When Malnutrition Lives in a Larger Body: Effective and Compassionate Interventions for Treating Binge Eating Disorder
Part 2 Questions and Answers
Amanda Mellowspring, MS, RDN, CEDRD-S April 7, 2022

1. Q: Regarding Carolina' case study, was her previous nutrition work (when she was told to focus on limiting CHO) with a RDN? That wouldn't be appropriate.

   A: *Correct, this is not appropriate and yet very common. This was a scenario of a client who was taken to see a nutritionist (before her ED) as a child by a mother concerned about her weight. This was a significant factor in what led to the onset of her binge behavior.*

2. Q: Are there any books that you recommend for RDNs interested in Eating Disorders?

   A: *Yes, the books listed within the reference list are highly recommended. In addition, I would recommend "Sick Enough" by Jennifer Gaudiani, "Eating Disorders: A Guide to Medical Care & Complications" by Philip Mehler, books by Carolyn Costin, and "Eating in the Light of the Moon" by Anita Johnston as a great book to conceptualize ED work. There are many more!*

3. Q: Do you have any suggestions for older adults who are overweight and malnourished?

   A: *Great question. It is so important to be realistic about behavior change and lifelong patterns, as well as the interplay of emotional experiences and food as comfort which can be significant for the older adult population. Increasing options to incorporate foods to improve nutritional health rather than working to decrease food/weight overall will likely have a better result on overall health status.*

4. Q: Is it okay to clarify how the client is using the term "binge"? The way that it is used clinically vs. in the regular world could differ.

   A: Yes, absolutely. That is what I was referring to in the early slide discussing "subjective bingeing". It is definitely important to be on the same page with the client.

5. Q: Is cue therapy the same as ERP?

   A: Arguably, yes. In my opinion, it differs in that we are working with clients to incorporate cue foods in normalized ways on a regular basis versus just providing exposure to them. The element of food adds a little difference.

6. Q: How do you create meal plans for binge eaters to make sure they are eating enough since they can be restrictive and overeat?

   A: *It is vital to create a plan that expects a minimum intake that is enough for the individual – baseline is 200 0kcals, although a client bingeing on 10,000 kcals per day will likely need a plan closer to 3000-4000 kcals (or more) to begin to adjust to normalized eating. Working on the goals of eating frequently enough and having succinct start and ends to meals and snacks are important to initiate the structure needed.*

7. Q: I was just wondering how you generate meal plans for people – do you use exchanges for macronutrients or just advise them to eat more frequently with meals that include a carb, protein and fat. They have meal plans for anorexia, but those meal plans might be too low in calories for people with binge eating.

   A: *I should start by saying that not every client needs a "meal plan" per se. Some people need structure that is as lenient as eating more frequently, including certain nutrients, etc. In question 6 I spoke a bit about meal plans also. I would not suggest introducing exchanges to BED clients as it often tends very quickly towards a rigid diet mentality. Over-structured meal plans can increase externalized eating and make internal awareness much more difficult.*

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8. Q: Is there a format or website you use, or just a trial and error approach until finding the correct meal plan?

   A: *It originates from the information obtained from the client. You want to consider basic nutritional needs, but also their lifestyle, realistic goals to create small successes, all while making sure they are not left hungry.*

9. Q: With the fairly stringent criteria for the diagnosis of malnutrition, how can we diagnose malnutrition in a patient with BED if they haven't lost weight, eat less than their needs, or have not had muscle/fat loss?

   A: *Great question. I think it is important that those things are ruled out. In a weight-centric medical approach, these are often assumed rather than fully assessed. It also does not account for the common occurrence that the body will compensate for being undernourished by slowing metabolism which can prevent weight loss. Some individuals, such as those with PCOS also have increased weight gain and symptomology with poor nutrition. Certainly, it would need to be considered person by person.*

10. Q: Can you please provide the information for providers from the *Academy for Eating Disorders (AED)*?

    A: *www.aedweb.org*

11. Q: Have you dealt with BED in the post-bariatric surgery patient and its specific MNT?

    A: *Yes, great question. Individuals who are post-bariatric surgery can present with any eating disorder, including BED. Some individuals may develop maladaptive ED behaviors post-surgery, while many had presenting ED behaviors prior to surgery that were not disclosed.*

12. Q: If a client states she feels her head and body are disconnected (to the point that she lives without full-length mirror/upon seeing herself in a full body mirror she experiences shock) is Mindful Eating practice not indicated? She has a chair yoga practice and meditates often.

    A: *Thank you for asking. For this client a few things come to mind. I would ensure that she is seeing a therapist and exploring the body relationship/disconnect more deeply. I would also collaborate with the therapist around readiness to explore more mind/body integration with eating. For instance, if she has trauma that is keeping her disconnected, it will be most helpful to allow the therapist to lead on the timing of this work as it can be overwhelming. If she reports experiencing her body in a different, more integrated way with yoga or meditation, I might possibly start with small sensory-related mindfulness practices related to food and encourage her to acknowledge the newness/discomfort of experiencing food and her body in this way.*

13. Q: How do you measure vitality?

    A: *It is really for the individual client to self-assess. We often pick up on their lifestyle changes and emotional shifts in session.*

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14. Q: What criteria would you use with BED patients to determine if they would be best treated in an inpatient setting or even hospitalized?

    A: *Good question. I would consider any co-occurring diagnoses, any complicating medical conditions, need for structure to block the binge behavior, and need for structure to eat enough.*

15. Q: What are your thoughts on the Academy of Nutrition and Dietetics clearing stating in the latest recommendations regarding MNT with obesity - that HAES/intuitive eating education should NOT be used?

    A: *The proposed recommendations were open for feedback, and I contributed. I strongly disagree with this. I am hopeful that a much better understanding of these approaches comes from the review process to avoid this being formalized within the final recommendations.*

16. Q: Can you talk more on how to re-introduce trigger foods for a binge eater?

    A: *Sure. First and foremost, a client must be nourished first in order to avoid this being a set-up for increased binge behavior. Cue exposure is intended to reintroduce these foods in less activating ways – normal meal/snack times without feeling overly hungry, included in a normalized way and normalized portion amount, and practicing staying engaged in the experience without shame.*

17. Q: Are there any additional suggestions for working with patients who are being treated for hormonal disorders such as Hashimoto's?

    A: *Depending on the severity of the hormonal disorder, the behavior may not qualify as BED. Many individuals with treated Hashimoto's benefit from the same approaches since we are addressing the behavior over the weight as a goal.*

18. Q: I am struggling with the purpose of spending time encouraging the eating of non-nutritive binge foods with patients that are malnourished. Do you recommend vitamin and mineral supplementation for these clients who are eating the binge foods and undereating nourishing food while working on normalizing the trigger foods?

    A: *Vitamin and mineral supplementation can be helpful for all ED individuals. In considering this overall, it may be helpful to think of a different angle: The goal is to reduce/stop the binge behavior. Restraint/avoidance of foods/shame increase the incidence of binge behavior. The "encouraging of non-nutritive binge foods" is not to improve nutrition status through those foods, it is to stop the bingeing which will in turn improve nutrition status through layers of recovery efforts.*