Title: Integrating cognitive behavioral approaches with nutrition counseling: the need for specialized training for dietitians working with eating disorders.

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Abstract:

Registered dietitians have gaps in knowledge and skills related to the identification, assessment, treatment, and prevention of eating disorders. Due to the deeply psychological nature of eating disorders and the importance of coordinated multidisciplinary treatment, registered dietitians who work with eating disorders should receive specialized training that extends beyond the minimum required for dietetic registration, including training in the realm of psychopathology and behavioral therapies to facilitate and support dietary behavior change in individuals more effectively. The paradigm of care needs to shift from informative nutrition education to a patient-centered approach of nutrition counseling with treating patients with eating disorders.


Introduction

Eating disorders, including anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified (EDNOS, which includes binge eating disorder), are complex psychological conditions that vary in severity and prognosis. As a result of their intricate nature, the treatment of eating disorders requires a multidisciplinary approach including the role of the registered dietitian, recognized as an important part of the treatment team. Although diagnoses fall outside of the realm of a dietitian, dietitians must be able to recognize and address the psychological nature of the conditions and treatment modalities, skills that require additional training beyond the minimum required for professional practice.

Although nutrition therapy plays an essential role in the treatment of eating disorders, it can present as particularly challenging for the practitioner. Central features of the disorder often include anxiety, fear of weight gain, denial, resistance to change, inaccuracy of self-report, relapse, avoidance of treatment, and difficulty establishing rapport. Nutritional factors are “both precipitating and perpetuating factors.” Normalization of eating behaviors, the central goal of the dietitian, often requires directly addressing the individual’s fears, which includes normalization of body weight and changing food and weight-related behaviors. The psychological issues aforementioned can present major challenges for the dietitian who may not be familiar with the psychiatric issues surrounding the
disorder or treatment. Furthermore, evidence-based guidelines on managing the nutritional needs of eating disorder patients are lacking.

**Background**

Lifetime prevalence estimates of eating disorders, outlined in the National Comorbidity Survey Replication, are 0.9% for anorexia nervosa, 1.5% for bulimia nervosa, and 3.5% for binge eating disorder for women; 0.3%, 0.5% and 2.0% respectively for men. However, many more cases may be underreported due to the difficulty recognizing early signs of eating disorders, variation in screening methods and referrals, the choice to not seek medical treatment, perceived stigma and the secretive nature of these disorders. Many cases simply do not meet threshold diagnostic criteria for an eating disorder. Furthermore, many individuals with an eating disorder do not want to be treated, and may consider “requirements for recovery…a failure.” This can result in up to 90% of those with an eating disorder remaining untreated.

Although the development of an eating disorder is speculated to result from the interplay of genetics, biology, and psycho-socio-cultural factors, a contributing factor to the development and maintenance of the disorders is poor or dysregulated nutrition. Given the nature and urgency of these conditions, nutrition experts must have the ability to identify, address, treat, or refer eating disorders.
Nutrition counseling, a “process by which a health professional with specialized training in nutrition helps people make healthy food choices and form healthy eating habits,” is recognized as an essential component in the treatment of eating disorders, from assessment to treatment and across the spectrum of care by the American Psychiatric Association, National Institute for Health and Clinical Excellence (NICE), and American Dietetic Association and American Academy of Pediatrics. In a position statement from the American Dietetic Association, dietitians are “uniquely qualified” to provide medical nutrition therapy to “promote the normalization of eating patterns and restore nutritional status”. Furthermore, the dietitian may be the first member of the healthcare team to encounter a patient, as patients may seek treatment via nutrition counseling before therapy; an RD may be the first to recognize an individual’s eating disorder, or they may be the first health care professional consulted by a referral.

Suggested roles of the dietitian include establishing healthy eating patterns, modeling healthy eating, challenging food myths through education, explaining the role of nutrition and food, focusing on issues of disordered thoughts and feelings around food, eating and body image; identifying disordered eating behaviors, evaluating diet, communicating pertinent nutrition information with other members of the multidisciplinary treatment team, assessing the appropriateness of a nutrition intervention given client’s emotional stability, and freeing a therapist from nutrition-related discussions.
A key focus in supporting literature suggests that dietitians work as a member of a multidisciplinary team, and not as sole practitioners, as eating disorders require a collaborative approach. This role requires the dietitian to understand professional boundaries, professional limitations, and responsibilities of each treatment team member. Recognizing boundaries includes the dietitian understanding and appreciating the specific role of each member of the multidisciplinary team, along with the psychotherapies and treatment modalities employed within each dimension of treatment. A dietitian who attempts to fill the role of the therapist oversteps appropriate professional boundaries.

**Concerns**

Counseling skills are and have been a concern of dietitians for decades. The training of the registered dietitian, not unlike other health professionals, devotes little time to training in counseling and behavior modification. The accrediting body, the American Dietetic Association, fails to acknowledge counseling skills as a central focus of dietetic training, stating those individuals wishing to become registered dietitians focus on “food and nutrition sciences, foodservice systems management, business, economics, computer science, culinary arts, sociology, communications, biochemistry, physiology, microbiology, anatomy and chemistry” – without mention of psychology or counseling. Furthermore, the nature of patient interactions in the clinical setting, including time constraints and few follow-up visits, may stunt the dietitians’ opportunity to develop and understand counseling and behavior modification.
Nutrition counseling is not a well defined skill, with “most practitioners learning on the job” \(^{17}\). Consequently, the role of the dietitian with the eating disorders patient varies tremendously, and many report feeling ill-prepared to work in this area \(^{17}\). Knowledge of eating disorders, including psychopathology, etiology, and treatment modalities such as behavior therapies, is highly variable amongst dietitians \(^{20,21}\). A survey representative of US dietitians working with eating disorders indicated need for research on the effectiveness of nutrition therapies and better understanding of the etiology, prevention, and identification of eating disorders in high-risk groups \(^{20}\). In the United Kingdom, a questionnaire to 394 dietitians indicated that dietetics training was perceived as particularly poor in psychotherapies, such as theories of cognitive and behavioral therapy (CBT); motivational interviewing techniques; group work skills; and in skills of relapse prevention \(^{22}\). In a recent survey of pediatric dietitians assessing confidence and views regarding nutrition techniques for eating disorders, the trends indicate an increased need for expanded education on eating disorders. Similar studies in Australia and Canada were conducted, consistently demonstrating low self-confidence throughout \(^{5,17,22}\).

Furthermore, distinctions are made between “nutrition therapists” and “nutrition educators” \(^{23}\). Nutrition educators operate short-term, with quick sessions that are solely content-based with the goal of improving knowledge without focusing on behavior. Nutrition therapists, however, shift their focus not only to content-based
topics for education but also to behaviors, thoughts, and feelings related to food and eating \(^{24}\). To encourage motivation and behavior change, it is essential that dietitians working with eating disorders operate as nutrition therapists.

_Screening_

While eating disorders vary in severity, the majority of patients, including those with anorexia nervosa, can be managed in an outpatient setting \(^{25}\). Nutrition professionals, whether entry level or specialty-level, may work in outpatient settings (i.e., hospitals, residential treatment programs, public health, research, private practice, education) and are expected to identify signs and symptoms of an eating disorder, and implement evidence-based modalities to treat or refer the individual \(^{11}\). This often extends beyond entry-level skills and training. The detection of an eating disorder requires the dietitian to be aware of risk factors, signs, and symptoms of anorexia nervosa, bulimia nervosa, and EDNOS including dietary habits (avoiding certain foods or foods groups, severe caloric restriction, binge and purge cycles), exercise habits, socio-cultural values (aesthetic of thinness), family history of an eating disorder, and physical and biological manifestations, including amenorrhea, other physical sequelae of starvation including gastro-esophageal reflux. Nutrition counselors must also be aware of special populations such as female athletes (i.e., presentation of the female athlete triad), a higher risk group due to the traits that make them successful in their sport (perfectionism, competitiveness, emphasis on leanness and concern with performance) \(^{11,12,26}\).
Treatment

Some techniques utilized by dietitians treating eating disorders are common to other areas of dietetics, such as nutrition assessment and education. However, eating disorders may present unique challenges for the dietitian. As illustrated in the Keys semi-starvation study, malnutrition leads to the development of significant emotional changes including depression and anxiety the more food is restricted. The biological and psychological consequences of malnutrition may perpetuate eating disorders and lead to serious medical complications including death. Furthermore, the presence of other psychiatric comorbidities, such as Axis I disorders (depression, anxiety, body dysmorphic disorder) and Axis II disorders (borderline personality disorders), are common in patients with eating disorders and fall outside of the expertise of the registered dietitian, further complicating the identification and treatment process. In the National Comorbidity Survey Replication, eating disorders were positively related to almost all of the core DSM-IV disorders including mood, anxiety, impulse-control, and substance use after controlling for age, sex, and race/ethnicity.

Dietitians must understand that severe eating disorders often require long-term treatment, which may include setbacks and relapses. Dietitians may be the only member of the treatment team not specifically trained to cope with the stress of relapse or the resistant patient. Furthermore, the measure of successes is often symptomatic improvement, when given the prolonged nature of some disorders,
practitioners may doubt their abilities if symptoms do not improve. Other issues that may arise with the eating disordered patient is transference and countertransference, issues that nutritionists are not trained in. Transference, or the emotions the client brings to the relationship, and countertransference, or the feelings the therapist develops about a patient, can further complicate the therapeutic relationship. Furthermore, patients may subconsciously or consciously discuss un-related issues with the dietitian as a way to avoid the issues of eating and nutrition.

Prevention

Dietitians can also play a significant role in the prevention of eating disorders and related complications, thus placing a demand on identification of disordered eating and eating disorder patterns while working to reverse thoughts and behaviors. As the frequency of dieting, body image and weight concerns continue to be ubiquitous in the United States today, dietitians can play a positive, preventative role by engaging and intervening at critical points for susceptible individuals, helping to promote accurate messages and positive attitudes about nutrition, to promote a healthy focus on body weight and diet composition.

Evidence-Based Psychotherapies

One prevailing theory suggests that eating disorders are fundamentally “cognitive disorders” - anorexia nervosa, bulimia nervosa, and EDNOS share a “core
psychopathology” that is rooted in distorted or dysfunctional thinking. Cognitive behavioral therapy (CBT) is designed to produce cognitive change. The objective of CBT is the modification of patient’s unhealthy thoughts and ideas and dysfunctional assumptions regarding eating, body image, and weight. CBT and nutrition counseling are widely utilized approaches to treating anorexia nervosa and bulimia nervosa. Dietary counseling within CBT focuses on meal regularity rather than composition of meals and snacks, and may include meal planning, education and weekly weighing, self-monitoring, achieving normal perceptions of hunger and satiety, and preventing or adjusting biological and psychological consequences of malnutrition. Dietitians who familiarize themselves with CBT will support and understand their patients who may be engaged with a psychotherapist by reassuring the patient with proper planning and estimation of portion sizes and helping to modify abnormal food and weight cognitions and beliefs.

Although the purpose of the dietitian is undisputed, literature outlining the optimal nutritional approaches is insufficient. Nutrition counseling has generally been found to be effective in conjunction with evidence-based psychotherapies for the treatment of bulimia nervosa and binge eating disorder such as CBT and motivational interviewing (MI). While nutrition intervention alongside other treatment modalities is recommended, there is insufficient evidence to support nutrition interventions alone as having an impact on weight change in people with eating disorders. While traditional nutrition counseling emphasizes the role of
cognitive factors that directly relate to food and eating behavior, little attention is placed on cognitions surrounding behavior and emotional problems, which does not increase motivation and might hinder a patient’s cooperation. Furthermore, evidence supports CBT as superior to nutritional counseling in preventing relapse in weight-restored patients.

Applications

The paradigm of care needs to shift from informative nutrition education to a patient-centered approach of nutrition counseling. Expanding skills in content knowledge, behavioral therapies, counseling skills, screening skills, and increased competencies of the eating disorders dietitian will require recognition and formalized training. The need for specialized training is well-documented, and could vary in intensity ranging from supervision and workshops to specialized tracks in dietetics programs that focus on counseling skills and behavioral therapies—in both cases encouraging patient-centered approach to behavior change.

Supervision that transcends disciplines would be beneficial for all members of the interdisciplinary team, particularly dietitians who may not be aware of the psychological and psychotherapeutic components of treatment. Establishing a continuing-education program involving collaborative peer supervision would function to improve communication among nutrition, medical, and mental health care providers on a treatment team while bridging treatment modalities to ensure
fluidity of care for the individual. The dietitian and psychotherapist may share some roles and boundaries, rendering supervision mutually beneficial.

Other psychotherapies dietitians may wish to be familiar with include Dialectical Behavioral Therapy (DBT), which targets emotional regulation by teaching skills to enhance patients' ability to regulate emotion. DBT is particularly useful with the borderline personality patient\(^{36}\). When utilized by a dietitian, nutrition counselors may assist in problem solving and learning of new food-related behaviors. Motivational Interviewing, a client-centered approach to encourage behavior change, may also be an effective tool to help patients work through ambivalence and reluctance to change\(^{37}\).

Modified nutritional counseling will better suit the treatment and prognosis of the individual by increasing patients' self-monitoring ability and promoting insight into eating behavior, including emotions, self-esteem, and interpersonal distress\(^{31}\). By highlighting nutritional psychology around food and the cognitive factors not directly related to weight and body image, dietitians can promote motivation towards a more structured CBT. Furthermore, CBT has been found equally as effective in bulimia nervosa whether administered by non-mental health professional or by mental health professional\(^ {26}\). Consistencies between nutritional counseling and CBT may further improve ability to successfully change behavior in eating disorders patients\(^ {31}\). Splitting, a negative result of pitting one professional against another, common in the treatment by multiple practitioners,
can also be minimized with consistencies in treatment, along with ample communication and a clear understanding of roles and consistencies in treatment. Psychotherapies can help the nutrition professional understand the dynamics of working with disordered eating and can help develop a more holistic approach to nutrition counseling.

Beyond the benefit to the patient, the dietitian who employs counseling techniques will increase proficiency and confidence to handle complex issues of even the most difficult patients. Furthermore, this confidence will facilitate teamwork with other mental health professionals. A dietitian who is better equipped to deal with resistance can avoid power struggles and develop a more collaborative working relationship with the patient and other team members.

**Conclusion**

Eating disorders are complex and deeply psychological in nature and require the assistance of a coordinated multidisciplinary treatment team including the expertise of a registered dietitian. To ensure fluidity of care and empirically-based treatment modalities, nutrition professionals who work with eating disorders should receive specialized training that extends beyond the minimum required for dietetic registration. Training should include knowledge in the realm of psychology and behavioral therapies, cross-discipline supervision, and workshops. Entry-level practitioners should be educated and exposed to screening, assessment, and treatment techniques by an eating disorders
specialist. Furthermore, most patients migrate among diagnoses over time, further necessitating the need for long-term treatment, including continued assessment and tailored intervention by the dietitian\textsuperscript{39}.

Nutrition professionals have gaps in knowledge and skills related to identification, assessment, and treatment of eating disorders that need to be addressed by shifting the paradigm of care from the nutrition educator to nutrition therapist. Registered dietitians need to embrace a broader role in the treatment of eating disorders.
References


APPENDIX

November 10, 2011

Dear Elsevier,

Enclosed is a manuscript to be considered for publication in the Journal of the American Dietetic Association. Please consider the enclosed manuscript, ‘Integrating cognitive behavioral approaches with nutrition counseling: the need for specialized training for dietitians working with eating disorders.’ (2,719 words, plus notes of 796 words), for the peer-reviewed category of “Commentary” in an upcoming issue of the Journal of the American Dietetic Association.

This original piece has neither been previously published nor submitted for consideration to any other journal. No author has any conflicts of interest to report.

I look forward to your decision.

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