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Feature Article

Eating Disorder Counseling in the Hemodialysis Population: A Perspective Summary

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Introduction

What are you afraid of? Maybe snakes, or like me, spiders, or maybe like my five year-old daughter, monsters in the closet or under the bed. Whatever that fear is, however irrational or rational it may be, it is real to you. Fear can cause panic-like symptoms, rapid or irregular heart rate, chest pain, difficulty breathing, dizziness and/or vertigo. Try to close your eyes and imagine facing your fear. You may feel all of those symptoms and as a response want to run away. Without tapping into that kind of fear, it is very difficult to understand and treat a person with an eating disorder (ED). ED patients may deal with an intense fear of gaining weight along with attachment and dependency issues. They can often become overwhelmed by emotions such as rejection, guilt and shame (1).

On the other side of the coin, how do you handle stress, good or bad? When life doesn't happen the way we plan, outlets are needed for disappointments or stresses. Charles R. Swindoll wrote, "Life is 10% what happens to you and 90% how you react to it." While some pound emotions out with exercise or talk with friends, loved ones, or therapists, others choose the less beneficial route of alcohol, drugs and other legal but addictive substances. If you are unable to understand that side of the coin, whether it is from experience or empathetic experience, it is very difficult to understand and treat a person with an ED.

One of the disheartening manifestations and what sets an ED apart from other addictions is the moral view of accomplishment attached by the ED patient to achieving control over their body (2). Another difference that sets an ED apart from typical addictive behavior is that one can live without an addictive substance, but one cannot live without food.

Eating disorders are rare conditions in chronic renal failure. It has been estimated that only 0.8 cases per million occur, resulting in approximately 220 cases at any one time (3,4). Several case studies have been published on ED in end stage renal disease (ESRD) (5,6). It has been postulated that diet and fluid restrictions

necessary for osteodystrophy management and healthy nutritional outcomes may potentially trigger ED in susceptible individuals (5). In caring for ESRD patients that present with low body weight and vomiting, organic causes must be ruled out. If no organic diagnosis is found, ED must be considered. In addition, patients with a history of an ED may present with ESRD secondary to the ED when no other reason for renal disease can be found. In the cases that have been documented, chronic hypokalemia was the prevalent link between ED and ESRD (7). Other potential causes may be chronic dehydration and a chronic low protein intake, causing a decrease in glomerular filtration rate (4).

The American Dietetic Association position on the nutrition intervention in the treatment of ED stipulates that the registered dietitian (RD) is integral in providing medical nutrition therapy as part of the interdisciplinary team, possibly consisting of a therapist, psychiatrist and primary care physician (8). The RD's role is to assess nutrition status, provide nutritional counseling, formulate dietary recommendations, and communicate with the interdisciplinary team. It is imperative that a person with or suspected of an ED be seen by a therapist, preferably one that has experience with ED patients. It is also key that the RD understands the boundaries and roles that each team member provides. Dietitians should help provide a collaborative approach with the patient and interdisciplinary team.

ED patients present with a wide array of common clinical features, which includes low motivation to change behaviors, denial of illness, perfectionism, inflexibility, mood intolerance, and core low self-esteem (9,10). ED patients are typically very untrusting, possibly due to intrusive, controlling or abusive past relationships, yet they have a strong inclination to seek approval (1,11). Dietitians are often viewed as an enemy or intruder. You may be greeted with severe hostility, anger, and hopelessness during consultations (1). The first step in successful treatment of an ED is when the individual admits that their behavior is a problem.

Nutritional Assessment

Nutritional assessment for an ED individual may be somewhat different from what you currently are utilizing as an assessment tool with renal patients. Attachment 1 is helpful in identifying specific areas for assessment when working with ED patients. The necessity of weighing a dialysis patient before and after treatment presents some difficulty amongst ED patients. Discussing the the weighing of a patient backwards with your interdisciplinary team, so that their weight cannot be seen, is one option. This may be necessary to cultivate adherence with the goal of edema-free weight restoration and to assist in the prevention of stress and triggers for the patient associated with weight changes. This method of weighing may also prevent purposeful fluid overload to misrepresent edema-free weight restoration.

Being knowledgeable about psychopharmacological medications utilized in the treatment of psychiatric disorders that additionally plague some ED patients is necessary. It is important to understand how dialysis may or may not affect the uptake of these medications. Many of the antidepressant medication interventions are ineffective in a starvation state due to the central nervous system depletion of serotonin, making substrate availability reuptake impossible (1). Other medications are highly protein bound and many ED patients are severely protein malnourished, making the medication useless.

Nutrition Goals

Nutritional goals include, but are certainly not limited to: normalizing eating patterns, restoration of weight and satiety signals, and assisting in the change of detrimental compensatory behaviors such as calorie counting, eating rituals, purging by vomiting, laxatives, diuretics, weight loss medications and supplements, amphetamines and/or strenuous exercise (12). The primary goal of promoting a healthy lifestyle must always be in focus and remain consistent. By assessing an ED patient and through communications with their therapist, you will find how to individualize the treatment plan. For instance, some ED patients that suffer with obsessive-compulsive disorder would not benefit from knowing ideal body weight ranges and quantitative caloric needs. A successful approach would be to look at oral intake. If intake is sub-optimal, counseling techniques should be focused on how and where to add foods that are considered "safe" but necessary, and cause the least amount of stress to the patient. The intent is that as therapy progresses less "safe" foods may be added or eating at regular intervals may be suggested. Some patients utilize alarms to assist in this behavior change. Others slowly add variety or eat a sufficient serving size. Engaging in social situations that include food and people may also be helpful. For others, moving away from regimented behaviors such as grocery shopping, food preparation and consumption is beneficial. One behavioral change at a time is encouraged, allowing the patient to make the decision on which behavior to focus. The end result will be a more normal and healthy relationship with food. As treatment progresses, constant reassurance may be necessary to quell the intense fear of gaining weight by reminding the patient that the focus is their health.

Nutrition Counseling

Nutritional counseling may include education about false beliefs regarding food and supplements. It may also include

Attachment 1

Nutrition Assessment Considerations for ED Patients

Name: _____ Age: _____ Ht: _____ Wt: _____

Therapist:_____ Physician:_____ Psychiatrist:_____
Name: _____
Address: _____
Phone: _____

Have you ever worked with a dietitian/nutritionist? No _____ If Yes, whom _____
Current medications: _____
Vitamin/mineral/herbal supplements: _____
How often do you weigh yourself? _____
Are you on birth control pills? Yes _____ No _____
Approximate date of last menstrual cycle? _____
Has your cycle ever ceased? Yes _____ at what weight _____ No _____
Do you experience problems with:

a) Constipation? No _____ Yes_____ Describe: _____
b) Diarrhea? No _____ Yes _____ Describe: _____
c) Nausea? No _____ Yes _____ Describe: _____
d) Feeling Bloated? No _____ Yes _____ Describe: _____

Circle any of the following that describes your eating patterns:

a) Eat 3 meals each day
b) Eat a 'normal' amount of food
c) Eat 3 meals with snacks
d) Restrict intake of food
e) Binge without purging
f) Binge followed by vomiting
g) Binge followed by restriction
h) Binge followed by laxatives
i) Binge followed by diuretics
j) Binge followed by exercise
k) Vomit without binging
l) Use laxatives
m) Use diuretics
n) Exercise excessively

Current Exercise Program: _____
_____

Past History with Exercise: _____
_____

Eating Pattern History: _____
_____
_____
_____
_____

24-Hour Recall: _____
_____
_____

Purging

Vomiting	How _____	How often _____	Use Ipecac Yes ____ No ___
Laxatives	Type _____	How many _____	How often _____
Enemas	Type _____	How many _____	How often _____
Diet pills	Type _____	How many _____	How often _____
Diuretics	Type _____	How many _____	How often _____
Amphetamines	Type _____	How many _____	How often _____

Fluid intake: _____ Alcohol intake: _____ Caffeine: _____
Chew Gum: _____ Smoke: _____ Food allergies: _____

Food Intolerances: _____

Eating Out: _____
Additional Information: _____
_____
_____

Profession: _____ Place of Employment: _____

Marital Status: Single _____ Married _____ Divorced _____Partnered _____

Children/Siblings: No _____ Yes _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____ Name _____ Age _____

Living situation: _____

Who knows about current eating patterns: _____

Any members of family with eating disorders: _____
Any members of family alcohol/drug abusers: _____

Plan:

Recovery Weight Range: _____
Recovery Kcal Needs:
Women: 655.1 + (9.6 x wt) + (1.8 x ht) – (4.7 x age) = BEE x 1.3
Men: 66.5 + (13.8 x wt) + (5 x ht) – (4.7 x age) = BEE x 1.3
Weight in kilograms, Height in centimeters
_____
_____
_____

Notes: _____
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Sent Referral Report Form: _____ Date: _____
Spoke with referral source: _____ Date: _____

explaining differences between preferences versus elimination of foods or groups of foods based on false information for weight control and health. Counseling should include genuine care, support and the fostering of a trusting relationship that promotes dietary adherence. Enhancing motivation to change is key in effectively treating ED patients (13). Motivating an individual to change may require discussing the perceived benefits and actual detriments of continuing the unhealthy behavior. Promoting the potential beneficial outcomes of changing to a healthier behavior should also be included.

Counseling techniques derived from supportive therapy include: support, acceptance and affection toward the patient or client, emphasizing collaboration rather than lecturing, communicating a hopeful attitude that goals can be achieved, recognizing a patient's defenses and respecting their boundaries, focusing on a patient's strengths, and acknowledging and rewarding accomplishments (2). Supportive therapy utilizes conversational style with active listening; recognizing verbal and nonverbal cues, open questioning, reflection, praise, reassurance, advice, and self-disclosure on a session-by-session basis (2). This means not having a planned agenda before the session. You must have a willingness to be non-judgmental, compassionate, accepting and open to discussing any topic, but focus direction on nutritional parameters (1,14). It is important to remember not to entertain bargaining or pressure to change.

Motivational interviewing (MI) is a technique that was born from the trans-theoretical model for alcohol-dependence treatment. It is defined as "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (12). MI has since been found to be an effective intervention technique across a wide range of health-related behaviors (12). Utilizing this technique requires continual attention to the patient's motivation (12). As is true with supportive therapy techniques and cognitive behavioral techniques, collaboration is a core component (12). The guiding principles of MI include expressing empathy and acceptance, showing discrepancy between unhealthy and healthy behaviors by eliciting the patient's own reasons for beneficial change, not opposing resistance but seeing resistance as an opportunity to approach in a different way, and support of self-efficacy (12).

There remain a number of barriers to ED treatment including the clinical manifestations of the disease itself, the high cost of treatment, and the complex medical and psychological dual diagnoses such as depression, anxiety disorders, substance abuse (which can also affect appetite and weight), and personality disorders (1,10). For example, starvation symptoms present clinically very similarly to depressive symptoms (1). In-center hemodialysis patients present communication difficulties for the RD due to the lack of privacy. It may be beneficial to meet with these individuals privately before or after treatment to foster a more trusting and open relationship.

Conclusion

As health professionals it is imperative that we do no harm, ensure safety, and provide timely and accurate nutritional information, care, and support to our patients. Discussions with patients should be two-way because patients are all individuals, and the goal may be different from our view based on individual morals and values. A recommendation for one person is not going to be applicable to everyone. It is critical to have an open mind to alternative understandings of situations (14). Education should not be limited to verbal modalities. Provision of written materials may assist an individual and their loved ones who process information differently. There is a lack of consensus clinically on the best modality of treatment (10), however, I hope that this article has provided some insight and helpful suggestions if an ED patient presents for nutritional intervention. In addition to ED patients, the aforementioned counseling techniques are likely to be beneficial with renal patients. We must understand as clinicians that ED is not a self-imposed disorder (10). Treatment adherence is only effective if a person is intrinsically motivated to change (11). If all else fails, you must be resigned to provide honest genuineness and focus on quality of life (1). ◆

References

1. Kaplan AS, Garfinkel PE. Difficulties in treating patients with eating disorders: A review of patient and clinician variables. *Can J Psychiat.* 1999;44(7):665-670.
2. McIntosh VV, Jordan J, Luty SE, et al. Specialist supportive clinical management for anorexia nervosa. *Int J Eat Disord.* 2006;39(8):625-632.
3. Fombonne E. Anorexia Nervosa. No evidence of an increase. *Br J Psychiat.* 1995;166:462-471.
4. Woodside DB, Colton P, Staab R, et al. Weight restoration in a patient with Anorexia Nervosa on Dialysis. *Int J Eat Disord.* 2005;38:380-382.
5. Desai AM, Perrone R, Dwyer J. Eating disorder in a hemodialysis patient: case report. *Nutr Rev.* 2005;63:423-426.
6. Fukunishi I, Kitaoka T, Shirai T, Watanabe S. Two male patients with bulimia nervosa having onset during hemodialysis therapy. *Psychosomatics*. 1997;38(5):511-512.
7. Abdel-Rahman EM, Moorthy AV. End-stage renal disease (ESRD) in patients with eating disorders. *Clin Nephrol*. 1997;47(2):106-111.

8. American Dietetic Association. Position of the American Dietetic Association: Nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders. *J Am Diet Assoc.* 2006;106(12):2073-2082.
9. Casasnovas C, Fernandez-Aranda F, Granero R, et al. Motivation to change in eating disorders: Clinical and therapeutic implications. *Eur Eat Disord Rev*. 2007;15(6):449-456.
10. Agras WS, Brandt HA, Bulik CM, et al. Report of the National Institutes of Health workshop on overcoming barriers to treatment research in anorexia nervosa. *Int J Eat Disord*. 2004;35(4):509-521.
11. Vansteenkiste M, Soenens B, Vandereycken W. Motivation to change in eating disorder patients: A conceptual clarification on the basis of self-determination theory. *Int J Eat Disord*. 2005;37(3):207-219.
12. American College of Sports Medicine. Position stand. The recommended quantity and quality of exercise for developing and maintaining cardiorespiratory and muscular fitness, and flexibility in healthy adults. *Med Sci Sports Exerc*. 1998;30(6):975-991.
13. Wilson GT, Schlam TR. The transtheoretical model and motivational interviewing in the treatment of eating and weight disorders. *Clinical Psychology Review*. 2004;24(3):361-378.
14. Dewald PA. Principles of supportive psychotherapy. *Am J Psychother*. 1994;48(4):505.