Nutrition Therapy Across the Recovery Spectrum

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CENTER FOR CHANGE

The E.D. Dietitian’s Role

- Assess intake
- Assess need for weight restoration
- Set meal plan
- Challenge/Dispel myths & fears about food
- Direct client to medical care
  - Concerns with refeeding syndrome
  - Discern allergies vs food avoidance
  - GI issues
- Direct the client to psychological/psychiatric care

The E.D. Dietitian’s Role continued

- Teach access to food options
  - Food resources for low income
  - Pre-prepared meals
- Teach cooking skills when available/appropriate
- Create space for accountability in recovery
- Help the client create a meal support system
Setting the Stage: Building a Strong Therapeutic Bond with our Clients

- Convey empathy
- Cultivate compassion
- Assertively challenge the eating disorder
- Motivate and inspire
- Beware of own E.D./body biases

Building Rapport with the Client

- The Challenge: Our goals may be in direct opposition to the patient’s goals
- The Solution: AN patients see a strong therapeutic relationship as central to their care, so those providing care should be understanding and non-judgemental (van Ommen et al., 2009; Tierney, 2008)

Assessing the Client

- Eating disorder history
  - Length of time engaged in behaviors
  - Severity of behaviors
    - Frequency of purging (# of times a day)
    - How induced (finger, object, chemical)
    - Number of times purged during each session of purging
    - How often weighing self and other body checking methods
- Weight history
  - Assess need for weight restoration
  - Clients cannot recover in an anorexic body – they would have to engage in E.D. behaviors in order to maintain weight below set point.
Assessing the Client

- Dietary recall
- Assess for risk of refeeding syndrome
- Review malnutrition symptom in different body systems
  - Poor hair or nail growth, poor wound healing, bruising easily, etc
  - Low level of energy, memory, and concentration
- Time spent thinking about food, weight, body, calories, and fat

Refeeding Syndrome

- **Disorder discovered** This syndrome was first observed and described after World War II when victims of starvation were noted to experience cardiac or neurologic dysfunction or both after being reintroduced to food.
- Electrolyte disturbances (primarily decreased levels of phosphorus, magnesium, or potassium) occur immediately upon the rapid initiation of refeeding—commonly within 12 or 72 hours—and can continue for the next 2 to 7 days.
- Cardiac complications can develop within the first week, often within the first 24 to 48 hours.³

Yantis M, Velander R.  How to recognize and respond to refeeding syndrome.  Nursing 2008; 38(S):34-39

Criteria from the guidelines of the National Institute for Health and Clinical Excellence for identifying patients at high risk of refeeding problems (level D recommendations*)

- Either the patient has one or more of the following:
  - Body mass index (kg/m²) <16
  - Unintentional weight loss >15% in the past three to six months
  - Little or no nutritional intake for >10 days
  - Low levels of potassium, phosphate, or magnesium before feeding
- Or the patient has two or more of the following:
  - Body mass index <18.5
  - Unintentional weight loss >10% in the past three to six months
  - Little or no nutritional intake for >5 days
  - History of alcohol misuse or drugs, including insulin, chemotherapy, antacids, or diuretics
Medical Care of Refeeding Syndrome

- Monitor electrolyte disturbances
  - Phosphorus
  - Magnesium
  - Potassium
- Monitor for low blood sugar
  - Added protein with meals/snacks if occurs
- Monitor for cardiac complications

Prevalence of Refeeding Syndrome


Conclusions

A total of 310 subjects:
Higher caloric diet on admission is associated with reduced LOS, but not increased rate of weight gain or rates of hypophosphatemia, hypomagnesemia, or hypokalemia. Refeeding hypophosphatemia depends on the degree of malnutrition but not prescribed caloric intake, within the range studied.

Refeeding Syndrome

Inpatient:
- Start around 1250-1750 kcal/day
- Increase 300-500 kcal every other day
- Medical team – treat low phosphorus with phosphorus
- Medical team – treat with elevation of feet, TED hose, Spironolactone
Assessing the Client

- Family history & influences on eating
  - Client example: EG neglect
  - Another example: AB served spoiled food while father ate steak
- Beliefs and attitudes towards food
- Ability to feel and recognize hunger/satiety

The Art & Science of Setting Weight Goals

- Best clinical judgement
  - Weight history
    - Age and eating style at that weight
  - Biological family history/body type
  - Golden question:
    - If you had not developed an eating disorder, what do you think your weight would be?
- Growth charts for adolescents and young adults
- Life span weight changes
  - "Freshman 15"
  - Older age body changes

Set Point Theory & Weight Goals


Current working hypotheses include roles for nutrients, dietary composition and organoleptic properties, hormones, neural pathways, various brain nuclei, and many neurotransmitters in the regulation of food intake. It seems appropriate to assume that the level at which body weight and body fat content are maintained represents the equilibria achieved by regulation of many parameters.
Ancel Keys Study

Minnesota Starvation Experiment was published in 1950 in a two-volume, 1,385-page text entitled The Biology of Human Starvation (University of Minnesota Press).

32 Men of Superior Mind and Body
- 3 months of control
- 6 months of semi-starve + exercise
- restricted to an average of 1570 calories/day for 6 months (eating 50% less calories, moderate exercise
- 3 months refeeding

Ancel Keys Study (cont.)

- Play with food
- Conflict Eating Style: stall vs. gulp
- Metabolism decreased 40%
- Body temperatures dropped and heart rates slowed
- At the end of the study, could freely eat and quickly returned to normal weight

Ancel Keys Study (cont.)

- Food Preoccupation
  - Subjects could not stop thinking about food
  - Food became the topic of their conversations and fantasies
  - Subjects reported vicarious pleasure from watching others eat or from smelling food
  - Some of the men hoarded food
  - Collect recipes
  - Study cookbooks
Ancel Keys Study (cont.)
- Some suffered from bouts of depression, irritability and mood swings
- Subjects lost interest in sex
- Increased anxiety

Application of the Keyes Study
- Similar symptoms to eating disorders developed purely due to dietary restriction and weight loss.
- Could weight loss/restricting induce the urges and behaviors we witness in those with Eating Disorders?
- Then, would restoration of caloric intake and natural (pre-ED) weight result in decrease or cessation of at least some of those signs/symptoms observed?

Additional Recommendations
- What does the research say?
  - ADA practice paper suggest threshold of BMI of 20 is associated with better outcomes for eating disorders
  - Position of the American Dietetic Association
The Art & Science of Setting Weight Goals

- What we observe in IP and RTC level of care:
  - The patient’s body image improves as they approach their natural weight.
  - Obsessive E.D./Body thoughts improve
  - E.D./food behaviors decrease
  - Return of menstruation (if lost)
  - Thermoregulation improves
  - Decreased anxiety and depression – anxiety may increase temporarily

Hypermetabolism

- What is it?

The increase in calories burned in patients on weight restoration resulting in a need to continually increase calorie level to promote appropriate continued weight restoration.

Creating a Treatment Plan

- Long-term Goals - Make verbage in the present time
  - Dietary
  - Body acceptance
  - Exercise
  - Other ED behavior areas
- Weekly Goals – Have the patient write in “I commit to...” form
  - Assess eating level needed
  - Create structure and meal support
  - Create a plan for self correction
  - Create a “stretch” from week to week

Center for Change Philosophy & Approach

HIGHLY STRUCTURED/STRICT IN THE BEGINNING TO ACHIEVING THE MOST FLEXIBLE PLAN TOLERATED BY THE CLIENT.

Recovery Directed Eating

Highly Structured Eating
- RD determines appropriate calorie level
- RD determines necessity of weight restoration
- Eat designated meal plan or drink equivalent Boost replacement

Self Plating/Family Style Eating
- RD teaches meal guidelines – i.e. entrée/side dishes
- Client chooses side options
- Later client chooses among entrée options—learning to honor craving/preference
- Eat or drink Boost replacement

Intuitive Eating
- Client listens to and learns to honor hunger/haltely cues
- Client learns to eat appropriately when cues may or may not be present
Application of RDE in Out Patient Setting

- Structured Eating Meal Plan – until weight restored
  - Meal planning sheets using:
    - Plate method (for most patients)
    - Calorie counting (for patients who constantly choose safe sides or cut portion sizes and need higher accountability)
    - Exchange system (for patients who prefer this method)
  - FBT – parents or loved one plates the client and give Boost when needed
  - Use scoop (#8 – 2 for entrée, 1 for side dishes)
  - Accountability – meal planning sheets vs Recovery Record

- Advantages
  - Trust the dietitian
  - Challenge the ED rules/beliefs about food
  - Brain and body are renourished & healed

The Plate Method

Weekly Meal Recording Sheet
### Weekly Meal Checkoff Sheet

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
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<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<tbody>
<tr>
<td><strong>Breakfast</strong></td>
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<td><strong>Snack</strong></td>
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<td><strong>Lunch</strong></td>
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### Application of RDE in Out Patient Setting

- **Increased flexibility—self plating “Family Style”**
  - Plate method
  - FBT – patient plates with supervision
  - Calorie counting and exchange system no longer needed
  - Self correct within the meal guidelines (i.e. add extra side/s)
- **Advantages**
  - Patient takes more responsibility and accountability
  - Increased variety/flexibility
  - Client takes more of the “reins” back from ED

### Application of RDE in Out Patient Setting

- **Intuitive Eating Level**
  - No longer using meal planning sheets
  - Clients report any ED behaviors w/in 24 hours
  - Self correction
  - May stop weighing patient at this level
  - Increased time between nutrition sessions
- **Advantages**
  - Patient takes more responsibility and accountability
  - Increased variety/flexibility
  - Client takes more of the “reins” back from ED
Tools of the Trade

- **Meal replacement supplements**
  - Boost vs Boost Plus vs Boost Compact
- **Meal preparation**
  - Blue Apron
- **Meal recording**
  - Recovery Record
- **Meal support**
  - Hiring meal support
  - Seeking volunteers
  - Family members & significant others
- **Discussing “bad” days/weeks**

Intuitive Eating in Eating Disorder Treatment

SOON TO BE PUBLISHED PILOT STUDY ON IMPACT OF INTUITIVE EATING ON PATIENTS WITH DIFFERENT TYPES OF EATING DISORDERS


- 2 year study of 120 patients
  - 39% with diagnosed AN
  - 36% with diagnosed BN
  - 37% with diagnosed EDNOS
- Patients given battery of assessment pre treatment, transition from IP to RTC and again at discharge. These measures included:
  - EAT – Eating Attitudes Test
  - BSQ – measuring body shape and feelings of self consciousness with one’s body
  - OQ-45 – 45 item outcome measure to assess severity of psychological symptoms
  - IE scale

- Results –
  - Patient’s scores on all of these measures at the time of discharge fell into normal ranges or close to it.
  - Changes on three measure were large and clinically significant:
    - EAT – Eating Attitudes Test
    - BSQ – measuring body shape and feelings of self-consciousness with one’s body
    - OQ-45 – 45 item outcome measure to assess severity of psychological symptoms
    - IE scale

Study Results

Other Studies


- Analysing data from a sample of 372 men and women recruited through the community, this study found that, in contrast to rigid dietary control, intuitive eating uniquely and consistently predicted lower levels of disordered eating and body image concerns. This intuitive eating-disordered eating relationship was mediated by low levels of dichotomous thinking and the intuitive eating-body image relationship was mediated by high levels of body appreciation.
COMMUNITY SUPPORT SERVICES

SUPPORTIVE TREATMENT

THE LONG ROAD TO RECOVERY

INTERVENTION

Topics for Dietary Sessions

- Education on Eating Disorders
- Eating Disorder behaviors
- Energy Availability
- The importance and role of macro/micro nutrients
- Changing brain pathways
- Malnourishment-induced brain damage & the process of healing
- Set point and metabolism
- Food Attitudes and how they developed

Food/Body Attitude Development

- Event that shaped how you feel about food or your body?
Food/Body Attitude Development

- Event that shaped how you feel about food or your body?
- What you told yourself about the event?
- What the result is of that interpretation?

Patient Example - AM –
- Her family had an “anytime snack bowl” of fruit
- Other food was locked up
- She interpreted that –
  - There are good and bad foods
  - She is bad for eating “bad” foods
  - She has no self control around the “bad” foods and therefore they need to be locked up
- Result –
  - Preoccupation with food – especially “bad” foods
  - Stealing, hiding, hoarding “bad” foods
  - May have played a role in the development of her eating disorder
Can the event that shaped how you feel about food or your body be changed?  
Can what you tell yourself about the event be changed?  
What is the result of the new interpretation?
Topics for Dietary Sessions

- Intuitive Eating basics
  - Dangers of dieting
  - Making peace with food
  - Coping with emotions without using food
  - Hunger/satiety
  - Emotional versus physical hunger

- Meal planning and grocery shopping

- Self-correcting for eating disorder behaviors
  - What did the patient learn from engaging in behaviors?
  - What would the patient do differently?
  - How do you make up for missed meal, purge or exercise?
  - Behavioral Chain Analysis for binge/over eating

Topics for Dietary Session

- Body Acceptance
  - How body image develops
  - Exercises to change body perception
  - Cultural and familial contributions to poor body image
  - Health at Every Size/Body Positive
  - YouTube Poodle Science
  - YouTube Dove commercials: “Legacy,” “Beautiful vs Average”
  - YouTube Steep Your Soul - Farmer Chris – Apricot Farms
Topics for Dietary Sessions

- Exercise vs Intuitive Movement
  - Exercise as a purging method
  - When exercise becomes an unhealthy coping mechanism
  - Exercise addiction
  - Intuitive/Harmonious movement
  - Contracts for Exercise
    - Pre-exercise snack
    - Post-exercise snack
    - Moderate intensity and duration

Sample Exercise Contract

- Written contract includes specific exercises, time frames, ranges of occurrence, nutrition requirements, and opportunity for journaling/reflection

<table>
<thead>
<tr>
<th>Day</th>
<th>Exercise</th>
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Jenn Burnell, MS RD/LDN CEDRD and Jessika Brown, MS, RD, CEDRD, CSSD

Topics for Dietary Sessions

- Importance of variety in meal plan
- Creating a safe place to eat
- Mindfulness and mindful eating
- Guilt and shame cycle of the eating disorder
- ED thoughts versus true self thoughts
- ED’s filter on food, weight, body, and fat
- Dangers of laxative and diuretic use/abuse
- Behavior chain analysis for ED behaviors
Experiential Sessions

- Eat Snack in Session
- Eat Meal in Session
- Restaurant/Fast Food pass
- Mindful Meals or Snacks
- Cooking Class
- Kitchen Organization
- Grocery shopping
- Clothing Pass

Meal/Snack Experientials with the Dietitian

- Patient bring in their own meal/snack
  - Assess according to the meal guidelines
  - Assess safe vs challenging
- Discuss goals for the experience
  - Distract from the ED thoughts vs eating mindfully
  - Safety nets/Coping skills
- Somatic Interventions
  - Exit room, leave ED outside the room and reenter the room
  - Put ED in hand, clench fist, then release tight grasp (& ED)
  - Deep breathing

Why Address Eating Disorder Behaviors?

- How many E.D. behaviors can a patient keep and recover?
- Challenge the OCD
- Wrestle the mind back from the eating disorder
- Secrets keep you sick
Meal Support Skills Training
- Family focused practice meals with dietitian and/or therapist and significant other/support person
- Meal support vs food police
  - Preparation – The more time you have spent developing the relationship, the more trust they will have in you.
  - Reminders – Discuss the intention/goals for the meal before starting
  - Compassion/Empathy – When the patients know you care about them – it increases your street cred.
    - “I care about you,”  “You are not alone,”  “We are on your team—I am on your team”

Meal Support Skills Training
- Non-confrontational – Present observations in matter of fact manner – no “orders”, not authoritatively
- Observe/Acknowledge –
  - “The struggle is real.”
  - “I see you have some anxiety. Is this a hard meal for you?”
  - “What would be helpful for you? – distraction, deep breaths, games, conversation, other coping skills?”
  - Give praise – “You are doing great! You are so brave to be here!”

Meal Support Skills Training
- General Announcements (Group Setting):
  - “I notice there is a lot of tearing of the food. Please only break in half once.”
  - “I notice a lot of food talk – let’s redirect the conversation.”
- After the meal –
  - “Let’s talk…”
  - “Tell me about it – How did that go for you?”
  - “Talk me through that, how was that meal for you?…”
Shenanigans – Ways Patients Avoid Calories

- Hiding food under the plate
- Hiding food in another food and giving Boost for just the one item (i.e. bread in soup)
- Smearing sauce, etc. on napkin and turning inside out
- Smearing/hiding food in sleeves or other clothing

- Mix sprite in water, watering down milk, soda, juice
- Throwing food under table in little pieces
- Food in waistband, sleeves, shoes, pockets
- Water loading
- Hiding magnets, batteries, heavy objects in underwear/bra/pockets, etc. for weight check ins

Assignments

- Recovery Vision Board – how they want to experience food, their body and exercise in recovery
- Eating Disorder Rules/Recovery Rules
- Challenge Foods vs Safe Foods
- Fears of Recovery
- Perks of Recovery
- Family Influences on Eating
- Eating Disorder Auto-Biography
- Secrets
- Meal planning
- Grocery planning
Personalizing Treatment in Out Patient Setting

- The client is the Pilot/Ship’s Captain
- When to weigh vs not weigh patients
- Blind weights vs known weights
- Disclosing calorie levels
- ERPT for OCD/ARFIDS
- Interventions for Night Eating
- Involving the family
What our Patients Said Helped them the Most

- Meals with dietitian - challenged me but was understanding
- Taught me that “secrets keep me sick” – even the tiny secrets
- Taught me to shop w/o E.D. at the grocery store
- Got to know me and my passion and interests
- Always took an interest in me.
- Was just with me during the most challenging times
- Always said, “Hi” when she saw me when she passed by

WITH BODY IMAGE

- Taught me to use body gratitudes
- Taught me that food makes my body stronger
- Taught me the facts and science about food
- Showed me the book, Beautiful You

Completing Nutrition Therapy

- Indicators of recovery from AN and BN
  - Metabolic rate increased to genetically predetermined level
  - Increased the variety of food to meet CHO, protein, FA and micronutrient needs
  - Food intake related body symptoms return to normal
  - Acceptance of non-tissue weight shifts
  - Establish a pattern that result in controlled healthful food intake
  - Able to recognize hunger and respond by eating in an appropriate and timely manner
Completing Nutrition Therapy

- Wean down visits to bi-monthly and monthly
- Let them know you remain there if needed
- Amount of time spent thinking about hunger, food, body, and weight decreased to 15-20% of total time
- Light to moderate aerobic exercise without feelings of compulsion to maximize exercise as a method of purging
- Caloric intake appropriate for weight goal
- Able to comfortably eat a variety of foods without fear, guilt, or anxiety
- Comfortable eating with family, significant others, and friends in others’ homes or in restaurants

A Final Word to the Wise

- Tolerate being the “bad guy”
- Put the blame where it goes – with the eating disorder
- Believe in change
- Celebrate small steps
- Stay in our lane
  - How did this affect you dietarily?
  - Great topic to discuss with your therapist.

A Final Word to the Wise

- Know when to pass the baton - HLOC
- Utilize group and individual supervision – including therapist groups
- Self compassion – this is brutal/challenging work in the trenches
A Final Word to the Wise

- Teach, live and breath “Health at Every Size”
- Love, honor and care for YOUR body

Question & Answer