Nutrition Therapy for Eating Disorders: What EVERY Dietitian Should know

Presenters:

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Carolina House Eating Disorder Treatment Programs
Objectives Part 1

- Types of Eating Disorders
- Identifying Eating Disorders in your Office
- Assessment tools for the RD
- What about weight
- Treating eating disorders
What exactly is an eating disorder?

- Eating disorders are neurobiological disorders rooted in the brain causing medical and psychological issues.
- They are NOT simply about “control” or weight management.
- Genetics are responsible for 50-83%.
- Two people can be living in the same house, undergo similar stressors, and both go on a diet. The one that is wired differently may take the diet to the next level (ED patterns and behaviors) while the other doesn’t.
Types of Eating Disorders

- **Anorexia Nervosa**
  - Restriction of energy intake leading to low body weight that is expected for age. Body Image Disturbance

- **Bulimia Nervosa**
  - Recurrent binge episodes and compensatory behaviors that are meant to prevent weight gain

- **Binge Eating Disorder**
  - Recurring episodes of eating large amounts of food, with feelings of loss of control.
# 9 Truths of ED

- **#1**: Many people with eating disorders look healthy, yet may be extremely ill.
- **#2**: Families are not to blame and can be the patients' and providers' best allies in treatment.
- **#3**: An eating disorder diagnosis is a health crisis that disrupts personal and family functioning.
- **#4**: Eating disorders are not choices, but serious biologically influenced illnesses.
- **#5**: Eating disorders affect people of all genders, ages, races, ethnicities, body shapes and weights, sexual orientations and socioeconomic statuses.
- **#6**: Eating disorders carry an increased risk for both suicide and medical complications.
- **#7**: Genes and environment play important roles in the development of eating disorders.
- **#8**: Genes alone do not predict who will develop eating disorders.
- **#9**: Full recovery from an eating disorder is possible. Early detection and intervention are important.
SCREENING
Don’t assume you know

• ANY client that we see can have or could develop an eating disorder

• Don’t assume anything by looking. EDs are rarely recognized by how someone looks

• Initially assess in your usual way, but keep an eating disorder in the back of your mind

• Do no harm
The Gun Metaphor

Also referred to as… The Perfect Storm

- GUN
- AMMUNITION
- Environment
- Genetics/Temperament: (something you cannot change)
- STRESS

Pulls the trigger

*Individuals will often manage stress by controlling food intake.
*65% of eating disorder patients have underlying anxiety disorder.
Cannot treat anxiety disorder until person is nourished

*65% of eating disorder patients have underlying anxiety disorder.
How does a client with an eating disorder show up in your office?

- Athlete
- Complicated dieting history
- DM, Type 1 (diabulimia)
- Polycystic Ovarian Syndrome
- Bariatric Surgery Patients
- Autism Spectrum or “Picky Eating”
- GI disturbances, such as IBS or food sensitivities
- Newly vegetarian
Temperament Traits: Anorexia Nervosa

- Perfectionism
- Personal self-imposed standards
- Punishment sensitivity
- Anxiety
- Rigidity with thinking
- Doubt
- Harm avoidant
- Low self-directedness
- OCD tendencies
- Experiential avoidance
Temperament Traits: Bulimia Nervosa

- Impulsive
- Compulsive
- Novelty-Seeking
What to look for

• Are they seeking weight loss? Weight history, desired weight
• Do they count calories? What happens if they eat more than their goal for the day?
• Do they ever feel out of control around food?
• How does it feel to talk about food?
• Are there foods they won’t eat because of a belief or rule? Is there flexibility around this?
• Pace of eating
What to look for

- Food rituals
- Do they ever sneak food? Have they lied about (not) having something?
- Do they feel the need to compensate for the calories they ate?
- Are they weighing themselves? How does this impact their food choices and mood for the rest of the day?
- Do they ever feel guilty or shameful during or after eating?
- What happens if they eat more than they wanted?
Screening Tools for Eating Disorders

- Eating Attitudes Test (EAT-26)
- EDGE tool
- BED Screening
- Female Athlete Screening Tool
- SCOFF
# EAT-26

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<thead>
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<th>Always</th>
<th>Usually</th>
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<tr>
<td>1. Am terrified about being overweight</td>
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<td>2. Avoid eating when I am hungry</td>
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<td>3. Find myself preoccupied with food</td>
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<td>4. Have gone on eating binges where I feel that I may not be able to stop</td>
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<td>5. Cut my food into small pieces</td>
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<td>6. Aware of the calorie content of foods that I eat</td>
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<td>7. Particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)</td>
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<td>8. Feel that others would prefer if I ate more</td>
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<td>9. Vomit after I have eaten</td>
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<td>10. Feel extremely guilty after eating</td>
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<td>11. Am preoccupied with a desire to be thinner</td>
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<td>12. Think about burning up calories when I exercise</td>
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<td>13. Other people think that I am too thin</td>
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<td>14. Am preoccupied with the thought of having fat on my body</td>
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<td>15. Take longer than others to eat my meals</td>
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<td>16. Avoid foods with sugar in them</td>
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<td>17. Eat diet foods</td>
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<td>18. Feel that food controls my life</td>
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<td>19. Display self-control around food</td>
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<td>20. Feel that others pressure me to eat</td>
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EDGE Symptom Survey

Please mark box for any and all items that apply.

1 = infrequent w/in the last month
2 = few times a week
3 = daily/many times a day

Physiological
☐ __Weakness, very tired
☐ __Low pulse _____ bpm
☐ __Dizziness, dizziness upon standing up from seated position
☐ __Cold hands and feet
☐ __Daytime sleepiness
☐ __Chest pain or discomfort
☐ __Ankle or feet swelling
☐ __Constipation
☐ __Abdominal pain
☐ __Diarrhea
☐ __Vomiting

☐ __Depression
☐ __Anxiety
☐ __Obsessive behavior
☐ __Obsessive thoughts
☐ __Over-concern with weight and shape

Behavioral
☐ __Active and restless, stand frequently when most people would sit
☐ __Disproportionate time spent thinking about food
☐ __Interest in recipes, food channel, and food shopping
☐ __Subjective or objective binge eating
☐ __Experience loss of control with eating
☐ __Hoards food; food seems
☐ __Statements about being or eating “healthy”
☐ __Avoidance of social situations with food
☐ __Eats meals too fast or too slow
☐ __Attempt to bargain about foods (“I will eat this if I don’t have to eat that”)
☐ __Inability to identify hunger or fullness
☐ __Unusually small portions
☐ __Inability to define or eat a balanced nutrient intake
☐ __Abnormal timing of meals and snacks
☐ __Offsetting food intake with exercise/food choices
☐ __Compensatory purging activity, including exercise
SCOFF Questionnaire

Do you make yourself SICK because you feel uncomfortably full?

Do you worry you have lost CONTROL over how much you eat?

Have you recently lost more than 14 pounds in the past 3 months?

Do you believe yourself to be FAT when others say you are too thin?

Would you say FOOD dominates your life?

Are you satisfied with your eating patterns?

Do you ever eat in secret?
ASSESSMENT
Assessment Tools Utilized by the Nutrition Therapist

- Health history, family history
- Lifestyle assessment including social impact of eating disorder
- Review of lab tests to assess nutrient status
- Food intake assessment and analysis
- Meal planning
- Metabolic assessment (RMR) and estimated needs analysis
Empower Yourself as a Clinician

- Medical Stability is Key
- Vital sign abnormalities are highly prevalent
- Adaptive, compensatory response to malnutrition
- “hibernation mode” – hypothermia, hypotension, hypoglycemia
Check Blood Pressure

- Keep cuff in your office
- Check for orthostatic hypotension
- Dizziness or light-headedness often key sign
- Dehydration, bradycardia, poor blood flow, weak heart, low blood glucose
Check Pulse

- Ask permission
- Make sure they have been sitting for 15 min
- Check for bradycardia <60 bpm
  - Heart muscle atrophy
- Have client walk across the room- check for tachycardia
  - Well-conditioned heart (athlete) will not display tachycardia
- Severe sinus bradycardia <50 bpm
  - Send to ER
  - EKG
  - Often times <45 while sleeping
Check Blood Glucose

- Keep glucometer in office- may keep one glucometer per client for comfort level
- Most times clients are asymptomatic
- Glucose <60 high risk
- Low glucose result of depletion of glycogen “building blocks” in liver
Check Other Physical Signs

- Cold extremities
- Edema
- Circulation-thumb print
- Lanugo
- Hair loss: malnourishment stops hair cells and other cells from dividing
4 C’s of Malnutrition

- Cold
- Crabby
- Constipation
- Poor Circulation
Amenorrhea

- Not always present even in critically ill clients
- Brain reverts back to pre-puberty
- Check estradiol once client weight restored
Gastroparesis

- Stomach goes on “vacation”
- Can cause GI emptying to be up to 5x slower
- Loss of normal stomach peristalsis
- Early fullness, bloating, gassiness, nausea
- Treatment: small, frequent, calorie dense meals, low fiber, liquid in between meals
TREATMENT
Anorexia Nervosa

- Restriction of energy intake
- Intense fear of gaining weight
- Body image disturbance
- Two types:
  - Restricting and Binge Eating/Purging Type
Anorexia Nervosa

- Initial goal: adequate calories
- Normalized and balanced eating will come in time
- Meet them where they are
- *Full weight restoration*
- 90% IBW- about 50% relapse
- Intuitive Eating---takes time
Anorexia Nervosa

- Extremely high calorie need—Color coded snack lists with varying calorie levels
- Require more calories to maintain the rate of weight gain
- Post weight restoration, these clients require more calories to maintain their weight
- Hypermetabolism usually lasts 3 to 6 months, but can last up to a year after weight restoration
Bulimia Nervosa

- Recurrent binge episodes
- Recurrent use of inappropriate behaviors to prevent weight gain
- Both B/P occur on average, >1/week for 3 months
- Self-evaluation focused on weight/shape
- Does not meet criteria for Anorexia
Bulimia Nervosa

- Initial goal is to stop the purging cycle
- Often 5 pound weight gain once purging stops. Fluid shifts
- Regular meals and snacks
- Need satisfying foods: fat
Binge Eating Disorder

- Recurring episodes of eating large amounts of food
- Feelings of loss of control during binge episodes, as well as marked distress
- Binge episodes occur, on average >1/week 3 months
Binge Eating Disorder

- Assess timing of food intake
- Regular meals and snacks
- Mindful eating with focus on the food
- Structure areas for eating: dining room table
- Weight loss is not primary goal ➔ can increase shame cycle
The Dreaded Question: what about their weight?

- The weight of the client is not the only issue or even the main issue
- Crucial to develop trust
- Set up plan ahead of time with client
- Clients we should always weigh: anorexia, laxative abuse, purging, just out of treatment center
Determining Goal Weight

- Typically set a 5 lb range with understanding this may change along the way
- Growth charts
- Weight history
- When do ED behaviors and thoughts begin to diminish?
- Don’t aim too low!
Our client has to develop trust with us

- Takes time
- Often these clients have been hurt in the past and are hesitant to trust
- You won’t automatically be seen as an ally - even if the patient initiated making the appointment
- They will want to know you are on their side, while still pushing their ED thoughts and behaviors into uncomfortable places
Trauma

- Many clients with an eating disorder have experienced some type of trauma
- What you hear might be uncomfortable
- Ensure client has therapist
- For many clients, food has been used as a form of punishment or abuse
- Clients need to know you are not the food police, food will not be used as punishment, food is medicine
- We need to learn how food was used in their trauma or abuse so we do not push too far too early in treatment
- Create new memories with food
What to do in session

- Learn to sit in silence with them
- Listen to what is not being said
- Learn to ask questions differently
- Don’t jump in and try to fix everything
- Meet them where they are at - when able, let them be involved in what to work on when
Create a safe, healing environment

- Humor, humanity, kindness, compassion, and empathy.
- Tough fairness
- Safe place for client to show frustration and anger
- Structured environment to share and process the relationship with the ED, and offer alternative behaviors to cope and manage emotions
- Explore and understand maladaptive thinking patterns directed at the behaviors and understanding of the disease
- Don’t be afraid of the client
Treatment Team

- We cannot treat these clients alone
- Therapist, Physician, Psychiatrist- make sure specialize in ED’s
- Authorization to Release/Obtain Confidential Information
- Talk with client ahead of time regarding communication with parents
Recovery

1) I don’t think I have a problem
2) I might have a problem but it’s not that bad
3) I have a problem but I don’t care
4) I want to change but I don’t know how and I’m scared
5) I tried to change but I couldn’t
6) I can stop some of the behaviors but not all of them
7) I can stop the behaviors, but not my thoughts
8) I am often free from behaviors and thoughts, but not all the time
9) I am free from behaviors and thoughts
10) I am recovered

- Carolyn Costin 8 Keys to Recovery from an Eating Disorder
Training and Mentorship

- Attend conferences: IAEDP, AED, BEDA, Renfrew
- Jessica Setnick, CEDRD, Boot Camp
- Connection with CEDRD or CEDS in your area for mentorship
- Consider CEDRD certification
UNDERSTANDING EATING DISORDER TREATMENT
Objectives Part 2

- Knowing when more is needed
- Different levels of care (LOC) of eating disorder treatment
- Overview of therapies used in eating disorder treatment
- Role of the dietitian in higher LOC
  - Differences than in an outpatient practice
- Transitioning back home – what a dietitian needs to know
A little about me...

- Registered Dietitian
  - Began as general Outpatient dietitian
  - Moved into Intensive Outpatient eating disorders program in private practice
  - Outpatient University/Hospital eating disorders clinic
    - Some Inpatient coverage
  - Carolina House – Residential Program Nutrition Therapist
    - Also Partial Hospitalization treatment

- Seen and done it all – understand how important it is to know what each other does!
Levels of Care for Eating Disorder Treatment

- Outpatient (OP)
- Intensive Outpatient (IOP)
- Partial Hospitalization/ Day Treatment (PHP)
- Residential Treatment Center (RTC)
- Inpatient Hospitalization (IP)
When to know if someone needs more care

- Unable to comply to recommendations, such as:
  - Eating adequate amounts at proper times
    - Not skipping meals
  - Adequate variety
  - Staying within set exercise parameters
  - Managing purging behaviors, including laxative or diuretic use

- Unable to gain weight
  - Especially if they are following your recommendations
<table>
<thead>
<tr>
<th></th>
<th>Medical Complications</th>
<th>Body Weight</th>
<th>Structure Needed for eating / wt gain</th>
<th>Ability to control exercise</th>
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<td><strong>Outpatient</strong></td>
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<td>&gt; 85% IBW</td>
<td>Self-Sufficient</td>
<td>Able to exercise for fitness - can</td>
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<td>Control compulsive overexercising</td>
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<td><strong>Intensive Outpatient</strong></td>
<td>Medically Stable</td>
<td>&gt; 80% IBW</td>
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<tr>
<td><strong>Partial Hospitalization</strong></td>
<td>No IV/NG feedings needed, multiple daily labs not needed</td>
<td>&gt; 80% IBW*</td>
<td>Needs some structure to gain weight</td>
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<td><strong>Residential</strong></td>
<td>HR &lt;40 bpm</td>
<td>&lt; 85% IBW</td>
<td>Needs supervision at all meals or will engage in symptoms</td>
<td>Structure required to prevent compulsive overexercising</td>
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<td>BG&lt;60 mg/dL</td>
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<td>K+&lt;3 meq/L</td>
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<td>Temp&lt;97.0</td>
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<td>Dehydration, orthostatic BP changes</td>
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Adapted from: Am J Psychiatry 157:1 January 2000 supplement; *2006 APA Revised Guidelines change
Sometimes they just can’t do it

- Not always lack of effort or motivation
- Validate the challenges
- Not a punishment/ abandonment to recommend a higher LOC
  - Liabilities
Goals of Different Levels of Care

- **IP:** Medical stabilization
- **RTC:** Weight restoration, symptom management, skill building
  - More intensive therapeutic opportunities
  - Help prepare self and environment for step-down
- **PHP:** Work on independence with strong therapeutic support
  - Sleep on own, meal(s) on own
- **IOP:** Begin real life with consistent support throughout the week
  - May go back to school, job
SO WHAT ARE SOME OF THE THERAPEUTIC INTERVENTIONS OF EATING DISORDER TREATMENT?
Therapy 101: Different modalities

- CBT
- DBT
  - RO-DBT
- ACT
- FBT
- IPT
- MI
- And others

Confused yet?
Cognitive Behavioral Therapy (CBT)

- Looking at how one’s thoughts and emotions affect behavior
  - Changing thoughts and emotions/reactions around thoughts will thus change the behavior
  - Examining evidence around negative thoughts and beliefs
  - Automatic, ingrained thoughts
Dialectical Behavioral Therapy (DBT)

- Designed by Marcia Linehan for clients with self harm, suicidality
  - Borderline Personality Disorder
- Skill based therapy- learning new behaviors
- Four Key Modules
  - Structured format
Four Modules of DBT

- **Mindfulness**
  - Non-judgmental, observe and describe
  - Being in the moment

- **Interpersonal Effectiveness**
  - Skills to ask for what one needs

- **Emotion Regulation**
  - Identifying emotions and learning skills to manage emotions

- **Distress Tolerance/ Reality Acceptance**
  - Willingness versus Willfulness
  - Radical Acceptance
Other aspects of DBT

- Individual and Group Therapy
- Skills Coaching
- Behavior Chain Analyses
- Diary Cards
Radically Open DBT (RO-DBT)

- Relatively new Modality created by Thomas Lynch
- Geared towards individuals with issues of overcontrol
  - Anorexia Nervosa
  - Obsessive Compulsive Personality Disorders
  - Autism Spectrum Disorders
Overcontrolled Temperament

- Emotionally constricted
- Harm Avoidant
- Low Novelty seeking
- Rigid
RO-DBT Core Features

- **Receptivity and Openness**: to new experience and disconfirming feedback in order to learn
- **Flexible-Control**: in order to adapt to changing environmental conditions
- **Intimacy & Connectedness (with at least one other person)**: species survival required capacities to form long-lasting bonds and work in groups and tribes

From presentation by Emily Shigley MSW LCSW – DBT Specialist at Carolina House. Also found on radicallyopen.net
Acceptance and Commitment Therapy (ACT)

- Form of CBT
- Uses mindfulness and behavioral activation to increase *psychological flexibility*
  - “The ability to contact the present moment without avoidance, enabling persistence or change in behavior in pursuit of goals or values”
- Acceptance of experiences, thoughts and feelings
  - Emotional pain
- Emotional separation/ cognitive defusion
- Being present
- Identifying values

*Hayes, Luoma, Bond, Masuda, Lillis 2006*
Family Based Therapy (FBT)

- Evidence-based indication for use in adolescents with AN
- FBT/Maudsley model does not indicate an RD
  - Still is often utilized as important part of meal planning
- Outpatient treatment
Interpersonal Therapy (IPT)

- Focus on client/patient’s relationships and how it affects how they see themselves
  - Help improve the relationships, or change the expectations about them
- Time-limited therapeutic intervention

Markowitz and Weissman 2004
Motivational Interviewing (MI)

- Client-centered and directed way to elicit change
  - Helpful when resistant to change
- Stages of Change
- “Roll with Resistance”
  - VERY different from Nutrition Education that is taught in school
  - Sit with ambivalence
Some MI Techniques

- Open Ended Questions
- Reflective Listening
- Listen for “Change Talk”
  - Mention of need, desire, ability
  - “should, could, want”
- Curiosity and exploration
  - Ask for permission
Others

- 12-Step Model
- Sensorimotor Psychotherapy
- EMDR
Nutrition “Therapy”

- First line of defense
- Critical to manage in early refeeding
  - Refeeding syndrome
  - Other physical discomforts/complications
    - Gastroparesis
    - Constipation
    - Edema
    - Reflux
- Restore to “healthy” weight
Nutrition Therapy versus Nutrition Education

• Exploring/Challenging food beliefs
  ◦ CBT and MI skills key
• Trauma and Food
• You WILL be the bad guy…
  ◦ Discussion of control
• Education is important – but on their terms
Weight Restoration Goals

- Phobic Threshold
  - Thinking of target weight as a phobia

- Weight Suppression
  - One weight does not fit all!
  - Importance of gathering weight history
Intuitive eating

- May not happen at higher levels of care
  - Unable to accurately sense hunger/satiety signals
    - Trauma, prolonged suppression
  - Signals may not be accurate for amount of energy needed, especially in refeeding

- Start with meal plan
  - Intuitive journaling to accompany plan
  - Transition towards intuitive choices
  - Intuitive portions as weight and metabolism normalize
    - May be up to a year

- Intuitive Eating always long term goal
Know your role in the treatment team

- SUPER important one!
- Know your scope of practice
  - Nutrition therapy, not therapy
- Communicate with other team members regularly
  - Attend meetings
  - Regular communication
Transitioning to lower LOC

- Use Meal Plan in transition period
  - Safety net
  - Even if practicing intuitive eating
- Communication!!!
If working with clients with eating disorder

- Teamwork essential

- Supervision
  - Case consultation
  - Take Care of YOU – this is hard work!
Thank You!
Questions?

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