

# **Anorexia Nervosa- The Nutrition Intervention**

**Ursula Philpot**

**Advanced Practitioner/Lecturer  
Eating Disorders**

# Introduction

- Virtually no evidence base yet!
- Guidelines for practice found in-  
Australia, UK (draft) , USA.
- A brief overview of Dietetic role in  
assessment and treatment interventions

# Anorexia-Diagnostic criteria

- Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected)
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles.



# Specify type

- **Restricting Type:** during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)
- **Binge-Eating/Purging Type:** during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

# Body Mass Index Grading

17.9 - 16.0 Severely underweight  
menstruation becomes intermittent /stops

15.9 - 14.0 Emaciated physical  
symptoms of starvation are priority- mental  
health act can be used if needed

13.9 - 12.0 Outpatient support in  
effective - hospitalisation needed

11.9 – 10.0 Death imminent

# Why Dietitians in Eating Disorders?

- We are experts in food and nutrition. Our unique skills & knowledge nutrition, food, sociology & psychology of food behaviour, & behaviour change skills
- Poor nutrition, and thoughts/ behaviors around food choice, appetite, and weight are common symptoms of Anorexia Nervosa, and they need to be addressed
- Addressing food and weight issues leaves other HCP's free to deal with the causes of the ED

# Dietetic Intervention –overall aims

- To help patients achieve and maintain normal nutritional status (in adults) and normal growth (in adolescents).
- To assist patients in establishing normal eating behaviours.
- To promote normal attitude to food.
- To stop compensatory behaviours
- To help patients develop appropriate responses to hunger and satiety cues.
- To help patients to trust food

# Dietetic role

- **Dietitians must work as part of a MDT**
- Nutrition must **not be** sole treatment
- **Assessment:** comprehensive assessment of weight, nutrition and motivation. Ensure all needs are being met- psychological, physical and nutritional.

## Not our role to:

- Diagnose (GP, psychologist, psychiatrist)
- Physically monitor (GP, Psychiatrist)
- Give psychological treatments (psychologist, psychiatrist, trained councillor)

# Dietetic role- tier 1 intervention

## **Mild ED (BMI >17, Binge/purge <3 x week)**

Brief intervention e.g. 3 sessions to assess and give feedback on food diary/education re physiology and healthy eating. Can be seen by non-specialist Dietitians

Can do brief intervention work (3-8 sessions) for binge eating disorder if appropriately skilled

# Dietetic role- tier 2 intervention

**Moderate** (BMI 17-15, binge/purge >3 x week)

Time limited intervention-6-8 sessions.

psychoeducation, group work, goal setting, problem solving and weight gain.

Dietitians must have had further training and supervision, and work as part of MDT

# Dietetic role- tier 3 intervention

**Severe (<15, daily binge/purge)**

Highly specialist role- long term contact

1 to 1 sessions

Motivational Enhancement, Psychoeducation,  
use of CBT techniques,

Safe refeeding at low weights

Requires further training++ & adequate  
supervision

# Dietetic Assessment

Anthropometry (weight and height –  
BMI, MAC, grip strength)

History of weight and eating problems- from  
childhood

Timeline

Family meal times

Current eating habits

Blood biochemistry and haematology

Compensatory behaviours

Motivation

Activity

Core skills in shopping/cooking/planning

Cognitive and emotional effects

beliefs and attitudes

Assessment of nutritional intake versus  
nutritional requirements

Current nutrition knowledge

Dietary rules

# Dietetic intervention- overview



# Normal Eating

Eating something at least  
3 times per day

Sometimes overeating

Sometimes under eating

Eating more of the foods  
that you enjoy the taste  
of, when you choose to

Eating less of the foods  
you like, as you know  
you can eat them in the  
future

Eating or not eating on  
occasions because you  
feel tense or 'stressed  
out'

# Normal Eating

Eating a variety of foods without feeling guilty

Eating in a flexible way so that it does not interfere with your work, study or social life

Eating sufficient food and a variety of foods, often enough to prevent bingeing

Eating when out socially in a similar manner to other people in the group

Eating 'fast food' occasionally as a 'treat'

# Normal Eating

Being aware that food is important for good health, but not the most important thing in life

Not counting calories, weighing food or following a strict diet

Not always eating low calorie foods

Not eating to lose weight, but knowing that you can 'watch your weight' if you want to

# Normal Eating

Not assuming that you can control the amount and type of food your body needs better than your body can

Not having to constantly weigh yourself for reassurance

Not playing games with yourself to prevent eating certain foods – allergies, vegetarianism etc.

# Nutritional management – binge/purge sub type

- Explaining link with dieting and bingeing
- Establishing eating enough not to binge- 3 regular meals and 3 snacks
- Identify trigger foods/situations
- use distraction/tolerance techniques
- Problem solving and goal setting
- Nutrition and weight education
- Working on compensatory behaviours with psychologist/nurse

# Tier 3 intervention-severe AN

- Management of refeeding syndrome and weight gain
- Use of Micronutrients
- Monitor & correct Mg,Ca,K, PO<sub>4</sub>
- Prescribing “safe” diet, fluid & weight boundaries
- Goal setting & problem solving
- Challenging beliefs through Nutrition & physiology education

# Returning to a healthy weight

- Rapid weight loss= rapid weight gain
- Previously overweight =rapid weight gain (fat cells just fill rather than have to be made)
- Long term low weight= most difficulty in gaining weight
- Teenagers can need 70-100kcal/kg
- Increased metabolism++
- Aim 1 kg/wk –inpatient/ 0.5kg outpatient



# Body composition after weight gain

- Usually 10% higher weight than previous
- Increased % fat
- More central adiposity
- 1 year later return to normal distribution

# Hospital admission situations

- Refer to liaison psychiatry
- Refer to Dietetics- careful refeeding!!
- If BMI <15 commence NG feeding, using Mental Health act if necessary
- Liaise with eating disorders specialist
- Follow a refeeding protocol. Feed until transfer to in-patient unit or medically safe BMI 15 or over

# Therapeutic relationship

- See regularly - weekly
- Build up trust
- Try to side with “well” side of the person. Focus on the behaviours, not the person doing them.
- Fear drives people to act in strange/horrible ways!

# Therapeutic relationship

- Clear & firm, but empathetic. Validate feelings & work on change
- Set boundaries
- What you will or won't talk about
- How long you have
- Stick to your boundaries on issues of safety
- Only negotiate on safe things such as type of CHO, not how much

# Addressing other problems

Prejudices

Discrimination

Low self-esteem

Families