Food for Recovery: Resolving Malnutrition and Disordered Eating Patterns in Addiction and Substance Abuse Populations

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As Registered Dietitians (RD) we know that we are the experts in food and nutrition, however it is important to always continue to create opportunities to expand and further demonstrate our expertise. There are healthcare fields that remain virtually untouched by our skill set. One critical area of our societal struggle has a significant void when it comes to nutrition support, and that is the treatment of addictions (substance use disorders or SUD). The fault lies on both sides, in that the addiction model has been in place for so long that it simply doesn’t know that nutrition counseling is missing, and we as RDs have not made it clear just how we can help those struggling from SUD. It has been my experience that with the appropriate utilization of nutrition education, and one-on-one dietary planning, a great deal can be done to strengthen the recovery process for those who are not only unsure of how and what to eat, but also don’t understand the basic physiological functions of their SUD on their body and body systems. It is amazing to observe the changes in mentality that can result in changes in behaviors, when a person simply obtains a basic knowledge of how the body is impacted by a particular substance!

The American Psychiatric Association defines addiction as a condition in “which the body must have a drug to avoid physical and psychological withdrawal symptoms.” There are two stages of addiction; stage 1 is dependence, in which their life is consumed with searching for the drug. Stage 2 is tolerance, in which the need to consume more and more of the drug is necessary in order to obtain the same effect.¹ There are emerging and evolving definitions of addiction, however for the purposes of this article we will stay with this traditional definition.

Currently, 23 million Americans struggle with addiction, and 140 million people worldwide suffer from alcohol dependence. While there are many treatment centers throughout the country, and treatment options for all variations of SUD, the decline in addiction behaviors is not evident. Heroin overdose rates doubled between 2010 and 2012 and since the early 1980s drug-related deaths have more than doubled. Today one in four deaths are attributed to alcohol, tobacco and illicit drug use. The need for continued support and practitioners in this arena are critical. The need to be constantly evaluating how we are treating addictions and what adjustments can be made to the current treatment process and treatment model to increase success rates are critical.

The classification and how society views addiction are areas of contention. As addiction falls into the realm of mental health, there is a gap between the medical and mental aspects of...
From the Chair
Diane Spear, MS, RDN, LD, FAND

My year as Chair for this fabulous group of dedicated nutrition professionals has been a whirlwind! Much has been accomplished and much more is on the horizon. The Executive Committee wrapped up the year with a weekend full of lively discussion and planning for 2017-2018. BHN’s Strategic Plan just got bigger!

I want to thank all the Executive Committee members and volunteers who have tirelessly worked to further the accomplishments of this remarkable DPG. Have you seen the Case Study CPE opportunities open to all BHN members at www.bhndpg.org? Six very different and relevant case studies were submitted by members willing to share their experience and wisdom working with the populations we serve. Much can be learned from these as well as our many CPE opportunities.

Can you keep a secret? BHN is planning a fabulous CPE event in the Fall that will blow you away! We are planning an Interactive Virtual Retreat like you have never seen before on hot topics in the behavioral health nutrition arena. At FNCE© 2018, BHN will be celebrating the 100th anniversary of the Academy in the 2nd Century Initiative Celebration. We have exciting plans that you will not want to miss! Stay tuned for more information on both fabulous events. And the winds of BHN keep blowing!

BHN Publications are being updated and developed as we speak. Work is in progress on development of a resource tool for RDNs practicing in mental health. A committee was formed and work is underway. The SOP/SOPP in mental health and addictions is close to completion. Updates to the IDD and Eating Disorder SOP/SOPPs will set sail in 2018. New Fact Sheets in eating disorders are on the way as well as the update to the IDD Resource Tool.

Have you gone onto the BHN Facebook site lately or catch us on Instagram? Our social media sites have increased in the number of views and follows in leaps and bounds. I encourage you to participate in our social media to strengthen and distinguish BHN in the world of nutrition and the public. Our membership is blessed to have many seasoned and knowledgeable experts who are willing to share. We also have a great student blog!

Thank you BHN for the whirlwind experience. I leave you with this thought. You can’t change the direction of the wind, but you can adjust the sails to get where you are going. Let BHN be the vessel that guides you to reach your destination!

Your Chair,
Diane Spear
the condition that need to be mended. An evaluation of addiction and the stigma of associated relapse rates, has been compared to the relapse rates of 3 common chronic medical illnesses: Type 1 Diabetes, Hypertension and Asthma. These chronic illness states have varying degrees of medical relapse rates and medical compliance, but come with little to no stigma for non-compliance with recommended treatment interventions. The study concluded that addiction should not be viewed as an acute condition but a chronic condition in which there should be medication compliance, insurance coverage and follow up treatment. Table 1 demonstrates that addiction relapse rates are very similar to the relapse rates of chronic medical conditions that do have concerning medical risk and potential mortality, yet we continue to stigmatize and judge those who may be unsuccessful in their addiction recovery. It commonly understood what the comment, “falling all of the wagon” is in reference to, however there is no stigma for the long term diabetic who continues to mismanage their blood sugar levels which results in the amputation of fingers and toes.

Consider that currently only 3 million of those struggling with SUD seek treatment, most will receive care for acute symptoms secondary to their substance use, but all too often do not address the greater issue. Furthermore, 1 and 3 substance abuse counselors leave their jobs each year, with 50% leaving the field altogether. Of those who serve as supervisors, there is an almost 25% turnover rate annually. Additionally, those who do have short tenures, often end up taking opportunities outside of the SUD field. The inclusion of one more professional expertise, (hint, hint: dietitians!), will help to support this challenging population and the amazing people who are doing a great deal of the difficult work.

Creating the Nutrition Model

Let us first evaluate the food culture that is most commonly seen in addiction treatment. We know that the first stage of recovery includes detoxification and withdrawal for which it is essential to have medical supervision (we will review this further shortly). The second step involves beginning to deal with increased cravings for substances. The tolerance of these cravings can often be improved through consumption of food and beverages; namely hyperphagia. Treatment centers unknowingly set up a situation in which food and beverage can become the new “issue”. This includes offering buffet style meals, menus that include comfort foods (energy dense, high fat), minimal fiber due to a lack of fruits and vegetables, no structure or regulation of portion sizes, and the all-day availability of snacks and sweets. The motivation behind this model is to keep the very challenging first steps of recovery as comfortable as possible. Alcoholics Anonymous even states, “One of the many doctors who had the opportunity of reading this book in manuscript form told us that the use of sweets was often helpful, of course depending upon a doctor’s advice. He thought all alcoholics should constantly have chocolate available for its quick energy value at times of fatigue. He added that occasionally in the night a vague craving arose which would be satisfied by candy. Many of us have noticed a tendency to eat sweets and have found this practice beneficial.” Another motivation is the understanding that SUD includes significant periods of minimal to poor food consumption and therefore malnutrition, medical conditions and energy deficiency abound and must be resolved.

This is where the RD work begins! The food model of treatment centers and sober living environments must be evaluated. The traditional approach includes a majority of the following:

- Open snack bar – fruit, granola bars, and candy.
- Open beverage station(s) – includes coffee, tea, energy drinks, soda, and water.
- Chef dictated menus with no RD consideration for macro and micronutrient balance.
- No food monitoring – the ability to eat as little or as much as desired is given to patient discretion.
- No nutrition education or nutrition counseling

Let us also briefly consider an emerging trend in dietary approaches in the addictions treatment model, this involves the elimination of sugar from...
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the diet and regulation of additional items that have been demonstrated to be abused within the SUD population during sobriety. The key similarity is that dietitians continue to be missing from the equation, and food selections and menu planning are solely the responsibility of the kitchen staff/Chef, with a further void of nutrition education to support understanding how or why this way of eating is necessary. This model may include the following items, but is specific to each treatment center:

- Limitations on caffeinated beverages, decaf is available. This includes no soda, energy drinks or beverages with artificial sweeteners.
- All food is prepared with naturally occurring sugars only (honey, agave nectar, stevia, etc)
- No foods with added sugar are served; including but not limited to most yogurts, salad dressings, cereals, beverages, desserts, etc.

Food is plated and not served family or buffet style as with traditional addiction treatment environments

Consider what we know as dietitians about those who have a broken relationship and poor understanding of balanced nutrition, as is the case with those who have years, and even decades, of addiction behaviors. Recovery must include re-learning how to eat, which is not limited to: what to eat, when to eat, where to eat, how to prepare food and this is not instinctive for the majority who are forced to face these questions. There are many concerns with the current food model, as we are now seeing that food plays a major role in addictions treatment and long-term recovery. You may be thinking “these are adults, let them do what they want!” Let us continue to evaluate these roles and the long-term effects of leaving this vulnerable population to their own devices. The most common nutrition behaviors seen in the recovering addict include:

1. No breakfast; general meal skipping
2. Increased intake of pre-prepared or processed foods
3. Poor food variety
4. Increased or restricted refined carbohydrate and sugar intake
5. Low protein, fruit and vegetable intake
6. Poor fiber and water intake
7. Excessive high calorie beverage intake
8. Excessive caffeine intake
9. Increased intake of supplements and meal replacement products
10. Strong desire for weight loss or weight gain

With these considerations, review the current nutrition process detailed in Image 2. Consider the fact that there are often not RDs available to help give guidance on how to make food and nutrition decisions. This includes not only how to make decisions to support balanced eating, but how to understand body cues and most importantly how foods can further be used to support any malnutrition or medical conditions that remain unresolved. It would be as if a doctor were to hand a patient a bottle full of a medication, but give no prescription or guidance on how to appropriately take them. The current addiction treatment cycle is lacking in dietary guidance, guidance that parents offer to their children at a young age when they are vulnerable and distracted, which is very similar to the SUD population as they establish their sobriety. How do we break this cycle?

There are 4 areas in which the RD can specifically enhance the recovery and treatment process: primary malnutrition, RD nutrition education, nutrition intervention/support and lifestyle skills related to food and wellness. The SUD population struggles from primary and secondary malnutrition, which have profound differences. (1) Primary malnutrition involves the substance(s) replacing food for energy and therefore malnutrition results, due to poor variety of food selection or general energy deficiency. Secondary malnutrition includes body systems that begin to function abnormally due to long term malnutrition; poor nutrient

Image 1: Traditional Nutrition Cycle in Addiction Treatment
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absorption and utilization, dental issues, reflux, stomach discomfort, diarrhea, constipation, metabolic changes, and neurological issues. Additional, incorporating RDs into the treatment team encourages clients to begin to use food to support mental health; anxiety, depression and mood stabilization. (3) Medical recovery with nutrition to support the healing body and further medical nutrition therapy specific to the substance(s) abused and (4) finally the reincorporation of lifestyle skills such as shopping, cooking, sleeping, exercise and overall physical wellness. The long term hope is to look at food in a completely different light, with the goal of creating a new result that supports the elimination of the addiction cycle (see Image 3).

Specific Nutrient Concerns

As with all specialty populations, there are specific areas of nutrient concerns that can result in the greatest impact resulting in fatigue, medical conditions and even mental health status. All three of these can be true, but let us focus on mental health. The World Health Organization (WHO) defines mental health as: “A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” Unfortunately, this does not hold true for many who combat SUD, let us evaluate some of the obstacles.

Anxiety and depression in addiction populations are triggered and linked to all substance use disorders. We can evaluate the levels of dopamine and serotonin as a natural means of working to help stabilize and support low mood with nutrition. The impact of food sources to trigger these neurotransmitters may not always be as appropriate as the need for medication management, but in the long term can help to assist in stabilizing these mood functions. In a brief overview, dopamine is synthesized by tyrosine which is found in foods derived from animal proteins: turkey, game meats, eggs, dairy, pork and seaweed. Typtophan synthesizes the neurotransmitter serotonin and works to stabilize mood, sleep, pain, emotion and even appetite; as low levels of serotonin can trigger cravings for carbohydrates. As previously evaluated in this paper, carbohydrates can often be restricted during and after the recovery process.

Well studied are the issues associated with chronic alcoholism and metabolism of B vitamins, namely B1 (thiamine) and B6 (pyridoxine). These B vitamin deficiencies can lead to dramatic medical and mental changes in behavior, often which can be overlooked or identified from a different cause. Wernicke’s encephalopathy involves neurological symptoms caused by biochemical lesions in the brain as a result of exhaustion of B vitamins, namely thiamine. Thiamine is critical in carbohydrate metabolism for energy, production of neurotransmitters (including GABA), lipid metabolism necessary for myelin production, amino acid modification and neuromodulation. Interruption of these functions can cause a triad of: confusion, ataxia (loss of control of body movements) and ophthalmoplegia (weakness or paralysis of the muscle of the eye). Only about 10% of patients will suffer from all three, but additional symptoms include: retinal hemorrhage, hearing loss, fatigue, irritability, psychomotor slowing, dysphagia, sleep apnea, epilepsy, memory impairment, amnesia, depression, psychosis, hypothermia, cardiac symptoms and infections that can lead to death. Alcoholism is not the only cause of Wernicke’s however, if the substance abuse is not disclosed or identified, any one of these symptoms can lead to a misdiagnosis that will overlook the severity of the condition or treat the symptoms independently. A continued evaluation of the Wernicke’s continuum is Korsakoff’s syndrome, a neurological disorder caused by a lack of thiamine in the brain, linked to severe malnutrition and alcoholism. The condition is characterized by anterograde amnesia, severe memory loss, confabulation, minimal content in conversations, lack of insight, and apathy; so closely compared to dementia.

Consider for a moment, can you identify 5 foods that are excellent sources of thiamine? Imagine that you could simply hand this short list of foods to a client, or Chef, in order to help prevent or resolve these issues (dietary replacement is the best treatment). In case you aren’t sure about thiamine food sources; trout, lean cuts of pork, macadamia nuts, sunflower seeds, and whole wheat bread have excellent thiamine content.
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Alcoholism

The areas of addictions where RDs have the greatest degree of understanding are the body systems that are impacted with chronic and excessive alcohol intake; namely hepatitis and cirrhosis. Alcohol absorption begins in the stomach, with as much as 20% being absorbed, resulting in the ability for it to reach the brain within 1 minute of consumption. Once absorbed ETOH travels to the liver for oxidation by alcohol dehydrogenase (enzyme); ETOH takes metabolic precedence, which can result in fatty acid build-up in the liver. As the liver is overwhelmed with the need to process the ETOH, the excess fatty acids begin to cause damage to the liver cells. The liver has the amazing ability to heal and regenerate, but compromising this system can result in permanent damage that is not reversible (cirrhosis). With chronic intake, the ETOH metabolism cannot sustain the demand on the liver, and this results in further damage of other body systems including but not limited to: protein energy malnutrition, hepatitis, cirrhosis, nutritional deficiencies and nutrient malabsorption (including vitamin A deficiency, zinc deficiency, B vitamin deficiency), hypoglycemia, food sensitivities, dehydration, electrolyte imbalance, osteoporosis, anemia, diabetes, and high blood pressure.14

Addressing alcohol recovery in treatment should include a three stage process. The first stage is supporting the detox and withdrawal process, including a very brief dietary assessment as the client is most likely to be very irritable, fatigued and confused (days 1-10). In order to best support this stage:

- Have basic foods available (crackers, smoothies, toast, cereals, etc) expect intake to be sporadic
- Provide adequate fluids (Gatorade, Pedialyte, water, juice, ginger ale, etc)
- Support nausea and fatigue with BRAT diet foods, peppermint and ginger; avoid vegetables, dairy and high fiber foods which can be irritating on the GI system
- Encourage food during moments of less fatigue

The second stage involves a full dietary initial assessment to obtain a history and to begin to build therapeutic rapport. The best time to do this, as the client will likely have a better memory and ability to go through the necessary questions, is once the initial detox is complete. It is also at this point that dietary recommendations should begin. Set some small goals but discuss and establish long term goals of sobriety. Here you will also begin to understand if weight concerns are an issue, current or past medical issues, or if there is a history of any disordered eating patterns.

The third stage is the long term nutrition education and continued dietary support and meal planning as needed. Often times, at the intensive levels of care the stays are not as long as would be desired (30-45 days), the expectations of change should be moderate. However, dietary counseling is critical at all levels of care. Throughout this process weight should also be monitored in a moderate fashion of once per week for all patients, and twice per week for those who may have some malnutrition or weight concerns.

Chemical Dependence

One of my greatest struggles when beginning to work with the addictions population was understanding the substances being abused and how they impacted the body during times of abuse and withdrawal. The creation of the Tables 2 and 3 below are designed

<table>
<thead>
<tr>
<th>Table 2: Street Drugs</th>
<th>Substance Use</th>
<th>Side Effects</th>
<th>Withdrawal</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cannabis</strong></td>
<td>↑</td>
<td>HR, anxiety, panic attacks, cough, respiratory infections</td>
<td>↓</td>
<td>Irritability, difficulty sleeping, nightmares</td>
</tr>
<tr>
<td><strong>Cocaine</strong></td>
<td>↓</td>
<td>HR, BP and temp; tremors, anxiety, insomnia, cardiac, stroke, seizures, nasal damage</td>
<td>↑</td>
<td>Depression, insomnia, psychomotor agitation</td>
</tr>
<tr>
<td><strong>Methamphetamine</strong></td>
<td>↓</td>
<td>HR, BP and temp; tremors, anxiety, insomnia, cardiac, stroke, seizures, dental damage, kidney, lung, neuro damage, violence</td>
<td>↑</td>
<td>Depression, reduced motor skills, verbal impairment</td>
</tr>
<tr>
<td><strong>MDMA</strong></td>
<td>short</td>
<td>Anxiety chills, sweating, muscle cramps, sleep issues, hyperthermia, hyponatremia, anxiety</td>
<td>short</td>
<td>Low mood, stress, emotional sensitivity</td>
</tr>
<tr>
<td><strong>Street Opioids</strong></td>
<td>↑↓</td>
<td>Dizziness, nausea, slow breathing, constipation, endocarditis, HIV, weight change</td>
<td>↑↓</td>
<td>Restlessness, muscle &amp; bone pain, insomnia, diarrhea, vomiting, cold flashes, leg twitching</td>
</tr>
</tbody>
</table>

**Most will have anxiety, cravings, agitation & fatigue**
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to help provide a quick reference to information that is critical when making nutrition and dietary recommendations.

Highlight: My experiences with Cannabis Withdrawal Syndrome (CSW) have been amongst the most intriguing and concerning. This is not due to the medical dangers, but more so the intensity of the withdrawal symptoms and the length of time in which the symptoms present. The Diagnostic Statistical Manual V details CSW to include 3 of the following, presenting within one week of cessation of use:
1. Irritability, anger, aggression
2. Nervousness or anxiety
3. Insomnia or sleep difficulty
4. Decreased appetite or weight loss
5. Restlessness
6. Depressed mood
7. Physical symptoms causing significant discomfort from at least one of the following: stomach pain, shakiness/tremors, sweating, fevers, chills and headache.

The criteria were determined through retrospective self-reported data from 384 subjects from their “most difficult” attempt to quit using cannabis. It was determined that 40.9% of the subjects met >3 of the criteria, most inhaled the cannabis through smoking joints, and smoking occurred on average of 22.6 days out of 30 previous to quitting smoking. Additionally, the average time of use was 11.2 years, the range was large with reports of 1-42 years of use.15 It is remarkable to understand that this substance is powerful and even more powerful with cessation of use. Take these considerations into account when working with the long or short term heavy cannabis use.

Lifestyle Skills

As was previously touched on, it is important to consider that addicts who are left to their own devices have a tendency to be drawn to functions of nutrition that can serve to curb their cravings. One key example is taking many supplements, in pill form, as a means to avoid food variety but also because taking pills can very likely be a familiar comfort to them. Artificial sweeteners are readily available and for those who are concerned about weight gain possibilities or realities, these can be abused to curb the natural cravings for “sweet” foods and control weight gain. The excessive intake of both caffeine and nicotine during treatment and recovery is a powerful obstacle. As both are stimulants they have profound impacts on hunger/fullness cues, hydration status, bowel regulation, sleep patterns (or lack thereof) and interfere with nutrient absorption. Nicotine use can also greatly impact food palatability and require creatively exploring food textures and combinations to improve food enjoyment.

Finally, there is often little to no understanding about proper food storage, food preparation, or how to grocery shop or budget for food costs within this population. The powerful impact of the RD skill set in working with this population specifically is evident. The list of need for our services are endless and that is why it is so important for us to now step forward and make it known that we are here to help.

One way to do this is to begin contacting treatment centers in your area and offering a once monthly nutrition education lecture. Keep the information basic and soon after the patients will begin asking (and sometimes demanding!) to learn more, and to have the opportunity to sit down and understand more about what they can do to not only remain sober, but how to use food as a tool to heal from the inside out.

References


Table 3: Prescription Drugs

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription</strong></td>
<td><strong>Side Effects</strong></td>
</tr>
<tr>
<td>Stimulants: Amphetamine &amp; Methylphenidate</td>
<td>Increased energy, appetite, alertness, irregular HR, hyperthermia, cardiovascular failure, seizure</td>
</tr>
<tr>
<td>Opioids: Codine, Morphine, Methadone</td>
<td>Pain relief, drowsiness, nausea, constipation</td>
</tr>
<tr>
<td>Central Nervous System: Barbiturates &amp; Benzodiazepines</td>
<td>Drowsiness, relaxation</td>
</tr>
</tbody>
</table>

*Note: Not all patients will struggle from this side effects, responses will vary.*

About the Author:
Megan is a Lecturer at Arizona State University in the School of Nutrition and Health Promotion, she teaches undergraduate management and nutrition courses, and developed an teaches an eating disorders and addictions graduate seminar as well; the first of it’s kind at the University. Megan was previously the Director of Nutrition and Culinary Services at Rosewood Centers for Eating Disorders and has 10 years’ experience developing and implementing wellness programs for men, women and adolescents struggling with eating disorders, addictions and mental illness. Megan emphasizes the importance of the mind-body connection in treatment and recovery. She is a 11-year veteran Certified yoga instructor, combining mindfulness practices and meditation techniques with traditional nutrition models in all areas of her profession. Her passion is teaching the yoga basics to new students and watching the connection begin; improving self-love and body acceptance and embracing all of the positive messages that yoga brings into the stress of daily Western life.
Megan is a Certified Eating Disorder Dietitian (CEDRD) and Approved Supervisor through the International Association of Eating Disorder Professionals (iaedp). She additionally serves as the Public Relations Chair for the Behavioral Health Nutrition dietetic practice group with an emphasis in Addictions, Mental Health and Eating Disorders, through the Academy of Nutrition and Dietetics and was recently appointed as the Phoenix Ambassador of the International Federation of Eating Disorder Dietitians.

CPE Questions for Food for Recovery: Resolving Malnutrition and Disordered Eating Patterns in Addiction and Substance Abuse Populations

1. Which of the following is a dietary concern when working with the recovering addictions population?
   a. Increased intake of pre-packaged foods
   b. Poor fiber and water intake
   c. Poor food variety
   d. All of the above

2. Currently the rates of addiction are:
   a. Beginning to decline
   b. On the rise
   c. Staying the same

3. It is critical to understand that when working with CWS you can most likely expect:
   a. Elevated mood and increased focus on food
   b. Isolation and weight gain
   c. Little to no side effects of withdrawal as cannabis is not addictive.
   d. Poor sleep, irritability and anxiety

4. Increased energy, decreased appetite, irregular heart rate and possible cardiovascular failure are all side effects with the use of which of the following substances?
   a. Cocaine
   b. Methamphetamine
   c. Opioids
   d. Stimulants

5. Thiamine is critical for neurological function, along with other metabolic processes. Which of the following conditions can be a result of chronic alcoholism and thiamine deficiency?
   a. Chronic traumatic encephalopathy
   b. Menkes syndrome
   c. Metabolic syndrome
   d. Wernicke’s encephalopathy
Orthorexia Comes of Age: Perspectives on the “Healthy” Eating Disorder

Marci Anderson, MS, CEDRD, LDN, CPT
Jessica Setnick, MS, RD, CEDRD-S

The History of Orthorexia
Orthorexia nervosa was coined and first used by Dr. Steven Bratman, MD in 1997 to describe an “obsession with healthy eating” that he observed among his family practice patients.1


Future Paths for Orthorexia
In 2016 an international panel was formed to begin the process of defining criteria for an orthorexia nervosa diagnosis. The proposed criteria will then need to be correlated with the actual human experience of orthorexia, to determine if they accurately identify and describe the behaviors and beliefs we are seeing in practice.

Once accurate criteria are in place, research will be needed to determine risk factors, create and evaluate treatment, describe what constitutes recovery/remission, possibly create prevention programs, and guide professionals on ethical issues.

Our field would benefit from being able to answer these currently unanswerable questions:

• How is orthorexia different from anorexia nervosa and from anxiety disorders such as obsessive-compulsive disorder or phobias?
• What makes orthorexia a mental illness as opposed to a personal choice about what and how to eat?
• How do we help individuals who must adhere to a specific medical diet to avoid becoming unhealthily obsessed with their eating?

• Can a person with orthorexia be compelled to receive treatment? Is it ethical to compel a person with orthorexia to violate his or her personal beliefs about eating to save his or her life?

Ultimately our goal as RDNs is to help all of our patients find the sweet spot of healthy eating that balances good nutrition and a good attitude about food and eating. For individuals with orthorexia, we may need different techniques to achieve the same goals.

The RDN Role
Because we assess our patients for their food-related stresses and issues, RDNs are the most likely of all health professionals to first identify an individual’s struggle with orthorexia.

Ideally we assess every patient for anxiety around eating and dysfunctional beliefs and behaviors with food, as well as self-esteem connected to food rules. If you are not already, you can start asking your patients these basic questions, and then follow up if the answers suggest there is a problem:

• Do you feel bad about yourself depending on what or how you eat? Do you ever punish yourself after eating something you shouldn’t have?
• Do you eat differently when you are alone as opposed to when there are other people around?
• How much of your day do you spend on food planning and preparation? Is this enjoyable or does it feel pressured and stressful?
• What happens when you are at a social function and you aren’t able to control what is served? Can you manage or do you feel nervous or guilty?

It is likely that orthorexia is the manifestation of some kind of mental illness through alterations in eating. Therefore successful treatment and recovery will likely require both medical nutrition therapy and mental health care.

In general RDNs are not trained to work closely with mental health professionals. Yet to be effective we need to become very comfortable communicating with our patients’ mental health care providers and making referrals to mental health care when needed.

If you work in a facility that offers mental health care, open a discussion with other members of your team about care for individuals with orthorexia. If you work in private practice or in a medical facility that does not provide mental health care, make connections with counselors, psychologists and psychiatrists in your area. Ascertain their experience, expertise and comfort working with individuals with eating disorders. Discuss the role that each of you will play and coordinate your treatment strategy on an ongoing basis.

RDNs are also excellent at providing personalized care that focuses on changing each person’s specific unhelpful behaviors. This is important in all areas of nutrition counseling, and it is essential in an area like orthorexia where we have no practice standards to guide us.

We have shared some of our experience here, and we know that many BHN RDNs are also helping patients with orthorexia. If you have had success helping someone with orthorexia, please consider writing about it so that other RDNs can learn from your experience. In the section to follow, Marci will share a case study to illustrate the assessment and counseling process.

Orthorexia: A Clinical Case Study by Marci Evans MS, CEDRD, LDN

The purpose of this case study is to bring theory into real life. I will share with you the assessment techniques and interventions I used in the treatment of a client who met the proposed diagnostic criteria established by Dr. Steven Bratman. Note: I have changed identifying information to protect the privacy of my client.

Meet Amy
• 29 year old female
• Lives with long-term boyfriend

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Orthorexia Comes of Age...

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- Clinical Psychology PhD Student
- History of trauma, illicit drug abuse, anxiety/depression, bulimia nervosa
  - reports none of these are currently an issue except for the anxiety
- Current: PCOS, dairy allergy
- Referred by her therapist

Her stated goals
1. Help me determine my nutritional needs & “make a plan”
2. Learn skills to decrease obsessive, perfectionist thinking and planning around food
3. My desire for perfect “health” has become opportunistic way for my old eating disorder to reemerge. I need your help to change that.
4. Balance, freedom, support, confidence

Assessment
I treat my assessment as an ongoing process rather than a one-time event at the first meeting. Below are a range of assessment questions and my impressions as I continued to get to know Amy. They are intended to reflect the myriad of domains an RDN must attend to when working with this population.

A Sampling of Basic Nutrition Assessment Questions
- What is your typical meal/snack pattern? Does it change during the week?
- Food prep, groceries, eating out, location, with whom, etc
- Food: loves, dislikes, fears, safe, binges, cravings, avoided
- Detoxes/Fasting, Cheat day

Marci’s Brief Impressions of Amy in Response to these Questions
- Calorically adequate, very low carbohydrate, repetitive, low satiety
- Detoxes and cleanses increasing with frequency and severity over past 6 months

A Sampling of Assessment Questions Related to Thoughts and Feelings About Food
- Time spent thinking about food & nutrition
- Emotions connected to food & eating
- Degree of deprivation, flexibility, spontaneity
- Social eating: where, with whom, how do you feel about it?
- Impact on social interactions & relationships

Marci’s Brief Impressions of Amy in Response to these Questions
- Significant strain on relationships & social interactions
- Hours each day reading about health and fitness negatively impacting school and work
- Consuming, stress, anxiety, guilt, shame, self-loathing
- Feelings of worthlessness- pure and clean eating giving her a feeling of value and purpose
- Psychological & emotional deprivation
- Major “carb” hang-up/clean eating/good/allowed

A Sampling of Assessment Questions Related to Body Image
- Likert Scale
  - Strongly Dislike → Dislike → Slightly Satisfied → Satisfied → Very Satisfied
- How do you feel about certain body parts/body composition
- Detailed weight history: correlate weight with age, life circumstances, mood, food and exercise behaviors
- Body checking: rituals, pinching, measuring, comparing, etc.
- Factors that alter perception or experience of body image: mood, beliefs about food, clothing, comparisons, menstrual cycle, social situations, etc.

Marci’s Brief Impressions of Amy in Response to these Questions
- Highly influenced by social media, social situations, and body checking
- Preoccupation with waist circumference, body composition measurements

A Sampling of Assessment Questions Related to Exercise
- Frequency, Type, Intensity, Time
- Attitudes & beliefs- i.e. why does exercising feel so important to you? What are your exercise goals?
- Relationship between food, exercise, and body image- i.e. do you have any rules about what you can/can’t eat based on exercise?
- Degree of flexibility- i.e. Do you ever miss planned workouts? If yes, how does that make you feel?
- Relationship between exercise & mental health
- Motivation to exercise
- Where & with whom

Marci’s Brief Impressions of Amy in Response to these Questions
- Positive mixed with problematic
- Untangle from food
- Feelings vs. appearance

Counseling Interventions
1. Build a treatment team. Orthorexia will likely have medical and mental health implications.
2. Take time to build rapport
  - Let Amy decide what feels most important to work on first. I often ask “what’s bothering you most about your current eating habits?”
  - “If you could change one thing, what would it be and why?”
  - If the client is not medically compromised, you have more leeway here.
3. Use Motivational Interviewing techniques to put the client in the driver’s seat and allow her to be her own advocate for change.
  - Open-Ended Questions: what about your eating isn’t working for you, what’s it like for you when…?, tell me more about that
  - Pros/Cons- developing an understanding of the benefits and costs of maintaining or changing behaviors is essential. “Even though your food rules keep you isolated, what are the positive feelings you get from no longer eating out at restaurants?”
4. Incorporate Acceptance and Commitment Therapy (ACT)
  - Complete a values assessment with your clients to target your interventions accordingly. Amy values personal relationships so she was willing to challenge some of her food rules so she could eat socially and in restaurants again.
5. Behavioral Interventions
  - Re-shaped her relationship to social media and online research: decreased time spent reading health articles from 3 hours to 30 minutes, deleted Instagram account, integrated body positive messaging into her social media feeds.

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Orthorexia Comes of Age...

continued from page 10

• Quit her gym due to its focus on body and performance measurements and found a gym that was more conducive to her goal of becoming less obsessed with perfection.
• Utilized food exposures to increase variety and satiety. Broadened her concept of health as encompassing physical, emotional, mental, relational, and spiritual to help her relax out of her perfectionism and fear-based thinking.

6. Bridge to Therapy
• Reflected both to Amy and her therapist how her obsession with managing her health was a false front for managing her social anxiety, feelings of deep-seeded inadequacy, and lack of self-worth.
• Reassured Amy that as we put health in its proper perspective she would be able to do the deeper work in therapy and ultimately be on the road to true well-being.

Jessica and I believe that the RDN is uniquely positioned to treat and significantly improve the lives of those patients suffering from Orthorexia. We hope this article and clinical case study empower you to feel greater confidence and skill when working in the eating disorder arena.

References

Caffeine Intoxication

Ruth Leyse-Wallace PhD

Caffeine, a methylxanthine, is a mild central nervous system stimulant. It inhibits chronotropic and inotropic activities of the adenosine receptor at moderate doses. At high doses it inhibits phosphodiesterase, causing accumulation of cAMP, and increases intracellular calcium. Toxic levels can result in severe hypokalemia, rhabdomyolysis, renal failure and lactatemia. Clinically it may simulate diabetic ketoacidosis.

Chronotropic: affecting the rate of rhythmic movements such as the heartbeat.
Inotropic: increasing or decreasing the force of muscular contractions

A case study reports a 27 year-old woman who had consumed 4 L of Coca Cola at a party two hours before being admitted to the hospital with tachycardia of 160 beats/minute, hyperglycemia of 289 mg/dL [N=70-200 mg/dL], hypokalemia of 2.24mm/L [N=3.5-5] and serum lactatemia of 5.94 mmol/L [N=0.5-2.2 mmol/L], among other S/S. Her urine was positive for ketones, glucose, leukocytes and erythrocytes.

Her consumption was approximately 10-10.5 mg caffeine/100 ml, or ~ 400-450 mg caffeine. A possible contributing factor to her condition was hyperglycemia, causing osmotic diuresis, leading to hyperinsulinemia, which caused an intracellular shift of potassium. A caffeine concentration of 50 mcg/ml indicates severe toxicity. Plasma caffeine of >80 mcg/ml or consuming >3 g of caffeine in a short period of time may cause death.

After 24 hours of observation this patient was free of symptoms.

Caffeine Intoxication is now included in the DSM5. The official diagnosis can be made when any 5 of the following symptoms are present: restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, or psychomotor agitation.

In addition to coffee, tea, colas, and over-the-counter pain relievers, sources of caffeine include liquid caffeine to mix with other beverages, caffeine shots, work-out supplements, and caffeine pills. Pure Caffeine Powder is sold in 124 gram packages and is gram per gram caffeine, providing 124,000 mg of caffeine per package. The FDA has sent warning letters to companies marketing caffeine powder.

References
http://www.caffeineinformer.com/caffeinated-killers

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Delegate Update
Cynthia Burke, MS, RD, LDN

The 2017 Virtual Spring House of Delegates (HOD) Meeting was held on April 22-23, 2017.

On Saturday, April 22nd the HOD conducted a dialogue session on Future Practice addressing the Mega Issue of How can credentialed nutrition and dietetics practitioners elevate the profession, expand opportunities, and enhance practice for the Second Century? The House Leadership Team shared efforts underway by the Academy and its organizational units to identify and meet the needs of the Second Century workforce.

Then, Delegates and meeting participants met to create a vision of a Second Century workplace, generate ideas to close the gap between current and future practice and identify recognized skills and professional development needed for current and future practitioners.

Areas identified by the Delegate’s visions of future practice ‘norms’ in the Second Century included Information Communication Technologies and Telehealth; Concierge Nutrition Practice Models, Nutrigenomics, Biometrics, and Personalized Nutrition; Integrating Behavioral Sciences - Mental, Emotional, And Spiritual Health; and Business, Consulting, and Entrepreneurism.

On Sunday, April 23rd the HOD continued the dialogue started at the Fall meeting on Wellness and Prevention and Appreciative Inquiry. Delegates and meeting participants described the stages of the Appreciative Inquiry process, formulated a plan for an open space session or follow-up session with constituents and identified additional uses for the Appreciative Inquiry process.

Voting:
After the virtual meeting two motions were crafted by the HOD leadership team. They are: 1. The Academy Bylaws Amendment, Associate Member Qualifications and Privileges of Membership; and 2. Academy Bylaws Amendment and CDR Nominations. The result of this vote will be available the end of May 2017.

As a reminder, efforts to advance education and credentialing are already underway and will be implemented over the next several years. The following is a brief summary.

CDR changed the degree requirement for dietitian registration eligibility, from a baccalaureate degree to a master’s degree, effective January 1, 2024. They have also launched the Essential Practice Competencies.

ACEND has released two versions of the draft standards for the associate, bachelor and master degree programs and is currently seeking public comment.

Additional in-depth information can be found at the CDR and ACEND websites.

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Visit www.eatrightFNCE.org to learn more today.
In the BHN Pipeline!

Check out the BHN website at bhndpg.org
- It features a calendar of events and opportunities to post activities related to our areas of practice. That can include local, state, national and international events sponsored by service and professional organizations, colleges and institutions, government and our members. You can submit an event for posting online.
- Check out the Marketplace in the shopping section where members can post books and guides that they developed and are for sale or services such as training and web-based resources.
- An online Forum in the member’s section where we encourage members to check out postings and to post your own general questions and share advice. Read the instructions to post and get started!
- Resources in all areas of practice are available on-line with links to national organizations, research, and more.
- There are six Case Studies with CEUs available in the member’s section.
- Additionally, there are nine Nutrition Fact sheets ready for use with your clients or others in the member’s section.
- There is always a recorded webinar to purchase or one to sign up for with a small fee or at no cost in the events section.

Communicating with Members
- Also, consider joining our EML to connect with about 300 BHN members at this time. Ask questions and get responses! This feature is in the member’s area on our website.

Mentoring program in the works
- We are continuing to work in developing our own program. We are looking for a member to coordinate this service with student member assistance. Please contact the Membership Chair if you have an interest in being a part of this program in any way.

BHN Speaker’s Bureau
- Go to the BHN website “Store” and the Speakers Bureau drop down to complete a survey if you are interested in participating.

Member survey
- Thank you to the 169 members who completed the member survey to get an idea of what people do, what they like about the DPG, what they would like to see the DPG do, and to get more participation in programs and services we want to provide. The survey went out the beginning of April for the month to collect 169 responses. The survey summary was distributed to the Executive Committee to review and use for program planning during and after the transition of officers meeting. The member survey is done every two years.

Membership
- We have 1714 members, up from 1681 last year. Student membership went from 276 to 295 this year.

Submit RDNs for BHN Awards!

It’s time to recognize colleges who demonstrate leadership and excellence in the field of behavioral health nutrition.

Nominations for awards are accepted beginning March 1, 2017. Start thinking about deserving BHN members.

There will be one recipient from each practice area and one distinguished member award.

Leadership may be demonstrated through this practice group and/or other work related to promotion of nutrition and health in populations served by BHN members. Leadership may also encompass contributions to the field in legislation, research, management, education, and publication.

Access BHN awards information and applications at http://www.bhndpg.org/members/awards-information/

Send your submission to chair@bhndpg.org.
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Contribute an article or topic for future BHNewsletter issues!
Contact
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or one of the BHN leaders listed in this newsletter.

A complete list of BHN Executive Committee members and volunteers is available at www.bhndpg.org.

Behavioral Health Nutrition Executive Officers 2016-2017

Mission: Empowering BHN members to excel in the areas of Addictions, Eating Disorders, Intellectual and Developmental Disabilities and Mental Health by providing resources and support.

Vision: Optimizing the physical and cognitive health of those we serve through nutrition education and behavioral health counseling.

Academy of Nutrition and Dietetics website: www.eatright.org
BHN website: bhndpg.org • BHN practice standards: www.bhndpg.org/members/practice-standards/