The Eating Disorder Healthy Eating Guide
About the Authors

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St Ann’s Hospital London 1997 -1999

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Professor Marie Bashir Centre
Terminology

Abbreviations

- ED = Eating Disorder
- AN = Anorexia Nervosa
- EDHE = The Eating Disorder Healthy Eating Pyramid
- CBT = Cognitive Behavioural Therapy

Subjects

- Preferred “Individuals with eating disorders”
- Shortened to Patients & Clients
SUMMARY

NUTRITION & EATING DISORDERS
EATING
in eating disorders

COOKING
Cooking without anxiety, for self & others

EATING OUT
Eat what others are eating; enjoy the occasion

WEIGHT
Allow fluctuations in weight, think about it a bit but not all the time

BALANCED NUTRITION
Meet nutrition requirements, No "exclusions"

ETIQUETTE
Not cutting food into tiny pieces, heating it many times

BALANCED THINKING
Not having lots of rules or not eating food if don't know what's in it

ENJOYMENT
Enjoying food because it tastes good without feeling guilty

BEHAVIOURS
Not having to exercise, vomit, take laxatives after eating
What does the literature say about dietetic practice?

1. Provide accurate nutritional information *i.e.* Calcium, iron requirements

2. Psycho-education *i.e.* effects of starvation, weight fluctuations, gut function, metabolism, dental health

3. Goal setting

4. Self monitoring *i.e.* Food & feelings diaries

5. Advice on *normal* eating patterns and behaviour *i.e.* Using appropriate utensils

6. Meal planning

7. Behavioural strategies *i.e.* Use portion controlled food

8. Participating in practical eating activities *i.e.* eating in a food court

9. Appetite regulation *i.e.* Increased confidence for recognising hunger; less fear of fullness
FOOD THINGS I WILL WORK ON THIS WEEK ……

i.e. eating a certain food, eating “X” cereal for breakfast

<table>
<thead>
<tr>
<th>GOAL 1:</th>
</tr>
</thead>
</table>

1a. What will help?

1b. What is a barrier?

1c. What resources do I need?

<table>
<thead>
<tr>
<th>3 things I achieved this week</th>
<th>3 things that WERE helpful for me in achieving my goals</th>
<th>3 things that WERE NOT helpful for me in achieving my goals</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
Technology enabled best practice for eating disorder treatment

<table>
<thead>
<tr>
<th>Time</th>
<th>Meal</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00 PM</td>
<td>Lunch: Under meal plan</td>
<td>Tuna / lettuce / avocado sandwich + water + coffee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No thoughts</td>
</tr>
<tr>
<td>10:30 AM</td>
<td>Morning tea: Met meal plan</td>
<td>Apple &amp; 1 / 4 cup almonds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have had to alter plans for today and I'm slightly put off by it. So many things my head is inspired to do but I cannot motivate or drive myself to do them.</td>
</tr>
<tr>
<td>7:00 AM</td>
<td>Breakfast: Under meal plan</td>
<td>2 Kiwi fruit / 3 weetbix / 1 glass milk / water</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No toast again. Perhaps I need to work on other urges and behaviours before I can deal with restricting and keeping to meal plan.</td>
</tr>
</tbody>
</table>

From July 2016, only using App based self-monitoring
RESEARCH PAPER

Nutrition and dietetic practice in eating disorder management

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†Department of Obstetrics and Gynaecology, University of Sydney, New South Wales, Australia
‡Department of Psychological Medicine, University of Sydney, New South Wales, Australia

Keywords
dietitian, eating disorder, normal eating, nutrition, refeeding, weight.

Abstract
Background: This review examines the current literature that is available on nutrition and dietetic practice in the treatment of eating disorders. Evidence-based guidelines on nutrition and dietetic practice in the management of eating disorder patients are lacking. Existing recommendations into Methods: A search of database eating disorders being reviewed to dietetic practice. Core dietary assessment, were not inclu

ORIGINAL RESEARCH

Eating disorder management in hospital patients: Current practice among dietitians in Australia

Susan HART, 1 2 Suzanne ABRAHAM, 1 2 Georgina LUSCOMBE 1 2 and Janice RUSSELL 2 3

1Department of Obstetrics and Gynaecology, Royal North Shore Hospital, 2The Northside Clinic, and 3Department of Psychological Medicine, University of Sydney, Sydney, New South Wales, Australia

Abstract
Aim: To examine dietetic practice during the management of eating disorders in inpatient and daypatient settings.
Methods: A survey was sent to dietitians working in the clinical management of eating disorders within Australia. Thirty-six qualified dietitians including all dietitians working at the specialist units in Australia participated in the study.
Results: Most dietitians aim to meet patients’ nutritional requirements by food alone without artificial feeding. High-energy supplements are the preferred method of increasing energy intake to eating disorder patients. Nasogastric feeding was a standard feeding practice for anorexia nervosa reported by one-third of dietitians. Total parental nutrition was not considered an option for nutritional rehabilitation. In the treatment of anorexia nervosa, variable energy intakes for individual patients were prescribed aiming for weight gain of up to 1.0 kg/week in inpatients and 0.5 kg/week in outpatients.
Conclusion: In Australia, there is no standard nutritional management for anorexia and bulimia nervosa. This survey establishes a baseline for nutritional management and practice of dietitians working with patients with eating disorders. Further research is needed regarding use of nasogastric feeding, and weight gain targets in anorexia nervosa.

Key words: dietitian, eating disorders, nutrition, rehabilitation, survey
Problems with a lack of published information on nutrition education

1. Nutrition intervention is delivered poorly

2. Nutrition intervention is not delivered at all

3. Nutrition intervention is delivered by non-dietitian clinicians

   “How hard can it be...everyone knows what normal eating is?”

   Personal communication
   Unnamed specialist eating disorder clinician
   International eating disorder conference

4. There is limited or poor research
   ◦ Conclusions made about the effectiveness of nutrition intervention are incorrect.
1. Potential for confusion?

- Lack of consistency of practice
  - Between dietitians?
  - Different treatment facilities?
  - Dietitians in same facility

- Leads to splitting i.e. in teams, between clinicians working with same patient
  - A defence mechanism in ED, commonly evident
  - Idealise one team member vs devalue the other
  - Leads to conflict between clinicians (if not managed)

- Limited guidance for less experienced clinician
Problems with a lack of published information on nutrition education

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2. Nutrition intervention is not delivered at all
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   “How hard can it be...everyone knows what normal eating is?”
   Personal communication
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4. There is limited or poor research
   ◦ Conclusions made about the effectiveness of nutrition intervention are incorrect.
Nutrition intervention is core intervention in the management of individuals with ED

DAA
American Dietetic Association
American Psychological Association
Academy of Eating Disorders (US based)
NICE Guidelines (UK)
ANZAED - Australia & New Zealand Academy of Eating Disorders
Royal Australian and New Zealand College of Psychiatrists
Problems with a lack of published information on nutrition education

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   • Conclusions made about the effectiveness of nutrition intervention are incorrect.
Nutrition Components in other Interventions

- **Common sense advice**
  - Establishing regular eating “*when you eat not what you eat*”
  - “*adopt a varied diet with the minimum number of avoided foods*”
  - Do not skip any meals
  - Use average sized portions of food determined from the eating habits of friends and relatives

- **Planning**
  - Always know when you are going to eat next
Specialist supportive clinical management (SSCM) McIntosh et al 2006

- Outpatient treatment, AN
- Emphasises the generic role of health professionals
- Manual developed for intervention
  - Limited or no referencing of the intervention
  - Resumption of normal eating and the restoration of weight
  - Education on “good nutrition & individual nutritional needs”
- “These strategies ....to be regarded as CBT techniques”
Problems with a lack of published information on nutrition education

1. Nutrition intervention is delivered poorly
2. Nutrition intervention is not delivered at all
3. Nutrition intervention is delivered by non-dietitian clinicians

“How hard can it be...everyone knows what normal eating is?”
Personal communication
Unnamed specialist eating disorder clinician
International eating disorder conference

4. There is limited or poor research
   ◦ Conclusions made about the effectiveness of nutrition intervention are incorrect.
4. Problematic research?

**Brief Report**

**Cognitive Behavior Therapy in the Posthospitalization Treatment of Anorexia Nervosa**

Kathleen M. Pike, Ph.D.
B. Timothy Walsh, M.D.
Kelly Vitousek, Ph.D.
G. Terence Wilson, Ph.D.
Joy Bauer, M.S., R.D.

**Objective:** This study provides what the authors believe is the first empirical evaluation of cognitive behavior therapy as a posthospitalization treatment for anorexia nervosa in adults.

**Method:** After hospitalization, 33 patients with DSM-IV anorexia nervosa were randomly assigned to 1 year of outpatient cognitive behavior therapy or nutritional counseling.

**Results:** The group receiving nutritional counseling relapsed significantly earlier and at a higher rate than the group receiving cognitive behavior therapy (53% versus 22%). The overall treatment failure rate (relapse and dropping out combined) was significantly lower for cognitive behavior therapy (22%) than for nutritional counseling (73%). The criteria for “good outcome” were met by significantly more of the patients receiving cognitive behavior therapy (44%) than nutritional counseling (7%).

**Conclusions:** Cognitive behavior therapy was significantly more effective than nutritional counseling in improving outcome and preventing relapse. To the authors’ knowledge, these data provide the first empirical documentation of the efficacy of any psychotherapy, and cognitive behavior therapy in particular, in posthospitalization care and relapse prevention of adult anorexia nervosa.

➢ RCT of Cognitive Behaviour Therapy v nutritional counselling

➢ Adult anorexia nervosa, N=33, 50 sessions in 1 year
Intervention

CBT:

- Manualised
- Delivered by doctorate-level licensed, experienced psychologists
Intervention

CBT:
- Manualised
- Delivered by doctorate-level licensed, experienced psychologists

Nutrition counselling:
- A manual based treatment of “well-established principles nutritional education and food exchanges”
- No tailored nutrition messages
- Delivered by doctorate-level psychologist
“The group receiving CBT had better clinical outcome than did the nutritional counseling group”

Usually misquoted in subsequent research as:

“CBT is superior” and “nutrition intervention is in effective”
WHY IS A TAILORED TOOL NECESSARY?
Lack of evidence based education materials for use with ED patients

Nutrition education tools designed for the whole community are adapted for ED patients
Clinician thoughts, beliefs & attitudes (weight/eating)

A CONSISTENT MESSAGE (the team “line”)

i.e. Agreed upon non-negotiables & the nutrition message

ED thoughts, beliefs & attitudes

Keep private & away from the dining table / therapy
Nutrition resource

- Targets nutritional requirements & abnormal dieting behaviours & is appropriate to needs of ED clients

- Addresses unique nutritional problems of ED clients that are not targeted by traditional nutritional tools (e.g. Australian Guide to Healthy Eating)

- Does not focus on common nutritional problems in the community which are not commonly issues for our clients

- Not misinterpreted and does not perpetuate disordered thinking and dieting behaviours
Nutrition resource

- Targets nutritional requirements & abnormal dieting behaviours & is appropriate to needs of ED clients
- Addresses unique nutritional problems of ED clients not targeted by traditional nutritional tools

Not misinterpreted and does not perpetuate disordered thinking and dieting behaviours.
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- Does not focus on obesity prevention (Community-level eating guides reflecting prevalent health issues in Western populations)
Nutrition resource

- Targets nutritional requirements & abnormal dieting behaviours & is appropriate to needs of ED clients
- Addresses unique nutritional problems of ED clients not targeted by traditional nutritional tools
- Does not focus on obesity prevention (Community-level eating guides reflecting prevalent health issues in Western populations)
- Not misinterpreted & does not perpetuate disordered thinking & dieting behaviours
Use fats and oils in small amounts

Eat plenty of vegetables of different types & colours

Choose reduced fat dairy products

Choose lean meats

Drink plenty of water & limit added sugar (soft drink, juice, cordial)

Limit foods containing saturated fat, added salt & added sugars

Choose mostly wholegrain/high fibre carbs

Avoid carbs cereals / grains

Excessive water and low calorie fluids

Over consume high fibre foods, fruits & vegetables at the expense of other food groups

Limit dairy foods & choose skim options Swap to products with “health halo”

Avoid red meat & choose vegetarianism & veganism

Total avoidance of “extra’s” & fun foods

Eliminate fats, compromising Essential Fatty Acids Fat soluble vitamins
Tailored nutrition messages

Tailored nutrition messages are more effective (Carbone, et al., 2002; Brug, et al 1999, Zoellner, 2010):

- contain relevant information
- use familiar language
- fit the consumer’s understanding and view of the world
- take into account values, beliefs, and specific interests of the target audience

Specialised tools have been developed for:

- Vegetarians (Haddad, 1999)
- Athletes (Mettler, 2009)
- The elderly (Russell)
- Specific cultural groups (Bacardi-Cascon, 2002; Song, et al., 2010)
Eating Disorder Healthy Eating Pyramid (EDHE)
5 CORE FOOD GROUPS & WATER

• Not overvaluing one group over another

• No specific message about fat content for calcium foods

• Water was included to emphasise adequate hydration (not over or under consumption)
Fluid Intake in Patients with Eating Disorders

Susan Hart, BSc1
Suzanne Abraham, PhD1*
Georgina Luscombe, BSc2
Janice Russell, MD3

ABSTRACT

Objectives: The current study examined the fluid intake of patients with eating disorders and factors that may influence the amount and type of fluid consumed. Subjects comprised 81 inpatients with eating disorders.

Methods: A 7-day semistandardized, retrospective fluid history was taken by a dietician when the subjects were admitted to an eating disorder unit. Total fluid consumed per day was measured, which included all energy-free, energy-containing, and caffeine-containing fluids (all in milliliters per kilogram). Age, body mass index (BMI), and eating disorder behaviors (purging, binge eating, and excessive exercise) were also evaluated.

Results: Fluid intakes ranged from 250 ml to >6 L per day, with an average of 2.7 L. Only 17% of patients had fluid intakes in the recommended range. The most commonly consumed beverages were water followed by diet cola, coffee, juice, and tea. The lower the BMI and the older the patient, the greater the fluid intake.

Conclusions: Fluid intake is variable and should be part of the clinical assessment of the eating disorder patient.

Keywords: fluid intake; eating disorders; body mass index; drinking behavior

(Int J Eat Disord 2005; 38:55–59)
SPREADS & ESSENTIAL FATTY ACIDS

• Deficiencies of essential fatty acids have been described (Holman, et al., 1995; Langan & Farrell, 1985, Hadigan, et al., 2000)

• A healthy diet should include these foods

• Describes in inclusive terms rather than conveying a sense that the foods should be avoided
FUN FOODS, EATING OUT & SOCIAL EATING

• ED patients are socially isolated
  • Extreme eating behaviours
  • Anxiety related to eating in social situations

• Higher energy snack foods or “fun” foods
  • Exposure and Response as a treatment
  • Assist with meeting dietary energy requirements
  • To challenge disordered beliefs ie “I should never eat these foods”
DIET FOODS & FILLERS

• Low energy foods:
  • Caffeinated beverages or diet soft drinks
  • Sauces
  • Spices, salt and pepper
  • Chewing gum

• When eaten in excessive quantities
  • Appetite suppressant
  • Difficulty in achieving recommended amounts of core food groups
  • Masking technique ie it looks like a large meal/snack
Eating Autonomy
LOW

Meal supervision
HIGH

Severe

Inpatient

Day Program

Outpatient

Meal supervision
LOW

Eating Autonomy
HIGH
PATIENT EVALUATION

1. To evaluate the nutrition messages conveyed by the EDHE

2. To compare this with the messages conveyed by a guide designed for the general population (the AGHE)

3. To compare the effectiveness of both education tools in addressing common ED nutrition beliefs and attitudes
RESULTS

N= 20 female patients receiving treatment for an ED
17 years and older
Receiving outpatient (n = 12) and day patient (n = 8)
Results – Questionnaire outcomes

Fats and oils

- ED tool:
  - Agree: 91
  - Neutral: 5
  - Disagree: 3

- Gen. tool:
  - Agree: 63
  - Neutral: 8
  - Disagree: 10

Legend:
- Agree
- Neutral
- Disagree
Results – Questionnaire outcomes

<table>
<thead>
<tr>
<th></th>
<th>ED tool</th>
<th>Gen. tool</th>
<th>ED tool</th>
<th>Gen. tool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fats/oils</strong></td>
<td>91</td>
<td>30</td>
<td>86</td>
<td>49</td>
</tr>
<tr>
<td><strong>“Bad” foods</strong></td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td><strong>Agree</strong></td>
<td>0%</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>10%</td>
<td>60%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Disagree</strong></td>
<td>90%</td>
<td>20%</td>
<td>30%</td>
<td>10%</td>
</tr>
</tbody>
</table>

- Fats/oils: 5/91 Agree, 8/30 Neutral, 10/86 Disagree
- “Bad” foods: 3/5 Agree, 4/8 Neutral, 49/16 Disagree
Results – Questionnaire outcomes

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<thead>
<tr>
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<th>ED tool</th>
<th>Gen. tool</th>
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<tr>
<td>Fats/oils</td>
<td>91</td>
<td>63</td>
</tr>
<tr>
<td>Junk foods</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>ED tool</th>
<th>Gen. tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Diet” foods not helpful</td>
<td>70</td>
<td>40</td>
</tr>
</tbody>
</table>

- Agree
- Neutral
- Disagree
19/20 patients preferred the EDHE tool.

**KEY MESSAGE**
- Discourages "good"/"bad" food thinking.

**JUSTIFICATION OF CONTENTS**
- Nutrients listed
- Some explanations

**RELEVANT TO TREATMENT**
- Fillers/diet foods

**REASSURANCE**
- Part of anxiety reduction
- High calorie foods ok
- "Reduces guilt"

"The pyramid (EDHE) includes everything. No foods look better or worse than the others".

"I like the messages, like, essential fatty acids are important for fat soluble vitamins".
1. “The AGHE sends messages that there are good foods and bad foods”

2. “I know I could easily manipulate that for my eating disorder”

3. The placement of the extra foods in a corner separate to the core five food groups was felt to be a negative aspect of the tool by many participants, indicating they were “bad” foods, and that the message was “don’t eat these foods”
CLINICIAN FEEDBACK ON THE EDHE
CLINICIAN EVALUATION

- 32 clinicians at ANZAED 2016
- 20 Dietitians versus 12 non-dietitians
- 29 ED specialists
- 90 minute workshop on EDHE
I would use the image with my patients

This guide would make communication with my patients much easier

Providing tailored information to ED patients is very important

I found using other guides with ED patients really confusing

I believe it is important for non-Dietitians to have a good understanding of nutritional principles

I would feel more confident using one of the community based guides for all Australians

I think 100% of discussions about food should be done by the dietitian

I believe it is important for non-Dietitians to have a good understanding of nutritional principles

Strongly Disagree

Strongly Agree

Neutral
The guide would help me to feel more confident talking about food and eating

I have confidence about making recommendations about fluid intake

I have confidence about making recommendations about carbohydrate

I have confidence about making recommendations about dairy products

I have confidence about making recommendations about dietary fat

I have confidence about making recommendations about diet foods and fillers

The workshop has made it clear why social eating experiences and prac groups are important
MODELLING OF PORTIONS AND MEAL PLANS FROM THE EDHE
Food Modeling

AIM

➢ To demonstrate that the amount of food recommended achieved nutritional adequacy when compared to the Nutrient Reference Values for Australian women aged 18 to 50
1. Develop our own data base (Foodworks, NUTTAB & Calorie King)

2. Select foods that ED patients would typically choose
   - *Sultana Bran rather than Fruit Loops*
   - *Stir fry rather than roast beef*

3. Select the target nutrient i.e. energy

4. Based an a 7 day sample meal plan = averaged to daily intake

5. Standardise the measurement tool
   - *Muesli 45 g OR ½ cup OR 1 sachet*
   - *Yoghurt 200 g OR 1 cup OR 1 carton*
RULES....

- Reasonable measures i.e. 1 Tbsp not 1 ½ Tbsp, trying to avoid fractions

- For an energy target, always go over
  - Target = 120 kcals
  - Options are 3 crackers (110 kcal) or 4 crackers (130 kcal)
  - Choose 130

- Fluids
  - Depends on activity levels
  - More to replaces losses: secondary to purging, if high exercise levels, or in hot weather
  - Also assessed by blood tests (having weekly to monthly depending on ED symptoms)

- Core foods
  - Potatoes, corn, sweet potato = Cereals/Grains
  - Legumes = Protein
<table>
<thead>
<tr>
<th>FOOD GROUP</th>
<th>What is the energy of 1 serve</th>
<th>Serves for maintenance?</th>
<th>Serves for weight gain?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARBOHYDRATE meals</td>
<td>170 kcals (710 kj)</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CARBOHYDRATE snacks</td>
<td>120 kcals (500 kj)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>PROTEIN</td>
<td>160 kcals (670 kj)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>VEGETABLES/SALAD</td>
<td>0 kcals</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>FRUIT</td>
<td>75 kcals (315 kj)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>CALCIUM FOODS</td>
<td>200 kcals (840 kj)</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>OILS &amp; SPREADS</td>
<td>40 kcals (168 kj)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>FUN FOODS</td>
<td>250 kcals (1045 kj)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>FLUIDS</td>
<td>1.5 to 2.0L /day</td>
<td>1.5 to 2.0L /day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintenance Average Day</td>
<td>Refeeding Average Day</td>
<td>Target</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Energy</strong></td>
<td>2227 kcals (9313 kj)</td>
<td>2671 kcals (11173 kj)</td>
<td></td>
</tr>
<tr>
<td><strong>Target Energy</strong></td>
<td>2250 kcals</td>
<td>2700 kcals</td>
<td></td>
</tr>
<tr>
<td><strong>Protein</strong></td>
<td>105 g</td>
<td>117 g</td>
<td>20% Energy</td>
</tr>
<tr>
<td><strong>Carbohydrate</strong></td>
<td>275 g</td>
<td>337 g</td>
<td>50% Energy</td>
</tr>
<tr>
<td><strong>Total Fat</strong></td>
<td>69 g</td>
<td>83 g</td>
<td>30% Energy</td>
</tr>
<tr>
<td><strong>Fibre</strong></td>
<td>38 g</td>
<td>45 g</td>
<td>&gt; 25 g</td>
</tr>
<tr>
<td><strong>Calcium</strong></td>
<td>1421 mg</td>
<td>1503 mg</td>
<td>&gt; 1300mg *</td>
</tr>
<tr>
<td><strong>Iron</strong></td>
<td>15.3 mg</td>
<td>17.9 mg</td>
<td>8 mg (EAR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>18 mg (RDI)</td>
</tr>
<tr>
<td><strong>Zinc</strong></td>
<td>12.2 mg</td>
<td>13.7 mg</td>
<td>8 mg</td>
</tr>
<tr>
<td><strong>Vitamin D</strong></td>
<td>4.8 ug</td>
<td>5.0 ug</td>
<td>5 ug</td>
</tr>
<tr>
<td><strong>Sodium</strong></td>
<td>2015 mg</td>
<td>2257 mg</td>
<td>&lt; 2300 mg</td>
</tr>
<tr>
<td><strong>Potassium</strong></td>
<td>4844 mg</td>
<td>5704 mg</td>
<td>&gt; 2800 mg</td>
</tr>
<tr>
<td><strong>Water</strong></td>
<td>3.1 L</td>
<td>3.6 L</td>
<td>2.8 L (Adequate Intake)</td>
</tr>
</tbody>
</table>

- Higher intake for amenorrhoea/post-menopause / bone health
- 1 fluid (tea/ coffee/water) with each meal and snack (6 X 250 mL per day)
Standard Meal Plan – Weight Maintenance

Breakfast
Morning Tea
Standard Meal Plan – Weight Maintenance

Lunch

- Sandwich
- Tuna salad
- Carrots
- Cucumber
- Lettuce
- Orange
- Water
Standard Meal Plan – Weight Maintenance

Afternoon Tea
Standard Meal Plan – Weight Maintenance

Dinner
Standard Meal Plan – Weight Maintenance

Supper
Further research and development

• Use with children and adolescents?
• Use with males?
• Use in binge eating disorder?
Questions about the Eating Disorder Healthy Eating Pyramid