CASE #1

13 year old went from 124.5# to 107.5# in just over 2 months. Parents report more anxiety, depression, anger and mood swings since the weight loss. Physician referred to RD.

Presentation	13 year old referred by pediatrician
Medical Diagnosis	Protein Calorie Malnutrition,
Nutrition diagnosis	Inadequate Energy Intake
Related to	Compulsive exercise, healthy eating
As evidence by	14% weight loss in 2 months; 81% IBW
Impression	Appropriate for family based treatment.
Intervention	Three meals and three snacks with caloric density. Psycho-education regarding symptoms. Parent education on increase caloric needs for weight restoration at 1 to 2 pounds/week. Discontinue all physical activity until medically cleared. Case collaboration and consultation with treatment team. Recommend therapist who utilizes FBT approach.

	DSM Language	Diagnosis given by therapist
Axis I	Clinical presentation	Anorexia Nervosa, r/o GAD OCD
Axis 2	Developmental disorders and personality disorders	Deferred
Axis 3	Physical Conditions	Bradycardia, postural orthostatic hypotension, 17 pound weight loss in 2 months
Axis 4	Severity of Psychosocial Stressors	Moderate – Severe

Nutrition Intervention for AN using family based treatment concepts

Anorexia or malnutrition	Nutrition Intervention	FBT protocol
Meals	Three meals and three snacks	Start with 1900 cals /day. Coach parents on phase I priorities.
Meal plan	Structured meal plan. Provide guidance for portions, but not measuring. Typically, no need for exchange system. Give feedback to increase calories to promote weight restoration.	Empower parents to increase food intake. Suggest caloric density, caloric beverages and liquid nutritional supplements. No discussion about numbers (kcals, grams) to the adolescent.
Schedule	Eat on schedule every 2 to 3 hours. Assist parent with preplanning meals. Helps to write out meal times to follow. Patient will not be able to rely on hunger cues initially.	Blend with normal family routines and suggest support at school. Often adolescent eats lunch with supervision from parents teachers or school counselors.
Snacks	Structure and supervision to avoid skipping snacks or only eating one item like fruit. Include solid food and fluids at every snack.	Snack list provided to parents. Give ideas for calorically adequate snacks. May need school supervision for am snack.
Carbohydrates	Expand carbohydrate choices. May be very rigid or limited. Identify caloric dense foods like granola, breads or snacks.	Empower parents to serve a variety of foods and menus that the family typically ate prior to illness.
Protein	Start with 60 grams/day then use 15% of total calories Encourage variety of foods to meet nutritional needs. Suggest meat 2 times a week.	Discontinue vegetarian eating if this in not something that was there before the ED started.

Anorexia or malnutrition	Nutrition Intervention	FBT protocol
Fats	Typically a fear food. Start with simple ways to increase fat intakes. Suggest trail mix, nuts, nut butters, dressings, avocado and guacamole. Support a variety of added fats like butter, sour cream, cream cheese, spreads and other higher fat recipes. Adolescent needs 25% to 35% of diet.	Coach parents to use oil in cooking and during family meals. Add fat in and on foods appropriately. e.g. butter on roll, dressing on salad. Note: recipes posted on the parent advocate web site use heavy whipping cream in shake recipes to help re-feed.
Fluids	Assess intake of caffeine and discontinue or limit the use of artificial sweeteners. Add in caloric beverages like 100% fruit juice. Assess for over consumption of water that may interfere with appetite.	Parents to pour the liquids or change the cup that the client has been using to monitor intakes.
Desserts/fun foods	Suggest that these items are in the meal plan from the beginning. List out at least three ideas that parents can serve. Provide consistent exposures/food challenges. Set up a plan to gradually incorporate more.	Parents to serve desserts in normal portions after dinner or in lunch menus. Review food dislikes list and ask parents what foods were true dislikes prior to ED.
Fiber	Fiber is moderate, increase grains and decrease the number of high fiber (filling foods). May need to decrease the total amount of veggies to normalize portions.	Have adolescent move away from cooking duties in the kitchen. This will allow the parents to normalize cooking and use methods to increase caloric density.
Calcium	At least 1300 mg/day food first as tolerated. Recommend 4 to 5 calcium or calcium fortified foods daily then supplement Calcium with Vitamin D as needed.	No fat free sugar free diet products. Direct to find yogurt with fat, increase the % fat in milk used.

Anorexia or malnutrition	Nutrition Intervention	FBT protocol
Vitamin and mineral supplement	Daily MVI. Supplement based on labs for zinc, iron and Vitamin D.	Set up regular time for parent to give the vitamins.
Variety	In lieu of the pre existing anxiety* disorder it is important to stress less variety to promote the most consistent weight gain.	Stay the course of weight restoration. Use more variety eventually when in phase II during food exposures.

*I have found that the sooner into treatment parents are able to re-integrate the previously consumed foods that began ED/fear foods the better.

Family based treatment assumptions	Parents	RD
Agnostic view of the illness	Don't waste time on the why?	Do not look for the cause of the illness.
Stance: Non- authoritarian Join with the family	Join with the family do not let them ask you to tell them what to do.	Serves as a consultant, expert in EDs and malnutrition.
Parent are responsible Empowerment	Help families see their strengths and current skills with menu planning, shopping, cooking etc.	Listen, ask, suggest, provide information, support, give positive feed back, use and give examples.
Externalize the illness Separate the child from the illness.	Don't be surprised when there is more conflict surrounding food, menus, eating, etc. No blaming.	Strategies to help embrace food as medicine.
Initial focus on the symptoms	Direct to read book by James Lock and Daniel LaGrange Help your Teenager Beat an Eating Disorder.	RD can take symptom check list**. This serves to help spell out exactly what is happening to the body. Can be the foundation for providing psycho-educational principals that often increase motivation.

** Symptom checklist See DEED member café table.

CASE #2

30 year old woman 5'4" 135 # BMI of 23.1, preoccupation about central weight gain and fluctuations.

Presentation	**30 year old referred by her OBGYN for nutritional management for her PCOS, weight gain.**
Medical Diagnosis	PCOS, hypokalemia
Nutrition diagnosis	Disordered Eating Pattern
Related to	Weight preoccupation, depression
As evidence by	Misuse of laxatives, diet pills, weight fluctuations, overconsumption of energy dense foods
Impression	Need full treatment team to assess and prioritize treatment for purging, and substance use.
Intervention	Normalized eating patterns. Increase protein intake to 20% of diet. D/C Laxatives and diet pills in coordination with treatment team. Increase fiber, fluids and consult MD for bowel support. Eventually address macronutrient distribution best for PCOS diagnosis. Case consultation.

	DSM Language	**Therapist Diagnosis**
Axis I	Clinical presentation	BN, Bipolar I, AUD, PSUD (alcohol, laxatives, diet pills)
Axis 2	Developmental disorders and personality disorders	r/o Borderline personality disorder
Axis 3	Physical Conditions	Hypokalemia, PCOS
Axis 4	Severity of Psychosocial Stressors	Lost another job, limited financial backing.

Nutrition Intervention for Case 2

ED type: Bulimia Laxative use purging	Nutrition Intervention
Meals	3 balanced meals may start with small portions and build up to normal portions.
Meal Plan	Structured meal plan to break chaotic eating
Schedule	Spread meals/snacks out to be calorically equal eaten no more than 4 hours apart
Snacks	Preplan snacks. Look for start and stop options. May avoid snacks during vulnerable times - at night.
Carbohydrate	Include in every meal. Use whole grains higher fiber and include some trigger foods as experiments.
Protein	Typically higher in protein 20% of calories. Include protein at every meal.
Dietary Fat	Meals and snacks must support satiety and satisfaction. List out added fats at every meal to use. Olive oil, salad dressing, nuts, seeds, avocado. Suggest foods high in omega three.
Fluids	Increased water needs (8 to 12 cups/day) is needed with Lithium. Increase fluids to help treat constipation that often occurs with decrease or d/c of vomiting and laxative use.
Fun/Desserts	Experiment with “safe treats” in base meal plan or do experiments.
Fiber/ Bowel support	High fiber diet, flax seed, whole grains, beans, F/V, May require Miralax and consult with physician. Often will require more than Miralax.
Supplements	One a day MVI, Omega three fatty acids, Vitamin D, Calcium 1000 mg/day food first.
Weight gain	Typically will see a 5# gain initially as vomiting decreases. Weight typically normalizes at or above normal weight.
Food records	Request self-monitoring of food, thoughts and feelings. Therapist may ask for alcohol, laxative, purging. Suggest Recovery record App or paper record keeping.