Eating and feeding management of eating disorders and the role of the dietitian

More than just a meal plan: the wider role of the dietitian in eating disorder treatment

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Abstract

Eating disorders are serious psychiatric conditions which severely compromise the ability to engage in normal day-to-day living. National guidance recommends that patients are treated not by individuals but a multidisciplinary team. In the past, dietitians have been excluded from some manualised treatments for eating disorders and this has led to poor investment within some teams. However, the dietetic role goes beyond refeeding management and meal planning. This paper highlights the multiple areas where dietitians have been embedded within specialist teams and have developed advanced practice. It also explores how dietitians can bring their expertise to all areas of eating disorder treatment, including meal support, prescribing, nasogastric feeding and therapy, including, but not limited to, all variations of eating disorder cognitive behavioural therapy, family therapies for eating disorders, guided self-help and specialist supportive clinical management.

Keywords: dietitian, feeding and eating disorders, outpatient, inpatient, nutritional therapy, dietetic counselling

Introduction

Eating disorders (EDs) are multidimensional heterogenous conditions, interlinked with complex psychosocial features, and are associated with some of the highest premature psychiatric mortality rates (1-3). Across all EDs, features include disordered eating and problematic compensatory behaviours, which can have a significant negative impact on mental health and wellbeing (4-6). Consequently, the inclusion of medical, psychological and dietetic input as part of a multidisciplinary team (MDT) approach has been recommended by consecutive national practice guidelines (7-9) and clinical practice standards (10, 11).

Dietitians are an under-represented profession within ED services (12) and their unique skills and knowledge are underutilised if they are restricted to simply devising meal plans or conducting one-off appointments. This paper aims to challenge the current status quo by exploring, outlining and defining the unique contributions and benefits that the dietetic profession brings to the management of EDs across treatment approaches and core aspects of nutritional care management.

The important role of dietetics in the treatment of individuals with a broad spectrum of severe mental illness has been highlighted (13), yet there remains a paucity of evidence regarding the unique contributions offered by a dietitian

(14, 15). It is difficult to extrapolate the unique contribution made by the dietitian when clinicians are working in a multiprofessional way across transdiagnostic treatment domains. A recent cross-sectional study noted that barriers to effective dietetic service provision include a lack of awareness by other clinicians of the dietetic role, in particular the capacity of dietitians to perform roles outside of refeeding management (13).

Dietitians are in a uniquely advantageous position to be able to bridge the core transdiagnostic domains of successful ED treatment, namely medical, nutritional and psychological management (16).

A skilled understanding of nutritional science and the consequences of malnutrition, together with behaviour change skills, positions this core dietetic expertise as integral in nutritional counselling (16). Dietitians must also possess the prerequisite skills required of any discipline to train and to deliver additional and advanced treatments safely. The important role of the dietitian as part of the MDT was highlighted by the results of a recent Delphi study which concluded that, from the perspective of service users and carers, the incorporation of the dietitian into patient care was welcomed positively (17).

Despite this, a 2020 review of the nutritional content of published adult ED treatment manuals found that only 36% recommended specific dietetic input as part of the MDT (18). Of further concern, this review concluded that 60% of such manuals contained unsubstantiated nutritional information, with only 9% including content written by a dietitian. Indeed, two of the most widely used and clinically adopted treatment manuals across age ranges, family-based therapy (FBT) and enhanced cognitive behavioural therapy (CBT-E), do not directly refer to the involvement of a dietitian (19, 20). Instead, the potential role of the dietitian is superseded by family oversight and guidance from a non-nutritionally trained mental health clinician. There are differences in approach to treatment between avoidant/restrictive food intake disorder (ARFID), anorexia nervosa (AN) and bulimia nervosa (BN); however, in ARFID the dietetic input is particularly important as ARFID is commonly associated with nutritional deficiencies (21). Specialist dietitians can be involved in delivering therapy after undertaking further training or by joining sessions led by other clinicians.

Supporting nutritional adequacy

Food is a central focus of ED psychopathology and some of the most challenging work patients undertake in ED treatment happens at the table, where the fears and distress occur and impact on a person's ability to eat (22, 23). Therefore, providing real-time support to overcome the restrictive rules, rituals and behaviours people with EDs have around food is vital for helping people manage the day-to-day difficulties their ED presents to them. Despite this, the skills and processes required to facilitate well-delivered and effective support at mealtimes is an under-researched and often overlooked area of ED care (24).

In addition to their core skillset, dietitians have a unique knowledge of the psycho-socio-cultural aspects of eating (25). This means that they are well placed to work collaboratively with individuals through the nutrition care process, not only to manage malnutrition and support nutritional rehabilitation, but also to tailor supported mealtime interventions to create the right conditions to achieve their food and eating goals. Dietitians are also able to help parents, young people and other clinicians in the MDT to navigate the recovery journey. Dietitians can critically analyse and stay abreast of societal trends and developments in foods, such as probiotics and clean eating, and can readily engage in discussions with young people to correct misunderstandings and influence more informed behaviours.

Dietitians are invaluable in the management of people with EDs who have comorbidities, for example, diabetes mellitus type 1, nutritional allergies and coeliac disease (26, 27). In some instances, this may also include facilitating the supportive use of nasogastric tube (NGT) feeding. Dietitians are uniquely positioned within the MDT and are well placed to have supportive conversations with patients regarding the need for this intervention and, importantly, how and when it might be discontinued. This skillset is especially important when considering the most medically unstable and psychologically unwell patients for whom treatment may include NGT feeding under restraint, which has significant psychological impact (28).

There is limited understanding of patient and healthcare professional perceptions and experiences of receiving and delivering dietetic care. A study by Heafala et al. (29) explored the perspectives of people with lived experience of an ED and reported that some described dietitians as "invaluable" for supporting their understanding of the role of nutrition in recovery, while working as part of a wider MDT, and that working with a dietitian was helpful for challenging self-limiting beliefs and behaviours, as well as facilitating behaviour change.

This evidence for the positive impact of dietetic intervention highlights the need for more research into the opportunities for dietetic support for patients, carers and healthcare professionals in managing the day-to-day difficulties of living with an ED.

Cognitive behavioural therapies adapted for eating disorders

CBT-E is designed to address the cognitive and behavioural processes that are maintaining the individual's ED. Core maintaining factors include malnutrition and dietary restraint, which dietitians are well placed to address. While standalone dietetic treatment is not supported as an intervention for EDs (30), research suggests that involving a dietitian in CBT-E may increase treatment efficacy (31). CBT-E training and supervision is widely available (20). For the MDT,

CBT-E offers a common language and a means of delivering a consistent message from team members. Once CBT-E training is completed, there are two options for the dietitian.

The first option is to work alongside the team and simply use the CBT-E principles within clinical practice. This can include re-establishing a pattern of regular eating, weight stability or weight gain, tackling dietary restraint, establishing monitoring of food and drink intake as well as any compensatory behaviours, and agreeing next steps or homework.

The second option is for the dietitian and a mental health professional to work together to deliver treatment. A new and recent strategy proposed in Australia is interprofessional CBT-E. This more formalised approach delegates interventions related to malnutrition, including dietary restriction and low body weight, as well as dietary restraint, to the dietitian while other mental health professionals deliver the content related to cognitive and behaviour change (31).

The novel treatment approach of adapting CBT-E and formally integrating dietetic treatment, where dietitians deliver content related to malnutrition and dietary restraint, has the potential to improve treatment outcomes.

Eating disorder–focused family therapy

For recovery, someone with an ED has to learn what to eat, how much to eat, when and why. They have to establish, or re-establish, a healthy relationship with food.

As a member of the MDT, the role of the dietitian is to identify the severity of malnutrition, the presence of disordered eating habits and deficits in nutritional skills and knowledge that inhibit the attainment of adequate nutrition (16). Especially in ED-focused family therapy, dietitians complement the MDT by supporting parents with practical aspects of meal planning, preparation and management at mealtimes, alongside psychoeducation for both parents and the young person on EDs, including the impact of low body weight on physical health and brain function (32). This is particularly important to allow the parents to regain their confidence which, in many cases, may have been eroded by their child's illness. It is important, however, that once parental confidence is regained, reliance on the dietitian is gradually reduced.

Dietitians have expert training and knowledge to support the management of medical risk associated with severe malnutrition, in conjunction with medical professionals. These risks are common in the early stages of an ED (16). In contrast, Mörkl et al. (32), in a study of nutritional literacy among 1000 mental health professionals in 52 countries, found that the majority of psychiatrists and psychologists (74 and 66%, respectively) had no training in nutrition. Mörkl et al. suggested this may be a reason for a lack of confidence among clinicians in discussing nutrition with patients and the limited nutritional education they were able to offer.

Although guidelines focus on the dietitian's role in treating and managing AN, the dietitian must align with the MDT and should not be treating young people with AN as sole practitioners (33). The role of the dietitian in providing nutritional advice within the MDT is particularly important, as research has shown that the nutritional knowledge of mental health practitioners is no better than that of a lay person (34). This was highlighted in a 2011 study in Australia (35) which found that non-dietitian health professionals had similar levels of nutritional knowledge to individuals with EDs. When there are comorbidities, suspected or proven food allergies or intolerances, or other overlapping medical conditions such as diabetes, the specialist skills of the dietitian are also needed.

Phase two of the therapeutic process, involving the gradual handing back of control of eating and food choices to the individual, is particularly well supported by the skills and knowledge of dietitians.

Phase three aims to return the individual to a normal developmental trajectory, which may include addressing psychological work.

Maudsley Model of Anorexia Treatment for Adults

Although the Maudsley Model of Anorexia Treatment for Adults (MANTRA) is a psychological therapy, it cannot be delivered without medical and nutritional risk monitoring and practitioners are encouraged to individualise MANTRA, delivering it flexibly. The dietitian can monitor nutrition, alongside delivering the nutritional psychoeducation and nutrition change sections (36).

The MANTRA nutritional section is unhelpful for some patients when delivered via workbook alone; for example, where self-evaluation of calories is encouraged. Dietitians can offer alternative ways to self-assess diet and energy intake without using calories, moving away from the focus on detail and numbers which are maintaining behaviours for many. Patients have stated that practical advice around nutrition would, in their opinion, improve the MANTRA treatment (37).

Nutritional needs can be complex. The MANTRA manual offers an overview of the basic nutritional needs of an omnivore without consideration for additional nutritional complexities. Dietitians are able to assess the nutritional adequacy of diets such as vegan, dairy-free, allergy and gluten-free, and address any under-nutrition or over-nutrition. They will also calculate the energy requirements needed to address the starved state that results from inadequate calorific intake and can offer psychoeducation to address nutritional or weight-based questions, thereby lowering anxiety.

Individualising MANTRA to the needs of the person includes a personalised nutrition approach. Legally, dietitians are the only healthcare professionals able to prescribe individualised meal plans and manipulate diet to treat disease (38).

Dietitians play their part in the delivery of MANTRA alongside the MDT by supporting individuals to meet their nutritional needs and addressing thinking styles around food. This may include, for example, encouraging a move away from calories to household or hand portioning and by offering advice on balancing meals and snacks. Addressing these issues allows the psychological therapist to focus on the other areas of MANTRA, such as interpersonal difficulties, without being drawn into conversations around food, weight or nutrition.

Schmidt et al. (36) stated that the dietitian's role within MANTRA is an initial dietetic assessment, with follow-up appointments as needed. However, for personalised nutritional advice to be offered, some teams are moving towards a co-delivery of MANTRA, with a psychological therapist working alongside the dietitian throughout the course of treatment. Alternatively, the dietitian might deliver the nutrition sections at specified time points.

Specialist supportive clinical management

Specialist supportive clinical management (SSCM) was developed by a team of psychiatrists and psychologists. However, since much of the psychoeducation is nutrition focused (39), the potential contribution of dietitians in SSCM should not be overlooked. SSCM has been the subject of four randomised controlled trials as well as a separate trial in which SSCM was modified for the treatment of longstanding EDs with a focus on quality of life and not weight restoration (40). Kiely et al. (41) outlined the six principles of SSCM and highlighted that SSCM can be delivered by a variety of clinicians; the dietetic input can be flexible as part of the overall SSCM strategy. Kiely at al. (41) included dietetics within their reconceptualisation of SCCM as a supportive role alongside other MDT members. It has also been suggested that dietitians could work in an assessment role, alongside the therapist, or in a consultancy role.

The target features of the ED laid out in the SCCM workbook by McIntosh et al. (39) relate to ED behaviours, physical/emotional consequences and related problems. The majority of these features are addressed as part of dietetic treatment plans. Kiely at al. (41) have suggested that if these features are not improving, dietetic support can be a valuable resource that allows a closer focus on these aspects, in contrast to the "broad brush strokes" approach that might be adopted by the principal clinician. Dietitians have the skills to offer specialist support and advice on person-centred nutrition and focus on physical health and weight restoration. Patient experience of SSCM shows that a focus on nutrition is often seen as a helpful aspect of the therapy (37).

Binge eating disorder and guided self-help

Dietitians are well placed to identify, assess, and treat binge eating disorder (BED) using interventions such as guided self-help (GSH) and CBT-E. BED is commonly associated with multiple comorbid conditions, including mood disorders, anxiety, substance misuse, impulse control issues, obesity, type 2 diabetes and various pain syndromes (42).

Approximately 30% of patients accessing community weight management services have features of BED (43). Research by Nickel et al. (44) indicates a frequent association of BED with neurodiversity, which has become an area of growing interest. Dietitians are skilled in screening and identifying EDs in settings and populations in which neurodevelopmental conditions are prevalent.

GSH is a first-line treatment for BED in all age groups in the UK National Institute for Health and Care Excellence guidance for the recognition and treatment of EDs (8). Dietitians working within weight management settings have been successfully trained to identify and deliver GSH treatment to individuals who have BED or disordered/emotional eating. The results of a study by Traviss-Turner et al. (43), showed that dietitians were very effective in delivering GSH to patients with BED, with results comparable to GSH delivered by mental health practitioners. A more recent study of a digitalised GSH intervention for BED in patients with diabetes was co-developed, delivered and co-supervised by dietitians (45).

A review of treatment manuals for EDs in 2023 found that only 36% recommended consultation with a dietitian as part of an MDT approach (17), and only 9% included content written by a dietitian. It was found that 60% of the manuals did not meet current evidence-based practice criteria. It is suggested that all manuals with nutritional content are written with appropriately trained and experienced dietitians in this field; they should be revised to reflect current research and the current evidence base and have a clear indication of when a referral to a dietitian is needed.

In summary, GSH intervention is appropriate for dietitian delivery to patients with BED in the context of obesity and diabetes. Research indicates the potential for other dietetic-led services to deliver GSH and to support patients with binge eating accessing the service.

Avoidant/restrictive food intake disorder

Nutritional deficiencies and suboptimal growth are core components of the diagnostic criteria of ARFID, and it is essential that dietitians are included as part of the assessment and treatment pathway, as stated in the NHS England framework (46). Dietitians are the only registered professionals within the NHS who can assess age-specific nutritional adequacy in relation to macronutrient and micronutrient content of diet and who can recognise the likely impact of

suboptimal intakes (47).

The dietitian's role includes taking a detailed feeding and development history, with a focus on nutritional intake and its impact on growth, as well as reviewing growth and development. Dietitians are skilled in taking detailed diet histories and analysing dietary intake from food diaries, which are essential elements of every assessment. They are also able to guide and interpret blood biochemistry where specific nutrients are thought to be deficient and advise on suitable vitamin and mineral supplementation (48). Many people with ARFID will need short-term prescriptions of a range of oral nutritional supplements to support weight and meet nutritional needs while they undertake psychological-based treatments. These treatment strategies may include cognitive behavioural therapy for ARFID, FBT for ARFID and food exposure. All of these interventions should be supported by a specialist ARFID dietitian with advanced training (47).

Prescribing

Dietitians can hold supplementary non-medical prescribing (NMP) rights, following completion of an approved programme. Supplementary prescribing differs from independent prescribing as prescribers are only able to prescribe a medicine within their clinical competence and as part of an agreed patient-specific clinical management plan. The clinical management plan outlines an agreed list of medications related to medical conditions and the prescriber is able to review these as part of an agreed partnership with a doctor (46, 49).

NMP dietitians can prescribe only clinically appropriate medicines within their own competencies and must comply with current legislation, professional guidance and workplace policies for prescribing (50). This could include medication to support the management of refeeding syndrome, for example, prescribing replacement of electrolytes such as potassium, magnesium and phosphate, and the prescribing of refeeding medications such as thiamine, vitamin B complex and suitable multivitamins. The role can include management of other vitamin and mineral deficiencies, for example, calcium carbonate, cholecalciferol and ferrous fumarate, and treatment of hypoglycaemia related to EDs. Another important area is to support appropriate prescribing of medications related to gastrointestinal issues often experienced in clients with EDs. These could include laxatives, proton-pump inhibitors and bisacodyl. Nutritional advice is offered alongside the pharmaceuticals (51).

Becoming an NMP allows for more efficient nutritional care for patients, involving both nutrition and pharmacology, and ultimately supports the client to access the assistance needed in a safe, effective and timely manner.

Discussion

Dietitians can actively participate in, and potentially enhance, various therapeutic models and aspects of treatment at every stage, provided they have undertaken adequate training and have both appropriate supervision and adequate hours within the team. There is a potential future role involving dietitian-led treatment interventions and services, including enhanced roles open to dietitians working with people with EDs.

Research carried out by McMaster et al. (17) suggests that patients and carers highly value the input from a dietitian at both the assessment stage and during treatment.

Despite the demonstrable value of dietetic involvement, a scoping review of English ED dietetic services has revealed underfunding for both children and young people and adults (52). This jeopardises the treatment of individuals with EDs and may constrain the clinical and therapeutic roles of the dietitian.

The field of mental health dietetics is evolving rapidly, with well-established models such as that pioneered in Australia (11), which includes ED skills credentialing, leading the way. A recent systematic review (14) supports the concept that the skills of the dietitian extend beyond refeeding, meal planning and provision of nutritional education alone. Dietitians are well placed to be able to combine their expertise in the field of nutrition with psychotherapeutic modalities when working with other members of the MDT.

Future directions for clinical and research work

Identifying outcomes that may be appropriate for dietetic interventions in the context of a multi-professional treatment approach can be problematic. We suggest the need for research in the following areas.

- Supporting nutritional adequacy, specifically exploring the benefit of dietetic involvement on the anxiogenic and iatrogenic effects of restraint feeding.
- A comparison between CBT-E and adapted CBT-E, in which the nutritional content is delivered by dietitians, would strengthen the argument for dietetic inclusion.
- Targeted evaluation of the impact of dietitian involvement in the form of psychoeducative support and tailored refeeding guidance during phase 1 of FT-AN/BN on clinical outcomes, parental refeeding confidence and the nutritional knowledge of the MDT.
- Research exploring the diversity of biopsychosocial characteristics across adult ED populations, for example, the proportion with allergies or religious, cultural or ethical exclusions and the role of the dietetic profession within

MANTRA.

- Development of the role of the dietitian potentially to take the lead professional role of supporting the patient using a SSCM and GSH for the BED framework.
- An evaluation of how outcomes and patient experiences of ARFID treatment and delivery may be influenced by dietitian involvement.
- Enhanced dietetic involvement in NMP might help to increase efficiencies in line with national workforce objectives and provide greater opportunity for evaluation of the patient experience.

Conclusion

Dietitians hold a unique position that enables them to offer nutritional therapy to individuals at every stage of ED recovery. There are emerging and exciting roles for dietitians within the field of ED treatment. The importance of dietitians within the MDT is becoming more widely recognised and consequently there is a broadening scope for the involvement of dietetic practice across services. To harness the potential of dietitians, and to continue to expand the scope of their work, it is important to acknowledge their expertise while providing thorough training, increasing allocation of resources and maintaining consistent supervision.

Declaration of interest

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Glossary

AN: Anorexia nervosa.

ARFID: Avoidant/restrictive food intake disorder. Described for the first time in the Diagnostic and Statistical Manual of Mental Health Disorders Fifth Edition (DSM-5), and the World Health Organization International Classification of Diseases 11th Revision (ICD 11).

BED: Binge eating disorder.

BN: Bulimia nervosa.

CBT-E: Enhanced cognitive behavioural therapy. A psychological treatment and form of cognitive behavioural therapy which uses cognitive and behavioural strategies together with psychoeducation. CBT-E treats all eating disorders and may be used across adolescents and adults in both community and inpatient settings.

ED: Eating disorders.

FBT: Family-based therapy. The leading evidence-based treatment for children and young people struggling with eating disorders, such as AN and BN. Divided into three phases: phase 1 focuses on the rapid restoration of physical health, orchestrated by parents; phase 2 involves gradually giving responsibility regarding eating back to the adolescent, to whatever extent is age-appropriate and normal for a particular family; phase 3 involves a review of adolescent development and evaluation of progress towards a return to normal family life.

FT-AN, FT-BN: Family therapy for AN, family therapy for BN. Adaptations of FBT developed by the Maudsley Hospital.

GSH: Guided self-help. A focused, low-cost, low-intensity, CBT-based treatment for BED that is an example of non-medical prescribing. GSH can be delivered via a workbook or digitally online, supported by a guide who has undertaken training and supervision in line with the University College London psychological competencies framework, as outlined by Health Education England.

MANTRA: Maudsley Model of Anorexia Nervosa Treatment for Adults. A manualised integrative therapy which addresses cognitive, emotional, relational and biological factors which tend to maintain AN and helps people to find alternative and more adaptive ways of coping. MANTRA is one of the three treatment options recommended for adult patients with AN.

MDT: Multidisciplinary team.

NGT: Nasogastric tube.

NMP: Non-medical prescribing. Refers to any prescribing completed by a healthcare professional other than a doctor or dentist.

SP: Supplementary prescribing. Prescription of medicines by non-medical healthcare professionals within an agreed clinical management plan in partnership with an independent prescriber. Dietitians can become supplementary prescribers and are legally permitted to prescribe medicines, including those that are off-label, off-licence or unlicensed, borderline substances, selected list scheme drugs and schedule 2, 3, 4 or 5 controlled drugs.

SSCM: Specialist supportive clinical management. A combination of clinical management and supportive psychotherapy for AN. Initially developed as a placebo treatment for clinical trials of MANTRA.

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