

# “Exploring the Complexities of Nutrition Therapy in the Outpatient Setting”



RENEWED EATING DISORDER CONFERENCE  
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# Top 7 Nutrition Therapy Complexities in OP



- Co-morbid occurring medical issues (i.e. blood sugar irregularities, food allergies)
- Co-morbid psychiatric illnesses (OCD, OCDP, borderline personality or substance abuse)
- Establishing an effective OP multidisciplinary team
- Weight restoration
- Treating pts. enmeshed in the “diet mentality”
- Defining “recovered” - moving pts. toward intuitive eating
- Knowing when to say “*when*”.

# Essentials for the Nutrition Therapist/RD



- Utilize the APA guidelines for nutrition therapy of the ED patient as a foundation.
- Utilize the SOP for RDs in Disordered Eating & Eating Disorders. (JADA August 2011).
- Approach work with these patients from counseling/therapy model vs. medical model.
- Treat the patient ... not the diagnosis.
- A multidisciplinary team approach is always recommended to treat ED patients.

# The Multidisciplinary Team



## Out Patient Team

- RD specializing in ED treatment.
- A therapist that treats EDs.
- Family Therapist
- M.D. that understands EDs
- A psychiatrist, as needed.
- Patient/client
- Depending on case – spouses, family members, coaches, etc.

## Residential Team

(In addition to OP team)

- Nurse
- Art, music or dance therapists.

# Components of an Effective OP Team



- Establish clearly defined roles – agreeing upon “overlaps” and boundaries.
- Point person may vary from case to case.
- Determine best options (fax, phone, secure email) for communication to guard against splitting and triangulation.
- Team members ascribe to similar philosophies for treating EDs.
- Identify frequency of updates.

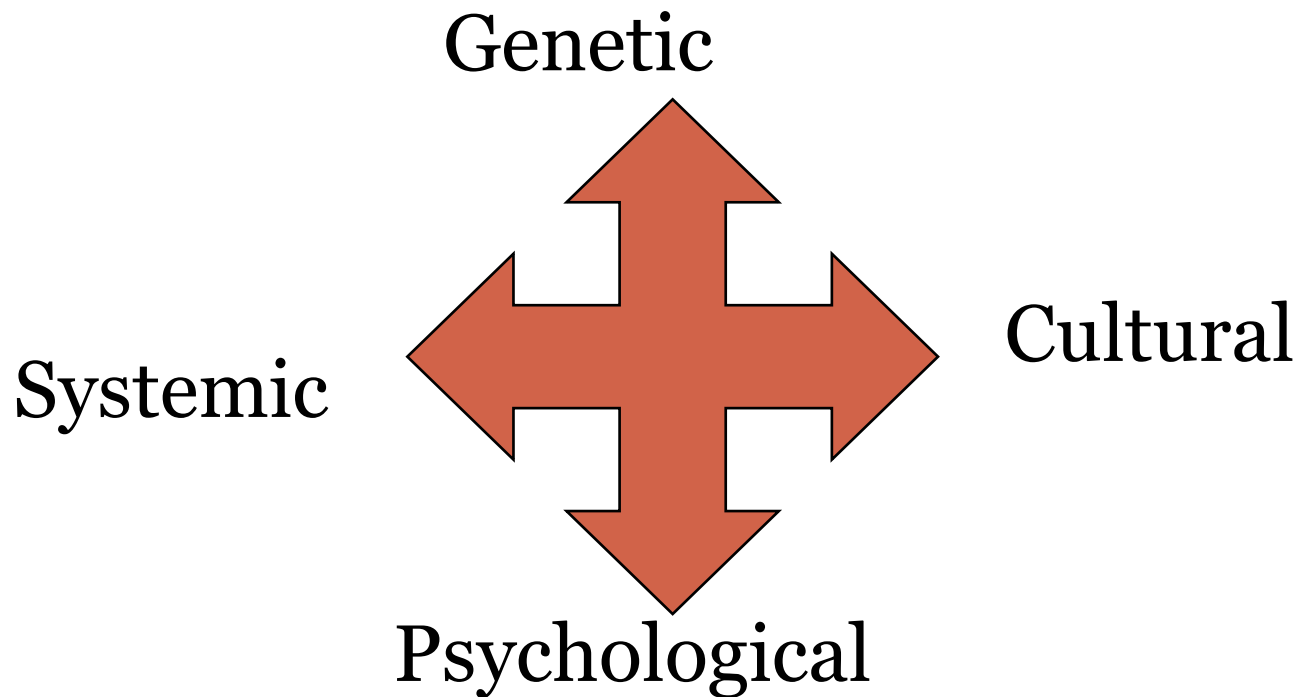
# What Contributes to Eating Disorders



## Dissatisfaction with Body and Fear of Food: A Social Illness

An Eating Disorder: not a “genetic mutation” that has swept the globe (Maine & Kelly, 2005)

# Eating Disorders are Multidetermined: Biopsychosocial Model



# What Causes an Eating Disorder?



## Intricate interplay between

- Genetics: Polygenetic Transmission
  - “Hard Wiring” (Vulnerability to Anxiety)
  - Personality/Temperament
- Environment
  - Insecure Attachment
  - Trauma
  - Culture (dieting)
- \*trauma and lack of relational support can impact laying and trafficking of neurons (Daitch, 2011)

# Eating Disorders and Temperment



## Psychological Correlates of Eating Disorders

- High Sensitivity
- Perfectionistic
- Control “Junkies”
  - Overestimate Risk (Harm Avoidance)
  - Underestimate Resources
  - Fearful of Novelty

# ...Environment Pulls the Trigger



## Latent Vulnerability Theory:

(Kaye & Welzin, 1991) Dieting and extreme weight loss alter neurochemistry

- Genetic vulnerability exposed
- Weight/nutritional restoration normalizes some biological (neurotransmitter, hormonal) factors
- Ancel Keys Semi-Starvation Study

# “It’s Not About the Food”



## Eating Disorder: A Disorder of the Self

Identity Derailed, Eclipsed by ED

- ❑ Impairment in Relationships
- ❑ Development Delayed

*But it is About the Food*



“Fat is the problem  
and  
Food is the problem  
so  
Dieting is the solution”



Not all diets develop into EDs,  
but EDs (almost) always develop out of  
dieting.

- ✦ Disordered eating and poor body image result from dieting
- ✦ Dieting girls 7-8 x more likely to develop ED

# Some Truths About the Role of the RD



- Nutrition therapy is recognized as essential in the multidisciplinary approach to treating eating disorders recommended by well respected American Psychiatric Association guidelines for ED treatment.
- The 2006 American Dietetic Association Position Paper on *Nutrition Intervention in the Treatment of Anorexia, Bulimia Nervosa, and Other Eating Disorders* identifies the RD as the most qualified health care professional to provide nutrition therapy.
- What we currently know about the effective role of the RD in the treatment of EDs is based more on clinical experience than empirical research.

# Common Blood Sugar Irregularities in the ED Population



- Incidence of EDs and DOE is 2 times more frequent in Type 1 Diabetes than in Type II Diabetes or Insulin Resistance (Pre-Diabetes). (Jones 2000)
- Type II, IR and or PCOS are the type of blood sugar irregularities that present most frequently in the outpatient setting.

# Nutrition Therapy for the ED Patient with Insulin Resistance (IR)



**Type 2 Diabetes**  
**Polycystic Ovarian Syndrome/Insulin**  
**Resistance**

# How are EDs and IR Related?



- The most common cause of IR in humans is obesity. (Tibald 2008)
- IR may lead to increased weight/body fat.
- Obesity/overweight may lead to dietary restraint, which may lead to ED behavior.
  - \*20 – 46% of those attending weight loss clinics meet screening scores for BED on the Eating Disorder Examination-Questionnaire (EDE-Q). (Crow, et al)

# How are EDs and IR Related?



- Certain medications used to treat EDs may contribute to excess body fat which can increase insulin resistance. (i.e. Remeron, Abilify or Zyprexa)
- IR may lead to type 2 diabetes.
- Several studies have demonstrated that BED is present in up to 25% of all type 2 diabetics.
- Constant binge eating may lead to chronic hyperinsulinemia.

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Screen all type 2 diabetic patients for possible eating disorder behaviors and cognitions.
- Assess for dieting history.
- Educate the patient regarding the difference between dieting and lifestyle change.
- Body fat loss and the desired improvements in insulin sensitivity will result from this process. (Diabetes Prevention Program research)

# What contributes to disordered eating?



- Dieting or restricted eating

“Starvation and self-imposed dieting appear to result in eating binges once food is available and in psychological manifestations such as preoccupation with food and eating, increased emotional responsiveness and dysphoria, and distractibility. Caution is thus advised in counseling clients to restrict their eating and diet to lose weight, as the negative sequelae may outweigh the benefits of restraining one’s eating.”

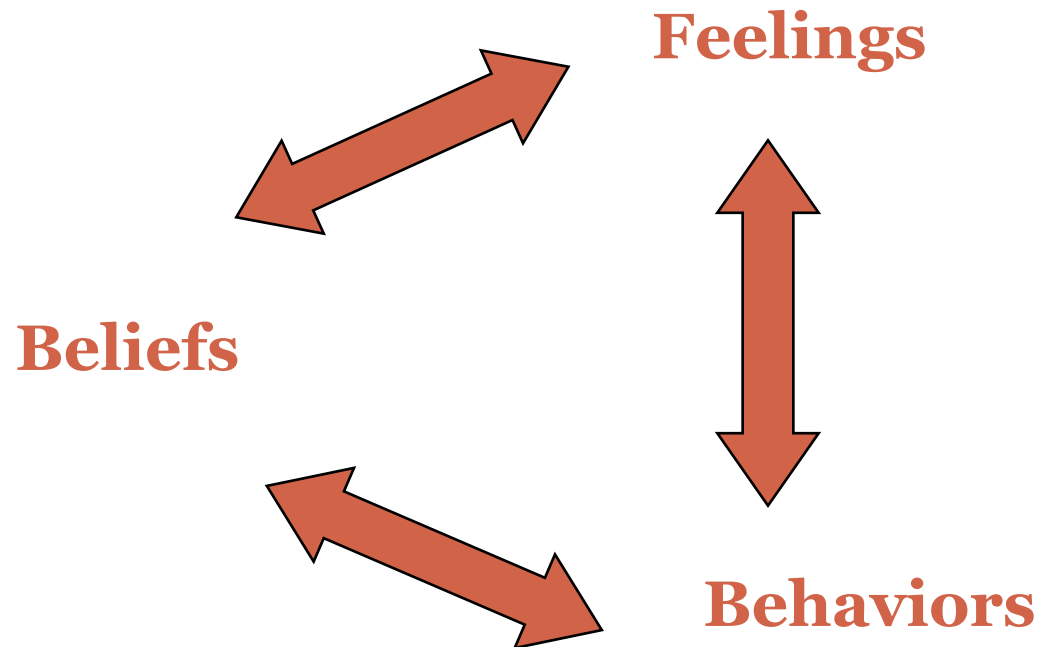
J Am Dietetic Assoc. 1996; 96:589-592

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Do not present dietary recommendations in a moralistic or legalistic manner.
- Encourage the patient to examine and challenge the “all or nothing” cognitive distortion that drives binge eating.
- Utilize the “skill development” analogy to help patients understand the process of achieving balance in their relationship to food, eating, activity and eventually their weight. (CBT)

# Cognitive – Behavior Therapy



**Pioneered by Albert Ellis and Aaron Beck in the 1960s, CBT is based on the theory that your beliefs determine your feelings and behaviors. If your beliefs are irrational ... your feelings and behaviors will follow suite!**

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Evaluate each patient as to their basic nutrition knowledge re: protein, carbohydrates and fats.
- Be aware that most of these patients may have “demonized” carbs. As a result of the all or nothing thinking ... these are the most frequent binge foods.
- Educate the patient re: complex carbs vs. simple carbs in relationship to serum glucose control.

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Initial dietary recommendations should be general.
  - Always consume foods that are primarily carb with a protein food.
  - Consume 3 to 4 “feedings” through out the day, being careful to not skip meals or go too long without eating.
  - Focus on increasing fiber content of foods containing carbs.
  - Increase consumption of low carb vegetables.

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- During the initial session make a strong case for food records.
  - Emphasize the records are “clue sheets”.
  - Use records that will give you info re: food related behaviors and cognitions, activity and behavior modification.
  - Remind patients that these records are not to invoke guilt or shame.

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Introduce the concept of monitoring for non-hunger or binge eating triggers (antecedents).
  - Emotional
  - Environmental
  - Social

You will find that most patients are already aware of many of their individual triggers. EDs and dieting prohibit one from learning how to “manage” these triggers.

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- As patients become comfortable with the general nutrition goals, gradually give them more structure.
  - Assess on a case by case basis.
  - Carb counting or use of the diabetic exchanges should be presented as “structured-flexibility”.
  - Work with patient to “normalize” binge foods through the skill development concept.

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Collaborate with the treatment team therapist to assist the patient in discovering alternative coping measures to reduce dependency on ED behaviors
- Encourage patient to implement “style of eating” techniques to move toward “intuitive eating”.
  - Reduce distracted eating.
  - Eat slowly.
  - Guard environment.

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Assess patients relationship with exercise/activity.
  - The “all or nothing” attitude may be complicating the patient’s commitment to regular physical activity.
  - Exercise/activity may be seen as only important for calorie burning or weight loss.
  - The patient may have false assumptions about activity. (i.e. “it will make me eat more”)

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Present the concept of regular physical activity as something as necessary as oxygen.
  - The absence or abuse of physical activity can hinder the connection to the hunger/craving/satisfied/full signals.
- Educate patient as to how consistent exercise can help with serum glucose regulation, stress management, lowered body fat percentage (less IR), and an improvement in current and future health concerns.

# Nutrition Therapy for Type 2 Diabetics with Eating Disorders



- Initial activity recommendations should emphasize non-stop movement of some sort to be done as many days per week as possible.
- Encourage patient not worry about duration or intensity until a frequency of 5 – 6 days per week is achieved. Some will need to start with only 10 minutes per day.
- Involve treatment team in encouraging patient to become more active.
- Eventually, the addition of strength training for a total of 2 hours/week can reduce abdominal body fat. (Schmitz, et al)

# Nutrition Therapy for the ED Patient with Polycystic Ovary Syndrome (PCOS)



- PCOS is a complex endocrine disorder that affects 5%-10% of reproductive age women. (Azziz, et al. 2004)
  - Number one cause of infertility.
  - High levels of androgens are present.
  - FSH levels are elevated.
  - Luteinizing hormones (LH) are low.
  - Sometimes cysts are formed due to hormonal imbalances.

# Nutrition Therapy for the ED Patient with Polycystic Ovary Syndrome (PCOS)



- PCOS symptoms include hirsutism on face and body, alopecia, acne, menstrual disturbances and rapid weight gain in the abdominal area.
- The estimation is that 50%-70% of PCOS patients are insulin resistant.
  - Serum glucose irregularities may lead to intense carb cravings.
  - These cravings and IR make weight loss difficult.

# Theories Regarding the Relationship Between PCOS and EDs



- Patients with PCOS begin dieting in an effort to lose weight and to control carbohydrate cravings.
  - This restriction may lead to hypoglycemic episodes.
  - The irregular blood sugar combined with body dissatisfaction may lead to binge behavior.
  - The cycle of restrict/binge/purge may lead to BN or EDNOS.  
*(McCluskey, et al. 1991, 1992)*

# Theories Regarding the Relationship Between PCOS and EDs



- Some research suggests that the hormonal imbalances that are present with BN may stimulate the growth of polycystic ovaries (McCluskey et al., 1992; Raphael et al., 1995).
- The chronic hyperinsulinemia that may result from the binge eating followed by starving or vomiting may be a factor linking BN and PCOS

# Nutrition Therapy for the ED Patient with Polycystic Ovary Syndrome (PCOS)



- Be aware that you may have clients come to you with PCOS that have undiagnosed EDs and vice versa.
- Medication (Metformin/glucophage) may be very helpful in minimizing hypoglycemic episodes. Make sure to communicate with team physician regarding this issue.

# Nutrition Therapy for the ED Patient with Polycystic Ovary Syndrome (PCOS)



- The nutrition goals and lifestyle recommendations for working with these patients will be similar to those made previously for type 2 patients.
- Patients who are dealing with infertility concerns that have resulted from PCOS may feel pressured from their OBGYN to lose weight to improve fertility chances. This pressure may spike ED behavior.
- Focusing on stabilization of serum glucose should be the initial goal of nutrition therapy.

## Case Study – PCOS/IR and ED

### Presenting Problems and History

9/16 – 16 yo African America F. EDNOS w/ OCD. 5'4" 126 lbs. Low wt. of 99 lbs. ED started @ 12 and ED behaviors had swung from restriction to binge eating for years. Rare purges. Just back from 2 months residential. On Prozac only.

### Strategies

- Began with structured flexibility plan with 3 meals, 2 snacks in the range of 1,800 kcal to 2,200 kcal.
- In Oct. was hospitalized for 15 days for suicidal ideation. Abilify added. Wt. started increasing rapidly. Pt. not overeating. Began IE work.
- By March wt. was 150 lbs.
- Expressed my concern re: abilify to psychiatrist.
- Jen asked to have more structure – gave exchanges to try for 2 weeks.
- With moderate activity wt. stabilized mid 180s for period of time.
- No menses and some blood sugar irregularities. I suspect IR/PCOS by May and refer to GP – diagnosed with PCOS. “No IR”. I still discuss carb/pro balance.
- Depression spiked first year of college – wt. 108 – 02/012. Off Abilify. Bipolar suspected.
- Abilify added back.

## Case Study Continued

- By August wt. range remaining in the mid 140s.
- Returns to school that fall, activity consistent. Starts skipping meals and consuming 4 – 5 regular soft drinks a day at one setting. “Craves them” IR?? Not menstruating. No one listens.
- Has severe hypoglycemic reaction after skipping dinner and consuming 5 soft drinks. Serum glucose at 60 when ambulance arrives. Wt. 150.
- By November wt. is 164.
- By Feb 12 wt. is 188. I refer to a diabetes specialist.
- Starts Glucophage diagnosed with IR/PCOS. Taken off Abilify. Low dose Lamictal. Wt. is stabilizing in the mid 150s.
- Wt. now in the mid 150s. We continue to work on blood sugar stabilization. Has tendency to skip meals, not exercise.

# Common Personality Disorders/Traits among ED Patients \*

\*Patients may exhibit a blend of PDs

## Obsessive-Compulsive

- Most common among AN, restricting type
- Often pre-morbid to ED
- Starvation and low body weight may spike O/C thoughts and behaviors. (Ancel Keys study on human starvation)
- May be present in some BED pts.

## Borderline Personality

- Prevalent in AN, binge/purge type (~ 25%)
- Very common among those with BN. (> 30%)
- May present with other impulse control problems.

# Nutrition Therapy for ED Patients with Co-Morbid Personality Disorders



A literature review demonstrates that there is a consensus from both practitioners and researchers that there is a high prevalence of personality disorders among ED patients. Because there are often indistinct differences between normal and abnormal personality, the exact prevalence is unclear. Rates ranged from 21% to 97%.

*Sansone, R.A., Levitt, J.L. (eds) Personality and Eating Disorders. New York: Taylor & Francis Group. 2006: (p14).*

# Practice Points to Assist with Nutrition Rehabilitation of the ED Patient with OCD



- OCD thoughts and behaviors in connection to food, eating, weight and exercise should be assessed during initial session.
  - Rituals re: calories, timing of meals, food types, etc.
  - Weighing self multiple times per day.
  - Excessive exercise.
  - Irrational beliefs about “getting fat”.
  - Checking rituals
- Realize that most recognize these obsessions are unreasonable.

## Practice Points to Assist with Nutrition Rehabilitation of the ED Patient with OCD



- Restoring low body weight may lessen the intensity of the obsessions/compulsions.
- Obsessions/compulsions may be about control or perfectionism.
- Dichotomous thinking prevails. (“All or Nothing”)
- Collaborate with treatment team to navigate the complications OCD brings to doing nutrition therapy.

# Practice Points to Assist with Nutrition Rehabilitation of the ED Patient with OCD



- Record keeping may exacerbate OCD.
- Use the concept of “structured-flexibility” when making recommendations.
- Make initial focus on increasing calorie and protein intake. Save the battle over variety and fat grams for later.
- Repeat nutrition/weight/eating truths regularly.
  - No foods are fattening.
  - Fat is not a feeling
  - Starving and excessive exercise will complicate genuine, rational weight management.
  - You do not have to burn all of the calories you consume.
  - Dietary restriction will continue to increase if not challenged.

# Practice Points to Assist with Nutrition Rehabilitation of the ED Patient with OCD



- Remind the patient of the connections and complications between dietary restriction and the obsessive/compulsive thoughts and behaviors.
- Challenge OCD rituals/rules re: food, eating, weight and exercise using the “shaping principle”.
  - Take cues for readiness from patient.
  - Praise and reassure patient for success, acknowledge the “tug of war” they are experiencing.
  - Expect lapses during time of increased stress or change.

# Practice Points to Assist with Nutrition Rehabilitation of the ED Patient with OCD



- **Indicators of recovery will include:**
  - Ability to eat in a variety of situations with less anxiety.
  - Finding a balanced relationship with activity.
  - Adequate intake of macronutrients for nutritional health and weight maintenance.
  - Decrease in frequency and intensity of food rituals.
  - Ability to recognize and confront cognitive distortions before they take complete control.
  - Active engagement in relapse prevention.

# OCD Case Study



## Presenting Problem

- 9/9/12 - 27 yo female with 10 year history of AN. High wt. of 130, low wt. 85. 5'6". During previous year had been in residential for 4 months (130 lbs.), became overwhelmed, started restricting, and had been hospitalized multiple times. Had just returned from another residential treatment program, did IOP, now referred to me for outpt. Wt. was 110 lbs. Medications were Prozac, Zyprexa. Highly restrictive intake. Less than 1,000 kcal, very rigid rules with foods. All or nothing- strong dichotomous thinking. Ex. – *Favorite foods – NONE! Foods not tolerated – ALL!*

# OCD Case Study Continued



## Strategy

- Slow, steady, specific. (Use contract?). She initially lost weight. Remained around 100 – 106 for many months. We worked on PSFAs to challenge food fears, used behavioral contracts, worked with Dr. and therapist to encourage wt. restoration. Low wt. made OCD rules more intense, meds not able to work well. By Feb. recommended tube feeding one more time. With more nourishment she was able to start addressing some rules, more successful with challenges. Had tube (1,200 Kcal per tube) for 2 1/2 months. Continued to be able to eat more by mouth.
- From 8/13 – 09/013 gained wt. rapidly up to 135 lbs. Zyprexa and mimicking boyfriends eating habits. Had no connections of her own with preferences or hunger-satisfied signals. Started expressing desires to diet. Now working on intuitive eating. No remaining food rituals. Becoming comfortable w/ body image issues and weight range.

# Practice Points to Assist with Nutrition Rehabilitation of the ED Patient with Borderline Personality Disorder/Traits



- **Borderline personality issues may include:**
  - Impulse control problems with food that begin with dietary restraint that leads to binge/purge cycles.
  - Presence of self-harm behaviors that might include burning or cutting.
  - Very volatile, labile emotions.
  - Dichotomous thinking (All or nothing)
  - Substance abuse or shoplifting problems
  - A tendency to either idealize or demonize treatment team members. (splitting)

# Practice Points to Assist with Nutrition Rehabilitation of the ED Patient with Borderline Personality Disorder/Traits



- These patients need consistency with treatment efforts.
  - Develop and maintain communication with all team members.
  - Be specific and direct regarding recommendations to assist patient with normalizing their eating behaviors.
  - Establish boundaries with borderlines (such as “if you are more than \_\_\_ minutes late for an appointment you will have to reschedule”) and do not waiver.
  - Most of these patients have a strong fear of abandonment.

# Practice Points to Assist with Nutrition Rehabilitation of the ED Patient with Borderline Personality Disorder/Traits



- Be prepared for suicidal threats and gestures.
- Using contracts with patients may give them the focus they need in the midst of erratic thoughts and behaviors.
  - Contract for limiting purging behaviors... not ceasing.
  - Work with other team members in developing contracts.

# Weight Restoration



- Weight restoration in an outpatient setting is complicated by the following factors:
  1. Inability of patient to be monitored at every meal/snack.
  2. Patient is engaged in more activity than in residential – even if exercise is eliminated.
  3. Patients often “sneak” exercise.
  4. It is more challenging to enforce supplementation.
- 1/2 pound to 1 pound of wt. restoration per week is recommended.

# Weight Restoration



- Present weight restoration as a vital and necessary part of recovery.
- Weight restoration is a barometer of the recovery process ... but not the only or best perspective as to how an individual's overall recovery journey is progressing.
- Be prepared to “sell” the benefits of weight restoration.
- Weight restoration should be a byproduct of the pt. progressing in other areas of ED recovery.

# WEIGHT RESTORATION AND QUALITY OF LIFE BENEFITS

## WEIGHT RESTORATION: WHAT TO LOOK FORWARD TO

1. Enjoyment of a wider variety of foods
2. Competence and ease at social functions
3. Ability to form and upkeep meaningful relationships
4. Increased physical energy
5. Sharper cognitive functioning related to memory and attention
6. Independence, freedom, serenity, and confidence

*Life without an eating disorder is truly amazing. I no longer spend all of my time obsessing about food and my body. I can now focus on what really matters to me in life. Genuine recovery from an eating disorder is about true independence. Keep moving forward and you will find that freedom.*

— JENNI SCHAEFER

# PHYSIOLOGICAL RISKS ASSOCIATED WITH INADEQUATE WEIGHT RESTORATION

## 1. CHRONIC ENERGY DEFICIENCY

- Depressed Basal Metabolic Rates (BMR)
  - BMR is the amount of energy-expended daily
- Depressed Leptin levels
- Leptin regulates energy intake and expenditure, including metabolism, and enhances the body's hunger and satiety signals

## 2. ELECTROLYTE DISTURBANCES

- Hypokalemia: Result of abusing vomiting, laxatives or diuretics
- Hyponatremia: Result of drinking excessive amounts of water. Can lead to comas, seizures or death

## 3. VITAL SIGN INSTABILITY

- Bradycardia: abnormally slow heart rate
- Orthostatic blood pressure changes: drop in systolic and diastolic blood pressures

## 4. CARDIOVASCULAR ABNORMALITIES

- Reduced heart size
- Diminished exercise capacity
- Increased risk for permanent heart damage

## 5. RESUMPTION OF MENSES

- Amenorrhea absence of menstruation

## 6. STRUCTURAL BRAIN CHANGES

- Enlargement of CSF spaces
- Loss of brain substance: both gray and white matter
- Cerebral atrophy which can contribute to decreased cognitive abilities including memory and attention

## 7. REDUCED BONE MASS

- Osteopenia: decreased bone mass

## 8. DECREASED PSYCHOLOGICAL FUNCTION

- Increase in depression, anxiety, and obsessive thinking
- Impaired attentional skills
- Impaired cognitive functioning, including memory

## 9. DEATH

- Anorexia Nervosa has the highest mortality rate of any psychological disorder

The Good News: Weight Restoration will prevent these physiological risks from occurring

(Golden, et al) (Polito, et al) & (L Scalfi, et al)

# WEIGHT RESTORATION & WHAT TO EXPECT

## TEMPORARY SIDE EFFECTS OF WEIGHT RESTORATION:

1. Bloating
2. Fluid Retention
3. Edema around ankles and eyes
4. Stomach cramps or discomfort
5. Gastrointestinal problems such as: constipation or slowed gastric emptying
6. Increase in body image anxiety

*These unpleasant symptoms are TEMPORARY, and will subside after a couple of weeks, once the body gets used to normal digestion of a regular eating pattern.*

## TIPS TO HELP REDUCE SYMPTOMS OF DISCOMFORT:

1. Adequate hydration
2. Consumption of adequate fiber
3. Monitoring blood electrolyte levels, fluid imbalance, and organ function
4. Monitor consumption of processed foods that are high in sodium
5. Limit consumption of carbonated beverages, and caffeinated beverages
6. Work towards accepting a normal body weight that is within a healthful range and can be maintained without an eating disorder

# Defining Recovery



Exhibit 20-2 Food-, Weight-, and Activity-Related Indicators of Recovery

## INDICATORS OF RECOVERY FROM ANOREXIA AND BULIMIA NERVOSA

### Normalized Food, Weight and Activity Related Behaviors

- 1) **METABOLIC RATE**  
Increased to genetically predetermined level.
- 2) **VARIETY OF FOODS**  
Expanded when necessary to meet High Quality Protein [HQP] (or equivalent, i.e., complimentary protein), Essential Fatty Acid [EFA], Carbohydrate [CHO] (includes simple and complex carbohydrate and fiber), Minerals, Vitamins, Water and other nutrient needs.
- 3) **FOOD INTAKE RELATED BODY SYMPTOMS**  
Returned to normalized:
  - Menstruation
  - Thermoregulation
  - Hair growth/health
  - Skin health
  - Dental health
  - Energy availability
  - Digestion/absorption functions
- 4) **NON-TISSUE WEIGHT SHIFTS**  
Acceptance of daily or weekly hydration changes resulting in temporary weight shifts.
- 5) **FOOD CONSUMPTION PATTERNS**  
Establishment of a pattern that results in controlled, healthful food intake.
- 6) **HUNGER**  
Ability to recognize hunger and respond by eating in an appropriate and timely manner.
- 7) **AMOUNT OF TIME SPENT THINKING ABOUT HUNGER, FOOD, BODY AND WEIGHT**  
Decreased to a maximum total of 15–20% of conscious time per day.
- 8) **EXERCISE LEVEL**  
Light to moderate aerobic exercise as a maximum and without feelings of compulsion to maximize exercise as a method of purging.
- 9) **CALORIC INTAKE APPROPRIATE FOR WEIGHT GOAL AND NORMALIZED METABOLIC RATE**  
As defined by BEE X Exercise factor formulas for weight maintenance, adjusted for weight gain or loss goals.
- 10) **FOOD FEARS**  
Ability to comfortably eat limited amounts of variety of foods if desired, without fear, guilt or anxiety.
- 11) **WEIGHT**  
Maintenance of weight within healthful range 90–120% Ideal Body Weight (adjusted for frame size) or between upper and lower set point thresholds. (Please note some individuals have set points for weight well above 120% of Ideal Body Weight.)
- 12) **SOCIAL EATING**  
Person feels comfortable eating with family, significant others and friends, and in others' homes or in restaurants when appropriate.

# The “Recovery Puzzle”! What are we really looking for in ED recovery?



# The Role of the Nutrition Therapist in Promoting ED Recovery



- Exposing the role dieting/dietary restriction can have in the development of EDs or the spiking of ED thoughts and behavior in the future is vital.
- Assisting patients in trusting the truths that they do know regarding weight, metabolism, calories, purging behaviors, etc. is part of the long-term role we can have in promoting sustained recovery.
  - CBT work re: food fears, social eating, trusting that fat is not a feeling, “full” does not mean “fat”.
  - Teaching skills to patients to help learn to manage their relationship with food in order to assuage desires to return to ED behaviors for control.
  - Work with patients in navigating the intuitive eating process.
  - Promote positive body image and self-esteem.

# Defining Recovery Research-Practice Gap



”Nowhere is the scientist/practitioner gap in the ED field more gaping than when it comes to answering the question: What is recovery? Views from the ivory tower and those from the therapy couch provide dramatically different vantage points”

Beth McGilley, PhD

Goal – Integrate perspectives of researchers, clinicians and clients/patients

# Defining Recovery: Research – Practice Gap



“A fundamental criticism of traditional quantitative ED research involves the nearly exclusive focus on the physical parameters of recovery from what are clearly biopsychosocial illnesses. Examining only the overt symptoms (e.g. restoration of weight or menses) and grouping outcomes ignores the psychosocial and spiritual dimensions of ED recovery as well as the diverse and essential personhood of the individuals subject to their torment.”

(Treatment of Eating Disorders: Bridging the Research – Practice Gap by McGilley, Bunnell, Maine)

# Defining Recovery: Research – Practice Gap



“Fifty years of quantitative research devoted to ED outcomes has provided extensive data, despite failing to provide comparable, consistent, and clinically meaningful definitions of what recovery entails (Berkman, Lohr & Bulik, 2007; Couturier & Lock, 2006; Jarman & Walsh, 1999; Steinhausen, 2008; Wonderlich, Gordon, Mitchell, Crosby, & Engel, 2009). Inconsistent definitions of successful outcome, as well as variations in design, measures, outcome ratings, dependent variables, populations, diagnostic categories and criteria, and the duration of follow-up, have generated an unwieldy body of literature with radical discrepancies. Indeed, given published ranges of recovery rates between 0-92% for AN (Steinhausen, 2002) and 13-69% for BN (Herzog et al., 1993), achieving recovery could be metaphorically construed as either a cakewalk or a death march.”

(Treatment of Eating Disorders: Bridging the Research – Practice Gap by McGilley, Bunnell, Maine)

# Defining Recovery



- Recovery goes beyond resolving the nutritional complexities.
- Recovery occurs in phases and may involve multiple lapses and relapses.
- Recovery entails truly becoming “well” from your eating disorder. (Beth McGilley, PhD concept)
- The ultimate goal is to lead the patient towards truly intuitive eating and living!

# When to Say “*When*”



- The outpatient team has the ethical obligation to terminate an individual if a higher level of care is deemed necessary and the pt. refuses to respect that professional decision.
- If it appears that there is no motivation, the pt. is missing appointments, not completing assignments, etc. the team must agree on the course of action that would be in the patient's best interest. Terminating a pt. can be a turning point for the individual.
- Not everyone afflicted with an eating disorder will choose to or be able to recover.

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