Nutrition Therapy Approach in the Treatment of Eating Disorders

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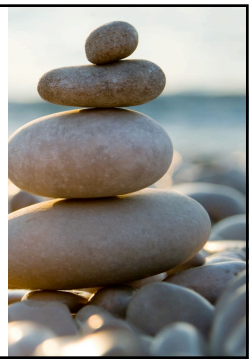


Roadmap

- Intro to Eating Disorders
- Nutrition philosophy and goals
- Role of the ED Dietitian
- Screening tool
- Levels of care
- General nutrition recommendations
- Eating stages of recovery
  - Refeeding
  - Mechanical
  - Mindful
  - Intuitive
- Non-diet approach

Intro to Eating Disorders

- Eating disorders are psychological diagnoses made by the presence of criteria listed in the Diagnostic and Statistical Manual (DSM-5) for the specific eating disorders
- The symptoms often occur on a continuum
- Eating disorders are progressive and can lead to death
- Second highest mortality rate of any psychological disorder

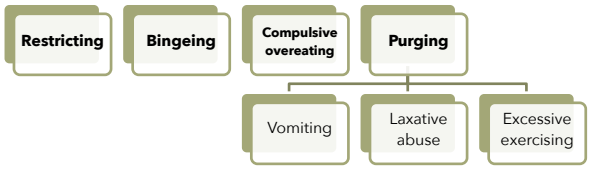
Stellefson Myers, Eileen. Winning the War Within 2nd ed. 2006, Helm Publishing.

Intro to Eating Disorders: DSM-5

- **Anorexia Nervosa**
- **Bulimia Nervosa**
- **Binge Eating Disorder**
- Other Specified Feeding or Eating Disorder
- Unspecified Feeding or Eating Disorder

Evelyn Attia, MD "Feeding and eating disorders- What's new in DSM-5?" October 18, 2013,.

Intro to Eating Disorders: Behaviors



Nutrition Philosophy

Nutrition therapy focuses on:

- *Normalizing* eating patterns
- *Repairing* the relationship with food and body
- *Trusting* hunger and satiety cues
- Practicing "All Foods Fit"
- Balance, variety, and moderation
- Healthy = balanced

Initial Nutrition Therapy Goals

Stabilize- set small-step goals to decrease/avoid ED behaviors

Refeed- set small-step goals to build on current intake

Patients re-train their digestive tract

Patients replete their bodies

Normalize eating patterns- *add structure* with schedule

Long-Term Nutrition Therapy Goals

PROGRESS THROUGH THE EATING STAGES OF RECOVERY

ABSTAIN FROM ED BEHAVIORS

LEGALIZE ALL FOODS

RESTORE WEIGHT IF NEEDED; ALLOW BODY TO FIND ITS PREFERRED WEIGHT

RELEASE FOOD RULES AND RITUALS

The Role of the ED Dietitian

Dietitians play a critical role in assessing the level of nutritional compromise and advising the rest of the treatment team and the patient on meal planning and meal supervision.

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications, 3rd ed. Baltimore, John Hopkins University Press, 2017.

The Role of the ED Dietitian

One-on-one initial assessment

- ED history and current behaviors
- Assess motivation
- Usual food intake
- Provide education
- Individualized meal plan and/or intake goals
- Ongoing nutrition education

Meal plans

- Start slow
- Do not include calories
- Food group servings

The Role of the ED Dietitian

One-on-one follow-up sessions

- Set weekly goals
- Discuss behavior change
- Discuss behaviors
- Identify triggers
- Educate

Blind weights

Active team member

Comprehensive Initial Nutrition Assessment

- Medical history
- Weight history
- Family history
- Eating behavior history and origin of eating disorder
- Review of specific behaviors
- Review of physical complications/side effects of ED
- Diet history and usual intake
- Dietary rules and rituals
- Fear, trigger, and safe foods
- Body image
- Calculation of nutritional needs
- Nutrition diagnosis
- Nutrition prescription

Practical Screening Tool for Providers

The SCOFF Questionnaire

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ver 14 pounds (one stone) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are thin?
- Would you say that **F**ood or exercise dominates your life?

*One point for every "yes"; a score of ⩾2 indicates a likely case of anorexia nervosa or bulimia

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications. 3rd ed. Baltimore, John Hopkins University Press. 2017.

Red Flags

- Preoccupation with weight, food, calories
- Uncomfortable eating around others
- Avoids eating around others, avoids social events involving food
- Engages in food rules or rituals, extreme diets
- Skips meals
- Noticeable fluctuations in weight

www.nationaleatingdisorders.org/warning-signs-and-symptoms

Red Flags

- **Amenorrhea**, irregular menstrual cycle, or other menstrual changes
- GI complaints
- Dry skin and hair, hair loss
- Decreased immune function
- Swollen parotid glands
- Abnormal nutrition-related labs

***If you notice red flags, ask detailed questions to get more information**

***Rule in* eating disorders before *ruling out* medical causes of symptoms**

www.nationaleatingdisorders.org/warning-signs-and-symptoms

Orthorexia- the "clean eating" disorder

- Excessive, obsessional concern about eating only healthy foods
- Eating habits ay rule a patient's life personally and socially
- Eating habits may become pervasive and have unhealthy consequences
- No current diagnostic criteria

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications, 3rd ed. Baltimore, John Hopkins University Press, 2017.

Levels of Care

Inpatient
↓
Residential
↓
PHP
↓
IOP
↓
Outpatient

Levels of Care

When to refer patients to a higher level of care (inpatient/residential/PHP):

- If eating disorder is moderate to severe
  (4 or more episodes of bingeing and/or purging/week)
- Substantial or rapid weight loss, especially < 75% IBW
- Significant medical symptoms (low potassium, unstable vital signs, etc.)

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications, 3rd ed. Baltimore, John Hopkins University Press, 2017.

Levels of Care

When to refer patients to a higher level of care (inpatient/residential/PHP):

- Self-harming behavior
- Suicide plans
- Co-occurring substance abuse or other significant psychiatric comorbidity
- Lack of response to outpatient treatment

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications. 3rd ed. Baltimore: John Hopkins University Press; 2017.

Assessing Weight Status

Ideal Body Weight (IBW):

- Goal for patients with anorexia nervosa
- **Females: 45 kg for 152 cm + 1.8 kg for each additional 2 cm** (100 lb for 5 ft + 5 lb for each additional inch)
- **Males: 48 kg for 152 cm + 2.2 kg for each additional 2 cm** (106 lb for 5 ft + 6 lb for each additional inch)
- **Healthy range** = +/- 10%
- **%IBW** = current weight ÷ IBW

Assessing Weight Status

- **%IBW** = current weight ÷ IBW
- Ex: 18 yo female is 162 cm (5'4") and 68 kg (150 lb)
  - 45 kg + (1.8 x 10/2) = 54 kg IDW
  - 100 lb + 20 lb = 120 lb IBW
  - **Healthy range** = 49-60 kg (108-132 lb)
  - **%IBW** = 68 kg (150 lb) ÷ 54 kg (120 lb) = 125%
- You try! 25yo male is 179 cm (5'11") and weighs 86 kg (190 lb)
  - IBW?
  - %IBW?

Assessing Weight Status

Patient's condition can be classified based on %IBW:

- Mild 10% below IBW
- Moderate 20% below IBW
- Severe 30% below IBW
- Critical >30% below IBW

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications. 3rd ed. Baltimore: John Hopkins University Press; 2017.

Assessing Weight Status

Body Mass Index (BMI):

- Calculation on the basis of height and weight
- Wt (Kg) ÷ Ht (m^2)

BMI		BMI	
18.5-24.9	WNL	25-29.9	Overweight
17.0-18.4	Malnutrition Grade 1	30-34.9	Obesity Gr 1
16.0 -16.9	Malnutrition Grade 2	35-39.9	Obesity Gr 2
< 16	Malnutrition Grade 3	>/ 40	Obesity Grade 3

Assessing Weight Status

Which one to use?

- Dietitians consider both IBW and BMI
- **Body composition**, if available:
  - Ensures body fat % is in healthy range
  - Can be a more specific indicator of healthy weight

Assessing Weight Status

Body Fat %

Women

Age	Healthy Range
20-40 yrs	21-33%
41-60 yrs	23-35%
61-79 yrs	24-36%

Age-Adjusted Body Fat Percentage Recommendations - NIH

Assessing Weight Status

Body Fat %

Men

Age	Healthy Range
20-40 yrs	8-19%
41-60 yrs	22-27%
61-79 yrs	25-30%

Age-Adjusted Body Fat Percentage Recommendations - NIH

Health At Every Size (HAES)

- There can be health in larger bodies
- Having an overweight or obese BMI doesn't automatically mean medical consequences
- HAES is a movement that celebrates body diversity and honors differences in size
- Challenges scientific and cultural assumptions

haescommunity.com

General Nutrition Recommendations

- 3 balanced meals + snacks per day
  - 50% carbohydrate
  - 25% fat
  - 25% protein
- Balance = 3 or more food groups per meal
  - Use Plate Planner as visual guide
- Water (30 mL/kg body weight)
- Exposure to fear/challenge/binge foods

Fear Foods

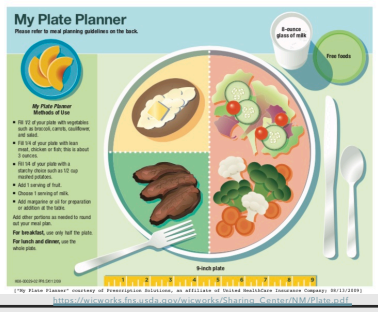
- Foods that are avoided by people with eating disorders out of fear of a negative consequence
- Foods one considers "bad" or "forbidden"
- Foods one thinks has too many calories or makes them feel out of control
- Foods that one thinks will lead to weight gain

Costin, et al. 8 Keys to Recovery from an Eating Disorder. New York, W.W. Norton & Company, 2012.

Plate Planner

A guide to balance and portion size

*Or MyPlate Plan at choosemyplate.gov



"My Plate Planner" courtesy of Prescription Solutions, an affiliate of United HealthCare Insurance Company. 08/13/2009.
https://wicworks.fns.usda.gov/wicworks/Sharing_Center/NM/Plate.pdf

Nutrition Education: Carbohydrate

- The body's primary and preferred source of fuel
- The brain's primary and preferred source of fuel (glucose)
- The body's most efficient source of energy
- Our bodies need 50-60% of daily intake from carbohydrate
- Food sources: grains, fruits, dairy, beans, some veggies

Carbohydrate

Complex carbs- sustained energy	Simple carbs- quick energy
• Eat over the course of the day at meals and snacks • Grains, wheat products (make half your grains whole) • Dairy (milk, yogurt) • Vegetables (corn, peas, potatoes, winter squash)	• Provides vitamins and minerals (fruit) • Can be used around exercise, training, academic tests • Fruit, juice • Sports drinks

Tip: Carbohydrate snack 30 minutes before exercise provides ***energy burst*** for performance

Eating Stages of Recovery

Refeeding
↓
Mechanical
↓
Mindful
↓↑
Intuitive

Refeeding Stage

- Early phase of nutritional replenishment
- Food = medicine
- Start low and gradually increase meal plan as tolerated
- Recommend easy-to-digest foods (low amount of vegetables and fiber)
- Recommend nutrient-dense foods (dairy, meat, etc.)

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications, 3rd ed. Baltimore, John Hopkins University Press, 2017.

Refeeding Stage

- Nutrition supplement, such as Boost or Ensure, may be needed to help with volume
- May take several weeks of meal plan increases to reach adequate intake, especially if patient becomes hypermetabolic
- In acute patients who have been severely restricting or purging, or are at very low weight or medically compromised, this stage may require medical supervision at the inpatient level of care
  - Monitor for *refeeding syndrome*

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications, 3rd ed. Baltimore, John Hopkins University Press, 2017.

Refeeding Syndrome

- A potentially catastrophic complication where patient can have low phosphorous levels that can cause cardiovascular collapse
- Occurs during the early stage of nutritional replenishment
- The lower the BMI, the greater the risk
- Reduced heart mass has difficulty with increase in blood volume
- Glucose load from food leads to low serum phosphorous levels, which can impair heart contraction

Mehler, et al. Eating Disorders: A Guide to Medical Care and Complications, 3rd ed. Baltimore, John Hopkins University Press, 2017.

Mechanical Eating Stage

- First step in restoring hunger/fullness cues
- Structured meal plan that patient follows, even in absence of hunger cues
- Restoration of appetite and normal eating begins mechanically
- Food = medicine
- This is an uncomfortable process
- May take several weeks for appetite to return

Mindful Eating

- Patients may begin mindful eating practices, even in the mechanical eating stage
- Involves paying full attention to the experience of eating, both inside and outside the body
- Encourages awareness of how eating effects mood or vise versa
- Encourages curiosity without judgment
- Ongoing throughout recovery and beyond
- Supports intuitive eating

Intuitive Eating

- Begin to learn to trust their body cues and become the expert of their own body
- Develop a healthy relationship with food, mind, and body
- Eat regular balanced meals without the structure of a meal plan, based on the body's needs and wants
- Feeding the body becomes more natural; have made peace with food
- Cannot occur in the presence of eating disorder symptoms
- The goal of long-term recovery; may take a year or more to begin to intuitively eat

INTERNAL VS. EXTERNAL CUES

Internal vs. External Cues

External Cues	Internal Cues
Calories	Hunger
Grams of fat, carbs, sugar, etc.	Fullness
Exchanges	Cravings
Portion sizes	Flavors, textures, colors, smells
Pyramids, plates, guidelines	
Clock	

10 Principles of Intuitive Eating

1. **Reject the diet mentality**
2. **Honor your hunger**
3. **Make peace with food**
4. **Challenge the food police**
5. **Discover the satisfaction factor**

Intuitiveeating.org

10 Principles of Intuitive Eating

6. Feel your fullness

7. Honor your feelings without using food

8. Respect your body

9. Movement- feel the difference

10. Honor your health- gentle nutrition

Intuitiveeating.org

Mindful vs. Intuitive- What's the difference?

- **Mindful eating** is a process of paying attention to your actual eating experience
- **Intuitive eating** is a broader philosophy that includes a healthy outlook on food, body, and exercise

Non-Diet Approach:
Promoting Food Permission vs. Restriction

- Restrictive eating and thinking supports the eating disorder
- In BED and bulimia, restricting is a set up for a binge
- Nutrition therapy focuses on an "all foods fit" approach that leads to food freedom, intuitive eating
- Must challenge years of diet messages that patients have internalized

Non-Diet Approach:
Promoting Food Permission vs. Restriction

- The fear is that permission leads to being "out of control"
- The reality is that *restriction* gives the eating disorder control, and *permission* leads to total control and body trust
- The *non-diet approach* is something that all providers can promote
- Encourage patients to break the diet cycle

Diets Don't Work

Weight

- Studies show that diets don't result in sustainable weight loss (Thomas et al. 2008)
- Two-thirds of dieters in studies regained more weight than they lost (Mann et al. 2007)

Carolyn Ross, *The Emotional Eating Workbook*

Diets Don't Work

Weight

- When you put your focus on health first, not weight, you're more likely to improve your health, self-esteem, and body image (Bacon and Aphramor 2011)
- When you put your focus on health first, not weight, you're more likely to lower your risk for heart disease, high blood pressure, and diabetes through size acceptance, intuitive eating, and increased activity levels (Bacon and Aphramor 2011)

Carolyn Ross, *The Emotional Eating Workbook*

Diets Don't Work

Underlying issues

- Dieting and other eating behaviors just address what's on the *surface*
- Surface level behaviors include overeating, bingeing, dieting, etc.
- Beneath the surface are emotions, core beliefs, and body sensations that drive these behaviors.
- When the dieting stops, the emotions and beliefs will still be there and will lead back to the behaviors.
- Connecting with and working through these emotions can lead to freedom from dieting and other behaviors.

Carolyn Ross, *The Emotional Eating Workbook*

Diets Don't Work

The diet is a set-up

- Diets involve restrictions, which are sometimes extreme. Restrictions of calories, specific nutrients, food groups, or foods.
- *Restriction is a set-up for overeating or bingeing behavior*, which continues the restrict/binge cycle.
- Severe restriction causes the body's metabolism to slow down and try to conserve fuel. The body tries to survive, just as if you were stranded on an island and trying to survive. It doesn't know the difference.

Starvation Study

- In the 1944 Ancel Keys "starvation study," men who followed the *semi-starvation* diet phase of *1,600 calories* showed *increased preoccupation with food*, as well as increased fatigue, irritability, depression, and apathy.
- When that phase was over, some engaged in *extreme overeating*. The men continued to show drastically unhealthy behaviors regarding food and overall mental health.

Baker, David & Keramidas, Natacha. (2013). The Psychology of Hunger. *American Psychological Association, Vol 44, No. 9*, page 66.

Starvation Study

- The men in the study also reported decreases in mental ability.
- Diets and restrictions affect our brains by depleting important neurotransmitters, which affects our moods.

Baker, David & Keramidas, Natacha. (2013). The Psychology of Hunger. *American Psychological Association, Vol 44, No. 9*, page 66.

Practical Tool: Alternatives to dieting

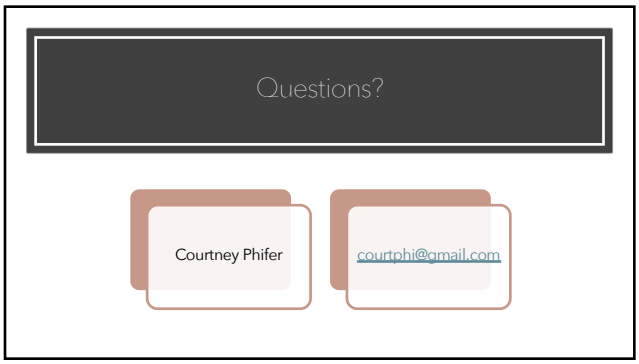
What can patients do instead of dieting to lead a healthier lifestyle?

- **Work on connection**
  - Emotions and beliefs
  - Hunger and fullness cues
  - Body sensations
- **Work on balance and moderation**
  - 3 balanced meals/day (see the *Plate Planner* for a simple guide)

Practical Tool: Alternatives to dieting

What can patients do instead of dieting to lead a healthier lifestyle?

- **Work on mindful eating**
- **Work on permission vs. restriction**
- **Work on body acceptance**


Questions?
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