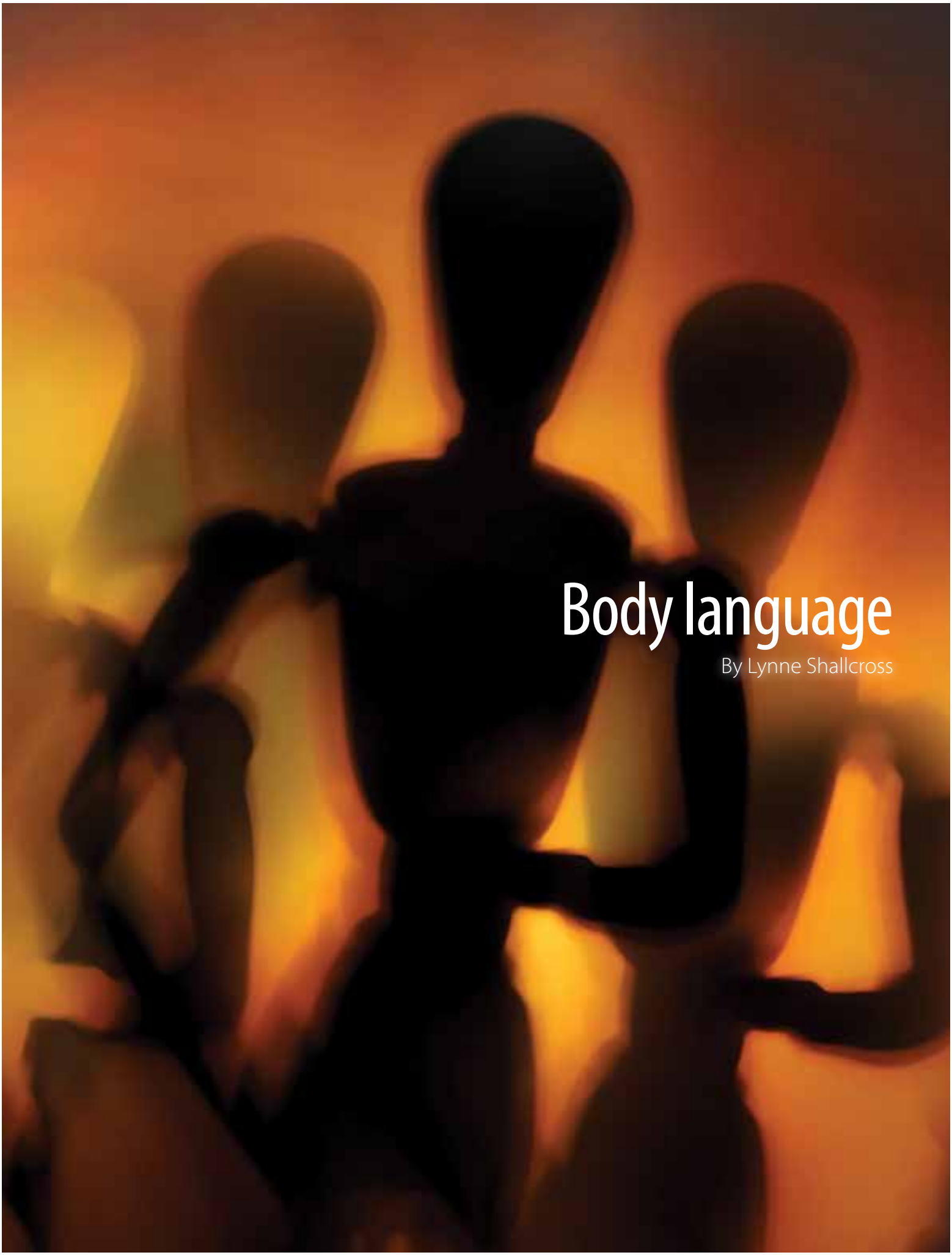

Body language

By Lynne Shallcross

Even if counselors don't specialize in eating disorders and body image, statistics show they need to embrace their roles in preventing, detecting and treating these issues that stretch across racial, cultural, gender and age lines

Thirty million Americans will struggle with a clinically significant eating disorder such as anorexia nervosa, bulimia nervosa or binge eating disorder at some point in their lives, according to the National Eating Disorders Association (NEDA).

Pressure to conform to the "thin ideal" starts early. The NEDA website indicates that between 40 and 60 percent of girls ages 6-12 are worried about their weight or becoming too fat.

In fact, for many years, eating disorders were thought to affect primarily adolescent girls and young adult women. In recent years, though, research has dictated that medical and mental health professionals widen their scopes and stay alert for eating disorders across racial, cultural, gender and age lines.

A case in point: Of the 30 million Americans who will experience an eating disorder during their lifetime, one-third will be men. Moreover, up to 43 percent of men are dissatisfied with their bodies, according to NEDA.

Older women aren't insulated from eating disorders either. A study published in 2012 in the *International Journal of Eating Disorders* found that 13 percent of women age 50 and older reported having symptoms of eating disorders. In the online survey of 1,849 American women, 79 percent of the older women said their weight or shape affected their self-perception, and 36 percent acknowledged dieting at least half the time over the previous five years.

Considering the statistics, it's safe to say that most counselors — including those who don't specialize in eating disorders and body image issues — are likely working with clients who struggle with those issues.

Even if eating disorders aren't a counselor's specialty, it may be in the client's best interest in certain cases for the counselor to work with that client, says Margo Maine, a clinical psychologist who has specialized in eating disorders and related issues for more than 30 years. "You may not be experienced in eating disorders, but you may be the only show in town," Maine says, adding that this is especially true in rural areas where community resources might be lacking.

Of the 30 million Americans who will experience an eating disorder during their lifetime, one-third will be men. Moreover, up to 43 percent of men are dissatisfied with their bodies.

Maine runs a private practice in West Hartford, Conn., and is a past president of NEDA. She says the first thing counselors should ask themselves when encountering a client with an eating disorder or body image issue is whether another accessible resource exists that would be better for the client. If an eating disorder specialist practices in the area and can treat the client, that might be preferable because working with a specialist generally produces better outcomes, Maine says. But if that is not an option, Maine suggests that counselors do everything they can to shore up their own knowledge of eating disorders while continuing to work with the client. This

"Research has shown that mothers who diet and value the thin ideal have daughters who also diet and struggle to achieve society's standard of beauty."

can include reading current professional literature on the topic, seeking resources from organizations such as NEDA and searching for available training.

Sometimes, a client won't disclose eating or body image issues at the onset of counseling. In such instances, the therapeutic relationship may develop before the counselor recognizes the symptoms, says Susan Belangee, a private practitioner in Canton, Ga., who has researched eating disorders for more than a decade. "At this point," she says, "it may be unethical to refer the client elsewhere for fear of abandoning the client and interrupting the healing process." In such cases, supervision and consultation will be key, says Belangee, a member of the American Counseling Association.

It is important for counselors to understand that, specialist or not, they shouldn't go it alone when treating a client with an eating disorder or body image issue, Maine says. Collaboration with other providers is a must and might include a dietician, a physician and a psychiatrist, she says.

Just ask

Millions of men and women possess a negative image of their bodies, says Laura Choate, an associate professor of counselor education at Louisiana State University and the editor of *Eating Disorders and Obesity: A Counselor's Guide to Prevention and Treatment*, which ACA published earlier this year. A portion of those people will engage in maladaptive eating or exercise practices, and then a small portion of those people will go on to develop eating disorders, Choate says.

Binge eating disorder, in particular, has been receiving more attention lately. In the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, binge eating disorder was diagnosable only under the category "eating disorders not otherwise specified." In the *DSM-5*, released in May, anorexia, bulimia and binge eating disorder have their own categories. A fourth category is "feeding and eating conditions not elsewhere classified."

In cases of binge eating disorder, Choate says, some clients binge to cope with their negative emotions. Other clients develop binge eating disorder through dieting and harboring an overvaluation of weight and shape, which leads to the initial instance of binge eating. "Over time, a client feels trapped in a cycle of dieting, followed by eventual bingeing, followed by subsequent feelings of shame, failure [and] low self-esteem for having 'failed' at dieting efforts. Which then leads to resolve to try harder next time, resulting in a repeat of the cycle," explains Choate, a member of ACA. "It is very hard to break out of this cycle without outside support. This is where counselors serve an important role."

Choate thinks recognition of binge eating as a standalone disorder is significant, in part because both the act of binge eating and binge eating disorder have been increasing in men and women across all races and ethnicities. She says binge eating disorder also deserves attention because it can lead to medical complications normally associated with obesity.

Many clients initially present to counseling with a variety of other issues, revealing their eating or body image concerns only after they become more comfortable with the counselor, Choate says. That is why counselors should screen clients for eating, weight and shape concerns as part of the intake process, she says.

Generally, counselors already ask clients a few questions about sleeping and eating, Choate says. This offers a natural segue into questions about general eating patterns (Do you ever diet? Do you follow rules about your eating?) and about bingeing (Have you ever felt a loss of control over eating? Have you ever done anything to compensate for the food you have eaten?).

"Incorporating these types of screening questions into routine intakes can help on the front end," Choate says. "Based on findings and depending on the counselor's level of expertise, he or she can either conduct more extensive assessment of the problem or refer to another mental health professional who specializes in the treatment of eating disorders."

Belangee recommends that counselors take a holistic approach in their initial assessment. In addition to asking about eating and exercise concerns and body image beliefs, it may be wise to inquire about the client's family of origin, she says. This can help counselors learn what values the client internalized growing up and how those values might be linked to what the client is dealing with currently.

"If a counselor suspects an eating disorder issue, it makes sense to investigate the factors that research has shown to be correlated with eating disorders," Belangee says. "Personality traits, such as seeking approval from others or perfectionistic tendencies, play a role in the development and maintenance of eating issues. Thus, using some type of personality assessment could be helpful. Other research has shown that mothers who diet and value the thin ideal have daughters who also diet and struggle to achieve society's standard of beauty. Disordered eating patterns and full-blown eating problems start from a sense of feeling 'less than,' so listening for where the client feels this may provide clues to the heart of the issue."

Environmental impact

According to Maine, an eating disorder is formed much like a perfect storm, meaning that no single element or event in a person's life can be pinpointed as the "cause" of the disorder. Instead, factors such as genetics, life events, family influence and cultural pressures line up to create an environment in which an eating disorder is conceived and then thrives.

After many years spent in the trenches treating eating disorders, Maine has concluded that nurture is a bigger factor

than nature. "Yes, you have some genetic factors, but it's really an intergenerational attitude toward weight, food and body image that will tip the scales," says Maine, the author or coauthor of five books on eating disorders and body image and also a contributor to Choate's book.

According to Choate, a triad of sociocultural influences affects a person's body image: media and the larger culture, family and peers. During childhood, family often holds the largest influence, Choate says, but media and peers gain the upper hand during adolescence and early adulthood.

The media, in particular, place great emphasis on the "thin ideal," Choate says. If people buy into that, they tend to tie their worth and value as a person to their shape and weight, she explains. The thin ideal portrayed in the media is for the most part unattainable, but the inability to "measure up" can leave some people with feelings of guilt and lead to negative body image, low self-esteem and an unhealthy focus on dieting. The combination of negative body image and dieting is one of the strongest risk factors for development of an eating disorder, Choate says.

Families have the capacity to negate — or reinforce — those media and cultural influences, Choate says. For example, a daughter's body image is highly influenced by how her mother feels about her own body, Choate says. If a mother regularly critiques her own body, her daughter is likely to grow up thinking it's normal to concentrate on her own flaws.

Belangee echoes the impact of the family environment. Research has long shown that family variables such as beliefs and values about size, shape and dieting are connected to eating disorder symptoms and behaviors, she says. "We learn by watching and interacting with our family members. If a child grows up in an environment where belonging is achieved by looking a certain way or eating [or] avoiding certain foods, or striving to be the best and second place is never good enough, the child will most likely strive to display those same values in order to gain love, acceptance and approval."

"Other research has shown connections between trauma and/or abuse and eating pathology," Belangee continues. "Perhaps the environment was so chaotic and

The combination of negative body image and dieting is one of the strongest risk factors for development of an eating disorder.

damaging that the child struggles to cope and belong, feeling the lack of love, approval and acceptance. Both situations set the stage for the child to feel uncertain about himself or herself, to question how he or she will find a place to fit in and to live fruitfully. Ultimately, though, it is the individual's decision about who he [or] she is in the face of these circumstances that plays the biggest role in the development of eating disorder symptoms and behaviors."

Perfectionism, where a person consistently judges only in terms of good or bad, black or white, with no variable in between, can also set the stage for eating disordered behaviors, Maine says. Loss can play a role as well, she says. Losses may be concrete, such as the death of a loved one, or more symbolic, such as an older sibling leaving for college.

Among adolescents and young adults, eating disorders tend to develop during times of stress and transition, Maine says. Times of high vulnerability tend to be between the ages of 13 and 15 and the ages of 17 and 19, she says.

"When you think about those two ages, there's a lot going on," she says. Between 13 and 15, kids are getting used to their rapidly changing bodies, while receiving less attention and structure from adults. Between 17 and 19, young adults are oftentimes preparing to leave home and become more independent for the first time. The stress of those or other transitions can be a key trigger in developing an eating disorder, Maine says.

Peer subcultures also exert influence, Choate says. Being part of a group that places emphasis on appearance — whether a social clique, a sports team or a sorority, for example — can ratchet up the pressure.

In addition, cultural pressures related to weight and shape can feel ever present on social media. "Whereas in the past, a client with an eating disorder might have felt isolated, she can now go online to receive 'support' from others who may cheer her on," Choate says. "A client can also gain information about dieting, excessive exercise and ways to compensate for calories. Further, social media sites give her ideals to strive for — models to emulate, body types to compare herself to. As an example, the current 'thigh gap' trend, where girls diet and

exercise excessively in order to achieve a 'gap' between the top of their thighs, is currently popularized on websites such as Pinterest and Instagram, among others."

'Not just a young woman problem'

As the statistics have begun to show, eating disorders and body image issues aren't restricted to adolescent and young adult women.

Maine points to research from 2007 indicating that nearly one-quarter of diagnosable cases of eating pathology occur in males. Although men exhibit the same kinds of eating disordered behaviors as women do, many men arrive at eating disorders via excessive exercise, Maine says. They may be eating, but not enough to support the amount of exercise in which they're engaging, she says.

In general, boys and men are valued for personal aspects beyond weight or shape, such as financial success and athletic ability, Choate says. So even if an adolescent male has a negative body image starting in boyhood, it may not affect his overall self-esteem because he feels valued for other things.

That said, men — like women — are still affected by cultural pressures to be thin, Choate says. In fact, the ideal image confronting men — thin *and* muscular — is growing increasingly unrealistic, just as it is for women. Choate points to the change in the shape and muscularity of G.I. Joe dolls over the years as an example of the cultural message that boys and men are receiving.

Men who are struggling with body image issues or eating disorders may use different language than women who are dealing with these issues, Belangee notes. For example, men may express the desire to be "toned" or "ripped," whereas women may be more likely to focus on being a certain weight or dress size.

Eating disorders in both men and women can sometimes be the result of bottled up emotions and feelings, Maine says. However, men are more likely than women to be discouraged from expressing those feelings, she points out, and if the feelings aren't expressed verbally, it is easy for self-destructive behaviors to crop up.

An important first step in working with men with eating disorders is to help them get past the shame, Maine says. This includes reminding them that they are far from the only men dealing with this problem. Additionally, she says, counselors can help men understand what function the eating disorder plays in their life and then supply them with healthier ways of dealing with those issues.

Women all across the age spectrum can experience eating disorder symptoms and body image issues. Unfortunately, Maine says, our culture and medical system don't tend to focus as much attention on adult women's issues, so eating disorders among older women often fly under the radar. As a culture, we tend not to believe that adults still struggle with eating disorders and body image issues, says Maine, who in 2005 coauthored the book *The Body Myth: Adult Women and the Pressure to Be Perfect* with Joe Kelly.

Women in midlife experience a host of potential transitions, Belangee says, including menopause, children "leaving the nest" and the loss of a spouse, whether through divorce or death. Each of these transitions can result in stress and questions of identity — "Who am I now?" As counselors, recognizing these

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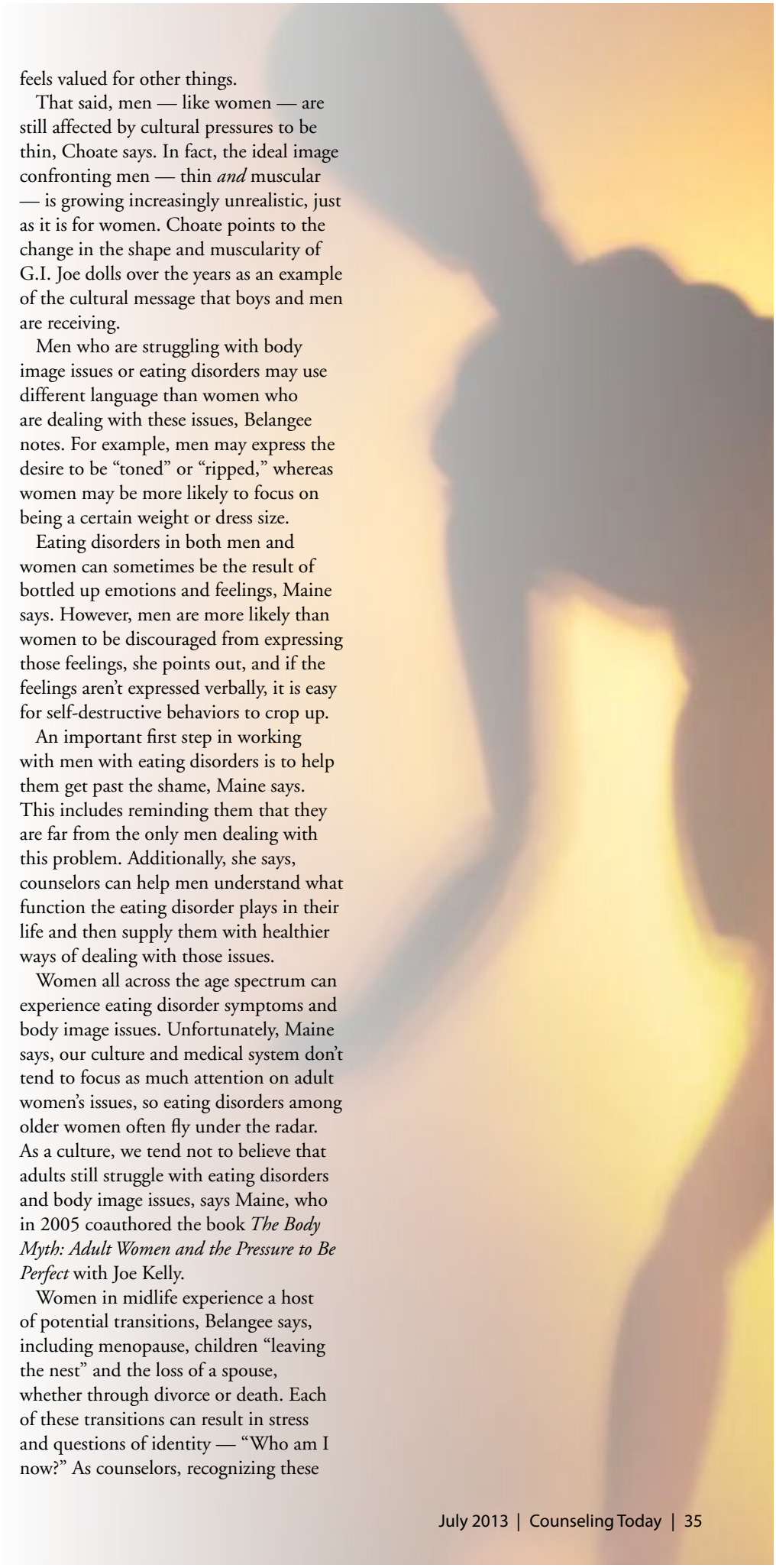

transitions goes hand in hand with taking a holistic view of clients, Belangee says. Counselors need to consider factors such as how clients view themselves, their sense of belonging and whether they turn to food as a way of coping, she says.

Maine agrees and adds fertility issues, child rearing, aging, career challenges and caring for aging parents to the list of stressors adult women regularly confront. But most of those transitions aren't recognized by society at large. "When you move from high school to college, there is recognition and acknowledgment," Maine says. "Once we get to be adults, that kind of acknowledgment doesn't happen."

Belangee points to a 2010 study from Oregon Health & Science University showing that women between the ages of 65 and 80 were just as likely as young adult women to feel fat or worry about their body shape. Among older women, the effects of an eating disorder can be even more dire, Belangee says, because their immune systems are generally not as strong as those of their younger counterparts and their general health can decline more rapidly.

Any mental health clinician treating adult women, regardless of specialization, is likely to come across either subclinical or full-blown eating disorder issues, Maine says. "It has to be on your radar screen that eating disorders are not just a young woman problem," she says.

Adult women are much less likely than younger women or adolescent girls to have pure anorexia or pure bulimia. Instead, Maine says, adult women may present with a mix of symptoms that would fall under the *DSM-5*'s category of feeding and eating conditions not elsewhere classified. Counselors must be careful not to overlook these women simply because they do not clearly meet the criteria for one specific category of eating disorder or another, Maine cautions.

Compounding the problem, she says, is that many adult women with eating disorder symptoms are embarrassed by their struggle and do not think it is acceptable to talk about. And, oftentimes, their health care providers don't bother to ask. In fact, Maine says, because the U.S. health care system is typically more focused on combatting obesity, anyone who loses weight is given kudos, not questioned about potentially unsafe eating habits.

Considering culture

Mental health clinicians tend to be less likely to recognize eating disorders in female clients of color, says Regine Talleyrand, associate professor in the counseling and development program at George Mason University. That's partly due to stereotypes that women of color are somehow protected from eating disorders because of their cultural norms, and partly due to stereotypes that only young Caucasian women develop eating disorders, she says.

But research has shown that women of color present with eating disorder symptoms at a rate equal to or higher than that of Caucasian women, says Talleyrand, a member of ACA who contributed a chapter on cultural considerations to *Eating Disorders and Obesity*.

However, minority clients may experience eating disorders, body image and treatment for these issues differently than do nonminority clients, says Ioana Boie, an assistant professor of counseling at Marymount University in Arlington, Va., who also contributed to Choate's book. Boie says minority clients tend to be underdiagnosed, undertreated and underrepresented in treatment programs

and research studies. These clients also tend to receive lower standards of care due to the lack of recognition and are more likely to discontinue treatment or have poor prognoses, according to Boie.

What is needed, Boie says, is better training on cultural sensitivity and more culturally sensitive assessments and treatments. For example, she says, family therapy and family education may need to take a more prominent role when working with minority clients with eating disorders because of the pronounced role that family plays in these clients' lives.

In addition, when it comes to clients of color, Talleyrand says counselors should consider factors other than peer group, family and media influence that may contribute to the development of eating disorders. She says these additional factors may include immigration, acculturative stress, racism, racial/ethnic identity, socioeconomic status and more.

Counselors should never assume that a client of color is somehow culturally "protected" from developing an eating disorder, Talleyrand warns. "All women should be assessed for all types of disordered eating behaviors and attitudes, given the fact that 90 percent of women experience body dissatisfaction. I would also say that counselors need to start looking beyond anorexia and bulimia since binge eating disorder is much more common among the general population, is finally being [given] its own diagnosis in the *DSM-5,* and some women of color engage in greater or equal levels of binge eating behaviors in comparison with their white counterparts."

Boie contends more research is needed in this area, including assessments to better capture body image dissatisfaction from a diverse perspective. These assessments should encompass concerns that are atypical for white clients, such as hair type, skin color or eye and nose shape, she says.

"For example, Mexican-American women may be less preoccupied about thinness but [more preoccupied] about maintaining a guitar-shaped body, with larger bust and hips and a thinner waist," says Boie, a member of ACA. "Therefore, a clinician may miss the typical drive for thinness."

"Remember to get a good picture of how culture may impact women's issues depending on their cultural identity, level of acculturation, generational status [and] intersection with other dimensions of diversity [such as] socioeconomic status, sexual orientation, etc.," she says. Rather than attempting to fit these clients into a mold, Boie believes counselors must try to understand the influence of cultural values and norms, both on clients' eating disorders and body image issues, and on the treatment and counseling relationship.

Finding the best way forward

Choate's mission in putting together the book *Eating Disorders and Obesity* was to provide counselors with a one-stop shop for best treatment practices and guidance for additional resources. The treatments shown to be most effective in treating eating disorders, Choate says, are enhanced cognitive behavior therapy (CBT-E), family-based therapy for child and adolescent clients with anorexia, interpersonal therapy (IPT) and dialectical behavior therapy (DBT).

With CBT-E, the first phase targets normalized eating, including three meals and two snacks a day. Once clients make that switch, they usually find their urge

Additional resources

Want to expand your knowledge on this topic? Here are some good places to start:

- *Eating Disorders and Obesity: A Counselor's Guide to Prevention and Treatment*, edited by Laura Choate, and published by ACA. This new book offers a practical and comprehensive look at the assessment, treatment and prevention of eating disorders and obesity (visit the ACA Online Bookstore at *counseling.org/publications/bookstore*).
- ACA's *Journal of Counseling & Development* featured a special section titled "Assessment, Prevention and Treatment of Eating Disorders: The Role of Professional Counselors," guest edited by Laura Choate, in its July 2012 issue.
- "Counseling College Women Experiencing Eating Disorder Not Otherwise Specified: A Cognitive Behavior Therapy Model" by Laura Choate, Spring 2010 *Journal of College Counseling*
- "The School Counselor's Role in Addressing Eating Disorder Symptomatology Among Adolescents" by Juleen K. Buser, *VISTAS Online*, 2012 (*counseling.org/knowledge-center/vistas*)
- "Eating Disorders Among Male College Students" by Joseph Birli, Naijian Zhang and Vickie Ann McCoy, *VISTAS Online*, 2012 (*counseling.org/knowledge-center/vistas*)
- "Drama Therapy as a Counseling Intervention for Individuals With Eating Disorders," by Dixie D. Meyer, *VISTAS Online*, 2010 (*counseling.org/knowledge-center/vistas*)
- National Eating Disorders Association (*nationaleatingdisorders.org*)
- Laura Choate also recommends the website Eating Disorders Resources for Recovery (*bulimia.com*) and the book *Overcoming Binge Eating* by Christopher G. Fairburn, published by Guilford Press in 1995.

to binge decreases, Choate says. During the second phase, the client and counselor begin looking at the cognitive side of the issue. They explore how the client might have overvalued weight and shape in the past and how the client can handle current and future problems without turning to eating or exercise.

Choate points out that although CBT-E is the most effective evidence-based treatment for eating disorders, it is only effective in up to 60 percent of cases. That clearly shows that more research on effective treatments is necessary, Choate says.

IPT has been tested against CBT-E. Although IPT is slower to work initially, at the one-year follow-up after clients finish treatment, CBT-E and IPT were shown to be equally effective, according to Choate. IPT doesn't focus on food, weight or shape at all, she says. Instead, the focus of treatment is on improving the person's interpersonal competence and relationships. The theory behind it, Choate explains, is that eating disorders develop as a result of interpersonal conflicts. For example, a female client may not be getting her needs met in relationships, or an adolescent transitioning through puberty might be struggling in her relationship with her parents. As clients learn to develop healthy relationships and get their needs met with the help of IPT, the importance of weight, shape and using food as a coping mechanism seems to diminish, Choate says.

DBT has shown effectiveness with clients dealing with binge eating, Choate says. The treatment assists them with developing healthier coping skills, tolerating distress and regulating their emotions.

Family-based therapy is appropriate for young clients who have anorexia and are still living at home, Choate says. With this approach, parents temporarily take control of feeding the child until the child gets back to a healthy weight. At that point, control over eating is gradually transferred back to the child.

Maine says using relational-cultural theory (RCT) is effective in treating adult women (a chapter of Choate's book is also devoted to RCT). Unlike approaches based in medical models, which can be depersonalizing and objectifying, Maine says RCT focuses on the client's resources and self-knowledge. RCT aims to examine the function of the eating disorder, which exposes for clients how it has become a Band-Aid for other issues such as feeling inadequate, powerless or confused about how to get their needs met.

RCT also places the counselor and client on equal footing, Maine says, with each serving as a key component in solving the problem. "I will say, 'I am the expert in eating disorders, but you are the expert of you. Alone, I can't solve your problems.' This equalizes the situation," Maine says. "I'm not more important. I'm just a guide."

In her counseling practice in Concord, Mass., ACA member Alice Rosen uses what she calls a "nondiet" approach with clients with eating disorders and body image issues. These clients make up approximately 75 percent of her caseload.

The diet mentality, Rosen explains, suggests to people that something is wrong with their bodies and that they don't have the resources within themselves to fix it, so they must rely on an external expert. A nondiet approach, on the other hand, teaches clients that they are qualified to be the expert if only they will listen to the cues their body provides, Rosen says.

Rosen teaches her clients mindfulness, encouraging them to pay nonjudgmental attention both to their body's cues and the food they eat. Mindfulness helps clients validate their hunger cues and realize true pleasure in eating and satiety, Rosen says. She also recommends that clients find gentle ways to feel at home in their bodies, such as practicing restorative yoga. For the emotional healing component to eating disorders and body image issues, Rosen gravitates toward the Internal Family Systems Model.

Counselors working with eating disorders and body image issues need a whole toolbox from which to choose, Maine says. But even as they stay abreast of all the effective treatments available, they also must know about the client

in front of them and what the best treatment fit might be based on that particular client's life, she says.

Seeing the whole client

In her work with clients with eating disorders, Belangee applies an Adlerian approach, which she says encourages counselors to understand who clients are as whole human beings within their environments. "[Alfred] Adler proposed that it was the desire to belong and find a place to fit in and contribute to society that motivated human behavior," Belangee says.

With an Adlerian approach, family dynamics play an important role because the family is the first place where individuals strive to find a place to belong and contribute, Belangee says. "Another key tenet of the theory is one's sense of self in relation to the world," she says. "Do we view ourselves as less than or inferior to others in some way?"

"Adler called the culmination of these factors the 'life style' or 'game plan for living,'" she continues. "The cornerstone of mental health is how much we feel that sense of belonging and contribute to the growth and well-being of our society. As we grow up and our circle widens, we then encounter more people and more situations that test our coping skills and sense of self. When we view a situation as more than we can handle, we may choose healthy coping resources, or if the stress is chronic, we may find our coping resources inadequate to meet the perceived demands of the situation. It is in these situations where someone might turn to eating disorders as a means of coping."

Similar to some other models, an Adlerian approach assumes that an eating disorder serves a purpose for the client. The first step for the counselor, then, Belangee says, is to get a complete picture of who the client is and walk in the client's shoes in the hopes of understanding what purpose those behaviors serve and why that coping mechanism makes sense to the client. "We could assume it's about thinness or control, but we might be very wrong," she says.

Counselors using an Adlerian approach might ask clients Adler's famous question: If you didn't have this issue in your life, how would your life be different? Peeling back the layers, the counselor might uncover what the client is afraid of. "Maybe the client is fearful of rejection, so he [or] she makes excuses of needing to go to the gym or of not being hungry to get out of dates or activities with the potential for meeting people," Belangee says. "The goals for the symptoms are as varied as the clients' perceptions of themselves and how they approach life."

"Once all the pieces of the puzzle are uncovered," she continues, "the counselor and client can work together to create more effective coping strategies to deal with the thoughts and emotions once handled by eating disorder symptoms and behaviors. This part of the process is very scary for the clients, particularly for those who struggled for years with eating disorder symptoms. The more concrete the strategy, the better able the client is to use it. Taking time in sessions to practice the new skills is always a good idea."

The potential for prevention

Choate points out that not everyone who has a negative body image also has an eating disorder, but everyone who has an eating disorder did start out with a negative body image. "From a prevention

aspect, that's so important to note," she says. "If we can intervene there and help clients to develop a healthier attitude toward their own weight and shape, to see there are other aspects to consider in their overall worth and value, that's where eating disorders are highly preventable."

Research Choate has conducted during the past few years has resulted in a model of body image resilience. In an article published in the journal *Sex Roles* last year, Choate and two colleagues examined factors present in young women who possess positive body image. These factors include:

- Family support and open communication
- Rejection of sociocultural pressures to achieve the thin ideal
- Rejection of the "superwoman myth," or the idea that women have to do it all
- Active coping skills
- Positive physical self-concept, encompassing an appreciation for the body and what it can do, not just how it looks

The "Body Project" by Eric Stice and Heather Shaw has the strongest empirical support of any prevention program designed for those at risk for negative body image and eating disorders, according to Choate. Stice and Shaw contributed a chapter to Choate's book on the project, which is aimed at helping young women recognize the costs of seeking the thin ideal.

When clients of any age go through stressful times, Maine says, they tend to change their eating habits. That might include undereating, bingeing or some combination of the two. For that reason, it is crucial that counselors ask clients about their eating habits when they are facing stress or transitions, she says.

Maine recommends that counselors normalize clients' eating changes and remind them that many people act similarly when undergoing stressful times. Counselors can then teach clients self-soothing alternatives to eating or restricting their food intake to provide their emotions an outlet.

The best help possible

Counselors who find themselves working with clients with eating disorders must keep ethical considerations in mind, Choate cautions. First, be mindful that treating eating disorders is a highly specialized area of practice that takes considerable training, knowledge and skills, she says. Counselors should know their scope of competence and when they may need to refer.

Second, she says, remember that an eating disorder is not something any counselor should attempt to treat on his or her own. The counselor must work as part of a multidisciplinary team that might include a physician, a nutritionist, a psychiatrist and others.

When it comes to eating disorders, the subject of client autonomy can raise ethical questions for counselors, Choate says. Counselors have an ethical mandate to promote a client's ability to make his or her own choices, but counselors also have an ethical responsibility to promote the client's well-being, she says. Sometimes a counselor, working alongside a physician, may have to support involuntary hospitalization if that becomes the only option for maintaining the client's well-being.

It is also crucial for counselors to be aware of their personal feelings about body image and eating disorders, Belangee says. Counselors need to understand how they feel about their own bodies, be aware of any issues they have related to food and know their own triggers, she says. Some counselors end up in the profession after their own personal histories of dealing with eating disorders. These counselors would be wise to seek consultation or even counseling of their own while working with this population, Belangee says.

Choate agrees. "Don't neglect self-awareness and self-care when working in this area. Just like our clients, counselors are vulnerable to societal pressures related to weight, shape and eating, and we have to make sure we are working on our own issues in this area."

The field of eating disorders treatment is complex and challenging, but Choate says it is important for counselors to realize and embrace the important role they have to play in preventing and treating these biopsychosocial issues. "Whether or not we choose to specialize in this area, our vital role in prevention, early detection and treatment cannot be overstated," she says. "As counselors, we are certainly on the front lines in our ability to provide primary or targeted prevention programs in both schools and communities. In addition, because of the breadth of our work roles and settings, we may also be among the first professionals to detect the presence of disordered eating symptoms in our clients. Therefore, we have a responsibility to be as prepared as possible to effectively assist our clients — ideally before their symptoms develop into chronic and potentially life-threatening conditions."

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