



11th Cyprus Dietetic & Nutrition Association International Conference

19-21 November, 2021

Learning Outcomes

- To increase knowledge around the scope of practice for a dietitian working in eating disorders
- To increase awareness of the extended assessment and screening process for eating disorders
- To ensure dietitians remain safe and effective within their practice with people with eating disorders

Assessment in Eating Disorders

Aetiology = formulation in mental health

Biochemical

Clinical

Dietetic

Environment

Stage and severity (B, C, D)

Nature of problem /diagnosis (A,E)

High eating disorder risk:

e.g. High body dissatisfaction, dieting

Ultra-high risk/ Prodrome states:

Sub-clinical, partial and/or intermittent symptoms

Early stage illness:

Symptoms for <3 years
Changes to brain, body & behaviour highly malleable

Targets for prevention or early intervention

Disease Progression / Severity

Full stage illness:

Established symptoms
Secondary changes to brain, body & behaviour solidify

Severe enduring illness:

Persistent symptoms (>7 years duration)
Changes to brain, body & behaviour become fixed
Disability and mortality

Biochemical and clinical

- MARSIPAN checklist
- https://www.rcpsych.ac.uk/docs/default-source/members/faculties/eating-disorders/marsipan/eating-disorders-cr189-checklist.pdf?sfvrsn=d6ce3bb1_4
- Are there significant risk factors?
- BMI <13 (adults) or <70% median BMI for age (under 18)?
- Recent loss of ≥ 1 kg for two consecutive weeks?
- Little or no nutrition for >5 days?
- Acute food refusal or <500kcal/day for >2 days
- in under 18s?
- Pulse <40?
- BP low with postural dizziness?
- Core temperature <35°C?
- Na <130mmol/L?
- K <3.0mmol/L?
- Raised transaminase?
- Glucose <3mmol/L?
- Raised urea or creatinine?
- ECG: e.g. bradycardia? QTc >450ms?



Dietetic

- Energy intake
- Macronutrients
- Rate of weight loss
- Food variety
- Fluid
- Caffeine/alcohol
- Micronutrients/supplements

Severity

Mild (outpatients)

- Weight suppression but not too low
- Biochemistry ok
- Binging up to 3 x a week
- Some compensatory behaviours



Severity

Moderate (outpatients/day patients)

- Weight loss /physical compromise but not dramatic eg < 0.5kg/wk
- BMI > 15 or > 80% wt/ht
- Regular Binging
- Biochemistry - some moderately out of range eg low potassium
- Regular compensatory behaviours



Severity

Severe (Intensive day patients/ inpatients)

- Weight loss /physical compromise dramatic > 0.5kg/wk
- BMI < 15 or < 75% wt/ht
- Multiple daily binging
- Biochemistry - out of range
- Regular compensatory behaviours
- Physically and psychologically compromised

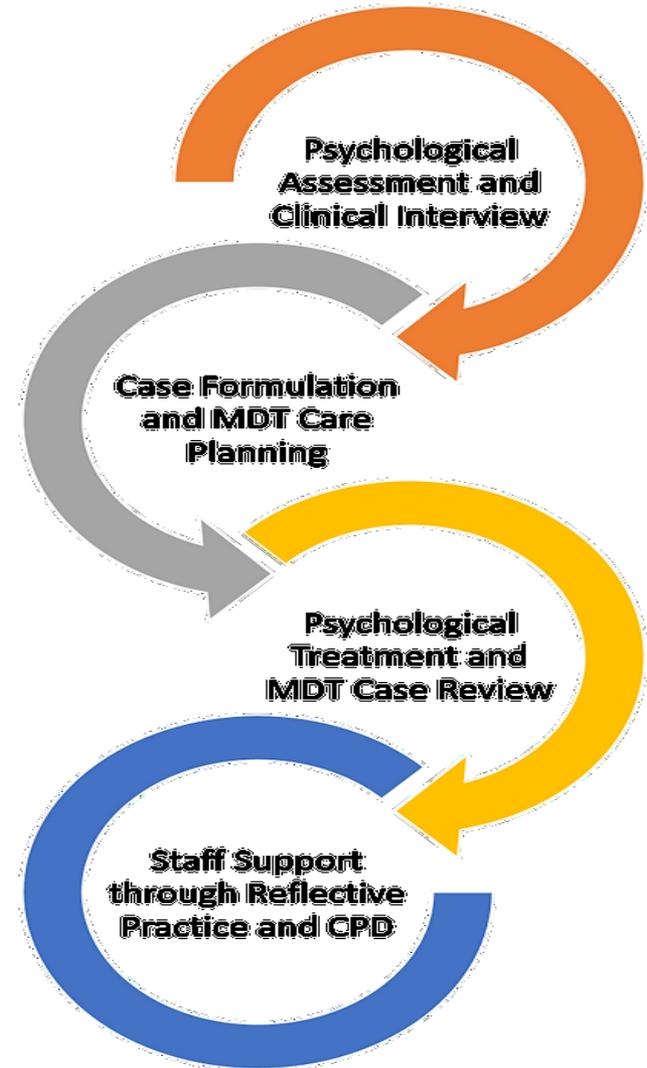


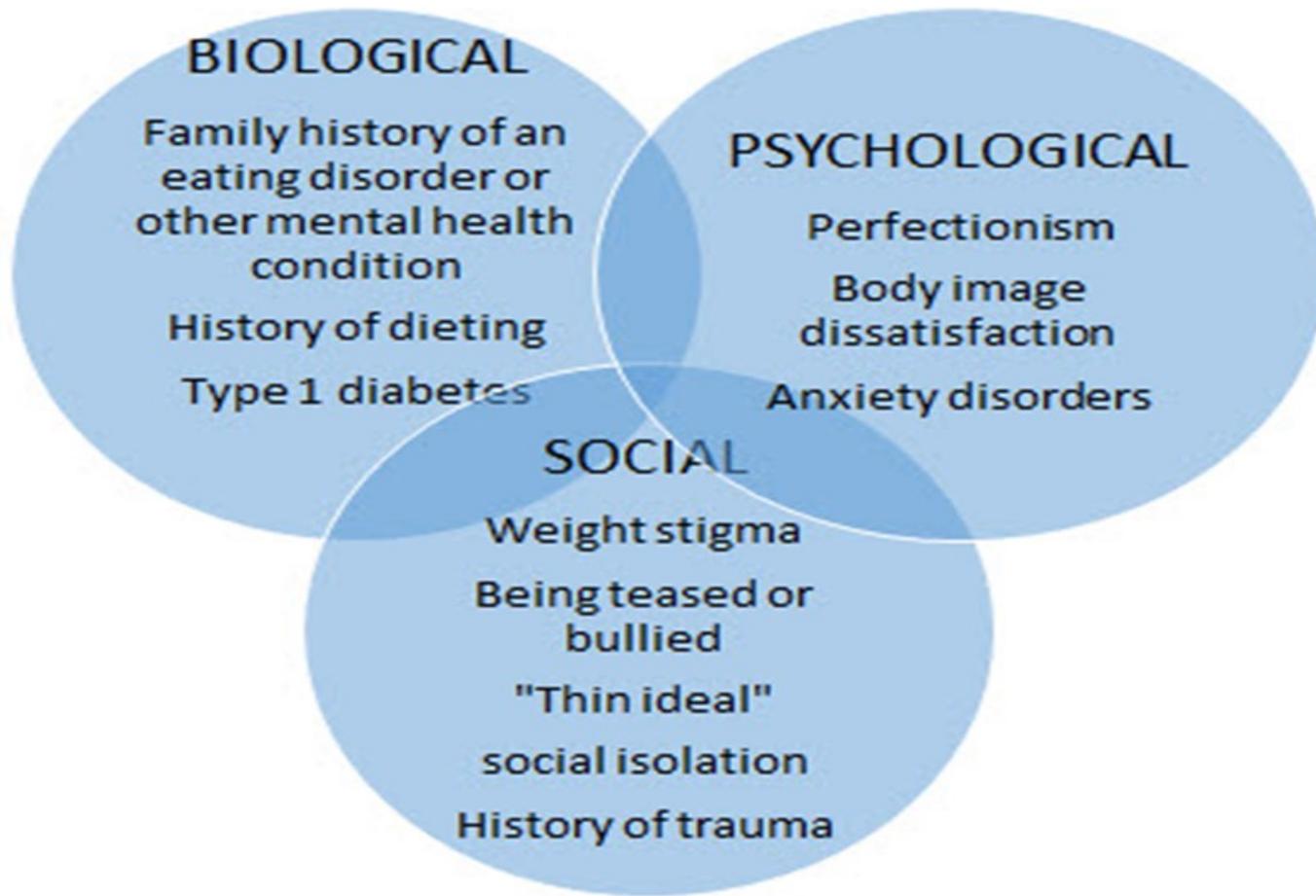
Level of Care for Eating Disorders

Level 5 Hospital	<ul style="list-style-type: none">▪ Hospital in-patient▪ Short-term▪ Crisis stabilization
Level 4 Residential	<ul style="list-style-type: none">▪ Residential in-patient▪ Long-term care: 24 hours a day treatment
Level 3 PHP	<ul style="list-style-type: none">▪ Partial hospitalization program/day program▪ 5 days a week, 8 hours a day▪ Similar to IOP, but more intensive and tightly structured
Level 2 IOP	<ul style="list-style-type: none">▪ Intensive out-patient treatment of 2-3 times week▪ Individual therapy, group therapy, nutrition therapy▪ Possibly support meals
Level 1 Out-patient	<ul style="list-style-type: none">▪ Scheduled appointments with multi-disciplinary treatment team▪ Medical provider, therapist, dietitian

Formulation

- Why formulate?
- Formulation vs diagnos





Simple Psychological Formulation

Presenting

Predisposing

Precipitating

Perpetuating

Protective



Predisposing

- Early feeding difficulties
- Poor early feeding practices
- high centile/over weight
- Family attitudes to food
- Low self-esteem
- Genetics
- Perfectionism
- Excessive compliance
- Adverse Childhood experiences (ACE's)
- Relatives with eating disorders



Precipitating Factors

- Bullying
- Change in relationship
- Separation
- Unhappy
- DIETING
- FOOD RESTICTION



FEAST Survey 2015

Cause	Cases	
Deciding to eat healthily	90	32%
Dieting to lose weight	77	27%
Overtraining in athletics	38	14%
Illness related loss of appetite (e g pneumonia)	18	6%
Becoming vegan/ vegetarian	12	4%
Fasting for religion/24 hour fast	2	1%
Other	44	16%



Perpetuating Factors

- Brain changes- increased rigid and inflexible thinking/ focus on detail.
- Cognitive view – distortion of shape and weight
- Interpersonal events – change in relationships
- Physiological – starvation of Anorexia
- Positive comments – control and body image
- Suppression of feelings- a way to help you cope



OCPD Traits in Eating Disorder

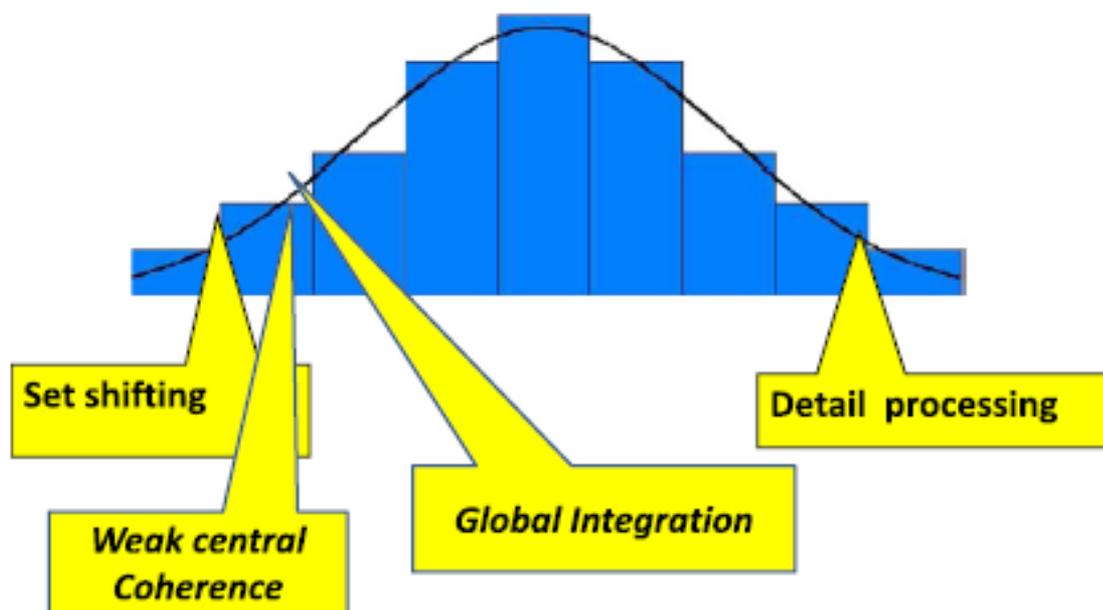


Figure 1 Obsessive compulsive personality traits. Legend A diagrammatic representation of traits related to obsessive compulsive personality disorder (OCPD) in eating disorders. Those that are mainly present in the acute, starved state are shown in italics.

Autistic
traits

Social and emotional Traits

The ability to accurately infer the emotional state of others and respond

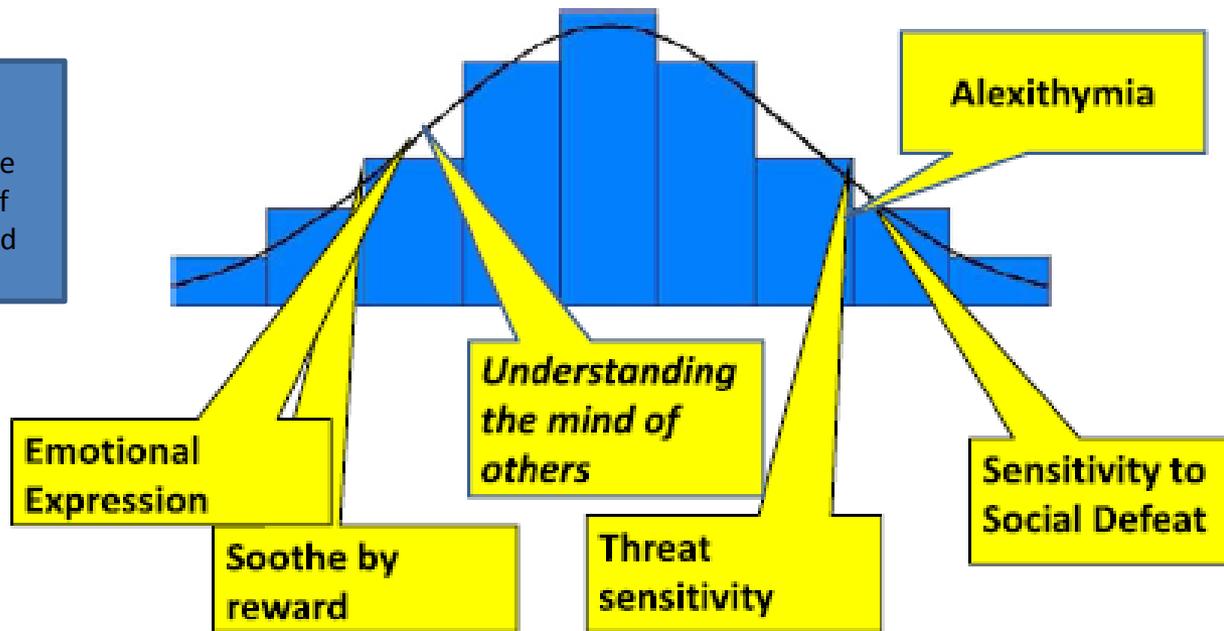


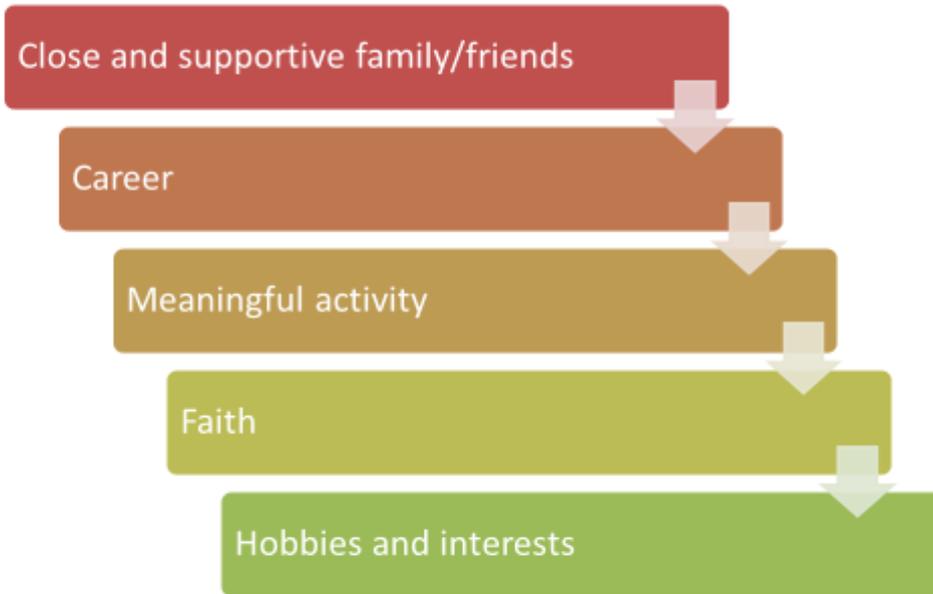
Figure 3 Social processing traits. Legend. A diagrammatic representation of social processing traits in eating disorders. Those that are mainly present in the acute starved state are shown in italics.

Maintaining factors

- Body checking
- Social media
- Comparison to others
- Avoiding behaviour's
- Compensatory behaviours



Protective Factors



What is the nature of the problem?

- Diagnosis?



What is the problem?

- Restriction (AN, ARFID, REDs)
- Binging (AN- B/P subtype, BN, BED)
- Compensatory behaviours (BN, AN-B/P subtype)
- Safety behaviours (AN, BN, ARFID)
- Fear of food /situations (AN, ARFID, BN, BED)
- Shape and Weight concern (AN, BN, BED)

Consider Other Presentations

- Trauma (1/3 of Bulimia Nervosa, 20% of BED, AN 20%)?
- ARFID- sensory issues or fear of eating (not fear of weight gain)?
- Autism (30% of patients with restrictive ED will have autism)?
- Comorbidities OCD/depression ?
- Personality Disorder and food refusal?

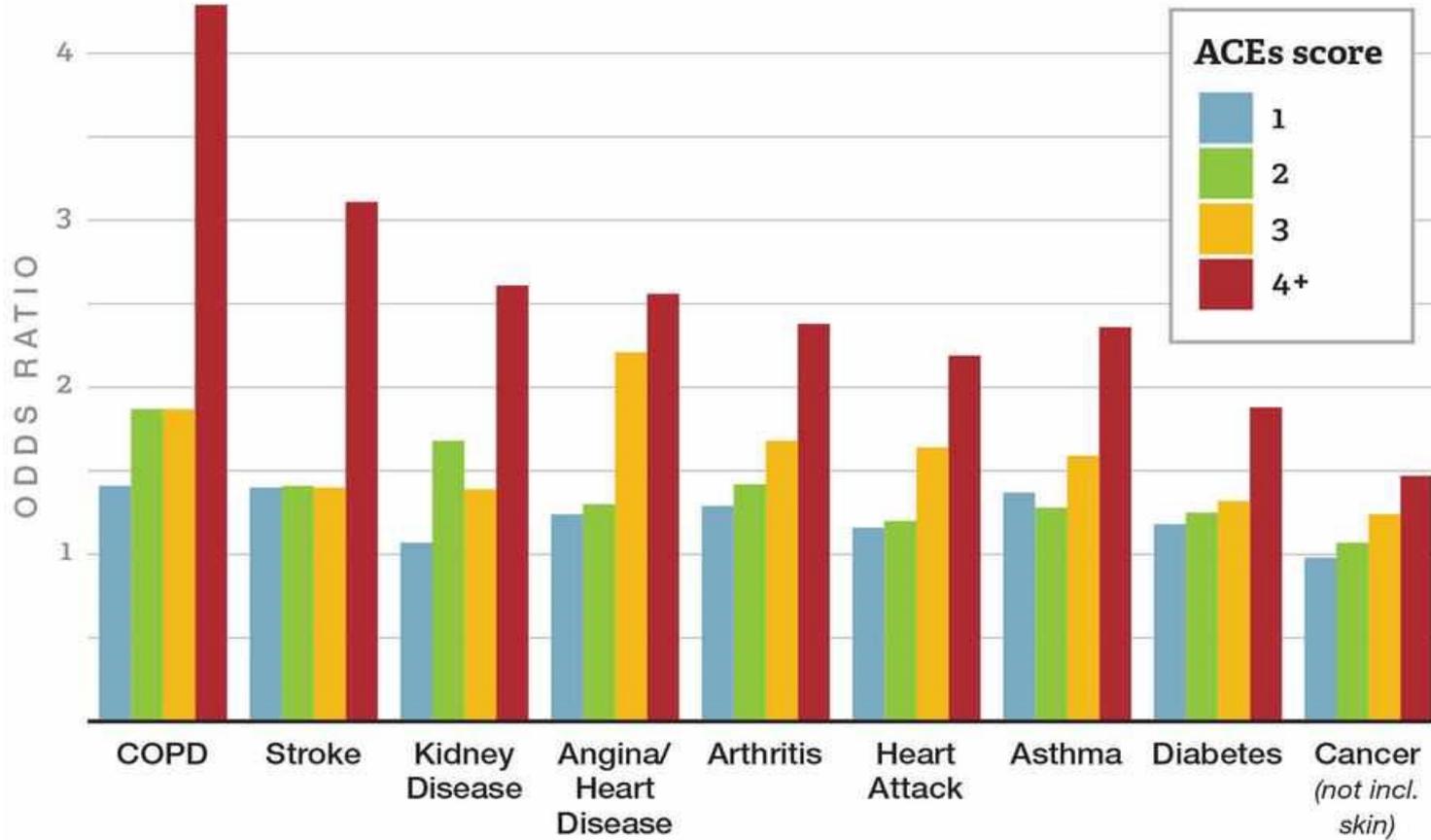


Adverse Childhood Experiences

- ACE
- Includes divorce, hospitalization, bullying, abuse, violence in the home, financial, homelessness, hardship, drug or alcohol in the family



LIKELIHOOD TO DEVELOP HEALTH CONDITIONS BASED ON ACES



This chart represents odds ratios, or how many times more likely an adult with ACEs is to experience a given health outcome compared to those without ACEs. For example, those with four or more ACEs are 4.3 times more likely to have chronic obstructive pulmonary disease (COPD), 2.4 times more likely to develop asthma, and 2.2 times more likely to have a heart attack than those without ACEs.

ACE EFFECT

BEHAVIOR



Lack of
Physical Activity



Smoking



Alcoholism



Drug Use



Missed Work

PHYSICAL & MENTAL HEALTH



Severe Obesity



Diabetes



Depression



Suicide Attempts



STDs



Heart Disease



Cancer



Stroke



COPD



Broken Bones

Disorders of Gut Brain Interaction

Table 2. Key Points in Patient Education About the Brain–Gut Axis, in Lay Language

In recent years, we have learned that the brain and the intestines are much more closely connected than was previously thought, and the brain actually plays a big role in keeping the functioning of the intestines normal and healthy.

1. The brain and the gut (intestines) communicate with each other continually through nerves and chemical signals.
2. The intestines send frequent messages to the brain to let the brain know about their condition, such as fullness from a meal or the need to have a bowel movement.
3. The brain usually dampens these nerve signals coming from the intestines so they are not uncomfortable, and keeps them outside our conscious awareness most of the time.
4. The brain sends frequent messages to the intestines, both in response to these internal messages from the gut and also to help tune the activity of gut muscles, secretion of acid and fluids in the gut, and immune activity, to help the intestines coordinate their functioning in the best way according to what is going on inside them and our lives (eg, telling the gut to increase stomach acid secretion when food is expected and instructing the intestines to inhibit its digestive activity during physical exercise).
5. This normal brain–gut communication can sometimes go wrong when something disturbs the brain or the nervous system for an extended time, such as very substantial life stress, strong negative emotions, or inadequate sleep. Inflammation or infection in the body can also make the normal brain–gut communication go awry. When that happens, for any reason, the brain perceives sensations from the gut more strongly than usual and may start sending inappropriate signals down to the gut that disturb intestinal functioning.

Because the brain is a part of the control system of the gut, it is often possible to get it to help reduce the intestinal disturbance and symptoms regardless of whether it is actively contributing to making the symptoms happen. This can be done by specialized psychological treatment, for example, CBT or gut-directed hypnosis, and also with medications that make the brain less sensitive to input from the intestines.



Avoidant Restrictive Food Intake Disorder (ARFID)

- Sensory

OR

- Specific fear based e.g chocking or vomiting

OR

- Lack of appetite/underweight



Overlap with AN

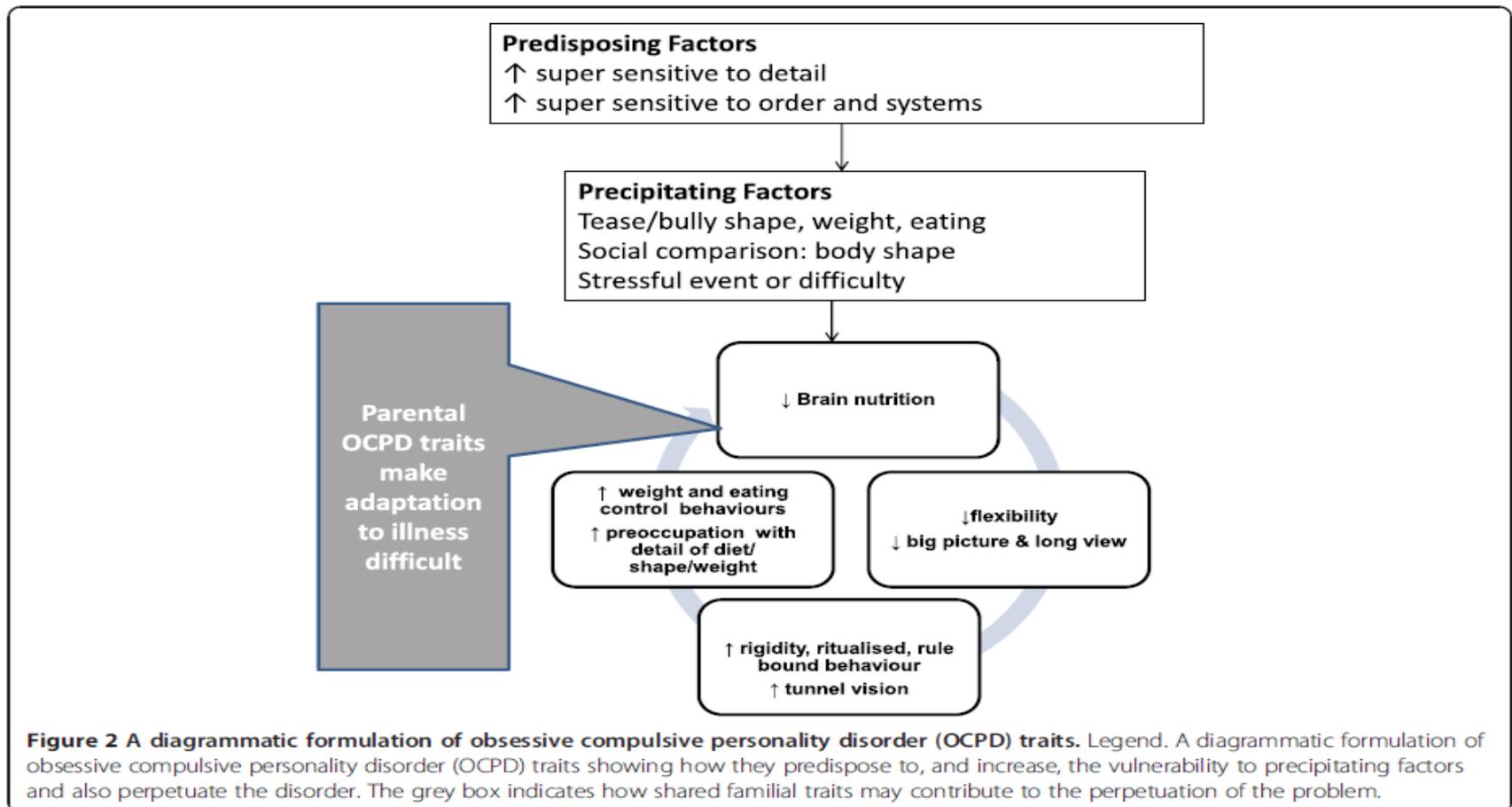
- Norris et al. 24 found that 12% of patients with ARFID transitioned to a diagnosis of AN during treatment, suggesting that a diagnosis of ARFID may serve as a risk factor for the development of AN
- Case reports presented by Maertens et al. suggest that weight concerns may emerge after refeeding in some individuals with comorbid ARFID and obsessive-compulsive disorder, resulting in the later diagnosis of AN that was not evident when patients were very underweight.

Norris ML, Robinson A, Obeid N, Harrison M, Spettigue W, Henderson K. Exploring avoidant/restrictive food intake disorder in eating disordered patients: a descriptive study. *Int J Eat Disord.* 2014;47(5):495–9.

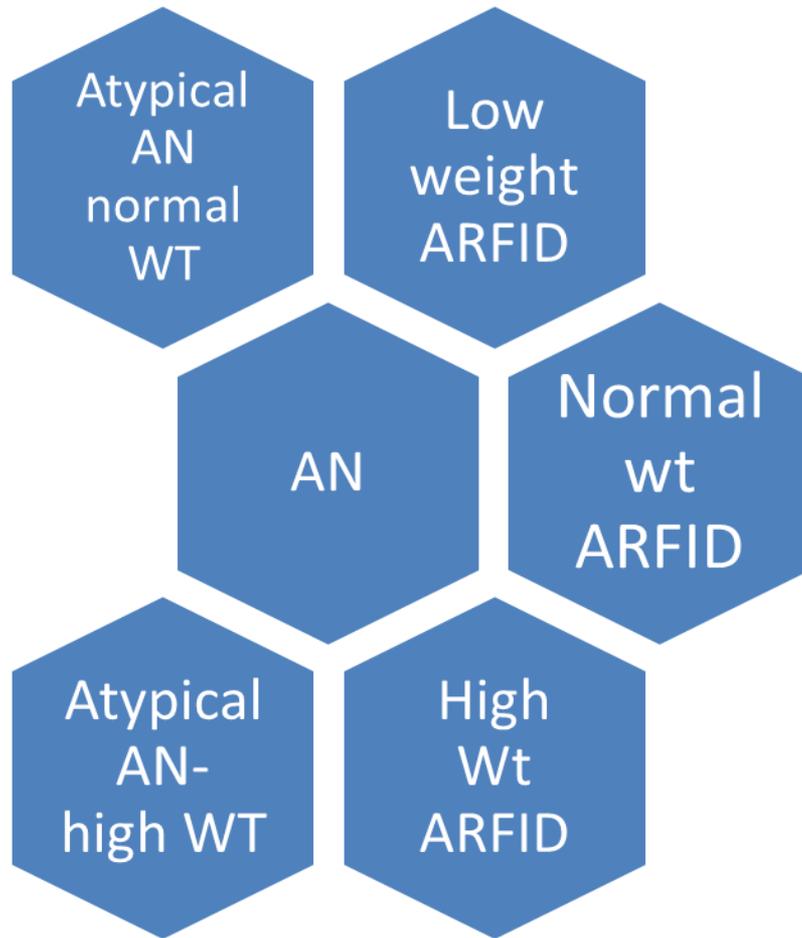


ARFID can lead to RED's and then to AN?

- Starvation can trigger AN in genetically susceptible individuals?



Which?



Assessment of ARFID

- A new semi-structured multi-informant interview—(PARDI) has recently been developed to diagnose ARFID in children and adults. The PARDI also provides dimensional ratings of relevant presentations (selective sensory-based eating; low interest or low appetite food avoidance; and restrictive eating due to fear of aversive consequences) and overall ARFID severity
- The PARDI appears acceptable to respondents and preliminary evidence of reliability and validity has been demonstrated in an initial sample. Larger-scale validation studies are currently underway. The PARDI is freely available to clinicians and researchers
- <https://onlinelibrary.wiley.com/doi/abs/10.1002/eat.22958>



ARFID/AN?

Similar

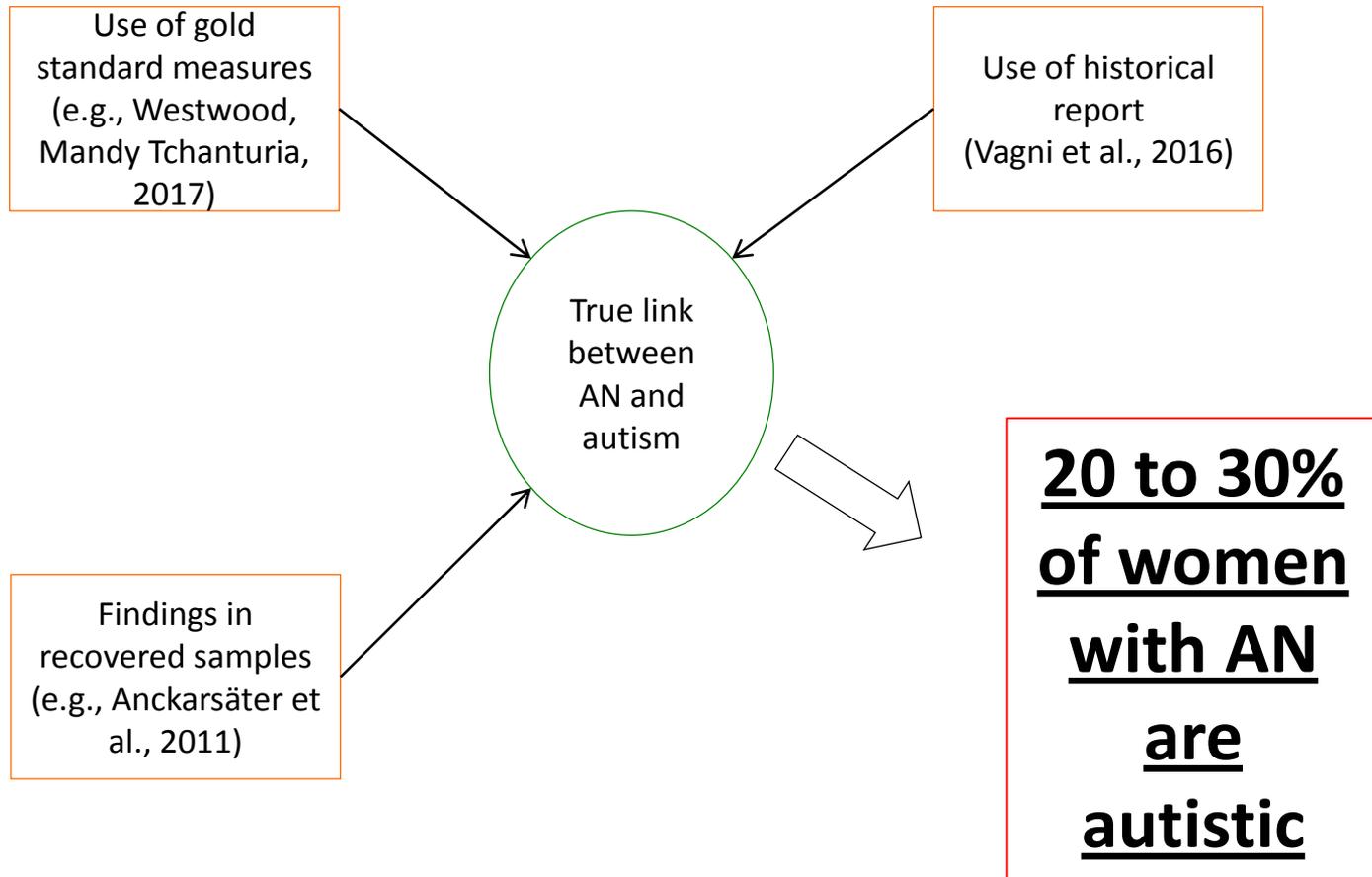
- Weight loss
- Restricted intake
- Mealtime conflict
- Social isolation
- impact on family
- systemic anxiety/compensation
- OCD/rigidity
- Weight /shape concern

Different

- Weight /shape issues take different form e.g. concern re number only or taking up space- no fear of Normal wt
- Diet composition- less “diet focused”
- Onset of difficulty earlier
- Sensory issues
- Non food sensory and cognitive clues e.g. numbers or colours, smells/images that stay



Is Autism also present?



Autism?

- AQ
- EQ
- Autistic Spectrum Disorders Toolkit
(rcgp.org.uk)



Core features Autism

Sensory aversions to some foods

Interoceptive difficulties sensing hunger

General sensory processing difficulties

Alexithymia

Emotional dysregulation

Social difficulties

Intolerance of uncertainty

Rigidity

Concrete, literal thinking around food, weight, diet

Special interest/obsessional thinking about food, weight, exercise

Autism-related difficulties

Sensory aversions to some foods

Interoceptive difficulties sensing hunger

General sensory processing difficulties

Alexithymia

Emotional dysregulation

Social difficulties

Intolerance of uncertainty

Rigidity

Concrete, literal thinking around food, weight, diet

Special interest/obsessional thinking about food, weight, exercise

External Influences

Negative emotional consequences

Function of RED

Coping mechanism

Impact on mood, and sense of self

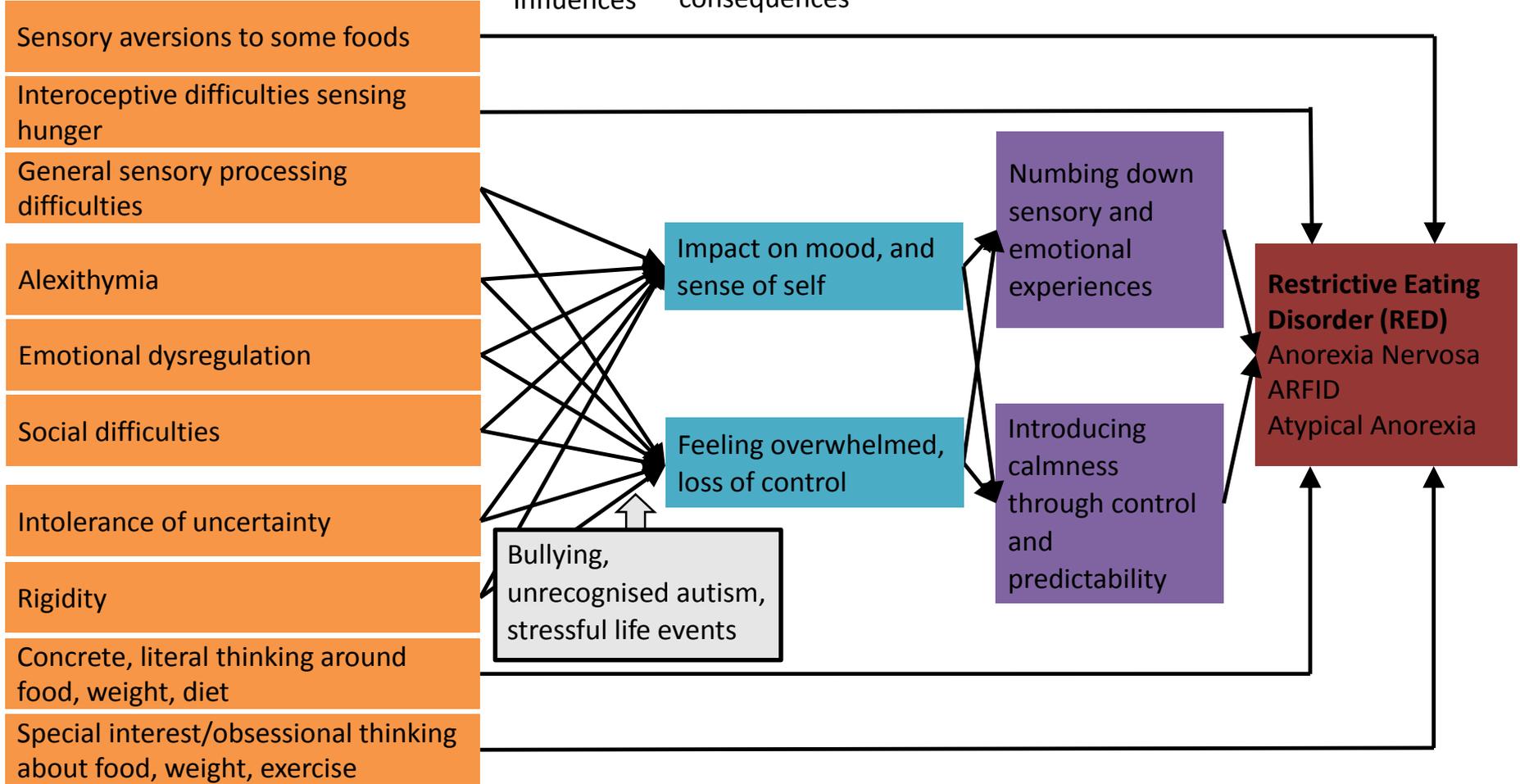
Feeling overwhelmed, loss of control

Numbing down sensory and emotional experiences

Introducing calmness through control and predictability

Restrictive Eating Disorder (RED)
Anorexia Nervosa
ARFID
Atypical Anorexia

Bullying, unrecognised autism, stressful life events



Take a detailed history



Sensory issues

Texture

Temperature

Colours

Smell

Environment



Communication difficulties

Speech

Interactions



Special interests



Dislike of change

Routine

Change in food presentation

Packaging

Sensory Processing Measures

[Adolescent / Adult Sensory Profile™ | Pearson Assessment](#)
pearsonclinical.co.uk

🏠 [Allied Health](#) > [Paediatric Assessments](#) > [Sensory](#) > [Adolescent / Adult Sensory Profile™](#)

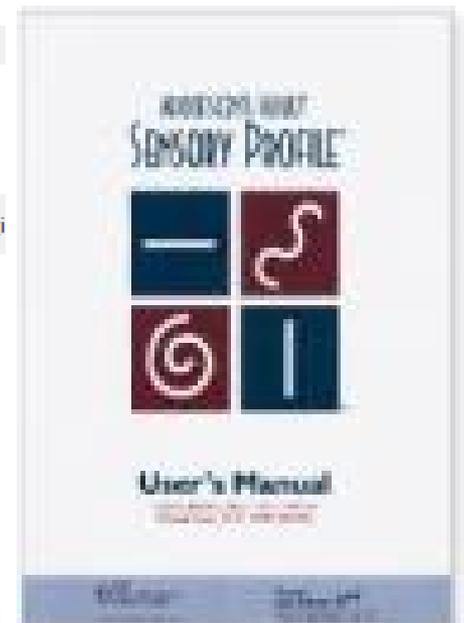
Adolescent / Adult Sensory Profile™

Home | Digital solutions | Moving Forwards | Training ▾ | Blog ▾ | Webinars | Updates ▾ | Regi

Frequently Asked Questions >	Identify sensory processing patterns and effects on functional performance
Permissions >	Author(s): Catana Brown, Winnie Dunn
Reference Materials >	Publication Year: 2002
Reviews >	Age Range: 11 years and older
Scoring and Reporting >	Administration: Individual - untimed

Need more information?

Qualification Code: [CL2](#)



Sensory Summary

Mark where you think you are on the below scales. Hypersensitivity means you are highly sensitive to sensations and may try and avoid them where possible; hyposensitivity means you have lower sensitivity and may try to seek out these sensations. There are examples below each scale. If you think you are neither hyper/hyposensitive and have no sensory differences, mark yourself in the middle as a 5.

Taste

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might add lots of salt to my food to make it taste stronger. If I am hypersensitive, I might prefer to eat bland foods as I find them too strong.

Smell

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might not notice strong smells and enjoy smelling essential oils. If I am hypersensitive, I might dislike smelly places like a canteen and find smells overpowering.

Vision

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might really like watching bright light displays. If I am hypersensitive, I might prefer to have lights dimmed or turned off.

Sound

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might turn my music up loud and dislike silence. If I am hypersensitive, I might dislike loud spaces and put my hands over my ears.

Touch

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might enjoy rubbing my hands on soft fabric or a soft toy. If I am hypersensitive, I might dislike and avoid touching certain fabrics.

Contributed by Emma Kinnard (PhD Student- PEACE Pathway) peacepathway.org

Texture

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

(Hyposensitive) (No sensory differences) (Hypersensitive)

If I am hyposensitive, I might really enjoy the feeling of certain food textures in my mouth (such as liking crunchy food). If I am hypersensitive, I might strongly dislike and avoid eating certain food textures (such as mashed potato).

[Source PEACE Pathway -](#)

Mental Capacity

Is the person able to :

- Recognise there is a problem and engage in help?
- Able to act on risks /concerns about health?



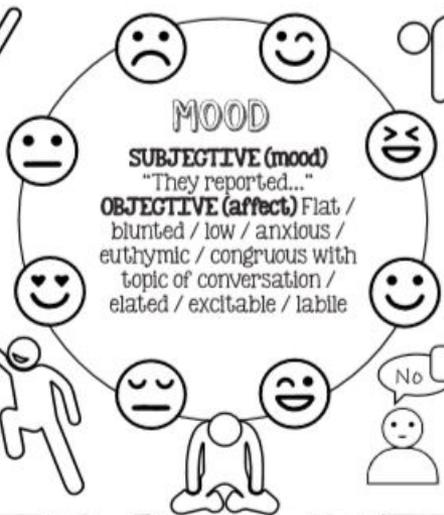
APPEARANCE & BEHAVIOUR

Calm / psychomotor agitation / eye contact / hostile, aggressive in manner / well kempt / evidence of self neglect / flamboyant dress / make up worn / clothes inappropriate for weather conditions / hypervigilant / suspicious in nature / tattoos or any significant features / overfamiliar



MOOD

SUBJECTIVE (mood) "They reported..."
OBJECTIVE (affects) Flat / blunted / low / anxious / euthymic / congruous with topic of conversation / elated / excitable / labile



INSIGHT

Lacks insight into being unwell / aware not normal self / unable to appreciate the extent of illness / full insight



SPEECH

Normal rate and volume / pressure of speech / poverty of speech / fluent / frequent pauses



MENTAL STATE EXAMINATION

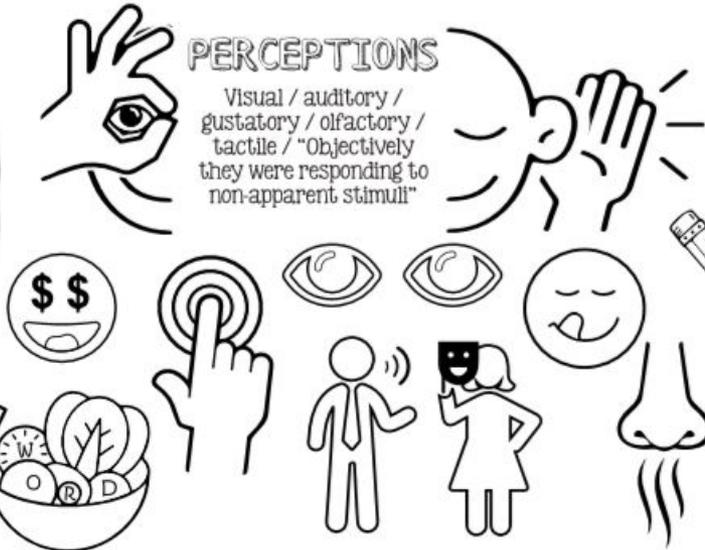
THOUGHT

FORM: "no formal thought disorder" / flight of ideas / loosening of associations / tangentiality / circumstantiality / word salad
CONTENT: varied and appropriate to conversation / over-valued ideas / pre-occupied by / ruminating on / delusions / obsessions



PERCEPTIONS

Visual / auditory / gustatory / olfactory / tactile / "Objectively they were responding to non-apparent stimuli"



COGNITION

Orientated to time, place and person / clock draw test / Addenbrooke's / MMSE



1. I DON'T THINK I HAVE A PROBLEM.

- It's my body so leave me alone.
- There are people who are a lot thinner (worse) than I am.

2. I MIGHT HAVE A PROBLEM BUT IT'S NOT THAT BAD.

- I only throw up once in a while.
- My physical didn't show anything wrong so I am OK.

3. I HAVE A PROBLEM BUT I DON'T CARE.

- I know throwing up isn't good for me, but it's working for me so I don't care.
- I could change if I wanted to, but I don't.

4. I WANT TO CHANGE BUT I DON'T KNOW HOW AND I'M SCARED.

- I want to eat normally, but I am afraid I will get fat (gain weight).
- I want to stop bingeing, but I can't figure out where to start.

5. I TRIED TO CHANGE BUT I COULDN'T.

- I told myself that I would not (fill in the blank) but I found myself doing it again.
- I don't feel like I can really ever (change) get well, so why keep trying?

6. I CAN STOP SOME OF THE BEHAVIORS BUT NOT ALL OF THEM.

- I could stop purging, but I will not be able to eat more.
- My eating has gotten better, but my exercise is out of control.

7. I CAN STOP THE BEHAVIORS, BUT NOT MY THOUGHTS.

- I can't stop thinking about food and bingeing all the time.
- I keep counting calories over and over in my head and still want to lose weight.

8. I AM OFTEN FREE FROM BEHAVIORS AND THOUGHTS, BUT NOT ALL THE TIME.

- I feel fine all day, but under stress I revert back to my unhealthy behaviors.
- I was fine, but wearing a bathing suit triggered my eating disorder thoughts, and with it some related behaviors.

9. I AM FREE FROM BEHAVIORS AND THOUGHTS.

- I feel mostly OK in my body and am able to eat things I want and not feel guilty or anxious afterwards.
- Once I had stopped the behaviors for a period of time, at some point I realized that I was no longer having the thoughts or urges.

10. I AM RECOVERED.

- For a long time now, I no longer have thoughts, feelings, or behaviors related to my eating disorder.
- I accept my body's natural size. My eating disorder is a thing of the past.

Safe and Effective Practice – Dietitian Role in Eating Disorders

A support system is
life-changing
for someone in eating
disorder recovery.



Jennifer McGurk, RDN, CDN, CEDRD-S
EatWithKnowledge.com

Safe and effective practice/role

Dietitians need a clear framework for working with patients safely and effectively. This role can be defined as dietetic treatment only, co-therapist, case management or nutrition risk management. These have different frameworks and processes and an understanding of these can help dietitians feel secure in the type of support they offer.



Dietitian role options for Eating Disorders

- Assessment and formulation
- Psychoeducation
- Behaviour change for recovery, partial recovery or to improve quality of life
- Support to stay ill safely
- Nutrition risk monitoring
- MDT Case management in transferring to hospital
- MDT Case management of intensive treatment e.g NG feeding/ feeding under restraint



Are you?...

- Assessment
- Treating
- Co- therapist
- Nutrition risk monitoring
- Case managing



Assess to treat

- Assess with a view to taking on for treatment
- Effective working- ensure that treatment offered is likely to work.
- Do not offer treatments if it is unlikely they will be successful e.g they have not work in past.
- Sometimes there are no good options!



Options?

- Patient not ready to engage in behaviour change work
- Do nothing?
- Nutrition risk monitoring and liaison with team
- Consider plan B- capacity assessment/ hospital



Role Case Management

- Patient too unwell for your service/outpatient treatment
- Stay involved to monitor risks and support transition to another service
- Duty of care to support transition



Role co-therapist

- Dietetic role- to be aware of psychological techniques such as CBT-E/ DBT/ CFT that are used to treat eating disorders etc and weave these techniques into your practice
- Examples: behavioural experiments, Socratic questions, theory around threat systems, distress tolerance .
- Focus of the sessions should still be food based
- Consider scope of practice limits if majority of the session is around non food topics



Do

- For <18 involving families (FBT)
- Ensure you work within an MDT not alone
- You screen and assesses before taking on for treatment
- Evaluate treatment /behaviour change within 4 weeks and change if not working change treatment



Don't

- See young people alone
- Work alone
- Work on psychological aspects of care without other practitioners being involved
- Spend more time on non food topics than food topics
- See patients alone who refuse physical monitoring or psychological input



Safe to work on outpatient basis?

- Do they have physical monitoring in place?
- Do they have psychological support in place?
- Are they mild to moderate in presentation?
- Do you have a plan B in place and discussed if they deteriorate?



Case 1

- You are asked to see a 15 year old who is losing weight with AN
- Family ask you to see her alone
- You check with child she is receiving physical monitoring- she says yes.
- She does not want family therapy or psychology



Case 2

- You are seeing a young adult for BN
- They are losing weight and vomiting 3 x a day
- They do not always attend for physical monitoring
- They cancel a lot of appointments
- They attend and tell you they have not eaten for anything for 2 days and have been vomiting



Case 3

- You are seeing a patient with Binge Eating Disorder who discloses past ACE's .



Case 4

- You see a patient who tells you they have a diagnosis of Anorexia Nervosa
- You assess and decide it is probably ARFID
- Patients presentation and history indicate they may have autism
- What do you do?

