underweight at the end of the study. No statistically significant difference was reported between

the two types of specialized treatment. However, in the "routine" treatment group, nearly half the patients gained no weight, and only 20% gained more than 10% of their pretreatment weight. In the specialized treatment groups, two-thirds of the patients gained weight, and between 23% and 38% gained at least 10%.

About a third of patients in the 3 specialized treatment groups no longer met DSM III-R criteria for anorexia nervosa at the end of the year. In contrast, only 5% of those in the "routine" treatment group no longer met the criteria for anorexia nervosa.

The authors note that patients with relatively intractable anorexia nervosa may benefit greatly from outpatient psychosocial treatment, often without the need for hospital admission. However, outpatient psychotherapy is not the treatment of choice because some patients are so ill that they will have to be hospitalized for life-saving care.

Gene Variation and Anorexia Risk

Studies of families and twins have shown that one form of a gene active in appetite stimulation may make some individuals more susceptible to developing anorexia nervosa, but thus far identifying the specific genes involved has been elusive.

Now researchers in the Netherlands and Germany report they have linked a particular form of a gene, agouti-related protein (AGRP), to susceptibility to anorexia nervosa. According to Dr. T. Vink, of University Medical Center, Utrecht, the Netherlands, this gene may more than double a person's risk of developing the eating disorder (*Molecular Psychiatry* 2001;6:325).

AGRP signals the brain that the body needs food. However, the gene variant may be less effective in signaling the brain during times of hunger. AGRP is only a single component and the scientists believe that a number of genes work with environmental influences to trigger anorexia nervosa and other eating disorders. One potentially helpful sidelight is that drugs that mimic AGRP activity may help stimulate normal appetite in some anorexia nervosa patients.

National Screening Program Shows Impact of Education

Last spring, the National Eating Disorders Screening Program (NEDSP) undertook the first nationwide eating disorders screening project in American high schools. The goal of the project

was to encourage teens with symptoms of untreated eating disorders to seek help. One year

later, investigators have shown that educational materials—in this case an informative video and other materials—do make a difference.

Dr. S. Bryn Austin and colleagues at Children's Hospital, Boston and NEDSP, Wellesley, MA, recently reported that the screening program and video significantly increased the number of students seeking help for symptoms of eating disorders. The researchers reported their results at the Academy for Eating Disorders meeting in Vancouver in May.

More than 35,000 students participated

One-hundred and fifty high schools in 30 states administered a short-report questionnaire that included the Eating Attitudes Test (EAT-20). More than 35,000 students completed the self-scored questionnaires. The students were advised to seek help if their scores showed a possible eating disorder. The schools were also given NESP educational materials and guidelines for referring at-risk students for assessment and/or treatment. About a month after the initial screening, a follow-up survey was administered to the same students.

Two elements that were important to the results were an educational video provided by NESP and the number of days the informative program was used. Approximately 4 more students per school sought help after seeing the video than at schools where the video wasn't shown. The schools also reported

an increase of 1 student seeking help for each additional day of educational programming.

Nearly 4,000 students from 30 states completed the post-study questionnaires. Among the students, 25% of girls and 13% of boys reported concerns about their dieting practices or had body image problems or reported that their score on the initial screening survey

indicated they should seek help for eating disorders symptoms. Among this subset, a greater

proportion of boys than girls (31.8% versus 23.4% reported they talked with an adult or began to attend a support group since participating in the screening program. Also within this group, African-American students were more likely than white students to report talking with an adult or beginning to attend a support program as a result of participating in the screening program.

Healthy Lifestyles on Campus? Not Yet

A sampling of students at Texas A&M suggests that college students seem to be better educated about nutrition and exercise, but many aren't adopting healthier lifestyles.

Jenna D. Anding, PhD, and other nutritionists evaluated 60 female students enrolled in 3 university aerobics classes. The researchers used the Self-Reported Activity Scale, a 10-point scale ranging from no exercise to more than 10 hours/week) and 3-day food records.

They measured height and weight, to calculate body mass index (BMI), and assessed physical activity and diet using self-reports. Eighty-five percent of the women were single and 90% lived off campus. The average age was 21 years, and 23% were Black, 32% White, 20% Asian, and 23% Hispanic. More than a third reported that they took the aerobics class to lose weight; others enrolled because it was required or to improve physical fitness.

Nutrition

Only 9 women ate 5 or more servings of fruits and vegetables daily, and none reported eating the minimum number of servings from the Food Pyramid. Mean total fat intake was 37% of total daily calories. Two-thirds ate too much saturated fat (11% of total daily calories), and 20% ate higher than recommended levels for daily cholesterol intake. Only 8% of the women got less than 10% of total daily calories from sugar—the average daily intake of sugar was 3204 mg; more than half had reported sodium intakes above 2400 mg/day.

Nearly 100% of the women followed at least one of the daily guidelines, specifically the alcohol guideline. None of the women included a variety of foods in their daily diet, but 25% got regular physical exercise. Only 8% chose a diet moderate in sugar and 65% in sodium, and only 17% chose a low-fat diet.

Only 33% of the women were physically active, and the rest were classified as sedentary. The authors note, however, that the women had enrolled in the aerobics class, perhaps in an attempt to become more active. Although the BMIs suggest healthy weights, 25% of the women were classified as overweight.

Another Effect of Anorexia Nervosa: Thyroid Atrophy

Patients with anorexia nervosa (AN) commonly have low triiodothyronine (T³) syndrome and blunted and delayed thyrotropin (TSH) response to exogenous thyrotropin-releasing hormone (TRH). Now there is evidence that AN causes diffuse shrinkage of the thyroid gland. According to researchers at Odense University Hospital, Odense, Denmark, such atrophy could hypothetically be part of a vicious cycle that perpetuates anorectic or depressive symptoms (*Int J Eat Disord* 2001; 29:230).

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The Danish researchers used ultrasound to compare 22 patients with anorexia nervosa and 44 age- and sex-matched normal-weight control subjects. Lean body mass was established by dual-energy x-ray absorptiometry. Blood tests included serum T4 levels (normal range: 65-135 nmol/l), determined by radioimmunoassay.

Smaller thyroid glands noted in AN patients

Thyroid volume was highly significantly reduced in the AN patients in comparison to the controls: 9.2 ml versus 17.8 ml. In addition, in the AN patients, thyroid size was not correlated to body mass index or to the amount of lean body mass.

Among the anorexia nervosa patients, 6 women (27%) had nonspecific discrete morphologic changes, including slight-to-moderate diffuse hypoechogenicity, or low reflection of sound, or heterogeneous thyroid echotexture, or an unclear reflection of sound. Thyroid shape was normal in the control group. None of the 6 patients had a family history of thyroid disease and they did not differ from the other patients as to thyroid hormone levels or duration of disease.

Thyroid disorders are clearly associated with affective disturbances and sometimes may persist even after appropriate supplementation. Looking at it another way, abnormalities of the thyroid axis have been noted in euthyroid patients with affective disorders as well as in AN patients. For example, a blunted and delayed TSH response to exogenously administered TRH has been reported in normal-weight patients with depressive illness (Loosen, 1985) and in from 25% to 50% of AN patients.

The authors believe that thyroid atrophy in AN patients is probably secondary to emaciation and low IGF-I levels. Once the process is underway, it could begin a vicious cycle, perpetuating anorectic or depressive symptoms.

BOOK REVIEW

Sensing the Self: Women's Recovery from Bulimia

(Sheila M. Reindl, Harvard University Press, 2001; 337 pages, \$29.95)

Sheila Reindl, a psychologist at Harvard's Bureau of Study Counsel, offers a perceptive account of the experience of bulimia nervosa and recovery from it. The material for this book was based on semi-structured interviews with 13 women, none of whom were ever Reindl's clients.

Instead, the women were recruited through personal referrals, self-help groups and posters on health-club bulletin boards. On average these women were 17 years old when their bulimia nervosa began, and they had been severely symptomatic for an average of five years. The women were all Caucasian, and the large majority were graduate students or professionals, educated and productive. Several wrestled with alcohol and drug problems and serious depression along with bulimia nervosa. With considerable nuance, in response to interview questions, they described their subjective experiences of the disorder, their ambivalent feelings about bulimic symptoms, the pivotal events that led them to seek help, and how they ultimately learned to sense and tolerate pain, adequacy, authenticity, pleasure, separateness, legitimacy, limitations and humanity.

Reindl's findings parallel those of other investigators such as Rorty (*Int J Eat Disord* 1993; 14:249). Recovery often required good social support, good therapists, good self-help groups and, sometimes, good medications. Reindl and her subjects appreciate the complexities of what goes into recovery—enhancing motivation and determination, promptings by external events, the nature and quality of personal and professional helpers, and sometimes a dose of good fortune.

Reindl's premise is that part of what led these women to bulimia nervosa in the first place, and part of what they had to grapple with and overcome, were deficits in self-structure and self-regulation. These deficits were due in part to profound disconnection from the women's own feelings and in part were a result of emotional neglect and/or abuse. They also constituted a defensive structure orga-

nized against the terrifying and disabling emotions that start with shame, which Reindl emphasizes as a core process for these women. Shame is then accompanied by humiliation, self-disparagement and self-doubt, all of which are so painful that defensive maneuvers are taken to thwart their full impact. Instead of staying steeped in psychic pain, these women relied on bulimic symptoms, thoughts, preoccupations, and behaviors to numb, dissociate and disconnect them from the extremely unpleasant emotional states they would otherwise have experienced. Recovery required reclaiming their sensations.

Using metaphors based on the fairytale *Beauty and the Beast*, Reindl develops interesting metaphors for certain aspects of the recovery process, describing how many of these women relate to their inner monsters and what they must finally do to put them to rest. Recovery requires acceptance and re-integration of the ugly, "beast part" of oneself, rather than attempts to simply banish or ban these beasts.

Inevitably, a book such as this, based on interviews with a relatively small group of demographically and culturally homogenous subjects, leaves many questions unanswered. For example, to what extent are the similarities in accounts and explanatory models due to the fact that these women have all grown up in the same culture, hearing and reading similar things about bulimia nervosa from friends and therapists? How do shame and bulimic behaviors influence one another regarding onset and persistence of symptoms? What other pathways of genesis and recovery exist for people with bulimia nervosa? Future qualitative research using larger samples and other types of subjects may provide answers.

This is a richly written book; the personal accounts are telling; and the implications that the author draws for practice and theory are thoughtful. Clinicians will immediately recognize the authenticity of these voices and appreciate the subtlety with which Reindl captures their painful experiences and challenges. Just as important, those still struggling with bulimia nervosa will find much here to ponder and much to offer hope and direction for their own recoveries.

—J.Y.

Countertransference: A Psychological Aspect of Nutritional Counseling A Challenging Case

I met “Emma” (not her real name) at a time when I was new to the field of eating disorders. She was a bright, articulate woman, 24 years of age, who was in her second year of law school. Emma had lived with severe bulimia nervosa since leaving home to begin her studies at the university. She had a love/hate relationship with her eating disorder. Although she despised it, binge-eating and purging allowed her to cope with the demands of school. Defiantly, she told me she did *not* need nutritional counseling. She stressed that she knew how to eat properly; she just had to get her act together. Her husband and her physician had made her come.

By then I had worked in the area long enough to know that it wasn't unusual for patients to resist treatment. But, in Emma's case, it was particularly difficult for me to accept. She was 17 weeks pregnant and deteriorating right before my eyes. As a result of her constant fears of gaining weight, her binge-eating and purging behaviors escalated. She had been unable to make any changes to her eating pattern; and, after two months of nutritional counseling, her weight was lower than when she first became pregnant.

Although I knew I was carrying out my professional responsibilities as a dietitian, I still felt incompetent. Even more difficult to acknowledge were the other emotions I felt toward Emma: I was angry and frustrated with her. She was in complete denial that her pregnancy was considered high risk. I felt hopeless that I would be able to help Emma make any progress.

My dietetic education had not prepared me for this counseling

experience. I was unsure whether my reaction to Emma was normal or a sign that I was not cut out for this line of work. I was concerned that my feelings would threaten our therapeutic alliance and affect my ability to continue providing nutritional care.

A Personal Reaction

For guidance I approached a colleague, Suja Srikameswaran, PhD, R.Psych, a psychologist with the Eating Disorders Program at St. Paul's Hospital. Suja helped me to understand that I was experiencing countertransference. Simply put, countertransference refers to the therapist's (or in this case, the nutrition professional's) personal reaction to what the client is saying or doing in the nutrition session. In this situation, Emma's pregnancy and her difficulty changing her eating patterns led me to feel angry and frustrated with her, and to feel ineffective as a dietitian.

The Impact of Countertransference on the Client and Dietitian

Countertransference can affect the patient-dietitian relationship in various ways. The dietitian may find herself communicating, overtly or covertly, her anger and frustration to the patient. This may be manifested in critical or judgmental comments made to the client about her lack of progress. In Emma's case, a nutrition professional might be tempted to lecture the client about the irresponsibility of her actions, given her pregnancy. The dietitian could then find herself “pushing” or threatening the client to change.

Anger and frustration to the client might include: keeping the patient waiting for her appointment, ending the session early, withdrawing from the therapeutic interaction, or otherwise letting the client know her/his displeasure and frustration.

Managing Countertransference

Countertransference is a common psychological dynamic that occurs within the counseling

process. Yet many dietitians are not adequately trained to cope with this issue in clinical practice.

Dr. Srikameswaran provided the following suggestions to help nutrition professionals manage countertransference in their sessions with eating-disordered patients:

- Be honest with yourself about the feelings that come up as a result of working with particular clients. The first step in managing countertransference is to identify when it occurs and under what circumstances. It may be that in terms of your own personal values, beliefs, and experiences, you are not best suited to provide nutritional counseling for a particular patient group.
- Be realistic in your own self-expectations. While it is not necessary to like every client you treat, it is necessary to provide a safe and respectful environment for all of them. Explore, with a trusted colleague, what you would have to change about your attitude or stance toward the client to help provide a supportive therapeutic environment.
- Create a support group with team members to discuss the potential impact personal life events could have on nutrition counseling sessions with clients. For instance, counseling a pregnant patient may be an emotional challenge for a dietitian who is trying to become pregnant herself. Getting together with other team members provides an opportunity to develop strategies to cope with feelings.
- Finally, ask for professional supervision from a psychologist or psychiatrist who works in the area. Often, this professional's experience can enhance the development of your therapeutic skills, which may help you deal more effectively with countertransference.

—Linda M. Watts, MA, RD

Age May Affect Clinical Presentation of an Eating Disorder

The unique physiologic, psychological, and developmental differences between adolescents and adults with eating disorders should be considered during diagnosis and treatment, according to the results of a recent study (*J Adolesc Health* 2001;28:222). For some teens, early, aggressive treatment may produce a better outcome.

Martin Fisher, MD, and researchers at North Shore University Hospital, Manhasset, NY, studied charts of women presenting with eating disorders to identify age-related differences on clinical presentation. The data came from 622 female patients treated for an eating disorder between 1980 and 1994. The cases were divided into 2 groups by age: 438 women younger than 20 years (9-19 years of age) and 184 women older than 20 (20-46 years of age). The researchers looked at demographic and family factors, weight loss and changes, eating-related behaviors, the diagnosis and severity of the disorder, and issues that arose during treatment.

Diagnosis, severity, and levels of denial

Thirty-five percent of the 622 women met DSM III-R criteria for anorexia nervosa, 20% met DSM III-R criteria for bulimia nervosa, and 4% had symptoms of both. The remaining women (41%) met the diagnosis for eating disorders not otherwise specified (EDNOS). Teens were more likely than adults to have a diagnosis of EDNOS, a lower global severity score, greater denial, and more reluctance to seek help. Teens also were more likely to have a history of fasting and elimination of junk food from their diets. More than 40% of the teens did not meet official DSM-III-R criteria for either anorexia or bulimia nervosa, compared with 34% of the adults.

The adults were significantly more likely than the teens to have

been losing weight for more than 1 year, to have greater total weight loss, a history of binge eating and laxative abuse, a history of use of diuretics and ipecac, a diagnosis of bulimia nervosa, and prior treatment with psychiatric medications. Adolescents 15-19 years of age reported significantly more of these behaviors than did younger teens.

The teens and adults did share some characteristics: parents' occupational level, height, weight, and percent ideal body weight at presentation, original ideal body weight, use of diet pills, elimination of meat and use of a low-fat diet, daily calorie intake, prior hospitalization for treatment of an eating disorder, and hospitalization during treatment.

Treating along a spectrum of disease

The authors suggest that teens present earlier in the course of their illness than do adults. In this study, some teens had less than 3 months of amenorrhea or had not lost enough weight to meet the DSM III-R criteria for anorexia nervosa. According to Dr. Fisher, this pattern is especially true of those in early adolescence, where failure to gain appropriate weight, as opposed to weight loss per se, may be the indicator for the eating disorder, and normal menstrual periods may not have been established. Vomiting and binge eating are also less common in teens, and thus they may not meet the DSM-III-R criteria for bulimia nervosa.

Weight loss patterns are also different for teens and young adults. In this study, teens generally presented with a shorter period of, but more rapid, weight loss—indicating an illness of shorter duration that presumably would be more amenable to treatment than that seen in adults. They also had a smaller total weight loss than did adults.

According to the authors, adolescents and young adults are often evaluated and treated at a different point on the spectrum of disease. This suggests that teens will have a better outcome if they

are treated with aggressive attempts to reverse weight loss and use of hospitalization. The researchers, who treat both teens and adults regularly, have found that teens usually have a more acute illness that requires a more aggressive approach, whereas adult patients generally have a more longstanding illness that calls for a less-aggressive, longer-term approach.

Girls Who Emulate Their Mothers Are Less Likely To Have Body Image Disorders

Girls who imitate their mothers are less likely to have low self-esteem or eating disorders, regardless of the mother's own body image. A team of researchers led by Dr. Jane Ellen Smith, a psychologist at the University of New Mexico, Albuquerque, found that if little girls said, "I want to be like my mom," they had a better body image, fewer eating disorders, and better self-esteem than girls who did not want to be like their mothers (*Int J Eat Disord*, 2001; 29:429).

The researchers studied 92 mother-daughter pairs of 8- to 13-year-old Hispanic and white girls from public schools in New Mexico. All girls were within normal body weight ranges and were selected for either having an especially high or especially low body self-image. The girls were asked to rate their body image, their self-esteem, and their relationship with their mother.

Age affected body image satisfaction

Overall, girls who were relatively thinner were more satisfied with their body types than girls who were heavier, even though all the girls were within normal weight limits. Race did not affect body image, but age did. Older girls nearing puberty showed significantly more dissatisfaction with their bodies than did younger girls. Also, a mother's dissatisfaction with her body and poor eating attitudes did not necessarily transfer to her daughter. Instead, the important factor was whether the girl wanted to be like her mother or not. Girls who identified with and tried to imitate their mother's personality were less likely to have self-esteem and body image problems.

Questions & Answers

'Pudgy' Patients During Rehabilitation

Q. During the course of nutritional rehabilitation from anorexia nervosa, many of my patients insist that they are really getting fat and misshapen. Are all these complaints due to their body image distortions? At times some of them actually do appear to be getting "pudgy" to me, and appear to be putting on extra weight around the midsection. (*B.L., Memphis*)

A. Your patients may be reacting to a very real phenomenon. Recent studies by Laurel Mayer and colleagues at Columbia University have shown that anorexia nervosa inpatients who gain about 3 lb per week to the point of discharge from the hospital tend to develop fat distributions that favor the central abdomen and hips, at least in the short run. (Mayer L, et al: Body-fat distribution before and after weight gain in anorexia nervosa. Presented at the Annual Meeting of the American Psychiatric Association, May 8, 2001, New Orleans.) These patterns of weight distribution differed from normal comparison group women, who tended to have less central fat.

The resulting appearance may be particularly distressing for recovering anorexia nervosa patients, who have been fearful of just such outcomes, and, according to Mayer

et al., may contribute to the risk of relapse. I reassure patients that normal redistribution is likely to occur as fat moves from these labile storage areas to more permanent, normal storage areas elsewhere in the body. Additional study is needed to determine just how and over what period of time these fat distributions will normalize.

—J.Y.

Unraveling the 'Japanese Paradox'

High body mass index (BMI) is a well-known ingredient of body dissatisfaction and increased risk for eating disorders. Researchers have found that BMI is not a good predictor of body dissatisfaction in all ethnic groups. Despite low BMIs overall, Japanese females scored very highly on measures of body dissatisfaction.

Alayne Yates, MD, and colleagues at John Burns School of Medicine, University of Hawaii, Honolulu, explored the paradox in a study of 211 Caucasian, 155 Japanese, 112 African-American, 79 Filipino, 70 Chinese, 70 Hawaiian/part Hawaiian, and 124 multiethnic college students. The students were asked to complete figure drawings (an index of body dissatisfaction), the self-loathing subscale (SLSS), an exercise-based scale that is highly correlated with eating disorders assessment methods, the Eating Disorder Inventory-2 (subsample only), and a symptom self-report inventory, and eating disorder symptoms.

Japanese women had highest body dissatisfaction scores

Dr. Yates and colleagues found highly significant BMI/ethnic group differences.

Japanese females scored the lowest on BMI yet had the highest SLSS and body dissatisfaction scores. There were no significant between-group differences in SLSS or body dissatisfaction.

The authors believe that decreased body-

reality checks and increased body dissatisfaction among Japanese females interact to increase their risk for an eating disorder. Further, they suggest that a useful strategy in cross-cultural research would be to factor the BMI score into the body dissatisfaction score, to produce a total body perception score.

In the Next Issue

Highlights of the International Conference on Eating Disorders

PLUS

- **Weight Management in Minority Groups**
- **New Strategies for Treating Eating Disorders**
- **Emerging Technologies in Eating Disorder Treatment**
- **Orthodox Jewish Teens Treated in a Day Program**
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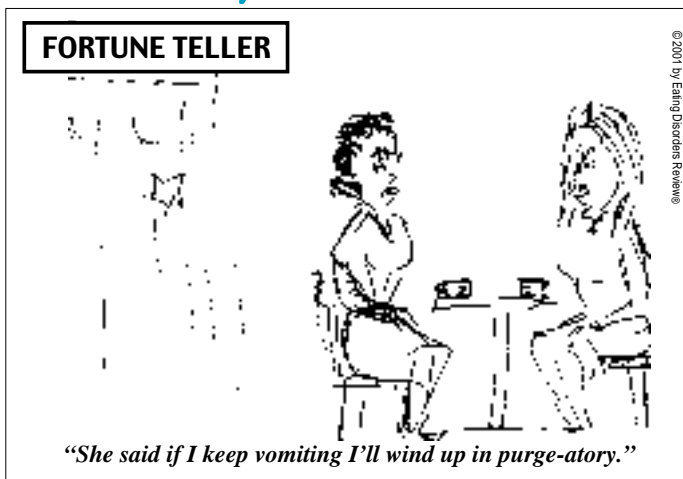
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Nibbles, by Hunter



"She said if I keep vomiting I'll wind up in purge-atory."