

Using Collaborative Care and the Recovery Model in Nutrition Care for Treating Patients with Eating Disorders

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We will discuss...

Recovery Model

Collaborative Care

Biases and Beliefs

Weight Goals

Nutrition Interventions

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Bulimia
ARFID
Anorexia



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- “SAMHSA defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential” (SAMSHA, 2023).
- “Anyone can recover and/or manage their conditions successfully” (SAMSHA, 2023).
- As professionals, maybe we need to look at recovery using a different lens.
- “to move towards recovery the individual must reach a ‘turning point’ where they develop insight into the function and consequences of AN and commit and take responsibility for recovery” (Stockford, 2019).
- In the meantime, help patients have some semblance of life and create a therapeutic relationship where we believe in them and are supportive.

Recovery
Model

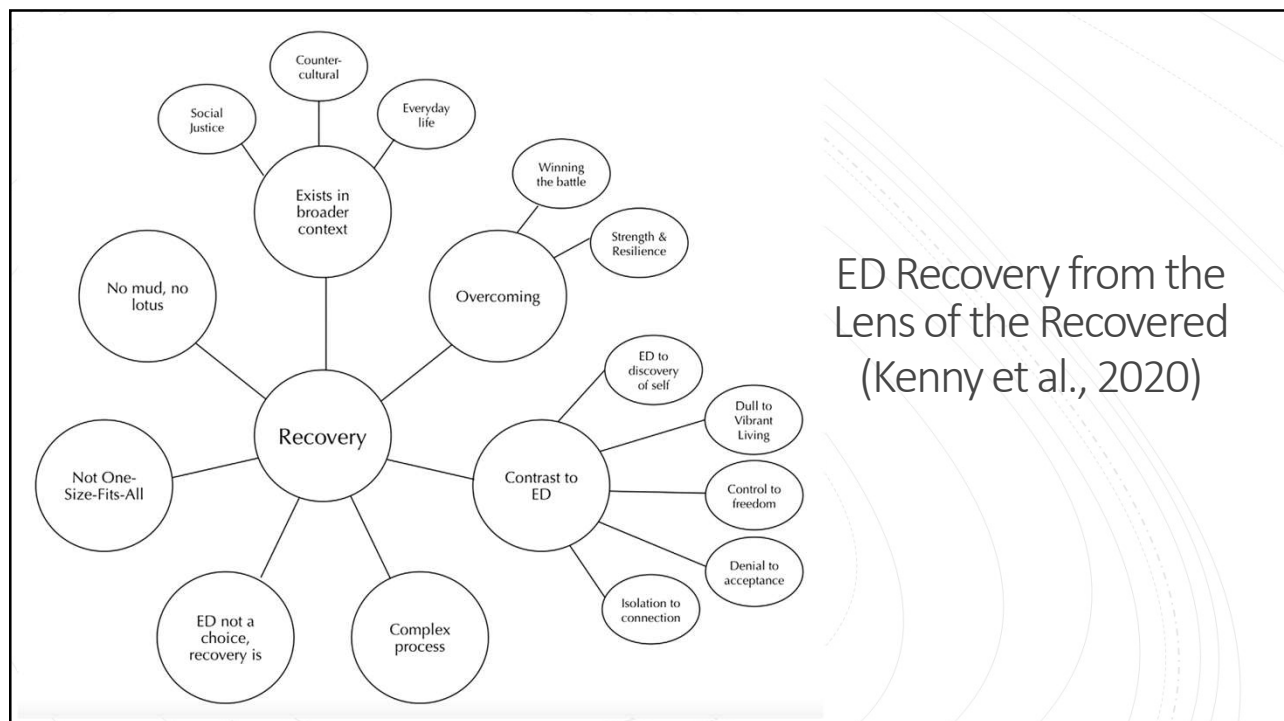
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Their version of recovery?

What is the patient's view of recovery?

- Lifepath, Values, Timeline
- Their route may be different.
- Functioning in life vs “full recovery”
- What they are capable of doing at the present moment is okay and they are not failing just because their recovery is not “picture perfect.”
- “Exploring recovery beyond perfection required participants to let go of a dominant vision of the perfect image of recovery—which is not easily done, particularly when so few visions of recovery are available to those seeking them” (LaMarre & Rice 2021).
- Having professionals and mentors with lived experience can be extremely helpful to give patients hope.

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Our Resistance vs. Theirs



“The patient is resistant...”

“Sometimes what we believe is a patient’s resistance is really our resistance to listening to the client and hearing what they say as valid.”

Our values, expectations, and beliefs may be trumping what they say theirs are.

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Collaborative Care

- Working with the patient to create the life or recovery they want.
- Increase outcomes in eating disorder symptoms, psychological functioning, increased well-being, and treatment satisfaction.
- Change how non-negotiables are delivered:
 - (1) provision of a rationale
 - (2) consistent implementation
 - (3) advance notice being given
 - (4) provision of choices (Geller et al., 2021)

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Power, Privilege, Authoritarian

Power and Privilege in a Treatment Setting

- Marginalized –weight, gender, age, ethnicity, etc.
- Intersectionality

Authoritarian

- Can cause resistance
- Even if the authoritarian is “right,” it does not matter
- Can expect too little or too much

Collaborative

- Obtain permission – Informed Consent
- Offer options- always the patient's choice *Exception

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Collaborative Care in Various Treatment Settings

Inpatient

- Speaking to them and not at them (less educational, more conversational)
- Weight goals- informed consent
- Encourage autonomy
- Offer options- always the patient's choice *Exception

Residential Treatment Setting

- Treat them as you would like to be treated
- Find out what recovery is to them
- Offer options and let them choose
- Encourage them to take initiative in their recovery

PHP/IOP

- Help them find support
- Encourage them to take initiative

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Eating Disorder Bias and How we May Limit Recovery

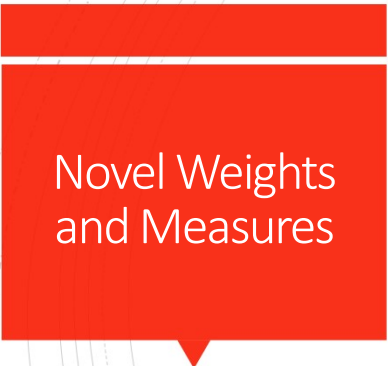
- What do you believe about a patient who has an eating disorder?
- How we speak about patients...and those that are readmitting.
- Professionals with Lived Experience
 - Motivating/Inspirational
 - Hiring professionals with lived experience
 - Fewer negative comments about patients
- Power of placebo – how we speak to patients can affect how well they do in treatment.
- RD Intern Weight and ED bias (Rahman, 2018)
- “Deviant Other” (LaMarre & Rice 2021)

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Usual Weights and Measures

- Pts knowing weigh
- How do we set goal body weight?
 - Growth Charts
 - Weight Before the ED
 - BMI
 - Set Point
- No Consensus in Defining Weight Restoration for Adolescents
- Difficult to predict in advance the weight that will support full recovery from AN
- When psychological recovery lags behind weight recovery it can be particularly difficult (Lebow et al., 2018)

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Novel Weights and Measures

Mass Index

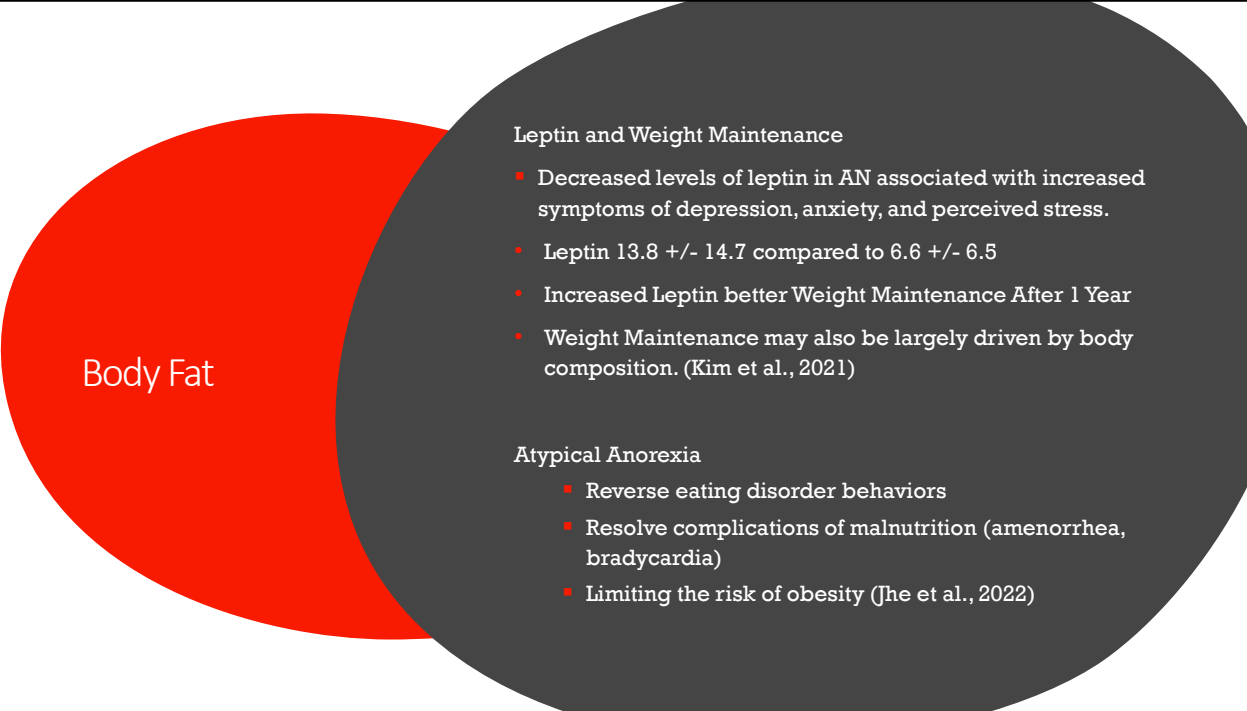
- MI = $0.53 \text{ m}/(\text{hs})$.
 - MI was larger than the BMI in 13 cases and lower in two cases
 - m=weight in kg, h=full height in meters, s=sitting height in meters (Lackner et al., 2019)

Body Fat %

- relative body weight without accurate and reliable assessment of body fat is a weak criterion for healthy weight
- Sum of Subcutaneous Adipose Tissue-
 - Ultrasound
 - Enormous BF% differences with similar BMIs.
 - BMI not adequate criterion for fat mass
 - Patients with BMI 13-17 had subcutaneous adipose tissue 1.3 to 58.2 mm (Lackner et al., 2019)
- 21.2% TBF cutoff point to resume menses (Tokatly Latzer et al., 2019)
- 27.5% +/- 4.4 BF better weight maintenance for 1 year 13.8 +/- 14.7 Leptin, ng/ml. Percent body fat and leptin were significantly higher in the group who maintained weight but there were no differences in predischARGE BMI, duration of illness, and duration of amenorrhea. (Kim et al., 2021)

Physiology of weight regain: Lessons from the classic Minnesota Starvation Experiment (Dulloo, 2021)

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Body Fat

Leptin and Weight Maintenance

- Decreased levels of leptin in AN associated with increased symptoms of depression, anxiety, and perceived stress.
- Leptin 13.8 +/- 14.7 compared to 6.6 +/- 6.5
- Increased Leptin better Weight Maintenance After 1 Year
- Weight Maintenance may also be largely driven by body composition. (Kim et al., 2021)

Atypical Anorexia

- Reverse eating disorder behaviors
- Resolve complications of malnutrition (amenorrhea, bradycardia)
- Limiting the risk of obesity (The et al., 2022)

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Nutrition Intervention and the Dietitians Role

- 91% of ED manuals had nutritionally-focused content
- 36% of the manuals recommended a dietitian be consulted as part of the team
 - FBT CBT- Two evidence-based practices
- 22 eating disorder treatment manuals
- 60% contained nutritional information not substantiated by evidence (Jeffrey & Heruc, 2020)
- RD provides nutrition information substantiated by evidence and allows the therapist to focus on the emotions, mental health, and reasons for developing an eating disorder.

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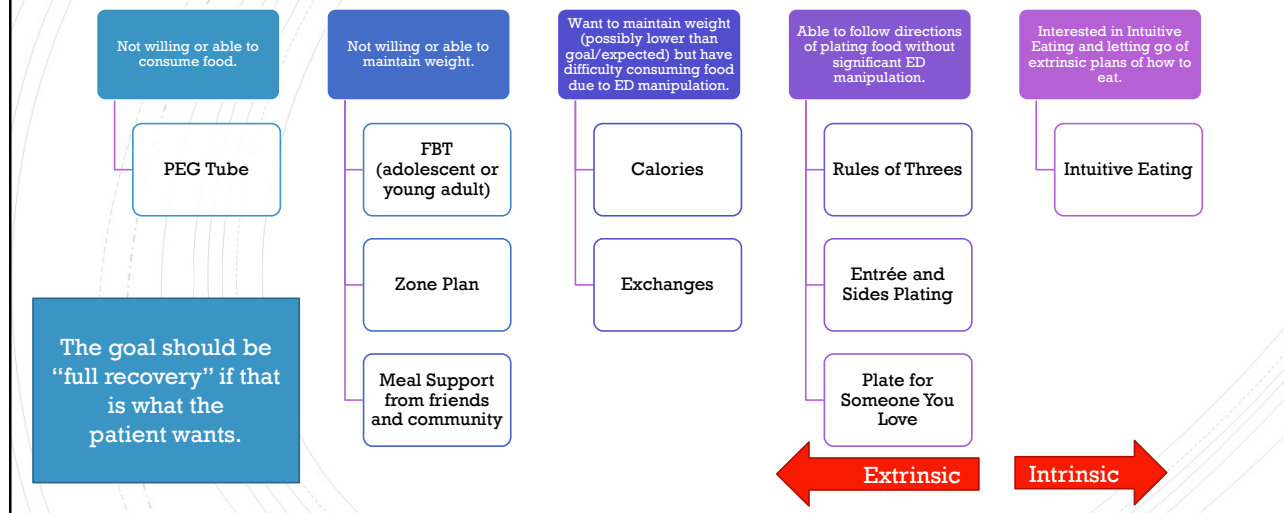
Nutrition Interventions

- Why have a variety of nutrition interventions?
- Dependent on what the patient or parents...
 - Want
 - Willing
 - Able



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Whatever they want for their recovery is okay.



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Nutrition Interventions

- Challenges and Extras
- Meal and Snacks with RDN
- Therapeutic Food Day
- Challenging Situations
- Abundance Eating
- Covert Behavior Rehearsal
- Hunger and Fullness Monitoring
- Scavenger Hunt
- Solo with Food
- Guided Intuitive Eating
- Mirrored Eating
- Grocery Store
- Convenience Store

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Recovery Commitments

I am eating three meals and two to three snacks everyday.

I am able to be honest about my food intake and keep a food journal as necessary.

I have attained a non-restrictive body weight where my body functions.

I am eating enough fat, protein, and carbohydrates so that I have regular and recognizable hunger and fullness cues.

I have made a commitment to not use eating disorder behaviors even when I am upset, triggered, or uncomfortable.

I have given up dieting and diet foods.

I have made a commitment not to weigh myself, calorie count, or read labels.

I am able to tolerate the unknown and “non-exacts” surrounding calories, weight fluctuations, body fluid shifts, etc.

I am able to recognize and monitor my hunger and fullness cues.

I have the desire to eat intuitively.

I am able to respond to my hunger and fullness cues and have given myself permission to eat what my body needs and craves.

I can cope with the emotions that I feel and the stress in my life without eating, purging, or restricting in response to the feelings.

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Thank you for attending!

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