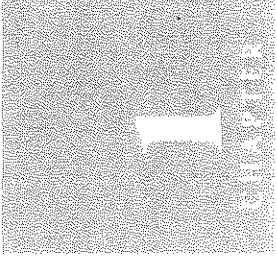


NUTRITION  
COUNSELING  
IN THE TREATMENT  
OF EATING  
DISORDERS

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## Basic Nutrition Counseling

This chapter describes basic nutrition counseling skills. Basic counseling focuses on the development of a collaborative relationship with patients which must be maintained for the successful delivery of information and interventions. This relationship is the backdrop that allows nutrition counselors to give direct guidance and to effectively help with goal-setting and problem-solving.

Nutrition counseling for eating disorders is a specialized approach focused on correcting disordered behaviors and beliefs in the areas of food and exercise. Nutrition counseling illuminates antecedents of food behaviors, provides nutrition information, supports experimentation with new behaviors, and assesses outcomes. The major aim of nutrition counseling is the replacement of disordered, unhealthy eating patterns with organized, healthy eating patterns. Nutrition counseling rightfully also includes a focus on weight restoration and monitoring.

Nutrition counseling is pragmatic with the well-defined goals of correction of eating disorder behavior and the establishment of a normal, care-free approach to eating and weight control (American Dietetic Association, 1994). Nutrition counseling is eclectic in that it employs cognitive-behavioral, interactional, relational, and educational techniques. Nutrition counseling is supportive of conjunctive therapies necessary for the patient's recovery including psychodynamic counseling, and likely, psychotropic medications.

## □ Establishing a Collaborative Relationship

It is well accepted that a collaborative relationship between counselor and patient is fundamental to any counseling endeavor. Saloff-Coste et al. (1993) and Reiff and Reiff (1992), writing specifically about nutrition counseling, come to the same conclusion about the nutrition counseling relationship. The difficulty of accomplishing this when the counselor must also tackle weight-related behaviors has been noted by Garner, Vitousek, and Pike (1997, p. 99) who conclude such relationships are “doomed if perceived by the patient as simply carrying out the objectives of others for weight gain or the elimination of weight control behaviors.” In many cases, however, this is exactly the nutrition counselor’s assignment.

Courtney, at only 17 years old, was already a five-year veteran of an eating disorder. She is a good example of the type of patient for whom establishing a collaborative relationship is essential, but also difficult. It was easy to see why Courtney’s previous nutritionist had found her frustrating to work with. Courtney’s life revolved around her anorexia, she had not developed any friendships or outside interests, preferring instead to spend time at home preparing the few special foods she would allow herself to eat.

The challenge is to help patients revise entrenched food beliefs, attitudes, and behaviors while remaining calm and philosophical about their dilemmas. The nutrition counselor’s job is made even more difficult by the fact that eating-disordered patients often think of themselves as completely self-sufficient. Regardless of the troubles patients are having, they feel that they should be able to take care of their problems themselves. Such patients resist professional help despite awareness of distress resulting from the eating disorder. Focusing on the establishment of a supportive rather than a confrontational relationship can help the nutrition counselor refrain from participating in the all too common power struggles these patients engender. Patients’ motivation to recover is enhanced when counselors acknowledge the difficulty of changing eating-disordered behaviors and sympathize with the patients’ distress at the prospect of changing (Vitousek, Watson, & Wilson, 1998).

Courtney’s nutritionist preceded thusly: “Courtney I am so glad to meet you. I’d like to be of help, but before we talk about how I can help you make your weight gain goals, I’d love to hear about your previous treatment experiences, especially what you liked and what you didn’t. Then maybe you and I can figure out how I can be of the most help to you.”

Courtney talked for a few minutes about how she hated doing the required self-monitoring records and that she found the nutrition sessions boring because, “all we talked about was what I ate and what I was going

to eat.” The following dialog illustrates how the nutritionist began to forge a collaborative working relationship:

*Nutritionist:* It is good to know that food records didn’t work for you. They are a basic technique and sometimes are helpful, but if you didn’t like doing them, there is no reason we should start with them. Is there anything you would like my help with?

*Courtney:* Well, I always dreamed that in my senior year I would spend spring break in France with the French Club, but my parents say that I can’t go because of my eating disorder.

*Nutritionist:* I can certainly see why your parents would feel this way. But on the other hand we would have about seven months to turn around your eating disorder. The trip doesn’t sound totally out of the question, but it would be lots of hard work to get you ready to go. I know from talking to your doctor that you have to gain some weight before you can go back to school in the fall. I can find out what your doctor would think about this plan and of course your parents would have to be agreeable.

*Courtney:* How much weight would I have to gain to go to France?

The budding collaboration illustrated above between Courtney and her nutritionist illustrates how in this atmosphere patients can begin addressing their weight-related fears. In subsequent sessions, Courtney was able to experiment with healthier behaviors that led to slow steady weight gain.

Bruch, a respected pioneer in the treatment of eating-disordered patients, encouraged the creation of counseling environments that are safe, secure, and free from threat, where the patient is a “true collaborator” and the tone is friendly and warm (Swift, 1991, p. 64). Davis (1991, pp. 78–79) says eating disorder counselors should have a “confident, comfortable expertise,” like a “kindly, benevolent, firm, steadfast parent, more powerful, more skilled, wiser than any patient.” Swift (1991, p. 64) describes the ideal counselor as an empathetic listener and a collaborator who provides supportive helpfulness and nonintrusive concern.

Establishing a collaborative relationship requires the counselor to be active and direct, to develop rapport, and to establish credibility, while being sympathetic, honest, and maintaining a sense of humor. These attributes can be developed by improving basic counseling skills. The active listening skills described by Ivey et al. (1987, pp. 50–53) are valuable. The counselor should establish good eye contact and sit with a slight forward lean about arm’s length or more from the patient. Consider offering a handshake at the first meeting. Speech should be moderate in tone and rate, yet include variations to convey warmth and interest. Open-ended questions help the counselor gather information. Use of “encouragers,”

such as “uh huh,” “tell me more,” “so . . .” helps patients continue to explore. Restatements and direct repetitions of the patient’s story let the patient know that the counselor understands. Hearing their thoughts restated helps patients better understand themselves. Reflecting back patients’ feelings, paraphrasing, and summarizing are also effective in bringing clarity.

### **Be Active and Direct**

An active collaborative approach can be signaled by asking, “How can I be of help?” or “What do you need help with?” This type of questioning helps the professional grasp the patient’s goals. The aim is to strike a balance between being advisor, facilitator, and teacher. When patients ask questions, it is generally best to directly and honestly answer. When patients ask for advice, answer in a way that encourages dialog: “What have you tried?” or, “What do you think would help?” If professionals never give advice, patients will experience them as withholding and resistant. If they always give advice and direction, then they will seem overbearing and intrusive (Humphrey, 1991, p. 335). Nutrition counselors should remember that their role is to provide information, advice, direction, and encouragement, but it is up to the patient to use these inputs to change behaviors (Fairburn et al., 1993, p. 368). Dwyer (1985, p. 31), however, reminds professionals that a “laissez-faire attitude,” which allows patients to engage in nutrition counseling at their own pace, will lead to stagnation and, in the case of anorexia, a stable or declining weight. Not only does this style of nutrition counseling impede behavioral progress, it inhibits psychotherapy as well.

### **Developing Rapport**

Rapport is built on the belief that patients are courageous when they recognize that they need help and then get the help they need (Hill & O’Brien, 1999, p. 9). The nutrition counselor should show genuine interest in the patient’s experiences, anxieties, obsessions, and misconceptions. Most eating-disordered patients will approach nutrition counseling with some ambivalence. Acknowledge that anorexic patients may feel forced to relinquish behaviors that make them feel special and in control. Suggest that bulimic patients, though often eager for treatment, may not feel ready to give up the sense of independence or even rebellion that their behaviors provide.

If the patient is a child, one must work harder to establish a collabora-

tive relationship as children are likely to believe professionals are “on the parents’ side.” Having sessions alone with young patients can help foster a therapeutic relationship. Strive, as much as possible, to use the patient’s syntax and language. For example, the counselor might find it helpful to say “when you make yourself sick” if the patient describes purging in this manner. Avoid using complicated words and concepts when simpler ways of saying the same thing are available.

A curious, interested, empathetic approach helps ambivalent patients feel understood. Make it clear that the patient’s attempts to correct her or his problems are appreciated. Stating that most people need professional help to recover is reassuring for patients to hear.

In every response, indicate that the patient and her or his experiences are taken seriously. Patients’ opinions, thoughts, struggles, and feelings should be responded to in ways that indicate that they are legitimate and of interest and value. Rose, a college student, believed that talking to her father on the phone caused her to binge. The sensitive professional might respond that the stress of a difficult phone conversation could easily trigger a binge particularly if one has not eaten all day.

It is wise for professionals to remember that though they may be quite experienced in treating eating disorders, they should not assume they understand a particular patient’s eating disorder. Many patients relish opportunities to tell their story and explore their own thoughts and feelings about their eating disorder. Some patients will need to relate the saga of their eating disorder before they can accept guidance. Otherwise, they are likely to feel they are receiving “canned” treatment or advice. Each patient’s story provides an opportunity to learn more about her or his perspective. Reflecting back to patients that their viewpoints “make sense” in the context of their eating disorders communicates empathy and respect. Nonetheless others focus on changing their problematic behaviors from the first few moments of the initial session rather than spending time recounting their past experiences.

Davis (1991, pp. 83–84) writes that “caring behaviors,” which help the patient to feel hopeful, nurtured, and valued, are an excellent counterpoint to the experience of living with an eating disorder. Working with eating-disordered patients’ misconceptions and maladaptive behaviors can be exasperating. Professionals should scrutinize their own attitudes if they find themselves arguing with patients.

### **Establishing Credibility**

For nutrition counseling to be successful, first the counselor must be utterly convinced that recovery is possible and that improvements in eating

behaviors are a very likely consequence of engaging in treatment. Patients can be told that even a long history of an eating disorder does not predict a poor outcome (Wilson et al., 1997, p. 79). Being careful to protect the confidentiality of others, nutrition counselors may talk briefly about their work with other patients or perhaps say something self-revealing (Davis, 1991, p. 78). Over the course of the initial session, professionals should describe their treatment philosophy and credentials. Davis (1991, p. 77) suggests that the counselor focus initial sessions on piquing the patient's interest and curiosity about treatment and the counselor rather than devoting the entire session to gathering clinical data.

Speculations about possible outcomes of improved eating behaviors is one way to get the patient's attention: "I am curious about how long it will take for your energy level to improve once you start eating more calories." Or, "I wonder how long it will take for your hair to respond to an increase in protein." Interjecting observations about other patients' strategies sets the stage for food planning at a later time: "A lot of my patients who are about your age find that adding peanut butter to their bagels really keeps them from overeating." An example of a self-revelation is: "There is nothing wrong with taking calcium supplements. I take them on days I haven't had enough milk."

Professionals who are confident, knowledgeable, firm, authoritative, and experienced are likely to have credibility with patients. Modeling healthy viewpoints on dieting, nutrition, health, and physical attractiveness has a positive impact on patients' beliefs and values about these issues (Garner et al., 1997, p. 100). A credible counselor is likely to create confidence in the patient that recovery is possible and that nutrition counseling will be effective. In addition, knowledge of a professional's long-term availability is associated with a positive prognosis (Vanderlinden, Norré, & Vandereycken, 1992, p. 177).

## □ Implementing Nutrition Interventions

Nutrition counselors use intervention techniques to help patients make behavior changes that over time reflect a new understanding, acquired from concurrent educational treatments, of their eating disorder, nutrition, and health. According to Hill and O'Brien (1999, p. 24), basic intervention techniques aimed at changing behaviors include (a) brainstorming possible behavior changes, (b) establishing specific goals, and then (c) implementing, evaluating, and modifying action plans. Tobin and Johnson (1991, pp. 387-388) suggest practitioners begin intervention-focused sessions listening to what patients have to say about their current eating dilemmas, focusing initially on the patient's most obvious problems and

the simplest solutions. Ask, "What bothers you the most?" and, "What are you already doing to remedy your situation?" Tobin and Johnson remind practitioners to pay particular attention to factors that hinder obvious solutions. A good example is Timothy, an older adolescent recovering from anorexia nervosa. Timothy was bothered by his lackluster soccer performance and became rightfully convinced that his minimal food intake was a factor. Though he was eating an energy bar before practice, he continued to lose weight. When asked if he could consume a sports drink with the energy bar, Timothy replied that he was worried about getting a stomach cramp. Hearing that most athletes don't develop cramps with snacks of this size galvanized Timothy's resolve to experiment with the additional drink.

The nutrition counselor should avoid offering suggestions that the patient may respond to by saying, "I already tried that and it didn't work." Before the nutrition counselor offers advice, patients should be quizzed about what strategies they have tried and how they feel about their past efforts. Patients should be given the chance to volunteer behavioral strategies. For example, nutrition counselors can ask, "What do you think you should do differently to prevent bingeing after school?" Or, "What would need to be different for you to make a change in your eating?"

An effective routine is to leave time at the end of each session for patients to generate a behavior assignment or list of assignments to be completed between sessions. Each patient, however, should be approached with an "open mind" about what behavioral actions she or he should be advised to take. In Timothy's case, he was reminded that since he had lost weight the week before, he needed to add substantial calories to his intake. This question was posed: "We've talked about how a drink before practice might really help, but what do you want to add?" Bruch reminds practitioners that their interventions should be based on their encounters with the patient, not clinical theory (Swift, 1991, p. 63). Explore the patient's readiness to modify her or his behaviors by asking, "What do you feel ready to work on?" Patients often have definite ideas of what they could do to improve their situations. Timothy, not quite ready to add the sports drink, responded, "I would really like to have that drink, but I know I would worry the whole time about getting a stomach cramp. How about if I add a big glass of juice to breakfast instead?" Reinforcing the patient's plan creates a climate of collaboration: "That is a great idea, Tim." Or, suggest an assignment that the patient then modifies. Later in treatment, Timothy again needed to increase his caloric intake. This time, the nutritionist suggested he add a dessert to lunch. Timothy replied, "I know I need to work a dessert into my daily plan, but I know I will obsess about it all afternoon and be distracted in the math class. Could I have the dessert after dinner when I have less to worry about?" Some patients are

able to proceed on their own once they realize the extent of the nutrition counselor's support. More typically, patients like Timothy need direct guidance some of the time, and when they do originate their own solutions they should be applauded. After a month of weekly visits, Timothy liked the positive feedback he received when he generated his own ideas: "I have another great idea I would like to try this week."

Effective interventions focus first on the problems patients find most bothersome. When possible, patients ought to devise their own behavioral plans and homework assignments. Most patients, however, will need assistance evaluating their progress and making modifications that support progress. In addition, time in each session should be devoted to helping patients cope with feelings that arise from changes in food-related behaviors. Each session should end with a review of the mutually agreed upon list of behaviors that the patient agrees to abide by between sessions. At the beginning of the next session, the plan's success should be evaluated and, if warranted, modifications negotiated.

## Goal Setting

The first principle of goal setting with eating-disordered patients is to aim small and low. Feasible, interim goals should be "operationalized" into behavioral assignments patients commit to fulfilling between sessions. The patient's progress, however modest, in achieving these assignments should be acknowledged and praised (Fairburn et al., 1993, p. 375).

After losing 30 pounds, Lucy, formerly a pleasantly plump young teen, was diagnosed with anorexia nervosa by her primary care practitioner. On her first visit to the nutritionist's, Lucy reported carefully counting every calorie so that her daily total was exactly 500 calories. After a cheerful repartee in which the nutritionist explained the need for calories and nutrients to maintain health and answered Lucy's questions about some of her physical symptoms, the nutritionist recommended that Lucy add 300 calories to her meager intake. The two of them then figured out several days' worth of food choices that would give her 800 calories. As the session was drawing to a close, Lucy became more agitated and finally confessed that she knew she couldn't eat 800 calories. "OK, let's make it 700 calories, but I will need to see you again before the end of the week to make sure you haven't lost weight. I am sure we will have to increase the calories then," the nutritionist replied. Lucy's weight was down a pound by week's end so as promised the calorie issue was again negotiated. But first after reviewing the notebook Lucy kept of her food intake, the nutritionist told Lucy what a good job she had done following the food plan.

"You clearly have to do at least 1000 calories a day this time, Lucy," the nutritionist patiently explained. Without complaint, Lucy agreed.

Before patients can successfully set or accomplish behavior goals, they need to be provided germane information and given help correcting misconceptions and changing cognitions. Patients will become more enthusiastic about experimenting with behavior goals if every effort has been made to offer solutions which are uniquely tailored to their situation. Make it clear how each behavior goal benefits the patient and addresses her or his particular concerns. Lucy, the patient described above, who counted calories so carefully, also conscientiously avoided consuming any dietary fat. At her third visit, Lucy asked the nutritionist if she knew what was causing all the little bruises she was finding on her arms and legs. "It could be one of two things," her nutritionist explained. "Your diet is very low in protein and contains no essential fatty acids; either or both of these deficiencies could contribute to the bruising. Another problem is that since you are eating so few calories, your body is having to burn up the little protein you eat for energy so it can't afford to take good care of your cells. I am sorry to say that bruising like this is quite common in anorexia." By the end of that visit, Lucy resolved to add another 300 calories and 10 grams of fat.

Most patients, regardless of the type of eating disorder from which they suffer, are either anxious about loss-of-control over eating, or body weight, or both. Patients should be assured that these concerns, and any others, are taken seriously and will be addressed in treatment. Always keep in mind that eating-disordered patients are often severely malnourished and consequently may not be able to think clearly. Patience and compassion are required as these patients may need to have behavioral goals and plans repeatedly clarified. Lucy, adamant about not wanting to revert to that pudgy teenager she once was, was reassured by her nutritionist time and again that one of the benefits of treatment was that she was going to learn how to eat well and learn how to maintain a healthy weight.

The nutrition counselor's role is to encourage and persuade patients to accomplish goals that are in their best interest. Establishing appropriate behavioral goals requires familiarity with the behaviors that perpetuate the patient's eating disorder and her or his goals for treatment. Patients should be queried about their recent and historical food-related problems and attempts at solutions. Be active, but also gentle, in helping patients choose sequential behavioral goals that match their problems and level of insight and understanding (Hill & O'Brien, 1999, pp. 21-24). Begin goal setting by asking, "What do you want to change about your eating?" Or, "What would your eating be like if you didn't have an eating disorder?" Lucy answered that she missed the carefree attitude she once had when it

came to food. Making routine the question, "What do you want to work on this week?" can prompt productive discussions about possible goals.

Goals should be specific, detailed, and relevant to the patient. Small, feasible goals are more likely to be attained than more ambitious ones. Patients should be directed to choose as goals behaviors that are under their own control. Instead of weight-change goals, for example, patients should be encouraged to select food- or exercise-related assignments, as these behaviors are under the patient's direct control. Jenny, who had become overweight as the result of her binge-eating habit, wanted to lose a significant amount of weight. Though the nutritionist was sympathetic and optimistic that Jenny could in time achieve her goals, Jenny was encouraged to pick a behavioral goal each week. The first week, Jenny agreed to pack a lunch for school rather than eat from the vending machine. The second week, Jenny suggested she stop for a frozen yogurt cone on her way home from school in lieu of grazing out of the refrigerator while she waited for dinner to be served. Encourage patients to speculate about possible obstacles by asking, "What would make this assignment difficult to achieve?"; or, "What problems will you have following through on this goal?"; and then, "How could you resolve these problems?" Or inquire, "Can you see yourself doing 'x'?" If the patient is not at least somewhat enthusiastic about the likelihood of the plan's success, revise the goals or return to further discussion about the patient's readiness to engage in goal setting. Before goals are agreed upon, both patient and professional should be "90%" sure the patient can be successful. As "success breeds success," mastering smaller goals will increase the patient's confidence to tackle more difficult goals.

Patients who are in treatment at the behest of another may admit to not wanting to give up their eating-disordered behaviors. A directed look at the "bigger picture" of their eating disorder and likely short- and long-term consequences may help such patients engage in nutrition treatment. Asking questions such as "What are your parents worried about?" or, "Can you imagine engaging in these eating behaviors at age 30?" or, "What would you suggest to someone else with a similar problem?" can help the resistant patient engage in goal setting. Other patients may dismiss nutrition-oriented interventions by saying, "I know everything there is to know about nutrition and eating disorders." One response is to agree that it is not unusual for patients to be well informed about nutrition and even eating disorders and to make it clear that working with knowledgeable patients is particularly rewarding for professionals. Add that the role of the nutrition counselor for such patients is to provide "direction and support" rather than to provide information. Knowledgeable patients can be asked, "What prevents you from making changes in your food behav-

iors?" Or even more specifically, "If you could manage food the way you know you should, what would you do about dinner?"

Avoid engaging in power struggles with patients who are resistant. If an impasse develops, return to discussion of the patient's situation and difficulties or their feelings about nutrition treatment. Ask, "How are you feeling about our sessions since it seems as though none of my suggestions have been helpful to you." Resistant patients often respond to suggested behavioral changes with, "yes, that is a good idea, *but*" and then list all the reasons they cannot comply. This usually indicates the patient has not accepted the professional's direction. Ivey et al. (1987) suggest an appropriate response might be, "You feel that my suggestion is not helpful. What might be more useful to you?" In this situation, Hill and O'Brien (1999, p. 313) recommend that the patient be advised to attempt an even smaller step. Paradoxically, they say, often when patients are not challenged, they are free to make progress. Marianne was such a patient. She had "read all the books on eating disorders" and had had years of previous treatment. According to her report, she had tried every possible nutrition intervention to no avail. Marianne didn't make progress until her nutritionist ceased providing advice, but asked instead, "Is there anything you want to try this next week?" Several weeks passed before Marianne was able to do more than maintain the status quo, then she began to make progress at her own pace.

Always on guard against becoming too invested in the patient's progress, the nutrition counselor must also avoid imposing her or his own values or food and exercise approaches on the patient. Yet, for most patients to engage in goal setting, they need to feel confident in the nutrition counselor's expertise. Time in initial sessions should be devoted to assuring patients that the counselor has the skills, experience, and, yes, the patience necessary to guide the patient's recovery.

As has been noted, each session should end with the patient committed to a plan that includes several behavioral goals. Appropriate behavioral goals or assignments (i.e., eat breakfast, add a protein serving to dinner, completing food records, or take a vitamin and mineral supplement) will become apparent over the course of the session. Further along in treatment, behavioral goals might include following a food or exercise plan or assignments to go food or clothes shopping. Although underweight patients may have weekly weight goals, these goals should "operationalized" so the patient has food and exercise assignments that will achieve the necessary weight gain. Writing out the plan or assignments is helpful for some patients (Fairburn et al., 1993, p. 375). Linehan (1993b, p. 19) suggests practitioners discuss semantics with patients. Some patients will prefer calling the plan or list of assignments "homework" so that they can

think of treatment much like a class, though other patients may feel demeaned by this terminology. Assigned tasks should be manageable. They should be designed to provide the patient with a sense of success and provide the professional with the opportunity to give positive feedback (Wilson et al., 1997, p. 81).

### Direct Guidance

Establishing and meeting specific behavioral goals usually requires direct guidance. Direct guidance is conveyed by offering advice, giving instruction, sharing clinical opinions, and providing information. Providing direct guidance also includes evaluating the patient's progress and suggesting modifications. Direct guidance, however, given before the patient's situation is adequately explored and a collaborative relationship develops, is likely to result in resistance, tension, and even anger (Hill & O'Brien, 1999, p. 299). Occasionally, patients have definite ideas of what they could do to improve their situation. Being inquisitive about the patient's own sense of where to begin can be productive: "What do you feel ready to work on?" or, "Where should we begin?" Asking patients, "What bothers you the most?" helps the nutrition counselor suggest relevant behavior goals. Behavioral goals proposed by patients should be enthusiastically endorsed though it may be necessary to suggest modifications. Katie, a bulimic for six years, desperately wanted to give up her binge-purge habit. After working on improving her food intake, she experimented with abstaining from purging, and found that if she didn't purge, her binges were smaller. Katie was commended for her dramatic turn-around. To avoid the likely sense of discouragement she would feel in the event of an inadvertent purge, Katie was advised to plan to record as many details about any purging episodes and the precipitating circumstances as she could, and then to bring these data to her next session.

Do not to overlook the patient's ability to generate ideas or solutions. "What do you think would work?" often generates productive strategies. Occasionally, a patient will require very little, if any, direct guidance (Garner, Garfinkel, & Bemis, 1982). Such patients make behavioral progress with just support and appreciation for their efforts and the knowledge that specific assistance is available if needed. Another long-term bulimic patient, who paid for monthly nutrition visits out of her tip money from her waitressing job, made remarkable progress with sessions devoted to her nutritionists' review and appreciation of the successes since the patient's last visit.

### Problem Solving

Problem solving involves analyzing what happened and what went wrong, and then helping patients revise their approach based on this analysis. Problem solving should be applied when patients are not making progress correcting food behaviors or body weight, or when they continue to have problems completing homework assignments or keeping appointments.

Fairburn et al. (1993, pp. 383–385) advise that patients adopt a commonsense problem-solving approach, namely, that they identify the problem and its antecedents, consider a variety of potential solutions, evaluate the effectiveness and feasibility of possible solutions, define the steps required to carry out the chosen solution, implement the chosen solution, then evaluate the results.

### Examining Pros and Cons

It is useful to involve patients in an examination of the pros and cons of their eating-disordered behaviors particularly if they continue to struggle in spite of treatment or if they have trouble keeping appointments (Agras & Apple, 1997, p. 63). This discussion can help replace an accompanying sense of frustration, for both nutrition counselor and patient, with a sense of resolution. It may be that the patient concludes she or he is not ready for nutrition treatment or that she or he needs to commit more time and effort toward treatment. Patients may need reminding that it takes time, patience, and practice to change behaviors. Perhaps the nutrition counselor may conclude that treatment needs to be refocused to better meet the patient's needs or that behavioral goals need to be revised.

### Aiming Low

It is not uncommon for professionals, or patients for that matter, to initially propose behavioral goals that are too difficult for the patient to achieve. "Downgrading" behavioral goals and reminding patients they are not required to change or to make rapid progress can paradoxically free reluctant patients to be less oppositional (Hill & O'Brien, 1999, p. 313). It was clear after several visits that Sadie, a twelve-year-old underweight anorexic patient, was adamantly opposed to weight gain and steadfastly committed to consuming no more than 1,000 calories per day. Her nutritionist kept in mind that if Sadie could not make sufficient progress to maintain stable health status she would be hospitalized. At a subsequent visit, Sadie was calmly advised that it was her choice to improve her eating and her weight in an outpatient setting rather than in an in-



patient program. This statement prompted many questions about typical hospital protocols which were answered matter-of-factly. Once Sadie heard that it was highly unlikely that hospital staff would allow her to continue to drink water instead of milk at meals, she was ready to work on dietary improvement of her own choosing.

Behavioral goals and food plans should be continually modified based on the patient's report of "what worked" and "what didn't work." Patients often need help recognizing unproductive behavioral patterns. It can be helpful to reflect cause-and-effect as in, "I noticed that you didn't binge the evenings you ate a better dinner."

### ***Being Patient Directed and Behaviorally Focused***

When patients are not making progress, the fault may lie with the professional who inadvertently has become too invested in whether and how patients change. It is best to let patients devise and revise behavioral goals by asking, "What do you want to work on this week?" or, "What would you like to do differently?" If patients have had a hand in formulating behavioral goals, they are more likely to take responsibility for their own progress than if the nutrition counselor simply tells them what to do. Conversely, some patients may be hindered because the professional is not focused on the fundamental goal of nutrition counseling—behavior change. Professionals who have a sensitive and perceptive style of nutrition counseling, in particular, need to guard against being diverted from focusing on behavior-change goals by patients' psychological issues. Patients who chose to focus on such issues in nutrition sessions should be referred to conjoint psychotherapy. Always bear in mind that the primary goal of nutrition counseling is behavioral change.

### ***Using Effective Self-Talk***

Self-talk includes rehearsed statements of facts and arguments that patients use to talk themselves out of engaging in eating-disordered behaviors and to support themselves in putting new behaviors into practice. Positive self-talk does not need to be believed to be effective in supporting behavioral change. Garner et al. (1985, p. 553) suggest that patients be taught to challenge their irrational thoughts that support eating-disordered behaviors with rehearsed coping phrases that patients can "parrot" when they have temporary lapse in motivation or early in treatment when their own reasoning capacity may be diminished by malnutrition. Examples of coping phrases include: "Following my food plan will control my weight." "Returning to the food plan will make it less likely I will binge in the future." For this technique to be effective, the nutrition coun-

selors should make sure patients understand the reasoning behind the parroted phrase. Patients who use self-talk over time may find that even their long-held beliefs have changed (Garner & Bemis, 1985, p. 122). During office visits, patients should practice specific self-talk litanies directed at addressing their tendencies to restrict, binge, or purge. Ask patients, "What could you say to yourself to avoid engaging in specific eating-disordered behavior?" Suggesting the patient "play the nutritionist" can also be helpful, as in, "What would my nutritionist say to me in this situation?" Garner and Bemis (1985, p. 122) offer a number of examples of effective self-talk, including: "I will finish each bite of my meal," "I will not get fat," "This is part of getting better," "My meal has been prescribed," "I must take my meal like medication," "I need food to keep me healthy, regardless of what I feel," "I am at a thin-normal weight."

### ***Employing Distraction***

Another helpful technique is the use of distraction. Patients can intentionally distract themselves from eating-disordered behaviors or thoughts by choosing to engage in alternative activities (see Appendix E). Ideal alternative activities are pleasurable and incompatible with bingeing or purging (Agras & Apple, 1997, pp. 73-74). Patients should be assisted in creating a list of activities they can use when they have eating-disordered urges. Typically, effective alternative activities are calling or writing a friend, using the computer, journaling, taking a bath, or going for a walk. Patients should be advised against choosing alternatives such as schoolwork or housework, because few will consistently choose unappealing activities over bingeing. Although bulimic and binge-eating patients are usually cautioned not to pair eating with other activities, highly anxious anorexic patients may benefit from diversions at meals and snacks. These patients can be distracted from their fears by eating with a trusted person. Playing cards or a board game or listening to music while eating can also be helpful.

### ***Assigning Homework***

Patients rarely make progress without doing homework (the new food-related behaviors the patient is to practice between office visits). Homework assures patients that they are actively engaged in treatment. Effective homework assignments are derived from the patient's previous successes and modified to address current difficulties. Typically, eating-disordered patients have trouble completing assignments that involve increasing planned food intake due to fear of weight gain. If a patient's weight is not currently monitored and she or he is struggling, weigh-ins should be seriously con-

sidered, as patients often imagine that their weight has increased when it has not.

Common homework conundrums are assignments that are too difficult or too vague. Consider asking patients how confident they are that they can complete the assignment. If they are not “90% sure” they can be successful, break down the desired behavior change into smaller increments which then can be assigned instead. In some cases the patient may not have fully grasped the rationale behind the assignment and would benefit from further clarification of relevant educational themes. Specificity helps. For example, “Can you abstain from purging on Thursday evenings?” or, “Can you add a slice of bread to your lunch?”

This may be the time to assign self-monitoring records (see Appendix F). Food monitoring provides increased awareness about behavioral problems. Increased awareness can make it easier for patients to change behaviors. Agras and Apple (1997, p. 64) recommend using data from the patient’s self-monitoring forms or self-reports to illustrate how homework assignments address particular problems. Food records can also show how a patient’s present behavior is unproductive: “Isn’t this interesting,” the nutritionist remarked to Dan, a purging anorexic. “I see from your food records that when you drink two cups of water with meals you almost always purge.”

It must be underscored that if homework is assigned, it *must* be reviewed at the subsequent session to be effective. When homework assignments are ignored by nutrition counselors, patients are likely to infer that the tasks are not important and cease to do them. Another negative outcome is that patients can conclude the nutrition counselor is not truly invested in their treatment.

In assigning homework, point out that progress usually does not occur unless there is a willingness to take some risks and experiment with new behaviors. Nevertheless, some patients improve from the paradoxical reminder that if they are not pleased with the results of behavior changes, they can revert to old behaviors. For example, the normal-weight patient, who is hesitant to agree to the assignment to add a serving of protein to dinner for fear of weight gain, can be assured that if she actually gains weight, she can choose to return to her more restrictive meal pattern. There is no advantage to engaging in power struggles with patients around homework assignments or other issues. Remain empathetic and reflective while expressing the conviction that progress and, eventually, recovery will result from modest but sustained behavior changes.

Throughout the course of treatment, it is important to enhance the patient’s confidence by noting and praising all progress, however modest. Restored hopefulness, in and of itself, has been shown to have a significant positive impact on eating-disordered behaviors (Connors, Johnson,

& Stuckey, 1984). Some patients, especially those who have suffered from an eating disorder in spite of years of treatment, will have difficulty making progress because they are resigned to their behaviors and cynical about the effectiveness of treatment. These patients will need regular “pep-talks,” gentle feedback, and encouraging support throughout treatment.

## □ Session Structure

Sessions need to be structured so they are therapeutic and conducive to achieving the goals of nutrition interventions. Patients should be greeted warmly and asked, in a general way, how they are doing. If the patient’s weight must be monitored, this should be done early in the session to allow plenty of time to process reactions to weigh-ins and to draw reasonable conclusions about the connection between behaviors and body weight.

Next, review any homework that had been assigned previously. Homework assignments include any agreements the patient made to alter or monitor behaviors at the previous session. Then significant time should be devoted to food planning and problem solving with special attention given to identification of behaviors which interfere with progress. Encourage patients to discuss apprehensions they may have about nutrition treatment, body weight, and food planning, and concerning physical complaints. The session ends with articulation of the treatment plan and assignment of homework. Homework is likely to consist of food and/or exercise behavior agreements or instructions to self-monitor behaviors. Throughout each session, be optimistic about the likelihood of the patient’s eventual success in overcoming the eating disorder and confident in your ability to guide and assist the patient in this endeavor.

## Initial Sessions

The primary goal of initial sessions is to set the stage for formation of a collaborative relationship. Creating a therapeutic bond requires empathy and obvious interest in patients and their food-related problems. Hill and O’Brien (1999, p. 25) describe empathy as an attitude of responding with genuine caring, deep respect, and lack of judgment. “You must have felt . . .” or, “It sounds like you . . .” are examples of empathetic replies. Hill and O’Brien also suggest using one’s own experiences or the experiences of others to help the patient feel understood, such as, “I feel like . . . when that happens” or, “Other patients have told me . . .” or, “Lots of people do just that . . .”. Responding in this way lets patients

know they have been understood and that their experiences are normal particularly for people who have eating disorders. "Normalizing" patients' experiences helps them feel more competent and more capable of making behavioral changes. Verbally acknowledging the patient's strengths and accomplishments is another way of helping the patient feel valued and capable of changing. Obviously, one can comment on the personal strength necessary for patients to acknowledge their need for help and to engage in treatment.

The first several minutes of the first session are crucial to the establishment of an effective working relationship. Asking, "How can I be of help?" emphasizes the collaborative nature of nutrition counseling. If the patient doesn't know the answer to this question—which is to be expected if the patient hasn't voluntarily sought help—then asking, "Why are you here?" is surprisingly effective (Johnson, 1985, p. 20). The anorexic patient may respond to the opening questions, by saying, "I am fine. I am only here because my mother or my doctor is worried about me." One possible response might be, "Oh, so you need my help reassuring your mother or your doctor. What are they worried about?" Dialogue like this helps patients find tangible reasons to participate in treatment. Oftentimes, reluctant patients are unable to identify any personal problems attributable to their eating-disordered behaviors. These patients may profit from hearing how the professional imagines eating-disordered symptoms have affected their lives. Something like, "Many of my patients who have lost as much weight as you have, have trouble keeping their hands warm," is likely to lead to further conversation. To further engage resistant patients, Davis (1991, pp. 77–78) suggests counselors strive to interest the patient in the counselor and in the treatment by self-disclosing details about themselves and their practice. An example of a self-disclosing statement is "I am partial to working with eating-disordered patients because it gives me an opportunity to work with such great people."

Once the patient's problems are identified, nutrition counselors should articulate their conviction that solutions exist and that they have the necessary expertise and experience to help the patient overcome these problems. These first sessions are aimed at reassuring and, even inspiring the patient about the potential for progress as the result of engaging in treatment. Further, Davis (1991, pp. 77–78) advises explaining how eating disorders usually develop and describing likely symptoms. Finally, Davis suggests telling patients that they do not have to be this way forever, and that it is in fact the professional who is responsible for the success or failure of treatment as a whole.

Disheartened by their own unsuccessful attempts to master their eating problems, bulimic and binge eaters are likely to be eager for assistance, but in dire need of hope. Such patients can be galvanized by offhand

references to positive research findings on the efficacy of behavioral treatments, as well as references to favorable outcomes from the professional's practice. Adult bulimic patients are usually quite eager to work with a professional who offers to help them control their eating behaviors. Conversely, younger patients (children, adolescents, and college students), who generally come into treatment on referral from a concerned professional, friend, or family member, are more likely to be indifferent or even hostile towards treatment. In initial sessions with younger patients, professionals should share information about the patient they have received prior to the visit and reiterate that their primary relationship is with the patient, not with the concerned others. Underscoring the confidential nature of counseling and explaining under what circumstances information may be shared with others is important to the therapeutic relationship. Patients who are minors need to be told they will be apprised before disclosures are made to parents or other professionals. Before information can be divulged about adult patients, they must sign consent for release of information. (See Appendix F for a sample form.)

Secondary to the establishment of a therapeutic relationship is obtaining a personal and dietary history. Although nutrition counselors are necessarily quite interested in food-related history, remember some patients will be bored and frustrated by extended history-gathering sessions. Hill and O'Brien (1999, p. 40) suggest the following questions, "Why don't you tell me about yourself, especially in reference to coming to see me today?" and, "What do you think is important for me to know about your [eating] problems?" This style of questioning encourages patients to "tell their story" at their own pace. Nevertheless, over the course of treatment, the patient's history should be fully explored in regards to eating behaviors, body weight, and knowledge and attitudes about food. One advantage to obtaining histories in installments is that time is allowed for response, further exploration, and education.

Another objective of initial sessions is exploration of the patient's motivations for and notions about nutrition treatment. Understanding the patient's perspective on these issues helps the nutrition counselor dispel misconceptions and anxieties, as well as draft first interventions that reinforce the formation of a collaborative relationship. By the time most patients seek nutrition counseling, either they or concerned others are experiencing fear or frustration as a result of the eating disorder. Yet patients have hesitated to seek professional help because of the expected commitment of time and money, the embarrassment that they need help, the fear of deeply exploring problems, the commonly held negative stereotypes about people who need counseling, or a combination of these concerns (Hill & O'Brien, 1999, pp. 8–9). Oftentimes, patients are apprehensive about nutrition treatment because they presuppose no one could

possibly understand their eating disorder or that they will be castigated for thoughts, feelings, and behaviors related to their eating disorder. Others are distrustful of professionals in general and resistant to the idea of entering into a therapeutic relationship that may foster dependency. Stern (1991, pp. 86–105) writes that eating-disordered patients tend to be paralyzed by the conflicting motivations of the “legitimate needs of the self” and the need for self-control, self-denial, and self-sacrifice typical of eating-disordered patients. Stern advises counselors to acknowledge, appreciate, accept, and respect all of these needs and to offer solutions that integrate these “opposing” needs.

Even first sessions should include giving simple behavioral assignments to be completed before the next scheduled session.

### Ending Sessions

The last few minutes of each session, particularly initial sessions, should be devoted to answering any questions patients may have. Hill and O'Brien (1999, Chapter 10) suggest a 15-minute rule in which counselors alert the patient that in a few minutes the session will end: “Do you have any questions you would like to ask me?” Should a patient ask a number of very personal questions, the nutrition counselor should explore what is prompting these questions and how the patient feels about the professional's disclosures. Homework assignments should be reiterated at the close of each session. Discuss with the patient whether the assignment should be put on paper, asking “Do you want to write down your assignment or have me do it for you?”

### Follow-Up Sessions

In succeeding sessions, allow patients to start spontaneously by saying, “What would you like to talk about today?” or, “How are you doing?” Encouraging patients to reflect on previous sessions is also productive, by asking, “How did you feel about our last session?”

### Appointment Frequency

Initially, nutrition counseling is most effectively provided on a weekly basis. Patients tend not to make behavioral progress with less frequent appointments unless they are highly self-motivated. Bi-weekly and then monthly sessions are indicated as the patient is able to meet and to maintain treatment goals with relative ease. Anorexic patients who must en-

gage in an intensive weight-gain program may benefit from more frequent sessions in order to manage their more volatile caloric needs and their anxiety about gaining weight too fast.

### Education

Both Cognitive-Behavioral Therapy (CBT) (Fairburn et al., 1993) and psychodynamic treatments for eating disorders (Tobin & Johnson, 1991, p. 390) include an educational component, at least initially. Patients need to be informed about basic nutrition, exercise physiology, and body weight regulation. They also need to hear about the adverse effects of dieting and chaotic eating, and the physical consequences of undereating, binge eating, self-induced vomiting, and laxative abuse. Another important educational theme is the contribution of sociocultural pressures in perpetuating eating disorders.

Hill and O'Brien (1999) offer the following advice on delivering educational messages to patients. First, find out what the patient already knows and determine what she or he needs to know. Second, communicate respect for the patient's point of view. Third, deliver educational messages in a nonjudgmental, compassionate, and even humorous manner. It is important not to lecture, but rather to weave educational material into interactions with the patient. Look for signs of interest and readiness on the part of the patient before embarking on an educational topic. Be aware and ready to discuss the patient's reaction to these topics. On issues about which the patient is likely to be misinformed, be ready to provide accurate and up-to-date facts. Professionals should be familiar with the latest “diet” books and be able to explain their fallacies.

### Interventions

Nutrition interventions aim to change patients' eating behaviors. To be effective at assisting patients in changing behaviors, help patients set realistic behavioral goals. They will need support and feedback to experiment with new behaviors. The first step in the process of setting behavioral goals is to identify antecedents. These are the thoughts and actions that precede and result in undesirable behaviors. For instance, because most patients find their bingeing behavior puzzling, they are likely to be intrigued by the statement, “There is always a reason for a binge-eating episode.” Also engaging is an invitation to join in the required detective work required to solve a eating-behavior mystery: “Let's figure out what set up your latest binge.” Mutual understanding of this chain of events

helps counselors and patients establish behavioral goals. The next step is an examination of the patient's previous efforts to solve problems and how the patient feels about these efforts. Ask, "What worked, what didn't, and why?" Revised goals should be specific, concrete, relevant to the patient, and be under the patient's control. Tobin and Johnson (1991, p. 385) suggest, in addition, that counselors ask themselves, "What is the smallest change in behavior that will make a significant impact on this patient's symptoms?" Another strategy is to ask each patient to "do one easy thing, one medium thing, and one hard thing per week." The easiest behaviors should be attempted first.

### Self-Monitoring

Written self-monitoring of behaviors and associated thoughts and feelings are basic to behavioral counseling approaches. In nutrition counseling, self-monitoring proves beneficial for both counselor and patient. The counselor is provided with a detailed description of the circumstances of the patient's eating problems and patterns and a concrete way to assess the patient's progress. Patients gain increased self-awareness of their eating problems and precipitating events. Self-monitoring can provide a sense of security for patients as they experiment with new behaviors. Another positive outcome for patients who self-monitor is the sense that they are actively working on their eating disorder between treatment sessions. Self-monitoring, in and of itself, may result in behavioral improvements. Self-monitoring, however, should be strategically, not routinely, prescribed. Some patients resist self-monitoring because they are embarrassed about their food behaviors or because they worry it will increase their preoccupation with food. If patients are making progress with homework assignments and behavioral and weight goals, self-monitoring is unnecessary. If patients are struggling, self-monitoring should be considered.

### Conclusion

Writers from both nutrition and psychotherapy professions emphasize the necessity of establishing a therapeutic collaborative relationship with patients before behavior change can be successfully implemented (Fairburn et al., 1993, p. 365; American Dietetic Association, 1994). The continuing challenge for nutrition counselors is to preserve therapeutic alliances with patients while delivering educational messages and interventions.

## 2 CHAPTER

# Advanced Nutrition Counseling

The advanced techniques described in this section are derived from psychological literature, but can be appropriately applied to nutrition counseling. These techniques give nutrition counselors the proficiency and confidence to handle the complex issues of even the most difficult patients. Furthermore, familiarity with psychological treatment approaches facilitates team work with mental health professionals.

The following portrayals of psychological therapies are intentionally brief and are focused on the methods of most value to nutrition counselors. Attention is also given to the Maudsley Method (Lock, le Grange, Agras, & Dare, 2001) and the basic helping skills articulated by Clara Hill and Karen O'Brien (1999). Both of these approaches offer an abundance of useful techniques for the nutrition counselor. The final sections of this chapter are devoted to a variety of topics and issues that arise in counseling relationships. Readers are encouraged to seek out cited references for more information.

Eating disorders are classified as psychological syndromes in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, American Psychiatric Association, 1994). Although diagnosing and treating psychological syndromes are in the psychotherapist's domain, nutritionists and other non-mental-health professionals who treat patients with eating disorders should be familiar with and understanding of psychological treatment theories and techniques. Furthermore, eating-disordered patients may

have dual diagnoses, such as borderline personality disorder along with their eating disorder. Such patients, considered difficult to treat, benefit from nutrition counseling that is grounded in basic counseling techniques. Finally, since most eating disorder treatment research is aimed at studying interventions conducted by professionals trained in psychology, nutritionists who are familiar with counseling approaches are better equipped to apply these research findings to their clinical practice.

## □ Behavioral Counseling

In essence, the nutrition counselor conducts a very specialized type of behavior counseling. Behavioral counseling is based on the ideas of John Watson and B. F. Skinner who theorized that behavior is determined by what happens as a result of the behavior. Behaviorists conclude that positive reinforcement increases the likelihood behaviors will occur again. Conversely, behaviors which are ignored or punished are likely to be extinguished. In behavioral counseling, counselor and patient explore together the context of the patient's behaviors in order to develop specific interventions aimed at extinguishing problematic behaviors and reinforcing positive behaviors. Behavior counselors solicit detailed descriptions of problematic behaviors from patients and focus on events occurring just prior to problematic behaviors. In addition, attention is paid to the consequences of problematic behaviors. Behaviorists use advice, opinion, information, feedback, and encouragement to assist patients in making behavioral changes. More information and guidance about behavior counseling techniques can be found in counseling textbooks such as those by Hill and O'Brien (1999) and Ivey et al. (1987).

One primary task for the nutrition counselor is to define the eating disorder as essentially a behavioral problem. This is not to say that the patient does not also have significant emotional, relational, or other psychological difficulties. In truth, these additional problems might well have put the patient at risk for developing an eating disorder. The nutritionist, nevertheless, concentrates on the patient's current thoughts, understandings, and behaviors that maintain the eating disorder, not on the factors that "caused" the eating disorder. The latter is the domain of the psychotherapist.

Nutrition counseling begins with a focus on antecedent and associated behaviors and consequences of the patient's current food behavior problems. By posing questions about the patient's recent and historical food-related problems, the nutrition counselor gathers data about patterns of concrete behaviors and actions. A non-judgmental "anthropological"

method of data collection allows for the formulation of a clear and precise behavioral definition of the patient's difficulties. When an anorexic patient loses weight, the patient's eating patterns should be investigated with curiosity. Begin the exploration by saying something like "Let's see if we can figure out what happened." In addition, it should be reflected that, in spite of many negative consequences, eating-disordered behaviors "make perfect sense" in light of the desire to lose weight, to relieve stress, to feel in control, or to satisfy the need for attention, to cite a few common examples. The expression of an empathetic, respectful understanding of the role the eating disorder plays in patients' lives helps them feel respected and reassured that the nutrition counselor can truly help them overcome food-related problems.

This approach allows the patient's eating disorder to be redefined as a food-, exercise- and/or weight-management problem for which there is an effective alternative management system. Some patients benefit from the reassurance that descriptions of other patients' "success stories" (minus any identifying information) provide. For others, hope is bestowed through references to clinical research which substantiate the effectiveness of behavior treatment.

Most patients need help experimenting with new behaviors, setting behavioral goals, and in assessing outcomes. Behavioral goals, of course, require action on the part of the patient. The most effective behavioral goals are specific, relevant to the patient, and achievable in the immediate future (Ivey et al., 1987). Tina, a 15-year-old anorexic-turned-bulimic, was able to agree to abstain from bingeing and purging on Friday afternoons so she could spend time with her school friends.

Behavior therapy has been found to be as effective as CBT in reducing binge-eating behaviors (Agras, 1993).

## □ Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy, which aims to integrate psychodynamic and behavioral therapies, has been much studied in its application to eating disorders treatment, particularly bulimia and binge-eating disorder (Fairburn, Marcus, & Wilson, 1993). CBT focuses on thoughts, beliefs, values, and the behaviors that maintain an eating disorder rather than on causal factors as does nutrition counseling. CBT includes educational components, the prescription of a meal plan, weight monitoring, and written self-observation. Familiarity with CBT approaches enables nutrition counselors to be supportive of patients who may also be engaged in CBT treatment with a psychotherapist.

Cognitive-behavioral theorists hypothesize that behaviors are influenced by one's current thoughts. Behaviors are changed by first examining and changing the cognitive errors that support the associated thoughts. Once thoughts are changed, then so, too, can behaviors be changed. It is the task of the counselor to look for the cognitive errors and problematic thoughts that support pathological behaviors.

Goldstein (1998) describes three common "cognitive errors." *Polarization* is seeing things as all good or all bad. *Personalization* occurs when patients view everything in terms of themselves. *Overgeneralization* means drawing conclusions well beyond the circumstances.

To patients, the CBT counselor explains that restrictive eating and overvalued ideas and concerns about weight and shape maintain eating-disordered behavior. Patients are instructed to follow a structured eating plan (i.e., at least three meals eaten at prescribed times), to consume feared foods, and to record food intake and purging behaviors, if applicable. Body weights are regularly monitored by the counselor, a health professional, or patients themselves. In addition, the counselor works with patients to correct erroneous thoughts about food and weight control, as well as, to develop problem-solving skills and relapse prevention plans.

CBT for bulimia and binge-eating disorder, applied as a programmed, time-limited (usually 20 sessions plus bi-monthly follow-ups) approach, has been found effective in reducing purging, bingeing, dieting, and in improving attitudes about shape and weight, depression, self-esteem, and social function in an impressive number of randomized controlled treatment trials. Positive results have been sustained at six-month, one-year, and five-year follow-ups (Wilson et al., 1997). Although research is lacking on application of CBT in treatment of anorexia nervosa, Garner and colleagues (1997, pp. 96-97) cite favorable clinical evidence.

The detailed CBT treatment manuals for bulimia and binge-eating disorder written by Fairburn et al. (1993) and the client workbook authored by Apple and Agras (1997), as well as the CBT manual supplement by Wilson et al.'s (1997) are invaluable resources for professionals. The Garner et al. (1997) adaptation of CBT methods for the treatment of anorexia nervosa is also available in treatment-manual format. These treatment manuals detail the use of food records, review the physical consequences of binge eating, purging, and starvation; and give evidence that proves the ineffectiveness of purging, and the adverse effects of dieting.

Fairburn et al. (1993) maintain that CBT may be unnecessarily intensive for some patients. CBT is counterindicated for patients who have psychotic symptoms, severe depression, risk of suicide, or substance abuse (Wilson et al., 1997). Ambivalent patients, who may have had several treatment failures, are often hesitant about committing to such a highly structured program. Adolescent patients can feel overwhelmed by the

fast pace of typical CBT programs. These patients, nonetheless, may benefit from selective use of CBT strategies. Fairburn and colleagues (1993), however, caution against any modification in CBT as it is only the standard application of CBT that had been proven to be effective in a randomized controlled trials.

Nutrition counselors need to consider the reservations of Wilson et al. (1997, pp. 82-83) about the use of CBT by practitioners without systematic training in its methods. Professionals without CBT training should familiarize themselves with the references in this section and consider contracting for supervision with a CBT-trained practitioner if they intend to utilize these methods in their counseling. As CBT often reveals a patient's very poor self-esteem or paralyzing concerns about shape and weight, nutrition counselors must be prepared to refer such patients for adjunctive psychotherapy. CBT-trained practitioners, on the other hand, will benefit from information provided in this text on meal planning, sound nutrition information, and from the detailed strategies for managing food restriction, bingeing, vomiting, and laxative abuse.

Of note, one clinical study found CBT equally effective whether administered by non-mental health professionals or by mental health professionals (Waller, Fairburn, McPherson, Kay, Lee, & Nowell, 1996).

## CBT Techniques

### Education

The initial phase of CBT treatment for eating disorders is educational. The practitioner teaches the patient that overconcern about weight and shape results in dietary restriction, negative mood, and low self-esteem. Such factors cause a "self-perpetuating cycle of binge eating and purging" which the practitioner can draw out on paper using the patient's own experiences and words (Apple & Agras, 1997, p. 22; Fairburn et al., 1993, pp. 386-389). The practitioner also informs the patient about the biological mechanisms of weight control; the physical consequences of binge eating, self-induced vomiting and laxative abuse; the ineffectiveness of vomiting and laxative abuse as means of weight control; and the adverse effects of dieting.

### Normalized Eating Pattern

The second phase of CBT treatment focuses on resumption of a normal pattern of eating—that is, three meals and two snacks per day, consumed at specified times. Development of alternative behavior strategies to inhibit bingeing and purging help patients adhere to a regular pattern of

eating. Examples of alternative behaviors which are "incompatible" with bingeing or purging include calling a friend, using the computer, exercising, taking a shower, brushing one's teeth, and so forth. (See Appendix E for more alternative behaviors.)

### Cognitive Restructuring

Cognitive restructuring, the third phase of CBT, is a potent method for changing the problematic thoughts that negatively influence food behaviors. First, the counselor helps patients identify irrational thoughts by restating and summarizing their thoughts. This reassures patients that they have been understood. Restatements help patients recognize irrational ideas and reassure them that the counselor understands their dilemmas. Restatements also provide the professional a moment in which to figure out how to intervene.

Problematic thoughts usually have negative connotations and are believed without examination. In the next step, the counselor, relying on factual information and clinical and personal experiences, provides persuasive counter-arguments that require patients to question the validity of their problematic thoughts. Patients are encouraged to examine whether they are confusing a "subjective impression"—feeling fat, for example—with "objective reality"—being medically overweight. In the final step, the counselor assists the patient in coming to a new conclusion now that the facts have been examined. The adoption of the new conclusion will require a shift in thinking; this shift is thought to result in behavioral change. Patients should practice the new way of thinking each time the problematic thought occurs. Whether the patient actually believes the new thought or not appears to be irrelevant in inducing behavioral change (Fairburn et al., 1993; Ivey et al., 1987; Wilson et al., 1997).

Cognitive restructuring can be applied to common food misconceptions, such as "eating fat will make me fat." Evidence that casts doubt on this thought can come from regular checks of the patient's weight on an accurate scale, comparing the patient's weight to standards from height and weight charts, and comparing the patient's fat intake to official health recommendations.

Two common problematic attitudes—overvaluing shape and weight, and equating self-control with dietary control—can also be tackled using cognitive restructuring (Fairburn et al., 1993). The counselor encourages patients to consider whether they benefit from maintaining these attitudes. Further, the counselor attempts to help patients see how these attitudes perpetuate their eating disorder.

Nutrition counselors should watch for expressions of faulty thinking about nutrition, food, and weight control. (See Appendix E, sample educational handouts that can help correct misinformation.) One way to re-

state a binge-eating patient's contention that eating breakfast leads to weight gain would be to say, "So you think that anyone who eats breakfast is destined to gain weight." "No, of course not, my roommate eats breakfast every morning and she is thin," the patient is likely to reply. Through gentle challenge and persuasion, nutrition counselors help patients shift their thinking and arrive at new conclusions. Patients can be encouraged to test their notions with behavioral experiments. An experiment can be suggested thusly, "While I know that eating breakfast will help keep your metabolism up and keep you from overeating later in the day, let's experiment this coming week to see if this is true for you."

For example, Deidre was afraid of putting salad dressing on the big salad she regularly ate for lunch:

*Nutritionist:* What is so scary about salad dressing?

*Deidre:* Well, it is high in fat and calories.

*Nutritionist:* (Explaining) Salad dressing is about half oil and half spices and vinegar, and spices and vinegar have no calories to speak of.

*Deidre:* But the oil is really a fat, isn't it?

*Nutritionist:* Oil is a very healthy fat that is a good source of essential fatty acids and fat-soluble vitamins which your diet, by the way, is quite low in. *Deidre:* But fat is fattening.

*Nutritionist:* I know that most people think so, but in reality no food is fattening. We gain fat if we consistently eat more calories than we need. It doesn't matter whether those calories come from protein, carbohydrates, or fat.

*Deidre:* So I won't gain weight if I add salad dressing to my salad if I don't eat too many calories?

*Nutritionist:* That's right. How much salad dressing do you like on your salad?

*Deidre:* I used to use about a tablespoon, but that is too much, isn't it?

*Nutritionist:* Well, that is a normal serving and only about 75 calories. Is that too much?

*Deidre:* (After a moment of thought) No, I guess not since I am suppose to be eating 2,000 calories every day.

*Nutritionist:* What would you have to tell yourself to be able to add salad dressing to your salad tomorrow?

*Deidre:* (With some confidence) That salad dressing is good for me and as long as I don't use too much, it isn't very high in calories.

When cognitive skills are affected by malnutrition or when patients are overwhelmed by anxiety, they may not be able to use cognitive restructuring to challenge irrational thoughts. Such patients should be directed to use rehearsed phrases (self-talk) to bolster their commitment to behavior change. (See Chapter 1 pp. 16–17 for more information on effective self-talk.)



## □ Dialectical Behavioral Therapy

Dialectical Behavioral Therapy, developed by Marsha Linehan (1993a) to treat chronically suicidal borderline patients, shows promise for eating-disordered patients (Safer, Telch, & Agras, 2001). DBT clinicians define dysfunctional patterns of behavior as attempts at problem-solving. The focus of treatment is balancing the acceptance of behavioral problems while, at the same time, working to help patients change their behaviors. DBT counselors concentrate on behaviors that interfere with "quality of life." Although neither controlled, randomized trials nor follow-up studies of DBT protocols for eating-disordered subjects have been published, such studies of borderline subjects indicate the effectiveness of DBT (Shearin & Linehan, 1994). A comprehensive treatment manual clearly outlining the DBT approach and associated strategies is available (Linehan, 1993b). Recently, Telch, Agras, and Linehan (in press) developed a DBT group treatment program for binge-eating disordered patients.

## DBT Techniques

Counselors using a DBT approach acknowledge to patients that the patients are doing the best they can, yet they need to do better. Keeping in mind another DBT concept "whatever patients are doing makes sense even if they are not making progress," counselors assist patients in problem-solving and learning new behaviors. For example, a counselor may say, "I understand why you behaved the way you did, now what could you do differently next time?" Relapses or failure to do homework are reframed as a joint problem, "How are we going to fix this? Do you have some ideas. I have some ideas. Let's hear yours first." In each session, the DBT counselor looks for effective behaviors and attitudes to validate. Sessions end with the counselor saying, "You are doing the best you can." DBT counselors may allow patients to call them between sessions to get coaching to avert a behavior problem. Patients, however, are not allowed to call to report "bad days" or for self-soothing. In their interactions with patients, DBT practitioners are encouraged to be nonjudgmental and matter-of-fact, to trust their intuition, to tell stories, and to use paradox, metaphors, irreverence, and humor to point out contradictions in patients' behaviors.

David, who regularly binged on sweets and high-fat snack foods, found the metaphor of the "red truck" helpful as he grappled with his nutritionist's instruction to begin to add back "forbidden" foods. This metaphor goes something like: "If children are put in a room full of toys

and are told they can play with any of the them except the red truck, when the adults leave the room, what do you think happens?"

*David:* Of course, they can't keep their hands off the red truck.

Gently his nutritionist explained that "forbidden foods" easily become "red trucks," in that we can't stay away from them when we are alone.

*Nutritionist:* We all know that in this scenario kids are only interested in the red truck because they are forbidden from playing with it. The kids that get to play with the red truck every day don't find the truck very special. We have to figure out a way for you to have a forbidden food every day.

*David:* Is that why you've been wanting me to have a dessert with dinner?

Practitioners should be on the constant lookout for improved attitudes and behaviors to compliment. In essence, DBT requires constant "cheerleading." Carla, an anorexic, was losing weight even though she was carefully following her food plan. Yet, Carla was praised for her efforts to follow her food plan, but almost in the same breath she was informed that the food plan would have to be amended.

Central to DBT is the concept of a "wise mind." A wise mind enables patients to distinguish between what is true and what they "feel" or "believe" to be true. In response to the common complaint "I feel fat" or "I think I am fat," the DBT practitioner might say, "I am interested in what you know to be true in your wise mind" (Linehan, 1993a, pp. 214-216).

Linehan recommends practitioners watch for opportunities to play the "devil's advocate" by expounding on possible extreme consequences of patients' attitudes and behaviors. A nutrition counselor might respond, somewhat tongue-in-check, to the patient who justifies fasting because she didn't do any exercise, "So you think that people in wheelchairs don't need to eat because they can't exercise? In fact, people in wheelchairs usually eat at least three meals a day." Linehan also suggests that the notion of "making lemonade out of lemons" helps practitioners approach patient's problems as opportunities to develop and practice new strategies: "It is opportune that you binged and purged yesterday afternoon so that today we can really figure out what precipitated your binge and what made you vulnerable." In what Linehan calls a behavioral "chain analysis," the practitioner leads the patient through an exhaustive analysis of what happened and why.

The DBT approach relies heavily on the collaborative generation of homework assignments. Practitioners are advised to explain the rationale behind suggested assignments. Patients are expected to actively practice assigned behaviors between sessions. Practitioners, when reviewing home-

work, are advised to not give more attention to analyzing the patient's difficulties than to analyzing their successes. See Linehan's comprehensive clinical text (1993a) and treatment manual (1993b) for an in-depth discussion of the strategies summarized above.

### □ The Maudsley Method

For adolescent patients with a short duration of anorexia nervosa, the Maudsley group in London has had good success empowering parents so that they can "refeed" their children (le Grange, 1999). In the Maudsley method, the treatment team simultaneously works to decrease parental guilt about their part in causing the eating disorder while increasing parental anxiety about the seriousness of their child's eating disorder. The hoped-for result is an increase in the parents' sense of urgency about their child's predicament and a new sense of parental responsibility for managing the child's eating behaviors. Parents are encouraged to rely on the same strategies they use to set limits around other issues. For example, parents are reminded that they are able to limit the time their child watches television regardless of how much the child desires to watch more. Likewise, they have successfully compelled their child to take an essential medication whether the child wanted to or not. Parents, patients, and even siblings are involved in sessions as the practitioner helps the family focus on the task of restoring the patient's weight and physical health. When the patient is able to eat well independently, control over eating is returned to the child. Siblings are encouraged to provide empathetic, noncritical support to the one struggling with the eating disorder and not to interfere with the parents' efforts to refeed the patient (le Grange, 1999, pp. 734–753; Robin et al., 1999, p. 1482; Treasure, 1997, p. 50).

### □ Helping Skills

Hill and O'Brien (1999) describe in their text, *Helping Skills: Facilitating Exploration, Insight, and Action*, counseling skills for non-psychologically-trained professionals. This text provides practical guidance for nutrition counselors with clear descriptions of basic counseling techniques and helpful "words to say." These skills, which correspond to many techniques employed by nutrition counselors, include assessing behaviors, teaching new behaviors and strategies, providing accurate information, reinforcing positive behavior changes, and assessing and modifying treatment plans. Such skills help counselors lead their clients from exploration to

insight and ultimately to action. Counselors establish rapport by listening carefully, asking open-ended questions, and occasionally restating the patient's conclusions or reflecting back the patient's feelings. In the exploration process, patients are encouraged to tell their stories and explore their thoughts and feelings. Gaining insight into their own role in perpetuating their problems makes it easier for patients to change. Counselors generate, explore, and suggest options for change, then ask the patient, "What would you like to do about this problem?" (Hill & O'Brien, 1999, p. 306). Counselors aim to maintain an empathetic manner and a comfortable pace as they provide feedback to patients about their attempts at behavior change.

### □ Counseling Issues

A variety of issues arise when working with patients with entrenched eating disorders, in difficult personal situations, and/or with coexisting psychiatric diagnoses. In general, patients in significant emotional distress are less likely to respond to brief nutrition counseling interventions. They are more likely to require long-term nutrition treatment and benefit from a compassionate, somewhat tenacious approach delivered by professionals who are available over the long-term and are confident that they can help patients in difficult situations manage their food issues. In extended treatment modalities, the relationship between nutrition counselors and their patients becomes an influential component of the therapy. To avoid pitfalls that can intrude on professionals' efforts to develop appropriate therapeutic relationships with these patients, consider the following.

### Counseling Ethics

First and foremost, counselors should do no harm. Patients should be allowed the right to make their own decisions if they do not do harm to themselves or to others. Counselors should aim to support the growth and development of patients by being sincere, dependable, and trustworthy. Giving honest feedback, keeping confidences, being on time for appointments, and being direct about one's availability outside of sessions and about whether or not phone calls will be accepted or e-mail answered all help foster therapeutic relationships (Hill & O'Brien, 1999).

In general, dual relationships (providing counseling to friends or other family members of current patients) should be eschewed. In some circumstances (e.g., when only one experienced nutritionist is available),

such relationships may be unavoidable. If so, counselors should first obtain approval from the original patient and take pains to keep treatment sessions devoted to each patient's individual treatment issues. Professionals should be prepared for times they may encounter patients in social settings. If this is likely to occur, a behavior plan should be discussed with patients in advance. When unexpected meetings occur, it is best to let patients take the initiative. In response, be courteous, but not engaging. Those who work with eating disordered patients should aim to personally eat and exercise in a responsible manner. Hill and O'Brien (1999) remind professionals that taking care of themselves ensures that they can competently care for others.

### Supervision

Nutrition counselors, especially those who treat difficult patients, are advised to arrange for formal supervision sessions (usually fees are equivalent to the supervisor's counseling fee) with an experienced psychotherapist. Supervision helps nutrition counselors understand and manage their countertransference (the emotional reactions of professionals to their patients) responses to patients' behavior which may include anger, guilt, defensiveness, helplessness, and even a desire to retaliate (Dennis & Sansone, 1991, p. 141). Another way to access professional tutelage is to join a team of mutually supportive professionals, who meet regularly for case conferences. Also worthwhile is the experience of co-leading an eating disorder group with a psychotherapist. Leading a therapy group together gives both professionals exposure to the other's style and areas of expertise. Enrolling in counseling courses, attending appropriate conferences, and self-study of counseling and eating disorder treatment texts and research journals also improve counseling skills. Garner and Garfinkel's *Handbook of Treatment For Eating Disorders* (1997), a comprehensive compilation of psychological treatments for eating disorders, and the *International Journal of Eating Disorders* are also highly recommended for non-psychotherapists and psychotherapists alike.

### Handling Unrelated Issues

Saloff-Coste et al. (1993) describe the territory of nutritionists as including any issue that perpetuates eating disordered patterns and interferes with a patient's efforts to improve her or his food behaviors. These topics, according to Saloff-Coste and colleagues, include self-esteem issues, lack of motivation, pessimism, and body image, but exclude early psycho-

logical issues such as relationships, fantasies, flashbacks of childhood sexual or physical abuse, memories, hearing dangerous voices, and suicidality.

There are several reasons nutritionists should not delve into these psychological areas: One, such subjects divert attention from nutrition issues and may be used by resistant patients for exactly this purpose. Two, nutritionists do not have the clinical training to effectively manage the emotional responses, particularly attachment and dependency issues, that exploration of these topics often engender in patients and professionals. In the same way, mental health providers may be overwhelmed or distracted from important psychological problems by in-depth discussions of food and weight.

Nutrition counselors and psychotherapists who provide joint treatment to patients should routinely communicate with each other, especially when patients initiate discussions of issues in the other professional's area of practice. Also important is that nutrition counselors make it standard practice to direct patients to bring up these issues themselves in subsequent sessions with either their psychotherapist or nutritionist.

In areas in which there is overlap between nutrition counseling and psychotherapy (e.g., body image issues) ask, "What does your psychotherapist say about that?" Mental health providers can use the same technique ("What does your nutritionist say about that?"), when patients ask nutrition-related questions of them.

Nevertheless, most patients will need to devote some time in nutrition sessions to describing the "non-food" aspects of their lives and personal dilemmas in order to feel understood and cared for by their nutrition counselor. Winocur (1990, p. 76) contends that unless patients experience nutritionists as being as concerned with their psychological issues as with their food issues, they are likely to "split off the nutritionist as the focus for negative feelings."

Psychological digressions should be permitted, but after employing "active listening" skills, nutrition counselors should always sensitively redirect the patient's attention back toward food-related issues. Particular care should be taken to remember that helping patients gain insight into why their food problems developed is not an appropriate focus for nutrition counseling.

As mentioned above, when significant "non-nutrition issues" are revealed, patients should be advised to share these issues with their psychotherapist. If significant psychological issues surface for patients not currently in therapy, the benefits of conjunctive psychotherapy ought to be discussed with them. Nutrition counselors should be able to provide patients with names and phone numbers of psychotherapists specializing in eating disorders. Tolerating a patient's persistent use of nutrition coun-

seling sessions to discuss psychological issues will dilute the nutrition treatment, as well as interfere with the patient's psychotherapy relationship.

### Referral for Psychotherapy

Eating-disordered patients may first enter treatment via a nutrition counselor. Before agreeing to treat such patients, some nutritionists require them to engage simultaneously in treatment with a psychotherapist. On the other hand, patients who are hesitant about seeking any treatment at all may feel exasperated by the prerequisite that they arrange for conjoint psychotherapy. If nutrition counselors are experienced in treating eating-disordered patients and are willing and ready to make referrals to mental health providers, then it is acceptable practice to begin treatment with patients as their sole counselor. Referrals to a psychotherapist, however, must be made if and when patients' psychological issues become apparent or begin to dominate nutrition sessions or when patients do not make expected progress. It goes without saying that eating-disordered patients should be followed by a medical provider.

Considerable effort needs to be devoted to avoiding the creation in patients of an unhealthy dependency on the nutrition counselor. Overly dependent patients often are reluctant to seek help from psychotherapists and rarely make sustainable progress improving eating-disordered behaviors. Encourage patients with significant psychological issues to engage in or remain in psychotherapy-oriented treatment to deal with their other issues. Such patients need to understand that there is more to their ultimate recovery than gaining control of their eating-disordered behaviors.

### Idealization

Nutrition counselors are likely to become very important to patients if they are compassionate and supportive. Johnson (1991, p. 193) advises that this idealization be managed "gracefully and thoughtfully." Idealization, Johnson argues, may be temporarily therapeutic, especially for patients who have been denied the experience of a responsive caregiver on whom they could depend. Gradually, the patient should be encouraged to develop a more realistic view of the nutrition counselor, but in the meantime the counselor may feel uncomfortable with the power and influence she or he has over the patient. In this case, a consultation with the patient's psychotherapist or the nutrition counselors' own support network is in order.

Johnson (1991, p. 192) warns that one downside to idealization is that patients may so want to please the professional that when relapse occurs they are inclined to not disclose their difficulties or even to lie. Patients may decline to work with additional professionals. They may want to socialize with the counselor outside of scheduled appointment times. Another repercussion is that professionals may become "overstimulated" by the level of esteem in which patients hold them and lose perspective about their own abilities or appropriate spheres of influence. In this context, nutrition counselors must guard against tendencies to offer advice in areas outside of their professional expertise or to initiate social contact with patients.

### Splitting

Splitting, which is often expressed as pitting one professional against another, is likely to occur when multiple providers are involved in treatment of the same patient. This phenomenon can be minimized by ample communication between team members, which must first be authorized by the patient. Splitting is also minimized if team members are clear about each other's roles and consistent in their articulation of this understanding to patients. Joint sessions in which treatment team members have the opportunity to present a "united front" can reduce splitting (Dennis & Sansone, 1991, p. 139). It is often necessary for nutrition counselors to remind patients that they will not keep secrets from other members of the treatment team.

### Countertransference

Difficult patients are likely to create significant countertransference in treatment providers. These feelings arise when the counseling relationship mimics relationships in the counselor's own life or when a patient's difficulties or personality style triggers emotional responses in the counselor. These feelings can lead to overinvolvement in a patient's recovery, or even in her or his life, ultimately hindering treatment progress.

Saloff-Coste and colleagues (1993) warn nutritionists against common countertransference-generated mistakes, such as making decisions for patients, becoming the patient's friend, scolding the patient, or colluding with the patient by sharing an attitude of hopelessness regarding the possibility of recovery. Nutrition counselors should guard against becoming too invested in their patient's progress or imposing their own values on the patient. When these things happen, the patient is likely to become

resistant or blame the counselor if things don't go well. Wooley (1991, p. 260) encourages clinicians to learn to accept occasional anger, criticism, and rejection from patients without retaliating or withdrawing. In advance of working with eating-disordered patients, nutrition counselors should work through any problems they may have with their own eating, weight, or exercise issues or prejudices based on body size. Strong countertransferential feelings may suggest that work with eating-disordered patients is not advised.

### Self-Disclosure

The following discussion is aimed at helping nutrition counselors determine appropriate boundaries around self-disclosure, namely the sharing of personal feelings and experiences with patients. Davis (1991), Hill and O'Brien (1999), Wooley (1991), and other humanistic therapists believe brief self-disclosures on the part of clinicians help create a therapeutic bond that patients find reassuring. Such disclosures free patients to make their own disclosures and prevent them from developing misconceptions about clinicians. Self-disclosures about what the nutrition counselor or other patients have tried in similar circumstances can be useful ways to express direct guidance.

Nevertheless, self-disclosure should be used sparingly, if at all. Too much disclosure can confuse patients about the nature of a counseling relationship. Before making a disclosure, nutrition counselors should always examine their motivation; self-disclosure must always be for the patient's benefit. Disclosures should be brief, with the focus of the session immediately returning to the patient's response to the disclosure and then to her or his issues. For instance, after a self-disclosure, the nutrition counselor might say, "I wonder if something similar might work for you?" (Hill & O'Brien, 1999, pp. 312-313).

Professionals should be prepared for requests from patients for personal information, such as their credentials, their age, whether married, and about children. Eating disordered patients often ask treatment professionals whether they personally have had an eating disorder. Hill and O'Brien (1999) advise that clinicians provide information to the degree that it feels comfortable, but more importantly to explore why the patient is curious about these details. One might encourage patients to say more by saying, "I am curious about why you would want to know about my background." For some professionals, a policy of refusing to disclose any personal information beyond professional credentials is the most comfortable. For others, brief disclosures in response to patients' inquiries feels appropriate. Wooley (1991) recommends that self-disclosures, if

made, always be truthful as patients are good at detecting less-than-honest responses.

### Caring Behaviors

Well-defined boundaries which minimize touch and expressions of affection maintain a professional relationship. Inexperienced counselors should be particularly cautious in these areas since patients easily misinterpret caring behaviors and may conclude the clinician desires a social relationship. For example, when patients become teary-eyed or cry, have tissues handy, but rather than offer a hug or consolation, give the patient a few moments before gently exploring what the patient is feeling. Davis (1991, p. 84), however, allows that compliments, hugs, and similar expressions of fondness can help promote recovery. Johnson (1991, p. 184) adds that when in doubt about how to respond to patients, "Err in the direction of being human, that is being honest and compassionate," but with the caveat, "Don't initiate anything with the patient that you are not prepared to continue for the rest of your life." Johnson (1991) reminds clinicians that withdrawing support or availability is more disruptive than to not offer it in the first place. Male clinicians should be especially cautious about touching female patients.

A stable and appropriate treatment environment in which sessions begin and end on time adds to the sense that patients are being cared for.

### Self-Harming Behaviors

It is appropriate for nutrition counselors to assess risk of serious self-harm by directly questioning patients about their intentions, such as asking, "Have you been thinking about suicide?", "Do you have a plan for hurting yourself or attempting suicide?", "Do you have means (weapon, alcohol, or pills) to hurt yourself?" (Hill & O'Brien, 1999, p. 161).

Assume when patients talk about the possibility of suicide they are asking for additional help; be ready to provide names and phone numbers of appropriate mental health professionals. It goes without saying that if patients acknowledge suicidal ideation and they are not currently in psychotherapy, they should be instructed, in no uncertain terms, to find a skilled therapist immediately. For patients already engaged in psychotherapy, say, "I would like your permission to share these concerns with your therapist."

Confidentiality no longer applies when patients indicate intent to harm themselves. If the nutrition counselor has any concern about a patient's

safety, the patient's psychotherapist, or a significant other if the patient is not engaged in psychotherapy, should be notified immediately.

It is good practice to request that patients promise not to hurt themselves and promise to contact their mental health provider (or the nutrition counselor if they have not engaged a psychotherapist) when they feel suicidal. Having patients sign a "contract" attesting to a "safety" plan comprising written instructions to contact a clinician before inflicting harm on one's self is very effective. Patients who cannot contract for their safety and who have a definite plan and means to harm themselves should not be left alone or sent home. If a mental health provider or crisis hotline is not available, the nutrition counselor should call an emergency number such as 911 for assistance.

Risk for suicidality should be carefully evaluated by a mental health professional and treated aggressively since eating-disordered patients are at higher-than-average risk (Bulik, Sullivan, & Joyce, 1999).

### Working with Patients with Coexisting Psychiatric Diagnoses

One of the most challenging and intriguing areas of nutrition counseling is the treatment of patients with coexisting psychiatric diagnoses. Treating these patients requires some familiarity with various mental disorders. A good resource in this regard is the APA's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV*; 1994) which provides a good overview of the characteristics of patients with specific mental diagnoses. Depression, obsessive-compulsive disorder, borderline personality disorder, posttraumatic stress disorder, substance abuse, bipolar disorder (manic-depression), and multiple personality disorder coexist with eating disorders with some frequency (Lewinsohn, Striegel-Moore, & Seeley, 2000). Consider the wisdom of insisting that patients with these diagnoses also participate in conjoint psychotherapy with a psychotherapist who is willing to engage in regular communication.

Patients with a coexisting psychiatric diagnosis will make slower-than-expected improvements in eating behaviors. For some, low-level eating-disordered behaviors may persist in spite of treatment, but overall functioning should improve (Johnson, 1991, p. 184). Written contracts outlining behavioral goals and plans for handling crises are particularly helpful in working with these patients.

Over the course of time, nutrition counselors no doubt will engage in treatment with patients who have undiagnosed comorbid psychiatric disorders. These patients (most often they will be bulimic) are likely to have a history of or current involvement in shoplifting, promiscuity, self-mutilation, drug or alcohol abuse, sexual abuse, or enmeshed interpersonal

relationships (Garner & Garfinkel, 1985, p. 31). Nutrition counselors should have a "low threshold" for insisting that patients with these kinds of difficulties also seek concurrent psychotherapy. Patients who report feeling helpless or hopeless, or those that bring significant psychological issues to nutrition sessions should also be referred for psychotherapy.

### Borderline Personality Disorder

Patients with borderline personality disorder benefit from nutrition therapy if it is provided as part of a team approach. These patients respond best to structured, directive, supportive interventions. Regular consults with the patient's psychotherapist are imperative as these are demanding patients, who are inclined to split clinicians. Dennis and Sansone (1991, p. 144) recommend the setting of firm, matter-of-fact, well defined, and repeatedly clarified limits around issues such as: availability of clinicians outside of sessions, phone calls, payment of fees, behavior within counseling sessions, and secret-keeping from other professionals. Borderline patients who are engaged in DBT-oriented therapy will benefit from a nutrition counselor who is familiar with that treatment approach.

### Sexual Abuse

Sexual abuse puts individuals at special risk for developing an eating disorder (Molinari, 2001; Vanderlinden & Vandereycken, 1996). It is not unlikely, therefore, that nutrition counselors will treat a significant number of patients who also have a history of abuse. Thus, nutrition counselors should have some understanding of appropriate therapeutic responses to patients with this type of history. First, nutrition counselors must keep in mind that delving into the patient's sexual abuse history is not their task, though patients may bring this information to sessions. Should patients disclose a history of sexual abuse, listen respectfully, respond with appropriate empathy, and be watchful for countertransference reactions that are inappropriate (e.g., a desire to comfort patients by hugging or excessive touch). It goes without saying that patients with sexual abuse history should also be working with a skilled psychotherapist.

### Body Image

For many patients, their sole or predominant reference for assessing self-worth is weight, shape, or thinness. Garner and Bemis (1985, p. 129) explain that body weight is appealing as a measure of worth because it is culturally sanctioned and "unambiguous, observable, and quantifiable."

Body image issues are clearly one area in which the nutritionist's territory unavoidably overlaps with the psychotherapist's (Saloff-Coste et al., 1993, p. 511).

Weight-related interventions usually provoke patients' body-image concerns and reveal deficits in self-esteem: For example, as underweight patients gain weight, their sense of self-esteem, which is likely to reside in weight-loss achievements, can be threatened. Unaddressed disturbances in body image interfere with most patients' ability to make progress on food behaviors and increase the likelihood of relapse (Fairburn et al., 1993, p. 385).

Psychotherapists are trained to pursue the origins of their patients' poor body image and low self-esteem, such as childhood teasing, negative feedback about their body from significant others, or a history of physical or sexual abuse. Psychotherapists help patients adopt more functional schemas for self-evaluation and self-esteem (Garner et al., 1997, p. 130). Nutrition counselors, on the other hand, focus on providing accurate feedback about body weight, education about healthy weight ranges and genetic determinants of body size, and information on the negative consequences of weight-loss behaviors. Both types of professionals should remind patients that while body type and size are fundamentally unalterable, it is aspects of personality that impart value to one's life (Saloff-Coste et al., 1993, p. 511). Nutrition counselors and psychotherapists should initiate discussions about cultural and social pressures that constantly bombard all those who live in westernized cultures. Such discussions can raise an appropriate sense of indignation that can help patients find a way to protect themselves from pressures to be unnaturally thin. Acknowledge to patients that it is unfortunate that weight loss is socially acceptable and measurable. Go on to explain that it is a no-win situation, however, since no amount of weight loss is satisfying if weight loss is the goal. Moreover, since substantial weight loss leads to metabolic compensations, subsequent weight loss is harder to achieve. The result: the further erosion of self-esteem by a sense of failure and guilt (Garner & Bemis, 1985, p. 129).

Body image distortion is a discrepancy between the patient's perception of her or his body size and shape and actual body size and shape. Johnson (1985, p. 22) suggests that practitioners query patients about how others assess their body size and eating habits. As well, patients can be asked how dissatisfaction with their weight, body size or shape interferes with their life. When patients react with hostility to this line of inquiry, it is likely that their body-image distortion is central to their sense of self and that they would benefit from psychotherapy if not already so engaged.

It appears that the body-image distortions commonly experienced by

eating disordered patients are part of the cognitive dysfunction that results from erratic eating and starvation. These sorts of body-image problems do not respond to direct treatment, but resolve with maintenance of a healthier weight and a food plan (Fairburn, Marcus, et al., 1993, p. 390).

Nutrition counselors can promote development of a healthier body image by helping patients recognize the degree to which they misperceive their body size and shape. Patients' current weight can be plotted on the body mass index (see Appendix B), or their clothing size can be compared to average. Furthermore, the nutrition counselor might challenge the patient's notion that happiness depends on achieving an idealized body size and shape (Saloff-Coste et al., 1993, p. 511). It can be pointed out that the patient's negative evaluation of her or his body does not indicate that one's body is unacceptable in size, shape, or weight, but it does illustrate that the patient "does not feel good" about her or his body.

Cognitive-restructuring techniques, such as decreasing negative thoughts about body shape and size, can be effective in addressing body-image issues (Fairburn, Marcus, et al., 1993, p. 385). Since poor body image is reinforced by thoughts and self-talk that are overly self-critical about body size and shape, patients should be instructed to notice their tendency to engage in such self-talk, and then to alter their internal dialog so that it is at least neutral on the topic of body size and weight. Wooley (1991, p. 261) suggests that experienced professionals who are comfortable with their own body image and eating habits, may find it useful to talk with patients about their own strategies for developing a healthy body image. Nevertheless, self-disclosures of this nature, offered too early in treatment, can easily be interpreted by patients as "propaganda" (Wooley, 1991, p. 261). On the other hand, it is generally beneficial to make frequent reiterations of the conviction that body-image disturbances are hallmarks of an eating disorder and that these problems are expected to improve as progress is made in treatment.

Patients must be advised to adopt healthier food behaviors despite body-image difficulties. Garner et al. (1982, p. 23) suggest that patients be taught "counterarguments" to avoid the cycle of thinking that justifies eating-disordered behaviors, such as, "I know that a cardinal feature of anorexia nervosa is misperception of my own size so I can expect to feel fat even though I am not." Patients can also learn to say, "I will experience my weight and shape more accurately and as thinner than I do now once I have recovered." Patients who actively avoid situations that may reveal their body size to others or themselves may benefit from "exposure" to their shape in mirrors and by wearing more revealing clothes (Fairburn, Marcus, et al., 1993, p. 390). Conversely for patients who obsessively check their body shape and size, it is often more beneficial to advise that

they temporarily avoid full-length mirrors and tighter clothes (Fairburn, Marcus, et al., 1993, p. 390; Garner et al., 1982, p. 22).

When patients who are chagrined to realize they have succumbed to cultural pressure to be thin, it can be helpful to engage in a compassionate discussion of the enormous pressures that emanate from society and the fashion industry, and even from family members, to diet and exercise in order to achieve unrealistic sizes and shapes.

### Working with Families

Nutrition counselors who work with children and adolescents will necessarily be involved with these patients' parents or other caregivers. The younger the patient, the more the parents should be involved. Professionals should keep parents abreast of their child's progress and be willing to answer their questions. Professionals should keep parents abreast of their child's progress and be willing to answer their questions, either by spending some time each session with parents or by making it a point to give them a call later. Parents are often demoralized, frustrated, and confused about their failure to manage their child's eating-disordered behaviors. But, once they receive support and reliable information, they can be an important asset.

One important task of nutrition counselors is to educate parents about the medical nature of a serious eating disorder. Parents should be encouraged to think of their role as one of helping their child convalesce from a serious illness. Point out that a child with an eating disorder often behaves in ways that are typical of children with life-threatening diseases. Understanding that an eating disorder often "regresses" a child developmentally so that emotional responses are more typical of a much younger child can help parents move beyond the unproductive "blaming" of themselves or their child for the child's current difficulties (Honig, 2000, p. 188).

Nutrition counselors must be careful preserve their therapeutic alliance with patients while providing support, direction, and education to the parents. One way of achieving both is to ask patients privately if there is anything their parents could do to be more helpful. Brandon, struggling with bulimia as he entered high school, had lots of ideas to share when asked by his nutritionist how his parents could aid in his recovery. "Do you think Mom would be willing to have an afterschool snack ready for me when I got home?" Brandon asked his nutritionist. "You know that is when I have the most trouble with bingeing."

"Well, let's ask her when we invite her in at the end of our session. Would it help if your mom sat with you while you ate your snack?"

"It might. I guess it is worth a try," Brandon agreed.

When parents are involved in treatment, it is imperative that they understand that the nutrition counselor's primary relationship is with their child, not with them. Parents may need referrals for their own psychotherapy support—individually, as a couple, or as a family. If parents engage a psychotherapist, it is essential that regular team consultations occur to ensure that patients and parents receive consistent messages from members of the professional team about their role in their child's treatment.

Garner and colleagues (1997, p. 97) advocate for a mix of individual and family meetings when a minor child is the patient. Early in treatment, at least one-quarter of each session should include attending parents. This gives the nutrition counselor opportunity to summarize the treatment plan, to answer parents' concerns, and to outline how parents should be involved in supporting their child's treatment plan. During the family portion of sessions, young patients should be encouraged to join in the discussion with their interpretations of food and treatment plans. Offering separate sessions or phone sessions to parents permits them to express frustration and anger while shielding the child from their parents' negative affect (Treasure, 1997).

Confidentiality can be explained to young patients by saying, "We will discuss together what your parents need to know." Patients and their parents should be informed that the nutrition counselor's practice is to apprise the patient of conversations with parents and concerned others. This practice reassures patients that the nutrition counselor will not "collude" with parents. Neither is collusion with young patients productive. Patients must come to understand that important information will not be kept from parents. Likewise, it is important that patients know their reports will be confirmed with parents. Patients should also be consulted before information is passed on to parents: "Do you mind if I share this information with your parents?" If the patient does "mind," the nutrition counselor must ascertain whether it is in the patient's best interest for the information to be shared with parents. If that is the case, the nutrition counselor may say something like, "I understand how you feel, but I am convinced your parents have to know."

Usually by the time a nutrition counselor is involved, parents have tried a number of unsuccessful tactics to control food behavior. Anxious parents who are unsure of how to respond to their child's food behaviors often oversupervise their child's food behaviors (Williams et al., 1985, p. 28). The nutrition counselor should have an in-depth conversation with the patient about what help she or he needs from parents and about what has "worked" and what hasn't. Asking the simple question of the child, "How can your parents be of help?" often yields productive suggestions. Investigate as well parents' impressions and concerns about their child's food behaviors as well as whether they are apprehensive about their involvement in the child's treatment.



Initially, at issue will be whether patients can be responsible for feeding themselves, whether parents should take over this responsibility temporarily, or whether there is some way the responsibility should be shared. Some younger patients are adamant about remaining solely responsible for their food behaviors; others are aware they need parental support, but they are not sure what would help. A week's experiment to test whatever strategies seem most appropriate can help families and professionals come to a common conclusion about a reasonable approach. One question that often arises is, should a parent "fix" the patient's plate at meals? "Let's talk about the pros and cons of such a plan," the nutrition counselor might respond. After hearing from the patient and her or his parents, the nutrition counselor can help the family agree to an approach that will be revised, if necessary, at the subsequent session.

The nutrition counselor, in essence, acts as a temporary intermediary for food decisions until both patient and parents regain confidence in their mutual abilities to negotiate ways to manage food-related issues. In this light, the nutrition counselor should model an approach to problem-solving that respects the needs and abilities of all family members while expecting the best from each. When parents are discouraged, as is often the case, it can be helpful for the nutrition counselor to suggest guidelines that they will enforce. The nutrition counselor's involvement in determining plans and behavior limits gives them an official "stamp of approval."

The food plan is a good example of a "limit" that must be observed. When patients negotiate a food plan with a nutrition counselor, parents are relieved of the often difficult task of determining what and how much their eating-disordered child will eat. Parents should be reminded that although there is nothing mysterious nor complicated about normal eating, food plans are a work in progress for an eating-disordered child who has significant food fears. At the same time, the nutrition counselor should bolster parents' sense that they are knowledgeable about components of a normal eating plan. Another simple truth that must be reiterated to parents and patients again and again, is that if the child is losing weight, then she or he is not eating enough. Whereas adolescent patients generally resist the idea of involving parents in food planning, they usually accept without hesitation the proposal that parents do food shopping and/or preparation for them. Finally, if a patient fails to make progress, additional parental involvement should be explored.

Parents must come to understand that the difficulty their child has complying with food plans and other aspects of treatment is not due to willfulness or disobedience, but it is more likely a natural consequence of an eating disorder. The nutrition counselor's ability to explain the patient's food-related dilemmas accurately and with passion to parents will help

increase their capacity to behave firmly, yet gently and empathetically, toward their child.

Parents who are not confident in setting limits around food behavior should be advised to call the nutrition counselor for advice when a dilemma occurs. Parents, too, can play the role of "coach" for their eating-disordered child by figuring out ways to encourage or distract their child during meals and snacks. Useful strategies include regular family meals and/or snack times at which all family members are expected to participate. Snacks can be improved when parents or siblings play cards or board games with the patient or read her or him a story while the snack is consumed. The family kitchen should be kept well stocked with the patient's favorite foods and components of the food plan. Bulimic children, however, may benefit by having a more limited supply of foods available at home. Some parents are effective in barring access to the bathroom for a certain amount of time after a meal to help a bulimic child decrease purging behaviors.

One of the most difficult issues for parents is deciding what to do when their child is not compliant in following her or his food plan or other treatment mandates. Parents should be encouraged to figure out in advance what rules they will adopt and what consequences they will mete out if rules are broken. When rules are broken, parents should be absolutely sure they will follow through on any consequences they have verbalized to their child no matter how their child threatens to react. Rules and consequences can vary in their strictness, but it is of utmost importance that parents believe in and are willing to defend their actions (Treatsure, 1997, pp. 56-57). Parents may agree to call the nutrition counselor for advice if their child cannot follow the food plan; they may limit television until the meal or snack is consumed; or parents may limit physical activity until weight is gained. If, however, the patient regularly chooses the consequence over complying with a parental rule, then the consequence may need to be revised because it is not "powerful" enough. When parents report chronic noncompliance with food-related "rules," time in the subsequent nutrition counseling session should be devoted to discussing privately with the child her or his hunches about why the rules were difficult to follow.

A helpful resource for parents is *The Parents' Guide to Childhood Eating Disorders* (Herrin & Matsumoto, 2002).

## Relapse

As patients progress, they need to understand that the road to recovery will include lapses and relapses. Because it is rare for patients to com-

pletely avoid eating-disordered behaviors, for some time to come, most will need a framework for managing occasional recurrence of these behaviors. Fairburn et al. (1993, pp. 392–393) recommend emphasizing the difference in deterioration between a lapse and relapse: Lapses can be corrected by the patient, relapses require professional help. In either case, special attention should be paid to the first six months after intensive treatment, as this is when serious relapses are most likely to occur (Kaplan & Olmsted, 1997, p. 359). Nutrition counselors can help patients reduce their vulnerability for relapse with the approaches described below. Patients should be assured that there are a myriad of effective coping strategies; it is just a matter of finding the right ones.

Help patients form realistic expectations for the future, including the possibility that they may have an occasional setback. It is important that patients understand that recovery usually includes a series of ups and downs. Expecting to be completely free of eating-disordered thoughts or behaviors is not realistic and increases vulnerability for relapse (Fairburn, Marcus, & Wilson, 1993, pp. 392–393).

Recommend that patients find a confidante. Fairburn and colleagues (1993, pp. 392–393) find that when patients confide in someone, they gain a perspective that can help them “get back on track.”

Instruct patients in problem-solving techniques. For instance, patients should learn to identify behaviors, thoughts, or situations (and their antecedents) that put them at risk for returning to eating-disordered behaviors. Patients should be particularly watchful for the following, which are known to increase risk of relapse: incessant thoughts about weight, shape, and size; “feeling fat”; heightened interest in dieting or exercise; a rekindling of the desire to overeat or purge; comments from others about weight or appearance; stress of any kind; holidays; new or difficult personal relationships; and major life transitions (Garner et al., 1997, pp. 137–138). The next step is to formulate a definite plan to do something positive to solve or at least minimize problems.

Encourage patients to interpret resurgence of eating-disordered thoughts as a possible signal of emotional distress or an indicator that food-related behaviors need attention. Viewed this way, such thoughts can serve as helpful reminders to patients to engage in some self-reflection.

Teach patients to recognize the obvious signs of impending relapse (recurring episodes of binge eating, dieting, or purging; significant changes in body weight; or loss of menstrual periods). Patients should be utterly convinced that dieting is a risky behavior. They should clearly understand how food restriction triggers the eating-disordered cycle.

Remind patients that continued adherence to a food plan is the key to continued recovery. Although some chafe at the structure imposed by a food plan and are eager to eat in a more carefree way as they recover,

lapsing patients should immediately return to a more structured plan. Such patients should be instructed to plan meals in even more detail, and in advance, so that they know exactly what and when they will be eating. Patients who self-monitored eating behaviors during treatment should consider resumption of monitoring.

Advise against obsessive self-weighting. Occasional weight checks, however, are recommended for recovering anorexic patients, who face increased risk of relapse as they approach weight goals and envision having to reduce food intake to maintain weight.

Remind patients that returning to nutrition therapy or other supportive treatment after relapse is a sign not of failure but of wisdom. Make the criteria for a recommended return to treatment crystal-clear. For example, the anorexic patient is advised to return if she or he should lose more than five pounds. A follow-up visit, if not a return to treatment, should be considered if the patient or others notice an increased obsession with food or weight. Patients, parents, and professionals should have a low threshold for determining when it would be prudent to return to treatment. Allison, a weight-recovered anorexic, is a case in point. Her parents recommended a return to treatment the summer prior to entering her freshman year in high school. They suspected that the social pressures that favored thinness in Allison's high school would put her at risk for a relapse.

Lastly, explain that lapses and relapses provide the opportunity for the development of more effective food and coping strategies.

## Inpatient Treatment

Outpatient nutrition counselors need to be familiar with inpatient treatment approaches, both hospital-based and residential so that they can help patients and their families understand how inpatient programs could be beneficial and when they should be considered. Furthermore, it is likely that occasionally nutrition counselors will treat patients who have recently been released from such programs.

Hospitalization or residential treatment remain important treatment options and should be recommended when outpatient treatment has not proved to be a viable option. Although there are no specific clinical guidelines for when admission to an inpatient program should occur, low body weight, medical concerns, or risk of serious self-harm are indicators that an inpatient stay may be necessary.

Patients must understand that hospitalization will be considered if they become medically unstable. One indicator of medical stability is body weight. Although weight criterion should be individualized to take into

account the patient's overall health status, hospitalization must be seriously considered when weight loss approaches 25% of pre-morbid weight or 25% of recommended weight for height (American Psychiatric Association, 2000, p. 5; Kaplan, 1993, p. 12). Regardless of how much weight has been lost, rapid weight loss in children and adolescents should trigger consideration of inpatient treatment (American Psychiatric Association, 2000, p. 5). Inpatient programs should also be contemplated for any patient whose weight loss cannot be arrested. Similar considerations should be given to very low-weight patients who are unable to gain despite intensive outpatient treatment (Becker et al., 1999, p. 1095).

Medical issues that indicate the need for immediate hospitalization are low potassium levels accompanied by electrocardiographic changes, the use of ipecac with cardiac enzyme changes, severe dehydration, acute abdominal symptoms (which may indicate gastric dilation or pancreatitis), low body temperature, arrhythmia (irregular heart beats), syncope (fainting), seizures, convulsions, psychosis, or high risk for suicide (Becker et al., 1999, p. 1095; Kaplan, 1993, p. 12). Patients whose low potassium levels are not remedied by electrolyte infusions (usually this indicates intractable purging) are candidates for longer-term inpatient programs. If food is refused over a number of days or excessive exercise is uncontrollable, an inpatient admission may be necessary to protect the patient's health. It is of utmost importance that nutrition counselors be alert to signs patients might be medically unstable and report any symptoms or behaviors which indicate impending physical instability to the patient's medical provider. Those working with a medically fragile patient should be in close communication with the patient's medical provider. Indeed, all eating-disordered patients should have their physical status regularly monitored by an experienced medical professional.

Longer-term residential treatment is usually preferential for patients who also have problems with suicidality, drugs or alcohol, self-mutilation, kleptomania, obsessive-compulsive behaviors, or sexual disinhibition unless they have shown definite progress in outpatient treatment (Vanderlinden et al., 1992, pp. 51, 161).

Hospitalizations may range from a few hours' stay in order to normalize potassium levels or for rehydration, to a week or longer to restore nutritional homeostasis. After patients are medically stabilized, it may be reasonable for them to return to intensive outpatient treatment. Longer hospitalizations and stays in residential programs, however, may help normalize eating patterns by providing external control over eating, purging, and exercise behaviors and, in essence, may "jump start" nutrition treatment. Another positive effect of hospitalization is that, more often than not, patients conclude that outpatient treatment is more palatable in comparison. Furthermore, following a hospital stay, patients are more likely

to experience the outpatient treatment team as "serious" about safety, treatment, and recovery. Clinicians can judiciously use the "threat" of hospitalization to motivate patients to more effectively engage in outpatient treatment.

Residential treatment stays typically range from several weeks to months. Patients need to know that residential treatment is a likely alternative if outpatient treatment fails to bring control to bingeing and purging behaviors, to excessive exercise, or to unremitting weight loss. When an eating disorder has proven to be chronic in nature, it makes clinical sense to intensify treatment with a residential placement rather than continue long-term unproductive outpatient treatment. Moreover, unremitting eating-disordered behaviors in a child can devastate family relationships. Parents are either completely unnerved by watching their child literally and/or figuratively waste her or his life away despite treatment or they are angry about their child's resistance to outpatient treatment, or both. Families of disruptive bulimic children may have difficulty coping with their child's food-related behaviors even with supportive family treatment. A residential stay (or a longer hospital admission) can provide needed respite, protecting family relationships so that in the future the patient and the family can more effectively live together.

It is expected that patients admitted to inpatient programs eventually will return to outpatient nutrition treatment. Rarely do short hospital stays help patients make substantial behavioral progress. More likely, patients remain wedded to their eating-disordered behaviors, looking forward, in fact, to resuming these behaviors once released from the hospital. Other patients, though ready to build on the "abstinence" obtained in the protective and structured environment of the residential treatment setting, often face a discouraging relapse on release. Unless there are compelling reasons indicating otherwise, assure patients and their families that the patient may resume outpatient nutrition treatment on release from inpatient care.

Ideally, inpatient treatment is followed by an aftercare treatment program that allows exposure to 'real life' situations in a therapeutic setting. Examples of aftercare programs include step-down programs, half-way houses, day hospitals, or partial programs. In rural areas, however, patients are often released directly to outpatient care. Regardless of the intensity of aftercare treatment, eating disorders severe enough to require inpatient treatment usually require significant additional outpatient treatment (Andersen, Bowers, & Evans, 1997, p. 345).

Patients often return to outpatient nutrition treatment with a food plan designed by the inpatient treatment staff. Unless the patient has lost all faith in this plan, outpatient nutrition counselors should help patients develop strategies to enhance adherence to their plan. It is not uncommon

mon for inpatient programs to utilize food plans based on "diabetic food exchanges" or the "food pyramid." Outpatient nutrition should make every effort to use the "language" and schema of the patient's current food plan. In this regard, it may be valuable to consult with the inpatient nutrition counselor, of course not without the patient's written permission. Furthermore, be slow in suggesting patients make any more than minor changes in their plans. If the patient is having difficulty, say, "What would your inpatient nutrition counselor say about that?" Eventually though struggling patients may need to be guided into the use of a food plan that is more suitable to life outside of a treatment center.

### Termination

Termination of treatment is associated with increased risk for relapse (Beumont et al., 1997, p. 183). As long-term availability of treatment (two to three years) is associated with positive prognosis in cases of severe eating disorders, be cautious about terminating patients earlier (Vanderlinden et al., 1992). One approach is to suggest that a reduction in the frequency of sessions is warranted because the patient has made significant progress. At the same time, it should be made clear that patients are always welcome back for a "tune-up." When termination is gradually approached, patients are less likely to experience it as cessation of support nor are they likely to develop an unhealthy dependency on professionals. Less frequently scheduled sessions allows patients to practice relapse-prevention and problem-solving strategies while still receiving professional support. It is not uncommon for patients to need a month's worth of additional sessions within a year of ceasing regular visits. Some patients, especially those with additional psychological diagnoses, may need to continue regularly scheduled appointments indefinitely to keep eating-disordered symptoms at bay.

Because it is not uncommon for eating-disordered patients, particularly anorexic patients, to experience termination as a rejection, any planned reduction in appointment frequency should be sensitively discussed. It is essential that patients do not feel abandoned once eating-disordered behaviors subside (Garner et al., 1982, p. 26).

Fairburn and colleagues (1993, p. 381) recommend practitioners consider terminating the treatment of patients who have not made significant improvements in eating-disordered behaviors in eight weeks of treatment. Typical indicators of ineffective treatment include bingeing episodes occurring more frequently than once per day or, in anorexic patients, continued weight loss. In these situations, nutrition counselors should consult with other treatment team members and consider making

continued sessions contingent on some signs of progress (Williams, Touyz, & Beumont, 1985, p. 28). It goes without saying that the decision to terminate treatment should only be made after consultation with other members of the treatment team.

### Conclusion

The resourceful nutrition counselor has a rich framework from which to develop a versatile array of interventions thanks to the work of those who have developed the behavior, cognitive-behavioral, dialectical behavioral treatment theories and methods described in this chapter. It is the task of nutrition counselors to work to develop appropriate therapeutic tactics and relationships with each patient and to deal with their own issues outside of this relationship, arranging for supervision if necessary.

Nutrition counselors should be watchful of patients who seemingly are engaged in nutrition counseling, but are not making any obvious behavioral progress. Although counselors should continue to express the conviction that recovery is possible, alternative or additional treatment approaches should be explored, if the patient is not engaged in concurrent psychotherapy, that should be recommended. For patients who have not been evaluated for appropriateness of pharmacological treatments, that should be encouraged as well. For patients who are not making progress despite team treatment, full or partial hospitalization or residential programs should be considered.

## Nutrition Education

Since the early 1980s when Garner and colleagues proposed that psychoeducation would help eating-disordered patients discontinue eating-disordered thoughts and behaviors, it has become a standard component of eating disorder treatment (Garner et al., 1982; Garner et al., 1985; Garner, 1997). Nutrition counselors should be familiar with the educational topics important in treatment of eating disorders articulated by Garner (1997), Fairburn et al. (1993), and Tobin and Johnson (1991): biological facts associated with body weight and starvation, the ineffectiveness of various methods of purging for weight control, the health consequences of eating disorders, and the cultural aspects of eating disorders. This chapter summarizes these subjects and additional topics fundamental to nutrition treatment of eating disorders.

Educational information has the most impact if it is presented early in treatment (McFarland, 1995). It is best received if delivered in a nonjudgmental and respectful fashion and in response to patients' questions or to their particular dilemmas. While it is important not to use scare tactics, patients deserve to be informed of the significant long-term risks eating disorders pose. Denise did not know that long-term bulimics will eventually almost for certain have painful, unsightly, and expensive dental problems. Anna was unaware that rapid weight loss usually leads to hair loss. Patience, gentleness, and empathy are required on the part of counselors as they deliver such messages. The malnutrition and anxiety

that plague most patients make it difficult for them to remember and process complex information. It is not unusual for patients to need reminding again and again about the details of basic concepts. Limiting information to just what a patient needs to know and putting important information in writing can be helpful. In order to guard against sounding didactic, present educational topics as discussion points, with the acknowledgment that misinformation abounds so that it is no surprise patients may hold erroneous beliefs about nutrition and biology.

### □ Educational Themes

Nutrition counselors should be prepared to enumerate the health consequences of unchecked eating-disordered behavior, to spell out the behavioral factors that perpetuate eating disorders, and to review basic nutrition facts. Patients should be reminded that most, if not all, the physical symptoms resulting from eating-disordered behaviors can either be avoided or reversed with weight restoration or cessation of bingeing and purging. Such symptoms, which are often of great concern to patients, include loss of hair, lanugo, dry and discolored skin, dizziness, "head rushes," intolerance to cold, brittle hair and nails, slow and/or irregular heart beat, constipation, fullness related to delayed gastric emptying, and depressive and obsessive symptoms. Related educational themes are summarized below. (See Appendix F for a patient handout that summarizes the following medical concerns.)

#### **Bones, Muscle, and Brains**

As the body attempts to maintain basic functioning on low caloric intake, long-term health maintenance is "put on hold." Consequently, hormone levels, bone health, muscle maintenance, and even brain, heart, and other organ cells are sacrificed. Particularly affected are bones. Severe bone loss has been documented in patients with anorexia nervosa-related amenorrhea (Baker, Roberts, & Towell, 2000; Rigotti, 1991). Information about the long-term health consequences of loss of menses is often quite compelling, specifically regarding compromised bone health and fertility (Agras, 2001). Patients are usually unaware that the only known treatment for anorexia-induced amenorrhea is the institution of eating patterns that lead to increased body weight (Grinspoon, Herzog, & Klibanski, 1997).

Muscle weakness, fatigue, and eventually muscle breakdown are also likely. Cerebral atrophy has been described in patients with anorexia nervosa and some patients with bulimia nervosa (Addolorato, Toranto, Capristo, & Gasbarrini, 1998; Krieg, Backmund, & Dirke, 1987). Malnu-

trition-related cardiovascular changes have led to sudden death (Cooke & Chambers, 1995).

#### **Purging**

Though eating-disordered patients usually believe to the contrary, they should be informed that self-induced vomiting and laxative abuse have been proven to be relatively ineffective in eliminating consumed calories. Laxatives decrease caloric absorption by only 1.2 percent (Bo-Linn, Santa Ana, Morawski, & Fordtran, 1983). Vomiting after bingeing leaves about 1,200 calories in the body (Kaye, Weltzin, Hsu, McConaha, & Bolton, 1993). Diuretics have no effect, whatsoever, on caloric absorption. Another proof is that patients who binge and purge eventually gain weight.

Self-induced vomiting leads to a variety of health problems. Esophageal and gastric irritation are painful. Esophageal scarring and narrowing make swallowing difficult; esophageal tears can be life threatening. Most patients find swollen salivary glands, while not dangerous, disturbing in their effect on appearance. Dental damage and the hemorrhages in and around the eyes from forceful vomiting can be unsightly. Less serious, but still concerning to patients, are the calluses or sores that appear on knuckles and over the back of hands. These lesions result from repeated scraping by teeth when patients initiate vomiting with their fingers.

Laxative abuse leads to constipation, finger swelling, and generalized edema. Over-the-counter diuretics rarely cause health problems, but prescription products are potentially dangerous. If abused, weakness, heart palpitations, and permanent damage to kidneys can result. Self-induced vomiting and laxative diuretic abuse cause head rushes, dehydration, and electrolyte disturbances. Dehydration and electrolyte problems can lead to serious cardiac, renal, and neurological complications. Purging leaves patients feeling emotionally irritable, tired, and weak. A rare but serious complication is pneumonia, which results if food is aspirated into the lungs during vomiting. Sudden death from irregular heart beat is a serious threat to underweight bulimics. The bingeing that precedes purging can cause life-threatening stomach tears. (See pp. 168–173 for more information on health problems associated with purging.)

#### **Nutrition and Dieting Myths**

It is of primary importance that those who interact with eating-disordered patients about nutrition issues be well informed so that they are able to point out dietary fallacies that perpetuate eating disorders. So many nutrition myths circulate in the media, however, that even professionals

may inadvertently disseminate misinformation. *Nutrition: Concepts and Controversies* (8th ed.) bySizer and Whitney (2000) is a helpful reference for basic nutrition and health facts. This comprehensive text is well referenced, yet written in lay language.

Many eating-disordered patients, particularly those of college age, feel well versed and knowledgeable about nutrition. But in truth, these patients have the tendency to give credence to many myths about food, health, and fitness. One common misconception is that taking vitamin and mineral supplements, sometimes in megadose amounts, will protect health despite eating-disordered behaviors. Another widespread belief is that adhering to a low-fat and low-cholesterol diet is necessary to maintain health. Not only do many young people follow dietary advice designed for adults who may be at risk for heart disease because of genetics or because these adults overeat, but they also misconstrue the meaning of a healthy low-fat diet. It is not uncommon for eating-disordered patients to believe that a "heart healthy" diet should exclude nearly all dietary fat when, in fact, the current public health definition of a low-fat diet allows for daily consumption of 65 to 85 grams of fat per day (30% of calories from fat). Similarly, eating-disordered patients are likely to believe that red meat—an excellent source of high quality protein and absorbable iron and zinc—is intrinsically an unhealthy food choice.

Clinicians should be cognizant of common food practices and nutrition-related concerns of eating-disordered patients and be well versed in prevailing weight-loss schemes. In the 1960s and early 1970s, it was noted that eating-disordered patients went to great lengths to avoid high-carbohydrate foods and to count calories (Russell, 1967; Beumot et al., 1981). In the 1980s through the 1990s, it was more typical for patients to avoid dietary fat and red meat and to express phobic thoughts about fat in food. These patients were likely to consume diets high in carbohydrate, but low in protein and fat. Over-concern with dietary fat has supplanted the previously almost universal concern about caloric intake noted in eating-disordered patients.

The last 15 years have seen vegetarianism and extreme health consciousness in dietary matters become widespread and socially acceptable. In two studies of eating-disordered patients, vegetarianism (defined loosely as avoidance of red meat) characterized 45% of a British population and 54% of an Australian sample (Kadambari, Gowers, & Crisp, 1986; O'Connor, Touyz, Dunn, & Beumont, 1987). In recent years, vegetarianism has become even more common in the general population. Gilbody, Kirk, and Hill (1999) found that 34% of a sample of British female undergraduates defined themselves as vegetarians (avoiding red meat).

Currently, high-protein, low-carbohydrate diets, like the "Dr. Atkins" and "Sugar Busters" diets, are popular weight-loss regimes. It is no sur-

prise, then, to see renewed concern among some eating-disordered patients, with the carbohydrate content of their diet, a characteristic of eating-disordered patients in the 1960s. It is important to reiterate that regardless of the dietary gimmick of any fad diet, weight loss is only achieved through caloric restriction.

Today, the typical eating-disordered patient aims to avoid red meat, high-fat foods, and high-sugar foods and views foods as either "good" or "bad." Inclined to feel different from others, it is not unusual for eating-disordered patients to believe, "Maybe others can eat dietary fat or meat (or whatever) and not get fat, but not me; my metabolism is just different." Generally patients progressively limit their intake of food over the duration of their eating disorder. Usually snacks are the first to be eliminated, then breakfast, followed by lunch. Patients who live with others may continue to eat near-normal dinners to avoid raising concern of family members. Some patients "justify" eating in the evening by limiting caloric intake during the day.

Anorexic patients may engage in compulsive behaviors such as cutting food into small pieces, eating only cold foods, using strong non-caloric condiments such as mustard and pepper, or drinking large amounts of non-caloric liquids. They may acknowledge a new interest in cooking, recipes, and food shopping. It is not unusual for eating-disordered patients to be employed in food-related jobs or even to feel compelled to "shop-lift" food. A surprising number of patients remain perplexed about why they engage in these behaviors and are not able to relate them to their eating disorder. They may express relief to know that their behaviors are characteristic of an eating disorder and that they usually resolve as their eating disorder resolves.

Since many eating-disordered patients vigilantly follow popular press reports on the latest weight-loss diets and other nutrition-related news, nutrition counselors should keep abreast of such trends. Eating-disordered patients often relish discussing these and other esoteric nutrition topics. While these and other discussions can increase the esteem and credibility of the professional in the eyes of such patients, be careful not to let these digressions sidetrack behavioral interventions.

An important nutrition precept is that an adequate diet can be achieved through an extremely varied array of foods. Another axiom is that the healthiness of any particular diet is evaluated by the total nutrient composition of that diet, not by the nutrient attributes, or lack thereof, of particular foods. As long as, on average, a diet meets nutritional requirements, it does not need to exclude all but "healthy" foods to be health-promoting. To patients, this can be explained thusly, "To be perfectly healthy, you do not have to eat perfectly." Since people have energy needs that are beyond the calories needed to meet nutrient needs, each person

has the option of providing for his or her caloric needs through consumption of only the very healthiest foods. Or, after satisfying nutrient needs, one may fulfill additional caloric requirements through foods chosen on the basis of taste alone. Being well fed in this way provides contentment, pleasure, and confidence in one's food choices. Another nutrition principle is that eating normally and well is not a matter of will power, but of responding to the body, which knows what it needs. Ultimately, eating is a naturally self-regulatory process driven and controlled by physiological factors of nutrient needs, hunger, and satiety.

### Metabolism

Metabolism is the sum of all cellular activities necessary to sustain life. Calories are units of energy. The calories needed to maintain metabolism plus the calories expended in physical activity account for one's total caloric needs. The caloric cost of metabolism is affected by height (taller people use more energy maintaining body temperature than do shorter people); age (younger people have faster metabolisms than older people); and muscle mass (muscles require more energy to maintain than fat tissues). Undereating, fasting, starvation, and malnutrition lower metabolic needs help cope with the potentially life-threatening consequences of low caloric intake.

Normally, exercise increases metabolic rate. But when caloric intake is inadequate, the body conserves energy despite regular exercise. Depressed metabolic rates have been measured in anorexia nervosa and bulimia (Schebendach et al., 1995). In anorexia nervosa, this is no doubt due to the cumulative effect of loss of muscle mass and decreased caloric intake. Signs of lowered metabolic rate in anorexic patients are bradycardia (slow heart rate), dry skin, brittle hair, constipation, cold intolerance, and fatigue (McComb, 1993, p. 102; Mitchell, Pomeroy, & Adson, 1997, p. 387). Over time, normal caloric intake and weight gain normalize metabolic rate. The low metabolism frequently found in bulimic patients is likely the result of erratic eating patterns.

### Famine Metabolism

Essential to surviving famine is the capacity to make metabolic adaptations and behave appropriately. Naturally, food becomes of utmost interest and is consumed when available. Continued conservation of calories and increased body fat stores ready the body to survive the next famine. Directing patients to visualize a "famine in the land" and the compulsory hunt for food can help them grasp the effect food restriction has on be-

haviors: "You are on high alert, all of your focus is on food. If you see food, you are interested in it because there are no guarantees about when you will eat again. The smart thing to do is to eat as much as you possibly can. Your body is smart, too. Famine lowers your body's metabolism so that when you feast, which you do whenever you can, your body is able to store many of the calories you eat as fat. The body does this so that you are ready and able to survive the next famine which will surely come."

### Starvation

Familiarity with the Keys' classic study of starved young male conscientious objectors during World War II provides ample data on the effect of starvation on physical and mental functioning and food behavior (Keys, Brozek, Henschel, Mickelsen, & Taylor, 1950). Keys' study is often used to illustrate that most symptoms associated with anorexia nervosa and bulimia are the result of starvation.

Keys' subjects entered the study in good physical and psychological health. After six months of consuming one-half of their normal food intake, the subjects developed labile mood, cognitive dysfunction, poor concentration, social withdrawal, obsessive and ritualized eating behaviors, insatiable appetites, binge eating, food cravings, apathy, anxiety, depression, irritability, and frequent outbursts of anger. These young men became negative, argumentative, withdrawn, and exhibited low self-esteem and relationship problems. Physical changes included: hair loss, gastrointestinal discomfort, edema, dizziness, headaches, increased fatigue, cold intolerance, lowered body temperature, decreased heart and metabolic rates, and decreased need for sleep. Cognitive changes included: impaired concentration, comprehension, and alertness. Food became the principal topic of conversation, reading, and daydreams. Food behaviors changed; of note were an increased interest in cooking; inordinate amount of time spent meal planning; food hoarding; increased gum chewing; increased consumption of liquids; and eventual bingeing. A very readable summary of Keys' study is found in Garner and Garfinkel's *Handbook of Treatment for Eating Disorders* (2nd ed.) (Garner, 1997, pp. 153-161).

### Body Weight

Much scientific evidence supports the notion that body weight is genetically predetermined to be relatively stable around a "set point" regardless of variations in daily intake and caloric expenditure. For still-growing individuals, set point is reflected in a biologically predetermined pattern



for growth and development. As long as diet and activity levels are reasonably healthy, one can assume as well that the resulting body weight is reasonably healthy. A healthy weight, by definition, is maintained without dietary restriction or overexercise. Very reassuring to patients is a professional's conviction that normal eating and exercise behaviors will lead to the maintenance of a healthy normal weight. Complicating the acceptance of a natural body weight for many patients is the fact that the benefits of thinness and the health consequences of overweight have been overemphasized by health professionals and the media (Ikeda et al., 1999).

### **Diets Do Not Work**

Dieting, in the popular sense, is a planned restriction of food intake with limits on when, how much, and/or what one can eat. The physical and psychological deprivation created by dieting leads to chronic hunger and heightened interest in eating and food, which lead in turn to the increased risk of binge eating. In a typical scenario, once a diet rule has been broken, dieters vow to return to dieting at some later date, but in the interim, they exhibit very little self-control over food intake, and are likely to eat large quantities of "forbidden" foods.

Food restriction is the pivotal behavior that propels most eating-disordered behaviors and symptoms. In anorexia nervosa, food restriction produces unhealthy weight loss. In bulimia and binge-eating disorder, restriction leads to bingeing. Animal studies show that after a period of imposed food restriction, as soon as food is available again, animals will overeat (Schwartz & Seeley, 1997).

### **Cultural Messages**

It is useful to sympathize with patients about the influence of the obvious and dominant cultural forces that promote thinness. Hearing the nutrition counselor express indignation about the current definitions of attractiveness and how this promotes eating-disordered behaviors can help patients garner strength to begin to overcome their eating disorder (Garner, 1997).

### **Conclusion**

The therapeutic presentation of health and nutrition topics is a standard component of nutrition counseling. Rarely, though, does just delivery of this material lead to a patient's recovery. In addition, most patients need direct guidance around food, weight, and exercise issues.

PART

II

# FOOD MANAGEMENT