Eating Disorders in Japan: A Comparison with The USA

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Summary: Although the number of patients with metabolic syndrome has been increasing recently, young females are still more likely to become thin. The incidence rate of eating disorders has been increasing rapidly since the late 1990s and growing closer to that of Western countries. In contrast to the Western countries we looked at in our study, there has been no national epidemiological survey in the past 10 years in Japan. Additionally, it is still not common that registered dietitians join in treatment of eating disorders and provide nutrition therapy in Japan. Thus, this paper gave the outline of eating disorders in Japan by summarizing and comparing with the situation in the United States. This study revealed the importance of large national epidemiological surveys, medical nutrition therapy, and the role of registered dietitians in order to encourage registered dietitians to provide nutrition therapy by joining the teams treating eating disorders.

Key words: eating disorders, nutrition, registered dietitian

Introduction

Recently, awareness of metabolic syndrome has been growing in the public eye as this issue has become more prevalent in Japanese society. The National Health and Nutrition Survey in 2012 showed 9.4% of females and 24.7% of males over the age of twenty were strongly suspected of having metabolic syndrome. Moreover, 23.6% of males and 7.7% of females are considered likely to develop metabolic syndrome in the future. Therefore, 1 out of 2 males and 1 out of 5 females are strongly suspected of having, or likely to develop metabolic syndrome.

On the other hand, the National Health and Nutrition Survey in 2012 also reported that 4.7% of males and 12.0% of females were underweight (BMI<18.5), especially 21.8% of females in their twenties. In addition, the National Health and Nutrition Survey in 2008 stated that females aged 20 to 30 are more likely to pursue a lower BMI than any other generation including those who are already underweight. These surveys showed that the number of people who were obese and have metabolic syndrome has been increasing, however, young females aged at 20 to 30 tended to become underweight.

With the increasing of underweight, the number of eating disorders in Japan has been increasing rapidly since the late of 1990s. Eating disorders are severe diseases that cause abnormal eating behaviors based on psychological factors and are very difficult to treat completely. They also have strong correlations with other diseases such as depression, alcohol dependency, type 1 diabetes, and so on. Therefore, it is very important to detect and treat eating disorders at the early stage in order to prevent them from becoming serious. However, no large national epidemiological survey has been conducted in the past ten years and registered dietitians do not join in the treatment of eating disorders.

Therefore this paper gave an outline of eating disorders in Japan by comparing them with the United States. We proposed the importance of the large national epidemiological survey, medical nutrition therapy, and the role of registered dietitians in the treatment of eating disorders.

Eating Disorders

1. What are Eating Disorders?
Eating disorders are not only unusual appetite and attitude to eating but abnormal eating behavior caused by...
psychological factors manifesting in two ways; 1) the excessive persistence of weight, 2) weight and body images influencing self-evaluation. Moreover, eating disorders have been affected and changed by social and cultural impacts at each generation. At the present, the American Psychological Association (APA) publishes DSM-4-TR (Diagnostic and statistical manual of mental disorders, 4th ed. Text Revision) (APA, 1994) and DSM-5 (APA, 2013), and World Health Organization (WHO) established ICD-10 (The ICD-10 Classification of Mental and Behavioral Disorders: Clinical descriptions and diagnostic guideline) (WHO, 1992). These criteria have been used in clinical situations and changed constantly.

2. Category and Characteristics

DSM-4 divides eating disorders into three groups, anorexia nervosa, bulimia nervosa, and Eating Disorder Not Otherwise Specified (EDNOS). EDNOS includes disorders of eating that do not meet the criteria for anorexia nervosa and bulimia nervosa. For example, a female patient could meet all criteria for anorexia nervosa except she has her regular menses. These eating disorders are not necessarily independent but are often related to each other, and anorexia nervosa in a person can change into bulimia nervosa or binge eating disorder, while bulimia nervosa sometimes changes to EDNOS or anorexia nervosa. DSM-5 defines that every eating disorder exhibits abnormal eating behavior, such as severe diet restriction, as well as other symptoms.

There are some key characteristics which patients with eating disorders show: skipping meals, binge eating, vomiting, pre-occupation with food, irregular meal time, unbalanced meal, fear of becoming fat, persistence of thinness and desire to be thin. Obsessive tendencies, poor personal relationships, and depression are also characteristics often associated with people who develop eating disorders.

a) Anorexia Nervosa

The representative characteristics of anorexia nervosa are excessive restriction of food, fasting, excessive exercise or binge eating and purging, and there are also subtypes of anorexia nervosa: restricting type and binge eating/purging type. Anorexia nervosa patients are 15% lighter than standard weight, thus they are thin.

Anorexia nervosa patients show intense fear of gaining weight or becoming fat, even if they are underweight. For example, sometimes their perception of any small change in their body’s appearance makes it difficult for them to go out. These compulsive behaviors become more serious as their starving and malnutrition grow worse. Individuals may restrict their meals, induce self-vomiting, and misuse laxatives, diuretics, or enemas. A medical doctor’s prescription is needed to get diuretics, therefore, misuse of them is not as common. However, anorexia nervosa patients sometimes are able to obtain them because of treatment for an edema.

Some anorexia nervosa patients deny their desire to be thin and their fear of becoming fat, and say they want to be fat. In contrast, in reality they are not able to stop their behaviors to become thin and do not seen to gain their weight. Hence, they can be diagnosed with anorexia nervosa.

b) Bulimia Nervosa

Bulimia nervosa is characterized by two types of binge eating. One is eating in a discrete period of time, such as within any two-hour period. Bulimia nervosa patients also eat an amount of food which is larger than most people would eat during a similar period of time and under similar circumstances. The other is a lack of control over eating during the episode, such as feeling that one cannot stop eating or control what or how much one is eating. They also feel self-loathing when they are not able to achieve weight loss through diet restriction, anxiety for repeating binge eating and weight gain after binge eating, and guilt for binge eating.

The cases in which eating disorder patients overeat followed by compensatory behaviors such as vomiting can lead to more serious problems such as suicide, alcohol and drug abuse, compared to non-compensatory behaviors.

3. The Reality of Eating Disorders (Japan-US comparison)

a) Eating Disorders in Japan

According to the national epidemiological research conducted in medical facilities (23401 facilities) throughout the country in 1998, the estimated prevalence of anorexia nervosa was 0.083~0.119%, bulimia nervosa was 0.043~0.059%, respectively.

The number of patients with anorexia nervosa had increased 4 fold. It is reasonable to believe that there are even more patients, because not all patients visit the doctor's office.

In regard to age, the onset of eating disorders is usually at the age of 10 to 19 years old, with anorexia nervosa often beginning in teens, while bulimia nervosa affects those in their twenties. However, the number of people developing eating disorders between 10 and 19 years old has been increasing in recent years, indicating the starting age for developing eating disorders is becoming earlier. In terms of sex, there are many more females with eating disorders than males, with 90% of patients being female. According to research of metropolitan areas in 2011, the number of youths suspected of suffer-
ing from eating disorders increased rapidly at eighth grade, and peaked among tenth through twelfth graders.

b) Eating Disorders in the USA

Hudson, et al\(^{[11]}\) stated that the prevalence of anorexia nervosa, bulimia nervosa among women in the US was 0.9%, and 1.5%, respectively, and that of anorexia nervosa, bulimia nervosa among men was 0.3%, and 0.5%, respectively. Most eating disorders develop during the beginning of adolescence, at 18 to 22 years old, as in 3.8% of women with eating disorders. Halaste\(^{[12]}\) said that the number of middle aged women with eating disorders was also an increasing trend. Hudson, et al\(^{[11]}\) reported that binge-eating disorder is more prevalent than both anorexia nervosa and bulimia nervosa. Swanson, et al\(^{[13]}\) stated that lifetime prevalence estimates of anorexia nervosa, bulimia nervosa, and binge eating disorder were 0.3%, 0.9%, and 1.6%, respectively. In addition, Hispanics were reported to have the highest rates of bulimia, while Whites were reported to have the highest rates of anorexia. The majority of those with eating disorders also met criteria for at least one other psychiatric disorder, such as depression. Each eating disorder was associated with higher levels of suicidal thoughts compared to those without an eating disorder\(^{[14]}\).

c) Differences and Similarities between Japan and Western countries

Recent Western reports showed that the prevalence of anorexia nervosa among women was 0.9~2.2%, and 0.2~0.3% among men\(^{[15]}\). For adolescent girls in the United States it was 0.5%\(^{[3]}\). In contrast to Japan, in Western countries the patients with eating disorders started increasing in the 1980s and reached a peak in the 1990s. In Japan, the number of people with eating disorders was only half of that in many Western countries at the time. However, since then it has increased twice in 20 years, matching or surpassing the statistics for many Western countries\(^{[4]}\).

Although the number of patients with eating disorders has been increasing rapidly since the late 1990s, not enough surveys have been done in the past 10 years to completely assess the problem\(^{[14,6]}\). However, it is very important to research practically for treatment, aid, and prevention, because eating disorders are a life-threatening disease. There is no easy way to know the potential number of patients with eating disorders, since it is often psychologically difficult for them to see medical doctors by themselves. For this reason, a large national survey needs to be conducted in order to determine the number of people suffering from eating disorders throughout the country, as well as the type of treatment and prevention measures that would need to be established in Japan.

4. Risk Factors

There are several factors that may contribute to the onset of eating disorders that interact with one another in complex ways. These factors include social-cultural factors, psychological factors, biological factors, as well as genetic factors.

a) Social Cultural Factors

The modern social perception that thinness is essential for beauty and excessive diets to become skinny are alright are common among women. This perception has great influence on the increase in the number of eating disorders in Japan\(^{[6]}\). The mass media always has many advertisements to encourage thinness and admires those who succeed in dieting. Cheney's study\(^{[6]}\) stated that exposure to Western television programs corresponded with the adoption of a slender body image ideal and a significant increase in body dissatisfaction, disordered eating patterns, and eating disorders among young women. On the other hand, according to Pike, et al.\(^{[17]}\), there was a relative absence of obesity in Japan, so the potential role of weight and shape concerns in accounting for body dissatisfaction may be overshadowed by failure to achieve other aspects of European-centric beauty, such as height, curvaceous bodies, large breasts, and blond hair. Therefore, the mass media and social media affect women's desire to become thin, making it a factor leading to disordered eating and eating disorders.

b) Psychological Risk Factors

Reports have shown that certain psychological problems are associated with certain eating disorders. Those with anorexia often also suffer from obsessive-compulsive disorder, those with bulimia often also have depression and anxiety, and negative self-evaluation and low self-esteem can be found in all patients with eating disorders\(^{[7]}\). Moreover, according to Cooley's research about female college freshmen\(^{[18]}\), body dissatisfaction was associated with eating disorders. These psychological features are risk factors for the onset of eating disorders.

c) Familial Risk Factors

These are some familial risk factors that cause and exacerbate eating disorders\(^{[9]}\), for example, family troubles such as separation and divorce of parents, poor contact with parents, excessive expectation from family, and so on. In addition, other family member's dieting, and negative comments about diet, body image and weight could be part of what can trigger eating disorders\(^{[20]}\).

The changes of family structure have been also related to the increase in the number of eating disorders. Japanese women were found at a reduced risk when compared to data from the West\(^{[17]}\). Japanese women were thought to be relatively protected from eating disorders by the stable, solid family system, healthy diet, and low
The rates of weight problems that characterized traditional Japanese culture\(^{27}\). However, now this Japanese culture is changed. A few decades ago, most Japanese households included the grandparents; three generations would live and eat together. On the other hand, now most families are nuclear families. Therefore, these changes contribute to the increasing in eating disorders in Japan.

d) Genetic Risk Factors

Not all those who have the psychological characteristics mentioned above develop eating disorders, but some of those become developing eating disorders. A recent study with twins showed that genetic factors play important roles in the sensitivity of eating disorders\(^{21}\).

Different genes affect development of anorexia nervosa and bulimia nervosa, and the heritability of the former is higher than that of the latter. However, as previously explained, anorexia nervosa and bulimia nervosa are not necessarily independent diseases\(^3\). Since there are correlations between genes that cause anorexia nervosa and those that cause bulimia nervosa, anorexia nervosa could change into bulimia nervosa, and vice versa, since both genes are in the same family\(^{21}\).

Therefore, although different genes affect the sensitivity of anorexia nervosa and bulimia nervosa, they are not different eating disorders which have totally different genetic and environmental factors, but rather similar eating disorders whose features overlap\(^{21}\).

e) Other Risk Factors

There are also other risk factors; unhealthy weight control is also one of risk factors causing binge eating and self-vomiting. In addition, the persistence with so-called "healthy food" could cause eating disorders. It is not recognized in DSM-4, however, this symptom called orthorexia nervosa has been increasing recently\(^{22}\).

**Treatment of Eating Disorders**

1. **Psychotherapy**

Eating disorders are mental illnesses related to psychological issues such as low self-esteem; problems with interpersonal relationships, depression, and so on. Therefore, psychotherapy is essential to treating eating disorders.

   a) Cognitive Behavioral Therapy

   Cognitive behavioral therapy is a talking therapy that can help patients with eating disorders’ mental problems by changing the way they think and behave\(^{23}\). Although it is commonly used to treat anxiety and depression, it can be useful for eating disorders\(^{31}\). Cognitive behavioral therapy cannot remove their problems, however, it can help by comparing the differences between how the patients think of the problem and the reality of the problem. The patients with eating disorders are likely to think the problem is worse than the reality of it and suffers from it. This therapy which is based on the concept that thoughts, feelings, physical sensations, actions, and environment are interconnected, therefore therapists encourage the patients to realize their inappropriate negative thoughts and feelings. Cognitive behavioral therapy only deals with the patient’s current problems rather than focusing on issues from their past\(^{21}\). It has been shown to be an effective way of treating a number of different mental health conditions, such as obsessive compulsive disorder, panic disorder, eating disorders, and so on\(^{24, 25}\).

   Cognitive behavioral therapy has proven effective at lessening the frequency of binge eating behaviors, abnormal compensatory responses, and normalizing cognitions in individuals with bulimia nervosa. However, use of cognitive behavioral therapy with anorexia nervosa is challenging because disruptions in neurotransmitter secretions and functions limit the patients’ response to treatment.

   There are some studies which show positive effects of cognitive behavioral therapy intervention. First, in a randomized controlled trial, interpersonal psychotherapy and cognitive behavioral therapy proved significantly more effective than behavioral weight loss treatment in eliminating binge eating after 2 years\(^{30}\). Other small cognitive behavioral therapy intervention studies for women who binge ate\(^{26}\) was shown to have the positive results. In that study, registered dietitians intervened through discussions, didactic information, reflection questions, and homework exercises.

   Following these interventions, measurements of binge-eating severity and frequency, depression, body image, and self-esteem showed improvement, although weight did not change significantly\(^{27}\).

   b) Family Based (Maudsley) Therapy

   According to some studies, family based therapy has effects on adolescents with anorexia nervosa. It promotes parental control of weight restoration while enhancing familial functioning as it relates to adolescent development\(^{28}\).

   Family based therapy is an intensive outpatient treatment where parents play an active and positive role because of the following reasons; firstly it helps to restore patients’ weight to normal levels expected of their age and height; secondly control over eating is given back to the adolescent\(^{20}\); thirdly, it encourages normal adolescent development through an in-depth discussion of these crucial developmental issues as they pertain to the child\(^{20}\).

   Family based therapy is an effective way to treat adolescents with anorexia nervosa sooner than other treatments. This therapy can prevent hospitalization and as-
sist the adolescent in her or his recovery, provided that parents are seen as a resource and that they are allowed to play an active role in treatment\(^9\). A detailed clinicians’ manual that shows how parents should be involved in this treatment has recently been developed\(^9\).

2. Medical Nutrition Therapy

a) The Importance of Nutrition Therapy

Eating disorders are severe diseases with abnormal eating behaviors based on psychological factors and very difficult to treat completely. They also have strong relations with other diseases such as depression, alcohol dependence, type 1 diabetes, and so on\(^5\). The complexities of eating disorders which are accompanied by various diseases and symptoms require a collaborative approach by an interdisciplinary team of mental health, nutrition, and medical specialists\(^22\).

Though eating disorders are not caused by diets themselves but rather stem from mental illness, medical nutrition therapy is an important treatment that can have a great influence on the patients’ prognosis. It plays a great role on stopping exacerbation of eating disorders and preventing complications.

Since nutrition therapy stimulates patients’ fear of obesity, it may backfire and make them more reluctant for treatment. Therefore, they need to be motivated with extreme care\(^10\).

Inappropriate food restriction affects amenorrhea.

Table 1  Roles and responsibilities of registered dietitians for nutritional treatment of eating disorders (modified from references 15 and 22)

<table>
<thead>
<tr>
<th><strong>Nutrition assessment</strong></th>
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<tbody>
<tr>
<td>Perform anthropometric measurements; height and weight history, complete growth chart, assess growth pattern, menstruation cycle</td>
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<tr>
<td>Interpret biochemical data</td>
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<tr>
<td>Evaluate dietary assessment; eating patterns, core attitudes regarding weight, shape, eating</td>
</tr>
<tr>
<td>Assess behavioral-environmental symptoms; food restriction, binging, preoccupation, vomiting or other purging, excessive exercise, inappropriate use of medications</td>
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<tr>
<td>Apply nutrition diagnosis and create a plan to resolve nutrition problems</td>
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<th><strong>Nutrition intervention</strong></th>
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<tbody>
<tr>
<td>Calculate and monitor energy and macronutrient intake to establish expected rate of weight change, and to meet body composition</td>
</tr>
<tr>
<td>Increase amount and variety of foods consumed, normal perceptions of hunger and satiety</td>
</tr>
<tr>
<td>Making eating plans to establish regular patterns of eating</td>
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<tr>
<td>Counsel individuals and other caregivers on food selection considering individual preferences, health history, physical and psychological factors, and resources</td>
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<tr>
<th><strong>Nutrition monitoring and evaluation</strong></th>
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<tbody>
<tr>
<td>Monitor rate of weight gain, adjust food intake to maintain weight</td>
</tr>
<tr>
<td>Communicate individual’s progress with team and make adjustments to plan accordingly</td>
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<th><strong>Care coordination</strong></th>
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<tr>
<td>Work collaboratively with treatment team, communicate nutrition needs across the continuum of settings (eg, inpatient, day treatment, outpatient)</td>
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<tr>
<td>Provide education</td>
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<tr>
<td>Advocate for evidence-based treatment and access to care</td>
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<th><strong>Advanced training</strong></th>
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<tr>
<td>Use advanced knowledge and skills relating to nutrition (eg, refeeding syndrome)</td>
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<tr>
<td>Seek specialized training in other counseling techniques (eg, cognitive behavior therapy)</td>
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bones, malnutrition, and the ups and downs of patients’ feelings. Even if enough energy is taken during strict food restriction, lack of calcium often happens and it causes some diseases related to bone metabolism. The nutrition balance is broken with abnormal limitation of food, vomiting, overeating, and weight gain and loss. As a result, it induces their poor health. This result was already proven by The Minnesota Starvation Experiment in 1950’s. This study observed people who had been made to starve by restricting food to lose 25% of their weight in six months and how subsequently they recovered. Through this study, it showed that starvation caused healthy people to change mentally in ways which are similar to the symptoms with eating disorders, such as depression, anxiety, irritability, and other psychiatric symptoms. Therefore, nutrition and eating behavior affect both physical and mental stress, and control cognitive functions. It is important to promote early recovery both physically and mentally by nutrition therapy conducted by a registered dietitian. The treatment of eating disorders requires an interdisciplinary team composed of a psychiatrist, a clinical psychologist, and several others. Registered dietitians are needed to collaborate with other specialists in their team to conduct nutrition therapy. In addition, exchanging opinions in the team and communicating with patients from a broad perspective are important. When they contact patients, forming a rapport and listening to the patients are also required. Since eating disorders are a complex mental illness, they need to understand the psychological and neurobiological aspects.

There are several aims of nutrition therapy; regaining and maintaining normal weight, forming normal eating and fixing abnormal attitudes to food and weight. The assessment of the patients’ nutrition status by registered dietitians contributes to team approach medicine, because food intake history is more accurate than biological checks and better for figuring out nutrition deficiency of micro nutrients than the present food intake. Moreover, registered dietitians are able to motivate them to change their eating behaviors through patient-centered interviews. On the other hand, patients with eating disorders have reluctance to eat high energy food and think such food should not be eaten. They feel guilty after eating these foods, so they often induce self-vomiting and take a laxative. Thus, registered dietitians need to educate them that they can eat high energy food and maintain normal weight as long as they do not overeat them.

b) Medical Nutrition Therapy and the Role of Registered Dietitians in the United States

The American Dietetic Association clearly stated that nutrition intervention, including nutritional counseling by a registered dietitian, was an essential component of team treatment of patients with anorexia nervosa, bulimia nervosa, and other eating disorders during assessment and treatment across the continuation of care. It requires a collaborative approach by an interdisciplinary team of mental health, nutrition, and medical specialists, due to the complexities of eating disorders, such as epidemiologic factors, treatment guidelines, special populations, and emerging trends highlighting the nature of eating disorders. Registered dietitians are integral members of treatment teams and are uniquely qualified to provide medical nutrition therapy for the normalization of eating patterns and nutritional status. However, this role requires understanding of the psychological and neurobiological aspects of eating disorders. Advanced training is needed to work effectively with this population. Further efforts with evidenced-based research must continue for improved treatment outcomes related to eating disorders, along with identification of effective primary and secondary interventions.

Registered dietitians’ role in the nutrition care of individuals with eating disorders is supported by the American Psychological Association, the Academy for Eating Disorders, and the American Academy of Pediatrics. Registered dietitians working with patients with eating disorders need a good understanding of professional boundaries, nutrition intervention, and the psychodynamics of eating disorders. Table 1 (modified from references 15 and 22) shows roles and responsibilities of registered dietitians for nutritional treatment of eating disorders.

Certain populations are vulnerable to eating disorders, such as athletes and adolescents. Dieting typically precedes a full-blown eating disorder, as an athlete restricts eating to achieve lower body weight for enhanced performance, for example. This tends to occur more often in sports that encourage a lean physique, such as running, wrestling, dance, and gymnastics. An athlete does not necessarily need to exhibit all symptoms to be at risk for compromised health and eating disorders; rather, the individual is assessed across a spectrum of abnormal behaviors. Registered dietitians play a role in the identification and treatment of disordered eating patterns in this vulnerable population.

Essential priorities for registered dietitians include collaboration and communication skills, advanced training, and an understanding of the complexities and sensitivities of eating behaviors. Also of note is that risks for eating pathology increase with dietary changes and weight management efforts. As registered dietitians participate in limiting the progression of eating disorders, they can support efforts for sustainable outcomes for eating disorder prevention, intervention, and treatment.
c) Medical Nutrition Therapy and the Role of Registered Dietitians in Japan

The clear statement about nutrition intervention for eating disorders including nutritional counseling by a registered dietitian might not exist in Japan, unlike the USA. Although some registered dietitians have joined in the treatment and received good feedback from patients with eating disorders, not all facilities collaborate with them to treat the patients\(^6\). Registered dietitians are not able to provide nutritional counseling to patients with health insurance settings in Japan. This makes it difficult for registered dietitians to join the treatment of eating disorders\(^6\).

Conclusion

The prevalence of eating disorders in Japan has been increasing rapidly since the late 1990's and getting closer to that in Western countries, because of the Westernized modern Japanese society which emphasizes excessive dieting to achieve a skinny body. Therefore, social-cultural prevention must be prepared to control mass media which promotes women to become ultra thin.

In contrast to the Western countries, there has been no national epidemiological survey about eating disorders in the past 10 years in Japan. Moreover, in the United States there are more detailed surveys of eating disorders focusing on the differences of prevalence of eating disorders between ethnic groups. The role of registered dietitians in caring for those with eating disorders is clearly mentioned, such as nutrition care for specific populations who are more vulnerable to eating disorders than others, such as athletes. Although nutrition intervention is important to change the patients’ eating behavior and recover their weight, it is necessary to detect and treat the patients at earlier stages for a complete recovery\(^1\). In Japan, the kind of guidance offered registered dietitians joining in the treatment of eating disorders and providing nutrition therapy has not been common. To improve the team treatment composed of various specialists such as psychiatrists, clinical psychologists, and registered dietitians, a large national survey should be conducted. In addition, the importance of medical nutrition therapy, and the role of registered dietitians for the treatment of eating disorders are acknowledged.

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Yamaguchi, Wakana, Tanaka and Homma

日本における摂食障害：米国との比較

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要約：近年、日本においてメタボリックシンドロームの患者数は増加する一方で、若い女性のやせの増加がおかがえる。日本における摂食障害の発症頻度は 1990 年代後半から急激に増加し欧米の国々と肩を並べてきている。しかし、欧米のように、日本ではここ 10 年間のきちんとした全国的な疫学調査がなされていない。また、日本では管理栄養士が介入した摂食障害の栄養指導はあまり行われてないのが現状である。これまでに米国の摂食障害の状況や摂食障害治療における米国の管理栄養士の役割と日本の現状を比較した論文は見当たらない。したがって、アメリカ合衆国と比较しながら、日本の摂食障害の現状をまとめた。その結果、管理栄養士が摂食障害治療チームに加わり栄養療法をえるように、正確な実態を把握するための全国的な調査の必要性および摂食障害治療における栄養療法の重要性を示し、管理栄養士の役割を見つけた。

キーワード：摂食障害、栄養、管理栄養士

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