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Beginning to Identify Trends among Dietitians Treating Eating Disorders: When Do You Make Referrals to Mental Health Care?

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INTRODUCTION

Registered Dietitians (RDs) apply their training in Medical Nutrition Therapy (MNT) together with their continuing education to provide nutrition counseling to patients. The Nutrition Care Process (NCP) provides structure for nutrition counseling, one facet of which is referrals to providers of other disciplines of care when a patient's needs fall outside of the RD Scope of Practice.[1,2]

Although RDs in any practice area may make a referral to mental health care (MHC), RDs with expertise in Eating Disorders (EDs) may be particularly aware of the frequently co-occurring psychiatric issues (anxiety, depression, addiction, obsessive-compulsive symptoms, post-traumatic stress and others) that can prevent or interfere with nutrition counseling and nutritional restoration.[3-7] While proper nutrition is essential for ED recovery, nutrition counseling alone will not repair the psychiatric and emotional components of EDs.[3,5-7] Concurrently, acute and chronic malnutrition exacerbate brain dysfunction and psychiatric symptoms, strengthening irrational thinking and maladaptive eating behaviors that maintain the ED cycle. Appropriate treatment of co-occurring disorders is necessary for stabilization and movement toward recovery.

In cases where the RD is the first professional to identify the symptoms of psychiatric or emotional distress, the RD may be responsible for making the referral to MHC, either directly or in consultation with the primary care professional.[8] No standard guidelines have been published regarding when, how, or under what circumstances an RD can or should make referrals to MHC, leaving the RD to rely on consultation with colleagues and/or his or her own clinical judgment. Experienced RDs have honed their expertise over time. Newer or less experienced RDs would likely benefit from at least general guidelines for triggers that indicate the need for such a referral.

Because of their special expertise in the mental health arena, ED RDs were selected as a population sample for this survey of referral practices. If trends can be identified in the clinical practice of experienced practitioners, they may provide a first step toward future development of profession-wide guidelines.[9]

METHODS

A 19-question survey about referral practices of RDs treating EDs was developed by the investigators based on published literature and clinical experience.[3-7] One hundred members of the International Federation of Eating Disorder Dietitians (IFEDD) who reside and practice in the United States were invited to anonymously

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complete the survey through a link to SurveyMonkey provided via email. The survey link was open for 5 months and closed once 40 responses were received. Participation in the survey was voluntary with no monetary compensation offered or provided.

Of the 19 questions, 15 allowed one response to multiple choices, three allowed multiple responses to multiple choices, and one question was open-ended with unlimited response length. Responses of quantitative data were compiled electronically into charts using the SurveyMonkey software. Open-ended responses were reviewed by hand, using qualitative methodology to identify trends.

To ensure that participants were in fact experienced in their area of practice, demographic questions requested respondent age, length of time as a dietitian, length of time treating individuals with EDs, professional credentials, work experience, and continuing education. Other questions surveyed familiarity with the RD Scope of Practice, preference for multidisciplinary team treatment of ED, and how the RD proceeds once a patient does not follow through on a mental health referral. The primary objective for the survey was to identify what triggers an experienced ED RD to refer a patient to MHC. This was assessed by the question, "How do you decide to make the recommendation that a patient meet with a mental health professional? (check all that apply)." Participants could select any or none of the 33 possible responses, and were offered an opportunity to add an unlimited number of additional reasons for referral. The response options were developed from published literature. Since the diagnosis of an ED is considered by many to be in itself a trigger for a mental health referral, individual signs included in the diagnostic criteria for ED, such as bingeing, purging and restrictive eating, were not included as potential responses in order to study the additional triggers for mental health care rather than the eating disorder itself.

RESULTS

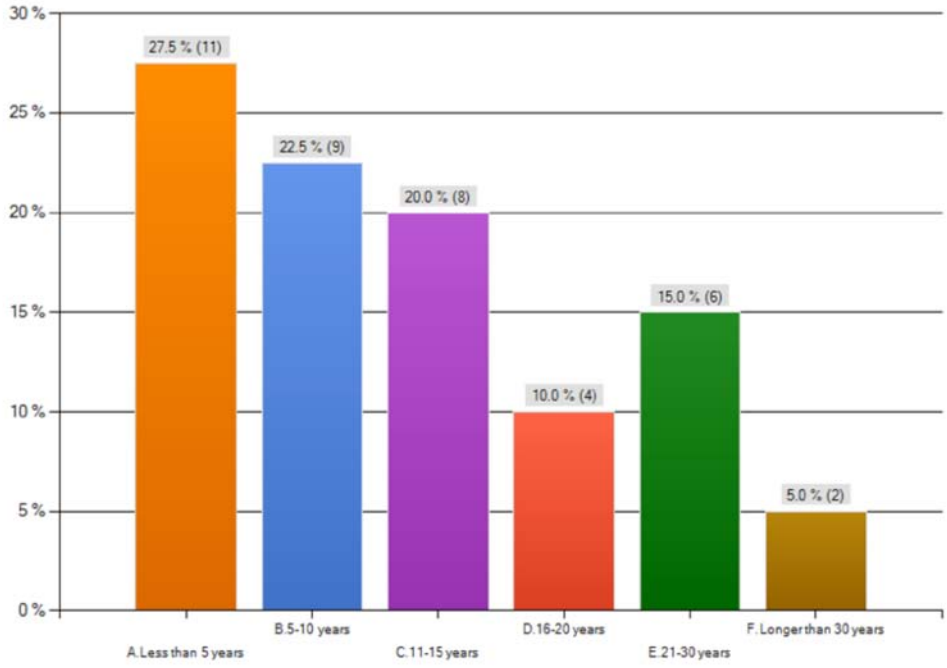
Participant Demographics

One hundred percent (n=40) of participants were female RDs 25 years of age or older living in the U.S. and working with individuals with eating disorders. The majority (62.2%) of RD participants practice in a private or community outpatient setting. Participants were asked separately about their years in practice specifically with individuals with EDs. Responses demonstrated a wide range of longevity in the field, shown in Figure 1, below.

The majority of participants reported continuing education in ED (97.3%), continuing education in counseling (79.5%), and continuing education

Figure 1

How many years have you been working with individuals with eating disorders?



in mental illness (56.4%). Over half (53.8%) of the RDs report holding an advanced degree in nutrition (MS or PhD) and 10.3% report holding a counseling license. Of the surveyed participants, 46.2% teach classes about EDs to students, and 35.9% teach continuing education about EDs.

Mental Health Referral

Of 40 participants, 37 (92.5%) responded to the primary objective question, regarding 33 symptoms that might trigger a MHC referral. An affirmative response to a symptom signified that it would trigger a MHC referral. Of those who responded, 100% responded affirmatively to "Patient reports being depressed" (100%). This was the only option that received a 100% affirmative response.

Other symptoms received between 37.8% and 97.3% affirmative response. Those symptoms receiving over 90% affirmative response were: "Patient reports cutting themselves or using self-mutilation" (97.3%), "Patient exhibits signs of other mental illnesses such as Obsessive Compulsive Disorder, Post Traumatic Stress Disorder and Panic Disorder" (94.6%), "Patient reports abusing drugs or alcohol" (91.9%) and "Patient reports extreme mood swings" (91.9%).

Those symptoms receiving less than a 45% responses were: "Patient looks frail at the first appointment" (40.5%), "Patient reports family history of eating disorders" (37.8%), "Patient reports not feeling physically attractive" (43.2%) and "Patient is secretive about their disease" (43.2%).

Affirmative responses to all 33 provided symptoms are summarized in Table 1, below (n=37).

Table 1

Responses to "How do you decide to make the recommendations that a patient meet with a mental health professional? (Check all that apply)"

Response	Affirmative Percent	Affirmative Count
Mental Illness		
Patient reports being depressed	100.0%	37
Patient exhibits signs of other mental illnesses such as Obsessive Compulsive Disorder, Post Traumatic Stress Disorder and Panic Disorder	94.6%	35
Patient reports extreme mood swings	91.9%	34
Self-harm		
Patient reports cutting themselves or using self-mutilation	97.3%	36
Patient reports abusing drugs or alcohol	91.9%	34
Patient reports history of suicide attempts	83.8%	31
Abuse from Others		
Patient reports history of sexual abuse	86.5%	32
Patient reports history of physical abuse	83.8%	31
Patient reports verbal abuse	83.8%	31
Poor Self-Esteem		
Patient reports having little or no self-confidence, and critiques oneself repeatedly	83.8%	31
Patient believes they will never get better	81.1%	30
Patient reports not feeling worthy of being loved	78.4%	29
Patient reports not feeling beautiful on the inside	56.8%	21
Patient reports they do not excel at anything	75.7%	28
Patient reports not being physically attractive	43.2%	16
Poor Progress during MNT		
Patient only focuses on body image	75.7%	28
Patient never talks about food, and digresses to other topics	78.4%	29
Patient continues to lose a significant amount of weight	78.4%	29
Patient is silent or extremely quiet at two or more appointments.	70.3%	26
Have counseled the patient five or more times, and have not have noticed any changes	62.2%	23
Patient is in denial about having an eating disorder	78.4%	29
Patient is secretive about their disease	43.2%	16
Patient looks frail at the first appointment	40.5%	15
Difficulty with Friends and Family		
Patient reports having arguments with co-workers/friends/family	67.6%	25
Patient reports being stressed with home life	62.2%	23
Patient reports being stressed with school/work	56.8%	21
Patient reports they want to feel more accepted by friends and family	54.1%	20
Patient reports feeling unappreciated	54.1%	20
Patient reports they want to feel more accepted by friends and family	45.9%	17
Patient reports feeling alone and scared	78.4%	29
Patient reports alienating themselves from friends and family	75.7%	28
Patient reports having marital issues	86.5%	32
Patient reports family history of eating disorders	37.8%	14

When sorted by length of time as an RD, responses were consistent throughout all groups. Additionally, 19 participants took the opportunity to report additional referral triggers in open-ended format in response to the prompt: "Please list any other signs or criteria that impact your decision to recommend a patient meet with a mental health professional." Write-in responses included (listed from those given by multiple respondents to those given by only one respondent):

- "All clients with an eating disorder" or similar (6 responses)
- "They are binging [sic], compulsively eating, purging, restricting" or similar (2 responses)
- "Conflict with family member/ family involvement" or similar (2 responses)
- "If there is lack of progress in our work" or similar (2 responses)
- "The level of care needed for their issues is beyond advanced nutrition counseling and requires a skilled mental health professional" or similar (2 responses)
- "Need for medication management/psychiatrist" (1 response)
- "If a patient is very "particular" about how they eat as in that they only eat organic/natural foods or are very picky to the point where there is apprehension around eating other foods." (1 response)
- "Requirement of the clinic" (1 response)
- "Recovered from ED, seeking healthy living support, History of dieting, no ED dx" (1 response)
- "Other risk factors --medical, prior or ongoing hx/saga of the ED, compulsive exercise" (1 response)

DISCUSSION

In the process of providing nutrition counseling, RDs often become privy to information outside the purview of MNT. Therefore RDs in all areas of practice will benefit from guidelines for making a MHC referral and improving their comfort level with making referrals. Due to the overlap of nutrition with psychiatric and psychological issues among ED patients, it is of even greater importance that RDs specializing in the ED field expand their knowledge of mental health issues as well as their network of mental health professional to whom they can refer.

As a pilot study, this project has several limitations. The intentional omission of common ED behaviors (binge eating, purging, compulsive exercise, etc.) as potential triggers may have unintentionally confused respondents, as evidenced by some open-ended responses. There is no way to measure the influence of "clinical impression" or "professional judgment" on responses, nor to validate that what respondents report is in fact what they practice. This study did not allow respondents to identify symptoms that would not trigger a MHC referral independently but that together with one or more other symptoms would combine to trigger a referral.

Interestingly, data compiled in this study indicated "Patient reports family history of eating disorder" is a low-level trigger for an RD to recommend MHC. Since a genetic correlation in the development of an ED has been documented,[1] this outcome raises the question of whether patients who report a family history of ED but do not exhibit other MHC-worthy qualifications should nevertheless be referred to MHC. Next steps could include surveying mental health professionals to see if they would identify the same referral triggers as the RDs and if they could contribute additional triggers for RDs to consider; identifying clusters of symptoms that trigger a referral only when reported in tandem; and designing a study that allows respondents to rate the urgency of a MHC referral for different symptoms.

CONCLUSION

Based on this survey of the professional practice of experienced ED RDs, a MHC referral is most often triggered by reports or signs of:

- Depression
- Self-harm
- Other mental illness
- Substance abuse
- Extreme mood swings

Many other symptoms may also warrant MHC, whether independently or in conjunction with other symptoms. The competent RD will continue to use a combination of clinical judgment and consultation with colleagues until standard guidelines for MHC referral are available.

Research DPG: CPE Article

Dietitians Referring to Mental Health Professionals

Question writer: Caroline Sullivan, MS, RD, CSSD, LD

1.) What co-morbid conditions may interfere with nutrition restoration in a patient with eating disorders?
- A. Addiction
- B. Depression
- C. Anxiety
- D. All of the above

2.) What type of guidelines would be helpful for new dietitians treating eating disorders?
- A. Medical nutrition therapy
- B. Mental health referral
- C. Standard refeeding process
- D. Weight gain protocol

3.) What was the main objective of the current study?
- A. Determine the experience level of eating disorder dietitians.
- B. Understand from where dietitians receive referrals.
- C. Observe the treatment practices of eating disorder dietitians.
- D. Investigate what triggers dietitians to refer to therapists.

4.) What was a strength of the polled population?
- A. Both genders were represented
- B. Length of experience in the field
- C. Diagnostic criteria knowledge
- D. Percentage with counseling licenses

5.) Dietitians appear to always refer to mental health professionals for which symptom?
- A. Obsessive calorie counting
- B. Negative body image
- C. Regular use of drugs
- D. Reports of depression

6.) Identify a weakness of the present study?
- A. The survey identified too many eating disorder symptoms.
- B. Study population did not exhibit sufficient experience.
- C. Data investigated impressions not objective symptoms.
- D. Typical eating disorder behavior was not investigated.

7.) What influence should further studies investigate?
- A. Impact of professional experience
- B. Multiple symptoms to trigger referral
- C. Frequency of referrals to therapists
- D. Mental health professionals' credentials

8.) What was the most frequent write-in response given?
- A. Long history of an eating disorder
- B. Medication recommended
- C. All patients given referrals
- D. Lack of resources to make referrals

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