

Nutrition Care for Individuals with Eating Disorders: Start-up Kit for Dietitians

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Eating disorders (EDs) are multifaceted mental health conditions that can bring about significant changes in one's eating and exercise behaviours. If left unaddressed, these changes can have serious impacts on an individual's physical and mental well-being. Dietitians play a crucial role in ED treatment. This handout aims to provide dietitians a starting point for delivering effective nutrition care to individuals with EDs in community settings. The guidelines are grounded in treatment principles that have been shown to promote healing from an ED, including person-centred care, recovery-oriented practice, trauma-informed care, and harm reduction.

Types of Eating Disorders

The following are brief definitions of the more common diagnoses. Refer to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for a comprehensive list of diagnoses and diagnostic criteria.

- **Anorexia Nervosa (AN):** Persistent energy restriction, with significantly low body weight and disturbed body image. Often accompanied by an intense fear of weight gain.
- **Bulimia Nervosa (BN):** Recurring cycles of binge eating and followed by purging behaviours.
 - **Binge-eating:** Consuming a large quantity of food in a relatively short period of time, with a feeling of loss of control.
 - **Purging:** Compensating for calorie intake, such as by self-induced vomiting, using laxatives or diet pills, over-exercising, or restricting.
- **Binge Eating Disorder (BED):** Recurring binge-eating episodes in the absence of compensatory behaviours.

- **Avoidant/Restrictive Food Intake Disorder (ARFID):** Restricted food intake and/or variety with significant impact on nutrition status or psychosocial functioning, but without weight or body image concerns. Reasons for avoidance/restriction may include a general disinterest in eating or food, high sensitivity to a sensory characteristic of food (e.g., appearance, smell, texture), and/or fear of experiencing an aversive outcome (e.g., digestive distress, choking, or vomiting).
- **Other Specified Feeding and Eating Disorder (OSFED):** EDs that do not meet the AN, BN, BED, or ARFID criteria. One example is atypical AN, where the person meets all AN criteria but has a “normal” or high BMI.

EDs can have many negative impacts on one's physical and psychological well-being. Some commonly-seen symptoms include fatigue, dizziness, changes in mood, and cognitive impairment. For further information, refer to the *Guidebook for Nutrition Treatment of Eating Disorders* (listed under Helpful Resources for Dietitians).

DEVELOPED IN COLLABORATION BETWEEN BODY BRAVE AND NEDIC



Eating Disorder vs. Disordered Eating

While EDs are formal diagnoses, disordered eating refers to a range of behaviours that are characteristic of an ED, but the frequency and/or severity do not yet meet criteria for an ED diagnosis. Disordered eating can evolve into an ED.



The Role of Dietitians in Recovery

The ideal care team for an individual with an ED is comprised of professionals from multiple disciplines and the individual's personal support system. At minimum, the professionals on the care team should include a primary care provider, a therapist, and a dietitian. The role of the dietitian in ED treatment includes:

- Conducting nutrition assessments and regular follow-ups
- Developing nutrition care plans
- Helping individuals implement their nutrition care plan
- Identifying and addressing dysfunctional thoughts or emotions related to eating, food, or body size
- Communicating and collaborating with other care team members, which may include family and significant others

Providing Nutrition Care to Individuals with Eating Disorders

Recovery from EDs is often thought of as the elimination of ED thoughts and behaviours. While this could be the goal for some individuals, others may benefit from a more individualized approach to recovery that has a different endpoint. Recovery could mean any state that allows the individual to live a satisfying life, even if ED thoughts or behaviours may still be present. A beneficial recovery goal is one that allows the individual to have hope. Relapses and ambivalence are common occurrences, and dietitians should work with the individual to overcome setbacks and maintain hope.

Potential Topics to Explore with Individuals with Eating Disorders

- The importance of adequate nutrition in physical and mental well-being
- Misconceptions around food and nutrition
- Diet culture
- Meal planning, grocery shopping, and cooking
- Possibility of meal support

Assessment

Because dieting and the pursuit of certain body types are so normalized, disordered eating and EDs often go undetected. Consider screening for disordered eating routinely during nutrition assessments; this will increase identification of individuals in

need of specialized care and/or referrals. In conducting nutrition assessments with individuals with EDs, aspects to pay particular attention to include the following:

Note that not all individuals with EDs need to be weighed regularly – or even at all. If medically necessary to track an individual's weight, frequency can range from once a week to once every several months in a community setting. Always ask for permission before discussing weight or weighing a client. For many clients, especially in the early stage of treatment, knowing their weight is extremely distressing. A weighing protocol that keeps their weight hidden to them can help limit their anxiety.

Anthropometrics:

- Weight history: current weight, recent weight changes, premonitory weight, highest and lowest weight
- BMI: although frequently used as an indicator of nutrition status, BMI is unreliable for many reasons (e.g., underestimating risks of having a lower weight, overestimating risks of having a higher weight, designed for use in assessing populations instead of individuals). Individuals who have a “normal” or high BMI may still be malnourished and/or experiencing disordered eating symptoms. If using BMI, it should be interpreted in the light of other assessment data.

Clinical:

- Psychiatric history: ED diagnosis, any previous ED treatment, other mental health conditions
- Medication use: any that commonly affect appetite or sense of taste or smell (e.g., stimulants, some anti-depressants and mood stabilizers)
- Abnormal vital signs (e.g., low body temperature, low blood pressure, low and/or irregular heartbeat)
- Menstruation: presence of periods, date of last period, regularity, contraception use
- Dental, chewing, and/or swallowing issues
- Gastrointestinal issues (e.g., delayed gastric emptying, diarrhea, constipation)
- Other physical signs of malnutrition or purging behaviour (e.g., brittle nails, thin hair, edema, cuts/calluses on top of finger joints)

Dietary:

- History of disordered eating
- Family history of dieting
- Food rules and/or rituals (e.g., not eating past a certain time, only eating foods prepared by oneself, weighing food before eating, chewing a specific number of times before swallowing)
- Avoided foods and “safe” foods
- Intake of “fillers” (e.g., coffee, diet drinks, sugar-free candy/gum, extremely large servings of vegetables, any other items consumed with the aim of minimizing calorie intake)
- Bingeing episodes
- Purging behaviours (e.g., vomiting, laxative use, exercising, fasting)
- Night eating
- Rumination (regurgitating and re-chewing food)
- Food and taste preferences
- Cultural food practices
- Hunger and fullness cues

Exercise:

- Frequency, amount, and intensity
- Exercise rules and/or rituals (e.g. exercising for a specific amount of time even if sick, exercising after eating)

Other Aspects of Eating Disorders:

- Attitudes toward weight and body shape: body dissatisfaction, fear of weight gain
- Self-monitoring behaviours: calorie-counting, self-weighing, body-checking (e.g., using various items to gauge/measure one’s body size, scrutinizing one’s reflection in mirrors)
- Substance use: drugs (e.g., stimulants, anabolic steroids), alcohol, smoking, vaping
- Avoiding social eating

Intervention

While nutrition treatment should generally aim for normalizing eating and exercising behaviours, it is important to meet the person where they are. ED behaviours are often used as coping strategies. The person may need to continue these behaviours until other coping strategies are in place with the help of mental health professionals. When trying to help clients advance in recovery, the Stages of Change model can be useful in identifying the client’s readiness to change and the support they may need. For instance, instead of asking the individual to abstain from ED behaviours right away, dietitians can try working with the individual to reduce the harm of these behaviours while moving toward recovery. A few examples of harm reduction are consuming high-potassium foods/drinks after vomiting, reducing exercise intensity, and staying connected with one’s healthcare team. Regardless of the disordered behaviours present, the initial focus of nutrition treatment should be supporting regular and adequate intake.

The **RAVES** model can be used as a guide to setting nutrition priorities during treatment.

R **REGULARITY** – Initially, focus on eating regularly throughout the day, without emphasis on quantity.

A **ADEQUACY** – When the individual is ready, they can focus on increasing quantity and getting adequate nutrition. Even if the person still has limited food variety, they can stick with safer foods for now to achieve regularity and adequacy.

V **VARIETY** – Upon readiness, the individual may start increasing food variety. Dietitians can also assist in experimenting with challenge foods and exploring the non-diet approach.

E **EATING SOCIALLY** – During this stage, dietitians can help the individual increase confidence in social eating and increase trust in foods prepared by others.

S **SPONTANEITY** – A later goal in nutrition treatment may be to increase flexibility in thoughts and behaviours around food. This often requires a healthier relationship with food and the ability to rely on one’s hunger/fullness cues. Ensuring that the individual has worked through the previous steps can prepare them for approaching spontaneity.



It is helpful to think of the RAVES model as a dial. Individuals may experience relapses and frustration when dialling up and progressing to higher stages. Dietitians can help individuals maintain hope by celebrating wins and reminding to dial back to lower stages as needed.



When and Where to Refer

Early interventions for medical and psychological well-being are associated with better outcomes. This is especially important for individuals with EDs since the true severity of EDs can often be masked. Encourage your clients to stay connected with their care team and to get regular medical monitoring. When needed, make appropriate referrals to help clients build their care team and connect with other health professionals (e.g., medical and mental health professionals, social workers).

- Referral to emergency medical services is indicated if the client presents acute medical symptoms (e.g., light-headedness, dizziness, fainting, chest pain, shortness of breath, palpitations, swelling around ankles, irregular heartbeat, abnormally slow or fast heartbeat).
- Referral to urgent psychiatric services is indicated if the client has mentions of self-harm or suicidal ideation.
- As appropriate, consider referring clients to higher levels of ED care (e.g., hospital-based out-patient or in-patient programs, day hospital). Although the waitlists for ED treatment programs are often very long due to a lack of funding for ED treatment, many treatment programs are fast to carry out assessments. Encourage clients to get assessed and stay connected with their care team for monitoring while waiting.

Helpful Resources for Dietitians

Guidelines and Trainings

Guidebook for Nutrition Treatment of Eating Disorders – Academy for Eating Disorders

https://higherlogicdownload.s3.amazonaws.com/AEDWEB/27a3b69a-8aae-45b2-a04c-2a078d02145d/UploadedImages/Publications_Slider/FINAL_AED_Purple_Nutrition_Book.pdf

- A comprehensive resource for dietitians, with detailed guidance for administering nutrition assessments and interventions.

Nutrition Assessment: Eating Disorders – InsideOut Institute

<https://insideoutinstitute.org.au/assets/nutrition-assessment-template.pdf>

- A handy guide to conducting a comprehensive nutrition assessment for individuals with EDs or disordered eating.

RAVES: A Back Pocket Guide to Developing Positive Food Relationships – Shane Jeffrey

<https://eatingdisorderscarerhelpkit.com.au/wp-content/uploads/2019/10/RAVES-Model.pdf>

- A convenient one-page explanation of the RAVES model, which provides a guide to progressing towards intuitive eating practices in ED recovery.

Eating Disorder Sensitivity Training for Dietitians – Body Brave

<https://bodypeace.learnworlds.com/course/ed-101-for-dietitians>

- An online course for people who practice nutrition work in community-based settings. Provides a starting point in training for ED nutrition care, with resources and recommendations for further training.

Harm Reduction for Eating Disorders: A Pathway for the Clinician and Motivation for the Client – The Victorian Centre of Excellence in Eating Disorders

<https://ceed.org.au/video/harm-reduction-for-eating-disorders-a-pathway-for-the-clinician-and-motivation-for-the-client/>

- A recorded webinar on harm reduction and how to apply harm reduction principles to nutrition care for individuals with EDs.